Bonitas

BONITAS MEDICAL FUND

ANNEXURE B

REGISTERED BY ME ON

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REGISTRAR OF MEDICAL SCHEMES

OPTIONS:

STANDARD

STANDARD SELECT

2024

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A ENTITLEMENT TO BENEFITS

A1 The Bonitas Fund Tariff is defined as the Bonitas monetary tariffs applicable in 2023 increased by an average of 6.5%.

A2 Beneficiaries are entitled to benefits as shown in this Annexure B, subject to the monetary limits and implementation restrictions set out herein, to the exclusions referred to in Annexure C of the Rules, to the general limitation and restriction of benefits set out in Annexure D of the Rules and to the procedural and other requirements set out in the main rules. Benefits are applicable per annum, unless otherwise stated in the Benefits Table in paragraph D below.

A3 Specialist Network appointed as the Scheme's DSP for PMBs (refer to Annexure D: 7.3.6), is applicable for all In and Out of hospital consultations and procedures.

A3.1 Specialist Network

A3.1.1 The Specialist Network includes, but is not limited to, the following specialists:

- Cardio Thoracic Surgery
- Cardiology
- Dermatology
- Gastroenterology
- Neurology
- Neurosurgery
- Obstetrics and Gynaecology
- Ophthalmology
- Orthopaedics
- Otorhinolaryngology (ENT)
- Paediatrics
- Plastic and Reconstructive Surgery
- Psychiatry
- Pulmonology
- Rheumatology
- Specialist Medicine
- Surgery
- Urology

A3.1.2 In-Specialist Network, in hospital Tariffs are applicable as follows:

- The contracted rate for Standard and Standard Select Options.

A3.1.3 In-Specialist Network, out of hospital Tariffs are applicable as follows:

- The contracted rate for Standard and Standard Select Options.

A4 In addition to the Specialist Network, the Scheme appointed the Oncology Network for the provision of oncology treatment for both in-and-out of hospital care for members enrolled on the Oncology programme.

B CHARGING OF BENEFITS, LIMITS INCLUDING OVERALL ANNUAL (OAL) LIMITS AND MEMBERSHIP CATEGORY

B1 On the Standard and Standard Select options, claims for services stated as being subject to payment from the Day-to-Day benefit in paragraph D below are allocated against the Day-to-Day benefits.

B2 When the Day-to-Day benefit is exhausted on the Standard and Standard Select options, no further benefits are available in respect of services payable from the Day-to-Day benefits, except for PMBs.

B3 Valid claims will be paid at 100% of the negotiated fee, or in the absence of such fee, 100% of the lower cost or Bonitas Tariff, or Uniform Patient Fee Schedule for Public hospitals, or 100% of the Bonitas Dental Tariff as prescribed or rendered by a medical dental and alternative healthcare practitioner or at a percentage as indicated in the table below.

The cost of a valid claim shall be determined for the purpose of reimbursing the member or the supplier and the share of such cost that the Fund will bear. The balance of the share of costs to make up 100% thereof shall be the member's responsibility except for Prescribed Minimum Benefits.

B4 Legally prescribed acute or chronic medicines claims will be reimbursed at 100% of (1) the single exit price plus the negotiated dispensing fee or (2) the single exit price plus 20% capped at a maximum of R20 (Vat exclusive) if a non-contracted pharmacy is used Both subject to the reimbursement limit, i.e. Medicine Price List and applicable formularies. Co-payments to apply where relevant.

B5 **MEMBERSHIP CATEGORY**

Member	=	M0
Member plus 1 dependant	=	M1
Member plus 2 dependants	=	M2
Member plus 3 and more dependants	=	M3+

B6 Mental Health in Hospital will be covered subject to the relevant managed healthcare programme, provided that the treatment is rendered in a designated service provider facility. The DSP facility must be an appropriate mental health facility as licensed by the Department of Health and credentialed to have: Dedicated psychiatric, beds dedicated psychiatric teams and psychiatric therapeutic programmes. Emergency admissions, defined as an afterhours admission, will be approved until the first working day whereupon the patient should be transferred to a credentialed psychiatric facility.

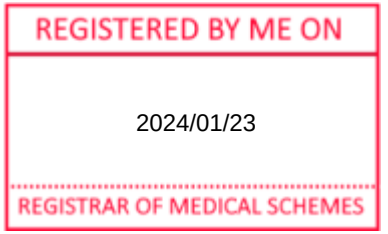
B7 The Infertility benefit includes the following procedures or interventions as prescribed by the Regulations to the Medical Schemes' Act 131 of 1998 in Annexure A, paragraph 9, Code 902M:

Hysterosalpingogram	Laparoscopy
The following blood test:	Hysteroscopy
Day 3 FSH/LH	Surgery (Uterus and tubal)
Oestradiol	Manipulation of ovulation defects and deficiencies
Thyroid functions (TSH)	Semen analysis (volume; count; mobility; morphology; MAR - (test)
Prolactin	Basic counselling and advice on sexual behaviour, temperature charts, etc
Rubella	Treatment of local infections
HIV	
VDRL	
Chlamydia	
Day 21 Progesterone	

B8 On the Standard and Standard Select Options, a member or beneficiary will be required to obtain a referral from a registered general practitioner for a specialist consultation. However should a member/beneficiary not have a referral, the claim will not be covered.

The following exceptions are applicable:

- 2 (two) Gynaecologist consultations or visits per annum for female beneficiaries;
- Maternity
- Children under the age of 2 (two) years, for Paediatrician visits or consultations
- Consultations with Oncologists and Haematologists
- Consultations with Ophthalmologists
- Specialist to specialist referral.



On depletion of benefits, PMB above limits will only be applicable via the contracted Designated Service Providers of the fund, subject to Regulation 8.

C PRESCRIBED MINIMUM BENEFITS (PMBs)

Prescribed Minimum Benefits as shown in Annexure A of the General Regulations, made in terms of the Medical Schemes' Act 131 of 1998; override all benefits indicated in this annexure, and are paid in full.

The Prescribed Minimum Benefits are available in conjunction with the Fund's contracted managed care programmes, which include the application of treatment protocols, medicine formularies, pre-authorisation and case management.

These measures have been implemented to ensure appropriate and effective delivery of Prescribed Minimum Benefits.

Out of hospital tests and specialist consultations, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.

See Annexure D – Paragraph 7 for a full explanation

D ANNUAL BENEFITS AND LIMITS

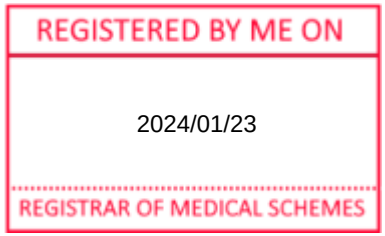
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	OVERALL ANNUAL LIMIT	No limit.	No limit.	
	DAY-TO-DAY BENEFIT	M : R12 780 M+1: R19 170 M+2: R21 300 M+3+: R23 430	M : R12 780 M+1: R19 170 M+2: R21 300 M+3+: R23 430	
	General Practitioner and Specialist Benefit	M : R3 200 M+1: R4 790 M+2: R5 330 M+3+: R6 390 Limited to and included in the Day-to-Day benefit. (See D5.1.3 and D5.1.4)	M : R3 200 M+1: R4 790 M+2: R5 330 M+3+: R6 390 Limited to and included in the Day-to-Day benefit. Subject to GP nomination from the GP Network. (See D5.1.3 and D5.1.4)	
D1	**ALTERNATIVE HEALTHCARE (See B1 & B3)**	M : R3 200 M+1: R4 790 M+2: R5 330 M+3+: R6 390 Limited to and included in the Day-to-Day benefit.	M : R3 200 M+1: R4 790 M+2: R5 330 M+3+: R6 390 Limited to and included in the Day-to-Day benefit.	
D1.1	**Homoeopathic Consultations and/or treatment**	Limited to and included in D1.	Limited to and included in D1.	
D1.2	**Homoeopathic Medicines**	Limited to and included in D1 at 80% of tariff.	Limited to and included in D1, at 80% of tariff.	
D1.3	**Acupuncture**	Limited to and included in D1.	Limited to and included in D1.	
D1.4	**Naturopathy Consultations and/or treatment and medicines**	• Limited to and included in D1. • Medicines paid at 80% of tariff	• Limited to and included in D1. • Medicines paid at 80% 0f tariff.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D1.5	**Osteopathy**	Limited to and included in D1.	Limited to and included in D1.	
D1.6	**Phytotherapy**	Limited to and included in D1.	Limited to and included in D1.	
D2	**AMBULANCE SERVICES (See B3)**	100% of cost if authorised by the preferred provider.	100% of cost if authorised by the preferred provider.	Subject to the contracted provider. Non-authorisation will result in non-payment except for PMBs.
D3	**APPLIANCES, EXTERNAL ACCESSORIES AND ORTHOTICS (See B3)**			Diabetic accessories and appliances (with the exception of glucometers) to be pre-authorised and claimed from the chronic medicine benefit (D11.3). Subject to frequency limits as per managed care protocols. The benefit excludes consultations/fittings, which are subject to D17.2.
D3.1	**In and Out of Hospital**			
D3.1.1	**General medical and surgical appliances, including wheelchairs and repairs, and large orthopaedic appliances**	• Limited to and included in the Day-to-Day benefit.	• Limited to and included in the Day-to-Day benefit.	Hiring or buying medical or surgical aids as prescribed by a medical practitioner.
D3.1.2	**Hearing Aids and repairs**	• Limited to R8 650 per device (maximum of two per family) over a three year cycle. • A 25% co-payment will apply to devices obtained from a non-DSP.	• Limited to R8 650 per device (maximum of two per family) over a three year cycle. • A 25% co-payment will apply to devices obtained from a non-DSP.	Subject to the Audiology Benefit Management Programme.
	Audiology Services	• Network: All tests and consultations limited to the Audiology Benefit Management Programme (ABM). • Non-network: Limited to and included in D1.	• Network: All tests and consultations limited to the Audiology Benefit Management Programme (ABM).	Subject to the Audiology Benefit Management Programme. The Benefit Booster (D27.2) does not apply.

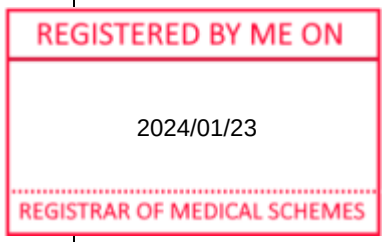
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	Hearing Aid Acoustic Services REGISTERED BY ME ON 2024/01/23 REGISTRAR OF MEDICAL SCHEMES	• Network: All tests and consultations limited to the Audiology Benefit Management Programme (ABM). • Non-network: Limited to and included in D1.	• Non-network: Limited to and included in D1. • Network: All tests and consultations limited to the Audiology Benefit Management Programme (ABM). • Non-network: Limited to and included in D1.	Subject to the Audiology Benefit Management Programme. The Benefit Booster (D27.2) does not apply.
D3.1.3	**CPAP Apparatus for sleep apnoea**	R8 130 per family, unless PMB.	R8 130 per family, unless PMB.	CPAP Machines are subject to the relevant managed healthcare programme and to its prior authorisation.
D3.1.4	**Stoma Products**	Limited to and included in D3.1.3 and thereafter funded from OAL, if PMB.	Limited to and included in D3.1.3 and thereafter funded from OAL, if PMB.	
D3.1.5	**Specific appliances, accessories**			Subject to the relevant managed healthcare programme and to its prior authorisation and if the treatment forms part of the relevant managed healthcare programme, out of hospital.
D3.1.5.1	**Oxygen therapy, and equipment (not including hyperbaric oxygen treatment)**	No limit if specifically authorised.	No limit if specifically authorised.	
D3.1.5.2	**Home Ventilators**	No limit if specifically authorised.	No limit if specifically authorised.	
D3.1.5.3	**Long leg callipers**	Limited to and included in D20.2.	Limited to and included in D20.2.	
D3.1.5.4	**Foot orthotics**	No benefit, unless PMB	No benefit, unless PMB.	
D3.1.5.5	**Insulin Pump Therapy or Continuous Glucose Infusion (CGM)**	• R85 000 per family per annum for insulin pump or CGM device. • Limited to one device per Type 1 Diabetic for beneficiaries younger than 18 years every 5 years; and	• R85 000 per family per annum for insulin pump or CGM device. • Limited to one device per Type 1 Diabetic for beneficiaries younger than 18 years every 5 years; and	• Subject to pre-authorisation by the relevant managed healthcare programme and its prior authorization. • Once the benefit for consumables is exceeded, the benefit for the pump or the appliance benefit may not be utilized to cover the cost.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• R85 000 per family for insulin pump or CGM consumables.	• R85 000 per family for insulin pump or CGM consumables.	
D4	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS**	No limit, if specifically authorised.	No limit, if specifically authorised.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D5	**CONSULTATIONS VISITS BY MEDICAL PRACTITIONERS (See B1 and B3)**	M : R3 200 M+1: R4 790 M+2: R5 330 M+3+: R6 390 Limited to and included in the Day-to-Day benefit.	M : R3 200 M+1: R R4 790 M+2: R5 330 M+3+: R6 390 Limited to and included in the Day-to-Day benefit.	On Standard Select, subject to nominating a maximum of two GPs from the GP Network and submitting the claim from the nominated GP.
D5.1	**General Practitioners (Including Virtual Consultations)**	REGISTERED BY ME ON 2024/01/23 REGISTRAR OF MEDICAL SCHEMES		This benefit excludes • Dental Practitioners and Therapists (D6), • Oncologists, Haematologists and Credentialed Medical Practitioners during active and post-active treatment periods (D14); • Paramedical Services (D17); • Physiotherapists and Biokineticists in hospital (D19.1).
D5.1.1	**In Hospital**	• No limit. • 100% of Bonitas Tariff for general practitioners.	• No limit. • 100% of Bonitas Tariff for general practitioners.	
D5.1.2.	**Out of Hospital**	• Subject to the General Practitioner and Specialist benefit in D5.	Subject to the General Practitioner and Specialist benefit in D5.	
D5.1.3	**In Network General Practitioners/Nominated General Practitioners for Standard Select (including virtual consultations)**	• Limited to and included in D5. • A network General Practitioner Risk benefit of 2 visits per family applies per annum, when the GP and Specialist consultation benefits are exhausted,	• Limited to and included in D5. • A network General Practitioner Risk benefit of 2 visits per family applies per annum, when the GP and Specialist benefits are exhausted,	This benefit applies to both nominated/non-nominated network GPs on Standard Select

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D5.1.4	**Non-Network General Practitioners/Non Nominated, for Standard Select (Virtual consultationsare limited to and included in D5.1.3)**	Limited to and included in the General Practitioner and Specialist benefit in D5.	• Limited to 2 out of area visits per family for non-nominated network GP visits. • Limited to and included in D5.	Consultations/visits with non-network GPs are limited to bona fide emergencies on Standard Select.
D5.1.5	**Childhood illness benefit**	2 GP consultations per beneficiary between the ages of 2 and 12 years paid from OAL.	2 GP consultations per beneficiary between the ages of 2 and 12 years paid from OAL.	
D5.2	**Medical Specialists (See A3, B3 and B8)**			
D5.2.1	**In Hospital**			
D5.2.1.1	**In Specialist Network**	• No limit • Subject to the contracted rate. (See Annexure D: 7.3.6).	• No limit • Subject to the contracted rate. (See Annexure D: 7.3.6).	All consultations and procedures within the specialist network will be paid at the contracted rate, with no co-payment applicable.
D5.2.1.2	**Out of Specialist Network**	• No limit • 100% of the Bonitas Tariff for non-network specialists.	• No limit • 100% of the Bonitas Tariff for non-network specialists.	All consultations and procedures outside the Specialist Network will be reimbursed up to the Bonitas Tariff. Co-payments are applicable for consultations and procedures charged in excess of the Bonitas Tariff.
D5.2.2	**Out of Hospital (See B1, B3 and B8)**	• 2 network specialist visits per family, per annum from OAL, subject to GP referral. • Subsequent vists are limited to and included in the GP and Specialist consultation benefit in D5. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists.	• 2 network specialist visits per family, per annum from OAL, subject to referral by a network GP. • Subsequent vists are limited to and included in the GP and Specialist consultation benefit in D5. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists. •	On Standard and Standard Select, referral to a specialist must be done by a registered general practitioner and a valid referral obtained. The following exceptions are applicable as per B8: • Two (2) Gynaecologist visits/consultations per annum for female beneficiaries; • Consultations and visits related to maternity; • Children under the age of two (2) years for Paediatrician visits/consultations; • Visits with Ophthalmologists, Haematologists and Oncologists. • Specialist to specialist referral.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
				Out of hospital tests and specialist consultations, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D5.2.3	**Infant Paediatric benefit (Consultation with a GP or Paediatrician)**	• 2 Paediatric consultations per beneficiary for children aged 0 - 12 months within the age bracket. • 2 Paediatric consultations per beneficiary for children aged 13 - 24 months, within the age bracket, included in the OAL.	• 2 Paediatric consultations per beneficiary for children aged 0 - 12 months within the age bracket. • 2 Paediatric consultations per beneficiary for children aged 13 - 24 months, within the age bracket, included in the OAL.	
D6	**DENTISTRY (See B3)**			Subject to the Bonitas Dental Management Programme. Benefits payable on the Standard Select Option is subject to a Designated Service Provider for in and out of hospital services. Specialists require pre-approval by the contracted provider. .
D6.1.1	**Consultations**	Limited to two general check-ups (once every 6 months) per beneficiary per year. Covered at BDT.	Limited to two general check-ups (once every 6 months) per beneficiary per year. Covered at BDT.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D6.1.2	**Fillings** REGISTERED BY ME ON 2024/01/23 REGISTRAR OF MEDICAL SCHEMES	• Covered at 100% of the BDT. • Fillings are granted once per tooth in 720 days. • Benefit for re-treatment of a tooth is subject to managed care protocols.	• Covered at 100% of the BDT. • Fillings are granted once per tooth in 720 days. • Benefit for re-treatment of a tooth is subject to managed care protocols.	Benefits for fillings are granted once per tooth in 720 days. Benefits for re-treatment of a tooth are subject to managed care protocols. A treatment plan and x-rays may be required for multiple fillings.
D6.1.3	**Plastic Dentures**	• Covered at 100% of the BDT. • One set of plastic dentures (an upper and a lower) in a 4 year period per beneficiary. • Subject to pre-authorisation.	• Covered at 100% of the BDT. • One set of plastic dentures (an upper and a lower) in a 4 year period per beneficiary. • Subject to pre-authorisation.	Subject to managed care protocols.
D6.1.4	**Extractions**	Covered at 100% of BDT and managed care protocols apply.	Covered at 100% of BDT and managed care protocols apply.	Subject to managed care protocols.
D6.1.5	**Root canal therapy**	Covered at 100% of BDT. Root canal therapy on wisdom teeth (3rd molars) and primary (milk) teeth is not covered.	Covered at 100% of BDT. Root canal therapy on wisdom teeth (3rd molars) and primary (milk) teeth is not covered.	Subject to managed care protocols.
D6.1.6	**Preventative Care**	2 Annual scale and polish treatments per beneficiary once every 6 months.	2 Annual scale and polish treatments per beneficiary once every 6 months.	No benefit for oral hygiene instructions. Benefit for fluoride is limited to beneficiaries from age 5 and younger than 16 years of age. Benefit for fissure sealants is limited to beneficiaries younger than 16 years of age.

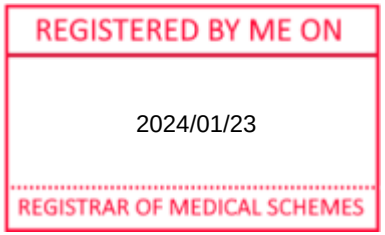
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D6.1.7	**Hospitalisation (general anaesthetic) and Moderate/Deep Sedation in the rooms** 	• Subject to pre-authorisation. • Admission protocols apply. • Certain maxillo-facial procedures are covered in hospital. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. • Multiple hospital admissions are not covered. • General anaesthetic benefits are available for the removal of impacted teeth. Benefit is subject to managed care protocols. • Covered at 100% of the BDT.	• Subject to pre-authorisation. • Subject to the Standard Select Hospital Network. • Admission protocols apply. • Certain maxillo-facial procedures are covered in hospital. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. • Multiple hospital admissions are not covered. • General anaesthetic benefits are available for the removal of impacted teeth. Benefit is subject to managed care protocols. • Covered at 100% of the BDT	• Pre-authorisation is required for Moderate/Deep Sedation in the rooms and is limited to extensive dental treatment where managed care protocols apply. • Co-payment of R3 500 per hospital admission applies for children younger than 5 years and R5 000 for any other admission, including removal of impacted teeth or medical condition; or • R2 500 upfront co-payment to apply for any admission, including removal of impacted teeth or medical admission if the dental treatment is done in a Day Clinic. • The co-payment to be waived if the cost of the service falls within the co-payment amount.
D6.1.8	**Inhalation Sedation in Dental Rooms**	Benefit is subject to managed care protocols. Covered at the BDT.	Benefit is subject to managed care protocols. Covered at the BDT.	
D6.1.9	**X-rays**	• Covered at 100% of the BDT for intra-oral x-rays. • Extra-oral x-rays will be covered at 100% of the BDT subject to 1 per beneficiary in a 3 year period.	• Covered at 100% of the BDT for intra-oral x-rays. • Extra-oral x-rays will be covered at 100% of the BDT subject to 1 per beneficiary in a 3 year period. •	Additional benefits for extra-oral x-rays may be considered where specialist dental treatment planning/follow-up is required.
D6.2	**SPECIALISED DENTISTRY (See B3)**			

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D6.2.1	**Crowns**	• 1 Crown per family per year, subject to pre-authorisation. • Benefits for crowns will be granted once per tooth in 5 years. • Covered at 100% of the BDT.	• 1 Crown per family per year, subject to pre-authorisation. • Benefits for crowns will be granted once per tooth in 5 years. • Covered at 100% of the BDT	• Subject to the dental managed care protocols. Failure to authorise will result in a 20% co-payment if authorisation is approved after the treatment has been done. • A treatment plan and x-rays may be required.
D6.2.2	**Partial Chrome Cobalt Frame Dentures**	• 1 partial frame (an upper or a lower) per beneficiary in a 5 year period. • Benefit is subject to managed care protocols. Covered at the BDT. • Subject to pre-authorisation.	• 1 partial frame (an upper or a lower) per beneficiary in a 5 year period. • Benefit is subject to managed care protocols. Covered at the BDT. • Subject to pre-authorisation.	Subject to managed care protocols.
D6.2.3	**Osseo-integrated Implants and orthognathic surgery (functional correction of malocclusion)**	No benefit.	No benefit.	
D6.2.4	**Oral Surgery**	Surgery in the dental chair. Covered at 100% of BDT.	Surgery in the dental chair. Covered at 100% of BDT.	A benefit for Tempero-mandibular joint therapy is limited to non-surgical interventions/treatments.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D6.2.5	**Orthodontic Treatment** REGISTERED BY ME ON 2024/01/23 REGISTRAR OF MEDICAL SCHEMES	• Subject to prior authorisation by the dental management programme. Benefit for fixed comprehensive treatment is limited to individuals from age 9 and under the age of 18 years in terms of the severity of the dental malocclusion determined by an international classification index. • Orthodontic treatment is granted once per beneficiary per lifetime. • Orthodontic treatment is limited to one beneficiary per annum except in the case of identically aged siblings at 80% of BDT.	• Subject to prior authorisation by the dental management programme. Benefit for fixed comprehensive treatment is limited to individuals from age 9 and under the age of 18 years in terms of the severity of the dental malocclusion determined by an international classification index. • Orthodontic treatment is granted once per beneficiary per lifetime. • Orthodontic treatmentis limited to one beneficiary per annum except in the case of identically aged siblings at 80% of BDT	Subject to the dental managed care protocols (Failure to pre- authorise will result in a payment only from date of post authorisation for the remaining months of treatment, provided that the treatment is clinically indicated).
D6.2.6	**Maxillo-facial surgery**	See D23.	See D23.	
D6.2.7	**Periodontal treatment**	• Pre-authorisation is required. • Benefits are limited to conservative, non-surgical therapy only. • Benefits will be applied to members who are registered on the Periodontal Programme. • Surgical treatment is excluded. • Covered at 100% of the BDT.	• Pre-authorisation is required. • Benefits are limited to conservative, non-surgical therapy only. • Benefits will be applied to members who are registered on the Periodontal Programme. • Surgical treatment is excluded. • Covered at 100% of the BDT.	
D7	**HOSPITALISATION (See B3)**			
D7.1	**Private hospitals and unattached operating theatres (See B3)**			Subject to the relevant managed healthcare programme and its prior authorisation.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D7.1.1	**In Hospital** 	• No limit. • Deep Brain Stimulation Implantation for Parkinson's Disease and intractable epilepsy is limited to R289 300 per beneficiary (excluding the prosthesis benefit). • Hip and knee arthroplasties are subject to the DSP. • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• No limit. • Subject to the Standard Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • Deep Brain Stimulation Implantation for Parkinson's Disease and intractable epilepsy is limited to R289 300 per beneficiary (excluding the prosthesis benefit). • Hip and knee arthroplasties are subject to the DSP. • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	Accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. No benefits will be granted if prior authorisation requirements are not complied with. This benefit excludes: hospitalisation for: • Osseo-integrated implants and orthognathic surgery (D6); • Maternity (D10); • Mental Health (D12); • Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16); • Renal Dialysis chronic (D22); • Refractive surgery (D23).
D7.1.2	**Medicine on discharge from hospital (TTO)** **(See B4)**	• Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R575 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme.	• Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R575 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme.	
D7.1.3	**Casualty / emergency room visits**			The risk benefit is maximum 2 visits per family either in a private or public hospital setting.
D7.1.3.1	**Facility fee**	• Limited to 2 emergency rooms visits per family,	• Limited to 2 emergency rooms visits per family,	Will be included in the hospital benefit if a retrospective authorisation is given by the

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		limited to and included in the OAL for bona fide emergencies. • 2 emergency rooms visits per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are limited to and included in the Day-to-Day benefit.	limited to and included in the OAL for bona fide emergencies. • 2 emergency rooms visits per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are limited to and included in the Day-to-Day benefit.	relevant managed healthcare programme for bona fide emergencies.
D7.1.3.2	**Consultations**	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 consultations per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 consultations per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2.	
D7.1.3.3	**Medicine**	See D11.1.	See D11.1.	
D7.2	**Public hospitals (See B3)**			Subject to the relevant managed healthcare programme and its prior authorisation.
D7.2.1	**In hospital**	No limit.	No limit.	Accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. No benefits will be granted if prior authorisation requirements are not complied with. This benefit excludes: hospitalisation for:

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
				• Osseo-integrated implants and Orthognathic surgery (D6); • Maternity (D10); • Mental Health (D12); • Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16); • Renal Dialysis chronic (D22); • Refractive surgery (D23).
D7.2.2	**Medicine on discharge from hospital (TTO) (See B4)**	• Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R575 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme. • See D7.1.2.	• Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R575 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme. • See D7.1.2.	
D7.2.3	**Casualty / emergency room visits**			The risk benefit is maximum 2 visits per family either in a private or public hospital setting.
D7.2.3.1	**Facility fee**	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies. • 2 emergency rooms visits per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are limited	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies. • 2 emergency rooms visits per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are limited	Will be included in the hospital benefit if retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		to and included in the Day-to-Day benefit.	to and included in the Day-to-Day benefit.	
D7.2.3.2	**Consultations**	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 consultations per family for beneficiaries under the age of 6 years, payable from the OAL. • Subsequent consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2.	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 consultations per family for beneficiaries under the age of 6 years, payable from the OAL. • Subsequent consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2.	
D7.2.3.3	**Medicine**	See D11.1.	See D11.1.	
D7.2.4	**Outpatient services**			
D7.2.4.1	**Facility fee**	• Limited to and included in the Day-to-Day benefit.	• Limited to and included in the Day-to-Day benefit.	
D7.2.4.2	**Consultations**	See D5.1.3, D5.1.4 and D5.2.2.	See D5.1.3, D5.1.4 and D5.2.2.	
D7.2.4.3	**Medicine**	See D11.1.	See D11.1.	
D7.3	**Alternatives to hospitalisation (See B3)**			Subject to the relevant managed healthcare programme and to its prior authorisation. Benefits for clinical procedures and treatment during stay in an alternative facility will be subject to the same benefits that apply to hospitalisation.
D7.3.1	**Physical Rehabilitation hospitals**	R61 480 per family, for all services.	R61 480 per family, for all services.	See D7.3

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D7.3.2	**Sub-acute facilities including Hospice**	R20 500 per family.	R20 500 per family.	This benefit includes nursing services for psychiatric nursing but excludes midwifery services. See D7.3.
D7.3.3	**Homebased Care including private nursing and Outpatient antibiotic therapy in lieu of hospitalisation**	• No limit. • Subject to pre-authorisation.	• No limit. • Subject to pre-authorisation.	Subject to the relevant managed healthcare programme.
D7.3.4	**Conservative Back Programme**	Subject to the Contracted Provider.	Subject to the Contracted Provider	
D7.3.5	**Terminal Care (Non-oncology)**	Limited to and included in D7.3.2, and above limits, subject to pre-authorisation.	Limited to and included in D7.3.2 and above limits, subject to pre-authorisation.	Subject to the relevant managed healthcare programme.
D8	**IMMUNE DEFICIENCY SYNDROME RELATED TO HIV INFECTION (SEE B3)**	• No limit. • Subject to PMBs.	• No limit. • Subject to PMBs.	Subject to registration on the relevant managed healthcare programme. Subject to clinical protocols.
D8.1	**Anti-retroviral medicine**	Limited to and included in D8 and subject to the DSP.	Limited to and included in D8 and subject to the DSP.	Subject to the relevant managed healthcare programme.
D8.2	**Related medicine**	Limited to and included in D8 and subject to the DSP.	Limited to and included in D8 and subject to the DSP.	
D8.3	**Related pathology**	Limited to and included in D8.	Limited to and included in D8.	Pathology as specified by the relevant managed healthcare programme, out of hospital.
D8.4	**Related consultations**	Limited to and included in D8.	Limited to and included in D8.	
D8.5	**All other services**	Limited to and included in D1 - D7 and D9 – D27.	Limited to and included in D1 - D7 and D9 – D27.	
D9	**INFERTILITY (See B3 and B7)**	Limited to interventions and investigations as prescribed by the Regulations to the Medical Schemes' Act 131 of 1998 in Annexure A, paragraph 9, Code 902M.	Limited to interventions and investigations as prescribed by the Regulations to the Medical Schemes' Act 131 of 1998 in Annexure A, paragraph 9, Code 902M.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D10	**MATERNITY (See B3)**			Subject to the relevant managed healthcare programme and to its prior authorisation.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D10.1	**Confinement in hospital** REGISTERED BY ME ON 2024/01/23 REGISTRAR OF MEDICAL SCHEMES	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Subject to the Standard Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	Delivery by a general practitioner or medical specialist and the services of the attendant paediatrician and/or anaesthetists are included. Included in the global obstetric fee is post-natal care by a general practitioner and medical specialist up to and including the six week post-natal consultation.
D10.1.1	**Medicine on discharge from hospital (TTO)** **(See B4)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	
D10.1.2	**Confinement in a registered birthing unit**	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used by a lactation specialist out of hospital.	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used by a lactation specialist out of hospital. • Subject to the Standard Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• Subject to the relevant managed healthcare programme and its prior authorisation. • Delivery by a midwife. • Hire of water bath and oxygen cylinder limited to and included in OAL. This must be hired from a practitioner who has a registered practice number. • One of the post-natal midwife consultations may be used for a lactation specialist consultation out of hospital.
D10.2	**Confinement out of hospital**	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used by a lactation specialist..	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used by a lactation specialist..	• Subject to the relevant managed healthcare programme and its prior authorisation. • Delivery by a midwife. • Hire of water bath and oxygen cylinder limited to and included in OAL. This must be hired from a practitioner who has a registered practice number. • One of the post-natal midwife consultations may be used for a lactation specialist.
D10.2.1	**Consumables and pharmaceuticals**	Limited to and included in D10.1.	Limited to and included in D10.1.	Registered medicine, dressings and materials supplied by a midwife out of hospital.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D10.3	**Related maternity services**	Limited to and included in D10.1.	Limited to and included in D10.1.	
D10.3.1	**Ante-natal consultations**	• 12 ante-natal consultations by a specialist, general practitioner or midwife per pregnancy. • R1 500 for ante-natal classes/exercises per pregnancy.	• 12 ante-natal consultations by a specialist, general practitioner or midwife per pregnancy. • R1 500 for ante-natal classes/exercises per pregnancy.	• The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network medical specialist.
D10.3.2	**Related tests and procedures**	• Pregnancy related tests and procedures. • 2 x 2D pregnancy scans. • 1 x amniocentesis per pregnancy.	• Pregnancy related tests and procedures. • 2 x 2D pregnancy scans. • 1 x amniocentesis per pregnancy.	
D11	**MEDICINE AND INJECTION MATERIAL (See B3 and B4)**	M : R3 200 M+1: R4 790 M+2: R5 330 M+3+: R6 390 Limited to and included in the Day-to-Day benefit.	M : R3 200 M+1: R4 790 M+2: R5 330 M+3+: R6 390 Limited to and included in the Day-to-Day benefit.	
D11.1	**Routine /(acute) medicine**	• Limited to and included in D11. • Subject to the acute DSP pharmacy network and acute medicines formulary list. • 20% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	• Limited to and included in D11. • Subject to the acute DSP pharmacy network and acute medicines formulary list. • 20% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme. The Medicine Exclusion List and the Pharmacy Products Management Document are applicable. This benefit excludes: • In-hospital medicine (D7); • Anti-retroviral medicine (D8); • Oncology medicine (D14); • Organ and haemopoietic stem cell (bone marrow) transplantation immunosuppressive medication (D16).
D11.1.1	**Medicine on discharge from hospital (TTO)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D11.1.2	**Contraceptives** 	• Limited to R1 950 per family. • Limited to females up to the age of 50 years. • Subject to the Bonitas Pharmacy Network. • 40% co-payment applies for the voluntary use of a non-network pharmacy.	• Limited to R1 950 per family. • Limited to females up to the age of 50 years. • Subject to the DSP pharmacy. • 40% co-payment applies for the voluntary use of a non-DSP pharmacy.	
D11.2	**Pharmacy Advised Therapy Schedules 0, 1 and 2 medicine advised and dispensed by a pharmacist**	• Limited to R850 per beneficiary. • R2 660 per family. • Limited to and included in D11. • Subject to the acute DSP pharmacy network and acute medicines formulary list. • 20% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	• Limited to R850 per beneficiary. • R2 660 per family. • Limited to and included in D11. • Subject to the acute DSP pharmacy network and acute medicines formulary list. • 20% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	
D11.3	**Chronic medicine (See B4)**	• Limited to R11 910 per beneficiary. • R23 900 per family. • 40% co-payment applies for the voluntary use of non-formulary drugs. • Subject to the Bonitas Pharmacy Network. • Above limits, PMBs and Bonitas Pharmacy Network apply. • 40% co-payment applies for non-formulary drugs used	• Subject to the DSP and limited to R11 910 per beneficiary • R23 900 per family. • 40% co-payment applies for the voluntary use of a non-DSP. • Only PMBs will be paid above limits and 40% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	Subject to registration on the relevant managed healthcare programme and to its prior authorisation and applicable formularies. Restricted to a maximum of one month's supply unless pre-authorised. [Includes diabetic disposables such as • syringes, • needles, • strips and • lancets The above are excluded from D3 and D11 if on the Diabetic Management Programme. This benefit excludes:

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		voluntarily and for the voluntary use of a non-DSP.		• In hospital medicine (D7); • Anti-retroviral drugs (D8); • Oncology medicine (D14); • Organ and haemopoietic stem cell (bone marrow) transplantation and immuno-suppressive medication (D16).
D11.3.1	**MDR and XDR-TB**	No limit, subject to managed care protocols and the DSP.	No limit, subject to managed care protocols and the DSP.	Subject to the relevant managed healthcare programme and its prior authorisation.
D11.4	**Specialised Drugs (See B4)**			
D11.4.1	**Non Oncology Biological Drugs applicable to monoclonal antibodies interleukins**	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation
D11.4.1.1	**Iron chelating agents for chronic use**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.1.2	**Human Immunoglobulin for chronic use**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.1.3	**Non calcium phosphate binders and calcimimetics**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.2	**Specialised Drugs for Oncology (See B4)**	See D14.1.3.	See D14.1.3.	
D12	**MENTAL HEALTH (See B3 and B6)**	• R49 330 per family, unless PMB.	• R49 330 per family, unless PMB. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme. Physiotherapy is not covered for mental health admissions.
D12.1	**In Hospital**	• Limited to and included in D12.	• Limited to and included in D12.	For accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items and procedures performed by general practitioners and psychiatrists. A maximum of three days' hospitalisation for beneficiaries admitted by a general practitioner or specialist physician. (See B6).
D12.1.1	**Medicine on discharge from hospital (TTO) (See B4 and B6)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	
D12.2	**Out of Hospital**			

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D12.2.1	**Medicine (See B4 and B6)**	Limited to and included in D11.	Limited to and included in D11.	
D12.3	**Rehabilitation for substance abuse (See B3)**	• Limited to and included in D12. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	• Limited to and included in D12. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme and to its prior authorisation. (See B6).
D12.3.1	**Medicine on discharge from hospital (TTO) (See B3 and B4)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	
D12.4	**Consultations and visits, procedures, assessments, therapy, treatment and/or counselling, in and out of hospital. (See B3)**	• R19 310 per family, limited to and included in D12. • Educational psychology visits and psychometry assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	• R19 310 per family, limited to and included in D12. • Educational psychology visits and psychometry assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	
D13	**NON-SURGICAL PROCEDURES AND TESTS (See B2 and B3)**			
D13.1	**In Hospital**	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners. • Subject to the Standard Select Hospital Network. • 30% co-payment to apply to all non-network admissions.	Subject to the relevant managed healthcare programme and its prior authorisation in hospital only. This benefit excludes: • Psychiatry and psychology (D12); • Optometric examinations (D15); • Pathology (D18); • Radiology (D21).
D13.2	**Out of hospital**	• Limited to and included in the Day-to-Day benefit.	• Limited to and included in the Day-to-Day benefit.	Out of hospital procedures, as specified in the aPMB care templates, will only accrue to the

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	Day-to-Day benefits once the aPMB entitlements are depleted.
D13.2.1	• **24 hr oesophageal PH studies** • **Breast fine needle biopsy** • **Circumcision** • **Laser tonsillectomy** • **Oesophageal motility studies** • **Vasectomy** • **Prostate Needle biopsy** **(See B3)**	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• Subject to relevant managed healthcare programme. • Co-payments will not apply if procedure is done in the doctors rooms. • Includes related consultation, materials, pathology and radiology if done in the rooms on the same day.
D13.3	**Sleep studies** **(See B3)**			Subject to the relevant managed healthcare programme and its prior authorisation.
D13.3.1	**Diagnostic Polysomnograms In and out of hospital**	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	If authorised by the relevant managed healthcare programme for dyssomnias e.g. central sleep apnoea, obstructive sleep apnoea, parasomnias or medical or psychiatric sleep disorders as part of neurological investigations by a relevant specialist.
D13.3.2	**CPAP Titration**	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	If authorised by the relevant managed healthcare programme for patients with obstructive sleep apnoea who meet the criteria for CPAP and where requested by the relevant specialist.
D14	**ONCOLOGY** **(See A4 & B3)**			Where more than one co-payment apply, the lower of the co-payments will be waived and the highest will be the member's liability.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D14.1	**PRE ACTIVE, ACTIVE & POST ACTIVE TREATMENT PERIOD** Rejected	• R266 300 per family for PMB ~~and~~ non-PMB oncology. • Thereafter, unlimited for PMB oncology. • Above benefit limit, non-PMB oncology, excluding specialised drugs, is unlimited at a network provider, subject to a 20% co-payment. • The Bonitas Oncology Network is the DSP for oncology services at the contracted network rate. • 100% of the Bonitas Tariff for services rendered by non-network oncology providers • 30% co-payment applies for services rendered by non-network oncology providers, subject to Regulation 8 (3).	• R266 300 per family for PMB ~~and~~ non-PMB oncology. • Thereafter, unlimited for PMB oncology. • Above benefit limit, non-PMB oncology, excluding specialised drugs, is unlimited at a network provider subject to a 20% co-payment. • The Bonitas Oncology Network is the DSP for oncology services at the contracted network rate. • 100% of the Bonitas Tariff for services rendered by non-network oncology providers. • 30% co-payment applies for services rendered by non-network oncology providers, subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and to its prior authorisation. • All costs related to approved cancer treatment, including PMB treatment, will add up to the oncology benefit limit. • Treatment for long-term chronic conditions that may develop as a result of chemotherapy and radiotherapy is not included in this benefit. • Benefit is for Oncologists, Haematologists and approved providers for consultations, visits, treatment and consumable material used in radiotherapy and chemotherapy. • The Oncology Network is the DSP for related oncology services at the Oncology Network (DSP) rate. • Pre- and post-active consultations and investigations are subject to Cancer Care Plans.
D14.1.1	**Medicine (excluding Specialised Drugs) See D14.1.3 (See B4)**	• Limited to and included in D14.1 and subject to the Oncology Medicine DSP. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to MPL and preferred product list.	• Limited to and included in D14.1 and subject to the Oncology Medicine DSP. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to MPL and preferred product list.	Subject to the Bonitas Oncology Medicine DSP Network.
D14.1.2	**Radiology and pathology (See B3)**	Limited to and included in D14.1.	Limited to and included in D14.1.	• Subject to the relevant managed healthcare programme and to its prior authorisation. • Limited to Cancer Care Plans in pre-active and post-active setting. • Specific authorisations are required for advanced radiology in addition to any

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
				authorisation that may have been obtained for hospitalisation.
D14.1.2.1	**PET and PET-CT (See B3)**	No benefit.	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation. Specific authorisations are required in addition to any authorisation that may have been obtained for hospitalisation.
D14.1.3	**Specialised Drugs (See B4)**			• Subject to the relevant managed healthcare programme and to its prior authorisation. • Specialised drugs include biological, immunologic and targeted therapies. • This list includes but is not limited to targeted therapies e.g. biologicals, and other non genericised chemotherapeutic agents. Subject to published list. • Unless otherwise stated below, any other diseases where the use of the drug is deemed appropriate by the managed health care organization, drugs will be funded from this benefit.
D14.1.3.1	**Biological drugs**	• R150 000 per family, limited to and included in D14.1. • No benefit applies above the Specialised Drug benefit limit, unless PMB.	• R150 000 per family, limited to and included in D14.1. • No benefit applies above the Specialised Drug benefit limit, unless PMB.	• Subject to oncology pre-authorisation, managed care protocols and processes. • The Specialised Drug List (SDL) is a list of drugs used for treatment of cancers and certain haematological conditions. It includes but is not limited to biologicals, certain enzyme inhibitors, immunomodulatory antineoplastic agents and other targeted therapies. The list is reviewed and published regularly.
D14.1.3.2	**Unregistered chemotherapeutic agents**	Limited to and included in D14.1.3.1.	Limited to and included in D14.1.3.1.	Subject to Section 21 approval by the South African Health Products Regulatory Authority (SAHPRA) and oncology pre-authorisation, managed care protocols and processes.
D14.1.4	**Flushing of J Line and/or Port (See B3)**	Limited to and included in D14.1.	Limited to and included in D14.1.	Subject to the relevant managed healthcare programme.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D14.1.5	**Brachytherapy materials (including seeds and disposables) and equipment (See B3)**	Limited to R57 680 per beneficiary and included in D14.1.	Limited to R57 680 per beneficiary and included in D14.1.	Subject to the relevant managed healthcare programme and to its prior authorisation, for services rendered by oncologists, radiotherapists and approved medical practitioners. The Oncology Network is the DSP for oncology related services at the Oncology Network (DSP) rate.
D14.2	**Oncology Social Worker (OSW) benefit**	• Limited to R3 330 per family. • Limited to and included in D14.1.	• Limited to R3 330 per family. • Limited to and included in D14.1.	Subject to the relevant managed healthcare protocols and its prior authorisation.
D14.3	**Palliative Care**	• No limit. • Subject to pre-authorisation. • Managed care protocols apply.	• No limit. • Subject to pre-authorisation. • Managed care protocols apply.	Subject to the relevant managed healthcare protocols and its prior authorisation.
D15	**OPTOMETRY (In and Out of Network) (See B3)**	• Limited to R7 385 per family. • Biennial benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• Limited to R7 385 per family. • Biennial benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• Subject to pre-authorisation by the contracted provider and subject to clinical protocols. • Failure to obtain pre-authorisation will result in no benefits. • Out-of-network benefits are available as an alternative to network benefits and not an additional benefit. • Frames and/or lenses are mutually exclusive to contact lenses.
D15.1	**Optometric refraction test, re-exam and/or composite exam, including tonometry and visual field test.**	• One per beneficiary, per benefit cycle, at network rates. • R380 out of network. • Limited to and included in D15.	• One per beneficiary, per benefit cycle, at network rates. • R380 out of network. • Limited to and included in D15.	• Contracted Providers – 100% of cost for a Composite Consultation inclusive of refraction, glaucoma screening, visual field screening and artificial intelligence screening. • Non-contracted Providers – Eye examination
D15.2	**Frames and/or lens enhancements**	• R1 340 per beneficiary in network. • R1 005 per beneficiary out of network or member refunds.	• R1 340 per beneficiary in network. • R1 005 per beneficiary out of network or member refunds.	On the Standard and Standard Select options, the frame value may be used towards frames and/or lens enhancements.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• Limited to and included in D15.	• Limited to and included in D15.	
D15.3	**Lenses**			
D15.3.1	**Single vision lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R215 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R215 per lens per beneficiary out of network. • Limited to and included in D15; or	Subject to contracted providers protocols.
D15.3.2	**Bifocal lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R460 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R460 per lens per beneficiary out of network. • Limited to and included in D15; or	
D15.3.3	**Multifocal lenses**	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R810 per base lens or R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R810 per base lens or R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.	
D15.3.4	**Contact lenses**	• Limited to R2 060 per beneficiary. • Limited to and included in D15.	• Limited to R2 060 per beneficiary. • Limited to and included in D15.	
D15.4	**Low vision appliances**	Limited to and included in D3.1.1.	Limited to and included in D3.1.1.	When prescribed by a registered Optometrist, Ophthalmologist, medical practitioner or supplementary optical practitioner.
D15.5	**Ocular prostheses**	Limited to and included in D20.2.	Limited to and included in D20.2.	When prescribed by a registered Optometrist, Ophthalmologist, medical practitioner or supplementary optical practitioner.
D15.6	**Diagnostic procedures**	Limited to and included in D15.1.	Limited to and included in D15.1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D15.7	**Readers**			
D15.7.1	**From a registered optometrist, ophthalmologist or supplementary optical practitioner**	Limited to and included in D15.2.	Limited to and included in D15.2.	1 pair of single vision reading and 1 pair of single vision distance lenses will only be paid in lieu of bifocals/ multifocals for patients who are unable to adapt to the wearing of these types of lenses. Subject to the preferred provider.
D15.7.2	**From a registered pharmacy**	No benefit.	No benefit.	
D16	**ORGAN AND HAEMOPOIETIC STEM CELL (BONE MARROW) TRANSPLANTATION AND IMMUNO-SUPPRESSIVE MEDICATION (INCLUDING CORNEAL GRAFTS) (See B3)**	• No limit • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the non-network medical specialist or general practitioner. • Corneal grafts are limited to R39 040 per beneficiary for local and imported grafts.	• No limit • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the non-network medical specialist or general practitioner. • Corneal grafts are limited to R39 040 per beneficiary for local and imported grafts. • Subject to the Standard Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	Subject to the relevant managed healthcare programme to its prior authorisation, no benefits will be granted for hospitalisation, treatments and associated clinical procedures if prior authorization is not obtained. Organ harvesting is limited to the Republic of South Africa excluding donor cornea and donor bone marrow.
D16.1	**Haemopoietic stem cell (bone marrow) transplantation (See B3)**	Limited to and included in D16.	Limited to and included in D16.	Haemopoietic stem cell (bone marrow) transplantation is limited to allogenic grafts and autologous grafts derived from Bone Marrow Registries in accordance with managed care protocols.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D16.2	**Immuno-suppressive medication (See B4)**	Limited to and included in D16 and subject to the DSP.	Limited to and included in D16 and subject to the DSP.	
D16.3	**Post transplantation biopsies and scans (See B3)**	Limited to and included in D16.	Limited to and included in D16.	
D16.4	**Radiology and pathology (See B3)**	Limited to and included in D16.	Limited to and included in D16.	For specified radiology and pathology services, performed by Pathologists, Radiologists and Haematologists, associated with the transplantation treatment.
D17	**PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS) (See B2 and B3)**			
D17.1	**In hospital**	• Limited to and included in D1, unless PMB. • 100% of the Bonitas Tariff.	• Limited to and included in D1, unless PMB. • 100% of the Bonitas Tariff.	Subject to referral by the treating practitioner.
D17.1.1	**Dietetics**	Limited to and included in D1.	Limited to and included in D1.	
D17.1.2	**Occupational Therapy**	Limited to and included in D1.	Limited to and included in D1.	
D17.1.3	**Speech Therapy**	Limited to and included in D1.	Limited to and included in D1.	
D17.2	**Out of hospital**	• Limited to and included in D1. • 100% of the Bonitas Tariff.	• Limited to and included in D1. • 100% of the Bonitas Tariff.	Out of hospital paramedical services, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D17.2.1	**Chiropractics**	Limited to and included in D1.	Limited to and included in D1.	This benefit excludes X-rays performed by chiropractors.
D17.2.2	**Dietetics**	Limited to and included in D1.	Limited to and included in D1.	
D17.2.3	**Genetic counselling**	Limited to and included in D1.	Limited to and included in D1.	
D17.2.4	**Occupational therapy**	Limited to and included in D1.	Limited to and included in D1.	
D17.2.5	**Orthoptics**	Limited to and included in D1..	Limited to and included in D1.	
D17.2.5	**Orthotists and Prosthetists**	Limited to and included in D1.	Limited to and included in D1.	
D17.2.7	**Private nurse practitioners**	Limited to and included in D1.	Limited to and included in D1.	Nursing services are included in the Alternatives to Hospitalisation benefit (D7) if pre-authorised by the relevant managed healthcare programme.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D17.2.8	**Speech therapy**	Limited to and included in D1.	Limited to and included in D1.	
D17.2.9	**Social workers**	Limited to and included in D1.	Limited to and included in D1.	
D18	**PATHOLOGY AND MEDICAL TECHNOLOGY (See B1 and B3)**	M : R3 200 M+1: R4 790 M+2: R5 330 M+3+: R6 390 Limited to and included in the Day-to-Day benefit.	M : R3 200 M+1: R4 790 M+2: R5 330 M+3+: R6 390 Limited to and included in the Day-to-Day benefit.	
D18.1	**In Hospital**	• No limit. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• No limit. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	Subject to the relevant managed healthcare programme
D18.2	**Out of hospital**	• Limited to and included in D18. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• Limited to and included in D18. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	Subject to Pathology Management Program. This benefit excludes: the specified list of pathology tariff codes included in the: • Maternity benefit, (D10); • Oncology benefit during the active and/or post active treatment period, (D14); • Organ and haemopoietic stem cell transplantation benefit,D16); • Renal dialysis chronic benefit,(D22) Out of hospital pathology, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D19	**PHYSICAL THERAPY (See B1 and B3)**			
D19.1	**In hospital Physiotherapy Biokinetics**	• Limited to and included in D1, unless PMB. • 100% of the Bonitas Tariff.	• Limited to and included in D1, unless PMB. • 100% of the Bonitas Tariff.	Subject to referral by the treating practitioner. Physiotherapy is not covered for mental health admissions. (See D12.)

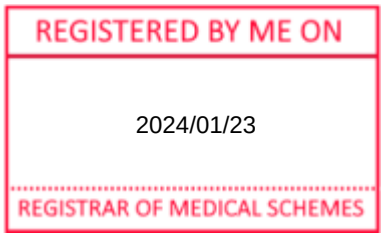
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D19.2	**Out of hospital Physiotherapy** **Biokinetics** **Podiatry**	• Limited to and included in D1. • 100% of the Bonitas Tariff.	• Limited to and included in D1. • 100% of the Bonitas Tariff.	Out of hospital physiotherapy and podiatry, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D20	**PROSTHESES AND DEVICES INTERNAL AND EXTERNAL (See B3)**			
D20.1	**Prostheses and devices internal (surgically implanted), including all temporary prostheses, or/and all accompanying temporary or permanent devices used to assist with the guidance, alignment or delivery of these internal prostheses and devices. This includes bone cement, bone graft substitutes, screws, pins and bone anchors.**	• R54 780 per family, unless PMB. • Sub-limit of R4 210 for a single intra-ocular lens. • R8 420 for bilateral lenses per beneficiary.	• R54 780 per family, unless PMB. • Sub-limit of R4 210 for a single intra-ocular lens. • R8 420 for bilateral lenses per beneficiary.	Subject to the relevant managed healthcare programme and to its prior authorisation. This benefit excludes Osseo-integrated implants for the purpose of replacing a missing tooth or teeth.
D20.1.1	**Cochlear implants**	• No benefit.	• No benefit.	
D20.1.2	**Internal Nerve Stimulator**	• R205 100 per family.	• R205 100 per family.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D20.2	**Prostheses external**	• Limited to and included in D20.1. • Limited to R6 520 per external breast prosthesis and limited to two per annum.	• Limited to and included in D20.1. • Limited to R6 520 per external breast prosthesis and limited to two per annum.	Subject to the relevant managed healthcare programme and to its prior authorisation. The benefit excludes consultations/fittings, which are subject to D17.2.
D21	**RADIOLOGY (See B2 and B3)**			
D21.1	**General radiology**			

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D21.1.1	**In hospital**	• No limit. • 100% of the Bonitas Tariff.	• No limit. • 100% of the Bonitas Tariff.	For diagnostic radiology tests and ultrasound scans. Authorisation is not required for MRI scans for low field peripheral joint examination of dedicated limb units.
D21.1.2	**Out of hospital** REGISTERED BY ME ON 2024/01/23 REGISTRAR OF MEDICAL SCHEMES	• Limited to and included in D18. • 100% of the Bonitas Tariff.	• Limited to and included in D18. • 100% of the Bonitas Tariff.	This benefit excludes: specified list of radiology tariff codes included in the • Maternity benefit, (D10), • Oncology benefit during the active treatment and/or post active treatment period, (D14); • Organ and haemopoietic stem cell transplantation benefit, (D16), • Renal dialysis chronic benefit, (D22). Authorisation is not required for MRI scans for low field peripheral joint examination of dedicated limb units. Out of hospital general radiology, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D21.2	**Specialised radiology**			
D21.2.1	**In hospital**	• R32 340 per family. • 100% of the Bonitas Tariff. • R1 770 co-payment applies per scan event, unless PMB or nuclear radio-isotope studies. • The co-payment to be waived if the cost of the service falls within the co-payment amount	• R32 340 per family. • 100% of the Bonitas Tariff. • R1 770 co-payment applies per scan event, unless PMB or nuclear radio-isotope studies. • The co-payment to be waived if the cost of the service falls within the co-payment amount	Subject to the relevant managed healthcare programme and to its prior authorisation. Specific authorisations are required in addition to any authorisation that may have been obtained for hospitalisation, for the following: • CT scans • MUGA scans • MRI scans • Radio isotope studies

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
				• CT colonography (virtual colonoscopy, limited to one per beneficiary per annum restricted to the evaluation of symptomaticpatients only). • MDCT coronary angiography, limited to one per beneficiary, restricted to the evaluation of symptomatic patients only.
D21.2.2	**Out of hospital**	Limited to and included in D21.2.1.	Limited to and included in D21.2.1.	See D21.2.1.
D21.3	**PET and PET-CT**	See D14.1.2.1.	See D14.1.2.1.	
D22	**RENAL DIALYSIS CHRONIC (See B3)**			
D22.1	**Haemodialysis and peritoneal dialysis**	• No limit. • 100% of the lower of the cost or Bonitas Tariff for all services, medicines and materials associated with the cost of renal dialysis, subject to the DSP network and Regulation 8 (3). • The contracted rate applies for the services rendered by a network specialist and 100% of the Bonitas Tariff for the services rendered by a non-network specialist. • Related medicine is subject to the DSP and Regulation 8 (3). • 20% co-payment applies for the voluntary use of a non-DSP.	• No limit. • 100% of the lower of the cost or Bonitas Tariff for all services, medicines and materials associated with the cost of renal dialysis, subject to the the DSP network and Regulation 8 (3). • The contracted rate applies for the services rendered by a network specialist and 100% of the Bonitas Tariff for the services rendered by a non-network specialist. • Related medicine is subject to the DSP and Regulation 8 (3). • 20% co-payment applies for the voluntary use of a non-DSP.	• Subject to the relevant managed healthcare programme and to its prior authorisation. • Authorised erythropoietin is included in (D4) • Acute renal dialysis is included in hospitalisation costs. See D7.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D22.2	**Radiology and pathology (See B3)**	Limited to and included in D22.1.	Limited to and included in D22.1.	As specified by the relevant managed healthcare programme.
D23	**SURGICAL PROCEDURES (See B3)**			Subject to the relevant managed healthcare programme and to its prior authorisation.
D23.1	**In hospital and unattached operating theatres and other minor surgical procedures that can be authorised in hospital.**	• Limited to and included in D7.1.1 or D7.2.1. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Co-payments apply – See paragraph D23.3 below. • Day surgery network applies for defined list of procedures. See D23.4.	• Limited to and included in D7.1.1 or D7.2.1. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Subject to the Standard Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • Co-payments apply – See paragraph D23.3 below. • Day surgery network applies for defined list of procedures. See D23.4.	This benefit excludes: • Osseo-integrated implants (D6); • Orthognathic and oral surgery (D6); • Maternity (D10); • Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16).
D23.1.1	**Refractive surgery**	No benefit.	No benefit.	
D23.1.2	**Maxillo-facial surgery**	• Limited to and included in D7.1.1 or D7.2.1. • 100% of the Bonitas Tariff for services rendered by the medical specialist.	• Limited to and included in D7.1.1 or D7.2.1. • 100% of the Bonitas Tariff for services rendered by the medical specialist.	Subject to the relevant managed healthcare programme and to its prior authorisation. For the surgical removal of • tumours • neoplasms • sepsis,

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
				• trauma, • congenital birth defects and other surgery not specifically mentioned in (D6). This benefit excludes: • Osseo-integrated implantation (D6); • Orthognathic surgery (D6); • Oral surgery (D6); • Impacted teeth (D6).
D23.2	**Out of hospital procedures in practitioner's rooms that are not mentioned in D23.2.1 or D23.2.2.**	• Limited to and included in the Day-to-Day benefit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the non-network medical specialist or general practitioner.	• Limited to and included in the Day-to-Day benefit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the non-network medical specialist or general practitioner.	• Subject to the relevant managed healthcare programme and to its prior authorisation. • Only where a hospital procedure is performed in the practitioner's rooms and is approved, will it be limited to and included in (D7) and OAL. • This benefit excludes services as above as well as Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication. (D16). • No co-payment applies if the procedure is done in the practitioner's rooms.
D23.2.1	**General procedures performed in specialist consulting rooms**	Limited to and included in D7.1.1 or D7.2.1 at enhanced rates for: • Endometrial biopsy (excluding after-care): (2434) • Implantation hormone pellets (excluding after-care): (2565). • Insertion of intra-uterine contraceptive device (IUCD) (excluding after-care): (2442) • Punch biopsy (excluding after-care): (2399) • Removal of tag or polyp: (2271) • Removal of small superficial benign lesions: (2272) • Removal of benign vulva tumour or cyst: (2277)		• Subject to pre-authorisation.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D23.2.2	**Specified procedures done in the specialist rooms or suitably equipped procedure room with correct equipment and monitoring facilities**	Limited to and included in D7.1.1 or D7.2.1 at enhanced rates for: • Biopsy during pregnancy (excluding after care): (2400) • Cervix encirclage: Removal items 2409 and 2411: without anaesthetic): (2415) • Colposcopy (excluding after-care): (2429) • Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room: (2392) • Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): Under anaesthetic: (2395) • Cystoscopy: (1949) • Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion: (2316) • Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat – Limited: (2317) • Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread: (2318) • Evacuation of uterus: Incomplete abortion: Before 12 weeks gestation: (2445) • Evacuation: Missed abortion: Before 12 weeks gestation: (2449) • Excision of benign lip lesion: (1485) • Excision of malignant lip lesion (1487) • Excision of superficial eyelid tumour: (3163) • Extensive resection for malignant soft tissue tumour including muscle: (0313) • Flap repairs (large, complicated): 0295 • Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.: (1676) • Full thickness skingraft repair: (0289) • Full thickness eyelid repair: (3189) • Full thickness lip repair: (1499) • Hymenectomy: (2283) • Hysterosalpingogram (excluding after-care): (2435) • Hysteroscopy (excluding after-care): (2436) • Hysteroscopy and polypectomy (excluding after-care): (2440) • Laser or harmonic scalpel treatment of the cervix: (2396) • Laser therapy of vulva and/or vagina (colposcopically directed): (2274) • Left-sided colonoscopy: (1656)		• Subject to pre-authorisation. 

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• Termination of pregnancy before 12 weeks: (2448) • Total colonoscopy: With hospital equipment (including biopsy): (1653) • Upper gastro-intestinal endoscopy: Hospital equipment: (1587) • Vulva and introitus: drainage of abscess: (2293)		REGISTERED BY ME ON 2024/01/23 REGISTRAR OF MEDICAL SCHEMES
D23.3	**PROCEDURES WHICH WILL ATTRACT A CO-PAYMENT:**			• Subject to the relevant managed healthcare programme and to its prior authorisation. • Where more than one co-payment applies to an admission/event, the lower of the co-payments will be waived and the highest will be the member's liability.
D23.3.1	**Procedures which will attract a co-payment:** **Hip and knee arthroplasty** **Cataract Surgery**	• Subject to a R35 250 co-payment: • when hip or knee arthroplasty is performed by a non-DSP. Subject to a R7 050 co-payment: • For the voluntary use of a non-DSP.	• Subject to a R35 250 co-payment for: • when hip or knee arthroplasty is performed by a non-DSP. Subject to a R7 050 co-payment: • For the voluntary use of a non-DSP.	The co-payment to be waived if the cost of the service falls within the co-payment amount
D23.4	**Day Surgery Procedures**	• Subject to the Day Surgery Network. • R2 590 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the Day Surgery Network. • R5 170 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and to its prior authorisation and subject to a defined list of procedures. • The co-payment to be waived if the cost of the service falls within the co-payment amount.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D24	**PREVENTATIVE CARE BENEFIT (See B3)**			
D24.1	**Women's Health** **Breast Cancer Screening**	• Mammogram Females age >40 years Once every 2 years.	• Mammogram Females age >40 years Once every 2 years.	Eligible beneficiaries may choose between the basic cytology test once every 3 years or HPV PCR test once every 5 years.
	Cervical Cancer Screening	• Pap Smear Females 21-65 years Once every 3 years.	• Pap Smear Females 21-65 years Once every 3 years.	
	Cervical Cancer Screening in HIV infection	• Pap Smear Females 21-65 years 1 basic cytology test per annum or the HPV PCR once every 5 years.	• Pap Smear Females 21-65 years 1 basic cytology test per annum or the HPV PCR once every 5 years.	
	Human Papilloma Virus (HPV) Vaccine	• Limited to 3 doses for females between 15 – 26 years. • One course per lifetime.	• Limited to 3 doses for females between 15 – 26 years. • One course per lifetime.	
D24.2	**Men's Health** **PSA test**	• Men 55-69 years, 1 per annum.	• Men 55-69 years, 1 per annum.	
D24.3	**General Health**	• HIV test annually • Flu vaccine annually, including the administration fee of the nurse practitioner.	• HIV test annually • Flu vaccine annually including the administration fee of the nurse practitioner.	HIV test is limited to one (1) per beneficiary per annum, either as part of Preventative Care or Health Risk Assessment. See D27.1.
D24.4	**Cardiac Health**	Full Lipogram From age 20 years Once every 5 years	Full Lipogram From age 20 years Every 5 years	
D24.5	**Elderly Health**	• Pneumococcal Vaccination including the administration fee of the nurse practitioner. Age >65 once every 5 years. • Faecal Occult Blood Test	• Pneumococcal Vaccination including the administration fee of the nurse practitioner. Age >65 once every 5 years. • Faecal Occult Blood Test	

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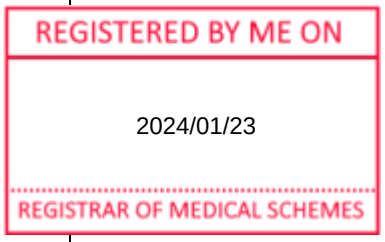
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		Ages 45-75 annually.	Ages 45-75 annually.	
D24.6	**Children's health Hypothyroidism** **Infant Hearing Screening** **Human Papilloma Virus (HPV) Vaccine**	• 1 TSH Test Age <1 month • One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist. • Limited to two doses for girls aged between 9 – 14years. • One course per lifetime.	• 1 TSH Test Age <1 month • One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist. • Limited to two doses for girls aged between 9 – 14years. • One course per lifetime.	
	Extended Program on Immunisation (EPI)	• Various Vaccinations including the administration fee of the nurse practitioner for children up to the age of 12 years.	• Various Vaccinations including the administration fee of the nurse practitioner for children up to the age of 12 years.	
D24.7	**Pertussis Booster Vaccine (Whooping Cough)**	• One booster vaccine per beneficiary between the ages of 07 and 64 years, every 10 years.	• One booster vaccine per beneficiary between the ages of 07 and 64 years, every 10 years.	
D24.8	**Hearing Loss Preventative Screening**	• Unlimited digital pre-screening for potential hearing loss subject to the Audiology Benefit Management programme	• Unlimited digital pre-screening for potential hearing loss subject to the Audiology Benefit Management programme	Screening options as available on the website and all other digital platforms offered by the Fund.
D25	**INTERNATIONAL TRAVEL BENEFIT** **Leisure travel:**	• For medical emergencies when travelling outside the borders of South Africa.	• For medical emergencies when travelling outside the borders of South Africa.	Subject to authorisation, prior to departure. • Additional benefits for Covid-19: o additional costs for compulsory medical quarantine limited to R1 000 per day to a

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	Business Travel:	○ 90 days excluding USA - R5 million per Member, R10 million for Member and Dependants ○ 90 days including USA – Maximum cover R500,000 for Member and Dependants. ○ 45 days excluding USA - R5 million per Member, 10 million for Member and Dependants ○ 45 days including USA - Maximum cover R500,000 for Member and Dependants. • Subject to approval protocols prior to departure.	○ 90 days excluding USA - R5 million per Member, R10 million for Member and Dependants ○ 90 days including USA – Maximum cover R500,000 for Member and Dependants. ○ 45 days excluding USA - R5 million per Member, 10 million for Member and Dependants ○ 45 days including USA - Maximum cover R500,000 for Member and Dependants. • Subject to approval protocols prior to departure.	maximum of R10 000 for accommodation and PCR testing up to R1 000. ○ The cover will only apply if a beneficiary tested positive. • (Manual labour excluded) • Pre-existing medical conditions are limited to R200 000 per family when hospitalized. • Subject to pre-authorisation of Emergency Medical expenses.
D26	**AFRICA BENEFIT**	• 100% of the usual, reasonable cost for in-and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	The Fund's liability will not exceed the global amount the Fund would in the ordinary course pay for such healthcare services given the Fund's claims experience in South Africa, subject to the benefits as per benefit plan.
D27	**WELLNESS BENEFIT**			
D27.1	**Health Risk Assessment (HRA) which includes** **Lifestyle questionnaire** **Wellness screening**	Wellness screening. One assessment per beneficiary per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to • blood pressure test • glucose test • cholesterol test	Wellness screening. One assessment per beneficiary per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to • blood pressure test • glucose test • cholesterol test	~~HIV test is limited to one (1) per beneficiary per annum,~~ either as part of Preventative Care or Health Risk Assessment. See D24.3. Rejected

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• body mass index. • hip to waist ratio • HIV counselling and testing.	• body mass index • hip to waist ratio • HIV counselling and testing.	
D27.2	**Benefit Booster (including out of hospital non-PMB day-to-day services as mentioned in D1, D5.1.3,D5.1.4, D5.2, D11.1, D11.2, D13.2, D17.2, D18.2, D19.2, D21.1.2 and virtual consultations)** 	Subject to completion of a Health Risk Assessment or the completion of an online wellness questionnaire per beneficiary. First level Benefit Booster, Limited to R1 000 per family, activated by completion of an online questionnaire. Limited to: • Alternative Health: D1 • GP consultations: D5.1.3 & 4 • Medical specialists: D5.2 • Acute medication: D11.1 • Pharmacy advised therapy: D11.2 • Non-surgical procedures: D13.2 • Paramedical services : D17.2 • Pathology: D18.2 • Physical therapy: D19.2 • General radiology: D21.1.2 Second level Benefit Booster applies when the first level benefit is depleted. Subject to the completion of a physical health risk assessment (HRA) at a participating pharmacy or wellness day. • Limited to R4 000 per family.	Subject to completion of a Health Risk Assessment or the completion of an online wellness questionnaire per beneficiary. First level Benefit Booster, Limited to R1 000 per family, activated by completion of an online questionnaire: Limited to:. • Alternative Health: D1 • GP consultations: D5.1.3 & 4 • Medical specialists: D5.2 • Acute medication: D11.1 • Pharmacy advised therapy: D11.2 • Non-surgical procedures: D13.2 • Paramedical services : D17.2 • Pathology: D18.2 • Physical therapy: D19.2 • General radiology: D21.1.2 Second level Benefit Booster applies when the first level benefit is depleted. Subject to the completion of a physical health risk assessment (HRA) at a participating pharmacy or wellness day. • Limited to R4 000 per family,	• Child dependants will qualify for the Benefit Booster once the main member or an adult beneficiary has completed a Health Risk Assessment or an online wellness questionnaire. • Valid qualifying claims will pay first from the Benefit Booster and thereafter from the relevant benefits as described in D1 – D24. • The first level Benefit Booster will become available when an online wellness questionnaire is completed by the main member or adult beneficiary. • When a main member or adult beneficiary completes the health risk assessment (HRA), the first and second level Benefit Booster will become available.