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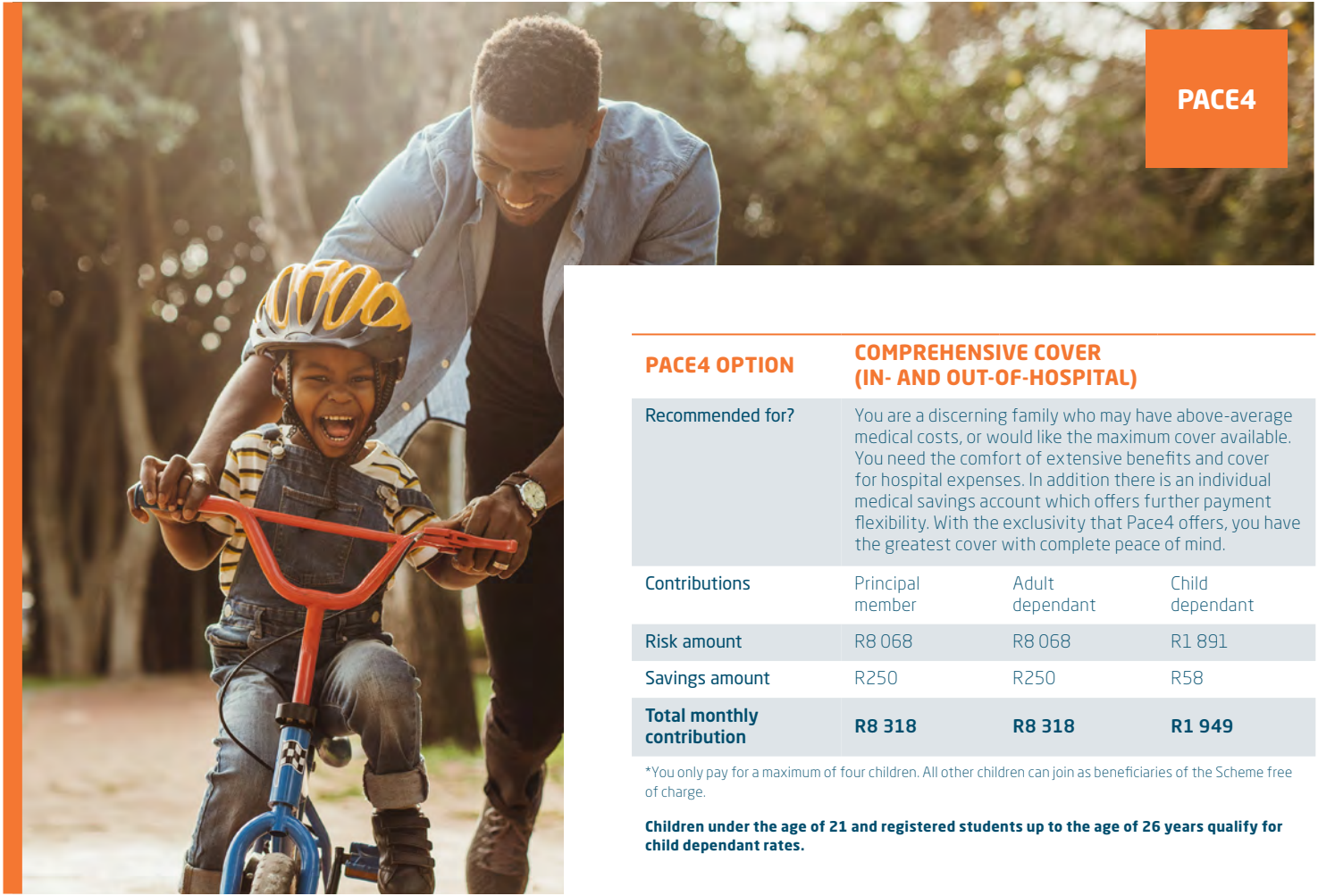

PACE4

PACE4 OPTION	COMPREHENSIVE COVER (IN- AND OUT-OF-HOSPITAL)		
Recommended for?	You are a discerning family who may have above-average medical costs, or would like the maximum cover available. You need the comfort of extensive benefits and cover for hospital expenses. In addition there is an individual medical savings account which offers further payment flexibility. With the exclusivity that Pace4 offers, you have the greatest cover with complete peace of mind.		
Contributions	Principal member	Adult dependant	Child dependant
Risk amount	R8 068	R8 068	R1 891
Savings amount	R250	R250	R58
Total monthly contribution	**R8 318**	**R8 318**	**R1 949**

*You only pay for a maximum of four children. All other children can join as beneficiaries of the Scheme free of charge.

Children under the age of 21 and registered students up to the age of 26 years qualify for child dependant rates.

PACE4 OPTION	COMPREHENSIVE COVER (IN- AND OUT-OF-HOSPITAL)
Savings account/Day-to-day benefits	Savings account available. Day-to-day benefits are available.
Value benefits	No co-payment or automatic self-payment gaps. Family Practitioner (FP) and Specialist consultations. Optometry. Dentistry. Maternity benefits.
Over-the-counter medicine	Savings account.

Method of benefit payment

On the Pace4 option in-hospital services, out-of-hospital services and preventative care are paid from Scheme risk. Once out-of-hospital risk benefits are depleted further claims will be paid from savings.

Benefits relating to conditions that meet the criteria for prescribed minimum benefits (PMBs) will be covered in full when using designated service providers (DSPs), and your annual and vested savings will not be affected.

In-hospital benefits

Note:

- All benefits mentioned below are subject to pre-authorisation, clinical protocols and funding guidelines
- Members are required to obtain pre-authorisation for all planned procedures at least 14 (fourteen) days before the event. However, in the case of an emergency, the member, their representative or the hospital must notify Bestmed of the member's hospitalisation as soon as possible or on the first working day after admission to hospital.
- Clinical protocols, preferred providers (PPs), designated service providers (DSPs), formularies, funding guidelines and the Mediscor Reference Price (MRP) may apply.

MEDICAL EVENT	SCHEME BENEFIT
Accommodation (hospital stay) and theatre fees	100% Scheme tariff.
Take-home medicine	100% Scheme tariff. Limited to 7 days' medicine.
Treatment in mental health clinics	100% Scheme tariff. Limited to 21 days per beneficiary.
Treatment of chemical and substance abuse	100% Scheme tariff. Limited to 21 days or R32 299 per beneficiary. Subject to network facilities.
Consultations and procedures	100% Scheme tariff.
Surgical procedures and anaesthetics	100% Scheme tariff.
Organ transplants	100% Scheme tariff.
Major medical maxillo-facial surgery strictly related to certain conditions	100% Scheme tariff.

MEDICAL EVENT	SCHEME BENEFIT
Dental and oral surgery (In- or out-of-hospital)	Limited to R20 187 per family.
Orthopaedic and medical appliances	100% Scheme tariff.
Pathology	100% Scheme tariff.
Basic radiology	100% Scheme tariff.
Specialised diagnostic imaging (Including MRI scans, CT scans and isotope studies. PET scans only included as indicated per option)	100% Scheme tariff.
Prosthesis (Subject to PP, otherwise limits and co-payments apply)	100% Scheme tariff. Limited to R134 419 per family.

Prosthesis – Internal
 	
Note: Sub-limit subject to the overall annual prosthesis limit.
 	
*Functional: Items utilised towards treating or supporting a bodily function.
	Sub-limits per beneficiary:
	• *Functional limited to R19 712
	• Vascular R49 873
	• Pacemaker (dual chamber) R62 637
	• Spinal including artificial disc R67 215
	• Drug-eluting stents R22 384
	• Mesh R19 712
	• Gynaecology/Urology R16 269
	• Lens implants R18 014 a lens per eye
	• Joint replacements:
	  • Hip replacement and other major joints R60 144
	  • Knee replacement R69 644
	  • Minor joints R22 384

Prosthesis – External	Limited to R30 993 per family. DSPs apply. Includes artificial limbs limited to 1 limb every 60 months.

MEDICAL EVENT	SCHEME BENEFIT
Oncology	Oncology programme. 100% of Scheme tariff. DSP applies. Access to extended protocols.
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation and DSPs.
Confinements (Birthing)	100% Scheme tariff.
Refractive surgery and all types of procedures to improve or stabilise vision (except cataracts)	100% Scheme tariff. Limited to R10 094 per eye.
Mammary surgery on the unaffected (non-cancerous) breast of a breast cancer patient	100% Scheme tariff for reconstructive surgery (which may include symmetrising, partial or total mastectomy etc.) on the unaffected (non-cancerous) breast of a breast cancer patient. The benefit is limited to R36 750 and is subject to pre-authorisation.
HIV/AIDS	100% Scheme tariff. Subject to pre-authorisation and DSPs.
Midwife-assisted births	100% Scheme tariff.
Supplementary services	100% Scheme tariff.
Alternatives to hospitalisation	100% Scheme tariff.
Palliative care and home-based care in lieu of hospitalisation	100% Scheme tariff. Limited to R15 000 per month over 3 months. Total benefit limited to R45 000. Subject to pre-authorisation and DSPs.

MEDICAL EVENT	SCHEME BENEFIT
Day procedures at a day-hospital facility	Day procedures at a day-hospital facility funded at 100% Scheme tariff. Subject to pre-authorisation. DSPs apply for PMBs.
International travel cover	Up to R10 million and a maximum of 90 days. Services rendered by Bryte Insurance and managed by ER24.
Emergency evacuation	Services rendered by ER24.

We are a Scheme managed by members, for members and will never compromise on quality service to you.

Out-of-hospital benefits

Note:

- Out-of-hospital benefits are paid at 100% Scheme tariff.
- Subject to sub-limits and benefits available in the day-to-day overall limit.
- Once the overall day-to-day limit is depleted the member may request payment from the savings account.
- Should you not use all of the funds available in your savings account these funds will be added to your savings account at the beginning of the following financial year.
- Clinical funding protocols, referred providers (PPs) designated service providers (DSPs), formularies, funding guidelines and the Mediscor Reference Price (MRP) may apply.
- Members are required to obtain pre-authorisation for all planned treatments and/or procedures.
- If you have a treatment plan for a registered Chronic Disease List (CDL) and/or Prescribed Minimum Benefit (PMB) condition/s, the services in the treatment plan will pay from the applicable day-to-day limit first. Once the limit is depleted, claims will continue to be paid from Scheme risk, up to the maximum quantity specified in the treatment plan.

MEDICAL EVENT	SCHEME BENEFIT
Overall day-to-day limit	M = R35 861, M1+ = R57 829.
FP and specialist consultations	Limited to M = R5 640, M1+ = R9 144. (Subject to overall day-to-day limit)
Diabetes primary care consultation	100% of Scheme tariff subject to registration with HaloCare. 2 primary care consultations at Dis-Chem Pharmacies limited to R359 per consulation. Paid first from the "FP and specialist consultations" day-to-day benefit, thereafter Scheme risk.
Basic and specialised dentistry	Limited to M = R12 454, M1+ = R21 021. (Subject to overall day-to-day limit) Orthodontics are subject to pre-authorisation.

MEDICAL EVENT	SCHEME BENEFIT
Medical aids, apparatus and appliances	Limited to R10 450 per family. Includes repairs to artificial limbs. (Subject to overall day-to-day limit)
Wheelchairs	Limited to R14 131 per family per 48 months.
Hearing aids	Limited to R36 098 per beneficiary per 24 months subject to pre-authorisation.
Insulin pump (excluding consumables)	100% Scheme tariff. Limited to R42 000 per beneficiary every 24 months. Subject to pre-authorisation.
Supplementary services	Limited to M = R5 640, M1+ = R11 102. (Subject to day-to-day overall limit)
Wound care benefit (incl. dressings, negative pressure wound therapy treatment and related nursing services - out-of-hospital)	Limited to R13 774 per family. (Subject to overall day-to-day limit)
Optometry benefit (PPN capitation provider)	Benefits available every 24 months from date of service. **Network Provider (PPN)** • Consultation - 1 per beneficiary. • Frame = R825 covered **AND** • 100% of cost of standard lenses (single vision **OR** bifocal **OR** multifocal) **OR** • Contact lenses = R1 850 **OR** **Non-network Provider** • Consultation - R350 fee at non-network provider • Frame = R598 **AND** • Single vision lenses = R210 **OR** • Bifocal lenses = R445 **OR** • Multifocal lenses = R770 • In lieu of glasses members can opt for contact lenses, limited to R1 850.

MEDICAL EVENT	SCHEME BENEFIT
Basic radiology and pathology	Limited to M = R5 640, M1+ = R11 102. (Subject to overall day-to-day limit)
Specialised diagnostic imaging (Including MRI scans, CT scans and isotope studies. PET scans only included as indicated per option)	MRI/CT scans: Maximum of 3 scans per beneficiary. PET scan: 1 scan per beneficiary. Subject to pre-authorisation.
Rehabilitation services after trauma	100% Scheme tariff.
HIV/AIDS	100% Scheme tariff. Subject to pre-authorisation and DSPs.
Oncology	Oncology programme. 100% of Scheme tariff. DSP applies. Access to extended protocols.
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation and DSPs.

Medicine

Note:

- Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers (PPs), designated service providers (DSPs), formularies, funding guidelines and the Mediscor Reference Price (MRP).
- Members will not incur co-payments for Prescribed Minimum Benefit (PMB) medications that are on the formulary for which there is no generic alternative.
- Approved Prescribed Minimum Benefit (PMB) biological and non-Prescribed Minimum Benefit (PMB) biological medicine costs will be paid from the Biological limit first. Once the limit is depleted, only PMB biological medicine costs will continue to be paid unlimited from Scheme risk.

*Please note that approved CDL, PMB and non-CDL chronic medicine costs will be paid from the non-CDL limit first. Thereafter, approved CDL and PMB chronic medicine costs will continue to be paid (unlimited) from Scheme risk.

BENEFIT DESCRIPTION	SCHEME BENEFIT
CDL and PMB chronic medicine*	100% Scheme tariff. Co-payment of 20% for non-formulary medicine.
Non-CDL chronic medicine*	28 conditions. 90% Scheme tariff. Limited to M = R19 889, M1+ = R39 958. Co-payment of 15% for non-formulary medicine.
Biologicals and other high-cost medicine	Limited to R492 077 per beneficiary.
Acute medicine	Limited to M = R8 906, M1+ = R13 834. 10% co-payment. (Subject to overall day-to-day limit)
Over-the-counter (OTC) medicine	Savings account.

Chronic conditions list

CDL	
CDL 1	Addison's disease
CDL 2	Asthma
CDL 3	Bipolar mood disorder
CDL 4	Bronchiectasis
CDL 5	Cardiomyopathy
CDL 6	Chronic renal disease
CDL 7	Chronic obstructive pulmonary disease (COPD)
CDL 8	Cardiac failure
CDL 9	Coronary artery disease
CDL 10	Crohn's disease
CDL 11	Diabetes insipidus
CDL 12	Diabetes mellitus type 1
CDL 13	Diabetes mellitus type 2
CDL 14	Dysrhythmias
CDL 15	Epilepsy
CDL 16	Glaucoma
CDL 17	Haemophilia
CDL 18	Hyperlipidaemia
CDL 19	Hypertension
CDL 20	Hypothyroidism
CDL 21	Multiple sclerosis
CDL 22	Parkinson's disease
CDL 23	Rheumatoid arthritis
CDL 24	Schizophrenia

CDL

CDL 25	Systemic lupus erythematosus (SLE)
CDL 26	Ulcerative colitis

NON-CDL

Non-CDL 1	Acne - severe
Non-CDL 2	Attention deficit disorder/Attention deficit hyperactivity disorder (ADD/ADHD)
Non-CDL 3	Allergic rhinitis
Non-CDL 4	Eczema – severe
Non-CDL 5	Migraine prophylaxis
Non-CDL 6	Gout prophylaxis
Non-CDL 7	Major depression
Non-CDL 8	Obsessive compulsive disorder
Non-CDL 9	Osteoporosis
Non-CDL 10	Psoriasis
Non-CDL 11	Urinary incontinence
Non-CDL 12	Paget's disease
Non-CDL 13	Gastro oesophageal reflux disease (GORD)
Non-CDL 14	Ankylosing spondylitis
Non-CDL 15	Hypopituitarism
Non-CDL 16	Osteoarthritis
Non-CDL 17	Alzheimer's disease
Non-CDL 18	Collagen diseases
Non-CDL 19	Dermatomyositis
Non-CDL 20	Motor neuron disease
Non-CDL 21	Neuropathy

NON-CDL

Non-CDL 22	Polyarteritis nodosa
Non-CDL 23	Scleroderma
Non-CDL 24	Sjögren's disease
Non-CDL 25	Trigeminal neuralgia
Non-CDL 26	Psoriatic arthritis
Non-CDL 27	Blepharospasm
Non-CDL 28	Dystonia

PMB

PMB 1	Aplastic anaemia
PMB 2	Chronic anaemia
PMB 3	Benign prostatic hypertrophy
PMB 4	Cushing's disease
PMB 5	Cystic fibrosis
PMB 6	Endometriosis
PMB 7	Female menopause
PMB 8	Fibrosing alveolitis
PMB 9	Graves' disease
PMB 10	Hyperthyroidism
PMB 11	Hypophyseal adenoma
PMB 12	Idiopathic thrombocytopenic purpura
PMB 13	Paraplegia/Quadriplegia
PMB 14	Polycystic ovarian syndrome
PMB 15	Pulmonary embolism
PMB 16	Stroke

Preventative care benefits

Note: Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers (PPs), designated service providers (DSPs), formularies, funding guidelines and the Mediscor Reference Price (MRP).

PREVENTATIVE CARE BENEFIT	GENDER AND AGE GROUP	QUANTITY AND FREQUENCY	BENEFIT CRITERIA
Flu vaccines	All ages.	1 per beneficiary per year.	Applicable to all active members and beneficiaries.
Pneumonia vaccines	Children <2 years. High-risk adult group.	Children: As per schedule of Department of Health. Adults: Twice in a lifetime with booster above 65 years of age.	Adults: The Scheme will identify certain high-risk individuals who will be advised to be immunised.
Travel vaccines	All ages.	Quantity and frequency depending on product up to the maximum allowed amount.	Mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits.
Paediatric immunisations	Babies and children.	Funding for all paediatric vaccines according to the state-recommended programme.	
Female contraceptives	All females of child-bearing age.	Quantity and frequency depending on product up to the maximum allowed amount. Mirena device - 1 device every 60 months.	Limited to R2 315 per beneficiary per year. Includes all items classified in the category of female contraceptives.
Back and neck preventative programme	All ages.	Subject to pre-authorisation.	Preferred providers (DBC/Workability Clinics). This is a preventative programme with the objective of preventing back and neck surgery. The Scheme may identify appropriate participants. Based on the first assessment, a rehabilitation treatment plan is drawn up and initiated over an uninterrupted period that will be specified by the provider.
Preventative dentistry	Refer to preventative dentistry section for details.		

PREVENTATIVE CARE BENEFIT	GENDER AND AGE GROUP	QUANTITY AND FREQUENCY	BENEFIT CRITERIA
Haemophilus influenzae Type B vaccine (HIB)	Children 5 years and younger.	1 vaccine at 6, 10 and 14 weeks after birth. 1 booster vaccine between 15 and 18 months.	If the booster vaccine was not administered timeously the maximum age to which it will be allowed is 5 years.
Mammogram	Beneficiaries (male and female) 40 years and older.	Once every 24 months.	Scheme tariff is applicable.
PSA screening	Males 50 years and older.	Once every 24 months.	Can be done at a urologist or FP. Consultation paid from the available consultation benefit/savings.
HPV vaccinations	Females 9-26 years of age.	3 vaccinations per beneficiary.	Vaccinations will be funded at MRP.
Bone densitometry	All beneficiaries 45 years and older.	Once every 24 months.	
Pap smear	Females 18 years and older.	Once every 24 months.	Can be done at a gynaecologist or FP. Consultation paid from the available consultation benefit/savings.

PREVENTATIVE CARE BENEFIT

Bestmed Tempo wellness programme Note: Completing your Health Assessment (previously HRA) unlocks the other Bestmed Tempo benefits. One parent must complete their Health Assessment (previously HRA) in order to unlock assessments for beneficiaries younger than 18.	The Bestmed Tempo wellness programme is focused on supporting you on your path to improving your health and realising the rewards that come with it. To ensure you achieve this, you will have access to the following benefits: Bestmed Tempo Health Assessment (previously HRA) for adults (beneficiaries 18 and older) which includes one of each of the following per year per adult beneficiary: • The Bestmed Tempo lifestyle questionnaire • Blood pressure check • Cholesterol check • Glucose check • HIV screening • Height, weight and waist circumference These assessments need to be done at a contracted pharmacy or on-site at participating employer groups. Bestmed Tempo Child Health Assessments: • Ages 13-17 years: Assessment performed by a Bestmed Tempo partner biokineticist (1 per beneficiary per year) • Ages 3-12 years: Assessment performed by a Bestmed Tempo partner occupational therapist (1 per beneficiary per year) • Ages 0-2 years: Baby growth and development assessments done at a Bestmed Tempo partner pharmacy clinic – 3 assessments per beneficiary per year Bestmed Tempo Nutrition Assessment: • Family nutritional assessment at a Bestmed Tempo partner dietitian (1 assessment per family per year). Bestmed Tempo Fitness and Nutrition programmes (beneficiaries 18 and older): • 3 personalised consultations with a Bestmed Tempo partner biokineticist • 3 personalised consultations with a Bestmed Tempo partner dietitian Bestmed Tempo Group Classes: • A range of group classes throughout the year to help encourage and support a healthier lifestyle regardless of your age or health status
Maternity benefits	100% Scheme tariff. Subject to the following benefits: Consultations: • 9 antenatal consultations at a FP **OR** gynaecologist **OR** midwife. • 1 post-natal consultation at a FP **OR** gynaecologist **OR** midwife. Ultrasounds**:** • 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a FP **OR** gynaecologist **OR** radiologist. • 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a FP **OR** gynaecologist **OR** radiologist. Supplements: • Any item categorised as a maternity supplement can be claimed up to a maximum of R100 per claim, once a month, for a maximum of 9 months.

Maternity care programme

Finding out you are pregnant comes with a whole lot of emotions, questions and information. Sometimes just knowing where to start and which information you can trust can be a challenge.

Pregnant members and dependants have access to the Maternity care programme. The programme provides comprehensive information and services and was designed with the needs of expectant parents and their support network in mind. We aim to give you support, education and advice through all stages of your pregnancy, the confinement and postnatal (after birth) periods.

Members need to register on the Bestmed Maternity care programme as soon as they receive confirmation of their pregnancy by means of a pathology test and/or scan from your family practitioner or gynaecologist. After you complete your registration, a consultant will contact you. If your pregnancy is associated with risks, the information will be forwarded to Bestmed's case managers who will contact you to help monitor your progress.

Please note that registering on the Maternity care programme does not confirm any other maternity benefits nor does it provide authorisation for the delivery as these benefits are subject to the Scheme's rules and underwriting. To enquire about these benefits please contact service@bestmed.co.za.

How to register:

Send an email to maternity@bestmed.co.za or call us on 012 472 6797.
Please include your medical scheme number and your expected delivery date in the email.

After registering on this programme you will receive:

- A welcome pack containing an informative pregnancy book about the stages of pregnancy.
- Maternity/baby gift. The selection form will be sent to you after the 12th week of your pregnancy.
- Access to a 24-hour medical advice line.
- Benefits through each phase of your pregnancy.

Preventative dentistry

Note:

Services mentioned below may be subject to pre-authorisation, clinical protocols and funding guidelines.

DESCRIPTION OF SERVICE	AGE	FREQUENCY
General full-mouth examination by a general dentist (incl. gloves and use of sterile equipment for the visit)	12 years and above. Under 12 years.	Once a year. Twice a year.
Full-mouth intra-oral radiographs	All ages.	Once every 36 months.
Intra-oral radiograph	All ages.	2 photos per year.
Scaling and/or polishing	All ages.	Twice a year.
Fluoride treatment	All ages.	Twice a year.
Fissure sealing	Up to and including 21 years.	In accordance with accepted protocol.
Space maintainers	During primary and mixed denture stage.	Once per space.

Disclaimer: General and option-specific exclusions apply.
Please refer to www.bestmed.co.za for more details.

Abbreviations

CDL = Chronic Disease List; DBC = Documentation Based Care (back rehabilitation programme); FP = Family Practitioner or Doctor; HPV = Human Papilloma Virus; M = Member; M1+ = Member and family; MRI/CT Scans = Magnetic Resonance Imaging/Computed Tomography Scans; MRP = Mediscor Reference Price; NPWT = Negative Pressure Wound Therapy; PET Scan = Positron Emission Tomography Scan; PPN = Preferred Provider Negotiators; PSA = Prostate Specific Antigen; PMB = Prescribed Minimum Benefit;

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Claims: travelclaims@brytesa.com

BESTMED HOTLINE, OPERATED BY KPMG
Should you be aware of any fraudulent, corrupt or unethical practices involving Bestmed, members, service providers or employees, please report this anonymously to KPMG.

Hotline:	080 111 0210 toll-free from any Telkom line
Hotfax:	080 020 0796
Hotmail:	fraud@kpmg.co.za
Postal:	KPMG Hotpost, at BNT 371, PO Box 14671, Sinoville, 0129, South Africa

For a more detailed overview of your benefit option and to receive a membership guide please contact service@bestmed.co.za.

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