Bonitas

BONITAS MEDICAL FUND
ANNEXURE B

OPTIONS:
STANDARD
STANDARD SELECT
PRIMARY

2018

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A ENTITLEMENT TO BENEFITS

A1 The Bonitas Fund Tariff is defined as the Bonitas monetary tariffs applicable in 2017 increased by an average of 5.7%.

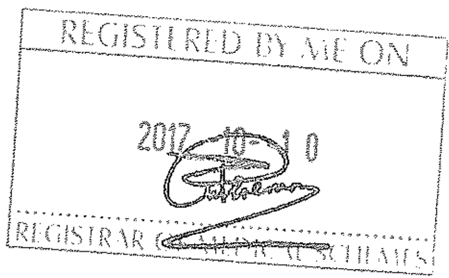
A2 Beneficiaries are entitled to benefits as shown in this Annexure B, subject to the monetary limits and implementation restrictions set out herein, to the exclusions referred to in Annexure C of the Rules, to the general limitation and restriction of benefits set out in Annexure D of the Rules and to the procedural and other requirements set out in the main rules.

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:

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



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

- 130% of Bonitas Tariff for Standard, Standard Select and Primary Options.

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

- 130% Bonitas Tariff for Standard, Standard Select and Primary Options.

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

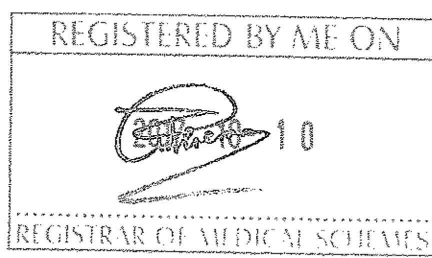
B1 On the Standard, Standard Select and Primary options, claims for services stated as being subject to payment from the Day-to-Day benefit in paragraph D below are allocated against the Day-to-Day benefits.

B2 When the Day-to-Day benefit is exhausted on the Standard, Standard Select and Primary 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 medicine claims will be reimbursed at 100% of (1) the single exit price plus the negotiated mark-up, or (2) the single exit price plus 26% capped at a maximum of R26 (Vat exclusive), Subject to a maximum fee as dictated by legislation. Both subject to the reimbursement limit, i.e. the Maximum Generic Price or Medicine Price List. Levies and co-payments to apply where relevant.



B5 MEMBERSHIP CATEGORY

Member	=	M0
Member plus 1 dependant	=	M1
Member plus 2 dependants	=	M2
Member plus 3 dependants	=	M3
Member plus 4 and more dependants	=	M4+

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, Standard Select and Primary 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:

- 1 (one) gynaecologist consultation or visit per annum for female beneficiaries;
- Maternity
- Children under the age of 2 (two) years, for paediatrician visits or consultations
- Consultations with Oncologists
- Consultations with Ophthalmologists.

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

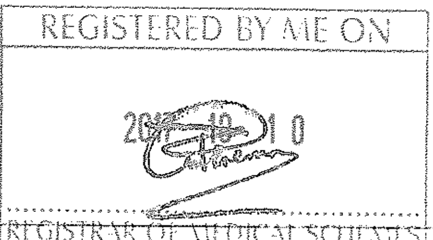
D ANNUAL BENEFITS AND LIMITS

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
	OVERALL ANNUAL LIMIT	No limit.	No limit.	No limit.	
	DAY-TO-DAY BENEFIT	M : R5 540 M+1: R8 430 M+2: R9 750 M+3: R10 650 M+4+: R11 600	M : R5 540 M+1: R8 430 M+2: R9 750 M+3: R10 650 M+4+: R11 600	M : R2 010 M+1 : R3 600 M+2: R4 230 M+3: R4 550 M+4+: R4 920	
	General Practitioner Network	M : R3 970 M+1: R5 820 M+2: R6 450 M+3: R6 770 M+4+: R7 350 (See D5.1.3 and D5.1.4)	M : R3 970 M+1: R5 820 M+2: R6 450 M+3: R6 770 M+4+: R7 350 Subject to GP nomination from the GP Network. (See D5.1.3 and D5.1.4)	M : R1 900 M+1: R3 490 M+2: R4 130 M+3: R4 440 M+4+: R5 030	
D1	**ALTERNATIVE HEALTHCARE (See B1 & B3)**	Subject to the Day-to-Day benefit.	Subject to the Day-to-Day benefit.	Subject to the Day-to-Day benefit.	
D1.1	**Homoeopathic Consultations and/or treatment**	Limited to and included in D1.	Limited to and included in D1.	Limited to and included in D1.	
D1.2	**Homoeopathic Medicines**	Limited to and included in D1.	Limited to and included in D1.	Limited to and included in D1.	
D1.3	**Acupuncture**	Limited to and included in D1.	Limited to and included in D1.	Limited to and included in D1.	
D1.4	**Naturopathy Consultations and/or treatment and medicines**	Limited to and included in D1.	Limited to and included in D1.	Limited to and included in D1.	
D1.5	**Osteopathy**	Limited to and included in D1.	Limited to and included in D1.	Limited to and included in D1.	

REGISTERED BY ME ON
2017-10-20
REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D1.6	**Phytotherapy**	Limited to and included in D1.	Limited to and included in D1.	Limited to and included in D1.	
D2	**AMBULANCE SERVICES (See B3)**	100% of cost if authorised by the preferred provider.	100% of cost if authorised by the preferred provider.	100% of cost if authorised by the preferred provider.	Subject to the contracted provider. Non-authorisation will result in non-payment except for PMBs.
D3	**APPLIANCES, EXTERNAL ACCESSORIES AND ORTHOTICS (See B3)**		REGISTERED BY ME ON 2017-10-10 REGISTRAR OF MEDICAL SCHEMES		Diabetic accessories and appliances (with the exception of glucometers) to be pre-authorised and claimed from the chronic medicine benefit (D11.3). Subject to preferred supplier agreements.
D3.1	**In and Out of Hospital**				
D3.1.1	**General medical and surgical appliances, including wheelchairs and repairs, and large orthopaedic appliances**	• R7 300 per family. • Subject to preferred supplier agreements.	• R7 300 per family. • Subject to preferred supplier agreements.	• R6 560 per family. • Subject to preferred supplier agreements.	Hiring or buying medical or surgical aids as prescribed by a medical practitioner.
D3.1.2	**Hearing Aids and repairs**	• R15 240 per family every two years. • A 20% co-payment will apply. • Benefit is available per beneficiary every two years (biennial) based on the last claim date.	• R15 240 per family every two years. • A 20% co-payment will apply. • Benefit is available per beneficiary every two years (biennial) based on the last claim date.	No benefit.	Hearing aids and repairs are subject to the relevant managed healthcare programme and to its prior authorisation. Subject to preferred supplier agreements.
D3.1.3	**CPAP Apparatus for sleep apnoea**	General appliance limit may be exceeded by R6 240 per family.	General appliance limit may be exceeded by R6 240 per family.	General appliance limit may be exceeded by R6 240 per family.	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.	Limited to and included in D3.1.3 and thereafter funded from OAL, if PMB.	

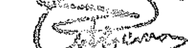
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D3.1.5	**Specific appliances, accessories**				Subject to the relevant managed healthcare programme and to its prior authorisation and if the treatment forms part of the relevant managed healthcare 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.	No limit if specifically authorised.	
D3.1.5.2	**Home Ventilators**	No limit if specifically authorised.	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.	Limited to and included in D20.2.	
D3.1.5.4	**Foot orthotics**	No benefit.	No benefit.	No benefit.	
D4	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS (See B3)**	No limit if specifically authorised.	No limit if specifically authorised.	No limit if specifically authorised.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D5	**CONSULTATIONS VISITS BY MEDICAL PRACTITIONERS (See B1 and B3)**				



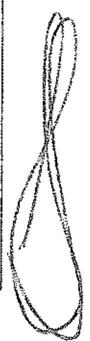
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D5.1	**General Practitioners**				This benefit excludes • Dental Practitioners and Therapists (D6), • Oncologists, Haematologists and Credentialed Medical Practitioners during active and post-active 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.	• No limit. • 100% of Bonitas Tariff for general practitioners.	
D5.1.2.	**Out of Hospital**	Subject to the General Practitioner benefit in D5.1.3 and D5.1.4.	Subject to the General Practitioner benefit in D5.1.3 and D5.1.4.	Subject to the General Practitioner Benefit in D5.1.3 and D5.1.4.	
D5.1.3	**In Network General Practitioners/Nominated General Practitioners for Standard Select**	M : R3 970 M+1: R5 820 M+2: R6 450 M+3: R6 770 M+4+: R7 350	M : R3 970 M+1: R5 820 M+2: R6 450 M+3: R6 770 M+4+: R7 350 Subject to GP Nomination from the GP Network.	M : R1 900 M+1: R3 490 M+2: R4 130 M+3: R4 440 M+4+: R5 030	On Standard Select, subject to nominating a GP from the GP Network and submitting the claim from the nominated GP.

REGISTERED BY ME ON 2017 -10- 10 REGISTRAR OF MEDICAL SCHEMES

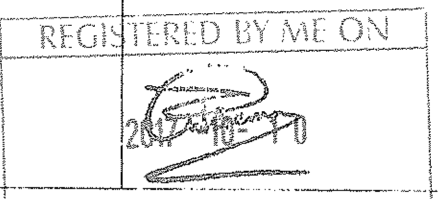
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D5.1.4	**Non-Network General Practitioners/Non Nominated, for Standard Select**	M : R1 290 M+1: R1 990 M+2: R2 170 M+3: R2 270 M+4+: R2 450 Limited to and included in the General Practitioner Network benefit D5.1.3.	M : R1 290 M+1: R1 990 M+2: R2 170 M+3: R2 270 M+4+: R2 450 Applicable to network or non-network GP consultations, except for nominated GP's. Limited to and included in the General Practitioner Network benefit D5.1.3.	M : R 615 M+1: R1 160 M+2: R1 320 M+3: R1 480 M+4+: R1 750 Limited to and included in the General Practitioner Network benefit D5.1.3.	
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.	1 GP consultation 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 ◦ 130% of Bonitas Tariff. (See Annexure D: 7.3.6).	◦ No limit ◦ 130% of Bonitas Tariff. (See Annexure D: 7.3.6).	◦ No Limit ◦ 130% of BonitasTariff (See Annexure D: 7.3.6).	All consultations and procedures within the specialist network will be paid at the negotiated Tariff, 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.	◦ 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.


REGISTERED BY ME ON 2017 -10- 10 REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D5.2.2	**Out of Hospital (See B1, B3 and B8)**	• 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Limited to and included in the Day-to-Day benefit and subject to referral by a general practitioner, except in the exceptional cases as per the remarks column.	• 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Limited to and included in the Day-to-Day benefit and subject to referral by a general practitioner, except in the exceptional cases as per the remarks column. REGISTERED BY ME ON 2017-10-10 REGISTRAR OF MEDICAL SCHEMES	• 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Limited to and included in the Day-to-Day benefit and subject to referral by a general practitioner, except in the exceptional cases as per the remarks column.	On Standard; Standard Select and Primary, 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: • One (1) gynaecologist visit/consultation 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 and oncologists. 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. • 2 Paediatric consultations per beneficiary for children aged 13 - 24 months, included in the OAL.	• 2 Paediatric consultations per beneficiary for children aged 0 - 12 months. • 2 Paediatric consultations per beneficiary for children aged 13 - 24 months, included in the OAL.	• 1 Paediatric consultation per beneficiary for children aged 0 - 12 months. • 1 consultation per beneficiary for children aged between 13 – 24 months, included in the OAL.	



PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D6	**DENTISTRY (See B3)**				Subject to the Dental Management Programme. Benefits payable on the Primary Option are subject to a Designated Service Provider Network for conservative out of hospital services.
D6.1.1	**Consultations**	Limited to two general check-ups (once every 6 months) per beneficiary per year. Covered at BDT.	Limited to two general check-ups (once every 6 months) per beneficiary per year. Covered at BDT.	Limited to two general check-ups (once every 6 months) per beneficiary per year. Covered at BDT.	
D6.1.2	**Fillings**	• Covered at 100% of the BDT. • Fillings are granted once per tooth in 365 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 365 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 365 days. • Benefit for re-treatment of a tooth is subject to managed care protocols.	Benefits for fillings are granted once per tooth in 365 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.	• 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.	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.	Covered at 100% of BDT. Root canal treatment is limited to the shortened dental arch (i.e. excl. Molars). Root canal therapy on primary (milk) teeth is not covered.	Subject to managed care protocols.



PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D6.1.6	**Oral Hygiene**	2 Annual scale and polish treatments per beneficiary once every 6 months.	2 Annual scale and polish treatments per beneficiary once every 6 months.	2 Annual scale and polish treatments per beneficiary once every 6 months.	No benefit for oral hygiene instructions. Benefit for fluoride is limited to beneficiaries from age 5 and younger than 16 years of age. Benefit for fissure sealants is limited to beneficiaries younger than 16 years of age.
D6.1.7	**Hospitalisation (general anaesthetic) and IV Conscious sedation in the rooms**	• Co-payment of R3 000 per hospital admission applies. • Subject to pre-authorisation. • Admission protocols apply. • Certain maxillo-facial procedures are covered in hospital. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. • Multiple hospital admissions are not covered. • General anaesthetic benefits are available for the removal of impacted teeth. Benefit is subject to managed care protocols. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• Co-payment of R3 000 per hospital admission applies. • Subject to pre-authorisation. • Subject to the Standard Select hospital Network. • Admission protocols apply. • Certain maxillo-facial procedures are covered in hospital. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. • Multiple hospital admissions are not covered. • General anaesthetic benefits are available for the removal of impacted teeth. Benefit is subject to managed care protocols. • Subject to the Standard Select hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• Co-payment of R3 000 per hospital admission applies. • Subject to pre-authorisation. • Admission protocols apply. • Certain maxillo-facial procedures are covered in hospital. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. • Multiple hospital admissions are not covered. • General anaesthetic benefits are available for the removal of impacted teeth. Benefit is subject to managed care protocols. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	Pre-authorisation is required for IV conscious sedation in the rooms and is limited to extensive dental treatment where managed care protocols apply.

REGISTERED BY ME ON
2017 -10- 10
REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D6.1.8	**Laughing gas 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.	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 in a 3 year period. • Additional benefits for extra-oral x-rays may be considered where specialist dental treatment planning/follow-up is required.	• 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 in a 3 year period. • Additional benefits for extra-oral x-rays may be considered where specialist dental treatment planning/follow-up is required.	• 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 in a 3 year period.	
D6.2	**ADVANCED DENTISTRY (See B3)**				
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.	• 1 Crown per family per year, subject to pre-authorisation. • Benefits for crowns will be granted once per tooth in 5 years.	No benefit.	• 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 Metal 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.	No benefit.	Subject to managed care protocols.

REGISTERED BY ME ON
2017-10-10
REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D6.2.3	**Osseo-integrated Implants and orthognathic surgery (functional correction of malocclusion)**	No benefit.	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.	Surgery in the dental chair. Covered at 100% of BDT.	A benefit for Tempero-mandibular joint therapy is limited to non-surgical interventions/treatments.
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	No benefit.	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.	See D23.	

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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
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.	• 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.	No benefit.	
D7	**HOSPITALISATION (See B3)**				
D7.1	**Private hospitals and unattached operating theatres (See B3)**				Subject to the relevant managed healthcare programme and its prior authorisation.
D7.1.1	**In Hospital**	• No limit. • Deep Brain Stimulation Implantation for Parkinson's Disease and intractable epilepsy is limited to R222 200 per beneficiary (excluding the prosthesis benefit). • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• 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 R222 200 per beneficiary (excluding the prosthesis benefit). • Hip and knee arthroplasties are subject to the DSP.	• No limit. • No benefit for Deep Brain Stimulation Implantation. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	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).

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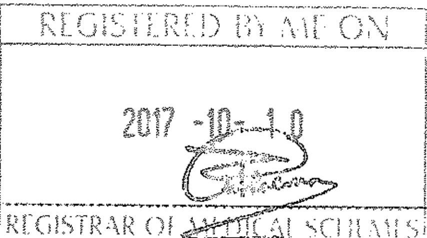
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D7.1.2	**Medicine on discharge from hospital (TTO) (See B4)**	R445 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme.	R445 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme.	R360 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**				
D7.1.3.1	**Facility fee**	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	Will be included in the hospital benefit if a retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies.
D7.1.3.2	**Consultations**	See D5.1.3, D5.1.4 and D5.2.2.	See D5.1.3, D5.1.4 and D5.2.2.	See D5.1.3, D5.1.4 and D5.2.2.	
D7.1.3.3	**Medicine**	See D11.1.	See D11.1.	See D11.1.	
D7.2	**Public hospitals (See B3)**				Subject to the relevant managed healthcare programme and its prior authorisation.



PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D7.2.1	**In hospital**	No limit.	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); • 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)**	R445 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme. See D7.1.2.	R445 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme. See D7.1.2.	R360 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**				

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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D7.2.3.1	**Facility fee**	• Limited to and included in the Day-to-Day benefit.	• Limited to and included in the Day-to-Day benefit.	• Limited to and included in the Day-to-Day benefit.	Will be included in the hospital benefit if retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies.
D7.2.3.2	**Consultations**	See D5.1.3, D5.1.4 and D5.2.2.	See D5.1.3, D5.1.4 and D5.2.2.	See D5.1.3, D5.1.4 and D5.2.2.	
D7.2.3.3	**Medicine**	See D11.1.	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.	• 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.	See D5.1.3, D5.1.4 and D5.2.2.	
D7.2.4.3	**Medicine**	See D11.1.	See D11.1.	See D11.1.	
D7.3	**Alternatives to hospitalisation (See B3)**		REGISTERED BY ME ON 2017-10-10 REGISTRAR OF MEDICAL SCHEMES		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**	R47 250 per family, for all services.	R47 250 per family, for all services.	R47 250 per family, for all services.	See D7.3

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D7.3.2	**Sub-acute facilities, Hospice, Private Nursing**	R15 760 per family.	R15 760 per family.	R15 760 per family.	This benefit includes nursing services for psychiatric nursing but excludes midwifery services. See D7.3.
D7.3.3	**Outpatient antibiotic therapy in lieu of hospitalisation**	• No limit. • Subject to pre-authorisation.	• No limit. • Subject to pre-authorisation.	• No limit. • Subject to pre-authorisation.	Subject to the relevant managed healthcare programme.
D7.3.4	**Conservative Back Programme**	Subject to the Contracted Provider.	Subject to the Contracted Provider.	Subject to the Contracted Provider.	
D7.3.5	**Terminal Care**	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.	Limited to and included in D7.3.2 and above limits, subject to pre-authorisation.	Subject to the relevant managed healthcare programme.
D8	**IMMUNE DEFICIENCY SYNDROME RELATED TO HIV INFECTION (SEE B3)**	No limit. Subject to PMBs.	No limit. Subject to PMBs.	No limit. Subject to PMBs.	Subject to registration on the relevant managed healthcare programme. Subject to clinical protocols.
D8.1	**Anti-retroviral medicine**	Limited to and included in D8 and subject to the DSP.	Limited to and included in D8 and subject to the DSP.	Limited to and included in D8 and subject to the DSP.	Subject to the relevant managed healthcare programme.
D8.2	**Related medicine**	Limited to and included in D8 and subject to the DSP.	Limited to and included in D8 and subject to the DSP.	Limited to and included in D8 and subject to the DSP.	
D8.3	**Related pathology**	Limited to and included in D8.	Limited to and included in D8.	Limited to and included in D8.	Pathology as specified by the relevant managed healthcare programme, out of hospital.
D8.4	**Related consultations**	Limited to and included in D8.	Limited to and included in D8.	Limited to and included in D8.	
D8.5	**All other services**	Limited to and included in D1 - D7 and D9 - D26.	Limited to and included in D1 - D7 and D9 - D26.	Limited to and included in D1 - D7 and D9 - D26.	

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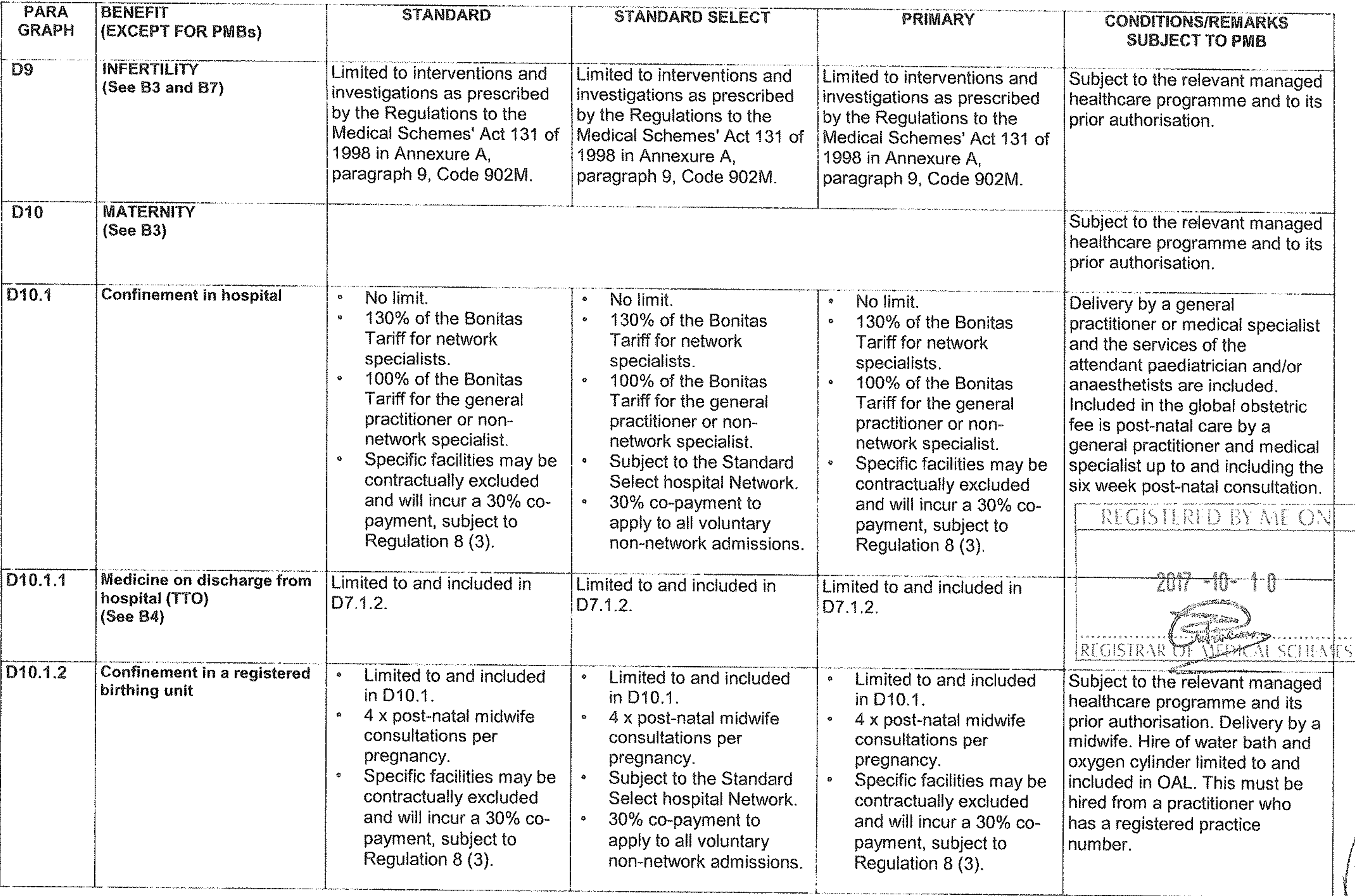

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D9	**INFERTILITY (See B3 and B7)**	Limited to interventions and investigations as prescribed by the Regulations to the Medical Schemes' Act 131 of 1998 in Annexure A, paragraph 9, Code 902M.	Limited to interventions and investigations as prescribed by the Regulations to the Medical Schemes' Act 131 of 1998 in Annexure A, paragraph 9, Code 902M.	Limited to interventions and investigations as prescribed by the Regulations to the Medical Schemes' Act 131 of 1998 in Annexure A, paragraph 9, Code 902M.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D10	**MATERNITY (See B3)**				Subject to the relevant managed healthcare programme and to its prior authorisation.
D10.1	**Confinement in hospital**	• No limit. • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• No limit. • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Subject to the Standard Select hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• No limit. • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	Delivery by a general practitioner or medical specialist and the services of the attendant paediatrician and/or anaesthetists are included. Included in the global obstetric fee is post-natal care by a general practitioner and medical specialist up to and including the six week post-natal consultation.
D10.1.1	**Medicine on discharge from hospital (TTO) (See B4)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	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. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy. • Subject to the Standard Select hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	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.

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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D10.2	**Confinement out of hospital**	◦ Limited to and included in D10.1. ◦ 4 x post-natal midwife consultations per pregnancy.	◦ Limited to and included in D10.1. ◦ 4 x post-natal midwife consultations per pregnancy.	◦ Limited to and included in D10.1. ◦ 4 x post-natal midwife consultations per pregnancy.	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.
D10.2.1	**Consumables and pharmaceuticals**	Limited to and included in D10.1.	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.	Limited to and included in D10.1.	
D10.3.1	**Ante-natal consultations**	◦ 12 ante-natal consultations by a specialist, general practitioner or midwife per pregnancy. ◦ R1 160 for ante-natal classes/exercises per pregnancy.	◦ 12 ante-natal consultations by a specialist, general practitioner or midwife per pregnancy. ◦ R1 160 for ante-natal classes/exercises per pregnancy.	◦ 6 ante-natal consultations by a specialist, general practitioner or midwife per pregnancy. ◦ No benefit for ante-natal classes/exercises.	◦ 130% of the Bonitas Tariff for network specialists. ◦ 100% of the Bonitas Tariff for the general practitioner or non-network medical specialist.
D10.3.2	**Related tests and procedures**	◦ Pregnancy related tests and procedures. ◦ 2 x 2D pregnancy scans. ◦ 1 x amniocentesis per pregnancy.	◦ Pregnancy related tests and procedures. ◦ 2 x 2D pregnancy scans. ◦ 1 x amniocentesis per pregnancy.	◦ Pregnancy related tests and procedures. ◦ 2 x 2D pregnancy scans. ◦ 1 x amniocentesis per pregnancy.	

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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D11	**MEDICINE AND INJECTION MATERIAL (See B3 and B4)**				
D11.1	**Routine /(acute) medicine**	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	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.	Limited to and included in D7.1.2.	
D11.1.2	**Contraceptives**	• Limited to R1 500 per family. • Limted to females of childbearing age. • Subject to the DSP pharmacy. • 40% co-payment applies for the voluntary use of a non-DSP pharmacy.	• Limited to R1 500 per family. • Limted to females of childbearing age. • Subject to the DSP pharmacy. • 40% co-payment applies for the voluntary use of a non-DSP pharmacy.	• Limited to R1 500 per family. • Limted to females of childbearing age. • Subject to the DSP pharmacy. • 40% co-payment applies for the voluntary use of a non-DSP pharmacy.	REGISTERED BY ME ON 2017-10-10 REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D11.2	**Pharmacy Advised Therapy Schedules 0, 1 and 2 medicine advised and dispensed by a pharmacist**	• Limited to R740 per beneficiary. • R2 240 per family. • Limited to and included in the Day-to-Day benefit.	• Limited to R740 per beneficiary. • R2 240 per family. • Limited to and included in the Day-to-Day benefit.	• Limited to R465 per beneficiary. • R1 360 per family. • Limited to and included in the Day-to-Day benefit.	
D11.3	**Chronic medicine (See B4)**	• Limited to R9 150 per beneficiary. • R18 360 per family. • 40% co-payment applies for the voluntary use of non-formulary drugs. • Above limits, PMBs and DSP apply. • 40% 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 R9 150 per beneficiary and R18 360 per family. • 40% co-payment applies for the voluntary use of a non-DSP. • Only PMBs will be paid above limits and 40% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	• Prescribed Minimum Benefits only at the DSP. • 40% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	Subject to registration on the relevant managed healthcare programme and to its prior authorisation and applicable formularies. Restricted to a maximum of one month's supply unless pre-authorised. [Includes diabetic disposables such as • syringes, • needles, • strips and • lancets The above are excluded from D3 and D11 if on the Diabetic Management Programme. This benefit excludes: • In hospital medicine (D7); • Anti-retroviral drugs (D8); • Oncology medicine (D14); • Organ and haemopoietic stem cell (bone marrow) transplantation and immuno-suppressive medication (D16).
D11.3.1	**MDR and XDR-TB**	No limit, subject to managed care protocols.	No limit, subject to managed care protocols.	No limit, subject to managed care protocols.	Subject to the relevant managed healthcare programme and its prior authorisation.
D11.4	**Specialised Drugs (See B4)**				

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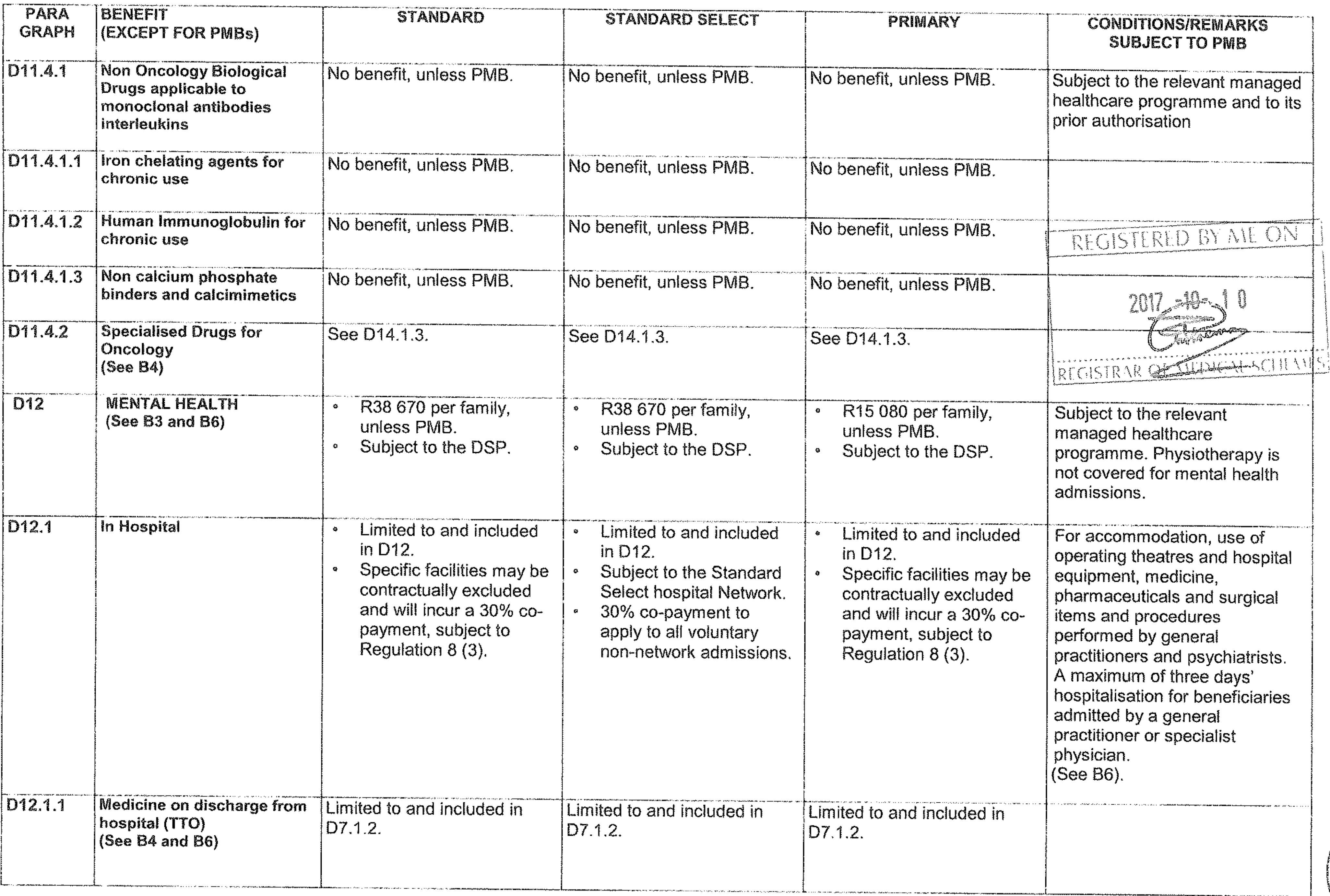

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D11.4.1	**Non Oncology Biological Drugs applicable to monoclonal antibodies interleukins**	No benefit, unless PMB.	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation
D11.4.1.1	**Iron chelating agents for chronic use**	No benefit, unless PMB.	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.1.2	**Human Immunoglobulin for chronic use**	No benefit, unless PMB.	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.	No benefit, unless PMB.	
D11.4.2	**Specialised Drugs for Oncology (See B4)**	See D14.1.3.	See D14.1.3.	See D14.1.3.	
D12	**MENTAL HEALTH (See B3 and B6)**	• R38 670 per family, unless PMB. • Subject to the DSP.	• R38 670 per family, unless PMB. • Subject to the DSP.	• R15 080 per family, unless PMB. • Subject to the DSP.	Subject to the relevant managed healthcare programme. Physiotherapy is not covered for mental health admissions.
D12.1	**In Hospital**	• Limited to and included in D12. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• Limited to and included in D12. • Subject to the Standard Select hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• Limited to and included in D12. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	For accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items and procedures performed by general practitioners and psychiatrists. A maximum of three days' hospitalisation for beneficiaries admitted by a general practitioner or specialist physician. (See B6).
D12.1.1	**Medicine on discharge from hospital (TTO) (See B4 and B6)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	

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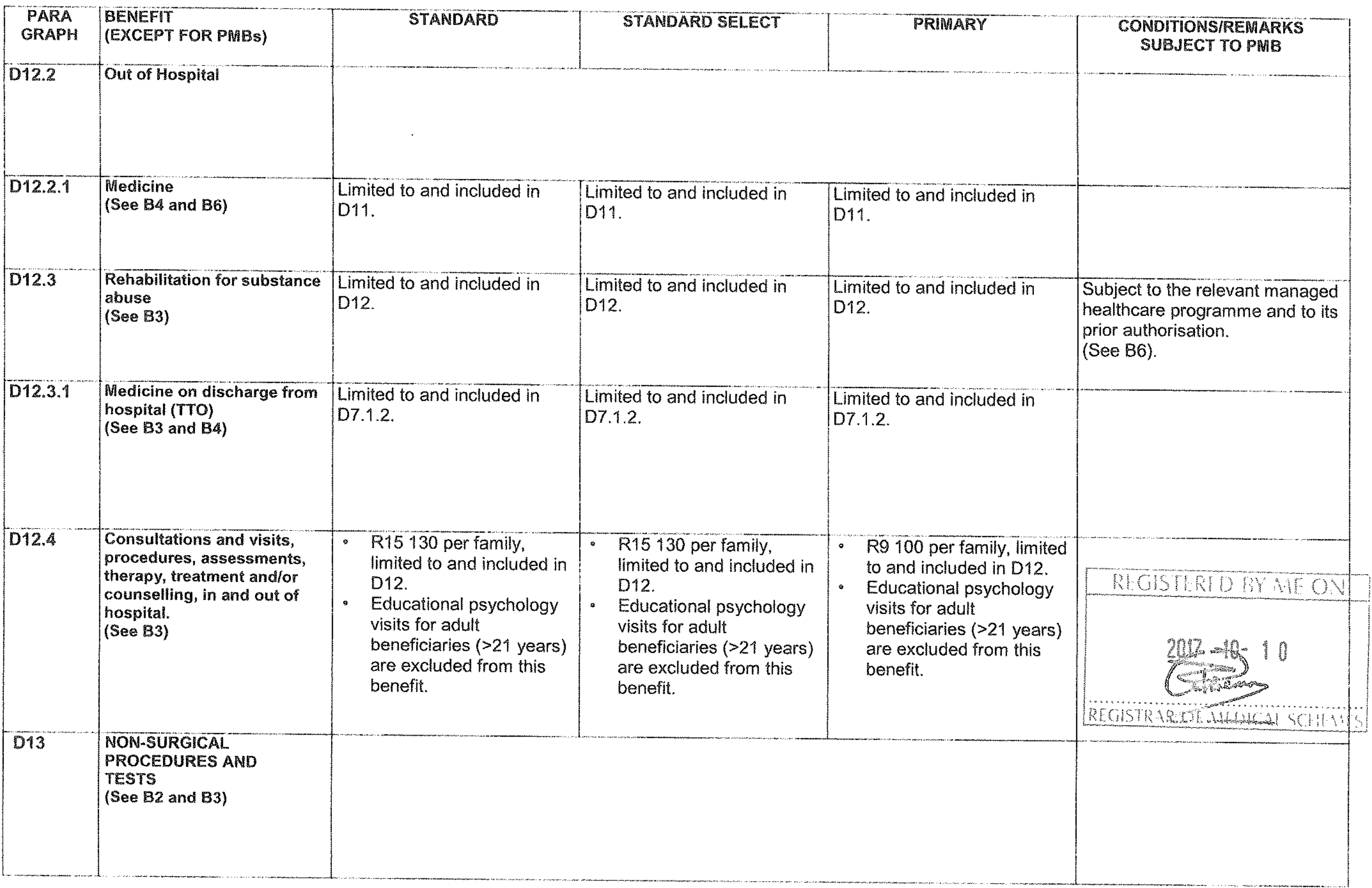

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D12.2	**Out of Hospital**				
D12.2.1	**Medicine** **(See B4 and B6)**	Limited to and included in D11.	Limited to and included in D11.	Limited to and included in D11.	
D12.3	**Rehabilitation for substance abuse** **(See B3)**	Limited to and included in D12.	Limited to and included in D12.	Limited to and included in D12.	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.	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)**	• R15 130 per family, limited to and included in D12. • Educational psychology visits for adult beneficiaries (>21 years) are excluded from this benefit.	• R15 130 per family, limited to and included in D12. • Educational psychology visits for adult beneficiaries (>21 years) are excluded from this benefit.	• R9 100 per family, limited to and included in D12. • Educational psychology visits for adult beneficiaries (>21 years) are excluded from this benefit.	
D13	**NON-SURGICAL PROCEDURES AND TESTS** **(See B2 and B3)**				

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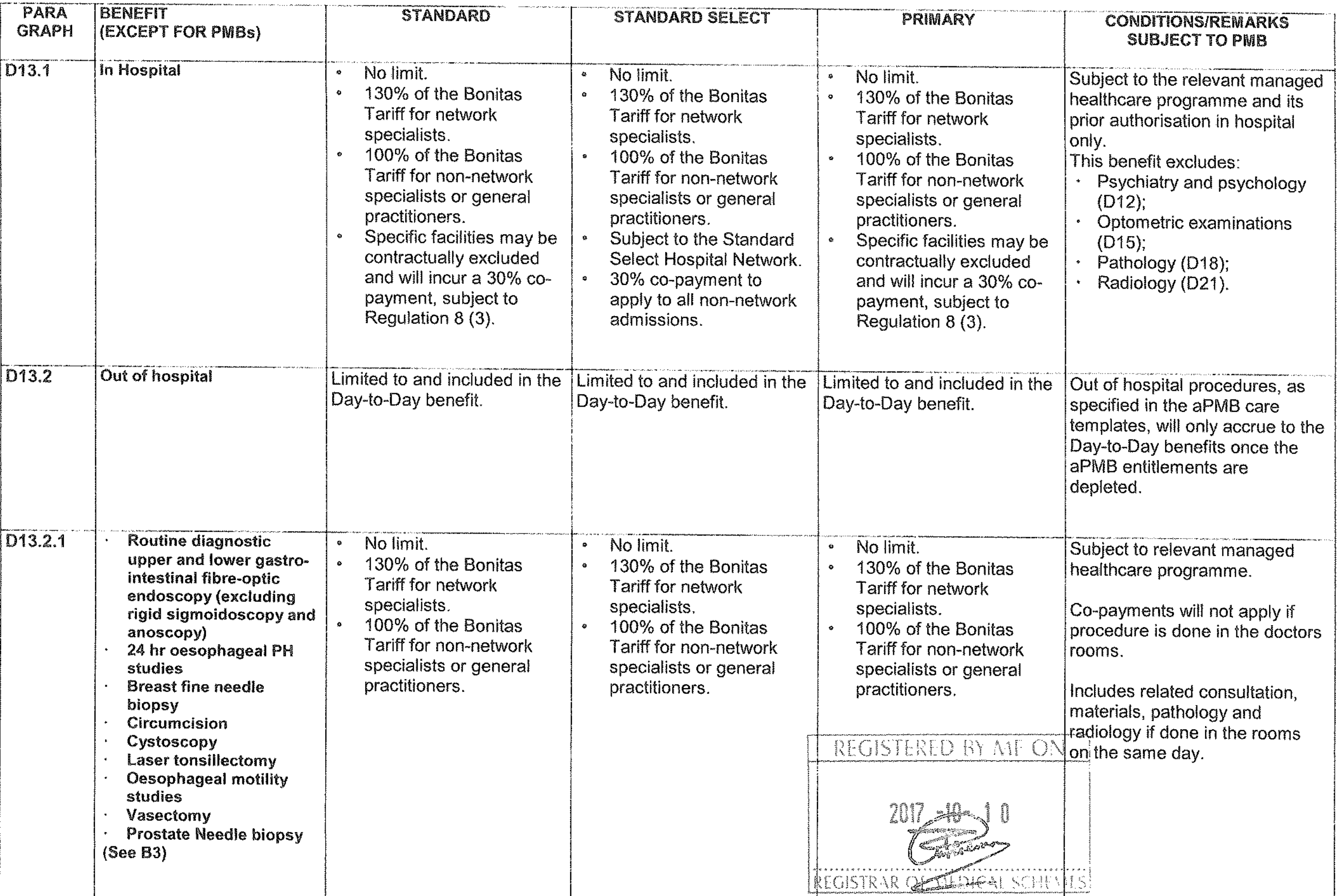

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D13.1	**In Hospital**	• No limit. • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• No limit. • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners. • Subject to the Standard Select Hospital Network. • 30% co-payment to apply to all non-network admissions.	• No limit. • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	Subject to the relevant managed healthcare programme and its prior authorisation in hospital only. This benefit excludes: · Psychiatry and psychology (D12); · Optometric examinations (D15); · Pathology (D18); · Radiology (D21).
D13.2	**Out of hospital**	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	Out of hospital procedures, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D13.2.1	· **Routine diagnostic upper and lower gastro-intestinal fibre-optic endoscopy (excluding rigid sigmoidoscopy and anoscopy)** · **24 hr oesophageal PH studies** · **Breast fine needle biopsy** · **Circumcision** · **Cystoscopy** · **Laser tonsillectomy** · **Oesophageal motility studies** · **Vasectomy** · **Prostate Needle biopsy** **(See B3)**	• No limit. • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• No limit. • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• No limit. • 130% of the Bonitas Tariff 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.

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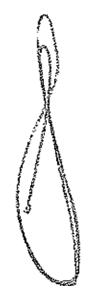
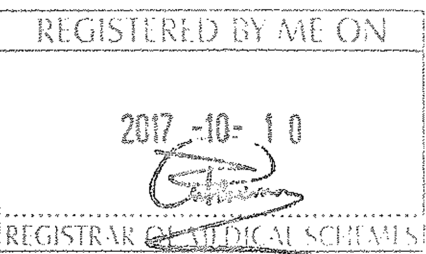


PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D13.3	**Sleep studies (See B3)**				Subject to the relevant managed healthcare programme and its prior authorisation.
D13.3.1	**Diagnostic Polysomnograms In and out of hospital**	No limit.	No limit.	No limit.	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.	No limit.	No limit.	If authorised by the relevant managed healthcare programme for patients with obstructive sleep apnoea who meet the criteria for CPAP and where requested by the relevant specialist.
D14	**ONCOLOGY (See B3)**				

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D14.1	**PRE ACTIVE, ACTIVE & POST ACTIVE TREATMENT PERIOD**	• R328 100 per family. • The ICON medical specialist network is the preferred provider for oncology services (excluding paediatric oncology and acute haematology), at the negotiated rate. • 100% of the Bonitas tariff for services rendered by non ICON medical specialists. • Above benefit, limited to PMBs and 40% co-pay for services rendered by non ICON medical specialists, subject to Regulation 8 (3).	• R328 100 per family. • The ICON medical specialist network is the preferred provider for oncology services (excluding paediatric oncology and acute haematology), at the negotiated rate. • 100% of the Bonitas tariff for services rendered by non ICON medical specialists. • Above benefit, limited to PMBs and 40% co-pay for services rendered by non ICON medical specialists, subject to Regulation 8 (3).	• R157 600 per family. • The ICON medical specialist network is the preferred provider for oncology services (excluding paediatric oncology and acute haematology), at the negotiated rate. • 100% of the Bonitas tariff for services rendered by non ICON medical specialists. • Above benefit, limited to PMBs and 40% co-pay for services rendered by non ICON medical specialists, subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and to its prior authorisation. • Treatment for long-term chronic conditions that may develop as a result of chemotherapy and radiotherapy is not included in this benefit. • Benefit for Oncologists, haematologists and accredited medical practitioners for consultations, visits, treatment and consumable material used in radiotherapy and chemotherapy. • The Specialist Network is the DSP for related oncology services at the Specialist Network (DSP) rate.
D14.1.1	**Medicine (See B4)**	Limited to and included in D14.1 and subject to the DSP.	Limited to and included in D14.1 and subject to the DSP.	Limited to and included in D14.1 and subject to the DSP.	
D14.1.2	**Radiology and pathology (See B3)**	Limited to and included in D14.1.	Limited to and included in D14.1.	Limited to and included in D14.1.	
D14.1.2.1	**PET and PET-CT (See B3)**	No benefit.	No benefit.	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation. Specific authorisations are required in addition to any authorisation that may have been obtained for hospitalisation. Only in a credentialed specialist practice.

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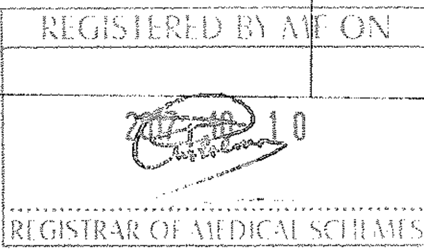
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D14.1.3	**Specialised Drugs** (See B4)				Subject to the relevant managed healthcare programme and to its prior authorisation. This list includes but is not limited to targeted therapies e.g. biologicals, tyrosine kinase inhibitors, and other non genericised chemotherapeutic agents. Subject to published list. Unless otherwise stated below, any other diseases where the use of the drug is deemed appropriate by the managed health care organization, drugs will be funded from this benefit.
D14.1.3.1	**Biological drugs**	No benefit, except for PMBs.	No benefit, except for PMBs.	No benefit, except for PMBs.	
D14.1.3.2	**Unregistered chemotherapeutic agents**	No benefit, except for PMBs.	No benefit, except for PMBs.	No benefit, except for PMBs.	Subject to Section 21 approval by the Medicines Control Council and pre-authorisation by the relevant managed healthcare programme.
D14.1.3.3	**Proteasome Inhibitors**	No benefit, except for PMBs.	No benefit, except for PMBs.	No benefit, except for PMBs.	
D14.1.3.4	**Certain Pyrimidine Analogues**	No benefit, except for PMBs.	No benefit, except for PMBs.	No benefit, except for PMBs.	
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.	Limited to and included in D14.1.	Subject to the relevant managed healthcare programme.



PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D14.1.5	**Brachytherapy materials (including seeds and disposables) and equipment (See B3)**	Limited to R42 110 per beneficiary and included in D14.1.	Limited to R42 110 per beneficiary and included in D14.1.	Limited to R42 110 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 credentialed medical practitioners. The Specialist Network is the DSP for oncology related services at the Specialist Network (DSP) rate.
D14.2	**Post-active Treatment period (See B3)**	Limited to and included in D14.1 during the remission period following the active treatment period, except for Prescribed Minimum Benefits.	Limited to and included in D14.1 during the remission period following the active treatment period, except for Prescribed Minimum Benefits.	Limited to and included in D14.1 during the remission period following the active treatment period, except for Prescribed Minimum Benefits.	
D14.2.1	**Flushing of J Line and/or Port (See B3)**	Limited to and included in D14.1.	Limited to and included in D14.1.	Limited to and included in D14.1.	Subject to the relevant managed healthcare programme.
D14.3	**Oncology Social worker (OSW) benefit**	• Limited to R2 700 per family, subject to the ICON (OSW) network. • Limited to and included in D14.1.	• Limited to R2 700 per family, subject to the ICON (OSW) network. • Limited to and included in D14.1.	• Limited to R2 700 per family, subject to the ICON (OSW) network. • Limited to and included in D14.1.	Subject to the relevant manage healthcare protocols and its prior authorisation.
D15	**OPTOMETRY (In and Out of Network) (See B3)**	• Limited to R5 550 per family. • Biennial benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• Limited to R5 550 per family. • Biennial benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• Limited to R4 270 per family. • Biennial benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	Subject to the preferred provider. Frames and/or lenses are mutually exclusive to contact lenses.
D15.1	**Optometric refraction test, re-exam and/or composite exam**	• One per beneficiary, per benefit cycle, at network rates. • R350 out of network. • Limited to and included in D15.	• One per beneficiary, per benefit cycle, at network rates. • R350 out of network. • Limited to and included in D15.	• One per beneficiary, per benefit cycle, at network rates. • R350 out of network. • Limited to and included in D15.	

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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D15.2	Frames	• R850 per beneficiary in and out of network. • Limited to and included in D15.	• R850 per beneficiary in and out of network. • Limited to and included in D15.	• R350 per beneficiary in and out of network. • Limited to and included in D15.	Including repairs.
D15.3	Lenses				
D15.3.1	Single vision lenses	• 100% towards the cost of clear lenses at network rates. • Limited to R150 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R150 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R150 per lens per beneficiary out of network. • Limited to and included in D15; or	Subject to contracted providers protocols.
D15.3.2	Bifocal lenses	• 100% towards the cost of clear lenses at network rates. • Limited to R325 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R325 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R325 per lens per beneficiary out of network. • Limited to and included in D15; or	
D15.3.3	Multifocal lenses	• 100% towards the cost of clear lenses at network rates. • Limited to R700 per lens per beneficiary out of network. • Limited to and included in D15.	• 100% towards the cost of clear lenses at network rates. • Limited to R700 per lens per beneficiary out of network. • Limited to and included in D15.	• 100% towards the cost of clear lenses at network rates. • Limited to R700 per lens per beneficiary out of network. • Limited to and included in D15.	REGISTERED BY ME ON 2017 -10- 10 REGISTRAR OF MEDICAL SCHEMES
D15.3.4	Contact lenses	• Limited to R1 850 per beneficiary. • Limited to and included in D15.	• Limited to R1 850 per beneficiary. • Limited to and included in D15.	• Limited to R1 225 per beneficiary. • Limited to and included in D15.	When prescribed by a registered optometrist, ophthalmologist, medical practitioner or supplementary optical practitioner.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D15.4	**Low vision appliances**	Limited to and included in D3.1.1.	Limited to and included in D3.1.1.	Limited to and included in D3.1.1.	When prescribed by a registered optometrist, ophthalmologist, medical practitioner or supplementary optical practitioner.
D15.5	**Ocular prostheses**	Limited to and included in D20.2.	Limited to and included in D20.2.	Limited to and included in D20.2.	When prescribed by a registered optometrist, ophthalmologist, medical practitioner or supplementary optical practitioner.
D15.6	**Diagnostic procedures**	Limited to and included in D15.1.	Limited to and included in D15.1.	No benefit.	
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.	No benefit.	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.	No benefit.	

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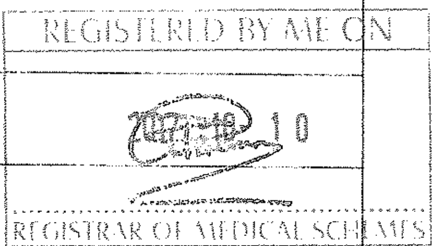
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D16	**ORGAN AND HAEMOPOIETIC STEM CELL (BONE MARROW) TRANSPLANTATION AND IMMUNO-SUPPRESSIVE MEDICATION (INCLUDING CORNEAL GRAFTS) (See B3)**	• No limit • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for the non-network medical specialist or general practitioner. • Corneal grafts are limited to R30 000 per beneficiary for local and imported grafts. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• No limit • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for the non-network medical specialist or general practitioner. • Corneal grafts are limited to R30 000 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.	• Prescribed Minimum Benefits only. • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for the non-network medical specialist or general practitioner. • No benefit for Corneal grafts unless PMB. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	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. REGISTERED BY ME ON 2017-10-10 REGISTRAR OF MEDICAL SCHEMES
D16.1	**Haemopoietic stem cell (bone marrow) transplantation (See B3)**	Limited to and included in D16.	Limited to and included in D16.	Limited to and included in D16.	Haemopoietic stem cell (bone marrow) transplantation is limited to allogenic grafts and autologous grafts derived from the South African Bone Marrow Registry.
D16.2	**Immuno-suppressive medication (See B4)**	Limited to and included in D16 and subject to the DSP.	Limited to and included in D16 and subject to the DSP.	Limited to and included in D16 and subject to the DSP.	
D16.3	**Post transplantation biopsies and scans (See B3)**	Limited to and included in D16.	Limited to and included in D16.	Limited to and included in D16.	
D16.4	**Radiology and pathology (See B3)**	Limited to and included in D16.	Limited to and included in D16.	Limited to and included in D16.	For specified radiology and pathology services, performed by pathologists, radiologists and haematologists, associated with the transplantation treatment.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D17	**PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS) (See B2 and B3)**				
D17.1	**In hospital**	No limit.	No limit.	No limit.	Subject to referral by the treating practitioner.
D17.1.1	**Dietetics**	Limited to and included in D17.1.	Limited to and included in D17.1.	Limited to and included in D17.1.	
D17.1.2	**Occupational Therapy**	Limited to and included in D17.1.	Limited to and included in D17.1.	Limited to and included in D17.1.	
D17.1.3	**Speech Therapy**	Limited to and included in D17.1.	Limited to and included in D17.1.	Limited to and included in D17.1.	
D17.2	**Out of hospital**	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	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	**Audiology**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.2	**Dietetics**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.3	**Genetic counselling**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.4	**Hearing aid acoustics**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.5	**Occupational therapy**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.6	**Orthoptics**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	



PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D17.2.7	**Podiatry**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.8	**Private nurse practitioners**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	Nursing services are included in the Alternatives to Hospitalisation benefit (D7) if pre-authorised by the relevant managed healthcare programme.
D17.2.9	**Speech therapy**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.10	**Social workers**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D18	**PATHOLOGY AND MEDICAL TECHNOLOGY (See B1 and B3)**				
D18.1	**In Hospital**	No limit.	No limit.	No limit.	Subject to the relevant managed healthcare programme

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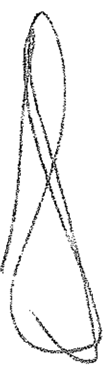

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D18.2	**Out of hospital**	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	Subject to Pathology Management Program. This benefit excludes: the specified list of pathology tariff codes included in the: · maternity benefit, (D10); · the oncology benefit during the active and/or post active treatment period, (D14); · organ and haemopoietic stem cell transplantation benefit,D16); · and the renal dialysis chronic benefit,(D22) Out of hospital pathology, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D19	**PHYSICAL THERAPY (See B1 and B3)**				
D19.1	**In hospital Physiotherapy Biokinetics**	No limit.	No limit.	No limit.	Subject to referral by the treating practitioner. Physiotherapy is not covered for mental health admissions. (See D12.)
D19.2	**Out of hospital Physiotherapy Biokinetics Chiropractics**	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	This benefit excludes X-rays performed by chiropractors. Out of hospital physiotherapy, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.

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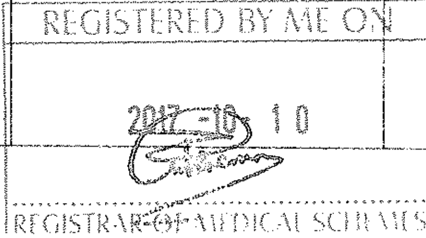

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D20	**PROSTHESES AND DEVICES INTERNAL AND EXTERNAL (See B3)**				
D20.1	**Prostheses and devices internal(surgically implanted), including all temporary prostheses, or/and all accompanying temporary or permanent devices used to assist with the guidance, alignment or delivery of these internal prostheses and devices. This includes bone cement, bone graft substitutes, screws, pins and bone anchors.**	• R42 100 per family. • Sub-limit of R3 225 for a single intra-ocular lens. • R6 450 for bilateral lenses per beneficiary. • Subject to preferred supplier agreements and Regulation 8 (3).	• R42 100 per family. • Sub-limit of R3 225 for a single intra-ocular lens. • R6 450 for bilateral lenses per beneficiary. • Subject to preferred supplier agreements and Regulation 8 (3).	• R30 000 per family. • Sub-limit of R3 225 for a single intra-ocular lens. • R6 450 for bilateral lenses per beneficiary. • Subject to preferred supplier agreements and Regulation 8 (3). • No benefit for joint replacement prostheses, unless PMB.	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. No benefit for implantable defibrillators & total ankle replacements unless PMB on Primary.
D20.1.1	**Cochlear implants**	• R264 500 per family. • Subject to preferred supplier agreements and Regulation 8 (3).	• R264 500 per family. • Subject to preferred supplier agreements and Regulation 8 (3).	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D20.1.2	**Internal Nerve Stimulator**	R157 700 per family.	R157 700 per family.	No benefit.	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 R5 000 per external breast prosthesis and limited to two per annum.	• Limited to and included in D20.1. • Limited to R5 000 per external breast prosthesis and limited to two per annum.	• No benefit, except for PMBs.	Subject to the relevant managed healthcare programme and to its prior authorisation.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D21	**RADIOLOGY** (See B2 and B3)				
D21.1	**General radiology**				
D21.1.1	**In hospital**	No limit.	No limit.	No limit.	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 the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	This benefit excludes: specified list of radiology tariff codes included in the • maternity benefit, (D10), • the oncology benefit during the active treatment and/or post active treatment period, (D14); • the 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.

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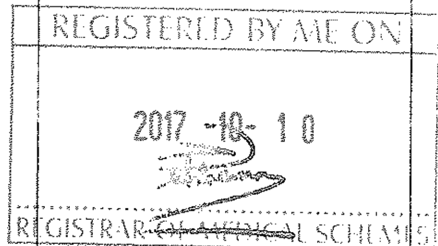
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D21.2	**Specialised radiology**				
D21.2.1	**In hospital**	R24 860 per family.	R24 860 per family.	R12 380 per family.	Subject to the relevant managed healthcare programme and to its prior authorisation. Specific authorisations are required in addition to any authorisation that may have been obtained for hospitalisation, for the following: • CT scans • MUGA scans • MRI scans • Radio isotope studies • CT colonography (virtual colonoscopy) (only in credentialed practices), limited to one per beneficiary per annum restricted to the evaluation of symptomaticpatients only). • MDCT coronary angiography (only in credentialed practices), 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.	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.	See D14.1.2.1.	



PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D22	**RENAL DIALYSIS CHRONIC (See B3)**				
D22.1	**Haemodialysis and peritoneal dialysis**	• No limit. • 100% of the lower of the cost or Bonitas Tariff for all services, medicines and materials associated with the cost of renal dialysis, subject to the DSP network and Regulation 8 (3). • 130% of the Bonitas Tariff for the services rendered by a network specialist and 100% of the Bonitas Tariff for the services rendered by a non-network specialist. • Related medicine is subject to the DSP and Regulation 8 (3). • 20% co-payment applies for the voluntary use of a non-DSP.	• No limit. • 100% of the lower of the cost or Bonitas Tariff for all services, medicines and materials associated with the cost of renal dialysis, subject to the the DSP network and Regulation 8 (3). • 130% of the Bonitas Tariff for the services rendered by a network specialist and 100% of the Bonitas Tariff for the services rendered by a non-network specialist. • Related medicine is subject to the DSP and Regulation 8 (3). • 20% co-payment applies for the voluntary use of a non-DSP.	• No limit. • 100% of the lower of the cost or Bonitas Tariff for all services, medicines and materials associated with the cost of renal dialysis, subject to the DSP network and Regulation 8 (3). • 130% of the Bonitas Tariff for the services rendered by a network specialist and 100% of the Bonitas Tariff for the services rendered by a non-network specialist. • Related medicine is subject to the DSP and Regulation 8 (3). • 20% co-payment applies for the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme and to its prior authorisation. Authorised erythropoietin is included in (D4). Acute renal dialysis is included in hospitalisation costs. See D7.
D22.2	**Radiology and pathology (See B3)**	Limited to and included in D22.1.	Limited to and included in D22.1.	Limited to and included in D22.1.	As specified by the relevant managed healthcare programme.
D23	**SURGICAL PROCEDURES (See B3)**				Subject to the relevant managed healthcare programme and to its prior authorisation.

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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D23.1	**In hospital and unattached operating theatres and other minor surgical procedures that can be authorised in hospital.**	• Limited to and included in D7.1.1 or D7.2.1 at 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Co-payments apply – See paragraph D23.3 below.	• Limited to and included in D7.1.1 or D7.2.1 at 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Co-payments apply – See paragraph D23.3 below.	• Limited to and included in D7.1.1 or D7.2.1 at 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Co-payments apply – See paragraph D23.3 below.	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.	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.	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, • 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 wisdom teeth (D6).

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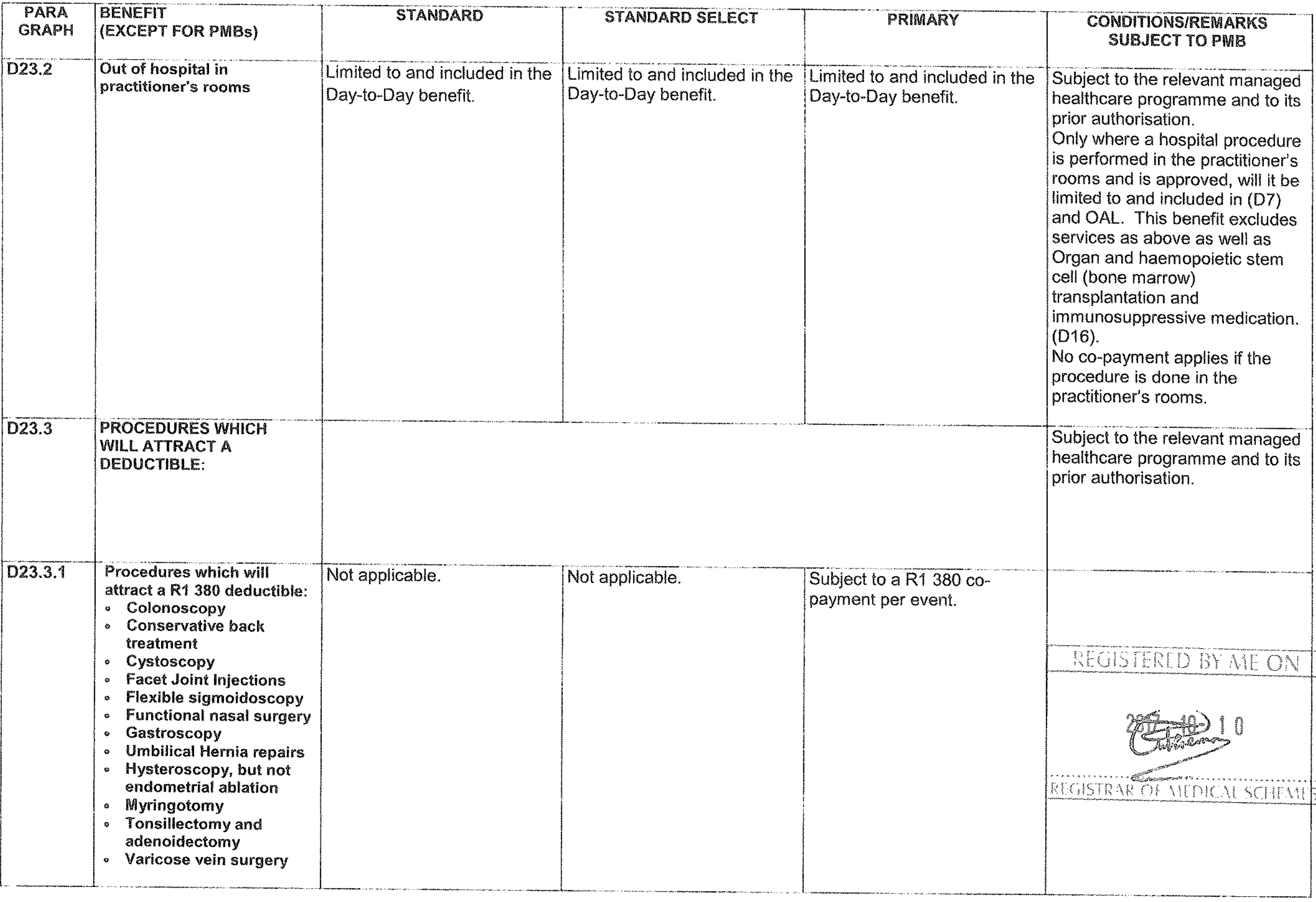
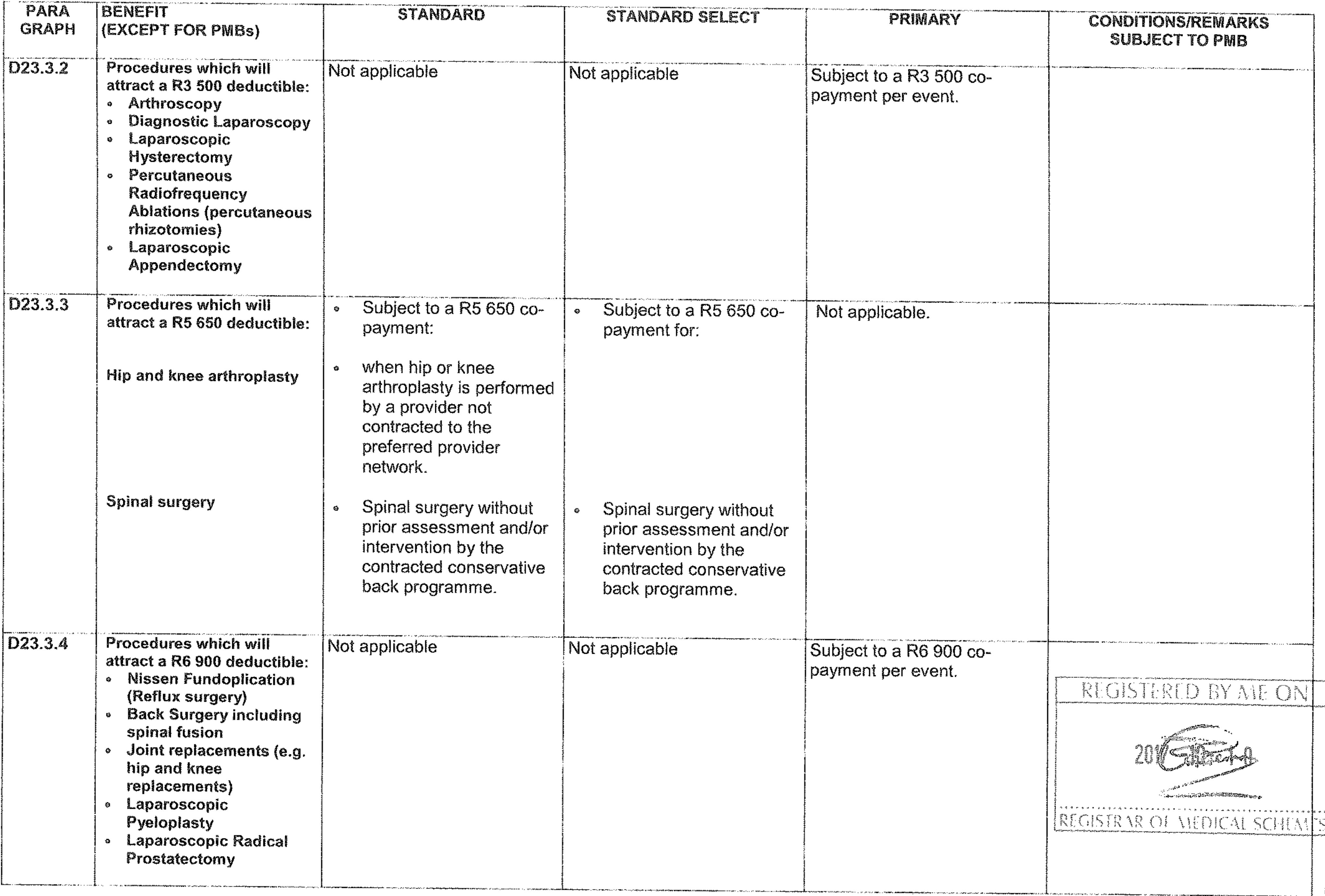
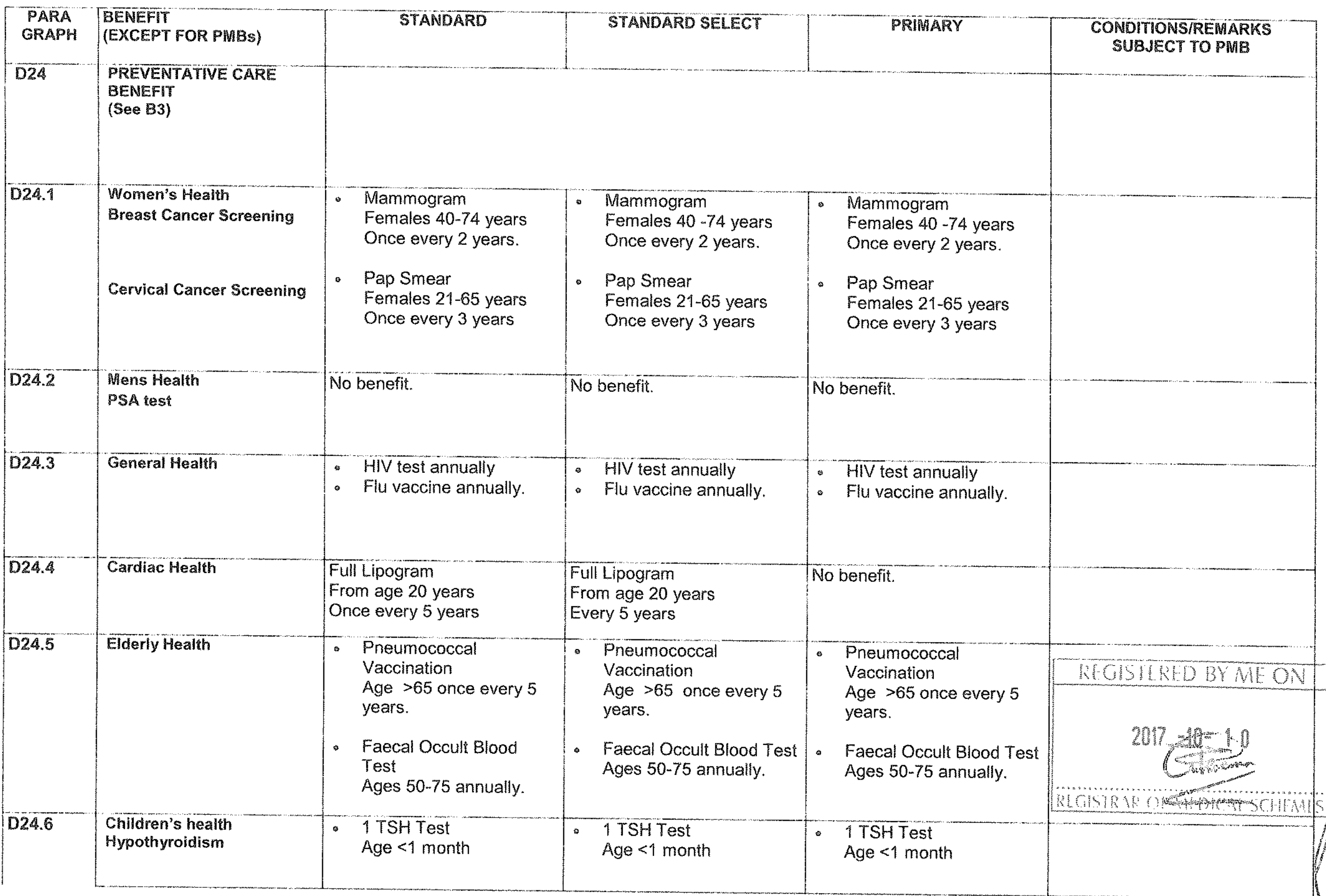


PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D23.2	**Out of hospital in practitioner's rooms**	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	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.
D23.3	**PROCEDURES WHICH WILL ATTRACT A DEDUCTIBLE:**				Subject to the relevant managed healthcare programme and to its prior authorisation.
D23.3.1	**Procedures which will attract a R1 380 deductible:** • Colonoscopy • Conservative back treatment • Cystoscopy • Facet Joint Injections • Flexible sigmoidoscopy • Functional nasal surgery • Gastroscopy • Umbilical Hernia repairs • Hysteroscopy, but not endometrial ablation • Myringotomy • Tonsillectomy and adenoidectomy • Varicose vein surgery	Not applicable.	Not applicable.	Subject to a R1 380 co-payment per event.	REGISTERED BY ME ON 2017-10-10 REGISTRAR OF MEDICAL SCHEMES



PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D23.3.2	**Procedures which will attract a R3 500 deductible:** • **Arthroscopy** • **Diagnostic Laparoscopy** • **Laparoscopic Hysterectomy** • **Percutaneous Radiofrequency Ablations (percutaneous rhizotomies)** • **Laparoscopic Appendectomy**	Not applicable	Not applicable	Subject to a R3 500 co-payment per event.	
D23.3.3	**Procedures which will attract a R5 650 deductible:** **Hip and knee arthroplasty** **Spinal surgery**	• Subject to a R5 650 co-payment: • when hip or knee arthroplasty is performed by a provider not contracted to the preferred provider network. • Spinal surgery without prior assessment and/or intervention by the contracted conservative back programme.	• Subject to a R5 650 co-payment for: • Spinal surgery without prior assessment and/or intervention by the contracted conservative back programme.	Not applicable.	
D23.3.4	**Procedures which will attract a R6 900 deductible:** • **Nissen Fundoplication (Reflux surgery)** • **Back Surgery including spinal fusion** • **Joint replacements (e.g. hip and knee replacements)** • **Laparoscopic Pyeloplasty** • **Laparoscopic Radical Prostatectomy**	Not applicable	Not applicable	Subject to a R6 900 co-payment per event.	REGISTERED BY ME ON 201 REGISTRAR OF MEDICAL SCHEMES



PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D24	**PREVENTATIVE CARE BENEFIT (See B3)**				
D24.1	**Women's Health** **Breast Cancer Screening** **Cervical Cancer Screening**	• Mammogram Females 40-74 years Once every 2 years. • Pap Smear Females 21-65 years Once every 3 years	• Mammogram Females 40 -74 years Once every 2 years. • Pap Smear Females 21-65 years Once every 3 years	• Mammogram Females 40 -74 years Once every 2 years. • Pap Smear Females 21-65 years Once every 3 years	
D24.2	**Mens Health** **PSA test**	No benefit.	No benefit.	No benefit.	
D24.3	**General Health**	• HIV test annually • Flu vaccine annually.	• HIV test annually • Flu vaccine annually.	• HIV test annually • Flu vaccine annually.	
D24.4	**Cardiac Health**	Full Lipogram From age 20 years Once every 5 years	Full Lipogram From age 20 years Every 5 years	No benefit.	
D24.5	**Elderly Health**	• Pneumococcal Vaccination Age >65 once every 5 years. • Faecal Occult Blood Test Ages 50-75 annually.	• Pneumococcal Vaccination Age >65 once every 5 years. • Faecal Occult Blood Test Ages 50-75 annually.	• Pneumococcal Vaccination Age >65 once every 5 years. • Faecal Occult Blood Test Ages 50-75 annually.	REGISTERED BY ME ON 2017 -10- 10 REGISTRAR OF MEDICAL SCHEMES
D24.6	**Children's health** **Hypothyroidism**	• 1 TSH Test Age <1 month	• 1 TSH Test Age <1 month	• 1 TSH Test Age <1 month	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
	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.	• One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	
	Extended Program on Immunisation (EPI)	No benefit.	No benefit.	No benefit.	
D25	**INTERNATIONAL TRAVEL BENEFIT**	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment. • The first R2 000 (or equivalent of local currency) in respect of out-of-hospital treatment per person per journey is payable by the member. • Subject to authorisation. • Not exceeding 90 days from date of departure from South Africa, for medical emergencies only.	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment. • The first R2 000 (or equivalent of local currency) in respect of out-of-hospital treatment per person per journey is payable by the member. • Subject to authorisation. • Not exceeding 90 days from date of departure from South Africa, for medical emergencies only.	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment. • The first R2 000 (or equivalent of local currency) in respect of out-of-hospital treatment per person per journey is payable by the member. • Subject to authorisation. • Not exceeding 90 days from date of departure from South Africa, for medical emergencies only.	• R5 000 000 per beneficiary per journey for both in-and-out-of-hospital treatment (R10 000 000 per family). • Emergency optical and dental illness expenses up to R10 000. • Medical evacuation, transport to medical centres, return to South Africa
D26	**AFRICA BENEFIT**	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	• 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.

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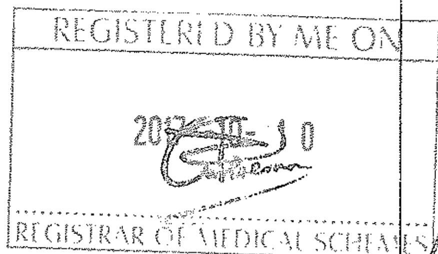
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	PRIMARY	CONDITIONS/REMARKS SUBJECT TO PMB
D27	**WELLNESS BENEFIT**				
D27.1	**Health Risk Assessment (HRA) which includes Lifestyle questionnaire Wellness screening**	Wellness screening. One assessment per beneficiary per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to • blood pressure test • glucose test • cholesterol test • body mass index. • hip to waist ratio.	Wellness screening. One assessment per beneficiary per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to • blood pressure test • glucose test • cholesterol test • body mass index • hip to waist ratio.	Wellness screening. One assessment per beneficiary per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to • blood pressure test • glucose test • cholesterol test • body mass index • hip to waist ratio.	
D27.2	**Wellness extender**	Subject to completion of a Health Risk Assessment per beneficiary. Limited to R1 670 per family. Limited to: • Physical examination by a Family practitioner • Dietician consultation • Biokineticist consultation • Physiotherapy consultation • Smoking cessation programme.	Subject to completion of a Health Risk Assessment per beneficiary. Limited to R1 670 per family. Limited to: • Physical examination by a Family practitioner • Dietician consultation • Biokineticist consultation • Physiotherapy consultation • Smoking cessation programme.	Subject to completion of a Health Risk Assessment per beneficiary. Limited to R1 210 per family. Limited to: • Physical examination by a Family practitioner • Dietician consultation • Biokineticist consultation • Physiotherapy consultation • Smoking cessation programme.	Child dependants will qualify for the wellness extender benefit once the main member or an adult beneficiary has completed a Health Risk Assessment. 

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