



BONITAS MEDICAL FUND ANNEXURE B

OPTIONS:
STANDARD
STANDARD SELECT

2026

REGISTERED BY ME ON
2025/12/18
REGISTRAR OF MEDICAL SCHEMES

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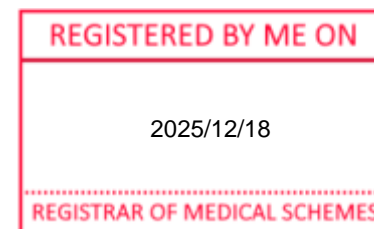
A ENTITLEMENT TO BENEFITS

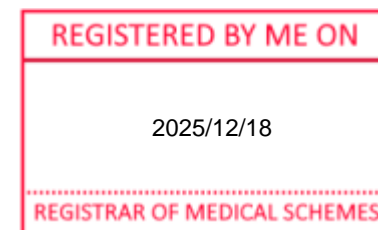
- A1 The Bonitas Fund Tariff is defined as the Bonitas monetary tariffs applicable in 2025 increased by an average of 4.0%
- A2 Beneficiaries are entitled to benefits as shown in this Annexure B, subject to the monetary limits and implementation restrictions set out herein, to the exclusions referred 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.

A5 The Scheme has appointed a PET scan network for the provision of PET scan services in and out of hospital, 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.

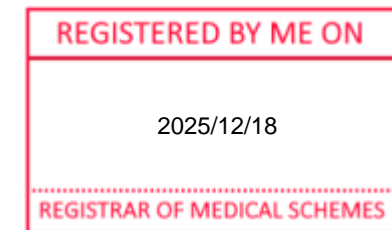
B3 Valid claims will be paid at 100% of the negotiated fee, or in the absence of such fee, 100% of the lower cost or Bonitas Tariff, or Uniform Patient Fee Schedule for Public hospitals, or 100% of the Bonitas Dental Tariff as prescribed or rendered by a medical dental and alternative healthcare practitioner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

Rejected

- 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
- Psychologist to Psychiatrist referral.
- Follow-up visits with one of the treating specialists, within 8 weeks of discharge from hospital, for the same condition.
- 1 (one) Urologist consultation/visit per annum for male beneficiaries.

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 : R13 980 M+1: R20 980 M+2: R23 310 M+3+: R25 640	M : R13 980 M+1: R20 980 M+2: R23 310 M+3+: R25 640	
	General Practitioner and Specialist Benefit	M : R3 500 M+1: R5 240 M+2: R5 830 M+3+: R6 990 Limited to and included in the Day-to-Day benefit. (See D5.1.3 and D5.1.4)	M : R3 500 M+1: R5 240 M+2: R5 830 M+3+: R6 990 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)	<div style="border: 1px solid red; padding: 5px; text-align: center;"> REGISTERED BY ME ON 2025/12/18 ***** REGISTRAR OF MEDICAL SCHEMES </div>
D1 ALTERNATIVE HEALTHCARE				
D1.1	Out of Hospital (See B1 & B3)	M : R3 500 M+1: R5 240 M+2: R5 830 M+3+: R6 990 Limited to and included in the Day-to-Day benefit.	M : R3 500 M+1: R5 240 M+2: R5 830 M+3+: R6 990 Limited to and included in the Day-to-Day benefit.	
D1.1.1	Homeopathic Consultations and/or treatment	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.2	Homeopathic Medicines	Limited to and included in D1.1 at 80% of tariff.	Limited to and included in D1.1, at 80% of tariff.	
D1.1.3	Acupuncture	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.4	Naturopathy Consultations and/or treatment and medicines	• Limited to and included in D1.1.	• Limited to and included in D1.1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		<ul style="list-style-type: none"> Medicines paid at 80% of tariff 	<ul style="list-style-type: none"> Medicines paid at 80% of tariff. 	
D1.1.5	Osteopathy	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.6	Phytotherapy	Limited to and included in D1.1.	Limited to and included in D1.1.	
D2 AMBULANCE SERVICES				
D2.1	Emergency Medical Transport (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				
D3.1	In and Out of Hospital	<div style="border: 2px solid red; padding: 10px; text-align: center;"> <p>REGISTERED BY ME ON</p> <p>2025/12/18</p> <p>.....</p> <p>REGISTRAR OF MEDICAL SCHEMES</p> </div>		<ul style="list-style-type: none"> Diabetic accessories and appliances (with the exception of glucometers and continuous glucose monitoring devices and consumables) 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.
D3.1.1	General medical and surgical appliances, including wheelchairs and repairs, and large orthopaedic appliances	<ul style="list-style-type: none"> Limited to and included in the Day-to-Day benefit. Blood pressure monitors for high risk beneficiaries, registered for Hypertension, are limited to R1 250 per family, subject to and included in the Day-to-Day benefit, once every 2 years. 	<ul style="list-style-type: none"> Limited to and included in the Day-to-Day benefit. Blood pressure monitors for high risk beneficiaries, registered for Hypertension, are limited to R1 250 per family, subject to and included in the Day-to-Day benefit, once every 2 years. 	Hiring or buying medical or surgical aids as prescribed by a medical practitioner.
D3.1.2	Audiology Benefit Management Benefit including Hearing Aids and repairs	<ul style="list-style-type: none"> Limited to R9 460 per device (maximum of two per family) over a three year cycle. 	<ul style="list-style-type: none"> Limited to R9 460 per device (maximum of two per family) over a three year cycle. 	<ul style="list-style-type: none"> Subject to the Hearing Loss Management Programme.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		<ul style="list-style-type: none"> A 25% co-payment will apply to devices obtained from a non-DSP. 	<ul style="list-style-type: none"> A 25% co-payment will apply to devices obtained from a non-DSP. 	
3.1.2.1	Audiology Services	<ul style="list-style-type: none"> Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). Non-network: Limited to and included in D1.1. 	<ul style="list-style-type: none"> Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). Non-network: Limited to and included in D1.1. 	<ul style="list-style-type: none"> Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). Non-network: Limited to and included in D1.1. The Benefit Booster (D27.2) does not apply.
3.1.2.2	Hearing Aid Acoustic Services	<ul style="list-style-type: none"> Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). Non-network: Limited to and included in D1.1. 	<ul style="list-style-type: none"> Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). Non-network: Limited to and included in D1.1. 	<ul style="list-style-type: none"> Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). Non-network: Limited to and included in D1.1. The Benefit Booster (D27.2) does not apply.
D3.1.3	CPAP Apparatus for sleep apnoea	R8 890 per family, unless PMB.	R8 890 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.	<div style="border: 2px solid red; padding: 10px; text-align: center;"> REGISTERED BY ME ON 2025/12/18 REGISTRAR OF MEDICAL SCHEMES </div>
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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D3.1.5.5	Insulin Pump Therapy or Continuous Glucose Infusion (CGM)	<ul style="list-style-type: none"> R65 000 per family for insulin pump.. Limited to one device per Type 1 Diabetic for beneficiaries younger than 18 years every 5 years; and R28 000 per annum for CGM device per Type 1 Diabetic for beneficiaries younger than 18 years. R93 000 per family for insulin pump or CGM consumables for Type 1 Diabetic for beneficiaries younger than 18 years. 	<ul style="list-style-type: none"> R65 000 per family for insulin pump. Limited to one device per Type 1 Diabetic for beneficiaries younger than 18 years every 5 years; and R28 000 for CGM device per Type 1 Diabetic for beneficiaries younger than 18 years. R93 000 per family for insulin pump or CGM consumables for Type 1 Diabetic for beneficiaries younger than 18 years. 	<ul style="list-style-type: none"> 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.
D4 BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS				
D4.1	In and Out of Hospital (See B3)	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				
D5.1	General Practitioners (Including Virtual Consultations) (See B1 and B3)	M : R3 500 M+1: R5 240 M+2: R5 830 M+3+: R6 990 Limited to and included in the Day-to-Day benefit.	M : R3 500 M+1: R5 240 M+2: R5 830 M+3+: R6 990 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. This benefit excludes <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> No limit. 	<ul style="list-style-type: none"> No limit. 	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		<ul style="list-style-type: none"> 100% of Bonitas Tariff for general practitioners. 	<ul style="list-style-type: none"> 100% of Bonitas Tariff for general practitioners. 	
D5.1.2.	Out of Hospital	<ul style="list-style-type: none"> Subject to the General Practitioner and Specialist benefit in D5.1. 	Subject to the General Practitioner and Specialist benefit in D5.1.	
D5.1.3	In Network General Practitioners/Nominated General Practitioners for Standard Select (including virtual consultations)	<ul style="list-style-type: none"> Limited to and included in D5.1. A network General Practitioner Risk benefit of 2 visits per family applies per annum, when the GP and Specialist consultation benefits are exhausted. 	<ul style="list-style-type: none"> Limited to and included in D5.1. 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
D5.1.4	Non-Network General Practitioners/Non Nominated, for Standard Select (Virtual consultations are limited to and included in D5.1.3)	Limited to and included in the General Practitioner and Specialist benefit in D5.1.	<ul style="list-style-type: none"> Limited to 2 out of area visits per family for non-nominated network GP visits. Limited to and included in D5.1. 	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	<ul style="list-style-type: none"> No limit Subject to the contracted rate. (See Annexure D: 7.3.6). 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> No limit 100% of the Bonitas Tariff for non-network specialists. 	<ul style="list-style-type: none"> 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. The member will be liable for the difference between private rates and the Bonitas Tariff.

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D5.2.2	Out of Hospital (See B1, B3 and B8) <div style="border: 1px solid red; padding: 5px; text-align: center;"> REGISTERED BY ME ON 2025/12/18 REGISTRAR OF MEDICAL SCHEMES </div>	<ul style="list-style-type: none"> 2 network specialist visits per family, per annum from OAL, subject to GP referral. Subsequent visits are limited to and included in the GP and Specialist consultation benefit in D5.1. The contracted rate applies for network specialists. 100% of the Bonitas Tariff for non-network specialists. 	<ul style="list-style-type: none"> 2 network specialist visits per family, per annum from OAL, subject to referral by a network GP. Subsequent visits are limited to and included in the GP and Specialist consultation benefit in D5.1. The contracted rate applies for network specialists. 100% of the Bonitas Tariff for non-network specialists. 	<p>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:</p> <ul style="list-style-type: none"> 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. Psychologist to Psychiatrist referral. Follow-up visits with one of the treating specialists within 8 weeks of discharge from hospital for the same condition. 1 (one) Urologist consultation/visit per annum for male beneficiaries. <p>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.</p>
D5.2.3	Infant Paediatric benefit (Consultation with a GP or Paediatrician)	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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				
D6.1	Basic Dentistry			
D6.1.1	Consultations (See B3)	Limited to two general check-ups (once every 6 months) per	Limited to two general check-ups (once every 6 months) per	Subject to the Bonitas Dental Management Programme. Specialists require pre-approval by the contracted provider.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		beneficiary per year. Covered at BDT.	beneficiary per year. Covered at BDT.	
D6.1.2	Fillings	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Benefit is subject to managed care protocols. Covered at 80% of the BDT. One set of plastic dentures (an upper and a lower) in a 4 year period per beneficiary. Subject to pre-authorisation. 	<ul style="list-style-type: none"> Benefit is subject to managed care protocols. Covered at 80% 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 (3 rd molars) and primary (milk) teeth is not covered.	Covered at 100% of BDT. Root canal therapy on wisdom teeth (3 rd 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.
D6.1.7	Hospitalisation (general anaesthetic) and Moderate/Deep Sedation in the rooms	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Subject to pre-authorisation. Pre-authorisation is required for Moderate/Deep Sedation in the rooms and is limited to extensive dental treatment where managed care protocols apply. The co-payment to be waived if the cost of the service falls within the co-payment amount.

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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		<ul style="list-style-type: none"> ○ A co-payment of R3 640 applies per hospital admission or R2 600 if treatment is done in a Day Clinic. • 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. <ul style="list-style-type: none"> ○ A co-payment of R5 200 applies per hospital admission or R2 600 if treatment is done in a Day Clinic. 	<ul style="list-style-type: none"> under the age of 5 years for extensive dental treatment. ○ A co-payment of R3 640 applies per hospital admission or R2 600 if treatment is done in a Day Clinic. • 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 <ul style="list-style-type: none"> ○ A co-payment of R5 200 applies per hospital admission or R2 600 if treatment is done in a Day Clinic. 	Rejected
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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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)			
D6.2.1	Crowns	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D6.2.2	Partial Chrome Cobalt Frame Dentures	<ul style="list-style-type: none"> 1 partial frame (an upper or a lower) per beneficiary in a 5 year period. Benefit is subject to managed care protocols. Covered at 80% of the BDT. Subject to pre-authorisation. 	<ul style="list-style-type: none"> 1 partial frame (an upper or a lower) per beneficiary in a 5 year period. Benefit is subject to managed care protocols. Covered at 80% of 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 Temporomandibular joint therapy is limited to non-surgical interventions/treatments.
D6.2.5	Orthodontic Treatment	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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 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	<ul style="list-style-type: none"> Pre-authorisation is required. 	<ul style="list-style-type: none"> Pre-authorisation is required. 	

REGISTERED BY ME ON

2025/12/18

REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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				
D7.1	Private hospitals and unattached operating theatres (See B3)			Subject to the relevant managed healthcare programme and its prior authorisation.
D7.1.1	In Hospital <div style="border: 2px solid red; padding: 5px; text-align: center;"> <p>REGISTERED BY ME ON</p> <p>2025/12/18</p> <p>*****</p> <p>REGISTRAR OF MEDICAL SCHEMES</p> </div>	<ul style="list-style-type: none"> No limit. Deep Brain Stimulation Implantation for Parkinson's Disease and intractable epilepsy is limited to R316 470 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) 	<ul style="list-style-type: none"> 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 R316 470 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: <ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Limited to and included in the OAL. Up to 7 days' supply, to a maximum of R605 per beneficiary per admission, 	<ul style="list-style-type: none"> Limited to and included in the OAL. Up to 7 days' supply, to a maximum of R605 per beneficiary per admission, 	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		except anticoagulants post surgery which will be subject to the relevant managed healthcare programme.	except anticoagulants post surgery which will be subject to the relevant managed healthcare programme.	
D7.1.3	Casualty / emergency room visits			The risk benefit without prior authorisation is maximum 2 emergency visits per family either in a private or public hospital setting.
D7.1.3.1	Facility fee	<ul style="list-style-type: none"> 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 to and included in the Day-to-Day benefit. 	<ul style="list-style-type: none"> 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 to and included in the Day-to-Day benefit. 	Will be included in the hospital benefit if a retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies.
D7.1.3.2	Consultations	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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. 	

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REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
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: <ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R605 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme. • See D7.1.2. 	<ul style="list-style-type: none"> • Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R605 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 without prior authorisation is maximum 2 emergency visits per family either in a private or public hospital setting.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D7.2.3.1	Facility fee	<ul style="list-style-type: none"> 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-authorization or non-emergency visits are limited to and included in the Day-to-Day benefit. 	<ul style="list-style-type: none"> 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-authorization or non-emergency visits are limited to and included in the Day-to-Day benefit. 	Will be included in the hospital benefit if retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies.
D7.2.3.2	Consultations <div style="border: 1px solid red; padding: 5px; margin: 10px auto; width: fit-content;"> REGISTERED BY ME ON 2025/12/18 REGISTRAR OF MEDICAL SCHEMES </div>	<ul style="list-style-type: none"> 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-authorization or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2. 	<ul style="list-style-type: none"> 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-authorization 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	<ul style="list-style-type: none"> Limited to and included in the Day-to-Day benefit. 	<ul style="list-style-type: none"> 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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
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	R67 270 per family, for all services.	R67 270 per family, for all services.	See D7.3
D7.3.2	Sub-acute facilities including Hospice	R21 570 per family.	R21 570 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	<ul style="list-style-type: none"> No limit. Subject to pre-authorisation. 	<ul style="list-style-type: none"> No limit. Subject to pre-authorisation. 	Subject to the relevant managed healthcare programme.
D7.3.4	Conservative Back Programme (Including treatment for shoulders and knees and a physiotherapy network where the nearest centre of excellence is greater than 30kms away).	Subject to the Contracted Provider. <div>Rejected</div>	Subject to the Contracted Provider	Subject to one treatment protocol per beneficiary per annum.
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				
D8.1	In and Out of Hospital (See B3)	<ul style="list-style-type: none"> No limit. Subject to PMBs. 	<ul style="list-style-type: none"> No limit. Subject to PMBs. 	<ul style="list-style-type: none"> Subject to registration on the relevant managed healthcare programme. Subject to clinical protocols.
D8.1.1	Anti-retroviral medicine	Limited to and included in D8.1 and subject to the DSP.	Limited to and included in D8.1 and subject to the DSP.	Subject to the relevant managed healthcare programme.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D8.2	Related medicine	Limited to and included in D8.1 and subject to the DSP.	Limited to and included in D8.1 and subject to the DSP.	
D8.3	Related pathology	Limited to and included in D8.1.	Limited to and included in D8.1.	Pathology as specified by the relevant managed healthcare programme, out of hospital.
D8.4	Related consultations	Limited to and included in D8.1.	Limited to and included in D8.1.	
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				
D9.1	Treatment related to 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				
D10.1	Confinement in hospital (See B3) <div style="border: 2px solid red; padding: 5px; text-align: center;"> <p>REGISTERED BY ME ON</p> <p>2025/12/18</p> <p>.....</p> <p>REGISTRAR OF MEDICAL SCHEMES</p> </div>	<ul style="list-style-type: none"> No limit. The contracted rate applies for network specialists. 100% of the Bonitas Tariff for the general practitioner or non-network specialist. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Subject to the relevant managed healthcare programme and to its prior authorisation. 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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D10.1.2	Confinement in a registered birthing unit	<ul style="list-style-type: none"> Limited to and included in D10.1. 4 x post-natal midwife consultations per pregnancy, of which one (1) can be used for a consultation with an accredited lactation specialist out of hospital. 	<ul style="list-style-type: none"> Limited to and included in D10.1. 4 x post-natal midwife consultations per pregnancy, of which one (1) can be used for a consultation with an accredited lactation specialist out of hospital. Subject to the Standard Select Hospital Network. 30% co-payment to apply to all voluntary non-network admissions. 	<ul style="list-style-type: none"> 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 can be used for a consultation with an accredited lactation specialist out of hospital.
D10.2	Confinement out of hospital <div style="border: 1px solid red; padding: 5px; margin: 10px 0;"> REGISTERED BY ME ON 2025/12/18 REGISTRAR OF MEDICAL SCHEMES </div>	<ul style="list-style-type: none"> Limited to and included in D10.1. 4 x post-natal midwife consultations per pregnancy, of which one (1) can be used for a consultation with an accredited lactation specialist. 	<ul style="list-style-type: none"> Limited to and included in D10.1. 4 x post-natal midwife consultations per pregnancy, of which one (1) can be used for a consultation with an accredited lactation specialist. 	<ul style="list-style-type: none"> 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 can be used for a consultation with an accredited 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.
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	<ul style="list-style-type: none"> 12 ante-natal consultations by a specialist, general practitioner or midwife per pregnancy. R1 580 for ante-natal classes/exercises per pregnancy. 	<ul style="list-style-type: none"> 12 ante-natal consultations by a specialist, general practitioner or midwife per pregnancy. R1 580 for ante-natal classes/exercises per pregnancy. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Pregnancy related tests and procedures. 2 x 2D pregnancy scans. 	<ul style="list-style-type: none"> Pregnancy related tests and procedures. 2 x 2D pregnancy scans. 	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		<ul style="list-style-type: none"> 1 x amniocentesis per pregnancy. 	<ul style="list-style-type: none"> 1 x amniocentesis per pregnancy. 	
D11 MEDICINE AND INJECTION MATERIAL				
D11.1	Routine /(acute) medicine (See B3 and B4)	M : R3 500 M+1: R5 240 M+2: R5 830 M+3+: R6 990 <ul style="list-style-type: none"> Limited to and included in the Day-to-Day benefit. 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. 	M : R3 500 M+1: R5 240 M+2: R5 830 M+3+: R6 990 <ul style="list-style-type: none"> Limited to and included in the Day-to-Day benefit. 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, Drug Reference Pricing and the Pharmacy Products Management Document are applicable. This benefit excludes: <ul style="list-style-type: none"> 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.	
D11.1.2	Contraceptives <div style="border: 1px solid red; padding: 5px; display: inline-block;">Rejected</div>	<ul style="list-style-type: none"> Limited to R2 050 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. 	<ul style="list-style-type: none"> Limited to R2 050 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. 	<ul style="list-style-type: none"> On Standard Select, contraceptive injectables may be obtained from a Bonitas Network Pharmacy. The non-DSP co-payment will not apply.
D11.1.3	Registered ante-natal vitamins during pregnancy	<ul style="list-style-type: none"> Limited to and included in D11.1 and D27.2. Limited to R200 per beneficiary per month. 	<ul style="list-style-type: none"> Limited to and included in D11.1 and D27.2. Limited to R200 per beneficiary per month. 	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		<ul style="list-style-type: none"> Subject to the medicine formulary. 	<ul style="list-style-type: none"> Subject to the medicine formulary. 	
D11.2	Pharmacy Advised Therapy Schedules 0, 1 and 2 medicine advised and dispensed by a pharmacist	<ul style="list-style-type: none"> Limited to R930 per beneficiary. R2 910 per family. Limited to and included in D11.1. 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. 	<ul style="list-style-type: none"> Limited to R930 per beneficiary. R2 910 per family. Limited to and included in D11.1. 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. 	<ul style="list-style-type: none"> Subject to the relevant managed healthcare programme. Subject to the Bonitas Pharmacy Network. The Medicine Exclusion List, Drug Reference Pricing, and the Pharmacy Products Management Document are applicable.
D11.3	Chronic medicine (See B4)	<ul style="list-style-type: none"> Limited to R13 030 per beneficiary. R26 150 per family. 30% 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. 30% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP. 	<ul style="list-style-type: none"> Subject to the DSP and limited to R13 030 per beneficiary. R26 150 per family. 30% co-payment applies for the voluntary use of a non-DSP. Only PMBs will be paid above limits, and 30% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP. 	<p>Subject to registration on the relevant managed healthcare programme and to its prior authorisation and applicable formularies. Subject to Drug Reference Pricing. Restricted to a maximum of one month's supply unless pre-authorised. [Includes diabetic disposables such as</p> <ul style="list-style-type: none"> syringes, needles, strips and lancets <p>The above are excluded from D3 and D11 if on the Diabetic Management Programme. This benefit excludes:</p> <ul style="list-style-type: none"> 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
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				
D12.1	Treatment and care related to Mental Health (See B3 and B6)	<ul style="list-style-type: none"> R51 900 per family, unless PMB. 	<ul style="list-style-type: none"> R51 900 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.
D12.1.1	In Hospital <div style="border: 1px solid red; padding: 5px; margin: 10px 0; text-align: center;"> REGISTERED BY ME ON 2025/12/18 ***** REGISTRAR OF MEDICAL SCHEMES </div>	<ul style="list-style-type: none"> Limited to and included in D12.1. 	<ul style="list-style-type: none"> Limited to and included in D12.1. 	<ul style="list-style-type: none"> 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).
D12.1.2	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			
D12.2.1	Medicine (See B4 and B6)	Limited to and included in D11.1.	Limited to and included in D11.1.	
D12.3	Rehabilitation for substance abuse (See B3)	<ul style="list-style-type: none"> Limited to and included in D12.1. Subject to the DSP. 	<ul style="list-style-type: none"> Limited to and included in D12.1. Subject to the DSP. 	Subject to the relevant managed healthcare programme and to its prior authorisation. (See B6).

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		<ul style="list-style-type: none">30% co-payment applies to the voluntary use of a non-DSP.	<ul style="list-style-type: none">30% co-payment applies to the voluntary use of a non-DSP.	
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.	<div>REGISTERED BY ME ON</div> <div>2025/12/18</div> <div>REGISTRAR OF MEDICAL SCHEMES</div>
D12.4	Consultations and visits, procedures, assessments, therapy, treatment and/or counselling, in and out of hospital. (See B3)	<ul style="list-style-type: none">R20 310 per family, limited to and included in D12.1.Educational psychology visits and psychometry assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	<ul style="list-style-type: none">R20 310 per family, limited to and included in D12.1.Educational psychology visits and psychometry assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	
D12.5	Mental Health Programme as managed via Active Disease Risk Management in Annexure D, paragraph 6.10	<ul style="list-style-type: none">Limited to R14 400 per beneficiary.Subject to enrolment on the relevant managed healthcare programme,	<ul style="list-style-type: none">Limited to R14 400 per beneficiary.Subject to enrolment on the relevant managed healthcare programme,	
D13 NON-SURGICAL PROCEDURES AND TESTS				
D13.1	In Hospital (See B2 and B3)	<ul style="list-style-type: none">No limit.The contracted rate applies for network specialists.100% of the Bonitas Tariff for non-network specialists or general practitioners.	<ul style="list-style-type: none">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: <ul style="list-style-type: none">Psychiatry and psychology (D12);Optometric examinations (D15);Pathology (D18);Radiology (D21).
D13.2	Out of hospital (See B2 and B3)	<ul style="list-style-type: none">Limited to and included in the Day-to-Day benefit.The contracted rate applies for network specialists.	<ul style="list-style-type: none">Limited to and included in the Day-to-Day benefit.The contracted rate applies for network specialists.	Out of hospital procedures, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		<ul style="list-style-type: none"> 100% of the Bonitas Tariff for non-network specialists or general practitioners. 	<ul style="list-style-type: none"> 100% of the Bonitas Tariff for non-network specialists or general practitioners. 	
D13.2.1	<ul style="list-style-type: none"> 24 hr oesophageal PH studies Breast fine needle biopsy Circumcision Laser tonsillectomy Oesophageal motility studies Vasectomy Prostate Needle biopsy (See B3) 	<ul style="list-style-type: none"> No limit. The contracted rate applies for network specialists. 100% of the Bonitas Tariff for non-network specialists or general practitioners. 	<ul style="list-style-type: none"> No limit. The contracted rate applies for network specialists. 100% of the Bonitas Tariff for non-network specialists or general practitioners. 	<ul style="list-style-type: none"> 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)	<div style="border: 2px solid red; padding: 5px; text-align: center;"> <p>REGISTERED BY ME ON</p> <p>2025/12/18</p> <p>REGISTRAR OF MEDICAL SCHEMES</p> </div>		Subject to the relevant managed healthcare programme and its prior authorisation.
D13.3.1	Diagnostic Polysomnograms In and out of hospital	<ul style="list-style-type: none"> No limit. The contracted rate applies for network specialists. 100% of the Bonitas Tariff for non-network specialists or general practitioners. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> No limit. The contracted rate applies for network specialists. 100% of the Bonitas Tariff for non-network specialists or general practitioners. 	<ul style="list-style-type: none"> 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				
D14.1	PRE ACTIVE, ACTIVE & POST ACTIVE TREATMENT PERIOD (See A4 & B3)	<ul style="list-style-type: none"> R280 100 per family for oncology. Unlimited for PMB oncology. 	<ul style="list-style-type: none"> R280 100 per family for oncology. Unlimited for PMB oncology. 	<ul style="list-style-type: none"> Subject to registration on the oncology management programme. All costs related to approved cancer treatment, including

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	<div style="border: 1px solid red; padding: 5px; text-align: center;"> <p>REGISTERED BY ME ON</p> <p>2025/12/18</p> <p>REGISTRAR OF MEDICAL SCHEMES</p> </div>	<ul style="list-style-type: none"> 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). 	<ul style="list-style-type: none"> 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). 	<p>PMB treatment, will add up to the oncology benefit limit.</p> <ul style="list-style-type: none"> 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-active, active and post-active consultations and investigations are subject to Cancer Care Plans. 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.
D14.1.1	Medicine (excluding Specialised Drugs) See D14.1.3 (See B4)	<ul style="list-style-type: none"> 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 Drug Reference Pricing and preferred product list. 	<ul style="list-style-type: none"> 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 Drug Reference Pricing 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.	<ul style="list-style-type: none"> Subject to the relevant managed healthcare programme and to its prior authorisation. Limited to Cancer Care Plans in pre-active, active and post-active setting. Specific authorisations are required for advanced radiology in addition to any authorisation that may have been obtained for hospitalisation.
D14.1.2.1	PET and PET-CT (See B3)	<ul style="list-style-type: none"> Limited to and included in D14.1 and one per family per annum. 	<ul style="list-style-type: none"> Limited to and included in D14.1 and one per family per annum. 	<ul style="list-style-type: none"> 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
		<ul style="list-style-type: none"> Subject to the use of a provider on the PET-CT scan network at the contracted rate. Services rendered by a non-network provider pay at 100% of the Bonitas Tariff, subject to a 25% non-network co-payment. 	<ul style="list-style-type: none"> Subject to the use of a provider on the PET-CT scan network at the contracted rate. Services rendered by a non-network provider pay at 100% of the Bonitas Tariff, subject to a 25% non-network co-payment. 	<ul style="list-style-type: none"> Specific authorisations are required in addition to any authorisation that may have been obtained for hospitalisation.
D14.1.3 <div style="border: 2px solid red; padding: 5px; margin: 10px auto; width: fit-content;"> <p style="text-align: center; color: red; font-weight: bold;">REGISTERED BY ME ON</p> <p style="text-align: center;">2025/12/18</p> <p style="text-align: center; color: red; font-weight: bold;">REGISTRAR OF MEDICAL SCHEMES</p> </div>	Specialised Drugs (See B4)			<ul style="list-style-type: none"> 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, immunologic and targeted therapy	<ul style="list-style-type: none"> R164 100 per family, limited to and included in D14.1. No benefit applies above the Specialised Drug benefit limit, unless PMB. 	<ul style="list-style-type: none"> R164 100 per family, limited to and included in D14.1. No benefit applies above the Specialised Drug benefit limit, unless PMB. 	<ul style="list-style-type: none"> 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 R63 110 per beneficiary and included in D14.1.	Limited to R63 110 per beneficiary and included in D14.1.	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Limited to R3 640 per family. Limited to and included in D14.1. 	<ul style="list-style-type: none"> Limited to R3 640 per family. Limited to and included in D14.1. 	Subject to the relevant managed healthcare protocols and its prior authorisation.
D14.3	Palliative Care	<ul style="list-style-type: none"> No limit. Subject to pre-authorisation. Managed care protocols apply. 	<ul style="list-style-type: none"> No limit. Subject to pre-authorisation. Managed care protocols apply. 	Subject to the relevant managed healthcare protocols and its prior authorisation.
D15 OPTOMETRY				
D15.1	In and Out of Network (See B3)	<ul style="list-style-type: none"> Biennial benefit. Benefit availability is subject to a 24 month cycle from last date of service. 	<ul style="list-style-type: none"> Biennial benefit. Benefit availability is subject to a 24 month cycle from last date of service. 	<ul style="list-style-type: none"> Subject to clinical protocols. 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.
D15.1.1	Optometric refraction test, re-exam and/or composite exam, including tonometry and visual field test.	<ul style="list-style-type: none"> One per beneficiary, per benefit cycle, at network rates. R420 out of network. Limited to and included in D15.1. 	<ul style="list-style-type: none"> One per beneficiary, per benefit cycle, at network rates. R420 out of network. Limited to and included in D15.1. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> R1 475 per beneficiary in network. R1 106 per beneficiary out of network or member refunds. Limited to and included in D15.1. 	<ul style="list-style-type: none"> R1 475 per beneficiary in network. R1 106 per beneficiary out of network or member refunds. Limited to and included in D15.1. 	On the Standard and Standard Select options, the frame value may be used towards frames and/or lens enhancements.

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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D15.3	Lenses			
D15.3.1	Single vision lenses	<ul style="list-style-type: none"> 100% towards the cost of clear lenses at network rates. Limited to R225 per lens per beneficiary out of network. Limited to and included in D15.1; or 	<ul style="list-style-type: none"> 100% towards the cost of clear lenses at network rates. Limited to R225 per lens per beneficiary out of network. Limited to and included in D15.1; or 	Subject to contracted providers protocols.
D15.3.2	Bifocal lenses	<ul style="list-style-type: none"> 100% towards the cost of clear lenses at network rates. Limited to R485 per lens per beneficiary out of network. Limited to and included in D15.1; or 	<ul style="list-style-type: none"> 100% towards the cost of clear lenses at network rates. Limited to R485 per lens per beneficiary out of network. Limited to and included in D15.1; or 	<div style="border: 2px solid red; padding: 10px; text-align: center;"> <p>REGISTERED BY ME ON</p> <p>2025/12/18</p> <p>.....</p> <p>REGISTRAR OF MEDICAL SCHEMES</p> </div>
D15.3.3	Multifocal lenses	<ul style="list-style-type: none"> 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. Limited to R850 per base lens or R50 per branded lens add-on per beneficiary out of network. Limited to and included in D15.1. 	<ul style="list-style-type: none"> 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. Limited to R850 per base lens or R50 per branded lens add-on per beneficiary out of network. Limited to and included in D15.1. 	
D15.3.4	Contact lenses	<ul style="list-style-type: none"> Limited to R2 185 per beneficiary. Limited to and included in D15.1. 	<ul style="list-style-type: none"> Limited to R2 185 per beneficiary. Limited to and included in D15.1. 	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
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 D15.1.1.	Limited to and included in D15.1.1.	
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 TRANSPLANTATION				
D16.1	ORGAN AND HAEMOPOIETIC STEM CELL (BONE MARROW) TRANSPLANTATION AND IMMUNO-SUPPRESSIVE MEDICATION (INCLUDING CORNEAL GRAFTS) (See B3)	<ul style="list-style-type: none"> 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 R42 710 per beneficiary for local and imported grafts. 	<ul style="list-style-type: none"> 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 R42 710 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. 	<ul style="list-style-type: none"> 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.

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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D16.1.1	Haemopoietic stem cell (bone marrow) transplantation (See B3)	Limited to and included in D16.1.	Limited to and included in D16.1.	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.
D16.2	Immuno-suppressive medication (See B4)	Limited to and included in D16.1 and subject to the DSP.	Limited to and included in D16.1 and subject to the DSP.	<div>REGISTERED BY ME ON</div> <div>2025/12/18</div> <div>REGISTRAR OF MEDICAL SCHEMES</div>
D16.3	Post transplantation biopsies and scans (See B3)	Limited to and included in D16.1.	Limited to and included in D16.1.	
D16.4	Radiology and pathology (See B3)	Limited to and included in D16.1.	Limited to and included in D16.1.	
D17 PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS)				
D17.1	In hospital (See B2 and B3)	<ul style="list-style-type: none">Limited to and included in D1, unless PMB.100% of the Bonitas Tariff.	<ul style="list-style-type: none">Limited to and included in D1, unless PMB.100% of the Bonitas Tariff.	<ul style="list-style-type: none">Subject to referral by the treating practitioner.Treatment approved as PMB will be covered from OAL and not accrue to D.1.1.
D17.1.1	Dietetics	Limited to and included in D1.1.	Limited to and included in D1.1.	<ul style="list-style-type: none">Treatment approved as PMB will be covered from OAL and not accrue to D.1.1.
D17.1.2	Occupational Therapy	Limited to and included in D1.1.	Limited to and included in D1.1.	<ul style="list-style-type: none">Treatment approved as PMB will be covered from OAL and not accrue to D.1.1.
D17.1.3	Speech Therapy	Limited to and included in D1.1.	Limited to and included in D1.1.	<ul style="list-style-type: none">Treatment approved as PMB will be covered from OAL and not accrue to D.1.1.
D17.2	Out of hospital	<ul style="list-style-type: none">Limited to and included in D1.1.100% of the Bonitas Tariff.	<ul style="list-style-type: none">Limited to and included in D1.1.100% 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 D1.1.	Limited to and included in D1.1.	This benefit excludes X-rays performed by chiropractors.
D17.2.2	Dietetics	Limited to and included in D1.1.	Limited to and included in D1.1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D17.2.3	Genetic counselling	Limited to and included in D1.1.	Limited to and included in D1.1.	
D17.2.4	Occupational therapy	Limited to and included in D1.1.	Limited to and included in D1.1.	
D17.2.5	Orthoptics	Limited to and included in D1.1.	Limited to and included in D1.1.	
D17.2.5	Orthotists and Prosthetists	Limited to and included in D1.1.	Limited to and included in D1.1.	
D17.2.7	Private nurse practitioners	Limited to and included in D1.1.	Limited to and included in D1.1.	Nursing services are included in the Alternatives to Hospitalisation benefit (D7) if pre-authorised by the relevant managed healthcare programme.
D17.2.8	Speech therapy	Limited to and included in D1.1.	Limited to and included in D1.1.	
D17.2.9	Social workers	Limited to and included in D1.1.	Limited to and included in D1.1.	
D18 PATHOLOGY AND MEDICAL TECHNOLOGY				
D18.1	In Hospital (See B1 and B3)	<ul style="list-style-type: none"> No limit. Subject to the DSP for pathology at negotiated rates. 100% of the Bonitas Tariff for services rendered by non-DSP providers. 	<ul style="list-style-type: none"> 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 (See B1 and B3)	<p>M : R3 500 M+1: R5 240 M+2: R5 830 M+3+: R6 990</p> <ul style="list-style-type: none"> Limited to and included in the Day-to-Day benefit. Subject to the DSP for pathology at negotiated rates. 	<p>M : R3 500 M+1: R5 240 M+2: R5 830 M+3+: R6 990</p> <ul style="list-style-type: none"> Limited to and included in the Day-to-Day benefit. Subject to the DSP for pathology at negotiated rates. 	<p>Subject to Pathology Management Program. This benefit excludes: the specified list of pathology tariff codes included in the:</p> <ul style="list-style-type: none"> 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) <p>Out of hospital pathology, as specified in the aPMB care templates, will only accrue to the</p>

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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		<ul style="list-style-type: none"> 100% of the Bonitas Tariff for services rendered by non-DSP providers. 	<ul style="list-style-type: none"> 100% of the Bonitas Tariff for services rendered by non-DSP providers. 	Day-to-Day benefits once the aPMB entitlements are depleted.
D19 PHYSICAL THERAPY				
D19.1	In hospital Physiotherapy Biokinetics (See B1 and B3)	<ul style="list-style-type: none"> Limited to and included in D1.1, unless PMB. 100% of the Bonitas Tariff. 	<ul style="list-style-type: none"> Limited to and included in D1.1, unless PMB. 100% of the Bonitas Tariff. 	<ul style="list-style-type: none"> Subject to referral by the treating practitioner. Physiotherapy is not covered for mental health admissions. Treatment approved as PMB will be covered from OAL and not accrue to D.1.1. (See D12.)
D19.2	Out of hospital Physiotherapy Biokinetics Podiatry	<ul style="list-style-type: none"> Limited to and included in D1.1. 100% of the Bonitas Tariff. 	<ul style="list-style-type: none"> Limited to and included in D1.1. 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				
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. (See B3)	<ul style="list-style-type: none"> R57 630 per family, unless PMB. Sub-limit of R4 610 for a single intra-ocular lens. R9 210 for bilateral lenses per beneficiary. 	<ul style="list-style-type: none"> R57 630 per family, unless PMB. Sub-limit of R4 610 for a single intra-ocular lens. R9 210 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. <div style="border: 1px solid red; padding: 5px; margin-top: 10px; text-align: center;"> REGISTERED BY ME ON 2025/12/18 REGISTRAR OF MEDICAL SCHEMES </div>
D20.1.1	Cochlear implants	<ul style="list-style-type: none"> No benefit. 	<ul style="list-style-type: none"> No benefit. 	
D20.1.2	Internal Nerve Stimulator	<ul style="list-style-type: none"> R224 400 per family. 	<ul style="list-style-type: none"> R224 400 per family. 	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
D20.2	Prostheses external	<ul style="list-style-type: none"> Limited to and included in D20.1. Limited to R7 130 per external breast prosthesis and limited to two per annum. 	<ul style="list-style-type: none"> Limited to and included in D20.1. Limited to R7 130 per external breast prosthesis and limited to two per annum. 	<ul style="list-style-type: none"> 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				
D21.1	General radiology (See B2 and B3)			
D21.1.1	In hospital	<ul style="list-style-type: none"> No limit. 100% of the Bonitas Tariff. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Limited to and included in D18.1. 100% of the Bonitas Tariff. 	<ul style="list-style-type: none"> Limited to and included in D18.1. 100% of the Bonitas Tariff. 	<p>This benefit excludes: specified list of radiology tariff codes included in the</p> <ul style="list-style-type: none"> 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). <p>Authorisation is not required for MRI scans for low field peripheral joint examination of dedicated limb units.</p> <p>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.</p>
D21.2	Specialised radiology			
D21.2.1	In hospital	<ul style="list-style-type: none"> R34 020 per family. 100% of the Bonitas Tariff. R1 860 co-payment applies per scan event, unless PMB 	<ul style="list-style-type: none"> R34 020 per family. 100% of the Bonitas Tariff. R1 860 co-payment applies per scan event, unless PMB 	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:

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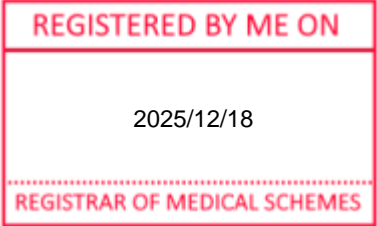
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		or nuclear radio-isotope studies. • The co-payment to be waived if the cost of the service falls within the co-payment amount.	or nuclear radio-isotope studies. • The co-payment to be waived if the cost of the service falls within the co-payment amount.	• CT scans • MUGA scans • MRI scans • Radio isotope studies • CT colonography (virtual colonoscopy, limited to one per beneficiary per annum restricted to the evaluation of symptomatic patients 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				
D22.1	Haemodialysis and peritoneal dialysis (See B3)	• 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.	• 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.	• 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.

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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		<ul style="list-style-type: none"> Related medicine is subject to the DSP and Regulation 8 (3). 20% co-payment applies for the voluntary use of a non-DSP. 	<ul style="list-style-type: none"> Related medicine is subject to the DSP and Regulation 8 (3). 20% co-payment applies for the voluntary use of a non-DSP. 	
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.
<div style="text-align: center;"> <p>REGISTERED BY ME ON</p> <p>2025/12/18</p> <p>REGISTRAR OF MEDICAL SCHEMES</p> </div>				
D23	SURGICAL PROCEDURES			
D23.1	In hospital and unattached operating theatres and other minor surgical procedures that can be authorised in hospital. (See B3)	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	<p>Subject to the relevant managed healthcare programme and to its prior authorisation. This benefit excludes:</p> <ul style="list-style-type: none"> Osseo-integrated implants (D6); Orthognathic and oral surgery (D6); Maternity (D10); Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16).

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D23.1.1	Refractive surgery	No benefit.	No benefit.	
D23.1.2	Maxillo-facial surgery 	<ul style="list-style-type: none"> Limited to and included in D7.1.1 or D7.2.1. 100% of the Bonitas Tariff for services rendered by the medical specialist. 	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> tumours neoplasms sepsis, trauma, congenital birth defects and other surgery not specifically mentioned in (D6). This benefit excludes: <ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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) 		<ul style="list-style-type: none"> 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	<p>Limited to and included in D7.1.1 or D7.2.1 at enhanced rates for:</p> <ul style="list-style-type: none"> • 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 skin graft 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) • Termination of pregnancy before 12 weeks: (2448) • Total colonoscopy: With hospital equipment (including biopsy): (1653) 		<ul style="list-style-type: none"> • Subject to pre-authorisation.

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		<ul style="list-style-type: none"> Upper gastro-intestinal endoscopy: Hospital equipment: (1587) Vulva and introitus: drainage of abscess: (2293) 		
D23.3	PROCEDURES WHICH WILL ATTRACT A CO-PAYMENT:	<div style="border: 2px solid red; padding: 10px; text-align: center;"> <p>REGISTERED BY ME ON</p> <p>2025/12/18</p> <p>.....</p> <p>REGISTRAR OF MEDICAL SCHEMES</p> </div>		<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Subject to a R38 560 co-payment: when hip or knee arthroplasty is performed by a non-DSP. 	<ul style="list-style-type: none"> Subject to a R38 560 co-payment for: when hip or knee arthroplasty is performed by a non-DSP. 	The co-payment to be waived if the cost of the service falls within the co-payment amount
	Cataract Surgery	<ul style="list-style-type: none"> Subject to a R7 420 co-payment: For the voluntary use of a non-DSP. 	<ul style="list-style-type: none"> Subject to a R7 420 co-payment: For the voluntary use of a non-DSP. 	
D23.4	Day Surgery Procedures	<ul style="list-style-type: none"> Subject to the Day Surgery Network. R5 440 co-payment to apply to all non-network admissions and subject to Regulation 8 (3). 	<ul style="list-style-type: none"> Subject to the Day Surgery Network. R7 100 co-payment to apply to all non-network admissions and subject to Regulation 8 (3). 	<ul style="list-style-type: none"> 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.
D24	PREVENTATIVE CARE BENEFIT			
D24.1	Women's Health Breast Cancer Screening	Mammogram <ul style="list-style-type: none"> Females age >40 years Once every 2 years. 	Mammogram <ul style="list-style-type: none"> Females age >40 years Once every 2 years. 	
	Cervical Cancer Screening	Pap Smear <ul style="list-style-type: none"> Females 21-65 years Once every 3 years. 	Pap Smear <ul style="list-style-type: none"> Females 21-65 years Once every 3 years. 	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	Cervical Cancer Screening in HIV infection	Pap Smear <ul style="list-style-type: none"> Females 21-65 years 1 basic cytology test per annum or the HPV PCR once every 5 years. 	Pap Smear <ul style="list-style-type: none"> Females 21-65 years 1 basic cytology test per annum or the HPV PCR once every 5 years. 	Eligible beneficiaries may choose between the basic cytology test once every 3 years or HPV PCR test once every 5 years.
	Human Papilloma Virus (HPV) Vaccine	<ul style="list-style-type: none"> Limited to 3 doses for females between 15 – 26 years. One course per lifetime. Limited to R1 140 per vaccine. 	<ul style="list-style-type: none"> Limited to 3 doses for females between 15 – 26 years. One course per lifetime. Limited to R1 140 per vaccine. 	<div style="border: 2px solid red; padding: 10px; text-align: center;"> <p>REGISTERED BY ME ON</p> <p>2025/12/18</p> <p>REGISTRAR OF MEDICAL SCHEMES</p> </div>
D24.2	Men's Health PSA test	<ul style="list-style-type: none"> Men 55-69 years, 1 per annum. 	<ul style="list-style-type: none"> Men 55-69 years, 1 per annum. 	
D24.3	General Health	<ul style="list-style-type: none"> HIV test annually Flu vaccine annually, including the administration fee of the nurse practitioner. 	<ul style="list-style-type: none"> HIV test annually Flu vaccine annually including the administration fee of the nurse practitioner. 	<ul style="list-style-type: none"> HIV test, either as part of Preventative Care or Health Risk Assessment. See D27.1. Upon a positive diagnosis, the HIV basket of care applies, subject to registration on the relevant managed healthcare programme.
D24.4	Cardiac Health	Full Lipogram <ul style="list-style-type: none"> From age 20 years Once every 5 years 	Full Lipogram <ul style="list-style-type: none"> From age 20 years Every 5 years 	
D24.5	Elderly Health	Pneumococcal Vaccination including the administration fee of the nurse practitioner. <ul style="list-style-type: none"> Age >65 once every 5 years. Faecal Occult Blood Test <ul style="list-style-type: none"> Ages 45-75 annually. 	Pneumococcal Vaccination including the administration fee of the nurse practitioner. <ul style="list-style-type: none"> Age >65 once every 5 years. Faecal Occult Blood Test <ul style="list-style-type: none"> Ages 45-75 annually. 	
D24.6	Children's health Hypothyroidism	<ul style="list-style-type: none"> 1 TSH Test Age <1 month 	<ul style="list-style-type: none"> 1 TSH Test Age <1 month 	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	Infant Hearing Screening	<ul style="list-style-type: none"> One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist. 	<ul style="list-style-type: none"> One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist. 	
	Neonatal Vision Screening: (For Retinopathy of prematurity (ROP) in neonates (<32 weeks gestational age and very low birth (<1500g))	<ul style="list-style-type: none"> Two vision screening tests per beneficiary for newborns up to 6 weeks, in or out of hospital, performed by an ophthalmologist. 	<ul style="list-style-type: none"> Two vision screening tests per beneficiary for newborns up to 6 weeks, in or out of hospital, performed by an ophthalmologist. 	Screening should be performed at 4 – 6 weeks chronological age or 31 – 33 weeks post-conceptual age (whichever comes later).
	Human Papilloma Virus (HPV) Vaccine	<ul style="list-style-type: none"> Limited to two doses for girls aged between 9 – 14 years. One course per lifetime. Limited to R1 140 per vaccine. 	<ul style="list-style-type: none"> Limited to two doses for girls aged between 9 – 14 years. One course per lifetime. Limited to R1 140 per vaccine. 	
	Extended Program on Immunisation (EPI)	<ul style="list-style-type: none"> Various Vaccinations including the administration fee of the nurse practitioner for children up to the age of 12 years. 	<ul style="list-style-type: none"> Various Vaccinations including the administration fee of the nurse practitioner for children up to the age of 12 years. 	<div style="border: 2px solid red; padding: 10px; text-align: center;"> <p>REGISTERED BY ME ON</p> <p>2025/12/18</p> <p>*****</p> <p>REGISTRAR OF MEDICAL SCHEMES</p> </div>
D24.7	Pertussis Booster Vaccine (Whooping Cough)	<ul style="list-style-type: none"> One booster vaccine per beneficiary between the ages of 07 and 64 years, every 10 years. 	<ul style="list-style-type: none"> One booster vaccine per beneficiary between the ages of 07 and 64 years, every 10 years. 	
D24.8	Hearing Loss Preventative Screening	<ul style="list-style-type: none"> Unlimited digital pre-screening for potential hearing loss subject to the Audiology Benefit Management programme 	<ul style="list-style-type: none"> 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.
D24.9	Weight Management Programme	<ul style="list-style-type: none"> Limited to 1 enrolment per beneficiary for beneficiaries, subject to qualifying criteria and successful enrolment on the programme. 	<ul style="list-style-type: none"> Limited to 1 enrolment per beneficiary for beneficiaries, subject to qualifying criteria and successful enrolment on the programme. 	Subject to the contract with the preferred provider

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D24.10	Smoking Cessation (GoSmokeFree)	<ul style="list-style-type: none"> Limited to and included in the Benefit Booster in D27.2 	<ul style="list-style-type: none"> Limited to and included in the Benefit Booster in D27.2 	
D25 INTERNATIONAL TRAVEL BENEFIT				
D25.1	Leisure travel: (Travelling for recreation, a holiday or visiting family and friends)	<p>For medical emergencies when travelling outside the borders of South Africa.</p> <ul style="list-style-type: none"> 60 days excluding USA – R1.2 million per Member, R1.2 million for Member and Dependants 60 days including USA – Maximum cover R500,000 for Member and Dependants. 	<p>For medical emergencies when travelling outside the borders of South Africa.</p> <ul style="list-style-type: none"> 60 days excluding USA – R1.2 million per Member, R1.2 million for Member and Dependants 60 days including USA – Maximum cover R500,000 for Member and Dependants. 	<p>Subject to authorisation, prior to departure.</p> <ul style="list-style-type: none"> Additional benefits for Covid-19: <ul style="list-style-type: none"> additional costs for compulsory medical quarantine limited to R1 000 per day to a maximum of R10 000 for accommodation and PCR testing up to R1 000. The cover will only apply if a beneficiary tested positive.
D25.2	<p>Business Travel: (Primarily for attending meetings, conferences, visiting suppliers and for administrative purposes)</p> <div style="border: 1px solid red; padding: 5px; margin-top: 10px;"> <p style="color: red; text-align: center; font-weight: bold;">REGISTERED BY ME ON</p> <p style="text-align: center;">2025/12/18</p> <p style="color: red; text-align: center; font-weight: bold;">REGISTRAR OF MEDICAL SCHEMES</p> </div>	<p>For medical emergencies when travelling outside the borders of South Africa.</p> <ul style="list-style-type: none"> 30 days excluding USA – R1.2 million per Member, R1.2 million for Member and Dependants 30 days including USA - Maximum cover R500,000 for Member and Dependants. Subject to approval protocols prior to departure. 	<p>For medical emergencies when travelling outside the borders of South Africa.</p> <ul style="list-style-type: none"> 30 days excluding USA – R1.2 million per Member, R1.2 million for Member and Dependants 30 days including USA - Maximum cover R500,000 for Member and Dependants. Subject to approval protocols prior to departure. 	<p>Subject to authorisation, prior to departure.</p> <ul style="list-style-type: none"> Additional benefits for Covid-19: <ul style="list-style-type: none"> additional costs for compulsory medical quarantine limited to R1 000 per day to a 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 – refers to any occupation or activity involving physical labour (use of hands or machinery)
D26 AFRICA BENEFIT				

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D26.1	In and Out of Hospital (See B3)	<ul style="list-style-type: none"> 100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. Subject to authorisation. 	<ul style="list-style-type: none"> 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 and Wellness screening <div style="border: 1px solid red; padding: 5px; text-align: center; color: red; font-weight: bold;">REGISTERED BY ME ON 2025/12/18 REGISTRAR OF MEDICAL SCHEMES</div>	<p>Wellness screening.</p> <ul style="list-style-type: none"> One assessment per beneficiary over the age of 21 years per annum by a registered provider, (wellness day or participating pharmacy). <p>Payable from OAL. Limited to</p> <ul style="list-style-type: none"> blood pressure test glucose test cholesterol test body mass index. hip to waist ratio HIV counselling and testing. 	<p>Wellness screening.</p> <ul style="list-style-type: none"> One assessment per beneficiary over the age of 21 years per annum by a registered provider, (wellness day or participating pharmacy). <p>Payable from OAL. Limited to</p> <ul style="list-style-type: none"> blood pressure test glucose test cholesterol test body mass index hip to waist ratio HIV counselling and testing. 	<ul style="list-style-type: none"> HIV test, either as part of Preventative Care or Health Risk Assessment. See D24.3. Upon a positive diagnosis, the HIV basket of care applies, subject to registration on the relevant managed healthcare programme.
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, D11.1.3, D11.2, D13.2, D17.2, D18.2, D19.2, D21.1.2, D24.10 and virtual consultations)	<ul style="list-style-type: none"> Subject to completion of a Health Risk Assessment and the completion of the mental health questionnaire per beneficiary over the age of 21 years at a preferred provider network pharmacy or wellness day. 	<ul style="list-style-type: none"> Subject to completion of a Health Risk Assessment and the completion of the mental health questionnaire per beneficiary over the age of 21 years at a preferred provider network pharmacy or wellness day. 	<ul style="list-style-type: none"> Child dependants under the age of 21 years will qualify for the Benefit Booster once the main member or an adult beneficiary has completed a physical Health Risk Assessment and the mental health questionnaire at a preferred provider network pharmacy or wellness day.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		<ul style="list-style-type: none"> Limited to R5 000 per family.. Limited to: Alternative Health: D1 GP consultations: D5.1.3 & 4 Medical specialists: D5.2 Acute medication: D11.1 Registered ante-natal vitamins during pregnancy: D11.1.3 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 Smoking cessation: D24.10 . 	<ul style="list-style-type: none"> Limited to R5 000 per family: Limited to: Alternative Health: D1 GP consultations: D5.1.3 & 4 Medical specialists: D5.2 Acute medication: D11.1 Registered ante-natal vitamins during pregnancy: D11.1.3 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 Smoking cessation: D24.10 . 	<ul style="list-style-type: none"> Valid qualifying claims will pay first from the Benefit Booster and thereafter from the relevant benefits as described in D1 – D24. When a main member or adult beneficiary completes the health risk assessment (HRA) and mental health questionnaire at a preferred provider network pharmacy or wellness day the Benefit Booster will become available. 20% co-payment will apply to all non-network GP consultations. Homeopathic medicines are excluded from the benefit.

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