Bonitas

BONITAS MEDICAL FUND

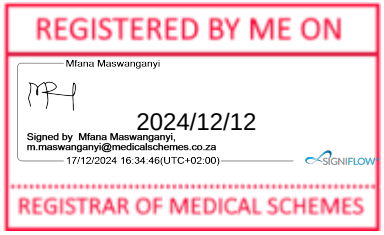
ANNEXURE B

OPTIONS:

STANDARD

STANDARD SELECT

2025



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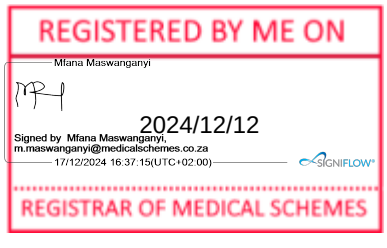


A ENTITLEMENT TO BENEFITS

A1 The Bonitas Fund Tariff is defined as the Bonitas monetary tariffs applicable in 2024 increased by an average of 5.2%.

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. Medicine Price List and applicable formularies. Co-payments to apply where relevant.

B5 MEMBERSHIP CATEGORY

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

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

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

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

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

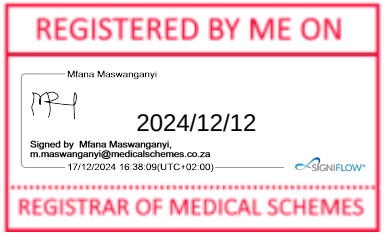
- 2 (two) Gynaecologist consultations or visits per annum for female beneficiaries;
- Maternity
- Children under the age of 2 (two) years, for Paediatrician visits or consultations
- Consultations with Oncologists and Haematologists
- Consultations with Ophthalmologists
- Specialist to specialist referral
- Psychologist to Psychiatrist referral.
- Follow-up visits with one of the treating specialists, within 8 weeks of discharge from hospital, for the same condition.

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

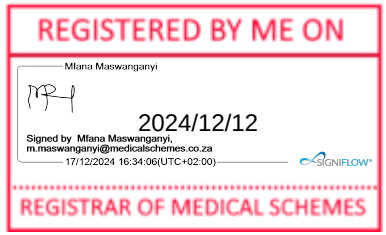
C PRESCRIBED MINIMUM BENEFITS (PMBs)

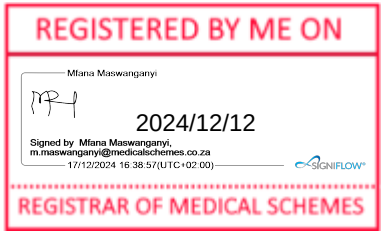
Prescribed Minimum Benefits as shown in Annexure A of the General Regulations, made in terms of the Medical Schemes' Act 131 of 1998; override all benefits indicated in this annexure, and are paid in full.
The Prescribed Minimum Benefits are available in conjunction with the Fund's contracted managed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

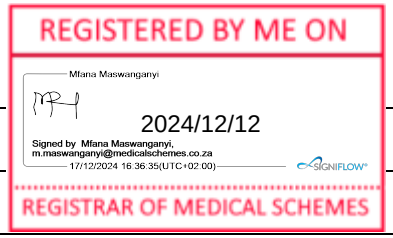


D ANNUAL BENEFITS AND LIMITS

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 440 M+1: R20 170 M+2: R22 410 M+3+: R24 650	M : R13 440 M+1: R20 170 M+2: R22 410 M+3+: R24 650	
	General Practitioner and Specialist Benefit	M : R3 370 M+1: R5 040 M+2: R5 610 M+3+: R6 720 Limited to and included in the Day-to-Day benefit. (See D5.1.3 and D5.1.4)	M : R3 370 M+1: R5 040 M+2: R5 610 M+3+: R6 720 Limited to and included in the Day-to-Day benefit. Subject to GP nomination from the GP Network. (See D5.1.3 and D5.1.4)	
D1	**ALTERNATIVE HEALTHCARE**			
D1.1	**Out of Hospital (See B1 & B3)**	M : R3 370 M+1: R5 040 M+2: R5 610 M+3+: R6 720 Limited to and included in the Day-to-Day benefit.	M : R3 370 M+1: R5 040 M+2: R5 610 M+3+: R6 720 Limited to and included in the Day-to-Day benefit.	
D1.1.1	**Homoeopathic Consultations and/or treatment**	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.2	**Homoeopathic 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. • Medicines paid at 80% of tariff	• Limited to and included in D1.1. • Medicines paid at 80% of tariff.	

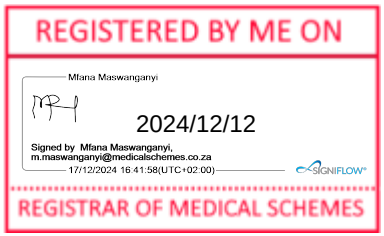
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D1.1.5	**Osteopathy**	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.6	**Phytotherapy**	Limited to and included in D1.1.	Limited to and included in D1.1.	
D2	**AMBULANCE SERVICES**			
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, EXTERNALACCESSORIES AND ORTHOTICS**			
D3.1	**In and Out of Hospital**			• 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**	• Limited to and included in the Day-to-Day benefit. • Blood pressure monitors for high risk beneficiaries, registered for Hypertension, are limited to R1 200 per family, subject to and included in the Day-to-Day benefit, once every 2 years.	• Limited to and included in the Day-to-Day benefit. • Blood pressure monitors for high risk beneficiaries, registered for Hypertension, are limited to R1 200 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**	• Limited to R9 100 per device (maximum of two per family) over a three year cycle. • A 25% co-payment will apply to devices obtained from a non-DSP.	• Limited to R9 100 per device (maximum of two per family) over a three year cycle. • A 25% co-payment will apply to devices obtained from a non-DSP.	• Subject to the Hearing Loss Management Programme.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
3.1.2.1	**Audiology Services**	• Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). • Non-network: Limited to and included in D1.1.	• Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). • Non-network: Limited to and included in D1.1.	• 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**	• Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). • Non-network: Limited to and included in D1.1.	• Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). • Non-network: Limited to and included in D1.1.	• 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 550 per family, unless PMB.	R8 550 per family, unless PMB.	CPAP Machines are subject to the relevant managed healthcare programme and to its prior authorisation.
D3.1.4	**Stoma Products**	Limited to and included in D3.1.3 and thereafter funded from OAL, if PMB.	Limited to and included in D3.1.3 and thereafter funded from OAL, if PMB.	
D3.1.5	**Specific appliances, accessories**			Subject to the relevant managed healthcare programme and to its prior authorisation and if the treatment forms part of the relevant managed healthcare programme, out of hospital.
D3.1.5.1	**Oxygen therapy, and equipment (not including hyperbaric oxygen treatment)**	No limit if specifically authorised.	No limit if specifically authorised.	
D3.1.5.2	**Home Ventilators**	No limit if specifically authorised.	No limit if specifically authorised.	
D3.1.5.3	**Long leg callipers**	Limited to and included in D20.2.	Limited to and included in D20.2.	
D3.1.5.4	**Foot orthotics**	No benefit, unless PMB	No benefit, unless PMB.	
D3.1.5.5	**Insulin Pump Therapy or Continuous Glucose Infusion (CGM)**	• R89 420 per family for insulin pump or CGM device. • Limited to one device per Type 1 Diabetic for	• R89 420 per family for insulin pump or CGM device. • Limited to one device per Type 1 Diabetic for	• Subject to pre-authorisation by the relevant managed healthcare programme and its prior authorization.



PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		beneficiaries younger than 18 years every 5 years; and • R89 420 per family for insulin pump or CGM consumables.	beneficiaries younger than 18 years every 5 years; and • R89 420 per family for insulin pump or CGM consumables.	• 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)** REGISTERED BY ME ON Mfana Maswanganyi 2024/12/12 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 17/12/2024 16:37:24(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES	M : R3 370 M+1: R5 040 M+2: R5 610 M+3+: R6 720 Limited to and included in the Day-to-Day benefit.	M : R3 370 M+1: R5 040 M+2: R5 610 M+3+: R6 720 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 • Dental Practitioners and Therapists (D6), • Oncologists, Haematologists and Credentialed Medical Practitioners during active and post-active treatment periods (D14); • Paramedical Services (D17); • Physiotherapists and Biokineticists in hospital (D19.1).
D5.1.1	**In Hospital**	• No limit. • 100% of Bonitas Tariff for general practitioners.	• No limit. • 100% of Bonitas Tariff for general practitioners.	
D5.1.2.	**Out of Hospital**	• Subject to the General Practitioner and Specialist benefit in D5.1.	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)**	• 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	• 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	This benefit applies to both nominated/non-nominated network GPs on Standard Select

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		Specialist consultation benefits are exhausted.	Specialist benefits are exhausted.	
D5.1.4	**Non-Network General Practitioners/Non Nominated, for Standard Select (Virtual consultationsare limited to and included in D5.1.3)**	Limited to and included in the General Practitioner and Specialist benefit in D5.1.	• 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**	• No limit • Subject to the contracted rate. (See Annexure D: 7.3.6).	• No limit • Subject to the contracted rate. (See Annexure D: 7.3.6).	All consultations and procedures within the specialist network will be paid at the contracted rate, with no co-payment applicable.
D5.2.1.2	**Out of Specialist Network**	• No limit • 100% of the Bonitas Tariff for non-network specialists.	• No limit • 100% of the Bonitas Tariff for non-network specialists.	All consultations and procedures outside the Specialist Network will be reimbursed up to the Bonitas Tariff. Co-payments are applicable for consultations and procedures charged in excess of the Bonitas Tariff.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D5.2.2	**Out of Hospital (See B1, B3 and B8)** 	• 2 network specialist visits per family, per annum from OAL, subject to GP referral. • Subsequent vists are limited to and included in the GP and Specialist consultation benefit in D5.1. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists.	• 2 network specialist visits per family, per annum from OAL, subject to referral by a network GP. • Subsequent vists are limited to and included in the GP and Specialist consultation benefit in D5.1. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists.	On Standard and Standard Select, referral to a specialist must be done by a registered general practitioner and a valid referral obtained. The following exceptions are applicable as per B8: • Two (2) Gynaecologist visits/consultations per annum for female beneficiaries; • Consultations and visits related to maternity; • Children under the age of two (2) years for Paediatrician visits/consultations; • Visits with Ophthalmologists, Haematologists and Oncologists. • Specialist to specialist referral. • Psychologist to Psychiatrist referral. • Follow-up visits with one of the treating specialists within 8 weeks of discharge from hospital for the same condition. Out of hospital tests and specialist consultations, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D5.2.3	**Infant Paediatric benefit (Consultation with a GP or Paediatrician)**	• 2 Paediatric consultations per beneficiary for children aged 0 - 12 months within the age bracket. • 2 Paediatric consultations per beneficiary for children aged 13 - 24 months, within the age bracket, included in the OAL.	• 2 Paediatric consultations per beneficiary for children aged 0 - 12 months within the age bracket. • 2 Paediatric consultations per beneficiary for children aged 13 - 24 months, within the age bracket, included in the OAL.	
D6	**DENTISTRY**			
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. Benefits payable on the Standard

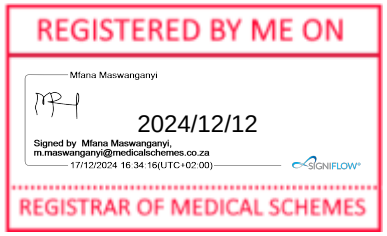
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		beneficiary per year. Covered at BDT.	beneficiary per year. Covered at BDT.	Select Option is subject to a Designated Service Provider for in hospital services. Specialists require pre-approval by the contracted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

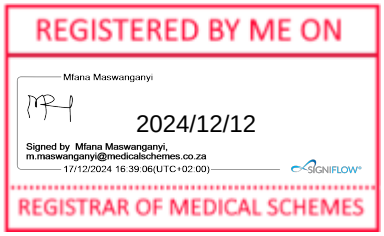
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB

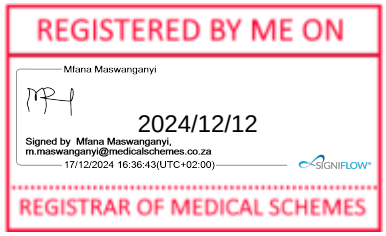
D6.1.7	**Hospitalisation (general anaesthetic) and Moderate/Deep Sedation in the rooms**	• Admission protocols apply.
		• Certain maxillo-facial procedures are covered in hospital.
		• General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment.
		  ○ A co-payment of R3 500 aplies per hospital admission or R2 500 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.
		  ○ A co-payment of R5 000 applies per hospital admission or R2 500 if treatment is done in a Day Clinic.
			• Subject to the Standard Select Hospital Network.
			• Admission protocols apply.
			• Certain maxillo-facial procedures are covered in hospital.
			• General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment.
			  ○ A co-payment of R3 500 aplies per hospital admission or R2 500 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
			  ○ A co-payment of R5 000 applies per hospital admission or R2 500 if treatment is done in a Day Clinic.
				• 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.
				
				REGISTERED BY ME ON
				Mfana Maswanganyi
				2024/12/12
				Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za
				17/12/2024 16:38:17(UTC+02:00) SIGNIFLOW
				REGISTRAR OF MEDICAL SCHEMES

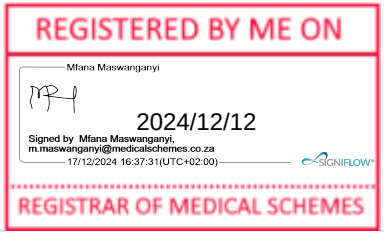
D6.1.8	**Inhalation Sedation in Dental Rooms**	Benefit is subject to managed care protocols. Covered at the BDT.	Benefit is subject to managed care protocols. Covered at the BDT.	
D6.1.9	**X-rays**	• Covered at 100% of the BDT for intra-oral x-rays. • Extra-oral x-rays will be covered at 100% of the BDT subject to 1 per beneficiary in a 3 year period.	• Covered at 100% of the BDT for intra-oral x-rays. • Extra-oral x-rays will be covered at 100% of the BDT subject to 1 per beneficiary in a 3 year period.	Additional benefits for extra-oral x-rays may be considered where specialist dental treatment planning/follow-up is required.
D6.2	**SPECIALISED DENTISTRY (See B3)**			

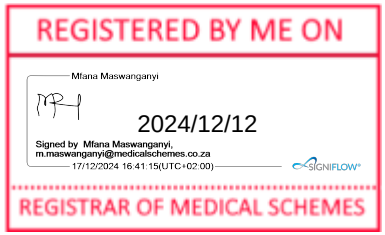
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D6.2.1	**Crowns**	• 1 Crown per family per year, subject to pre-authorisation. • Benefits for crowns will be granted once per tooth in 5 years. • Covered at 100% of the BDT.	• 1 Crown per family per year,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

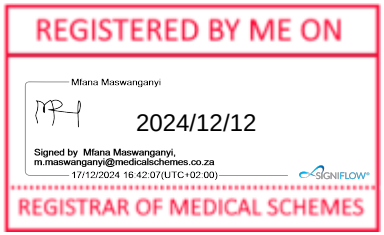


PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D6.2.5	**Orthodontic Treatment**	• Subject to prior authorisation by the dental management programme. Benefit for fixed comprehensive treatment is limited to individuals from age 9 and under the age of 18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

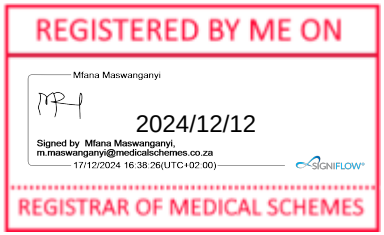
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D7.1.1	**In Hospital** 	• No limit. • Deep Brain Stimulation Implantation for Parkinson's Disease and intractable epilepsy is limited to R304 300 per beneficiary (excluding the prosthesis benefit). • Hip and knee arthroplasties are subject to the DSP. • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• No limit. • Subject to the Standard Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • Deep Brain Stimulation Implantation for Parkinson's Disease and intractable epilepsy is limited to R304 300 per beneficiary (excluding the prosthesis benefit). • Hip and knee arthroplasties are subject to the DSP. • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	Accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. No benefits will be granted if prior authorisation requirements are not complied with. This benefit excludes: hospitalisation for: • Osseo-integrated implants and orthognathic surgery (D6); • Maternity (D10); • Mental Health (D12); • Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16); • Renal Dialysis chronic (D22); • Refractive surgery (D23).
D7.1.2	**Medicine on discharge from hospital (TTO)** **(See B4)**	• Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R605 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme.	• Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R605 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme.	
D7.1.3	**Casualty / emergency room visits**			The risk benefit is maximum 2 visits per family either in a private or public hospital setting.
D7.1.3.1	**Facility fee**	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies.	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies.	Will be included in the hospital benefit if a retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies.

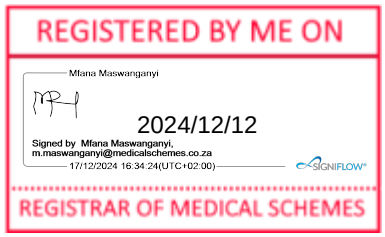
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• 2 emergency rooms visits per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are limited to and included in the Day-to-Day benefit.	• 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.	
D7.1.3.2	**Consultations**	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 consultations per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 consultations per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2.	
D7.1.3.3	**Medicine**	See D11.1.	See D11.1.	
D7.2	**Public hospitals (See B3)**			Subject to the relevant managed healthcare programme and its prior authorisation.
D7.2.1	**In hospital**	No limit.	No limit.	Accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. No benefits will be granted if prior authorisation requirements are not complied with. This benefit excludes: hospitalisation for: • Osseo-integrated implants and Orthognathic surgery (D6); • Maternity (D10);

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
				• Mental Health (D12); • Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16); • Renal Dialysis chronic (D22); • Refractive surgery (D23).
D7.2.2	**Medicine on discharge from hospital (TTO) (See B4)**	• Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R605 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme. • See D7.1.2.	• Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of 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 is maximum 2 visits per family either in a private or public hospital setting.
D7.2.3.1	**Facility fee**	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies. • 2 emergency rooms visits per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are limited to and included in the Day-to-Day benefit.	• 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 retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies.

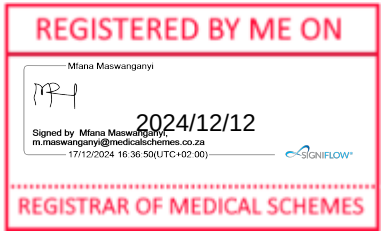
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D7.2.3.2	**Consultations**	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 consultations per family for beneficiaries under the age of 6 years, payable from the OAL. • Subsequent consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2.	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 consultations per family for beneficiaries under the age of 6 years, payable from the OAL. • Subsequent consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2.	
D7.2.3.3	**Medicine**	See D11.1.	See D11.1.	
D7.2.4	**Outpatient services**			
D7.2.4.1	**Facility fee**	• Limited to and included in the Day-to-Day benefit.	• Limited to and included in the Day-to-Day benefit.	
D7.2.4.2	**Consultations**	See D5.1.3, D5.1.4 and D5.2.2.	See D5.1.3, D5.1.4 and D5.2.2.	
D7.2.4.3	**Medicine**	See D11.1.	See D11.1.	
D7.3	**Alternatives to hospitalisation (See B3)**			Subject to the relevant managed healthcare programme and to its prior authorisation. Benefits for clinical procedures and treatment during stay in an alternative facility will be subject to the same benefits that apply to hospitalisation.
D7.3.1	**Physical Rehabilitation hospitals**	R64 680 per family, for all services.	R64 680 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**	• No limit. • Subject to pre-authorisation.	• No limit. • Subject to pre-authorisation.	Subject to the relevant managed healthcare programme.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D7.3.4	**Conservative Back Programme**	Subject to the Contracted Provider.	Subject to the Contracted Provider	
D7.3.5	**Terminal Care (Non-oncology)**	Limited to and included in D7.3.2, and above limits, subject to pre-authorisation.	Limited to and included in D7.3.2 and above limits, subject to pre-authorisation.	Subject to the relevant managed healthcare programme.
D8	**IMMUNE DEFICIENCY SYNDROME RELATED TO HIV INFECTION**			
D8.1	**In and Out of Hospital (See B3)**	• No limit. • Subject to PMBs.	• No limit. • Subject to PMBs.	• Subject to registration on the relevant managed healthcare programme. • Subject to clinical protocols.
D8.1.1	**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.
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)**	• No limit. • The contracted rate applies for network specialists.	• No limit. • The contracted rate applies for network specialists.	• 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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	• 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.	paediatrician and/or anaesthetists are included. Included in the global obstetric fee is post-natal care by a general practitioner and medical specialist up to and including the six week post-natal consultation.
D10.1.1	**Medicine on discharge from hospital (TTO) (See B4)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	
D10.1.2	**Confinement in a registered birthing unit** 	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used by a lactation specialist out of hospital.	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used by a lactation specialist out of hospital. • Subject to the Standard Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• Subject to the relevant managed healthcare programme and its prior authorisation. • Delivery by a midwife. • Hire of water bath and oxygen cylinder limited to and included in OAL. This must be hired from a practitioner who has a registered practice number. • One of the post-natal midwife consultations may be used for a lactation specialist consultation out of hospital.
D10.2	**Confinement out of hospital**	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used by a lactation specialist..	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used by a lactation specialist..	• Subject to the relevant managed healthcare programme and its prior authorisation. • Delivery by a midwife. • Hire of water bath and oxygen cylinder limited to and included in OAL. This must be hired from a practitioner who has a registered practice number. • One of the post-natal midwife consultations may be used for a lactation specialist.
D10.2.1	**Consumables and pharmaceuticals**	Limited to and included in D10.1.	Limited to and included in D10.1.	Registered medicine, dressings and materials supplied by a midwife out of hospital.
D10.3	**Related maternity services**	Limited to and included in D10.1.	Limited to and included in D10.1.	
D10.3.1	**Ante-natal consultations**	• 12 ante-natal consultations by a specialist, general	• 12 ante-natal consultations by a specialist, general	• The contracted rate applies for network specialists.

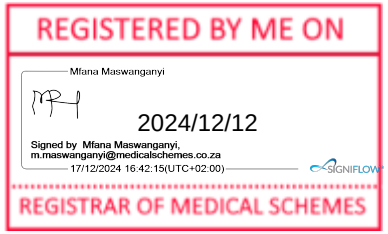
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		practitioner or midwife per pregnancy. • R1 580 for ante-natal classes/exercises per pregnancy.	practitioner or midwife per pregnancy. • R1 580 for ante-natal classes/exercises per pregnancy.	• 100% of the Bonitas Tariff for the general practitioner or non-network medical specialist.
D10.3.2	**Related tests and procedures**	• Pregnancy related tests and procedures. • 2 x 2D pregnancy scans. • 1 x amniocentesis per pregnancy.	• Pregnancy related tests and procedures. • 2 x 2D pregnancy scans. • 1 x amniocentesis per pregnancy.	
D11	**MEDICINE AND INJECTION MATERIAL**			
D11.1	**Routine /(acute) medicine (See B3 and B4)** 	M : R3 370 M+1: R5 040 M+2: R5 610 M+3+: R6 720 • 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 370 M+1: R5 040 M+2: R5 610 M+3+: R6 720 • 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 and the Pharmacy Products Management Document are applicable. This benefit excludes: • In-hospital medicine (D7); • Anti-retroviral medicine (D8); • Oncology medicine (D14); • Organ and haemopoietic stem cell (bone marrow) transplantation immunosuppressive medication (D16).
D11.1.1	**Medicine on discharge from hospital (TTO)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	
D11.1.2	**Contraceptives**	• 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.	• 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.	

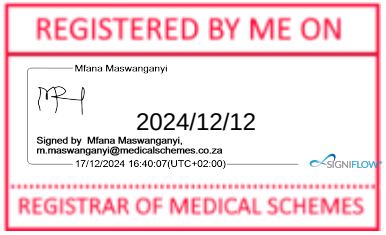
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D11.1.3	**Registered ante-natal vitamins during pregnancy**	• Limited to and included in D11.1 and D27.2. • Limited to R195 per beneficiary per month. • Subject to the medicine formulary.	• Limited to and included in D11.1 and D27.2. • Limited to R195 per beneficiary per month. • Subject to the medicine formulary.	
D11.2	**Pharmacy Advised Therapy Schedules 0, 1 and 2 medicine advised and dispensed by a pharmacist**	• Limited to R895 per beneficiary. • R2 800 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.	• Limited to R895 per beneficiary. • R2 800 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.	
D11.3	**Chronic medicine (See B4)** 	• Limited to R12 530 per beneficiary. • R25 140 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.	• Subject to the DSP and limited to R12 530 per beneficiary. • R25 140 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.	Subject to registration on the relevant managed healthcare programme and to its prior authorisation and applicable formularies. Restricted to a maximum of one month's supply unless pre-authorised. [Includes diabetic disposables such as • syringes, • needles, • strips and • lancets The above are excluded from D3 and D11 if on the Diabetic Management Programme. This benefit excludes: • In hospital medicine (D7); • Anti-retroviral drugs (D8); • Oncology medicine (D14); • Organ and haemopoietic stem cell (bone marrow) transplantation and immuno-suppressive medication (D16).

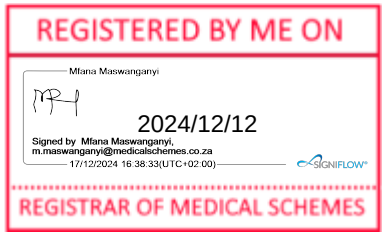
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D11.3.1	**MDR and XDR-TB**	No limit, subject to managed care protocols and the DSP.	No limit, subject to managed care protocols and the DSP.	Subject to the relevant managed healthcare programme and its prior authorisation.
D11.4	**Specialised Drugs (See B4)**			
D11.4.1	**Non Oncology Biological Drugs applicable to monoclonal antibodies interleukins**	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation
D11.4.1.1	**Iron chelating agents for chronic use**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.1.2	**Human Immunoglobulin for chronic use**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.1.3	**Non calcium phosphate binders and calcimimetics**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.2	**Specialised Drugs for Oncology (See B4)**	See D14.1.3.	See D14.1.3.	
D12	**MENTAL HEALTH**			
D12.1	**Treatment and care related to Mental Health (See B3 and B6)**	• R51 900 per family, unless PMB.	• 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** 	• Limited to and included in D12.1.	• Limited to and included in D12.1.	• 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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D12.3	**Rehabilitation for substance abuse (See B3)**	• Limited to and included in D12.1. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	• Limited to and included in D12.1. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme and to its prior authorisation. (See B6).
D12.3.1	**Medicine on discharge from hospital (TTO) (See B3 and B4)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	
D12.4	**Consultations and visits, procedures, assessments, therapy, treatment and/or counselling, in and out of hospital. (See B3)**	• 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.	• 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.	REGISTERED BY ME ON Mfana Maswanganyi 2024/12/12 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 17/12/2024 16:37:39(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES
D12.5	**Mental Health Programme as managed via Active Disease Risk Management in Annexure D, paragraph 6.10**	• Limited to R13 850 per beneficiary. • Subject to enrolment on the relevant managed healthcare programme,	• Limited to R13 850 per beneficiary. • Subject to enrolment on the relevant managed healthcare programme,	• Subject to the relevant managed healthcare programme and its prior authorisation for out of hospital treatment only. • PMB treatment and the Mental Health Programme claims will not pay concurrently.
D13	**NON-SURGICAL PROCEDURES AND TESTS**			
D13.1	**In Hospital (See B2 and B3)**	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners. • Subject to the Standard Select Hospital Network.	Subject to the relevant managed healthcare programme and its prior authorisation in hospital only. This benefit excludes: • Psychiatry and psychology (D12); • Optometric examinations (D15); • Pathology (D18); • Radiology (D21).

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
			• 30% co-payment to apply to all non-network admissions.	
D13.2	**Out of hospital (See B2 and B3)**	• Limited to and included in the Day-to-Day benefit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• Limited to and included in the Day-to-Day benefit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	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.
D13.2.1	• **24 hr oesophageal PH studies** • **Breast fine needle biopsy** • **Circumcision** • **Laser tonsillectomy** • **Oesophageal motility studies** • **Vasectomy** • **Prostate Needle biopsy** **(See B3)**	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• Subject to relevant managed healthcare programme. • Co-payments will not apply if procedure is done in the doctors rooms. • Includes related consultation, materials, pathology and radiology if done in the rooms on the same day.
D13.3	**Sleep studies (See B3)**			Subject to the relevant managed healthcare programme and its prior authorisation.
D13.3.1	**Diagnostic Polysomnograms In and out of hospital**	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	If authorised by the relevant managed healthcare programme for dyssomnias e.g. central sleep apnoea, obstructive sleep apnoea, parasomnias or medical or psychiatric sleep disorders as part of neurological investigations by a relevant specialist.
D13.3.2	**CPAP Titration**	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	If authorised by the relevant managed healthcare programme for patients with obstructive sleep apnoea who meet the criteria for CPAP and where requested by the relevant specialist.
D14	**ONCOLOGY**			
D14.1	**PRE ACTIVE, ACTIVE & POST ACTIVE TREATMENT PERIOD**	• R280 100 per family for oncology.	• R280 100 per family for oncology.	• Subject to registration on the oncology management programme. All costs related

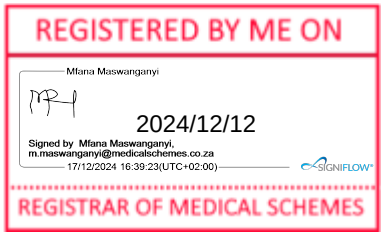
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	(See A4 & B3) 	• Unlimited for PMB oncology. • Above benefit limit, non-PMB oncology, excluding specialised drugs, is unlimited at a network provider, subject to a 20% co-payment. • The Bonitas Oncology Network is the DSP for oncology services at the contracted network rate. • 100% of the Bonitas Tariff for services rendered by non-network oncology providers • 30% co-payment applies for services rendered by non-network oncology providers, subject to Regulation 8 (3).	• Unlimited for PMB oncology. • Above benefit limit, non-PMB oncology, excluding specialised drugs, is unlimited at a network provider subject to a 20% co-payment. • The Bonitas Oncology Network is the DSP for oncology services at the contracted network rate. • 100% of the Bonitas Tariff for services rendered by non-network oncology providers. • 30% co-payment applies for services rendered by non-network oncology providers, subject to Regulation 8 (3).	to approved cancer treatment, including PMB treatment, will add up to the oncology benefit limit. • Treatment for long-term chronic conditions that may develop as a result of chemotherapy and radiotherapy is not included in this benefit. • Benefit is for Oncologists, Haematologists and approved providers for consultations, visits, treatment and consumable material used in radiotherapy and chemotherapy. • The Oncology Network is the DSP for related oncology services at the Oncology Network (DSP) rate. • Pre-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)**	• 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 reference pricing and preferred product list.	• Limited to and included in D14.1 and subject to the Oncology Medicine DSP. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to 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.	• 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)**	• Limited to and included in D14.1 and one per family per annum.	• Limited to and included in D14.1 and one per family per annum.	• 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
		• 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.	• 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.	• Specific authorisations are required in addition to any authorisation that may have been obtained for hospitalisation.
D14.1.3	**Specialised Drugs (See B4)** 			• Subject to the relevant managed healthcare programme and to its prior authorisation. • Specialised drugs include biological, immunologic and targeted therapies. • This list includes but is not limited to targeted therapies e.g. biologicals, and other non genericised chemotherapeutic agents. Subject to published list. • Unless otherwise stated below, any other diseases where the use of the drug is deemed appropriate by the managed health care organization, drugs will be funded from this benefit.
D14.1.3.1	**Biological, immunologic and targeted therapy**	• R157 800 per family, limited to and included in D14.1. • No benefit applies above the Specialised Drug benefit limit, unless PMB.	• R157 800 per family, limited to and included in D14.1. • No benefit applies above the Specialised Drug benefit limit, unless PMB.	• Subject to oncology pre-authorisation, managed care protocols and processes. • The Specialised Drug List (SDL) is a list of drugs used for treatment of cancers and certain haematological conditions. It includes but is not limited to biologicals, certain enzyme inhibitors, immunomodulatory antineoplastic agents and other targeted therapies. The list is reviewed and published regularly.
D14.1.3.2	**Unregistered chemotherapeutic agents**	Limited to and included in D14.1.3.1.	Limited to and included in D14.1.3.1.	Subject to Section 21 approval by the South African Health Products Regulatory Authority (SAHPRA) and oncology pre-authorisation, managed care protocols and processes.
D14.1.4	**Flushing of J Line and/or Port (See B3)**	Limited to and included in D14.1.	Limited to and included in D14.1.	Subject to the relevant managed healthcare programme.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D14.1.5	**Brachytherapy materials (including seeds and disposables) and equipment (See B3)**	Limited to R60 680 per beneficiary and included in D14.1.	Limited to R60 680 per beneficiary and included in D14.1.	• Subject to the relevant managed healthcare programme and to its prior authorisation, for services rendered by oncologists, radiotherapists and approved medical practitioners. • The Oncology Network is the DSP for oncology related services at the Oncology Network (DSP) rate.
D14.2	**Oncology Social Worker (OSW) benefit**	• Limited to R3 500 per family. • Limited to and included in D14.1.	• Limited to R3 500 per family. • Limited to and included in D14.1.	Subject to the relevant managed healthcare protocols and its prior authorisation.
D14.3	**Palliative Care**	• No limit. • Subject to pre-authorisation. • Managed care protocols apply.	• No limit. • Subject to pre-authorisation. • Managed care protocols apply.	Subject to the relevant managed healthcare protocols and its prior authorisation.
D15 OPTOMETRY				
D15.1	**In and Out of Network (See B3)** 	• Biennial benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• Biennial benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• 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.**	• One per beneficiary, per benefit cycle, at network rates. • R400 out of network. • Limited to and included in D15.1.	• One per beneficiary, per benefit cycle, at network rates. • R400 out of network. • Limited to and included in D15.1.	• 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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D15.2	**Frames and/or lens enhancements**	• R1 405 per beneficiary in network. • R1 054 per beneficiary out of network or member refunds. • Limited to and included in D15.1.	• R1 405 per beneficiary in network. • R1 054 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.
D15.3	**Lenses**			
D15.3.1	**Single vision lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R215 per lens per beneficiary out of network. • Limited to and included in D15.1; or	• 100% towards the cost of clear lenses at network rates. • Limited to R215 per lens per beneficiary out of network. • Limited to and included in D15.1; or	Subject to contracted providers protocols.
D15.3.2	**Bifocal lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R460 per lens per beneficiary out of network. • Limited to and included in D15.1; or	• 100% towards the cost of clear lenses at network rates. • Limited to R460 per lens per beneficiary out of network. • Limited to and included in D15.1; or	
D15.3.3	**Multifocal lenses**	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R810 per base lens or R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.1.	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R810 per base lens or R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.1.	REGISTERED BY ME ON Mfana Maswanganyi 2024/12/12 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 17/12/2024 16:34:31(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES
D15.3.4	**Contact lenses**	• Limited to R2 120 per beneficiary. • Limited to and included in D15.1.	• Limited to R2 120 per beneficiary. • Limited to and included in D15.1.	
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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
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)**	• 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 R41 070 per beneficiary for local and imported grafts.	• No limit • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the non-network medical specialist or general practitioner. • Corneal grafts are limited to R41 070 per beneficiary for local and imported grafts. • Subject to the Standard Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• Subject to the relevant managed healthcare programme to its prior authorisation, no benefits will be granted for hospitalisation, treatments and associated clinical procedures if prior authorization is not obtained. • Organ harvesting is limited to the Republic of South Africa excluding donor cornea and donor bone marrow.

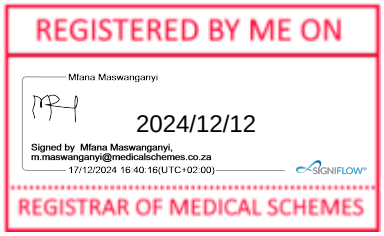


PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D16.1.1	**Haemopoietic stem cell (bone marrow) transplantation (See B3)**	Limited to and included in D16.1.	Limited to and included in D16.1.	Haemopoietic stem cell (bone marrow) transplantation is limited 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.	
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.	For specified radiology and pathology services, performed by Pathologists, Radiologists and Haematologists, associated with the transplantation treatment.
D17	**PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS)**			
D17.1	**In hospital (See B2 and B3)**	• Limited to and included in D1, unless PMB. • 100% of the Bonitas Tariff.	• Limited to and included in D1, unless PMB. • 100% of the Bonitas Tariff.	• Subject to referral by the treating practitioner. • 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.	• 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.	• 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.	• Treatment approved as PMB will be covered from OAL and not accrue to D.1.1.
D17.2	**Out of hospital**	• Limited to and included in D1.1. • 100% of the Bonitas Tariff.	• 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.	
D17.2.3	**Genetic counselling**	Limited to and included in D1.1.	Limited to and included in D1.1.	

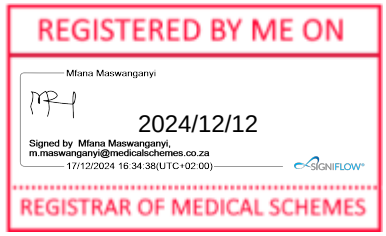
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D17.2.4	**Occupational therapy**	Limited to and included in D1.1.	Limited to and included in D1.1.	
D17.2.5	**Orthoptics**	Limited to and included in D1.1.	Limited to and included in D1.1.	
D17.2.5	**Orthotists 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)**	• No limit. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• No limit. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	Subject to the relevant managed healthcare programme
D18.2	**Out of hospital (See B1 and B3)**	M : R3 370 M+1: R5 040 M+2: R5 610 M+3+: R6 720 • Limited to and included in the Day-to-Day benefit. • Subject to the DSP for pathology at negotiated rates.	M : R3 370 M+1: R5 040 M+2: R5 610 M+3+: R6 720 • Limited to and included in the Day-to-Day benefit. • Subject to the DSP for pathology at negotiated rates.	Subject to Pathology Management Program. This benefit excludes: the specified list of pathology tariff codes included in the: • Maternity benefit, (D10); • Oncology benefit during the active and/or post active treatment period, (D14); • Organ and haemopoietic stem cell transplantation benefit,D16); • Renal dialysis chronic benefit,(D22)

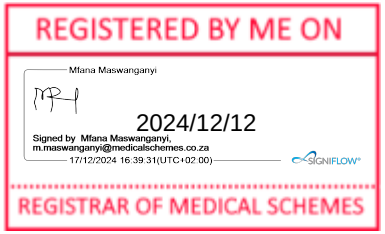
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• 100% of the Bonitas Tariff for services rendered by non-DSP providers.	Out of hospital pathology, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D19	**PHYSICAL THERAPY**			
D19.1	**In hospital Physiotherapy Biokinetics (See B1 and B3)**	• Limited to and included in D1.1, unless PMB. • 100% of the Bonitas Tariff.	• Limited to and included in D1.1, unless PMB. • 100% of the Bonitas Tariff.	• 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**	• Limited to and included in D1.1. • 100% of the Bonitas Tariff.	• 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)**	• R57 630 per family, unless PMB. • Sub-limit of R4 430 for a single intra-ocular lens. • R8 860 for bilateral lenses per beneficiary.	• R57 630 per family, unless PMB. • Sub-limit of R4 430 for a single intra-ocular lens. • R8 860 for bilateral lenses per beneficiary.	Subject to the relevant managed healthcare programme and to its prior authorisation. This benefit excludes Osseo-integrated implants for the purpose of replacing a missing tooth or teeth.
D20.1.1	**Cochlear implants**	• No benefit.	• No benefit.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D20.1.2	**Internal Nerve Stimulator**	• R215 800 per family.	• R215 800 per family.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D20.2	**Prostheses external**	• Limited to and included in D20.1. • Limited to R6 860 per external breast prosthesis and limited to two per annum.	• Limited to and included in D20.1. • Limited to R6 860 per external breast prosthesis and limited to two per annum.	• Subject to the relevant managed healthcare programme and to its prior authorisation. • The benefit excludes consultations/fittings, which are subject to D17.2.
D21 RADIOLOGY				
D21.1	**General radiology (See B2 and B3)**			
D21.1.1	**In hospital**	• No limit. • 100% of the Bonitas Tariff.	• No limit. • 100% of the Bonitas Tariff.	For diagnostic radiology tests and ultrasound scans. Authorisation is not required for MRI scans for low field peripheral joint examination of dedicated limb units.
D21.1.2	**Out of hospital**	• Limited to and included in D18.1. • 100% of the Bonitas Tariff.	• Limited to and included in D18.1. • 100% of the Bonitas Tariff.	This benefit excludes: specified list of radiology tariff codes included in the • Maternity benefit, (D10), • Oncology benefit during the active treatment and/or post active treatment period, (D14); • Organ and haemopoietic stem cell transplantation benefit, (D16), • Renal dialysis chronic benefit, (D22). Authorisation is not required for MRI scans for low field peripheral joint examination of dedicated limb units. Out of hospital general radiology, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D21.2	**Specialised radiology**			
D21.2.1	**In hospital**	• R34 020 per family. • 100% of the Bonitas Tariff. • R1 860 co-payment applies per scan event, unless PMB	• 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.

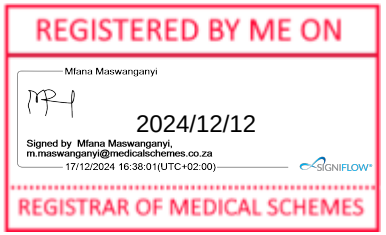
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		or nuclear radio-isotope studies. • The co-payment to be waived if the cost of the service falls within the co-payment amount.	or nuclear radio-isotope studies. • The co-payment to be waived if the cost of the service falls within the co-payment amount.	Specific authorisations are required in addition to any authorisation that may have been obtained for hospitalisation, for the following: • CT scans • MUGA scans • MRI scans • Radio isotope studies • CT colonography (virtual colonoscopy, limited to one per beneficiary per annum restricted to the evaluation of symptomaticpatients only). • MDCT coronary angiography, limited to one per beneficiary, restricted to the evaluation of symptomatic patients only.
D21.2.2	**Out of hospital**	Limited to and included in D21.2.1.	Limited to and included in D21.2.1.	See D21.2.1.
D21.3	**PET and PET-CT**	See D14.1.2.1.	See D14.1.2.1.	
D22	**RENAL DIALYSIS CHRONIC**			
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. • Related medicine is subject to the DSP and Regulation 8 (3).	• No limit. • 100% of the lower of the cost or Bonitas Tariff for all services, medicines and materials associated with the cost of renal dialysis, subject to the the DSP network and Regulation 8 (3). • The contracted rate applies for the services rendered by a network specialist and 100% of the Bonitas Tariff for the services rendered by a non-network specialist. • Related medicine is subject to the DSP and Regulation 8 (3).	• Subject to the relevant managed healthcare programme and to its prior authorisation. • Authorised erythropoietin is included in (D4) • Acute renal dialysis is included in hospitalisation costs. See D7.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• 20% co-payment applies for the voluntary use of a non-DSP.	• 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.
D23	**SURGICAL PROCEDURES**			
D23.1	**In hospital and unattached operating theatres and other minor surgical procedures that can be authorised in hospital. (See B3)**	• Limited to and included in D7.1.1 or D7.2.1. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Co-payments apply – See paragraph D23.3 below. • Day surgery network applies for defined list of procedures. See D23.4.	• Limited to and included in D7.1.1 or D7.2.1. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Subject to the Standard Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • Co-payments apply – See paragraph D23.3 below. • Day surgery network applies for defined list of procedures. See D23.4.	Subject to the relevant managed healthcare programme and to its prior authorisation. This benefit excludes: • Osseo-integrated implants (D6); • Orthognathic and oral surgery (D6); • Maternity (D10); • Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16).
D23.1.1	**Refractive surgery**	No benefit.	No benefit.	
D23.1.2	**Maxillo-facial surgery**	• Limited to and included in D7.1.1 or D7.2.1. • 100% of the Bonitas Tariff for services rendered by the medical specialist.	• Limited to and included in D7.1.1 or D7.2.1. • 100% of the Bonitas Tariff for services rendered by the medical specialist.	Subject to the relevant managed healthcare programme and to its prior authorisation. For the surgical removal of • tumours • neoplasms • sepsis, • trauma,

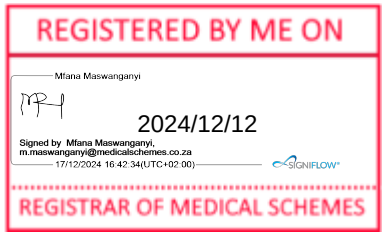
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
				• congenital birth defects and other surgery not specifically mentioned in (D6). This benefit excludes: • Osseo-integrated implantation (D6); • Orthognathic surgery (D6); • Oral surgery (D6); • Impacted teeth (D6).
D23.2	**Out of hospital procedures in practitioner's rooms that are not mentioned in D23.2.1 or D23.2.2.**	• Limited to and included in the Day-to-Day benefit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the non-network medical specialist or general practitioner.	• Limited to and included in the Day-to-Day benefit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the non-network medical specialist or general practitioner.	• Subject to the relevant managed healthcare programme and to its prior authorisation. • Only where a hospital procedure is performed in the practitioner's rooms and is approved, will it be limited to and included in (D7) and OAL. • This benefit excludes services as above as well as Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication. (D16). • No co-payment applies if the procedure is done in the practitioner's rooms.
D23.2.1	**General procedures performed in specialist consulting rooms**	Limited to and included in D7.1.1 or D7.2.1 at enhanced rates for: • Endometrial biopsy (excluding after-care): (2434) • Implantation hormone pellets (excluding after-care): (2565). • Insertion of intra-uterine contraceptive device (IUCD) (excluding after-care): (2442) • Punch biopsy (excluding after-care): (2399) • Removal of tag or polyp: (2271) • Removal of small superficial benign lesions: (2272) • Removal of benign vulva tumour or cyst: (2277)		• Subject to pre-authorisation. 
D23.2.2	**Specified procedures done in the specialist rooms or suitably equipped procedure room with correct equipment and monitoring facilities**	Limited to and included in D7.1.1 or D7.2.1 at enhanced rates for: • Biopsy during pregnancy (excluding after care): (2400) • Cervix encirclage: Removal items 2409 and 2411: without anaesthetic): (2415) • Colposcopy (excluding after-care): (2429) • Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room: (2392) • Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): Under anaesthetic: (2395) • Cystoscopy: (1949)		• Subject to pre-authorisation.

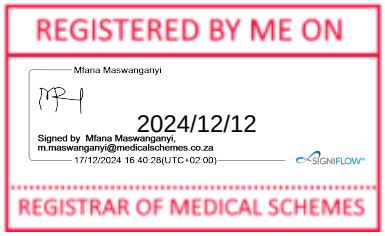
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion: (2316) • Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat – Limited: (2317) • Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread: (2318) • Evacuation of uterus: Incomplete abortion: Before 12 weeks gestation: (2445) • Evacuation: Missed abortion: Before 12 weeks gestation: (2449) • Excision of benign lip lesion: (1485) • Excision of malignant lip lesion (1487) • Excision of superficial eyelid tumour: (3163) • Extensive resection for malignant soft tissue tumour including muscle: (0313) • Flap repairs (large, complicated): 0295 • Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.: (1676) • Full thickness skingraft repair: (0289) • Full thickness eyelid repair: (3189) • Full thickness lip repair: (1499) • Hymenectomy: (2283) • Hysterosalpingogram (excluding after-care): (2435) • Hysteroscopy (excluding after-care): (2436) • Hysteroscopy and polypectomy (excluding after-care): (2440) • Laser or harmonic scalpel treatment of the cervix: (2396) • Laser therapy of vulva and/or vagina (colposcopically directed): (2274) • Left-sided colonoscopy: (1656) • Termination of pregnancy before 12 weeks: (2448) • Total colonoscopy: With hospital equipment (including biopsy): (1653) • Upper gastro-intestinal endoscopy: Hospital equipment: (1587) • Vulva and introitus: drainage of abscess: (2293)		
D23.3	**PROCEDURES WHICH WILL ATTRACT A CO-PAYMENT:**			• Subject to the relevant managed healthcare programme and to its prior authorisation. • Where more than one co-payment applies to an admission/event, the lower of the co-payments will be waived and the highest will be the member's liability**.**

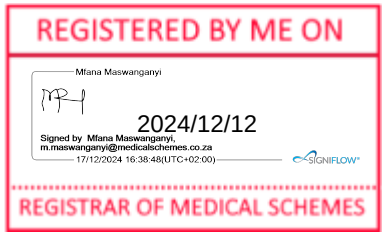
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D23.3.1	**Procedures which will attract a co-payment:**			
	Hip and knee arthroplasty	• Subject to a R37 080 co-payment: • when hip or knee arthroplasty is performed by a non-DSP.	• Subject to a R37 080 co-payment 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	• Subject to a R7 420 co-payment: • For the voluntary use of a non-DSP.	• Subject to a R7 420 co-payment: • For the voluntary use of a non-DSP.	
D23.4	**Day Surgery Procedures**	• Subject to the Day Surgery Network. • R2 720 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the Day Surgery Network. • R5 440 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and to its prior authorisation and subject to a defined list of procedures. • The co-payment to be waived if the cost of the service falls within the co-payment amount.
D24	**PREVENTATIVE CARE BENEFIT**			
D24.1	**Women's Health** **Breast Cancer Screening**	Mammogram • Females age >40 years • Once every 2 years.	Mammogram • Females age >40 years • Once every 2 years.	
	Cervical Cancer Screening	Pap Smear • Females 21-65 years • Once every 3 years.	Pap Smear • Females 21-65 years • Once every 3 years.	Eligible beneficiaries may choose between the basic cytology test once every 3 years or HPV PCR test once every 5 years.
	Cervical Cancer Screening in HIV infection	Pap Smear • Females 21-65 years • 1 basic cytology test per annum or the HPV PCR once every 5 years.	Pap Smear • Females 21-65 years • 1 basic cytology test per annum or the HPV PCR once every 5 years.	
	Human Papilloma Virus (HPV) Vaccine	• Limited to 3 doses for females between 15 – 26 years. • One course per lifetime.	• Limited to 3 doses for females between 15 – 26 years. • One course per lifetime.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• Limited to R1 100 per vaccine.	• Limited to R1 100 per vaccine.	
D24.2	**Men's Health** **PSA test**	• Men 55-69 years, 1 per annum.	• Men 55-69 years, 1 per annum.	
D24.3	**General Health**	• HIV test annually • Flu vaccine annually, including the administration fee of the nurse practitioner.	• HIV test annually • Flu vaccine annually including the administration fee of the nurse practitioner.	• HIV test, 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 • From age 20 years • Once every 5 years	Full Lipogram • From age 20 years • Every 5 years	
D24.5	**Elderly Health**	Pneumococcal Vaccination including the administration fee of the nurse practitioner. • Age >65 once every 5 years. Faecal Occult Blood Test • Ages 45-75 annually.	Pneumococcal Vaccination including the administration fee of the nurse practitioner. • Age >65 once every 5 years. Faecal Occult Blood Test • Ages 45-75 annually.	
D24.6	**Children's health** **Hypothyroidism**	• 1 TSH Test Age <1 month	• 1 TSH Test Age <1 month	
	Infant Hearing Screening	• One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	• 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))**	• Two vision screening tests per beneficiary for newborns up to 6 weeks, in or out of	• Two vision screening tests per beneficiary for newborns up to 6 weeks, in or out of	Screening should be performed at 4 – 6 weeks chronological age or 31 – 33 weeks post-conceptional age (whichever comes later).

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		hospital, performed by an ophthalmologist.	hospital, performed by an ophthalmologist.	
	Human Papilloma Virus (HPV) Vaccine	• Limited to two doses for girls aged between 9 – 14years. • One course per lifetime. • Limited to R1 100 per vaccine.	• Limited to two doses for girls aged between 9 – 14years. • One course per lifetime. • Limited to R1 100 per vaccine.	
	Extended Program on Immunisation (EPI)	• Various Vaccinations including the administration fee of the nurse practitioner for children up to the age of 12 years.	• Various Vaccinations including the administration fee of the nurse practitioner for children up to the age of 12 years.	
D24.7	**Pertussis Booster Vaccine (Whooping Cough)**	• One booster vaccine per beneficiary between the ages of 07 and 64 years, every 10 years.	• One booster vaccine per beneficiary between the ages of 07 and 64 years, every 10 years.	
D24.8	**Hearing Loss Preventative Screening**	• Unlimited digital pre-screening for potential hearing loss subject to the Audiology Benefit Management programme	• Unlimited digital pre-screening for potential hearing loss subject to the Audiology Benefit Management programme	Screening options as available on the website and all other digital platforms offered by the Fund.
D24.9	**Weight Management Programme**	• Limited to 1 enrolment per beneficiary for beneficiaries, subject to qualifying criteria and successful enrolment on the programme.	• 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
D24.10	**Smoking Cessation (GoSmokeFree)**	• Limited to and included in the Benefit Booster in D27.2	• Limited to and included in the Benefit Booster in D27.2	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D25	**INTERNATIONAL TRAVEL BENEFIT**			
D25.1	**Leisure travel: (Travelling for recreation, a holiday or visiting family and friends)**	For medical emergencies when travelling outside the borders of South Africa. • 60 days excluding USA – R2.5 million per Member, R2.5 million for Member and Dependants • 60 days including USA – Maximum cover R500,000 for Member and Dependants.	For medical emergencies when travelling outside the borders of South Africa. • 60 days excluding USA – R2.5 million per Member, R2.5 million for Member and Dependants • 60 days including USA – Maximum cover R500,000 for Member and Dependants.	Subject to authorisation, prior to departure. • Additional benefits for Covid-19: ○ 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	**Business Travel: (Primarily for attending meetings, conferences, visiting suppliers and for administrative purposes)** 	For medical emergencies when travelling outside the borders of South Africa. • 30 days excluding USA – R2.5 million per Member, R2.5 million for Member and Dependants • 30 days including USA - Maximum cover R500,000 for Member and Dependants. • Subject to approval protocols prior to departure.	For medical emergencies when travelling outside the borders of South Africa. • 30 days excluding USA – R2.5 million per Member, R2.5 million for Member and Dependants • 30 days including USA - Maximum cover R500,000 for Member and Dependants. • Subject to approval protocols prior to departure.	Subject to authorisation, prior to departure. • Additional benefits for Covid-19: ○ 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**			
D26.1	**In and Out of Hospital** **(See B3)**	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	The Fund's liability will not exceed the global amount the Fund would in the ordinary course pay for such healthcare services given the Fund's claims experience in South Africa, subject to the benefits as per benefit plan.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D27	**WELLNESS BENEFIT**			
D27.1	**Health Risk Assessment (HRA) which includes Lifestyle questionnaire and Wellness screening** 	Wellness screening. • One assessment per beneficiary over the age of 21 years per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to • blood pressure test • glucose test • cholesterol test • body mass index. • hip to waist ratio • HIV counselling and testing.	Wellness screening. • One assessment per beneficiary over the age of 21 years per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to • blood pressure test • glucose test • cholesterol test • body mass index • hip to waist ratio • HIV counselling and testing.	• 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**)	• Subject to completion of a Health Risk Assessment or the completion of an online wellness questionnaire per beneficiary over the age of 21 years. • First level Benefit Booster, Limited to R1 000 per family, activated by completion of an online questionnaire. • Limited to: • Alternative Health: D1 • GP consultations: D5.1.3 & 4 • Medical specialists: D5.2	• Subject to completion of a Health Risk Assessment or the completion of an online wellness questionnaire per beneficiary over the age of 21 years. • First level Benefit Booster, Limited to R1 000 per family, activated by completion of an online questionnaire: • Limited to:. • Alternative Health: D1 • GP consultations: D5.1.3 & 4 • Medical specialists: D5.2	• 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 Health Risk Assessment or an online wellness questionnaire. • Valid qualifying claims will pay first from the Benefit Booster and thereafter from the relevant benefits as described in D1 – D24. • The first level Benefit Booster will become available when an online wellness questionnaire is completed by the main member or adult beneficiary. • When a main member or adult beneficiary completes the health risk assessment

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• Acute medication: D11.1 • Registered ante-natal vitamins during pregnancy: D11.1.3 • Pharmacy advised therapy: D11.2Non-surgical procedures: D13.2 • Paramedical services : D17.2 • Pathology: D18.2 • Physical therapy: D19.2 • General radiology: D21.1.2 • Smoking cessation: D24.10 • Second level Benefit Booster applies when the first level benefit is depleted. • Subject to the completion of a physical health risk assessment (HRA) at a participating pharmacy or wellness day. • Limited to R4 000 per family.	• 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 • Second level Benefit Booster applies when the first level benefit is depleted. • Subject to the completion of a physical health risk assessment (HRA) at a participating pharmacy or wellness day. • Limited to R4 000 per family,	(HRA), the first and second level Benefit Booster will become available.