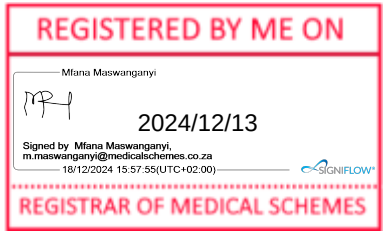
Bonitas



BONITAS MEDICAL FUND

ANNEXURE B

OPTIONS:

BONSAVE

BONFIT SELECT

2025

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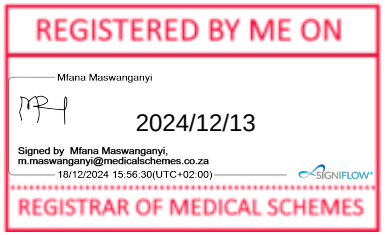
A ENTITLEMENT OF BENEFITS

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

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

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

A3.1 Specialist Network



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

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

A3.1.2 In-Specialist Network, in hospital Tariffs are applicable as follows:
- The contracted rate for the BonSave and BonFit Select Option.

A3.1.3 In Specialist Network, out of hospital Tariffs are applicable as follows:
- The contracted rate for the BonSave and BonFit Select Options.

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

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

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

B1 On the BonSave and BonFit Select Options claims for services stated as being subject to payment from the Personal Medical Savings Account are allocated against the Personal Medical Savings Account.

B2 When a member's Personal Medical Savings Account is exhausted on the BonSave and BonFit Select Options, no further benefits are available in respect of services payable from the Personal Medical Savings Account, 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 dependants	=	M3
Member plus 4 or more dependants	=	M4

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

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

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

REGISTERED BY ME ON
Mfana Maswanganyi
2024/12/13
Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za
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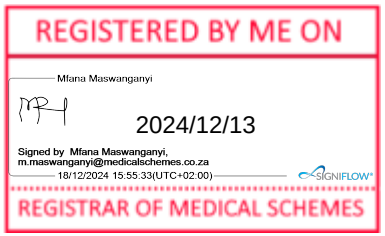
REGISTRAR OF MEDICAL SCHEMES

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



The following exceptions are applicable:

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

On depletion of benefits, PMB above limits will only be applicable via the contracted Designated Service Providers of the Fund, (where relevant), 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 payable 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.

See Annexure D – Paragraph 7 for a full explanation

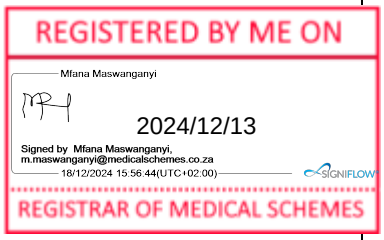
D ANNUAL BENEFITS AND LIMITS.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
	OVERALL ANNUAL LIMIT	No limit.	No limit.	
	PERSONAL MEMBER SAVINGS ACCOUNT	Subject to available savings.	Subject to available savings.	
	General Practitioner Network	Not applicable.	Not applicable.	
D1	**ALTERNATIVE HEALTHCARE**			
D1.1	**Out of Hospital**	Subject to available savings.	Subject to available savings.	
D1.1.1	**Homoeopathic Consultations and/or Treatment (See B1 &B3)**	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.2	**Homoeopathic Medicines**	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.3	**Acupuncture**	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.4	**Naturopathy Consultations and/or Treatment and Medicines.**	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.5	**Phytotherapy**	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.6	**Osteopathy**	Limited to and included in D1.1.	Limited to and included in D1.1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D2	**AMBULANCE SERVICES**			
D2.1	**Emergency Medical Transport (See B3)**	100% of cost if authorised by the preferred provider.	100% of cost if authorised by the preferred provider.	Subject to the contracted provider. Non-authorisation will result in non-payment except for PMBs.
D3	**APPLIANCES, EXTERNAL ACCESSORIES AND ORTHOTICS**			
D3.1	**In and Out of Hospital**			• Diabetic accessories and appliances - (with the exception of glucometers) to be pre-authorised and claimed from the chronic medicine benefits D11.3. • Subject to frequency limits as per managed care protocols. • The benefit excludes consultations/fittings, which are subject to D17.2.
D3.1.1	**General Medical and Surgical Appliances, including Wheelchairs and repairs, and Large Orthopaedic Appliances (See B3)**	Subject to available savings.	Subject to available savings.	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**	Subject to available savings.	Subject to available savings.	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 D3.1.1 unless PMB.	Limited to and included in D3.1.1 unless 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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
				managed healthcare programme, out of hospital.
D3.1.5.1	**Oxygen Therapy, 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**	Subject to available savings.	Subject to available savings.	
D4	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS**			
D4.1	**In and Out of Hospital (See B3)**	No limit if specifically authorised	No limit if specifically authorised.	Subject to the relevant managed healthcare programme and to its prior authorisation.

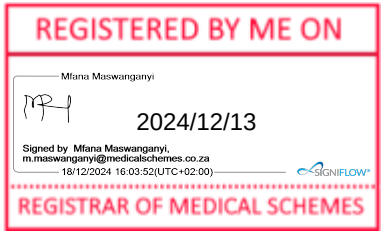
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D5	**CONSULTATIONS AND VISITS BY MEDICAL PRACTITIONERS**			
D5.1	**General Practitioners Including Virtual Consultations with network GPs) (See B2 and B3)**			This benefit excludes the following as they are covered under services mentioned elsewhere in this Annexure: • Dental Practitioners and Therapists (D6), • Ante-natal visits and consultations (D10); • Psychiatrists, Psychologists, Psychometrists and Registered Counsellors (D12); • Oncologists, Haematologists and Approved 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 (Including Virtual Consultations with network GPs)**	• 100% of Bonitas Tariff for general practitioners. • Subject to available savings. A General Practitioner Risk benefit of • 1 consultation per beneficiary to a maximum of • 2 per family, per annum when savings are exhausted	• 100% of Bonitas Tariff for general practitioners. • Subject to available savings. A General Practitioner Risk benefit of • 1 consultation per beneficiary to a maximum of • 2 per family, per annum when savings are exhausted	On the BonSave and BonFit Select options, when the GP Risk benefit is not utilised in full, the remainder of the consultations do not carry over to the next benefit year.
D5.1.3	**Childhood Illness Benefit**	1 GP consultation 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 Specialist (See A3; B3, and B8)**			

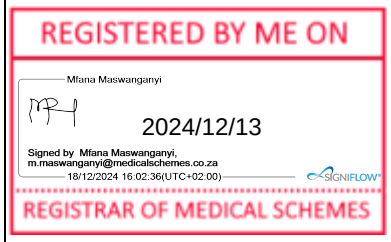
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D5.2.1	**In Hospital** 			This benefit excludes the following as they are covered under services mentioned elsewhere in this Annexure: • Dental Practitioners and Therapists (D6), • Ante-natal visits and consultations (D10); • Psychiatrists, Psychologists, Psychometrists and Registered Counsellors (D12); • Oncologists, Haematologists and Approved Medical Practitioners during active and post-active treatment periods (D14); • Paramedical Services (D17); • Physiotherapists and Biokineticists in hospital (D19.1).
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 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 A3, B3 and B8)**	• Subject to available savings. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for non-network specialists. • Subject to referral by a general practitioner, except in the exceptional cases as per the remarks column.	• Subject to available savings. • The contracted rate applies for network specialists. • 100% of Bonitas Tariff for non-network Specialists. • Subject to referral by a general practitioner, except in the exceptional cases as per the remarks column.	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 OncologistsSpecialist to specialist referral. • Psychologist to Psychiatrist referral.

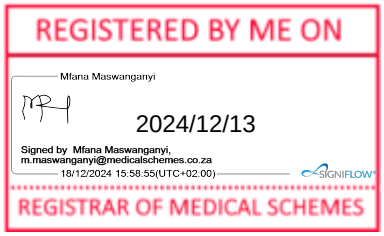
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
				• Follow-up visits with one of the treating specialists within 8 weeks of discharge from hospital for the same condition.
D5.2.3	**Infant Paediatric Benefit (Consultation with a GP or Paediatrician)**	• 2 Paediatric consultations per beneficiary for children aged 0 - 12 months within the age bracket. • 1 Paediatric consultation 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. • 1 Paediatric consultation per beneficiary for children aged 13 - 24 months within the age bracket, included in the OAL.	
D6	**DENTISTRY**			
D6.1	**BASIC DENTISTRY (SEE B3)**			Subject to the Dental Management Programme.
D6.1.1	**Consultations**	Limited to two general check-ups (once in 6 months) per beneficiary per year. Covered at the BDT.	Limited to two general check-ups (once in 6 months) per beneficiary per year. Covered at the BDT.	
D6.1.2	**Fillings**	Subject to available savings. Fillings are granted once per tooth every 2 years. Covered at the BDT	Subject to available savings. Fillings are granted once per tooth every 2 years. Covered at the BDT	• A treatment plan and x-rays may be required for multiple fillings. • Benefit for re-treatment of a tooth is subject to managed care protocols.
D6.1.3	**Plastic Dentures and Associated Laboratory Costs**	• Subject to available savings. • One set of plastic dentures (an upper and a lower) per beneficiary in a 4-year period • Benefit for a mouth guard is available for both the clinical and the associated laboratory fee (no pre-authorisation required). • Benefit subject to managed care protocols.	• Subject to available savings. • One set of plastic dentures (an upper and a lower) per beneficiary in a 4-year period • Benefit for a mouth guard is available for both the clinical and the associated laboratory fee (no pre-authorisation required). • Benefit subject to managed care protocols.	• Subject to pre-authorisation. • No benefit for the clinical fee of denture repairs, denture tooth replacements and the addition of a soft base to new dentures.

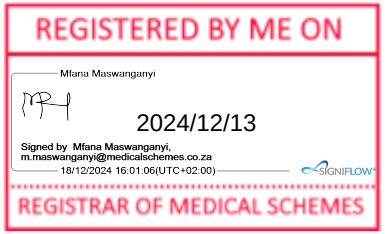
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
		• Covered at the BDT.	• Covered at the BDT.	
D6.1.4	**Extractions**	• Subject to available savings. • Subject to managed care protocols. • Covered at the BDT.	• Subject to available savings. • Subject to managed care protocols. • Covered at the BDT.	
D6.1.5	**Root Canal Therapy**	• Subject to available savings. • Subject to managed care protocols. • Covered at the BDT.	• Subject to available savings. • Subject to managed care protocols. • Covered at the BDT.	
D6.1.6	**Preventative Care**	• 2 Annual scale and polish treatments per beneficiary once every 6 months. • Covered at the BDT.	• 2 Annual scale and polish treatments per beneficiary once every 6 months. • Covered at the BDT.	• No benefit for oral hygiene instructions. • Benefit for fluoride is limited to 2 treatments per year for beneficiaries from age 5 and younger than 16 years of age. • Benefit for fissure sealants is limited to 1 per tooth in a 3-year period for beneficiaries younger than 16 years of age.
D6.1.7	**Hospitalisation (general anaesthetic) and Moderate/Deep Sedation in the Rooms**	• Subject to pre-authorisation. • Subject to managed care protocols. • Admission protocols apply. • Multiple hospital admissions are not covered. • Subject to the BonSave Hospital Network. • 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3).	• No benefit for in hospital (general anaesthetic) dentistry or Moderate/Deep Sedation dentistry, except for PMBs. • Subject to pre-authorisation. • Subject to the BonFit Select Hospital Network. • 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3).	• Pre-authorisation is required for Moderate/Deep Sedation in the rooms and is limited to extensive conservative dental treatment where managed care protocols apply. • A co-payment of R5 000 per hospital admission applies on BonSave for the removal of impacted teeth only. or • R2 500 upfront co-payment to apply for removal of impacted teeth if the dental treatment is done in a Day Clinic. • The co-payment on BonSave to be waived if the cost of the service falls within the co-payment amount.
D6.1.8	**Inhalation Sedation in Dental Rooms**	Covered at 100% of the BDT.	No benefit.	Subject to managed care protocols.

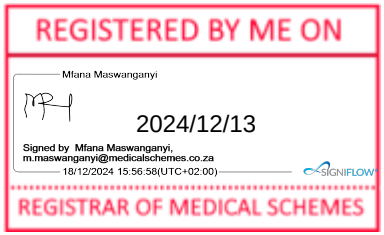
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D6.1.9	**X-rays**	• Subject to available savings. • Covered at 100% of the BDT for intra-oral x-rays. • Extra-oral x-rays will be covered at 100% of the BDT subject to 1 per beneficiary in a 3-year period.	• Subject to available savings. • 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.	• Subject to managed care protocols. • Additional benefits for extra-oral x-rays may be considered where specialised dental treatment planning/follow-up is required.
D6.2	**SPECIALISED DENTISTRY (See B3)**			
D6.2.1	**Crowns** REGISTERED BY ME ON Mfana Maswanganyi 2024/12/13 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 18/12/2024 15:55:42(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES	• Subject to available savings. • 3 crowns per family per year. • Benefit for crowns will be granted once per tooth in a 5-year period. • Subject to managed care protocols. • A pontic on a 2nd molar, where the 3rd molar is a crown retainer, is subject to managed care protocols. • Covered at the BDT.	• Subject to available savings. • 3 crowns per family per year. • Benefit for crowns will be granted once per tooth in a 5-year period. • Subject to managed care protocols. • A pontic on a 2nd molar, where the 3rd molar is a crown retainer, is subject to managed care protocols. • Covered at the BDT.	• Subject to pre-authorisation. • A treatment plan and X-rays may be requested.
D6.2.2	**Partial Chrome Cobalt Frame Dentures**	• Subject to available savings. • 2 partial frames (an upper and a lower) per beneficiary in a 5-year period. • Subject to managed care protocols. • Covered at the BDT.	• Subject to available savings. • 2 partial frames (an upper and a lower) per beneficiary in a 5-year period. • Subject to managed care protocols. • Covered at the BDT.	Subject to pre-authorisation.
D6.2.3	**Osseo-integrated Implants and Orthognathic Surgery (functional correction of malocclusion)**	No benefit.	No benefit.	
D6.2.4	**Oral Surgery**	• Subject to available savings. • Surgery in the dental chair for the removal of impacted teeth only. • Covered at 100% of the BDT.	• Subject to available savings. • Subject to managed care protocols. • Covered at 100% of the BDT.	• Subject to managed care protocols. • Temporo-mandibular joint (TMJ) therapy: Limited to non-surgical intervention/treatments. • Oral pathology procedures (cysts and biopsies, the surgical treatment of tumours of the jaw and soft tissue tumours):

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
				• Claims will only be covered if supported by a laboratory report that confirms diagnosis. • Benefit for the closure of an oral-antral opening (code 8909): Subject to motivation and managed care protocols
D6.2.5	**Orthodontic Treatment** 	• Benefit for orthodontic treatment granted once per beneficiary per lifetime • Benefit for fixed comprehensive treatment is limited to individuals from age 9 and younger than 18 years of age. • Subject to managed care protocols • Covered at 100% of the BDT • Subject to available savings.	• Benefit for orthodontic treatment granted once per beneficiary per lifetime • Benefit for fixed comprehensive treatment is limited to individuals from age 9 and younger than 18 years of age. • Subject to managed care protocols • Covered at 100% of the BDT • Subject to available savings.	• Subject to pre-authorisation. • Benefit for orthodontic treatment will be granted where function is impaired. • Benefit will not be granted where orthodontic treatment is required for cosmetic reasons. The associated laboratory costs will also not be covered. • On pre-authorisation, cases will be clinically assessed by using an orthodontic needs analysis. Benefit allocation is subject to the outcome of the needs analysis and funding may be granted up to 100% of the BDT. • Only one family member may commence orthodontic treatment in a calendar year.
D6.2.6	**Maxillo-facial Surgery**	See D23.	See D23.	
D6.2.7	**Periodontal Treatment**	• Subject to available savings. • Benefit will only be applied to members registered on the Periodontal Programme. • Benefit limited to conservative, non-surgical therapy only. • Subject to managed care protocols. • Covered at 100% of the BDT	• Subject to available savings. • Benefit will only be applied to members registered on the Periodontal Programme. • Benefit limited to conservative, non-surgical therapy only. • Subject to managed care protocols. • Covered at 100% of the BDT	Subject to pre-authorisation.
D7	**HOSPITALISATION**			
D7.1	**Private Hospitals and unattached operating theatres (See B3)**			Subject to the relevant managed healthcare programme and its prior authorisation.

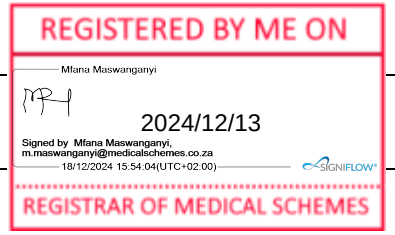
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D7.1.1	**In Hospital** 	• No limit. • No benefit for Deep Brain Stimulation Implantation. • No benefit for Joint Replacements, unless PMB. • No benefit for back and neck surgery, unless PMB. • Subject to the BonSave Hospital Network. • 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3). • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• No limit. • Subject to the BonFit Select Hospital Network. • 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3). • No benefit for Deep Brain Stimulation Implantation. • 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.	Subject to the managed health care programme and prior authorisation. Accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. This benefit excludes: hospitalisation for: • Osseo-integrated implants • Orthognathic surgery (D6); • Maternity (D10); • Mental Health (D12); • Organ and haemopoietic stem cell (bone marrow) transplantation immunosuppressive medication (D16); • Renal Dialysis chronic (D22); • Refractive surgery (D23.1.1).
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 R500 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 R500 per beneficiary per admission, except anticoagulants post-surgery which will be subject to the relevant managed healthcare programme.	Where the script amount exceeds the benefit, the balance will be subject to available savings.
D7.1.3	**Casualty/Emergency Room Visits**			The risk benefit is maximum 2 visits per family either in the private or public hospital setting.
D7.1.3.1	**Facility Fee**	• Limited to 2 emergency room visits per family, included in the OAL for bona fide emergencies. • 2 emergency room visits per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies.	• Limited to 2 emergency room visits per family, included in the OAL for bona fide emergencies. • 2 emergency room 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)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
		• Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are subject to available savings.	• Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are subject to available savings.	
D7.1.3.2	**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 for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.2 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 for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.2 and D5.2.2.	
D7.1.3.3	**Medicine**	See D11.1.	See D11.1.	
D7.2	**Public Hospitals (See B3)**			

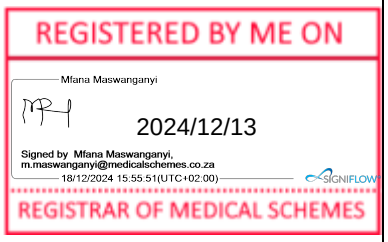
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D7.2.1	**In Hospital** 	No limit.	No limit.	Subject to the managed health care programme and prior authorisation. Accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. 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 B3 and B4)**	• Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R500 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 R500 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant managed healthcare programme. • See D7.1.2.	Where the script amount exceeds the benefit, the balance will be subject to available savings.
D7.2.3	**Casualty/Emergency Room Visits**			The risk benefit is maximum 2 visits per family either in the private or public setting.
D7.2.3.1	**Facility Fee**	• Limited to 2 emergency room visits per family, included in the OAL for bona fide emergencies.	• Limited to 2 emergency room visits per family, included in the OAL for bona fide emergencies.	Will be included in the hospital benefit if retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies.

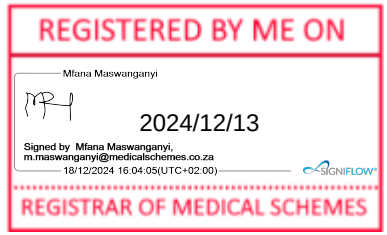
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
		• 2 emergency room visits per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are subject to available savings.	• 2 emergency room visits per family for beneficiaries under the age of 6 years, payable from the OAL for bona fide emergencies. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are subject to available savings.	
D7.2.3.2	**Consultations**	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • 2 consultations per family for beneficiaries under the age of 6 years payable from the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are subject to D5.1.2 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 subject to D5.1.2 and D5.2.2.	
D7.2.3.3	**Medicine**	See D11.1.	D11.1.	
D7.2.4	**Outpatient Services**			
D7.2.4.1	**Consultations**	See D5.1.2 and D5.2.2.	See D5.1.2 and D5.2.2.	
7.2.4.2	**Medicine**	See D11.1.	See D11.1.	
D7.3	**Alternative to Hospitalisation (See B3)**			• Subject to the relevant managed healthcare programme and to its prior authorisation • Benefits for clinical procedures and treatment during stay in an alternative facility will be subject to the same benefits that apply to hospitalisation.
D7.3.1	**Physical Rehabilitation Hospitals**	R64 680 per family for all services.	R64 680 per family for all services.	See D7.3.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D7.3.2	**Sub-acute Facilities including Hospice**	R21 570 per family.	R21 570 per family.	This benefit includes psychiatric nursing but excludes midwifery services. See D7.3.
D7.3.3	**Homebased Care including Private Nursing and Outpatient Antibiotic Therapy in lieu of Hospitalisation**	• No limit. • Subject to pre-authorisation.	• No limit. • Subject to pre-authorisation.	Subject to the relevant managed healthcare programme.
D7.3.4	**Conservative Back Programme**	Subject to the Contracted Provider.	Subject to the Contracted Provider.	Subject to the relevant managed healthcare programme.
D7.3.5	**Terminal Care (Non-oncology)**	Limited to and included in D7.3.2 and above limits, subject to pre-authorisation.	Limited to and included in D7.3.2 and above limits, subject to pre-authorisation.	Subject to the relevant managed healthcare programme.
D8	**IMMUNE DEFICIENCY SYNDROME RELATED TO HIV INFECTION**			
D8.1	**In and Out of Hospital (See B3)**	• No limit. • Subject to PMBs.	• No limit. • Subject to PMBs.	Subject to registration on the relevant managed healthcare programme. Subject to clinical protocols.
D8.1.1	**Anti-retroviral Medicine**	Limited to and included in D8.1 and subject to the DSP.	Limited to and included in D8.1 and subject to the DSP.	
D8.1.2	**Related Medicine**	Limited to and included in D8.1 and subject to the DSP.	Limited to and included in D8.1 and subject to the DSP.	
D8.1.3	**Related Pathology**	Limited to and included in D8.1.	Limited to and included in D8.1.	Pathology as specified by the relevant managed healthcare programme, out of hospital.
D8.1.4	**Related Consultations**	Limited to and included in D8.1.	Limited to and included in D8.1.	
D8.1.5	**All Other Services**	Limited to and included in D1 - D7 and D9 – D27.	Limited to and included in D1 - D7 and D9 – D27.	

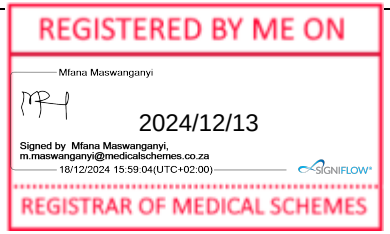


PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D9	**INFERTILITY**			
D9.1	**In and Out of Hospital (See B3 and B7)**	Limited to interventions and investigations as prescribed by the Regulations to the Medical Schemes' Act 131 of 1998 in Annexure A, paragraph 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 its prior authorisation.
D10	**MATERNITY**			
D10.1	**Confinement in Hospital (See B3)**	No limit. The contracted rate applies for network specialists. 100% of the Bonitas Tariff for the general practitioner or non-network specialist. Subject to the BonSave Hospital Network. 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3).	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 BonFit Select Hospital Network. 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and to its prior authorisation. • Delivery by a general practitioner or medical specialist and the services of the attendant paediatrician and/or anaesthetists are included. Included in 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.	Where the script amount exceeds the benefit, the balance will be subject to available savings.
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 for a lactation specialist consultation out of hospital. • Subject to the BonSave Hospital Network. • 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3).	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used for a lactation specialist consultation out of hospital. • Subject to the BonFit Select Hospital Network. • 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and its prior authorisation. • Delivery by a midwife. • Hire of water bath and oxygen cylinder limited to and included in OAL. This must be hired from a practitioner who has a registered practice number. • One of the post-natal midwife consultations may be used for a lactation specialist consultation out of hospital.

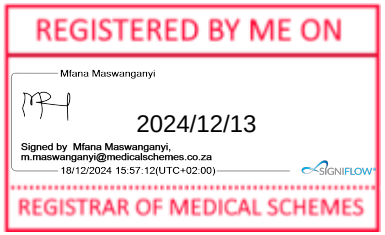
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D10.2	**Confinement out of Hospital** 	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used for a lactation specialist consultation.	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used for a lactation specialist consultation.	• 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.
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**	• 6 ante-natal consultations by a specialist, general practitioner or midwife. • R1 530 for ante-natal classes/exercises per pregnancy.	• 6 ante-natal consultations by a specialist, general practitioner or midwife. • Ante-natal classes /exercises are payable from available savings.	• The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.
D10.3.2	**Related Tests and Procedures**	• Pregnancy related tests and procedures. • 2 x 2D pregnancy scans. • 1 x amniocentesis per pregnancy.	• Pregnancy related tests and procedures. • 2 x 2D pregnancy scans. • 1 x amniocentesis per pregnancy.	
D11	**MEDICINE AND INJECTION MATERIAL**			
D11.1	**Routine/ (Acute) Medicine (See B3 and B4)**	Subject to available savings.	Subject to available savings.	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 and 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.	Where the script amount exceeds the benefit, the balance will be subject to available savings.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D11.1.2	**Contraceptives**	• Limited toR1 970 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 970 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.	
D11.1.3	**Registered ante-natal vitamins during pregnancy**	• Limited to and included in D11.1 and D27.2. • Limited to R195 per beneficiary per month. • Subject to the medicine formulary.	• Limited to and included in D11.1 and D27.2. • Limited to R195 per beneficiary per month. • Subject to the medicine formulary.	
D11.2	**Pharmacy Advised Therapy Schedules 0, 1, 2 and Medicine advised and dispensed by a Pharmacist.**	Limited to and included in D11.1.	Limited to and included in D11.1.	
D11.3	**Chronic Medicine (See B4)**	• Prescribed Minimum Benefits only at the DSP. • 30% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP. • R160 per beneficiary per month for Depression, subject to managed care protocols and the DSP.	• Prescribed Minimum Benefits only at the DSP. • 30% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP. • R160 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 • lancets for patients not registered 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 immunosuppressive medication (D16).
D11.3.1	**MDR and XDR-TB**	• No limit. • Subject to managed care protocols. • Subject to the DSP.	• No limit. • Subject to managed care protocols	Subject to the relevant managed healthcare programme and to its prior authorisation.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
			• Subject to the DSP.	
D11.4	**Specialised Drugs (See B4)**			
D11.4.1	**Non Oncology Biological Drugs applicable to Monoclonal antibodies Interleukins**	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D11.4.1.1	**Iron Chelating Agents for Chronic use**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.1.2	**Human Immunoglobulin for Chronic use**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.1.3	**Non Calcium Phosphate Binders and Calcimimetics**	No benefit, unless PMB.	No benefit, unless PMB.	
D11.4.2	**Specialised Drugs for Oncology (See B4)**	See D14.1.3.	See D14.1.3.	
D12	**MENTAL HEALTH**			
D12.1	**Treatment and care related to Mental Health (See B3 and B6)**	R41 190 per family, unless PMB. Subject to the DSP. 30% co-payment applies to the voluntary use of a non-DSP.	R41 190 per family, unless PMB. Subject to the DSP. 30% co-payment applies to the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme. Physiotherapy is not covered for mental health admissions.
D12.1.1	**In Hospital**	• Limited to and included in D12.1. • Subject to the BonSave Hospital Network. • 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3).	• Limited to and included in D12.1. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	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.)

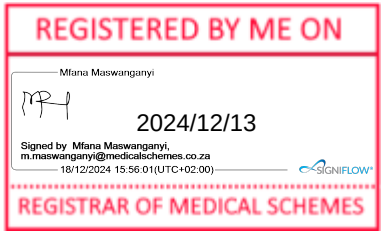
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D12.1.2	**Medicine on discharge from Hospital (TTO) (See B4 and B6)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	Where the script amount exceeds the benefit, the balance will be subject to available savings.
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 of Substance Abuse (See B3)**	• Limited to and included in D12.1. • Subject to the DSP. • 30% co-payment applies for the voluntary use of a non-DSP.	• Limited to and included in D12.1. • 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.	Where the script amount exceeds the benefit, the balance will be subject to available savings.
D12.4	**Consultations and Visits, Procedures, Assessments, Therapy, Treatment and/or Counselling, in and out of Hospital. (See B3)**	• R20 310 per family, limited to and included in D12.1. • Educational psychology visits and psychometry assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	• Prescribed Minimum Benefit only. Subject to D12.1. • Educational psychology visits and psychometry assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	
D12.5	**Mental Health Programme as managed via Active Disease Risk Management in Annexure D, paragraph 6.10**	• Limited to R13 850 per beneficiary. • Subject to enrolment on the relevant managed healthcare programme,	• Limited to R13 850 per beneficiary. • Subject to enrolment on the relevant managed healthcare programme,	• Subject to the relevant managed healthcare programme and its prior authorisation for out of hospital treatment only. • PMB treatment and the Mental Health Programme claims will not pay concurrently.
D13	**NON-SURGICAL PROCEDURES AND TESTS**			
D13.1	**In Hospital (See B2 and B3)**	• No limit • The contracted rate applies for network specialists.	• No limit. • The contracted rate applies for network specialists.	Subject to the relevant managed healthcare programme and its prior authorisation in hospital only. This benefit excludes: • Psychiatry and psychology (D12); • Optometric examinations (D15);

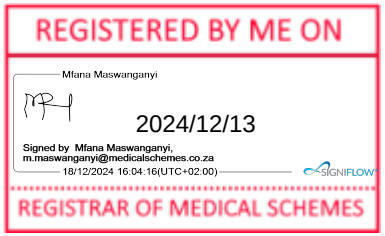
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
		• 100% of the Bonitas Tariff for the non-network specialist or general practitioner. • Subject to the BonSave Hospital Network. • 30% co-payment to apply to all non-network admissions.	• 100% of the Bonitas Tariff for the non-network specialist or general practitioner . • Subject to the BonFit Select Hospital Network. • 30% co-payment to apply to all non-network admissions.	• Pathology (D18); • Radiology (D21).
D13.2	**Out of Hospital (See B2 and B3)**	Subject to available savings.	Subject to available savings.	
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 the general practitioner or non-network specialist.	• No limit • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	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 to 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 the general practitioner or non-network specialist.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	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 the general practitioner or non-network specialist.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	If authorised by the relevant managed healthcare programme for patents with obstructive sleep apnoea who meet the criteria for CPAP and where requested by the relevant specialist.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D14	**ONCOLOGY**			
D14.1	**Pre active, Active & Post active Treatment Period (See A4 & B3)** 	• R224 100 per family for oncology • 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 the voluntary use of services rendered by non-network oncology providers, subject to Regulation 8 (3).	• R224 100 per family for oncology. • 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 at the contracted network rate. • 100% of the Bonitas Tariff for services rendered by non-network oncology providers. • 30% co-payment applies for the voluntary use of services rendered by non-network oncology providers, subject to Regulation 8 (3).	• Subject to registration on the oncology management programme. 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-active, active and post-active consultations and investigations are subject to Cancer Care Plans. • Where more than one co-payment applies, the lower of the co-payments will be waived and the highest will be the member's liability.
D14.1.1	**Medicine (excluding Specialised Drugs See D14.1.3)** **(See B4)**	• Limited to and included in D14.1 and subject to the Oncology Medicine DSP. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to reference pricing and preferred product list.	• Limited to and included in D14.1 and subject to the Oncology Medicine DSP. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to reference pricing and preferred product list.	Subject to the Bonitas Oncology Medicine DSP Network.
D14.1.2	**Radiology and Pathology (See B3)**	Limited to and included in D14.1.	Limited to and included in D14.1.	• Subject to the relevant managed healthcare programme and to its prior authorisation. • Limited to Cancer Care Plans in pre-active, active and post-active setting.

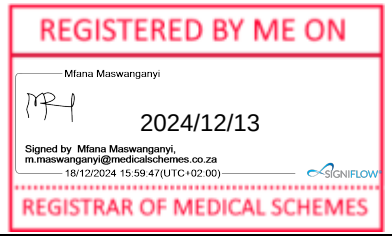
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
				• Specific authorisations are required for advanced radiology in addition to any authorisation that may have been obtained for hospitalisation.
D14.1.2.1	**PET and PET – CT (See B3)**	• PMB only, subject to the use of a provider on the PET-CT scan network at the contracted rate. • Services rendered by a non-network provider pay at 100% of the Bonitas Tariff, subject to a 25% non-network co-payment.	• PMB only, subject to the use of a provider on the PET-CT scan network at the contracted rate. • Services rendered by a non-network provider pay at 100% of the Bonitas Tariff, subject to a 25% non-network co-payment.	• Subject to the 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 the 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 a 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 R60 680 per beneficiary and included in D14.1.	Limited to R60 680 per beneficiary and included in D14.1.	Subject to the relevant managed healthcare programme and to its prior authorisation, for services rendered by Oncologists, Radiotherapists and approved medical practitioners.The Oncology Network is the DSP for oncology related services at the Oncology Network (DSP) rate.
D14.2	**Oncology Social Worker (OSW) Benefit**	• Limited to R3 500 per family.	• Limited to R3 500 per family..	Subject to the relevant managed healthcare protocols and its prior authorisation.

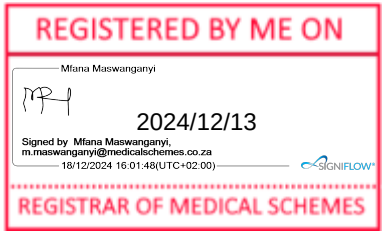
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
		• Limited to and included in D14.1.	• Limited to and included in D14.1.	
D14.3	**Palliative Care**	• No limit. • Subject to pre-authorisation. • Managed care protocols apply.	• No limit. • Subject to pre-authorisation. • Managed care protocols apply.	Subject to the relevant managed healthcare protocols and its prior authorisation.
D15	**OPTOMETRY**			
D15.1.	**In and Out of Network (See B3)**	Subject to available savings. No benefit for lens enhancements (tints and coatings).	Subject to available savings. No benefit for lens enhancements (tints and coatings).	Subject to clinical protocols. Out-of-network benefits are available as an alternative to network benefits and not an additional benefit.
D15.1.1	**Optometricrefraction test, re-exam and/or composite exam, tonometry and visual field test**	• One per beneficiary per benefit cycle, at 100% of the network tariff. • R400 out of network. • Limited to and included in D15.1.	• One per beneficiary per benefit cycle, at 100% of the network tariff. • R400 out of network. • Limited to and included in D15.1.	• 100% of cost for a Composite Consultation inclusive of the refraction, a glaucoma screening, visual field screening and artificial intelligence screening at a contracted provider. • Non-contracted providers – Eye examination
D15.2	**Frames**	• Limited to and included in D15.1. • 100% of the network tariff.	• Limited to and included in D15.1. • 100% of the network tariff.	
D15.3	**Lenses**			
D15.3.1	**Single Vision Lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R215 per lens per beneficiary out of network. • Limited to and included in D15.1; or	• 100% towards the cost of clear lenses at network rates. • Limited to R215 per lens per beneficiary out of network. • Limited to and included in D15.1; or	Subject to contracted providers protocols.
D15.3.2	**Bifocal Lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R460 per lens per beneficiary out of network.	• 100% towards the cost of clear lenses at network rates. • Limited to R460 per lens per beneficiary out of network.	

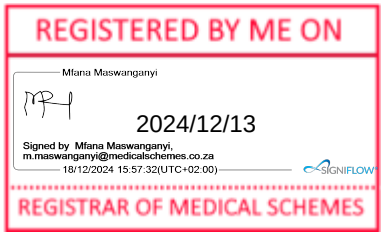
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
		• Limited to and included in D15.1; or	• Limited to and included in D15.1; or	
D15.3.3	**Multifocal Lenses** 	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R810 per base lens and R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.1.	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R810 per base lens and R50 branded lens add-on per beneficiary out of network. • Limited to and included in D15.1.	
D15.3.4	**Contact Lenses**	• Limited to and included in D15.1. • Limited and included in D15.1 except for Keratoconus where it is limited to R2 890 included in D3.1.1.	Limited to and included in D15.1.	
D15.4	**Low Vision Appliances**	Limited to and included in D3.1.1.	Limited to and included in D3.1.1.	When prescribed by a registered Optometrist, Ophthalmologist, medical practitioner or supplementary optical practitioner.
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.	No benefit.	
D15.7	**Readers**			
D15.7.1	**From a registered Optometrist, Ophthalmologist or Supplementary Optical Practitioner**	Limited to and included in D15.1.	No benefit	
D15.7.2	**From a registered Pharmacy**	Limited to and included in D15.1.	No benefit.	

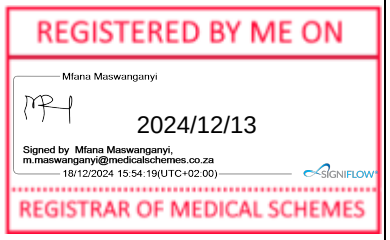
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D16	**ORGAN TRANSPLANTATION**			
D16.1	**ORGAN TRANSPLANTS AND HAEMOPOIETIC STEM CELL (BONE MARROW) TRANSPLANTATION AND IMMUNO-SUPPRESIVE MEDICATION INCLUDING CORNEAL GRAFTS) (See B3)** 	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Corneal grafts are limited to R41 070 per beneficiary for local and imported grafts. • Subject to the BonSave Hospital Network. • 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3).	• No limit • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialists. • No benefit for Corneal grafts unless PMB. • Subject to the BonFit Select Hospital Network. • 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme to its prior authorisation. • No benefits will be granted for hospitalisation, treatments and associated clinical procedures if prior authorisation is not obtained. • Organ harvesting is limited to the Republic of South Africa excluding donor cornea and donor bone marrow.
D16.1.1	**Haemopoietic Stem Cell (Bone Marrow Transplantation (See B3)**	Limited to and included in D16.1.	Limited to and included in D16.1.	Haemopoietic stem cell (bone marrow) transplantation is limited to allogenic grafts and autologous grafts derived from Bone Marrow Registries in accordance with managed care protocols.
D16.2	**Immuno-suppressive Medication (See B4)**	Limited to and included in D16.1 and subject to the DSP.	Limited to and included in D16.1 and subject to the DSP.	
D16.3	**Post Transplantation Biopsies and Scans (See B3)**	Limited to and included in D16.1.	Limited to and included in D16.1.	
D16.4	**Radiology and Pathology (See B3)**	Limited to and included in D16.1.	Limited to and included in D16.1.	For specified radiology and pathology services, performed by Pathologists, Radiologists and Haematologists, associated with the transplantation treatment.
D17	**PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS)**			
D17.1	**In Hospital (See B2 and B3)**	Subject to available savings, unless PMB.	Subject to available savings, unless PMB.	Subject to referral by the treating practitioner.

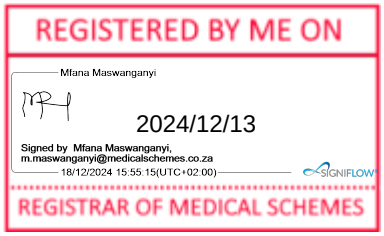
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D17.1.1	**Dietetics**	• 100% of Bonitas Tariff. • Limited to and included in D17.1.	• 100% of Bonitas Tariff. • Limited to and included in D17.1.	
D17.1.2	**Occupational Therapy**	• 100% of Bonitas Tariff. • Limited to and included in D17.1.	• 100% of Bonitas Tariff. • Limited to and included in D17.1.	
D17.1.3	**Speech Therapy**	• 100% of Bonitas Tariff. • Limited to and included in D17.1.	• 100% of Bonitas Tariff. • Limited to and included in D17.1.	
D17.2	**Out of Hospital**	• Subject to available savings. • 100% of Bonitas Tariff.	• Subject to available savings. • 100% of Bonitas Tariff.	
D17.2.1	**Audiology**	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.2	**Chiropractics**	Limited to and included in D17.2.	Limited to and included in D17.2.	This benefit excludes X-rays performed by chiropractors.
D17.2.3	**Dietetics**	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.4	**Genetic Counselling**	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.5	**Hearing Aid Acoustics**	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.6	**Occupational Therapy**	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.7	**Orthoptics**	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.8	**Orthotists and Prosthetists**	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.9	**Private Nurse Practitioners**	Limited to and included in D17.2.	Limited to and included in D17.2.	Nursing services are included in the Alternatives to Hospitalisation benefit (D7) if pre-authorised by the relevant managed healthcare programme.
D17.2.10	**Speech Therapy**	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.11	**Social Workers**	Limited to and included in D17.2.	Limited to and included in D17.2.	
D18	**PATHOLOGY AND MEDICAL TECHNOLOGY**			
D18.1	**In Hospital (See B2 and B3)**	• No limit.	• No limit.	Subject to the relevant managed healthcare programme.

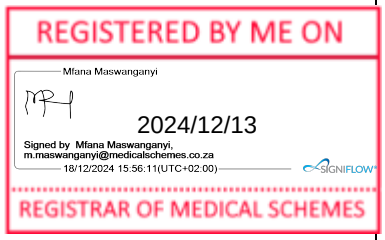
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
		• Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	
D18.2	**Out of Hospital** 	• Subject to the available savings. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• Subject to the available savings. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	Subject to the Pathology Management Program. 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).
D19	**PHYSICAL THERAPY**			
D19.1	**In Hospital Physiotherapy Biokinetics (See B2 and B3)**	• Subject to available savings unless PMB. • 100% of Bonitas Tariff.	• Subject to available savings 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 (See B2 and B3)**	Subject to available savings.	Subject to available savings.	
D20	**PROSTHESES AND DEVICES INTERNAL AND EXTERNAL**			
D20.1	**Prostheses and devices internal(surgically implanted), including all temporary prostheses, or/and all accompanying temporary or permanent devices used to assist with the guidance, alignment or delivery of these internal prostheses and devices. This includes bone cement, bone graft**	• R41 070 per family, unless PMB. • Sub-limit of R4 430 for a single intra-ocular lens. • R8 860 for bilateral lenses per beneficiary. • 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.

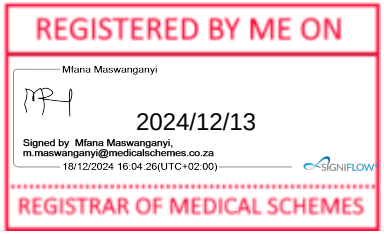
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
	substitutes, screws, pins and bone anchors. **(See B3)**			
D20.1.1	**Cochlear Implants**	No benefit.	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D20.1.2	**Internal Nerve Stimulator**	No benefit.	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D20.2	**Prostheses External**	• Subject to available savings, 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**			
D21.1	**General Radiology (See B2 and B3)**			
D21.1.1	**In Hospital**	• No limit. • 100% of the Bonitas Tariff.	• No limit. • 100% of the Bonitas Tariff.	For diagnostic radiology tests and ultrasound scans. Authorisation is not required for MRI scans for low field peripheral joint examination of dedicated limb units.
D21.1.2	**Out of Hospital** 	Subject to available savings.	Subject to available savings.	This benefit excludes: specified list of radiology tariff codes included in the • Maternity benefit, (D10), • Oncology benefit during the active treatment and/or post active treatment period, (D14); • Organ and haemopoietic stem cell transplantation benefit, (D16), • Renal dialysis chronic benefit, (D22). Authorisation is not required for MRI scans for low field peripheral joint examination of dedicated limb units.
D21.2	**Specialised Radiology**			

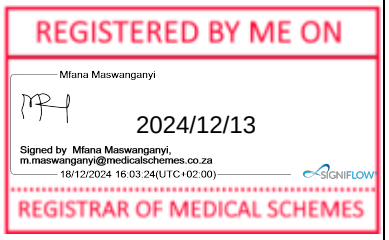
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D21.2.1	**In Hospital** 	• R30 430 per family. • 100% of the Bonitas Tariff. • R1 860 co-payment per scan event, unless PMB or nuclear radio-isotope studies. • The co-payment to be waived if the cost of the service falls within the co-payment amount.	• R20 550 per family. • 100% of the Bonitas Tariff. • R1 860 co-payment 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 symptomatic patients only) • MDCT coronary angiography, limited to one per beneficiary restricted to the evaluation of symptomatic patients only.
D21.2.2	**Out of Hospital**	Limited to and included in D21.2.1.	Subject to available savings.	See D21.2.1.
D21.3	**PET and PET – CT**	See D14.1.2.1.	See D14.1.2.1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D22	**RENAL DIALYSIS CHRONIC**			
D22.1	**Haemodialysis and Peritoneal Dialysis (See B3)** 	• No limit. • 100% of the lower of the cost or Bonitas Tariff for all services, medicines and materials associated with the cost of renal dialysis, subject to the DSP network and Regulation 8 (3). • The contracted rate applies for the services rendered by a network specialist. • 100% of the Bonitas Tariff for the services rendered by a non-network specialist. • Related medicine are 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 are 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D23	**SURGICAL PROCEDURES**			
D23.1	**In Hospital and Unattached Operating Theatres and other Minor Surgical Procedures that can be authorised in Hospital (See B3)** 	• Limited to and included in D7.1.1 or D7.2.1. • The contracted rate applies for services rendered by the network specialist. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Subject to the BonSave Hospital Network. • 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3). • Co-payments apply – See paragraph D23.3 below. • Day surgery network applies for defined list of procedures. See D23.4.	• Limited to and included in D7.1.1 or D7.2.1. • The contracted rate applies for services rendered by network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Subject to the BonFit Select Hospital Network. • 30% co-payment to apply to all non-network admissions, subject to Regulation 8 (3). • Co-payments apply – See paragraph D23.3 below. • Day surgery network applies for defined list of procedures. See D23.4.	Subject to the relevant managed healthcare programme and to its prior authorisation. This benefit excludes: • Osseo-integrated implants (D6); • Orthognathic and oral surgery (D6); • Maternity (D10); • Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16).
D23.1.1	**Refractive Surgery**	No benefit.	No benefit.	
D23.1.2	**Maxillo-facial Surgery**	• Limited to and included in D7.1.1 or D7.2.1. • 100% of the Bonitas Tariff for services rendered by the medical specialist.	• Limited to and included in D7.1.1 or D7.2.1. • 100% of the Bonitas Tariff for services rendered by the medical specialist.	Subject to the relevant managed healthcare programme and to its prior authorisation. For the surgical removal of • tumours • neoplasms • sepsis, • trauma, • 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 or D23.2.2**	• Subject to available savings. • The contracted rate applies for services rendered by the network specialist.	• Subject to available savings. • The contracted rate applies for services rendered by the network specialist.	• 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

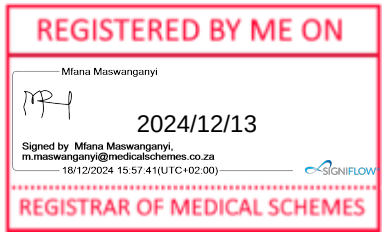
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
		• 100% of the Bonitas Tariff for services rendered by the non-network specialist.	• 100% of the Bonitas Tariff for services rendered by the non-network specialist.	approved, will it be limited to and included in (D7) and OAL. • This benefit excludes services as above as well as Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication. (D16). • No co-payment applies if the procedure is done in the practitioner's rooms.
D23.2.1	**General procedures performed in specialist consulting rooms**	Limited to and included in D7.1.1 or D7.2.1 at enhanced rates for: • Endometrial biopsy (excluding after-care): (2434) • Implantation hormone pellets (excluding after-care): (2565). • Insertion of intra-uterine contraceptive device (IUCD) (excluding after-care): (2442) • Punch biopsy (excluding after-care): (2399) • Removal of tag or polyp: (2271) • Removal of small superficial benign lesions: (2272) • Removal of benign vulva tumour or cyst: (2277)		• Subject to pre-authorisation.
D23.2.2	**Specified procedures done in the specialist rooms or suitably equipped procedure room with correct equipment and monitoring facilities**	Limited to and included in D7.1.1 or D7.2.1 at enhanced rates for: • Biopsy during pregnancy (excluding after care): (2400) • Cervix encirclage: Removal items 2409 and 2411: without anaesthetic): (2415) • Colposcopy (excluding after-care): (2429) • Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room: (2392) • Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): Under anaesthetic: (2395) • Cystoscopy: (1949) • 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)		• Subject to pre-authorisation.

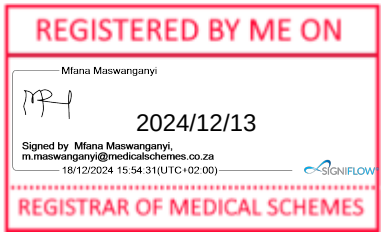
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
		• Extensive resection for malignant soft tissue tumour including muscle: (0313) • Flap repairs (large, complicated): 0295 • Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.: (1676) • Full thickness skingraft repair: (0289) • Full thickness eyelid repair: (3189) • Full thickness lip repair: (1499) • Hymenectomy: (2283) • Hysterosalpingogram (excluding after-care): (2435) • Hysteroscopy (excluding after-care): (2436) • Hysteroscopy and polypectomy (excluding after-care): (2440) • Laser or harmonic scalpel treatment of the cervix: (2396) • Laser therapy of vulva and/or vagina (colposcopically directed): (2274) • Left-sided colonoscopy: (1656) • Termination of pregnancy before 12 weeks: (2448) • Total colonoscopy: With hospital equipment (including biopsy): (1653) • Upper gastro-intestinal endoscopy: Hospital equipment: (1587) • Vulva and introitus: drainage of abscess: (2293)		
D23.3	**PROCEDURES THAT 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**.**
23.3.1	**Procedures which will attract a R1 940 co-payment when done in a hospital or day clinic:** • **Colonoscopy** • **Conservative back treatment** • **Cystoscopy** • **Facet Joint Injections** • **Flexible sigmoidoscopy** • **Functional nasal surgery**	Subject to a R1 940 co-payment per event.	Subject to a R1 940 co-payment per event.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
	• **Gastroscopy** • **Hysteroscopy, but not endometrial ablation** • **Myringotomy** • **Tonsillectomy and adenoidectomy** • **Umbilical Hernia repairs** • **Varicose vein surgery**			
D23.3.2	**Procedures which will attract a R4 930 co-payment:** • **Arthroscopy** • **Diagnostic Laparoscopy** • **Laparoscopic Hysterectomy** • **Percutaneous Radiofrequency Ablations (percutaneous rhizotomies)**	Subject to a R4 930 co-payment per event.	Subject to a R4 930 co-payment per event.	
D23.3.3	**Procedures which will attract a R9 130 co-payment:** • **Nissen Fundoplication (Reflux surgery)** • **Laparoscopic** • **Pyeloplasty** • **Laparoscopic Radical Prostatectomy**	Subject to a R9 130 co-payment per event.	Subject to a R9 130 co-payment per event.	
D23.3.4	**Procedures which will attract a R7 420 co-payment:** **Cataract Surgery**	Subject to a R7 420 co-payment per event: • For the voluntary use of a non-DSP.	Subject to a R7 420 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 720 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the Day Surgery Network. • R5 440 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and to its prior authorisation and subject to a defined list of procedures. • The co-payment to be waived if the cost of the service falls within the co-payment amount**.**

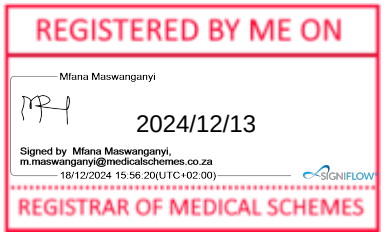
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D24	**PREVENTATIVE CARE BENEFIT (See B3)**			
D24.1	**Women's Health Breast Cancer Screening**	Mammogram • Females age >40 years • Once every 2 years.	Mammogram • Females age >40 years • Once every 2 years.	
	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 R1 100 per vaccine.	• Limited to 3 doses for females between 15 – 26 years. • One course per lifetime. • Limited to R1 100 per vaccine.	
D24.2	**Men's Health PSA Test**	• Men 55-69 years, 1 per annum.	• Men 55-69 years, 1 per annum.	
D24.3	**General Health**	• HIV test annually. • Flu vaccine annually, including the administration fee of the nurse practitioner.	• HIV test annually. • Flu vaccine annually, including the administration fee of the nurse practitioner.	• HIV test, either as part of Preventative Care or Health Risk Assessment. See D27.1. • Upon a positive diagnosis, the HIV basket of care applies, subject to registration on the relevant managed healthcare programme.
D24.4	**Cardiac Health**	No benefit.	No benefit.	
D24.5	**Elderly Health**	Pneumococcal Vaccination, including the administration fee of the nurse practitioner. • Age >65 Once every 5 years.	Pneumococcal Vaccination, including the administration fee of the nurse practitioner. • Age >65 Once every 5 years.	

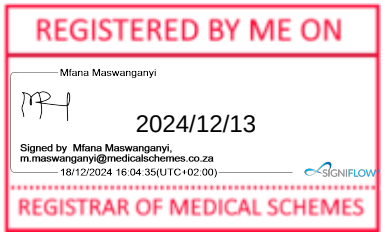
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
		Faecal Occult Blood Test • Ages 45-75 annually.	Faecal Occult Blood Test • Ages 45-75 annually..	
D24.6	**Children's Health Hypothyroidism**	• 1 TSH Test Age <1 month	• 1 TSH Test Age <1 month	
	Infant Hearing Screening	• One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	• One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	
	Neonatal Vision Screening: (For Retinopathy of prematurity (ROP) in neonates (<32 weeks gestational age and very low birth (<1500g))	• Two vision screening tests per beneficiary for newborns up to 6 weeks, in or out of hospital, performed by an ophthalmologist.	• Two vision screening tests per beneficiary for newborns up to 6 weeks, in or out of hospital, performed by an ophthalmologist.	Screening should be performed at 4 – 6 weeks chronological age or 31 – 33 post-conceptional age (whichever comes later).
	Human Papilloma Virus (HPV) Vaccine	• Limited to two doses for girls aged between 9 – 14 years. • One course per lifetime. • Limited to R1 100 per vaccine.	• Limited to two doses for girls aged between 9 – 14 years. • One course per lifetime. • Limited to R1 100 per vaccine.	
	Extended Program on Immunisation (EPI)	• Various Vaccinations, including the administration fee of the nurse practitioner for children up to the age of 12 years.	• Various Vaccinations, including the administration fee of the nurse practitioner for children up to the age of 12 years.	As per State EPI protocols.
D24.7	**Smoking Cessation (GoSmokeFree)**	• Limited to and included in available savings and the Benefit Booster in D27.2.	• Limited to and included in available savings and the Benefit Booster in D27.2.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D25	**INTERNATIONAL TRAVEL BENEFIT**			
D25.1	Leisure Travel: **(Travelling for recreation, a holiday or visiting family and friends)**	• For medical emergencies when travelling outside the borders of South Africa. • 60 days excluding USA – R2.5 million per Member, R2.5 million for Member and Dependants • 60 days including USA – Maximum cover R500,000 for Member and Dependants.	• For medical emergencies when travelling outside the borders of South Africa. • 60 days excluding USA – R2.5 million per Member, R2.5 million for Member and Dependants • 60 days including USA – Maximum cover R500,000 for Member and Dependants.	• Subject to authorisation, prior to departure. • Additional benefits for Covid-19: ○ additional costs for compulsory medical quarantine limited to R1 000 per day to a maximum of R10 000 for accommodation and PCR testing up to R1 000. ○ The cover will only apply if a beneficiary tested positive.
D25.2	Business Travel: **(Primarily for attending meetings, conferences, visiting suppliers and for administrative purposes)** 	• 30 days excluding USA – R2.5 million per Member, R2.5 million for Member and Dependants • 30 days including USA - Maximum cover R500,000 for Member and Dependants. • Subject to approval protocols prior to departure.	• 30 days excluding USA – R2.5 million per Member, R2.5 million for Member and Dependants • 30 days including USA - Maximum cover R500,000 for Member and Dependants. • Subject to approval protocols prior to departure.	Subject to authorisation, prior to departure. • Additional benefits for Covid-19: ○ additional costs for compulsory medical quarantine limited to R1 000 per day to a maximum of R10 000 for accommodation and PCR testing up to R1 000. ○ The cover will only apply if a beneficiary tested positive. • Manual labour excluded - refers to any occupation or activity involving physical labour (use of hands or machinery). Subject to pre-authorisation of Emergency Medical expenses.”
D26	**AFRICA BENEFIT**			
D26.1	**In and Out of Hospital** **(See B3)**	100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. Subject to authorisation.	100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. Subject to authorisation.	The Fund’s liability will not exceed the global amount the Fund would in the ordinary course pay for such healthcare services given the Fund’s claims experience in South Africa, subject to the benefits as per benefit plan.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
D27	**WELLNESS BENEFIT**			
D27.1	**Health Risk Assessment (HRA) which includes** **Lifestyle Questionnaire** **Wellness screening** 	Wellness screening. • One assessment per beneficiary over the age of 21 years per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). • Payable from OAL. Limited to: • blood pressure test • glucose test • cholesterol test • body mass index • hip to waist ratio. • HIV counselling and testing.	Wellness screening. • One assessment per beneficiary over the age of 21 years per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). • Payable from OAL. Limited to: • blood pressure test • glucose test • cholesterol test • body mass index • hip to waist ratio. • HIV counselling and testing.	• HIV test, either as part of Preventative Care or Health Risk Assessment. See D24.3. • Upon a positive diagnosis, the HIV basket of care applies, subject to registration on the relevant managed healthcare programme.

D27.2	**Benefit Booster (including out**	• Subject to completion of a	• Subject to completion of a	• Child dependants under the age of 21 years

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONSAVE	BONFIT SELECT	CONDITION/REMARKS SUBJECT TO PMB
	of hospital non-PMB day-to-day services as mentioned in D1, D5.1.3, D5.1.4, D5.2, D11.1, D11.1.3, D11.2, D13.2, D17.2, D18.2, D19.2, D21.1.2, D24.7 and virtual consultations). 	Health Risk Assessment or the completion of an online wellness questionnaire per beneficiary over the age of 21 years. • First level Benefit Booster, • Limited to R1 000 per family, activated by completion of an online wellness questionnaire. • Limited to: ○ Alternative Health: D1 ○ GP consultations: D5.1.3 & 4. ○ Medical specialists: D5.2 ○ Acute medication: D11.1 ○ Registered ante-natal vitamins during pregnancy: D11.1.3 ○ Pharmacy advised therapy: D11.2 ○ Non-surgical procedures: D13.2 ○ Paramedical services : D17.2 ○ Pathology: D18.2 ○ Physical therapy: D19.2 ○ General radiology: D21.1.2 ○ Smoking Cessation: D24.7 • Second level Benefit Booster applies when the first level benefit is depleted. • Subject to the completion of a physical health risk assessment (HRA) at a participating pharmacy or wellness day. • Limited to R4 000 per family.	Health Risk Assessment or the completion of an online wellness questionnaire per beneficiary over the age of 21 years. • Limited to R1 440 per family. • Limited to: ○ Alternative Health: D1 ○ GP consultations: D5.1.3 & 4. ○ Medical specialists: D5.2 ○ Acute medication: D11.1 ○ Registered ante-natal vitamins during pregnancy: D11.1.3 ○ Pharmacy advised therapy: D11.2 ○ Non-surgical procedures: D13.2 ○ Paramedical services : D17.2 ○ Pathology: D18.2 ○ Physical therapy: D19.2 ○ General radiology: D21.1.2 ○ Smoking cessation: D24.7.	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) on BonSave, the first and second level Benefit Booster will become available.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