

2025



Pace1

Benefit Summary

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PACE1 OPTION	COMPREHENSIVE COVER (IN- AND OUT-OF-HOSPITAL)		
Recommended for?	Those seeking comprehensive in-hospital and out-of-hospital benefits as well as extensive day-to-day benefits to cover extensive out-of-hospital expenses.		
Contributions	Principal member	Adult dependant	Child dependant
Risk amount	R4 622	R3 247	R1 166
Medical savings account	R1 085	R761	R274
Total monthly contribution	R5 706	R4 008	R1 440

* You pay for a maximum of three children. Any additional children can join as beneficiaries of the Scheme at no additional cost.

Dependants under the age of 24 years are regarded as child dependants.

PACE1 OPTION	COMPREHENSIVE COVER (IN- AND OUT-OF-HOSPITAL)
Savings account/ Day-to-day benefits	Savings account available. Day-to-day benefits are available.

Method of benefit payment

On the Pace1 option in-hospital benefits are paid from the Scheme risk. Some out-of-hospital benefits are paid from the annual savings first and once depleted will be paid from the day-to-day benefit. Once the day-to-day benefit is depleted, claims can be paid from the available vested savings. Some preventative care benefits are available from the Scheme risk benefit.

Benefits relating to conditions that meet the criteria for Prescribed Minimum Benefits (PMBs) will be covered in full when using designated service providers (DSPs). This will not affect your savings (annual or vested).

In-hospital benefits

Note:

- All members must obtain pre-authorisation for planned procedures at least 14 (fourteen) days before the event. However, in the case of an emergency, you, your representative or the hospital must notify Bestmed of your hospitalisation as soon as possible or on the first working day after admission to hospital.
- Clinical protocols, preferred providers, 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 if claimed on the day of discharge. Limited to: ▪ A maximum of 7 days treatment if claimed as part of the hospital account, or ▪ R200 if claimed from a retail pharmacy on the day of discharge. No benefit if not claimed on the date of discharge.
Biological medicine during hospitalisation	Limited to R34 828 per family per annum. Subject to pre-authorisation and funding guidelines.
Treatment in mental health facilities	Approved PMBs at DSPs. Limited to a maximum of 21 days per beneficiary per financial year in hospital including inpatient electroconvulsive therapy and inpatient psychotherapy, OR 15 contact sessions for out-patient psychotherapy per beneficiary per financial year. Subject to pre-authorisation.
Treatment of chemical and substance abuse	Benefits shall be limited to the treatment of PMB conditions and subject to the following: ▪ Pre-authorisation ▪ DSPs ▪ 21 days' stay for in-hospital management per beneficiary per annum.
Consultations and procedures	100% Scheme tariff.
Surgical procedures and anaesthetics	100% Scheme tariff.

MEDICAL EVENT	SCHEME BENEFIT
Organ transplants	100% Scheme tariff (PMBs only).
Stem cell transplants	100% Scheme tariff. (PMBs only)
Major maxillofacial surgery, strictly related to certain conditions	100% Scheme tariff. Limited to R15 800 per family per annum.
Dental and oral surgery (in or out of hospital)	Limited to R9 768 per family per annum.
(Prosthesis sub-limits form part of overall Internal prosthesis limit subject to preferred provider, otherwise limits and co-payments apply)	100% Scheme tariff. Limited to R109 167 per family per annum.
Prosthesis – Internal	Sub-limits per beneficiary per annum: *Functional R37 342. - Vascular R71 390. - Pacemaker (single and dual chamber) R67 943. - Spinal including artificial disc R39 788. - Drug-eluting stents - subject to Vascular prosthesis limit. - Mesh R14 939. - Gynaecology/urology R10 773. - Lens implants R8 188 a lens per eye.
Note: sub-limits form part of overall Internal prosthesis subject to availability of overall prosthesis limit.	
*Functional: Items used to replace or augment an impaired bodily function.	
Exclusions (Prosthesis sub-limits form part of overall Internal prosthesis limit subject to preferred provider, otherwise limits and co-payments apply)	Joint replacement surgery (except for PMBs). PMBs subject to prosthesis limits: - Hip replacement and other major joints R40 506. - Knee replacement R53 866. - Other minor joints R16 735.

MEDICAL EVENT	SCHEME BENEFIT
Prosthesis – External	Limited to R27 723 per family. DSPs apply. Includes artificial limbs limited to 1 limb every 60 months. Repair work to artificial limbs will be funded from the out-of-hospital Medical aids, apparatus and appliances benefit.
Orthopaedic and medical appliances Note: Appliances directly relating to the hospital admission and/or procedure	100% Scheme tariff. Limited to R15 000 per family per annum. Subject to PMB level of care.
Pathology	100% Scheme tariff.
Basic radiology	100% Scheme tariff.
Specialised diagnostic imaging - in and/or out of hospital (including MRI scans, CT scans and nuclear/isotope studies). PET scans only included as indicated per benefit option.	100% Scheme tariff. Limited to a combined in- and out-of-hospital benefit of R40 000 per family per annum. Co-payment of R2 000 per scan, not applicable for PMBs. PET scans are limited to one (1) scan per beneficiary per annum. Not subject to the abovementioned limit and co-payment. Subject to pre-authorisation.
Oncology	Oncology programme. 100% Scheme tariff. Subject to pre-authorisation, protocols and DSP.
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation and DSPs.
Confinements (birthing)	100% Scheme tariff.
Midwife-assisted births	100% Scheme tariff.

MEDICAL EVENT	SCHEME BENEFIT
Breast surgery for cancer	Treatment of the unaffected (non-cancerous) breast will be limited to PMB provisions and is subject to pre-authorisation and funding guidelines.
Refractive surgery and other procedures done to improve or stabilise vision (except cataracts)	100% Scheme tariff. Subject to pre-authorisation and protocols. Limited to R10 859 per eye.
HIV/AIDS	100% Scheme tariff. Subject to pre-authorisation and DSPs.
Supplementary services	100% Scheme tariff.
Alternative to hospitalisation (i.e. procedures done in the doctor's rooms)	100% Scheme tariff.
Advanced illness benefit	100% Scheme tariff, limited to R87 068 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.
Day procedures	Day procedures performed in a day hospital by a DSP provider will be funded at 100% network or Scheme tariff, subject to pre-authorisation, protocols, funding guidelines and DSPs. A co-payment of R2 746 will be incurred per event if a day procedure is done in an acute hospital that is not a day hospital. If a DSP is used and the DSP does not work in a day hospital, the procedure shall be paid in full if it is done in an acute hospital, if it is arranged with the Scheme before the time.

MEDICAL EVENT	SCHEME BENEFIT
International medical travel cover	- Holiday travel: Limited to 90 days and R5 000 000 per family, i.e. members and dependants. Limited to R1 000 000 per family for travel to the USA. - Business travel: Limited to 60 days and R5 000 000 per family, i.e. members and dependants. Limited to R1 000 000 per family for travel to the USA.



Out-of-hospital benefits

Note:

- Some indicated benefits are paid from the annual savings at 100% Scheme tariff.
- Once the annual savings account is depleted benefits will be paid from Scheme risk at 100% Scheme tariff (limits apply).
- Should you not use all of the funds available in your savings account these funds will be transferred into a vested savings account after 5 months and will remain your property.
- Any vested credit in your vested savings account may be used for out-of-hospital expenses that are not covered by the Scheme, or should you, for instance, have reached your out-of-hospital/day-to-day overall annual limit or the sub-limits as indicated in your benefit guide.
- Clinical funding protocols, preferred 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 specified in the treatment plan.

MEDICAL EVENT	SCHEME BENEFIT
Overall day-to-day limit	M = R13 187, M1+ = R26 373.
General Practitioner (GP), nurse and specialist consultations	Savings first. Limited to M = R2 715, M1+ = R5 459. (Subject to overall day-to-day limit)
Basic and specialised dentistry	Savings and then from day-to-day limits. Orthodontic: Subject to pre-authorisation. Limited to M = R4 998, M1+ = R10 142. (Subject to overall day-to-day limit)
Medical aids, apparatus and appliances	Savings first. Limited to R13 934 per family. Includes repairs to artificial limbs. 100% Scheme tariff. (Subject to overall day-to-day limit).
Continuous/Flash Glucose Monitoring (CGM/FGM)	Refer to medical aids, apparatus and appliances limit listed above.
Wheelchairs	Subject to medical apparatus and appliance limits.
Hearing aids (Subject to pre-authorisation)	Limited to R9 678 per family every 24 months. 100% Scheme tariff. Subject to pre-authorisation
Supplementary services	Savings first. Limited to M = R5 329, M1+ = R11 061. (Subject to overall day-to-day limit)
Wound care benefit (including dressings, negative pressure wound therapy treatment and related nursing services - out-of-hospital)	100% Scheme tariff. Savings first. Limited to R4 381 per family. (Subject to overall day-to-day limit)

MEDICAL EVENT	SCHEME BENEFIT
Optometry benefit	Benefits available every 24 months from date of service. Network Provider (PPN) - Consultation - One (1) per beneficiary. - Frame = R1 210 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) OR - Contact lenses = R2 025 OR Non-network Provider - Consultation - R400 fee at non-network provider - Frame = R908 AND - Single vision lenses = R215 OR - Bifocal lenses = R460 OR - Multifocal lenses = R1 040 (consisting of R810 per base lens plus R230 per branded lens add-on) In lieu of glasses members can opt for contact lenses, limited to R2 025
Basic radiology and pathology	100% Scheme tariff. Savings first. Limited to M = R3 950, M1+ = R7 901. (Subject to overall day-to-day limit)
Specialised diagnostic imaging - in and/or out of hospital (including MRI scans, CT scans and nuclear/isotope studies). PET scans only included as indicated per benefit option.	100% Scheme tariff. Limited to a combined in- and out-of hospital benefit of R40 000 per family per annum. Co-payment of R2 000 per scan, except for an involuntary use of a non-DSP for a PMB condition. PET scans are limited to one (1) scan per beneficiary per annum. Not subject to the aforementioned limit and co-payment. Subject to pre-authorisation.

MEDICAL EVENT	SCHEME BENEFIT
Rehabilitation services after trauma	100% Scheme tariff.
Back and neck preventative programme	Benefits payable at 100% of contracted fee. Subject to pre-authorisation, protocols and DSPs.
HIV/AIDS	100% Scheme tariff. Subject to pre-authorisation and DSPs.
Oncology	Oncology programme. 100% of Scheme tariff. Subject to pre-authorisation, protocols and DSP.
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation and DSPs.



Medicine benefits

Note:

- Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers (PPs), designated service providers (DSPs), formularies, funding guidelines, the Mediscor Reference Price (MRP) and the exclusions referred to in Annexure C of the registered Rules.
- Members will not incur co-payments for approved PMB medications that are on the formulary for which there is no generic alternative.

BENEFIT DESCRIPTION	SCHEME BENEFIT
CDL and PMB chronic medicine*	100% Scheme tariff. Co-payment of 25% for non-formulary medicine.
Non-CDL chronic medicine*	7 conditions. 90% Scheme tariff. Limited to M = R8 044, M1+ = R16 087. Co-payment of 25% for non-formulary medicine.
Biological medicine	PMBs only as per funding protocol.
Other high-cost medicine	100% Scheme tariff. Subject to pre-authorisation.
Acute medicine	Savings first. Limited to M = R2 846, M1 + = R5 890. (Subject to overall day-to-day limit)
Over-the-counter (OTC) medicine	**Member choice: 1. R1 161 OTC limit OR 2. Access to full savings for OTC purchases (after R1 161 limit) = self-payment gap accumulation. Includes sunscreen, vitamins and minerals with NAPPI codes on Scheme formulary. Subject to the available savings.

*Please note that the approved Chronic Disease List (CDL), Prescribed Minimum Benefit (PMB) and non-Chronic Disease List (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.

Approved medicine for the following conditions are not subject to the Chronic medicine limit: organ transplant, chronic renal failure, multiple sclerosis and haemophilia. Medicine claims will be paid directly from Scheme risk.

**The default OTC choice is 1. R1 161 OTC limit per family. Members wishing to choose the self-payment gap accumulation option are welcome to contact Bestmed.



Chronic conditions list

CDL	
CDL 1	Addison disease
CDL 2	Asthma
CDL 3	Bipolar disorder
CDL 4	Bronchiectasis
CDL 5	Cardiac failure
CDL 6	Cardiomyopathy
CDL 7	Chronic obstructive pulmonary disease (COPD)
CDL 8	Chronic renal disease
CDL 9	Coronary artery disease
CDL 10	Crohn 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	HIV/AIDS
CDL 19	Hyperlipidaemia
CDL 20	Hypertension
CDL 21	Hypothyroidism
CDL 22	Multiple sclerosis
CDL 23	Parkinson disease

CDL	
CDL 24	Rheumatoid arthritis
CDL 25	Schizophrenia
CDL 26	Systemic lupus erythematosus (SLE)
CDL 27	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*

*Approved medicine claims will continue to be paid from Scheme risk once the non-CDL limit is depleted.

PMB	
PMB 1	Aplastic anaemia
PMB 2	Benign prostatic hyperplasia
PMB 3	Cerebral palsy
PMB 4	Chronic anaemia
PMB 5	COVID-19
PMB 6	Cushing disease

PMB

PMB 7	Endometriosis
PMB 8	Female menopause
PMB 9	Fibrosing alveolitis
PMB 10	Graves disease
PMB 11	Hyperthyroidism
PMB 12	Hypophyseal adenoma
PMB 13	Idiopathic thrombocytopenic purpura
PMB 14	Paraplegia/quadriplegia
PMB 15	Polycystic ovarian syndrome
PMB 16	Pulmonary embolism
PMB 17	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.	
Baby growth and development assessments	0-2 years.	3 assessments per year.	Assessments are done at a Bestmed Network Pharmacy Clinic.
Female contraceptives	All females of child-bearing age.	Quantity and frequency depending on product up to the maximum allowed amount.	Limited to R2 678 per beneficiary per year. Includes all items classified in the category of female contraceptives.
Intrauterine device (IUD) insertion	All females of child-bearing age.	1 device every 5 years.	Consultation and procedure by a gynaecologist or GP.
Preventative dentistry	Refer to the preventative dentistry section p. 12 for details.		
Mammogram	Females 40 years and older.	Once every 24 months.	100% Scheme tariff.
PSA screening	Males 50 years and older.	Once every 24 months.	Can be done at a urologist, GP or network pharmacy clinic. Consultation paid from the available savings/consultation benefit.
HPV vaccinations	Females 9-26 years of age.	3 vaccinations per beneficiary.	Vaccinations will be funded at MRP.
Pap smear (procedure and consultation)	Females 18 years and older.	Once every 24 months.	Can be done at a gynaecologist, GP or pharmacy clinic.

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

Preventative dentistry

Note:

Benefits below may be subject to pre-authorisation, clinical protocols, preferred providers (PPs), designated service providers (DSPs), formularies and funding guidelines.

DESCRIPTION OF SERVICE	AGE	FREQUENCY
General full-mouth examination by a general dentist (including 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 (i.e. every 6 months from the date of service).
Fluoride treatment	All ages.	Twice a year (i.e. every 6 months from the date of service).
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 detail.

Abbreviations

CDL = Chronic Disease List; DBC = Documentation Based Care (back rehabilitation programme); GP = General Practitioner or Doctor; HPV = Human Papilloma Virus; M = Member; M1+ = Member and family; MRP = Mediscor Reference Price; NPWT = Negative Pressure Wound Therapy; PMB = Prescribed Minimum Benefits; PPN = Preferred Provider Negotiators.



Maternity benefits

Note:

Benefits below may be subject to registration, preferred providers (PPs), designated service providers (DSPs), formularies, funding guidelines and the Mediscor Reference Price (MRP).

100% Scheme tariff. Subject to the following benefits:

Consultations:

- 9 antenatal consultations at a GP OR gynaecologist OR midwife.
- 1 post-natal consultation at a GP OR gynaecologist OR midwife.

Ultrasounds:

- 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a GP OR gynaecologist OR radiologist.
- 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a GP OR gynaecologist OR radiologist.

Supplements:

- Any item categorised as a maternity supplement can be claimed up to a maximum of R139 per claim, once a month, for a maximum of 9 months.

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

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) period.

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 GP 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 registration on the Maternity care programme, you will also receive the Bestmed Maternity care programme registration confirmation letter, indicating all necessary information as stated below:

Our third-party service provider, DLA, will be in contact within the next two to three weeks via email, requesting you to complete a registration form. Keep an eye on your inbox (including the spam folder) for this email. Completing this form will ensure you are registered on their database to ensure you receive maternity information, additional support if the pregnancy is identified as a high-risk pregnancy and a gift on behalf of Bestmed after 14 weeks gestation. DLA will guide you through the process of selecting a gift.

The registration form and gift selection form must be returned to DLA directly. The maternity gift will only be sent after week 14 of your pregnancy.

Registration also provides you with access to a 24-hour medical advice line and benefits through each phase of your pregnancy.



Tempo



Bestmed Tempo wellness programme

Note: Completing your Tempo Lifestyle Screening unlocks the other Bestmed Tempo benefits.

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:

Tempo Lifestyle Screening for adults (beneficiaries 16 years and older) which includes one of each of the following per year per adult beneficiary:

- The Tempo lifestyle questionnaire
- Blood pressure check
- Cholesterol check
- Glucose check
- Height and weight measurement

These screenings need to be done at a contracted pharmacy, Tempo partner biokineticist, or on-site at participating employer groups.

Bestmed Tempo physical wellbeing and nutrition benefits (beneficiaries 16 and older):

Physical wellbeing

- 1 x (face-to-face) physical health assessment at a Tempo partner biokineticist
- 1 x follow-up (virtual or face-to-face) consult to obtain your personalised exercise plan from the Tempo partner biokineticist

Nutrition

- 1 x (face-to-face) nutrition assessment at a Tempo partner dietitian
- 1 x follow-up (virtual or face-to-face) consult to obtain your personalised healthy-eating plan from the Tempo partner dietitian

In addition to the Tempo physical wellbeing and nutrition benefits, you will also have access to Tempo Wellness Webinars hosted monthly. The webinars are themed around mental health and various other wellness-related topics.

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



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 **068 376 7212**
 **012 472 6500**
 **www.bestmed.co.za**
 **Bestmed Medical Scheme**
 **Bestmed Medical Scheme**



HOSPITAL AUTHORISATION

Tel: 080 022 0106
Email: authorisations@bestmed.co.za

CHRONIC MEDICINE

Tel: 086 000 2378
Email: medicine@bestmed.co.za
Fax: 012 472 6760

CLAIMS

Tel: 086 000 2378
Email: service@bestmed.co.za (queries)
claims@bestmed.co.za (claim submissions)

MATERNITY CARE

Tel: 012 472 6797
Email: maternity@bestmed.co.za

WALK-IN FACILITY

Block A, Glenfield Office Park,
361 Oberon Avenue, Faerie Glen,
Pretoria, 0081, South Africa

POSTAL ADDRESS

PO Box 2297, Arcadia, Pretoria, 0001, South Africa

NETCARE 911

Tel: 082 911
Email: customer.service@netcare.co.za (queries)

INTERNATIONAL MEDICAL TRAVEL INSURANCE (EUROP ASSISTANCE)

Tel: 0861 838 333
Claims and emergencies: assist@europassistance.co.za
Travel registrations: bestmed-assist@linkham.com

PMB

Tel: 086 000 2378
Email: pmb@bestmed.co.za

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

COMPLAINTS

Tel: +27 (0)86 000 2378
Email: escalations@bestmed.co.za
(Subject box: Manager, escalated query)
Postal address: PO Box 2297, Pretoria, Gauteng, 0001

CMS ESCALATIONS

Should an issue remain unresolved with the Scheme, members can escalate to the Council for Medical Schemes (CMS) Registrar's office:

Fax Complaints: 086 673 2466.
Email Complaints: complaints@medicalschemes.co.za

Postal Address:
Private Bag X34, Hatfield, 0028

Physical Address:
Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue,
Eco Park, Centurion, 0157

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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