Bonitas

BONITAS MEDICAL FUND

ANNEXURE B

OPTIONS:

PRIMARY

PRIMARY SELECT

2024

TABLE OF CONTENT

A ENTITLEMENT TO BENEFITS

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

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

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

A3.1 Specialist Network

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

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

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

- The contracted rate for Primary and Primary Select Options.

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

- The contracted rate for Primary and Primary Select Options.

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

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

B1 On the Primary and Primary 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 Primary and Primary Select options, no further benefits are available in respect of services payable from the Day-to-Day benefits, except for PMBs.

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

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

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

B5 MEMBERSHIP CATEGORY

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

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

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

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

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

The following exceptions are applicable:

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

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

C PRESCRIBED MINIMUM BENEFITS (PMBs)

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

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

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

Out of hospital tests and GP and specialist consultations, as specified in the aPMB care templates, will accrue to the Day-to-Day benefits and the aPMB entitlements from rand one..

See Annexure D – Paragraph 7 for a full explanation

D ANNUAL BENEFITS AND LIMITS

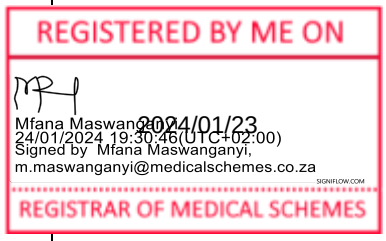
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	OVERALL ANNUAL LIMIT	No limit.	No limit.	
	DAY-TO-DAY BENEFIT	M : R5 330 M+1 : R8 520 M+2: R10 650 M+3+: R11 720	M : R5 330 M+1 : R8 520 M+2: R10 650 M+3+: R11 720	
	General Practitioner and Specialist Benefit	M : R2 130 M+1: R3 730 M+2: R4 790 M+3+: R4 790 Limited to and included in the Day-to-Day benefit.	M : R2 130 M+1: R3 730 M+2: R4 790 M+3+: R4 790 Limited to and included in the Day-to-Day Benefit. Subject to GP nomination from the GP Network.	
D1	**ALTERNATIVE HEALTHCARE (See B1 & B3)**	M : R2 130 M+1: R2 660 M+2: R3 200 M+3+: R3 200 Limited to and included in the Day-to-Day benefit.	M : R2 130 M+1: R2 660 M+2: R3 200 M+3+: R3 200 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% of tariff.	
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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
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)**	REGISTERED BY ME ON Mfana Maswanganyi 2024/01/23 24/01/2024 19:28:40(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za SIGNFLOW.COM 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 frequency limits as per managed care protocols. The benefit excludes consultations/fittings, which are subject to D17.2.
D3.1	**In and Out of Hospital**			
D3.1.1	**General medical and surgical appliances, including wheelchairs and repairs, and large orthopaedic appliances**	• Limited to and included in the Day-to-Day benefit.	• Limited to and included in the Day-to-Day benefit.	Hiring or buying medical or surgical aids as prescribed by a medical practitioner.
D3.1.2	**Hearing Aids and repairs**	No benefit.	No benefit.	
D3.1.3	**CPAP Apparatus for sleep apnoea**	R7 820 per family, unless PMB.	R7 820 per family, unless PMB.	CPAP Machines are subject to the relevant managed healthcare programme and to its prior authorisation.
D3.1.4	**Stoma Products**	Limited to and included in D3.1.3 and thereafter funded from OAL, if PMB.	Limited to and included in D3.1.3 and thereafter funded from OAL, if PMB.	
D3.1.5	**Specific appliances, accessories**			Subject to the relevant managed healthcare programme and to its prior authorisation and if the treatment forms part of the relevant managed healthcare programme, out of hospital.
D3.1.5.1	**Oxygen therapy, and equipment (not including hyperbaric oxygen treatment)**	No limit if specifically authorised.	No limit if specifically authorised.	
D3.1.5.2	**Home Ventilators**	No limit if specifically authorised.	No limit if specifically authorised.	
D3.1.5.3	**Long leg callipers**	Limited to and included in D20.2.	Limited to and included in D20.2.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D3.1.5.4	**Foot orthotics**	No benefit, unless PMB.	No benefit, unless PMB.	
D4	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS (See B3)**	No limit if specifically authorised.	No limit if specifically authorised.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D5	**CONSULTATIONS, VISITS BY MEDICAL PRACTITIONERS (See B1 and B3)**	M : R2 130 M+1: R3 730 M+2: R4 790 M+3+: R4 790 Limited to and included in the Day-to-Day benefit.	M : R2 130 M+1: R3 730 M+2: R4 790 M+3+: R4 790 Limited to and included in the Day-to-Day benefit. Subject to GP nomination from the GP Network.	On Primary Select, subject to nominating a maximum of two GPs from the GP Network and submitting the claim from the nominated GP. Out of hospital GP and specialist consultations, as specified in the aPMB care templates, will accrue to the Day-to-Day benefits and the aPMB entitlements from rand one.
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 Primary Select (including virtual consultations)**	• Limited to and included in D5. • A network General Practitioner Risk benefit of 1 visit per family applies per annum, when the Day-to-Day benefits are exhausted,	• Limited to and included in D5. • A network General Practitioner Risk benefit of 1 visit per family applies per annum, when the Day-to-Day benefits are exhausted,	This benefit applies to both nominated/non-nominated network GPs on Primary Select

REGISTERED BY ME ON
Mfana Maswanganyi 2024/01/23
24/01/2024 19:34:26(UTC+02:00)
Signed by Mfana Maswanganyi,
m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM
REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D5.1.4	**Non-Network General Practitioners/Non Nominated, for Primary Select (Virtual consultations are limited to and included in D5.1.3)**	Limited to and included in the General Practitioner and Specialist benefit in D5.	• Limited to 2 out of area visits per family for non-nominated network GP visits • Limited to and included in D5.	Consultations/visits with non-network GPs are limited to bona fide emergencies on Primary Select Out of hospital GP consultations, as specified in the aPMB care templates, will accrue to the Day-to-Day benefits and the aPMB entitlements from rand one.
D5.1.5	**Childhood illness benefit**	1 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. • The contracted rate applies. (See Annexure D: 7.3.6).	• No limit. • The contracted rate applies. (See Annexure D: 7.3.6).	All consultations and procedures within the specialist network will be paid at the contracted rate, with no co-payment applicable.
D5.2.1.2	**Out of Specialist Network**	• No limit • 100% of the Bonitas Tariff for non-network specialists.	• No limit • 100% of the Bonitas Tariff for non-network specialists.	All consultations and procedures outside the Specialist Network will be reimbursed up to the Bonitas Tariff. Co-payments are applicable for consultations and procedures charged in excess of the Bonitas Tariff.
D5.2.2	**Out of Hospital (See B1, B3 and B8)**	• 1 network specialist visit per family, per annum from OAL, subject to GP referral, • Subsequent visits are limited to and included in the GP and Specialist benefit in D5. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists.	• 1 network specialist visit per family, per annum from OAL, subject to referral by a GP on the network, • Subsequent visits are limited to and included in the GP and Specialist benefit in D5. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists.	On Primary and Primary Select, referral to a specialist must be done by a registered general practitioner and a valid referral obtained. The following exceptions are applicable as per B8: • Two (2) Gynaecologist visits/consultations per annum for female beneficiaries; • Consultations and visits related to maternity; • Children under the age of two (2) years for Paediatrician visits/consultations; • Visits with Ophthalmologists, Haematologists and Oncologists; • Specialist to specialist referral.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
				Out of hospital tests and specialist consultations, as specified in the aPMB care templates, will accrue to the Day-to-Day benefits and the aPMB entitlements from rand one.
D5.2.3	**Infant Paediatric benefit (Consultation with a GP or Paediatrician)**	• 1 Paediatric consultation per beneficiary for children aged 0 - 12 months within the age bracket. • 1 consultation per beneficiary for children aged between 13 – 24 months within the age bracket, included in the OAL.	• 1 Paediatric consultation per beneficiary for children aged 0 - 12 months within the age bracket. • 1 consultation per beneficiary for children aged between 13 – 24 months within the age bracket, included in the OAL.	
D6	**DENTISTRY (See B3)**			Subject to the Dental Management Programme. Benefits payable on the Primary and Primary Select Options 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.	1 out of network emergency consultation allowed per beneficiary per year for treatment of pain and sepsis relief, limited to codes: 8104,8201, 8307 & 8132 only. Subject to managed care protocols.

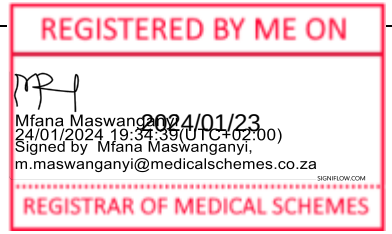
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D6.1.2	**Fillings**	• Covered at 100% of the BDT. • Fillings are granted once per tooth in 720 days. • Benefit for re-treatment of a tooth is subject to managed care protocols.	• Covered at 100% of the BDT. • 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 80% of the BDT. • One set of plastic dentures (an upper and a lower) in a 4 year period for beneficiaries 21 years and older. • 20% co-payment applies. • The appropriate laboratory codes will be covered with a 20% co-payment. • Subject to pre-authorisation.	• Covered at 80% of the BDT. • One set of plastic dentures (an upper and a lower) in a 4 year period for beneficiaries 21 years and older • 20% co-payment applies. • The appropriate laboratory codes will be covered with a 20% co-payment.. • Subject to pre-authorisation.	Subject to managed care protocols.
D6.1.4	**Extractions**	Covered at 100% of BDT and managed care protocols apply.	Covered at 100% of BDT and managed care protocols apply.	Subject to managed care protocols.
D6.1.5	**Root canal therapy**	Covered at 100% of BDT. Root canal treatment is limited to the shortened dental arch (i.e. excl. Molars). Root canal therapy on 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.
D6.1.6	**Preventative Care**	• 2 Annual scale and polish treatments per beneficiary once every 6 months. • Covered at 100% of BDT.	• 2 Annual scale and polish treatments per beneficiary once every 6 months. • Covered at 100% of BDT.	No benefit for oral hygiene instructions. Benefit for fluoride is limited to beneficiaries from age 5 and younger than 16 years of age. Benefit for fissure sealants is limited to beneficiaries younger than 16 years of age.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D6.1.7	**Hospitalisation (general anaesthetic) and Moderate/Deep Sedation in the rooms**	• Subject to pre-authorisation. • Admission protocols apply. • Certain maxillo-facial procedures are covered in hospital. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. • Multiple hospital admissions are not covered. • General anaesthetic benefits are available for the removal of impacted teeth. Benefit is subject to managed care protocols.	• Subject to pre-authorisation. • Subject to the Primary Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • 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. • Co-payment of R3 500 per hospital admission applies for children younger than 5 years and R5 000 for any other admission, including removal of impacted teeth or medical condition.or • R2 500 upfront co-payment to apply for any admission, including removal of impacted teeth or medical admission if the dental treatment is done in a Day Clinic. • The co-payment to be waived if the cost of the service falls within the co-payment amount.
D6.1.8	**Inhalation Sedation in Dental Rooms**	Benefit is subject to managed care protocols. Covered at the BDT.	Benefit is subject to managed care protocols. Covered at the BDT.	
D6.1.9	**X-rays**	• Covered at 100% of the BDT for intra-oral x-rays. • Extra-oral x-rays will be covered at 100% of the BDT subject to 1 per beneficiary in a 3 year period.	• Covered at 100% of the BDT for intra-oral x-rays. • Extra-oral x-rays will be covered at 100% of the BDT subject to 1 per beneficiary in a 3 year period.	
D6.2	**SPECIALISED DENTISTRY (See B3)**			
D6.2.1	**Crowns**	No benefit.	No benefit.	
D6.2.2	**Partial Chrome Cobalt Frame Dentures**	No benefit.	No benefit.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
				REGISTERED BY ME ON Mfana Maswanganyi 2024/01/23 24/01/2024 19:31:44(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES
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**	No benefit.	No benefit.	
D6.2.6	**Maxillo-facial surgery**	See D23.	See D23.	
D6.2.7	**Periodontal treatment**	No benefit..	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. • No benefit for Deep Brain Stimulation Implantation. • No benefit for joint replacements, unless PMB. • No benefit for back and neck surgery, unless PMB.	• No limit. • Subject to the Primary Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • No benefit for Deep Brain Stimulation Implantation.	Accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. No benefits will be granted if prior authorisation requirements are not complied with. This benefit excludes: hospitalisation for:

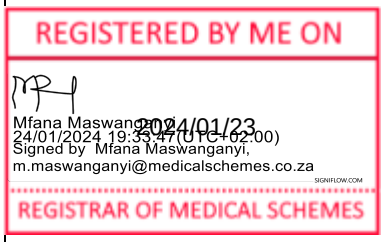
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• No benefit for joint replacements, unless PMB. • No benefit for back and neck surgery, unless PMB. • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• 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 R445 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 R445 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme.	
D7.1.3	**Casualty / emergency room visits**			The risk benefit is maximum 2 visits per family either in a private or public hospital setting.
D7.1.3.1	**Facility fee**	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies. • 2 emergency rooms visits per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies.	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies. • 2 emergency rooms visits per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies.	Will be included in the hospital benefit if a retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are limited to and included in the Day-to-Day benefit.	• Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are limited to and included in the Day-to-Day benefit.	
D7.1.3.2	**Consultations**	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 consultations per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2.	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 consultations per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2.	
D7.1.3.3	**Medicine**	See D11.1.	See D11.1.	
D7.2	**Public hospitals (See B3)**			Subject to the relevant managed healthcare programme and its prior authorisation.
D7.2.1	**In hospital**	No limit.	No limit.	Accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. No benefits will be granted if prior authorisation requirements are not complied with. This benefit excludes: hospitalisation for: • Osseo-integrated implants and Orthognathic surgery (D6); • Maternity (D10); • Mental Health (D12);

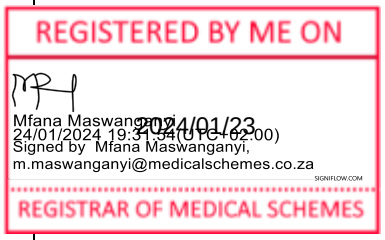
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
				• Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16); • Renal Dialysis chronic (D22); • Refractive surgery (D23).
D7.2.2	**Medicine on discharge from hospital (TTO) (See B4)**	• Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R445 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 R445 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme. • See D7.1.2.	
D7.2.3	**Casualty / emergency room visits**			The risk benefit is maximum 2 visits per family either in a private or public hospital setting.
D7.2.3.1	**Facility fee**	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies. • 2 emergency rooms visits per family for beneficiaries under the age of 6 years, payable from the OAL. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are limited to and included in the Day-to-Day benefit.	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies. • 2 emergency rooms visits per family for beneficiaries under the age of 6 years, payable from the OAL. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are limited to and included in the Day-to-Day benefit.	Will be included in the hospital benefit if retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D7.2.3.2	**Consultations**	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 visits per family for beneficiaries under the age of 6 years, payable from the OAL. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2.	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 visits per family for beneficiaries under the age of 6 years, payable from the OAL. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.4 and D5.2.2.	
D7.2.3.3	**Medicine**	See D11.1.	See D11.1.	
D7.2.4	**Outpatient services**			
D7.2.4.1	**Facility fee**	• Limited to and included in the Day-to-Day benefit.	• Limited to and included in the Day-to-Day benefit.	
D7.2.4.2	**Consultations**	See D5.1.3, D5.1.4 and D5.2.2.	See D5.1.3, D5.1.4 and D5.2.2.	
D7.2.4.3	**Medicine**	See D11.1.	See D11.1.	
D7.3	**Alternatives to hospitalisation (See B3)**			Subject to the relevant managed healthcare programme and to its prior authorisation. Benefits for clinical procedures and treatment during stay in an alternative facility will be subject to the same benefits that apply to hospitalisation.
D7.3.1	**Physical Rehabilitation hospitals**	R57 890 per family, for all services.	R57 890 per family, for all services.	See D7.3
D7.3.2	**Sub-acute facilities including Hospice**	R19 310 per family.	R19 310 per family.	This benefit includes nursing services for psychiatric nursing but excludes midwifery services.

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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D10.1	**Confinement in hospital** 	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	• No limit. • The contacted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Subject to the Primary 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 Primary Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• Subject to the relevant managed healthcare programme and its prior authorisation. • Delivery by a midwife. • Hire of water bath and oxygen cylinder limited to and included in OAL. This must be hired from a practitioner who has a registered practice number. • One of the post-natal midwife consultations may be used for a lactation specialist consultation out of hospital.
D10.2	**Confinement out of hospital**	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used by a lactation specialist.	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy of which one (1) may be used by a lactation specialist.	• Subject to the relevant managed healthcare programme and its prior authorisation. • Delivery by a midwife. • Hire of water bath and oxygen cylinder limited to and included in OAL. This must be hired from a practitioner who has a registered practice number. • One of the post-natal midwife consultations may be used for a lactation specialist.
D10.2.1	**Consumables and pharmaceuticals**	Limited to and included in D10.1.	Limited to and included in D10.1.	Registered medicine, dressings and materials supplied by a midwife out of hospital.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D10.3	**Related maternity services**	Limited to and included in D10.1.	Limited to and included in D10.1.	
D10.3.1	**Ante-natal consultations**	• 6 ante-natal consultations by a specialist, general practitioner or midwife per pregnancy. • No benefit for ante-natal classes/exercises.	• 6 ante-natal consultations by a specialist, general practitioner or midwife per pregnancy. • No benefit for ante-natal classes/exercises.	• The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network medical specialist.
D10.3.2	**Related tests and procedures**	• Pregnancy related tests and procedures. • 2 x 2D pregnancy scans. • 1 x amniocentesis per pregnancy.	• Pregnancy related tests and procedures. • 2 x 2D pregnancy scans. • 1 x amniocentesis per pregnancy.	
D11	**MEDICINE AND INJECTION MATERIAL (See B3 and B4)**	M : R1 600 M+1: R2 660 M+2: R3 200 M+3+: R3 200 Limited to and included in the Day-to-Day benefit.	M : R1 600 M+1: R2 660 M+2: R3 200 M+3+: R3 200 Limited to and included in the Day-to-Day benefit.	
D11.1	**Routine /(acute) medicine**	• Limited to and included in D11. • Subject to the acute DSP pharmacy network and acute medicines formulary list. • 20% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	• Limited to and included in D11. • Subject to the acute DSP pharmacy network and acute medicines formulary list. • 20% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme. The Medicine Exclusion List and the Pharmacy Products Management Document are applicable. This benefit excludes: • In-hospital medicine (D7); • Anti-retroviral medicine (D8); • Oncology medicine (D14); • Organ and haemopoietic stem cell (bone marrow) transplantation immunosuppressive medication (D16).
D11.1.1	**Medicine on discharge from hospital (TTO)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D11.1.2	**Contraceptives** 	• Limited to R1 870 per family. • Limited to females up to the age of 50 years. • Subject to the Bonitas Pharmacy Network. • 40% co-payment applies for the voluntary use of a non-network pharmacy.	• Limited to R1 870 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 R535 per beneficiary. • R2 130 per family. • Limited to and included 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 R535 per beneficiary. • R2 130 per family. • Limited to and included in D11. • Subject to the acute DSP pharmacy network and acute medicines formulary list. • 20% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	
D11.3	**Chronic medicine (See B4)**	• 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. • R150 per beneficiary per month for Depression, subject to managed care protocols and the 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. • R150 per beneficiary per month for Depression, subject to managed care protocols and the 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);

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
				• Anti-retroviral drugs (D8); • Oncology medicine (D14); • Organ and haemopoietic stem cell (bone marrow) transplantation and immuno-suppressive medication (D16).
D11.3.1	**MDR and XDR-TB**	No limit, subject to managed care protocols and the DSP.	No limit, subject to managed care protocols and the DSP.	Subject to the relevant managed healthcare programme and its prior authorisation.
D11.4	**Specialised Drugs (See B4)**			
D11.4.1	**Non-Oncology Biological Drugs applicable to monoclonal antibodies interleukins**	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation
D11.4.1.1	**Iron chelating agents for chronic use**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.1.2	**Human Immunoglobulin for chronic use**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.1.3	**Non calcium phosphate binders and calcimimetics**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.2	**Specialised Drugs for Oncology (See B4)**	See D14.1.3.	See D14.1.3.	
D12	**MENTAL HEALTH (See B3 and B6)**	• R18 120 per family, unless PMB.	• R18 120 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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	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.	
D12.3	**Rehabilitation for substance abuse (See B3)**	• Limited to and included in D12. • Subject to the DSP. • 30% co-payment applies for the voluntary use of a non-DSP.	• Limited to and included in D12. • Subject to the DSP. • 30% co-payment applies for 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)**	• R11 630 per family, limited to and included in D12. • Educational psychology visits and psychometry assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	• R11 630 per family, limited to and included in D12. • Educational psychology visits and psychometry assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	
D13	**NON-SURGICAL PROCEDURES AND TESTS (See B2 and B3)**			
D13.1	**In Hospital**	• No limit. • The contacted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists or general practitioners. • Subject to the Primary 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. • The contracted rate applies for network specialists.	• Limited to and included in the Day-to-Day benefit. • The contracted rate applies for network specialists.	Out of hospital procedures, as specified in the aPMB care templates, will accrue to the Day-to-Day benefits and the aPMB entitlements from rand one.

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

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Mfana Maswanganyi 2024/01/23
24/01/2024 19:34:56(UTC+02:00)
Signed by: Mfana Maswanganyi,
m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM
REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D14.1	**PRE ACTIVE, ACTIVE & POST ACTIVE TREATMENT PERIOD** Rejected	• R213 000 per family for PMB ~~and~~ non-PMB oncology. • Thereafter, unlimited for PMB oncology • Above benefit limit, non-PMB oncology is unlimited at a network provider, subject to a 20% co-payment. • The Bonitas Oncology Network is the DSP for oncology services at the contracted network rate. • 100% of the Bonitas Tariff for services rendered by non-network oncology providers. • 30% co-payment applies for services rendered by non-network oncology providers, subject to Regulation 8 (3).	• R213 000 per family for PMB ~~and~~ non- PMB oncology. • Thereafter, unlimited for PMB oncology • Above benefit limit, non-PMB oncology is unlimited at a network provider, subject to a 20% co-payment. • The Bonitas Oncology Network is the DSP for oncology services at the contracted network rate. • 100% of the Bonitas Tariff for services rendered by non-network oncology providers. • 30% co-payment applies for services rendered by non-network oncology providers, subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and to its prior authorisation. • All costs related to approved cancer treatment, including PMB treatment, will add up to the oncology benefit limit. • Treatment for long-term chronic conditions that may develop as a result of chemotherapy and radiotherapy is not included in this benefit. • Benefit is for Oncologists, Haematologists and approved providers for consultations, visits, treatment and consumable material used in radiotherapy and chemotherapy. • The Oncology Network is the DSP for related oncology services at the Oncology Network (DSP) rate. • Pre- and post-active consultations and investigations are subject to Cancer Care Plans.
D14.1.1	**Medicine (See B4)**	• Limited to and included in D14.1 and subject to the Oncology Medicine DSP. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to MPL and preferred product list.	• Limited to and included in D14.1 and subject to the Oncology Medicine DSP. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to MPL and preferred product list.	Subject to the Bonitas Oncology Medicine DSP Network.
D14.1.2	**Radiology and pathology (See B3)**	Limited to and included in D14.1.	Limited to and included in D14.1.	• Subject to the relevant managed healthcare programme and to its prior authorisation. • Limited to Cancer Care Plans in pre-active and post-active setting. • Specific authorisations are required for advanced radiology in addition to any authorisation that may have been obtained for hospitalisation.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D14.1.2.1	**PET and PET-CT (See B3)**	No benefit.	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation. Specific authorisations are required in addition to any authorisation that may have been obtained for hospitalisation.
D14.1.3	**Specialised Drugs (See B4)**	No benefit, except for PMBs.	No benefit, except for PMBs.	• Subject to oncology authorisation, managed care protocols and processes. • The Specialised Drug List (SDL) is a list of drugs used for treatment of cancers and certain haematological conditions. It includes but is not limited to biologicals, certain enzyme inhibitors, immunomodulatory antineoplastic agents and other targeted therapies. The list is reviewed and published regularly.
D14.1.3.1	**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 oncology pre-authorisation, managed care protocols and processes.
D14.1.4	**Flushing of J Line and/or Port (See B3)**	Limited to and included in D14.1.	Limited to and included in D14.1.	Subject to the relevant managed healthcare programme.
D14.1.5	**Brachytherapy materials (including seeds and disposables) and equipment (See B3)**	Limited to R57 680 per beneficiary and included in D14.1.	Limited to R57 680 per beneficiary and included in D14.1.	Subject to the relevant managed healthcare programme and to its prior authorisation, for services rendered by Oncologists, Radiotherapists and credentialed medical practitioners. The Oncology Network is the DSP for oncology related services at the Oncology Network (DSP) rate.
D14.2	**Oncology Social Worker (OSW) benefit**	• Limited to R3 330 per family.. • Limited to and included in D14.1.	• Limited to R3 330 per family.. • Limited to and included in D14.1.	Subject to the relevant managed healthcare protocols and its prior authorisation.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D14.3	**Palliative Care**	• No limit. • Subject to pre-authorisation. • Managed care protocols apply.	• No limit. • Subject to pre-authorisation. • Managed care protocols apply.	Subject to the relevant managed healthcare protocols and its prior authorisation.
D15	**OPTOMETRY (In and Out of Network) (See B3)**	• Limited to R5 695 per family. • Biennial benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• Limited to R5 695 per family. • Biennial benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• Subject to pre-authorisation by the contracted provider and subject to clinical protocols. • Failure to obtain pre-authorisation will result in no benefits. • Out-of-network benefits are available as an alternative to network benefits and not an additional benefit. • Frames and/or lenses are mutually exclusive to contact lenses.
D15.1	**Optometric refraction test, re-exam and/or composite exam, including tonometry and visual field test.**	• One per beneficiary, per benefit cycle, at network rates. • R380 out of network. • Limited to and included in D15.	• One per beneficiary, per benefit cycle, at network rates. • R380 out of network. • Limited to and included in D15.	• Contracted Providers: 100% of cost for a Composite Consultation inclusive of the refraction, a glaucoma screening, visual field screening and artificial intelligence screening. • Non-contracted provider – Eye examination
D15.2	**Frames and/or lens enhancements**	• R605 per beneficiary in network. • R454 per beneficiary out of network or member refunds. • Limited to and included in D15.	• R605 per beneficiary in network. • R454 per beneficiary out of network or member refunds. • Limited to and included in D15.	On the Primary and Primary 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.
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.	• 100% towards the cost of clear lenses at network rates. • Limited to R460 per lens per beneficiary out of network.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• Limited to and included in D15; or	• Limited to and included in D15; or	REGISTERED BY ME ON Mfana Maswanganyi 2024/01/23 24/01/2024 19:33:56(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za SIGNFLOW.COM REGISTRAR OF MEDICAL SCHEMES
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 and 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 and R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.	
D15.3.4	**Contact lenses**	• Limited to R1 430 per beneficiary. • Limited to and included in D15	• Limited to R1 430 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**	No benefit.	No benefit.	
D15.7	**Readers**			
D15.7.1	**From a registered optometrist, ophthalmologist or supplementary optical practitioner**	No benefit.	No benefit.	
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)**	• Prescribed Minimum Benefits only. • The contracted rate applies for network specialists.	• Prescribed Minimum Benefits only. • The contracted rate applies for network specialists.	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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	(See B3)	• 100% of the Bonitas Tariff for the non-network medical specialist or general practitioner. • No benefit for Corneal grafts unless PMB.	• 100% of the Bonitas Tariff for the non-network medical specialist or general practitioner. • No benefit for Corneal grafts unless PMB. • Subject to the Primary Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	limited to the Republic of South Africa excluding donor cornea and donor bone marrow.
D16.1	**Haemopoietic stem cell (bone marrow) transplantation (See B3)**	Limited to and included in D16.	Limited to and included in D16.	Haemopoietic stem cell (bone marrow) transplantation is limited to allogenic grafts and autologous grafts derived from Bone Marrow Registries in accordance with managed care protocols
D16.2	**Immuno-suppressive medication (See B4)**	Limited to and included in D16 and subject to the DSP.	Limited to and included in D16 and subject to the DSP.	
D16.3	**Post transplantation biopsies and scans (See B3)**	Limited to and included in D16.	Limited to and included in D16.	
D16.4	**Radiology and pathology (See B3)**	Limited to and included in D16.	Limited to and included in D16.	For specified radiology and pathology services, performed by Pathologists, Radiologists and Haematologists, associated with the transplantation treatment.
D17	**PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS) (See B2 and B3)**			
D17.1	**In hospital**	• Limited to and included in D1, unless PMB. • 100% of the Bonitas Tariff.	• Limited to and included in D1 unless PMB. • 100% of the Bonitas Tariff.	Subject to referral by the treating practitioner.
D17.1.1	**Dietetics**	Limited to and included in D1..	Limited to and included in D1.	
D17.1.2	**Occupational Therapy**	Limited to and included in D1.	Limited to and included in D1.	
D17.1.3	**Speech Therapy**	Limited to and included in D1.	Limited to and included in D1.	
D17.2	**Out of hospital**	Limited to and included in D1.	Limited to and included in D1.	Out of hospital paramedical services, as specified in the aPMB care templates, will accrue

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
				to the Day-to-Day benefits and the aPMB entitlements from rand one.
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.	
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 : R2 130 M+1: R2 660 M+2: R3 200 M+3+: R3 200 Limited to and included in the Day-to-Day benefit.	M : R2 130 M+1: R2 660 M+2: R3 200 M+3+: R3 200 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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D18.2	**Out of hospital**	• Limited to and included in D18. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• Limited to and included in D18 • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	Subject to Pathology Management Program. This benefit excludes: the specified list of pathology tariff codes included in the: • Maternity benefit, (D10); • Oncology benefit during the active and/or post active treatment period, (D14); • Organ and haemopoietic stem cell transplantation benefit,D16); • Renal dialysis chronic benefit,(D22) Out of hospital pathology, as specified in the aPMB care templates, will accrue to the Day-to-Day benefits and the aPMB entitlements from rand one.
D19	**PHYSICAL THERAPY (See B1 and B3)**			
D19.1	**In hospital Physiotherapy Biokinetics**	• Limited to and included in D1, unless PMB. • 100% of Bonitas Tariff.	• Limited to and included in D1, unless PMB. • 100% of 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 Bonitas Tariff.	• Limited to and included D1. • 100% of Bonitas Tariff.	Out of hospital physiotherapy and podiatry, as specified in the aPMB care templates, will accrue to the Day-to-Day benefits and the aPMB entitlements from rand one.
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,**	• No benefit, except for PMBs. • No benefit for joint replacements, unless PMB. • No benefit for back and neck surgery, unless PMB.	• No benefit, except for PMBs. • No benefit for joint replacements, unless PMB. • No benefit for back and neck surgery, 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 and Primary Select.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	screws, pins and bone anchors.			
D20.1.1	**Cochlear implants**	• No benefit.	• No benefit.	
D20.1.2	**Internal Nerve Stimulator**	• No benefit.	• No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D20.2	**Prostheses external**	• No benefit, except for PMBs.	• No benefit, except for PMBs.	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 Bonitas Tariff.	• No limit. • 100% of 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 Bonitas Tariff.	• Limited to and included in D18. • 100% of 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); • 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 accrue to the Day-to-Day benefits and the aPMB entitlements from rand one.
D21.2	**Specialised radiology**			

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D21.2.1	**In hospital**	• R15 170 per family. • 100% of the Bonitas Tariff. • R2 130 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.	• R15 170 per family. • !00% of the Bonitas Tariff. • R2 130 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)	PRIMARY	PRIMARY 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 the DSP network and Regulation 8 (3). • The contracted rate appliesfor 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). • The contracted rate applies for the services rendered by a network specialist and 100% of the Bonitas Tariff for the services rendered by a non-network specialist. • Related medicine is subject to the DSP and Regulation 8 (3). • 20% co-payment applies for the voluntary use of a non-DSP.	• Subject to the relevant managed healthcare programme and to its prior authorisation • Authorised erythropoietin is included in (D4). • Acute renal dialysis is included in hospitalisation costs. See D7.
D22.2	**Radiology and pathology (See B3)**	Limited to and included in D22.1.	Limited to and included in D22.1.	As specified by the relevant managed healthcare programme.
D23	**SURGICAL PROCEDURES (See B3)**			Subject to the relevant managed healthcare programme and to its prior authorisation.
D23.1	**In hospital and unattached operating theatres and other minor surgical procedures that can be authorised in hospital.**	• Limited to and included in D7.1.1 or D7.2.1. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Co-payments apply – See paragraph D23.3 below. • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• Limited to and included in D7.1.1 or D7.2.1. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Subject to the Primary Select Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • 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).

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
			• Day Surgery Network applies for defined procedures. (See paragraph D23.4)	
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 wisdom teeth (D6).
D23.2	**Out of hospital procedures in practitioner's rooms that are not mentioned in D23.2.1 and D23.2.2.**	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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D23.2.1	**General procedures performed in specialist consulting rooms**	Limited to and included in D7.1.1 or D7.2.1 at enhanced rates for: • Endometrial biopsy (excluding after-care): (2434) • Implantation hormone pellets (excluding after-care): (2565). • Insertion of intra-uterine contraceptive device (IUCD) (excluding after-care): (2442) • Punch biopsy (excluding after-care): (2399) • Removal of tag or polyp: (2271) • Removal of small superficial benign lesions: (2272) • Removal of benign vulva tumour or cyst: (2277)		• Subject to pre-authorisation.
D23.2.2	**Specified procedures done in the specialist rooms or suitably equipped procedure room with correct equipment and monitoring facilities**	Limited to and included in D7.1.1 or D7.2.1 at enhanced rates for: • Biopsy during pregnancy (excluding after care): (2400) • Cervix encirclage: Removal items 2409 and 2411: without anaesthetic): (2415) • Colposcopy (excluding after-care): (2429) • Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room: (2392) • Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): Under anaesthetic: (2395) • Cystoscopy: (1949) • Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion: (2316) • Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat – Limited: (2317) • Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread: (2318) • Evacuation of uterus: Incomplete abortion: Before 12 weeks gestation: (2445) • Evacuation: Missed abortion: Before 12 weeks gestation: (2449) • Excision of benign lip lesion: (1485) • Excision of malignant lip lesion (1487) • Excision of superficial eyelid tumour: (3163) • Extensive resection for malignant soft tissue tumour including muscle: (0313) • Flap repairs (large, complicated): 0295 • Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.: (1676)		• Subject to pre-authorisation.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		• Full thickness skingraft repair: (0289) • Full thickness eyelid repair: (3189) • Full thickness lip repair: (1499) • Hymenectomy: (2283) • Hysterosalpingogram (excluding after-care): (2435) • Hysteroscopy (excluding after-care): (2436) • Hysteroscopy and polypectomy (excluding after-care): (2440) • Laser or harmonic scalpel treatment of the cervix: (2396) • Laser therapy of vulva and/or vagina (colposcopically directed): (2274) • Left-sided colonoscopy: (1656) • Termination of pregnancy before 12 weeks: (2448) • Total colonoscopy: With hospital equipment (including biopsy): (1653) • Upper gastro-intestinal endoscopy: Hospital equipment: (1587) • Vulva and introitus: drainage of abscess: (2293)		
D23.3	**PROCEDURES WHICH WILL ATTRACT A CO-PAYMENT:**			• Subject to the relevant managed healthcare programme and to its prior authorisation. • Where more than one co-payment applies to an admission/event, the lower of the co-payments will be waived and the highest will be the member's liability.
D23.3.1	**Procedures which will attract a R1 840 co-payment when done in a hospital or day clinic:** • **Colonoscopy** • **Conservative back treatment** • **Cystoscopy** • **Facet Joint Injections** • **Flexible sigmoidoscopy** • **Functional nasal surgery** • **Gastroscopy** • **Hysteroscopy, but not endometrial ablation**	Subject to a R1 840 co-payment per event.	Subject to a R1 840 co-payment per event.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
	• **Myringotomy** • **Tonsillectomy and adenoidectomy** • **Umbilical Hernia repairs** • **Varicose vein surgery**			
D23.3.2	**Procedures which will attract a R4 690 co-payment:** • **Arthroscopy** • **Diagnostic Laparoscopy** • **Laparoscopic Hysterectomy** • **Percutaneous Radiofrequency Ablations (percutaneous rhizotomies)**	Subject to a R4 690 co-payment per event.	Subject to a R4 690 co-payment per event.	
D23.3.3	**Procedures which will attract a R8 680 co-payment:** • **Nissen Fundoplication (Reflux surgery)** • **Laparoscopic Pyeloplasty** • **Laparoscopic Radical Prostatectomy**	Subject to a R8 680 co-payment per event.	Subject to a R8 680 co-payment per event.	
D23.3.4	**Procedures which will attract a R7 050 co-payment:** **Cataract Surgery**	Subject to a R7 050 co-payment per event: • For the voluntary use of a non-DSP.	Subject to a R7 050 co-payment per event: • For the voluntary use of a non-DSP.	• Subject to the relevant managed healthcare programme and to its prior authorisation. • The co-payment to be waived if the cost of the service falls within the co-payment amount.
D23.4	**Day Surgery Procedures**	• Subject to the Day Surgery Network. • R2 590 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the Day Surgery Network. • R5 170 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and to its prior authorisation and subject to a defined list of procedures. • The co-payment to be waived if the cost of the service falls within the co-payment amount.
D24	**PREVENTATIVE CARE BENEFIT (See B3)**			

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D24.1	**Women's Health** **Breast Cancer Screening**	• Mammogram Females age >40 years Once every 2 years.	• Mammogram Females age >40 years Once every 2 years.	
	Cervical Cancer Screening	• Pap Smear Females 21-65 years Once every 3 years.	• Pap Smear Females 21-65 years Once every 3 years.	Eligible beneficiaries may choose between the basic cytology test once every 3 years or HPV PCR test once every 5 years.
	Cervical Cancer Screening in HIV infection	• Pap Smear Females 21-65 years 1 basic cytology test per annum or the HPV PCR once every 5 years.	• Pap Smear Females 21-65 years 1 basic cytology test per annum or the HPV PCR once every 5 years.	
	Human Papilloma Virus (HPV) Vaccine	• Limited to 3 doses for females between 15 – 26 years. • One course per lifetime.	• Limited to 3 doses for females between 15 – 26 years. • One course per lifetime.	
D24.2	**Men's Health** **PSA test**	• Men 55-69 years, 1 per annum.	• Men 55-69 years, 1 per annum.	
D24.3	**General Health**	• HIV test annually • Flu vaccine annually, including the administration fee of the nurse practitioner.	• HIV test annually • Flu vaccine annually, including the administration fee of the nurse practitioner.	HIV test is limited to one (1) per beneficiary per annum, either as part of Preventative Care or Health Risk Assessment. See D27.1.
D24.4	**Cardiac Health**	No benefit.	No benefit.	
D24.5	**Elderly Health**	• Pneumococcal Vaccination, including the administration fee of the nurse practitioner. Age >65 once every 5 years. • Faecal Occult Blood Test Ages 45-75 annually.	• Pneumococcal Vaccination, including the administration fee of the nurse practitioner. Age >65 once every 5 years. • Faecal Occult Blood Test Ages 45-75 annually.	

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Signed by Mfana Maswanganyi,
m.maswanganyi@medicalschemes.co.za
SIGNFLOW.COM
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PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D24.6	**Children's health Hypothyroidism** **Infant Hearing Screening** **Human Papilloma Virus (HPV) Vaccine**	• 1 TSH Test Age <1 month • One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist. • Limited to two doses for girs aged between 9 – 14years. • One course per lifetime.	• 1 TSH Test Age <1 month • One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist. • Limited to two doses for girls aged between 9 – 14years. • One course per lifetime.	REGISTERED BY ME ON Mfana Maswanganyi 2024/01/23 24/01/2024 19:29:28(UTC+02:00) Signed by: Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES
	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.
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 ○ 90 days including USA – Maximum cover R500,000 for Member and Dependants. ○ 45 days excluding USA – R5 million per Member, 10 million for Member and Dependants	• 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 ○ 90 days including USA – Maximum cover R500,000 for Member and Dependants. ○ 45 days excluding USA – R5 million per Member, 10 million for Member and Dependants	Subject to authorisation, prior to departure. • Additional benefits for Covid-19: ○ additional costs for compulsory medical quarantine limited to R1 000 per day to a maximum of R10 000 for accommodation and PCR testing up to R1 000. ○ The cover will only apply if a beneficiary tested positive. • (Manual labour excluded) • Pre-existing medical conditions are limited to R200 000 per family when hospitalized. • Subject to pre-authorisation of Emergency Medical expenses.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
		○ 45 days including USA – Maximum cover R500,000 for Member and Dependants. • Subject to approval protocols prior to departure..	○ 45 days including USA – Maximum cover R500,000 for Member and Dependants. • Subject to approval protocols prior to departure.	
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. Rejected

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	PRIMARY	PRIMARY SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D27.2	**Benefit Booster (including out of hospital non-PMB day-to-day services as mentioned in D1, D5.1.3, D5.1.4, D5.2, D11.1, D11.2, D13.2, D17.2, D18.2, D19.2, D21.1.2 and virtual consultations).**	Subject to completion of a Health Risk Assessment or an online wellness questionnaire per beneficiary. First level Benefit Booster, Limited to R700 per family, activated by completion of an online wellness questionnaire. Limited to: • Alternative Health: D1 • GP consultations: D5.1.3 & 4. • Medical specialists: D5.2 • Acute medication: D11.1 • Pharmacy advised therapy: D11.2 • Non-surgical procedures: D13.2 • Paramedical services : D17.2 • Pathology: D18.2 • Physical therapy: D19.2 • General radiology: D21.1.2 Second level Benefit Booster applies when the first level benefit is depleted. Subject to the completion of a physical health risk assessment (HRA) at a participating pharmacy or wellness day. • Limited to R2 800 per family.	Subject to completion of a Health Risk Assessment or an online wellness questionnaire per beneficiary. First level Benefit Booster, Limited to R700 per family, activated by completion of an online wellness questionnaire. Limited to: • Alternative Health: D1 • GP consultations: D5.1.3 & 4. • Medical specialists: D5.2 • Acute medication: D11.1 • Pharmacy advised therapy: D11.2 • Non-surgical procedures: D13.2 • Paramedical services: D17.2 • Pathology: D18.2 • Physical therapy : D19.2 • General radiology: D21.1.2 Second level Benefit Booster applies when the first level benefit is depleted. Subject to the completion of a physical health risk assessment (HRA) at a participating pharmacy or wellness day. • Limited to R2 800 per family.	• Child dependants will qualify for the Benefit Booster once the main member or an adult beneficiary has completed a Health Risk Assessment or an online wellness questionnaire. • Valid qualifying claims will pay first from the Benefit Booster and thereafter from the relevant benefits as described in D1 – D24. • The first level Benefit Booster will become available when an online wellness questionnaire is completed by the main member or adult beneficiary. • When a main member or adult beneficiary completes the health risk assessment (HRA), the first and second level Benefit Booster will become available.

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Mfana Maswanganyi
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REGISTRAR OF MEDICAL SCHEMES