Bonitas

BONITAS MEDICAL FUND

ANNEXURE B

OPTIONS:

STANDARD

STANDARD SELECT

2023

REGISTERED BY ME ON

2022/11/15

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29/11/2022 18:14:41(UTC+02:00)
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REGISTRAR OF MEDICAL SCHEMES

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A ENTITLEMENT TO BENEFITS

A1 The Bonitas Fund Tariff is defined as the Bonitas monetary tariffs applicable in 2022 increased by an average of 6.2%.

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.

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 and Standard Select Options.

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

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

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

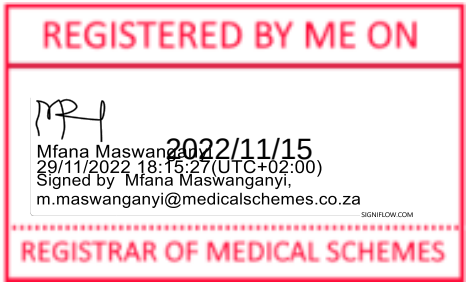
B1 On the Standard and Standard Select options, claims for services stated as being subject to payment from the Day-to-Day benefit in paragraph D below are allocated against the Day-to-Day benefits.

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). Both subject to the reimbursement limit, i.e. Medicine Price List. 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	

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REGISTRAR OF MEDICAL SCHEMES

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
- Consultations with Ophthalmologists
- Specialist to specialist referral.

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

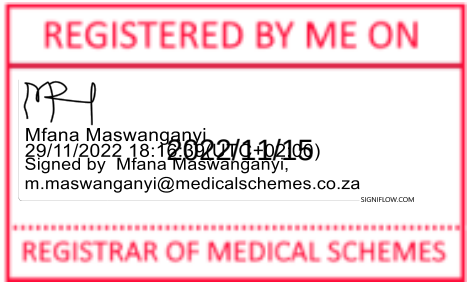
C PRESCRIBED MINIMUM BENEFITS (PMBs)

Prescribed Minimum Benefits as shown in Annexure A of the General Regulations, made in terms of the Medical Schemes' Act 131 of 1998; override all benefits indicated in this annexure, and are paid in full.
The Prescribed Minimum Benefits are available in conjunction with the Fund's contracted managed care programmes, which include the application of treatment protocols, medicine formularies, pre-authorisation and case management.
These measures have been implemented to ensure appropriate and effective delivery of Prescribed Minimum Benefits.
Out of hospital tests and specialist consultations, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.

See Annexure D – Paragraph 7 for a full explanation

D ANNUAL BENEFITS AND LIMITS

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	OVERALL ANNUAL LIMIT	No limit.	No limit.	
	DAY-TO-DAY BENEFIT	M : R12 000 M+1: R18 000 M+2: R20 000 M+3+: R22 000	M : R12 000 M+1: R18 000 M+2: R20 000 M+3+: R22 000	
	General Practitioner and Specialist Benefit	M : R3 000 M+1: R4 500 M+2: R5 000 M+3+: R6 000 Limited to and included in the Day-to-Day benefit. (See D5.1.3 and D5.1.4)	M : R3 000 M+1: R4 500 M+2: R5 000 M+3+: R6 000 Limited to and included in the Day-to-Day benefit. Subject to GP nomination from the GP Network. (See D5.1.3 and D5.1.4)	
D1	**ALTERNATIVE HEALTHCARE (See B1 & B3)**	M : R3 000 M+1: R4 500 M+2: R5 000 M+3+: R6 000 Limited to and included in the Day-to-Day benefit.	M : R3 000 M+1: R4 500 M+2: R5 000 M+3+: R6 000 Limited to and included in the Day-to-Day benefit.	
D1.1	**Homoeopathic Consultations and/or treatment**	Limited to and included in D1.	Limited to and included in D1.	
D1.2	**Homoeopathic Medicines**	Limited to and included in D1 at 80% of tariff.	Limited to and included in D1, at 80% of tariff.	
D1.3	**Acupuncture**	Limited to and included in D1.	Limited to and included in D1.	
D1.4	**Naturopathy Consultations and/or treatment and medicines**	• Limited to and included in D1. • Medicines paid at 80% of tariff	• Limited to and included in D1. • Medicines paid at 80% 0f tariff.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D1.5	**Osteopathy**	Limited to and included in D1.	Limited to and included in D1.	
D1.6	**Phytotherapy**	Limited to and included in D1.	Limited to and included in D1.	
D2	**AMBULANCE SERVICES (See B3)**	100% of cost if authorised by the preferred provider.	100% of cost if authorised by the preferred provider.	Subject to the contracted provider. Non-authorisation will result in non-payment except for PMBs.
D3	**APPLIANCES, EXTERNAL ACCESSORIES AND ORTHOTICS (See B3)**			Diabetic accessories and appliances (with the exception of glucometers) to be pre-authorised and claimed from the chronic medicine benefit (D11.3). Recommend use of preferred supplier and subject to frequency limits as per managed care protocols. The benefit excludes consultations/fittings, which are subject to D17.2.
D3.1	**In and Out of Hospital**			
D3.1.1	**General medical and surgical appliances, including wheelchairs and repairs, and large orthopaedic appliances**	• Limited to and included in the Day-to-Day benefit. • Recommend use of preferred supplier.	• Limited to and included in the Day-to-Day benefit. • Recommend use of preferred supplier.	Hiring or buying medical or surgical aids as prescribed by a medical practitioner.
D3.1.2	**Hearing Aids and repairs**	• R8 930 per family, and the balance from the available Day-to-Day benefit. • A 20% co-payment will apply. • Benefit is available per beneficiary every five years based on the last claim date.	• R8 930 per family, and the balance from the available Day-to-Day benefit.. • A 20% co-payment will apply. • Benefit is available per beneficiary every five years based on the last claim date.	Hearing aids and repairs are subject to the relevant managed healthcare programme and to its prior authorisation. Recommend use of preferred supplier.
D3.1.3	**CPAP Apparatus for sleep apnoea**	R7 630 per family, unless PMB.	R7 630 per family, unless PMB.	CPAP Machines are 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
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 (CGI)**	• R51 010 per family per annum for insulin pump or CGM device. • Limited to one device per Type 1 Diabetic for beneficiaries younger than 18 years every 5 years; and • R25 740 per family for insulin pump or CGM consumables.	• R51 010 per family per annum for insulin pump or CGM device. • Limited to one device per Type 1 Diabetic for beneficiaries younger than 18 years every 5 years; and • R25 740 per family for insulin pump or CGM consumables.	• Subject to pre-authorisation by the relevant managed healthcare programme and its prior authorization. • Once the benefit for consumables is exceeded, the benefit for the pump or the appliance benefit may not be utilized to cover the cost.
D4	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS**	No limit, if specifically authorised.	No limit, if specifically authorised.	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
D5	**CONSULTATIONS VISITS BY MEDICAL PRACTITIONERS (See B1 and B3)**	M : R3 000 M+1: R4 500 M+2: R5 000 M+3+: R6 000 Limited to and included in the Day-to-Day benefit.	M : R3 000 M+1: R4 500 M+2: R5 000 M+3+: R6 000 Limited to and included in the Day-to-Day benefit.	On Standard Select, subject to nominating a maximum of two GPs from the GP Network and submitting the claim from the nominated GP.
D5.1	**General Practitioners (Including Virtual Consultations)**			This benefit excludes • Dental Practitioners and Therapists (D6), • Oncologists, Haematologists and Credentialed Medical Practitioners during active and post-active treatment periods (D14); • Paramedical Services (D17); • Physiotherapists and Biokineticists in hospital (D19.1).
D5.1.1	**In Hospital**	• No limit. • 100% of Bonitas Tariff for general practitioners.	• No limit. • 100% of Bonitas Tariff for general practitioners.	
D5.1.2.	**Out of Hospital**	Subject to the General Practitioner and Specialist benefit in D5.	Subject to the General Practitioner and Specialist benefit in D5.	
D5.1.3	**In Network General Practitioners/Nominated General Practitioners for Standard Select (including virtual consultations)**	Limited to and included in D5.	Limited to and included in D5.	
D5.1.4	**Non-Network General Practitioners/Non Nominated, for Standard Select (excluding virtual consultations which are limited to and included in D5.1.3)**	Limited to and included in the General Practitioner and Specialist benefit in D5.	• Limited to 2 out of area visits per family for non-nominated network GP visits. • Limited to and included in D5.	Consultations/visits with non-network GPs are limited to bona fide emergencies.
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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
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).	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.	All consultations and procedures outside the Specialist Network will be reimbursed up to the Bonitas Tariff. Co-payments are applicable for consultations and procedures charged in excess of the Bonitas Tariff.
D5.2.2	**Out of Hospital (See B1, B3 and B8)**	• 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Limited to and included in the GP and Specialist benefit in D5. 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 GP and Specialist benefit in D5. and subject to referral by a general practitioner, except in the exceptional cases as per the remarks column.	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 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. • Specialist to specialist referral. 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.

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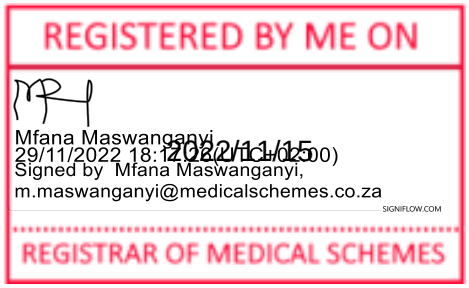
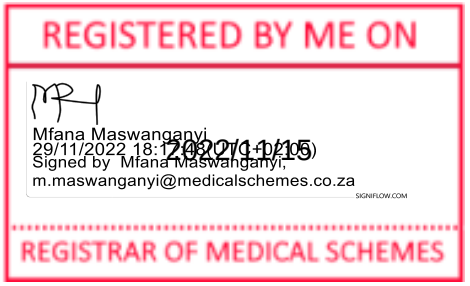
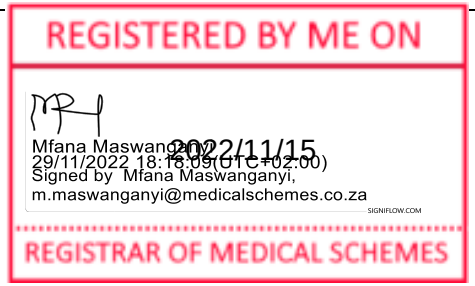
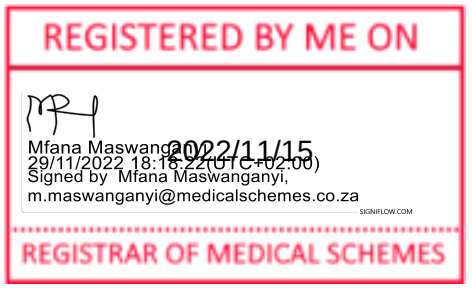
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D5.2.3	**Infant Paediatric benefit (Consultation with a GP or Paediatrician)**	• 2 Paediatric consultations per beneficiary for children aged 0 - 12 months within the age bracket. • 2 Paediatric consultations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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
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.
D6.1.7	**Hospitalisation (general anaesthetic) and Moderate/Deep Sedation in the rooms**	• Co-payment of R3 500 per hospital admission applies for children younger than 5 years and R5 000 for any other admission, including removal of impacted teeth or medical condition. • 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.	• Co-payment of R3 500 per hospital admission applies for children younger than 5 years and R5 000 for any other admission, including removal of impacted teeth or medical condition. • 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.	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

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

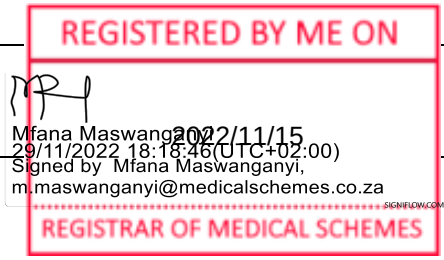
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D6.2.3	**Osseo-integrated Implants and orthognathic surgery (functional correction of malocclusion)**	No benefit.	No benefit.	
D6.2.4	**Oral Surgery**	Surgery in the dental chair. Covered at 100% of BDT.	Surgery in the dental chair. Covered at 100% of BDT.	A benefit for Tempero-mandibular joint therapy is limited to non-surgical interventions/treatments.
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.	• 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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
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 R271 600 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 R271 600 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 R540 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 R540 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.	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
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.	
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); • 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 R540 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 R540 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme. • See D7.1.2.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D7.2.3	**Casualty / emergency room visits**			
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.	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.	
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**	R57 730 per family, for all services.	R57 730 per family, for all services.	See D7.3
D7.3.2	**Sub-acute facilities including Hospice**	R19 250 per family.	R19 250 per family.	This benefit includes nursing services for psychiatric nursing but excludes midwifery services. See D7.3.

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



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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
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 practitioner or midwife per pregnancy. • R1 410 for ante-natal classes/exercises per pregnancy.	• 12 ante-natal consultations by a specialist, general practitioner or midwife per pregnancy. • R1 410 for ante-natal classes/exercises per pregnancy.	• 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.	
D11	**MEDICINE AND INJECTION MATERIAL (See B3 and B4)**	M : R3 000 M+1: R4 500 M+2: R5 000 M+3+: R6 000 Limited to and included in the Day-to-Day benefit.	M : R3 000 M+1: R4 500 M+2: R5 000 M+3+: R6 000 Limited to and included in the Day-to-Day benefit.	
D11.1	**Routine /(acute) medicine**	• Limited to and included in D11. • Subject to the acute DSP pharmacy network and acute medicines formulary list. • 20% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	• Limited to and included in D11. • Subject to the acute DSP pharmacy network and acute medicines formulary list. • 20% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme. The Medicine Exclusion List and the Pharmacy Products Management Document are applicable. This benefit excludes: • In-hospital medicine (D7); • Anti-retroviral medicine (D8); • Oncology medicine (D14); • Organ and haemopoietic stem cell (bone marrow) transplantation immunosuppressive medication (D16).

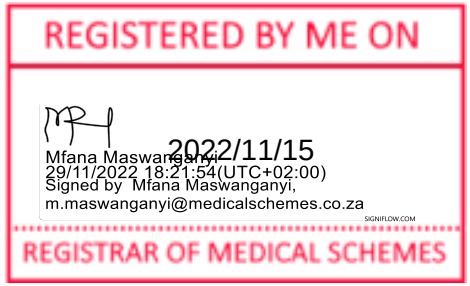
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D11.1.1	**Medicine on discharge from hospital (TTO)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	
D11.1.2	**Contraceptives**	• Limited to R1 830 per family. • Limited to females 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.	• Limited to R1 830 per family. • Limited to females up to the age of 50 years. • Subject to the DSP pharmacy. • 40% co-payment applies for the voluntary use of a non-DSP pharmacy.	
D11.2	**Pharmacy Advised Therapy Schedules 0, 1 and 2 medicine advised and dispensed by a pharmacist**	• Limited to R800 per beneficiary. • R2 500 per family. • Limited to and included in D11. • Subject to the acute DSP pharmacy network and acute medicines formulary list. • 20% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	• Limited to R800 per beneficiary. • R2 500 per family. • Limited to and included in D11. • Subject to the acute DSP pharmacy network and acute medicines formulary list. • 20% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	REGISTERED BY ME ON Mfana Maswanganyi 29/11/2022 18:29:03 (UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za SIGNFLOW.COM 2022/11/15 REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D11.3	**Chronic medicine (See B4)**	• Limited to R11 180 per beneficiary. • R22 440 per family. • 40% co-payment applies for the voluntary use of non-formulary drugs. • Subject to the Bonitas Pharmacy Network within benefits. • 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 R11 180 per beneficiary • R22 440 per family. • 40% co-payment applies for the voluntary use of a non-DSP. • Only PMBs will be paid above limits and 40% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	Subject to registration on the relevant managed healthcare programme and to its prior authorisation and applicable formularies. Restricted to a maximum of one month's supply unless pre-authorised. [Includes diabetic disposables such as ・ syringes, ・ needles, ・ strips and ・ lancets The above are excluded from D3 and D11 if on the Diabetic Management Programme. This benefit excludes: ・ In hospital medicine (D7); ・ Anti-retroviral drugs (D8); ・ Oncology medicine (D14); ・ Organ and haemopoietic stem cell (bone marrow) transplantation and immuno-suppressive medication (D16).
D11.3.1	**MDR and XDR-TB**	No limit, subject to managed care protocols and the DSP.	No limit, subject to managed care protocols and the DSP.	Subject to the relevant managed healthcare programme and its prior authorisation.
D11.4	**Specialised Drugs (See B4)**			
D11.4.1	**Non Oncology Biological Drugs applicable to monoclonal antibodies interleukins**	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation
D11.4.1.1	**Iron chelating agents for chronic use**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.1.2	**Human Immunoglobulin for chronic use**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.1.3	**Non calcium phosphate binders and calcimimetics**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.2	**Specialised Drugs for Oncology (See B4)**	See D14.1.3.	See D14.1.3.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D12	**MENTAL HEALTH (See B3 and B6)**	• R46 320 per family, unless PMB.	• R46 320 per family, unless PMB. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme. Physiotherapy is not covered for mental health admissions.
D12.1	**In Hospital**	• Limited to and included in D12.	• Limited to and included in D12.	For accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items and procedures performed by general practitioners and psychiatrists. A maximum of three days' hospitalisation for beneficiaries admitted by a general practitioner or specialist physician. (See B6).
D12.1.1	**Medicine on discharge from hospital (TTO) (See B4 and B6)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	
D12.2	**Out of Hospital**			
D12.2.1	**Medicine (See B4 and B6)**	Limited to and included in D11.	Limited to and included in D11.	
D12.3	**Rehabilitation for substance abuse (See B3)**	• Limited to and included in D12. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	• Limited to and included in D12. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme and to its prior authorisation. (See B6).
D12.3.1	**Medicine on discharge from hospital (TTO) (See B3 and B4)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	
D12.4	**Consultations and visits, procedures, assessments, therapy, treatment and/or counselling, in and out of hospital. (See B3)**	• R18 130 per family, limited to and included in D12. • Educational psychology visits for adult beneficiaries (>21 years) are excluded from this benefit.	• R18 130 per family, limited to and included in D12. • Educational psychology visits for adult beneficiaries (>21 years) are excluded from this benefit.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D13	**NON-SURGICAL PROCEDURES AND TESTS (See B2 and B3)**			
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.	• 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.	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. • 130% of the Bonitas Tariff 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. • 130% of the Bonitas Tariff 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	• **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.	• 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D13.3.1	**Diagnostic Polysomnograms In and out of hospital**	• 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.	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. • 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.	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)**			
D14.1	**PRE ACTIVE, ACTIVE & POST ACTIVE TREATMENT PERIOD**	• R250 000 per family for non-PMB oncology. • Unlimited for PMB oncology. • The Bonitas Oncology Network medical specialist is the preferred provider for oncology services at the negotiated rate. • 100% of the Bonitas tariff for services rendered by non-network oncology medical specialists. • Above limit, the benefit is unlimited at a network provider, subject to a 20% co-payment. • 30% co-payment applies for services rendered by non-network oncology medical specialists, subject to Regulation 8 (3).	• R250 000 per family for non-PMB oncology. • Unlimited for PMB oncology. • The Bonitas Oncology Network medical specialist network is the preferred provider for oncology services at the negotiated rate. • 100% of the Bonitas tariff for services rendered by non-network oncology medical specialists. • Above limit, the benefit is unlimited at a network provider subject to a 20% co-payment. • 30% co-payment applies for services rendered by non-network oncology 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D14.1.1	**Medicine (See B4)**	• Limited to and included in D14.1 and subject to the DSP. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to MPL and preferred product list.	• Limited to and included in D14.1 and subject to the DSP. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to MPL and preferred product list.	
D14.1.2	**Radiology and pathology (See B3)**	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.	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.
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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D14.1.3.2	**Unregistered chemotherapeutic agents**	No benefit, except for PMBs.	No benefit, except for PMBs.	Subject to Section 21 approval by the South African Health Products Regulatory Authority (SAHPRA) 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.	
D14.1.3.4	**Certain Pyrimidine Analogues**	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.	Subject to the relevant managed healthcare programme.
D14.1.5	**Brachytherapy materials (including seeds and disposables) and equipment (See B3)**	Limited to R54 160 per beneficiary and included in D14.1.	Limited to R54 160 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.	
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.	Subject to the relevant managed healthcare programme.
D14.3	**Oncology Social worker (OSW) benefit**	• Limited to R3 130 per family, subject to the Bonitas Oncology (OSW) network. • Limited to and included in D14.1.	• Limited to R3 130 per family, subject to the Bonitas Oncology (OSW) network. • Limited to and included in D14.1.	Subject to the relevant managed healthcare protocols and its prior authorisation.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D14.4	**Palliative Care**	• No limit. • Subject to pre-authorisation. • Managed care protocols apply.	• No limit. • Subject to pre-authorisation. • Managed care protocols apply.	Subject to the relevant managed healthcare protocols and its prior authorisation.
D15	**OPTOMETRY (In and Out of Network) (See B3)**	• Limited to R7 035 per family. • Biennial benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• Limited to R7 035 per family. • Biennial benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• Subject to pre-authorisation by the contracted provider and subject to clinical protocols. • Failure to obtain pre-authorisation will result in no benefits. • Out-of-network benefits are available as an alternative to network benefits and not an additional benefit. • Frames and/or lenses are mutually exclusive to contact lenses.
D15.1	**Optometric refraction test, re-exam and/or composite exam, including tonometry and visual field test.**	• One per beneficiary, per benefit cycle, at network rates. • R365 out of network. • Limited to and included in D15.	• One per beneficiary, per benefit cycle, at network rates. • R365 out of network. • Limited to and included in D15.	• Contracted Providers – 100% of cost for a Composite Consultation inclusive of refraction, glaucoma screening, visual field screening and artificial intelligence screening. • Non-contracted Providers – Eye examination
D15.2	**Frames and/or lens enhancements**	• R1 340 per beneficiary in network. • R1 005 per beneficiary out of network or member refunds. • Limited to and included in D15.	• R1 340 per beneficiary in network. • R1 005 per beneficiary out of network or member refunds. • Limited to and included in D15.	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; or	• 100% towards the cost of clear lenses at network rates. • Limited to R215 per lens per beneficiary out of network. • Limited to and included in D15; or	Subject to contracted providers protocols.

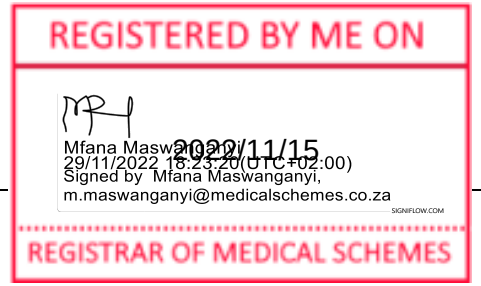
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D15.3.2	**Bifocal lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R460 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R460 per lens per beneficiary out of network. • Limited to and included in D15; or	
D15.3.3	**Multifocal lenses**	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R810 per base lens or R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R810 per base lens or R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.	
D15.3.4	**Contact lenses**	• Limited to R2 060 per beneficiary. • Limited to and included in D15.	• Limited to R2 060 per beneficiary. • Limited to and included in D15.	
D15.4	**Low vision appliances**	Limited to and included in D3.1.1.	Limited to and included in D3.1.1.	When prescribed by a registered optometrist, ophthalmologist, medical practitioner or supplementary optical practitioner.
D15.5	**Ocular prostheses**	Limited to and included in D20.2.	Limited to and included in D20.2.	When prescribed by a registered optometrist, ophthalmologist, medical practitioner or supplementary optical practitioner.
D15.6	**Diagnostic procedures**	Limited to and included in D15.1.	Limited to and included in D15.1.	
D15.7	**Readers**			

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D15.7.1	**From a registered optometrist, ophthalmologist or supplementary optical practitioner**	Limited to and included in D15.2.	Limited to and included in D15.2.	1 pair of single vision reading and 1 pair of single vision distance lenses will only be paid in lieu of bifocals/ multifocals for patients who are unable to adapt to the wearing of these types of lenses. Subject to the preferred provider.
D15.7.2	**From a registered pharmacy**	No benefit.	No benefit.	
D16	**ORGAN AND HAEMOPOIETIC STEM CELL (BONE MARROW) TRANSPLANTATION AND IMMUNO-SUPPRESSIVE MEDICATION (INCLUDING CORNEAL GRAFTS) (See B3)**	• No limit • 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 R36 660 per beneficiary for local and imported grafts.	• 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 R36 660 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.
D16.1	**Haemopoietic stem cell (bone marrow) transplantation (See B3)**	Limited to and included in D16.	Limited to and included in D16.	Haemopoietic stem cell (bone marrow) transplantation is limited to allogenic grafts and autologous grafts derived from 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.	
D16.3	**Post transplantation biopsies and scans (See B3)**	Limited to and included in D16.	Limited to and included in D16.	
D16.4	**Radiology and pathology (See B3)**	Limited to and included in D16.	Limited to and included in D16.	For specified radiology and pathology services, performed by pathologists, radiologists and haematologists, associated with the transplantation treatment.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D17	**PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS) (See B2 and B3)**			
D17.1	**In hospital**	• Limited to and included in D1, unless PMB. • 100% of the Bonitas Tariff.	• Limited to and included in D1, unless PMB. • 100% of the Bonitas Tariff.	Subject to referral by the treating practitioner.
D17.1.1	**Dietetics**	Limited to and included in D1.	Limited to and included in D1.	
D17.1.2	**Occupational Therapy**	Limited to and included in D1.	Limited to and included in D1.	
D17.1.3	**Speech Therapy**	Limited to and included in D1.	Limited to and included in D1.	
D17.2	**Out of hospital**	• Limited to and included in D1. • 100% of the Bonitas Tariff.	• Limited to and included in D1. • 100% of the Bonitas Tariff.	Out of hospital paramedical services, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D17.2.1	**Audiology**	Limited to and included in D1.	Limited to and included in D1.	
D17.2.2	**Chiropractics**	Limited to and included in D1.	Limited to and included in D1.	This benefit excludes X-rays performed by chiropractors.
D17.2.3	**Dietetics**	Limited to and included in D1.	Limited to and included in D1.	
D17.2.4	**Genetic counselling**	Limited to and included in D1.	Limited to and included in D1.	
D17.2.5	**Hearing aid acoustics**	Limited to and included in D1.	Limited to and included in D1.	
D17.2.6	**Occupational therapy**	Limited to and included in D1.	Limited to and included in D1.	
D17.2.7	**Orthoptics**	Limited to and included in D1..	Limited to and included in D1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D17.2.8	**Orthotists and Prosthetists**	Limited to and included in D1.	Limited to and included in D1.	
D17.2.9	**Private nurse practitioners**	Limited to and included in D1.	Limited to and included in D1.	Nursing services are included in the Alternatives to Hospitalisation benefit (D7) if pre-authorised by the relevant managed healthcare programme.
D17.2.10	**Speech therapy**	Limited to and included in D1.	Limited to and included in D1.	
D17.2.11	**Social workers**	Limited to and included in D1.	Limited to and included in D1.	
D18	**PATHOLOGY AND MEDICAL TECHNOLOGY (See B1 and B3)**	M : R3 000 M+1: R4 500 M+2: R5 000 M+3+: R6 000 Limited to and included in the Day-to-Day benefit.	M : R3 000 M+1: R4 500 M+2: R5 000 M+3+: R6 000 Limited to and included in the Day-to-Day benefit.	
D18.1	**In Hospital**	• No limit. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• No limit. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	Subject to the relevant managed healthcare programme
D18.2	**Out of hospital**	• Limited to and included in D18. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• Limited to and included in D18. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	Subject to Pathology Management Program. This benefit excludes: the specified list of pathology tariff codes included in the: ・ maternity benefit, (D10); ・ 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D19	**PHYSICAL THERAPY (See B1 and B3)**			
D19.1	**In hospital Physiotherapy Biokinetics**	• Limited to and included in D1, unless PMB. • 100% of the Bonitas Tariff.	• Limited to and included in D1, unless PMB. • 100% of the Bonitas Tariff.	Subject to referral by the treating practitioner. Physiotherapy is not covered for mental health admissions. (See D12.)
D19.2	**Out of hospital Physiotherapy Biokinetics Podiatry**	• Limited to and included in D1. • 100% of the Bonitas Tariff.	• Limited to and included in D1. • 100% of the Bonitas Tariff.	Out of hospital physiotherapy and podiatry, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D20	**PROSTHESES AND DEVICES INTERNAL AND EXTERNAL (See B3)**			
D20.1	**Prostheses and devices internal (surgically implanted), including all temporary prostheses, or/and all accompanying temporary or permanent devices used to assist with the guidance, alignment or delivery of these internal prostheses and devices. This includes bone cement, bone graft substitutes, screws, pins and bone anchors.**	• R51 440 per family, unless PMB. • Sub-limit of R3 950 for a single intra-ocular lens. • R7 900 for bilateral lenses per beneficiary. • Recommend use of preferred supplier	• R51 440 per family, unless PMB. • Sub-limit of R3 950 for a single intra-ocular lens. • R7 900 for bilateral lenses per beneficiary. • Recommend use of preferred supplier.	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, unless PMB.	• No benefit, unless PMB.	
D20.1.2	**Internal Nerve Stimulator**	• R192 600 per family.	• R192 600 per family.	Subject to the relevant managed healthcare programme and to its prior authorisation.



PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D20.2	**Prostheses external**	• Limited to and included in D20.1. • Limited to R6 120 per external breast prosthesis and limited to two per annum.	• Limited to and included in D20.1. • Limited to R6 120 per external breast prosthesis and limited to two per annum.	Subject to the relevant managed healthcare programme and to its prior authorisation. The benefit excludes consultations/fittings, which are subject to D17.2.
D21	**RADIOLOGY (See B2 and B3)**			
D21.1	**General radiology**			
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. • 100% of the Bonitas Tariff.	• Limited to and included in D18. • 100% of the Bonitas Tariff.	This benefit excludes: specified list of radiology tariff codes included in the • maternity benefit, (D10), • 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D21.2	**Specialised radiology**			
D21.2.1	**In hospital**	• R30 370 per family. • 100% of the Bonitas Tariff. • R1 660 co-payment applies per scan event, unless PMB or nuclear radio-isotope studies. • The co-payment to be waived if the cost of the service falls within the co-payment amount.	• R30 370 per family. • 100% of the Bonitas Tariff. • R1 660 co-payment applies per scan event, unless PMB or nuclear radio-isotope studies. • The co-payment to be waived if the cost of the service falls within the co-payment amount.	Subject to the relevant managed healthcare programme and to its prior authorisation. Specific authorisations are required in addition to any authorisation that may have been obtained for hospitalisation, for the following: • CT scans • MUGA scans • MRI scans • Radio isotope studies • CT colonography (virtual colonoscopy, limited to one per beneficiary per annum restricted to the evaluation of symptomaticpatients only). • MDCT coronary angiography, limited to one per beneficiary, restricted to the evaluation of symptomatic patients only.
D21.2.2	**Out of hospital**	Limited to and included in D21.2.1.	Limited to and included in D21.2.1.	See D21.2.1.
D21.3	**PET and PET-CT**	See D14.1.2.1.	See D14.1.2.1.	
D22	**RENAL DIALYSIS CHRONIC (See B3)**			

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
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.	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.	As specified by the relevant managed healthcare programme.
D23	**SURGICAL PROCEDURES (See B3)**	REGISTERED BY ME ON 2022/11/15 Mfana Maswanganyi 29/11/2022 18:24:09(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES		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
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. • Day surgery network applies for defined list of procedures. See D23.4.	• 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. • Subject to the Standard Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • Co-payments apply – See paragraph D23.3 below. • Day surgery network applies for defined list of procedures. See D23.4.	This benefit excludes: • Osseo-integrated implants (D6); • Orthognathic and oral surgery (D6); • Maternity (D10); • Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16).
D23.1.1	**Refractive surgery**	No benefit.	No benefit.	
D23.1.2	**Maxillo-facial surgery**	• Limited to and included in D7.1.1 or D7.2.1. • 100% of the Bonitas Tariff for services rendered by the medical specialist.	• Limited to and included in D7.1.1 or D7.2.1. • 100% of the Bonitas Tariff for services rendered by the medical specialist.	Subject to the relevant managed healthcare programme and to its prior authorisation. For the surgical removal of • tumours • neoplasms • sepsis, • trauma, • congenital birth defects and other surgery not specifically mentioned in (D6). This benefit excludes: • Osseo-integrated implantation (D6); • Orthognathic surgery (D6); • Oral surgery (D6); • Impacted teeth (D6).

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D23.2	**Out of hospital in practitioner's rooms**	• Limited to and included in the Day-to-Day benefit. • 130% of the Bonitas Tariff 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. • 130% of the Bonitas Tariff 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.
D23.3	**PROCEDURES WHICH WILL ATTRACT A DEDUCTIBLE:**			• Subject to the relevant managed healthcare programme and to its prior authorisation. • Where more than one co-payment applies to an admission/event, the lower of the co-payments will be waived and the highest will be the member's liability**.**
D23.3.1	**Procedures which will attract a deductible:** **Hip and knee arthroplasty** **Cataract Surgery**	• Subject to a R33 100 co-payment: • when hip or knee arthroplasty is performed by a non-DSP. Subject to a R6 620 co-payment: • For the voluntary use of a non-DSP.	• Subject to a R33 100 co-payment for: • when hip or knee arthroplasty is performed by a non-DSP. Subject to a R6 620 co-payment: • For the voluntary use of a non-DSP.	The co-payment to be waived if the cost of the service falls within the co-payment amount
D23.4	**Day Surgery Procedures**	• Subject to the Day Surgery Network. • R2 430 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the Day Surgery Network. • R4 850 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	Subject to the relevant managed healthcare programme and to its prior authorisation and subject to a defined list of procedures. The co-payment to be waived if the cost of the service falls within the co-payment amount.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D24	**PREVENTATIVE CARE BENEFIT (See B3)**			
D24.1	**Women's Health** **Breast Cancer Screening** **Cervical Cancer Screening**	• Mammogram Females age >40 years Once every 2 years. • Pap Smear Females 21-65 years Once every 3 years.	• Mammogram Females age >40 years Once every 2 years. • Pap Smear Females 21-65 years Once every 3 years.	
D24.2	**Men's Health** **PSA test**	• Men 45-69 years, 1 per annum.	• Men 45-69 years, 1 per annum.	
D24.3	**General Health**	• HIV test annually • Flu vaccine annually, including the administration fee of the nurse practitioner.	• HIV test annually • Flu vaccine annually including the administration fee of the nurse practitioner.	HIV test is limited to one (1) per beneficiary per annum, either as part of Preventative Care or Health Risk Assessment. See D27.1.
D24.4	**Cardiac Health**	Full Lipogram From age 20 years Once every 5 years.	Full Lipogram From age 20 years Every 5 years.	
D24.5	**Elderly Health**	• Pneumococcal Vaccination including the administration fee of the nurse practitioner. Age >65 once every 5 years. • Faecal Occult Blood Test Ages 50-75 annually.	• Pneumococcal Vaccination including the administration fee of the nurse practitioner. Age >65 once every 5 years. • Faecal Occult Blood Test Ages 50-75 annually.	
D24.6	**Children's health** **Hypothyroidism**	• 1 TSH Test Age <1 month	• 1 TSH Test Age <1 month	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	Infant Hearing Screening **Human Papilloma Virus (HPV) Vaccine**	• One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist. • Limited to two doses for girls aged between 9 – 14years.	• One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist. • Limited to two doses for girls aged between 9 – 14years.	
	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.	As per State EPI protocols.
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.	
D25	**INTERNATIONAL TRAVEL BENEFIT** **Leisure travel:** **Business Travel:**	• For medical emergencies when travelling outside the borders of South Africa. ○ 90 days excluding USA - R5 million per Member, R10 million for Member and Dependants ○ 45 days including USA – Maximum cover R500,000 for Member and Dependants. ○ 45 days excluding USA - R5 million per Member, 10 million for Member and Dependants ○ 45 days including USA - Maximum cover R500,000 for Member and Dependants. • Subject to approval protocols prior to departure.	• For medical emergencies when travelling outside the borders of South Africa. ○ 90 days excluding USA - R5 million per Member, R10 million for Member and Dependants ○ 45 days including USA – Maximum cover R500,000 for Member and Dependants. ○ 45 days excluding USA - R5 million per Member, 10 million for Member and Dependants ○ 45 days including USA - Maximum cover R500,000 for Member and Dependants. • Subject to approval protocols prior to departure.	Subject to authorisation, prior to departure. • The three months' age limit will not apply. • 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) • Pre-existing medical conditions are limited to R200 000 per family when hospitalized. • Subject to pre-authorisation of Emergency Medical expenses.

REGISTERED BY ME ON
2022/11/15
REGISTRAR OF MEDICAL SCHEMES
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29/11/2022 18:25:02(UTC+02:00)
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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D26	**AFRICA BENEFIT**	• 100% of the usual, reasonable cost for in-and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	The Fund's liability will not exceed the global amount the Fund would in the ordinary course pay for such healthcare services given the Fund's claims experience in South Africa, subject to the benefits as per benefit plan.
D27	**WELLNESS BENEFIT**			
D27.1	**Health Risk Assessment (HRA) which includes** **Lifestyle questionnaire** **Wellness screening**	Wellness screening. One assessment per beneficiary per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to • blood pressure test • glucose test • cholesterol test • body mass index. • hip to waist ratio • HIV counselling and testing.	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 • HIV counselling and testing.	HIV test is limited to one (1) per beneficiary per annum, either as part of Preventative Care or Health Risk Assessment. See D24.3.

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Mfana Maswanganyi
29/11/2022 18:22:20 (UTC+02:00)
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REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D27.2	**Benefit Booster (including out of hospital day-to-day services as mentioned in D1, D5.1.3,D5.1.4, D5.2, D11.1, D11.2, D13.2, D17.2, D18.2, D19.2, D21.1.2 and virtual consultations)**	Subject to completion of a Health Risk Assessment or the completion of an online wellness questionnaire per beneficiary. Limited to R2 000 per family. Limited to: • Alternative Health: D1 • GP consultations: D5.1.3 & 4 • Medical specialists: D5.2 • Acute medication: D11.1 • Pharmacy advised therapy: D11.2 • Non-surgical procedures: D13.2 • Paramedical services : D17.2 • Pathology: D18.2 • Physical therapy: D19.2 • General radiology: D21.1.2	Subject to completion of a Health Risk Assessment or the completion of an online wellness questionnaire per beneficiary. Limited to R2 000 per family: Limited to:. • Alternative Health: D1 • GP consultations: D5.1.3 & 4 • Medical specialists: D5.2 • Acute medication: D11.1 • Pharmacy advised therapy: D11.2 • Non-surgical procedures: D13.2 • Paramedical services : D17.2 • Pathology: D18.2 • Physical therapy: D19.2 • General radiology: D21.1.2	• Child dependants will qualify for the Benefit Booster once the main member or an adult beneficiary has completed a Health Risk Assessment or an online wellness questionnaire. • Valid qualifying claims will pay first from the Benefit Booster and thereafter from the relevant benefits as described in D1 – D24.