Bonitas

BONITAS MEDICAL FUND

ANNEXURE B

OPTIONS:

BONCOMPREHENSIVE

BONCLASSIC

BONCOMPLETE

2022

REGISTERED BY ME ON

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REGISTRAR OF MEDICAL SCHEMES

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A ENTITLEMENT OF BENEFITS

A1 The Bonitas Fund Tariff is defined as the Bonitas monetary tariffs applicable in 2021 increased by an average of 3.9%

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

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

A3.1 Specialist Network

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

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

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

- 130% of Bonitas Tariff for the BonComplete and BonClassic Options.

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

- 130% Bonitas Tariff for the BonComplete and BonClassic Options.

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

B1 On the BonComplete, BonClassic and BonComprehensive Options claims for services stated as being subject to payment from the personal medical savings account are allocated against the personal medical savings account and / or threshold benefit**.**

B2 When a member's personal medical savings account is exhausted on the BonClassic Option no further benefits is available in respect of services payable from the personal medical savings account.

B3 When the member's personal medical savings account is exhausted on BonComplete and BonComprehensive options, further claims are paid by the member until a specific threshold is reached, whereupon further benefits become available, referred to as the Threshold benefit as set out in B7 below.

B4 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 or 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.

B5 Legally prescribed acute or chronic medicines claims will be reimbursed at 100% of (1) the single exit price plus the negotiated dispensing fee or (2) the single exit price plus 20% capped at a maximum of R20 (Vat exclusive). Both subject to the reimbursement limit, i.e. Medicine Price List. Co-payments to apply where relevant.

B6 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

B7 Once the personal medical savings account has been exhausted on the BonComprehensive option, the member shall be liable for all expenses until the cumulative threshold has been reached, thereafter the benefits shall be paid above threshold.
Claims in respect of out of hospital expenses which will accumulate to the threshold will be marked "YES" against "Acc" in the column headed "CONDITIONS / REMARKS." Claims will accumulate to threshold at Bonitas Tariff. Any difference between the cost of an account and the Bonitas Tariff will not accumulate towards the Threshold, although this difference may be covered from available savings.

Once the personal medical savings account has been exhausted on the BonComplete option, the member shall be liable for all expenses until the cumulative threshold has been reached, thereafter the benefits shall be subject to the above threshold limit. Claims in respect of out of hospital expenses which will accumulate to the threshold will be marked "YES" against "Acc" in the column headed "CONDITIONS / REMARKS." Claims will accumulate to threshold at Bonitas Tariff. Any difference between the cost of an account and the Bonitas Tariff will not accumulate towards the Threshold, although this difference may be covered from available savings.

The above threshold benefit for out of hospital expenses on BonComprehensive and BonComplete shall be subject to applicable sub-limits and/or co-payments, once accumulated costs have exceeded the following cumulative threshold levels:

		BonComprehensive	BonComplete
Member		R22 980	R10 108
Add per adult dependant	=	R21 162	R8 186
Add per child dependant	=	R5 440	R2 647

B8 The above threshold benefit becomes available after medical expenses are incurred and paid from the available medical savings facility, and if this is exhausted, paid by the member or beneficiary direct to the provider, until a threshold level of such total expenditure is reached in accordance with the table above whereupon further benefits become payable, identified as "above threshold benefit". For each individual service category where a limit applies, the individual limits remains in place and the threshold benefit only applies in cases where the limit has not yet been reached. Once a benefit limit or sub-limit has been reached, no further claims can be paid from the above threshold benefit in respect of that specific benefit for the remainder of the year. If a benefit is unlimited, the above threshold benefit once it becomes applicable is also unlimited on BonComprehensive, unless otherwise stated in the schedule of benefits.

Threshold Level

The extent of the threshold level is determined as at 1 January each year, or at the time the member joins the Fund, by adding together the threshold levels given in the table above for the principal member, adult dependant(s) (where applicable) and child dependant(s) (where applicable) to arrive at a total amount per family. The threshold level will be adjusted pro-rata during a benefit year should a member join during the course of the year and/or when a dependant is added or removed, or when a child dependant becomes an adult dependant.

B9 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.

B10 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	

B11 A member or beneficiary will be required to obtain a referral from a registered general practitioner for a specialist consultation. However should a member/beneficiary not have a referral, the claim will not be covered.

The following exceptions are applicable:

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

On depletion of benefits, PMB above limits will only be applicable via the contracted Designated Service Providers of the Fund (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)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
	OVERALL ANNUAL LIMIT	No limit.	No limit.	No limit.	
	PERSONAL MEMBER SAVINGS ACCOUNT	Subject to available savings and/or above threshold benefit.	Subject to available savings.	Subject to available savings and/or above threshold benefit.	
	ABOVE THRESHOLD BENEFIT	Sub-limits apply, where relevant.	Not applicable.	P: R5 050 A: R2 970 C: R1 290	
	General Practitioner Network	Not applicable.	Not applicable.	Not applicable.	
D1	**ALTERNATIVE HEALTHCARE (See B4)**	Subject to available savings and/or above threshold benefit.	Subject to available savings.	Subject to available savings and/or above threshold benefit.	Acc Yes
D1.1	**Homoeopathic Consultations and/or treatment**	Limited to and included in D1.	Limited to and included in D1.	Limited to and included in D1.	
D1.2	**Homoeopathic Medicines**	• Limited to and included in D1. • Paid at 80% of tariff when paid from the above threshold benefit.	Limited to and included in D1.	• Limited to and included in D1. • Paid at 80% of tariff when paid from the above threshold benefit.	
D1.3	**Acupuncture**	Limited to and included in D1.	Limited to and included in D1.	Limited to and included in D1.	
D1.4	**Naturopathy Consultations and/or treatment and medicines.**	• Limited to and included in D1. • Medicines are paid at 80% of tariff when paid from the above threshold benefit.	Limited to and included in D1.	• Limited to and included in D1. • Medicines are paid at 80% of tariff when paid from the above threshold benefit.	
D1.5	**Phytotherapy**	Limited to and included in D1.	Limited to and included in D1.	Limited to and included in D1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D1.6	**Osteopathy**	Limited to and included in D1.	Limited to and included in D1.	Limited to and included in D1.	
D2	**AMBULANCE SERVICES (See B4)**	100% of cost if authorised by the preferred provider.	100% of cost if authorised by the preferred provider.	100% of cost if authorised by the preferred provider.	Subject to the contracted provider. Non-authorisation will result in non-payment except for PMBs. Acc: No
D3	**APPLIANCES, EXTERNAL ACCESSORIES AND ORTHOTICS (See B4)**				Diabetic accessories and appliances - (with the exception of glucometers) to be pre-authorised and claimed from the chronic medicine benefits D11.3. Recommend use of preferred supplier and subject to frequency limits as per managed care protocols. The benefit excludes consultations/fittings which are subject to D17.2.
D3.1	**In and Out of Hospital**				
D3.1.1	**General medical and surgical appliances, including wheelchairs and repairs, and large orthopaedic appliances**	• Subject to available savings. • Recommend use of preferred supplier.	• Subject to available savings. • Recommend use of preferred supplier.	• Subject to available savings and/or above threshold benefit. • Recommend use of preferred supplier.	Hiring or buying medical or surgical aids as prescribed by a medical practitioner. Acc: Yes

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D3.1.2	**Hearing Aids and repairs**	• Limited to R28 250 per family over a five year cycle. • A 10% co-payment will apply. • Benefit is available per beneficiary every five years based on the last claim date.	• Limited to R18 500 per family per annum over a five year cycle. • A 10% co-payment will apply. • Benefit is available per beneficiary every five years based on the last claim date.	• Limited to and included in D3.1.1. • Benefit is available per beneficiary every five years based on the last claim date.	Hearing aids and repairs are subject to the relevant managed healthcare programme and to its prior authorisation. Recommend use of preferred supplier. Acc: Yes, when paid from savings
D3.1.3	**CPAP Apparatus for sleep apnoea**	Limited to and included in D3.1.1.	Limited to and included in D3.1.1.	Limited to and included in D3.1.1.	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.	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 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.	No limit if specifically authorised.	
D3.1.5.2	**Home Ventilators**	No limit if specifically authorised.	No limit if specifically authorised.	No limit if specifically authorised.	
D3.1.5.3	**Long leg callipers**	Limited to and included in D20.2.	Limited to and included in D20.2.	Limited to and included in D20.2.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D3.1.5.4	**Foot orthotics**	Subject to available savings only.	Subject to available savings.	Subject to available savings only.	Foot orthotics are not payable from the above threshold benefit on BonComprehensive and BonComplete.
D4	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS (See B4)**	No limit if specifically authorised.	No limit if specifically authorised.	No limit if specifically authorised.	Subject to the relevant managed healthcare programme and to its prior authorisation and if the treatment forms part of the relevant managed healthcare programme, out of hospital.
D5	**CONSULTATIONS AND VISITS BY MEDICAL PRACTITIONERS (See B4)**				
D5.1	**General Practitioners (Including Virtual Consultations)**				This benefit excludes • Dental Practitioners and Therapists (D6), • ante-natal visits and consultations (D10); • Psychiatrists, Psychologists, Psychometrists and Registered Counsellors (D12); • Oncologists, Haematologists and Credentialed Medical Practitioners during active and post-active treatment periods (D14); • Paramedical Services (D17); • Physiotherapists and Biokineticists in hospital (D19.1).
D5.1.1	**In Hospital**	No limit at 100% of Bonitas Tariff for general practitioners.	No limit at 100% of Bonitas Tariff for general practitioners.	No limit at 100% of Bonitas Tariff for general practitioners.	Acc: No

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D5.1.2	**Out of Hospital GP consultations, Including virtual consultations with network GPs**	100% at Bonitas Tariff for general practitioners. Subject to available savings and/or above threshold benefit.	100% of Bonitas Tariff for general practitioners. Subject to available savings.	100% of Bonitas Tariff for general practitioners. Subject to available savings and/or above threshold benefit.	Acc: Yes
D5.1.3	**Childhood illness benefits**	2 GP consultations per beneficiary between the ages of 2 and 12 years paid from OAL.	No benefit.	1 GP consultation per beneficiary between the ages of 2 and 12 years paid from OAL.	Acc: No
D5.2	**Medical Specialist (See A3;B4, B8 and B11)**				
D5.2.1	**In Hospital**	• No limit • 150% of Bonitas Tariff for medical and dental specialists.	• No limit • 130% of Bonitas Tariff for network specialists. • 100% of Bonitas Tariff for non-network specialists.	• No limit • 130% of Bonitas Tariff for network specialists. • 100% of Bonitas Tariff for non-network specialists.	All consultations and procedures within the Specialist Network will be paid at the negotiated Tariff, with no co-payment applicable. Acc: No
5.2.2	**Out of Hospital (See A3)**	• 100% at Bonitas Tariff. Subject to available savings and/or above threshold benefit.	• Subject to available savings. • 130% of Bonitas Tariff for network specialists. • 100% of Bonitas Tariff for non-network Specialists.	• Subject to available savings and/or above threshold benefit. • 130% of Bonitas Tariff for network specialists. • 100% of Bonitas Tariff for non-network specialists.	Referral to a specialist must be done by a registered general practitioner and a valid referral obtained. The following exceptions are applicable as per B11: • 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 and oncologists. Acc: Yes

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D5.2.3	**Infant Paediatric Benefit (Consultation with a GP or Paediatrician)**	• 3 Paediatric consultations per beneficiary for children aged 0 - 12 months within the age bracket. • 2 Paediatric consultations per beneficiary for children aged 13 - 24 months within the age bracket, included in the OAL.	No benefit.	• 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.	Acc: No
D6	**DENTISTRY (SEE B4)**				Subject to the Dental Management Programme. Acc: Yes, when paid from savings.
D6.1	**BASIC DENTISTRY**		Limited to R5 138 per family per annum.		
D6.1.1	**Consultations**	• Once in 6 months • Subject to available savings and/or above threshold threshold benefit.	• 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.	Subject to the Dental Management Programme.
D6.1.2	**Fillings**	• Subject to available savings and/or above threshold benefit. • Fillings are granted once per tooth every 2 years. Benefit for re-treatment of a tooth is subject to managed care protocols.	• Covered at 100% of the BDT. • Fillings are granted once per tooth every 2 years. Benefit for re-treatment of a tooth is subject to managed care protocols.	• Covered at 100% of the BDT. • Fillings are granted once per tooth every 2 years. Benefit for re-treatment of a tooth is subject to managed care protocols.	Benefits for fillings are granted once per tooth every 2 years. Benefits for re-treatment of a tooth are subject to managed care protocols. A treatment plan and x-rays may be required for multiple fillings.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D6.1.3	**Plastic dentures and associated Laboratory costs**	• One set of plastic dentures (an upper and a lower) per beneficiary in a 4 year period. • Subject to available savings and/or above threshold benefit. • Subject to pre-authorisation.	• Covered at 100% of the BDT. • One set of plastic dentures (an upper and a lower) in a 4 year period per beneficiary. • Subject to pre-authorisation.	• Covered at 100% of the BDT. • One set of plastic dentures (an upper and a lower) in a 4 year period per beneficiary. • Subject to pre-authorisation.	Subject to managed care protocols.
D6.1.4	**Extractions**	Subject to available savings and/or above threshold benefit.	Covered at 100% of BDT and managed care protocols apply.	Covered at 100% of BDT and managed care protocols apply.	Subject to managed care protocols.
D6.1.5	**Root Canal therapy**	Subject to available savings and/or above threshold benefit.	Covered at 100% of BDT and managed care protocols apply.	Covered at 100% of BDT and managed care protocols apply.	Root canal treatment on third molars and primary (milk) teeth is not covered on all options.
D6.1.6	**Preventative Care**	Once in 6 months. Subject to available savings and/or above threshold benefit.	2 Annual scale and polish treatments per beneficiary (once in 6 months). Covered at the BDT.	2 Annual scale and polish treatments per beneficiary (once in 6 months). Covered at the BDT.	No benefit for oral hygiene instructions. Benefit for fluoride is limited to beneficiaries from age 5 and younger than 16 years of age. Benefit for fissure sealants is limited to beneficiaries younger than 16 years of age

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D6.1.7	**Hospitalisation (general anaesthetic) and Moderate/Deep Sedation in the rooms**	• Subject to pre-authorisation. • Certain maxillo-facial procedures are covered in hospital. Admission protocols apply. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. • Multiple hospital admissions are not covered. • General anaesthetic benefits are available for the removal of impacted teeth. Benefit is subject to managed care protocols. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• Subject to pre-authorisation. • A co-payment of R3 500 per hospital admission applies for children younger than 5 years and R5 000 for any other admission including removal of impacted teeth or medical condition. • Certain maxillo-facial procedures are covered in hospital. • Admission protocols apply. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. • Multiple hospital admissions are not covered. • General anaesthetic benefits are available for the removal of impacted teeth. Benefit is subject to managed care protocols. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• Subject to pre-authorisation. • A co-payment of R3 500 per hospital admission applies for children younger than 5 years and R5 000 for any other admission, including removal of impacted teeth or medical admission. • Certain maxillo-facial procedures are covered in hospital. • Admission protocols apply. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. • Multiple hospital admissions are not covered. • General anaesthetic benefits are available for the removal of impacted teeth. Benefit is subject to managed care protocols. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	Pre-authorisation is required for moderate/deep sedation in the rooms and is limited to extensive dental treatment where managed care protocols apply. The co-payments on BonClassic and BonComplete 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. • Subject to available savings and/or above threshold benefit.	• Covered at 100% of the BDT. • Subject to managed care protocols.	• Covered at 100% of the BDT. • Subject to managed care protocols.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D6.1.9	**X-rays**	• Covered at 100% of the BDT for intra-oral x-rays. Extra-oral x-rays will be covered at 100% of the BDT subject to 1 in a 3 year period. • Additional benefits for extra-oral x-rays may be considered where specialist dental treatment planning/follow-up is required. • Subject to available savings and/or above threshold benefit.	• Covered at 100% of the BDT for intra-oral x-rays. • Extra-oral x-rays will be covered at 100% of the BDT subject to 1 in a 3 year period. • Additional benefits for extra-oral x-rays may be considered where specialist dental treatment planning/follow-up is required.	• Covered at 100% of the BDT for intra-oral x-rays. • Extra-oral x-rays will be covered at 100% of the BDT subject to 1 in a 3 year period. • Additional benefits for extra-oral x-rays may be considered where specialist dental treatment planning/follow-up is required.	
D6.2	**ADVANCED DENTISTRY (See B4)**	Subject to available savings and/or above threshold benefit.	Limited to R6 186 per family per annum.	No benefit unless otherwise specified.	Subject to pre-authorisation and dental management protocols.
D6.2.1	**Crowns**	• Covered at 100% of the BDT. • 3 crowns per family per year, subject to pre-authorisation. • Benefits for crowns will be granted once per tooth in 5 years. Subject to available savings and/or above threshold benefit.	• 1 Crown per family per year. • Subject to pre-authorisation. • Benefits for crowns will be granted once per tooth in 5 years.	• 1 Crown per family per year. • Subject to pre-authorisation. • Benefits for crowns will be granted once per tooth in 5 years.	• Subject to the dental management protocols. • Failure to authorise will result in a 20% co-payment if authorisation is approved after the treatment has been done. • A treatment plan and x-rays may be requested.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D6.2.2	**Partial Chrome Cobalt Frame Dentures**	• Covered at 100% of the BDT. 2 partial metal frame dentures (upper and lower) per beneficiary in a 5 year period. • Full metal dentures are not covered. • Subject to available savings and/or above threshold benefit. • Subject to pre-authorisation.	• Covered at 100% of the BDT. • 2 partial metal frame dentures (upper and lower) per beneficiary in a 5 year period. • Full metal dentures are not covered. • Subject to pre-authorisation	• Covered at 100% of the BDT. • 1 partial metal frame denture (an upper or lower) per beneficiary in a 5 year period. • Full metal dentures are not covered. • Subject to pre-authoristion.	Subject to managed care protocols.
D6.2.3	**Osseo-integrated Implants and orthognathic surgery (functional correction of malocclusion)**	• Limited to 2 implants per beneficiary in a 5 year period at 100% of BDT. • The cost of implant components is limited to R2 994 per implant. • No benefit for orthognathic surgery. • Subject to available savings and/or above threshold benefit.	No benefit.	No benefit.	Includes all stages of treatment required to achieve the end result of placing an implant supported tooth or teeth into spaces left by previous removal of natural teeth and surgical placement and exposure of implants. Hospital and Anaesthetist accounts will not attract benefit if treatment is done In Hospital
D6.2.4	**Oral Surgery**	Surgery in the dental chair. Covered at 100% of BDT.	Surgery in the dental chair. Covered at 100% of BDT.	Surgery in the dental chair. Covered at 100% of BDT.	Benefits for Tempero-mandibular joint therapy are limited to non-surgical interventions/treatments.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D6.2.5	**Orthodontic Treatment**	• Subject to prior authorisation by the dental management programme. • Benefit for fixed comprehensive treatment is subject to prior authorisation by the dental management programme for beneficiaries from the age of 9 and under the age of 18 years in terms of the severity of the dental malocclusion determined by an international classification index. • Orthodontic treatment is limited to one beneficiary per annum except in the case of identically aged siblings at 100% of BDT. • Subject to available savings and/or above threshold benefit.	• Subject to prior authorisation by the dental management programme. • Benefit for fixed comprehensive treatment is subject to prior authorisation by the dental management programme for beneficiaries from the age of 9 and under the age of 18 years in terms of the severity of the dental malocclusion determined by an international classification index. • Orthodontic treatment is limited to one beneficiary per annum except in the case of identically aged siblings at 100% of BDT.	• Subject to prior authorisation by the dental management programme. • Benefit for fixed comprehensive treatment is subject to prior authorisation by the dental management programme for beneficiaries from the age of 9 and under the age of 18 years in terms of the severity of the dental malocclusion determined by an international classification index. • Orthodontic treatment is limited to one beneficiary per annum except in the case of identically aged siblings at 65% of BDT.	Subject to the dental management protocols. (Failure to pre-authorise will result in a payment only from date of post authorisation for the remaining months of treatment, provided that the treatment is clinically indicated).
D6.2.6	**Maxillo-facial surgery**	See D23.1.2.	See D23.1.2.	See D23.1.2.	
D6.2.7	**Periodontal treatment**	• Benefits are limited to conservative, non-surgical therapy only. • Benefits will be applied to members who are registered on the Periodontal Programme. Surgical treatment is excluded. • Subject to available savings and/or above threshold benefit.	• Benefits are limited to conservative, non-surgical therapy only. • Benefits will be applied to members who are registered on the Periodontal Programme. • Surgical treatment is excluded. • Subject to pre-auhorisation	• Benefits are limited to conservative, non-surgical and maintenance therapy only. • Benefits will be applied to members who are registered on the Periodontal Programme. • Surgical treatment is excluded. • Subject to pre-authorisation.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D7	**HOSPITALISATION (See B4)**				
D7.1	**Private Hospitals and unattached operating theatres (See B4)**				Subject to the relevant managed healthcare programme and its prior authorisation.
D7.1.1	**In Hospital**	• No limit. • Deep Brain Stimulation Implantation for Parkinson's and intractable epilepsy is limited to R255 700 per beneficiary (excluding the prosthesis benefit). • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3). • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• No limit. • No benefit for Deep Brain Stimulation Implantation. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3). • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• No limit. • No benefit for Deep Brain Stimulation Implantation. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3). • 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). Acc: No
D7.1.2	**Medicine on discharge from hospital (TTO) (See B5)**	Limited to and included in the OAL. Up to 7 days' supply, to a maximum of R595 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 R510 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 R450 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. Acc: Yes, when paid from savings.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D7.1.3	**Casualty/emergency room visits**				
D7.1.3.1	**Facility fee**	Limited to available savings and/or above threshold benefit.	Subject to available savings.	Subject to available savings and/or above threshold benefit.	Will be included in the hospital benefit if a retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies. Acc: Yes, when paid from savings.
D7.1.3.2	**Consultations**	See D5.1.2 and D5.2.2.	See D5.1.2 and D5.2.2.	See D5.1.2 and D5.2.2.	
D7.1.3.3	**Medicine**	See D11.1.	See D11.1.	See D11.1.	
D7.2	**Public hospitals (See B4)**				
D7.2.1	**In hospital**	No limit.	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 (D23.1.1). Acc: No

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D7.2.2	**Medicine on discharge from hospital (TTO) (See B5)**	Limited to and included in the OAL. Up to 7 days' supply, to a maximum of R595 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 R510 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 R450 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. Acc: Yes, when paid from savings.
D7.2.3	**Casualty/emergency room visits**				
D7.2.3.1	**Facility Fee**	• Subject to authorisation of bona fide emergencies. • Limited to available savings and/or above threshold benefit.	• Subject to authorisation of bona fide emergencies. • Subject to available savings.	• Subject to authorisation of bona fide emergencies. • Subject to available savings and/or above threshold benefit.	Will be included in the hospital benefit if retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies. Acc: Yes, when paid from savings.
D7.2.3.2	**Consultations**	See D5.1.2 and D5.2.2.	See D5.1.2 and D5.2.2.	See D5.1.2 and D5.2.2.	
D7.2.3.3	**Medicine**	See D11.1.	D11.1.	See 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.	See D5.1.2 and D5.2.2.	
D7.2.4.2	**Medicine**	See D11.1.	See D11.1.	See D11.1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D7.3	**Alternative to hospitalisation (See B4)**				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. Acc: No
D7.3.1	**Physical Rehabilitation hospitals**	R54 360 per family for all services.	R54 360 per family for all services.	R54 360 per family for all services.	See D7.3.
D7.3.2	**Sub-acute facilities including Hospice**	R18 130 per family.	R18 130 per family.	R18 130 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.	• No limit. • Subject to pre-authorisation.	Subject to the relevant managed healthcare programme.
D7.3.4	**Conservative Back Programme**	Subject to the Contracted Provider.	Subject to the Contracted Provider.	Subject to the Contracted Provider.	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.	Limited to and included in D7.3.2 and above limits, subject to pre-authorisation.	Subject to the relevant managed healthcare programme.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D8	**IMMUNE DEFICIENCY SYNDROME RELATED TO HIV INFECTION (SEE B4)**	• No limit. • Subject to PMBs.	• No limit. • Subject to PMBs.	• No limit. • Subject to PMBs.	Subject to registration on the relevant managed healthcare programme. Subject to clinical protocols. Acc: No
D8.1	**Anti-retroviral medicine**	Limited to and included in D8.	Limited to and included in D8 and subject to the DSP.	Limited to and included in D8 and subject to the DSP.	
D8.2	**Related medicine**	Limited to and included in D8.	Limited to and included in D8 and subject to the DSP.	Limited to and included in D8 and subject to the DSP.	
D8.3	**Related pathology**	Limited to and included in D8.	Limited to and included in D8.	Limited to and included in D8.	Pathology as specified by the relevant managed healthcare programme, out of hospital.
D8.4	**Related consultations**	Limited to and included in D8.	Limited to and included in D8.	Limited to and included in D8.	
D8.5	**All other services**	Limited to and included in D1 - D7 and D9 - D26.	Limited to and included in D1 - D7 and D9 - D26.	Limited to and included in D1 - D7 and D9 - D26.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D9	**INFERTILITY (See B4 and B10)**	Limited to interventions and investigations as prescribed by the Regulations to the Medical Schemes' Act 131 of 1998 in Annexure A, paragraph 9, Code 902M.	Limited to interventions and investigations as prescribed by the Regulations to the Medical Schemes' Act 131 of 1998 in Annexure A, paragraph 9, Code 902M.	Limited to interventions and investigations as prescribed by the Regulations to the Medical Schemes' Act 131 of 1998 in Annexure A, paragraph 9, Code 902M.	Subject to the relevant managed healthcare programme, and its prior authorisation. Acc: No
D10	**MATERNITY (See A3 & B4)**				Subject to the relevant managed healthcare programme and to its prior authorisation. Acc: No
D10.1	**Confinement in hospital**	• No limit, at 150% of the Bonitas Tariff for the medical specialist. • 100% of the Bonitas Tariff for the general practitioner • Accommodation in a private room is limited to 2 days for a normal vaginal delivery and 3 days for a caesarean section in the post delivery period. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• No limit, 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• No limit, 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	Delivery by a general practitioner or medical specialist and the services of the attendant paediatrician and/or anaesthetists are included. Included in 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 B5)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
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. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used for a lactation specialist consultation out of hospital. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used for a lactation specialist consultation out of hospital. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and its prior authorisation. • Delivery by a midwife. • Hire of water bath and oxygen cylinder limited to and included in OAL. This must be hired from a practitioner who has a registered practice number. • One of the post-natal midwife consultations may be used for a lactation specialist consultation out of hospital.
D10.2	**Confinement out of hospital**	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used 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.	• 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.	Limited to and included in D10.1.	Registered medicine, dressings and materials supplied by a midwife out of hospital.
D10.3	**Related maternity services**	• Limited to and included in D10.1.	• Limited to and included in D10.1.	• Limited to and included in D10.1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D10.3.1	**Ante-natal consultations**	• 12 ante-natal consultations by a specialist, general practitioner or midwife. • R1 330 for ante-natal classes/exercises per pregnancy.	• 12 ante-natal consultations by a specialist, general practitioner or midwife. • R1 330 for ante-natal classes /exercises per pregnancy.	• 6 ante-natal consultations by a specialist, general practitioner or midwife. • R1 330 for ante-natal classes /exercises per pregnancy.	
D10.3.2	**Related tests and procedures**	• Pregnancy related tests and procedures. • 2 x 2D pregnancy scans. • 1 x amniocentesis per pregnancy.	• Pregnancy related tests and procedures. • 2 x 2D pregnancy scans. • 1 x amniocentesis per pregnancy.	• Pregnancy related tests and procedures. • 2 x 2D pregnancy scans. • 1 x amniocentesis per pregnancy.	
D11	**MEDICINE AND INJECTION MATERIAL (See B4 and B5)**				
D11.1	**Routine/ (acute) medicine**	• Subject to available savings and above threshold benefit, limited to R15 000 per family when paid from the above threshold benefit. • 20% co-payment applies above threshold for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	• Subject to available savings.	• Subject to available savings and/or above threshold benefit. • 20% co-payment applies above threshold for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme. Subject to the Bonitas Pharmacy Network. 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). Acc: Yes
D11.1.1	**Medicine on discharge from hospital (TTO)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	Acc: Yes, when paid from savings.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D11.1.2	**Contraceptives**	• Limited to R1 720 per family. • Limited to females up to the age of 50 years.	• Limited to R1 720 per family. • Limited to females up to the age of 50 years. • Subject to the DSP pharmacy. • 40% co-payment applies for the voluntary use of a non-DSP pharmacy.	• Limited to R1 720 per family. • Limited to females up to the age of 50 years. • Subject to the DSP pharmacy. • 40% co-payment applies for the voluntary use of a non-DSP pharmacy.	Acc: No
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.	Limited to and included in D11.1.	Acc: Yes
D11.3	**Chronic medicine (See B4)**	• R30 190 per family. • R15 160 per beneficiary. • As specified in Annexure D paragraph 6.4.3. • Above limits, PMBs apply. • 40% co-payment applies for non formulary drugs used voluntarily.	• R25 680 per family. • R12 420 per beneficiary. • As specified in Annexure D paragraph 6.4.3. • Subject to the Bonitas Pharmacy Network. • Above limits, PMBs and DSP apply. • 40% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	• Prescribed Minimum Benefits plus the 4 conditions for children, as specified in Annexure D paragraph 6.4.3, at the DSP. • 40% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP.	Subject to registration on the relevant managed healthcare programme and to its prior authorisation and applicable formularies. Restricted to a maximum of one month's supply unless pre-authorised. Includes diabetic disposables such as • syringes, • needles, • strips • 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). Acc: No

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
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 DSP.	• No limit. • Subject to managed care protocols. • Subject to the DSP.	Acc: No
D11.4	**Specialised Drugs (See B4)**				The non oncology specialised drug list is a continuously evolving list of high cost drugs, not listed on the National Department of Health Essential Drug List (EDL), used for the treatment of chronic conditions. This list includes but is not limited to biological drugs (biological therapy for inflammatory arthritides, inflammatory bowel disease, chronic demyelinating polyneuropathies, chronic hepatitis, botulinum toxin, palivizumab). Unless otherwise stated below, any other diseases where the use of the drug is deemed appropriate by the managed health care organization, drugs will be funded from this benefit. Subject to published list. Acc: No

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D11.4.1	**Non Oncology Biological Drugs applicable to monoclonal antibodies interleukins**	• R207 900 per family. • Subject to clinical protocols.	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D11.4.2	**Specialised Drugs used in the management of retinal disorders applicable to monoclonal antibodies intravitreal implants photosensitizing agents**	• R55 640 per family. Limited to and included in D11.4.1. • Subject to clinical protocols.	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation for the treatment of Retinal disorders.
D11.4.3	**Iron chelating agents for chronic use**	Limited to and included in D11.4.1.	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D11.4.4	**Human Immunoglobulin for chronic use**	Limited to and included in D11.4.1.	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D11.4.5	**Non calcium phosphate binders and calcimimetics**	Limited to and included in D11.4.1.	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation of renal osteodystrophy as a result of chronic kidney disease. The co-payment will be applicable to the non-PMB diseases.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D12	**MENTAL HEALTH (See B4 and B9)**	• R50 360 per family, unless PMB.	• R44 270 per family, unless PMB.	• R34 610 per family, unless PMB.	Subject to the relevant managed healthcare programme. Physiotherapy is not covered for mental health admissions. Acc: No
D12.1	**In Hospital**	• Limited to and included in D12. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• Limited to and included in D12. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• Limited to and included in D12. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	For accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items and procedures performed by general practitioners and psychiatrists. A maximum of three days' hospitalisation for beneficiaries admitted by a general practitioner or specialist physician. (See B9.)
D12.1.1	**Medicine on discharge from hospital (TTO) (See B5)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	Acc: Yes, when paid from savings.
D12.2	**Out of Hospital**				
D12.2.1	**Medicine (See B5)**	Limited to and included in D11.	Limited to and included in D11.	Limited to and included in D11.	
D12.3	**Rehabilitation of substance abuse (See B4)**	• Limited to and included in D12. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	• Limited to and included in D12 • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	• Limited to and included in D12. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme and to its prior authorisation. (See B9).
D12.3.1	**Medicine on discharge from hospital (TTO) (See B5)**	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	Limited to and included in D7.1.2.	Acc: Yes, when paid from savings.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D12.4	**Consultations and visits, procedures, assessments, therapy, treatment and/or counselling, in and out of hospital. (See B4)**	• R17 070 per family, limited to and included in D12. • Educational psychology visits for adult beneficiaries (>21 years) are excluded from this benefit.	• R17 070 per family, limited to and included in D12. • Educational psychology visits for adult beneficiaries (>21 years) are excluded from this benefit.	• R17 070 per family, limited to and included in D12. • Educational psychology visits for adult beneficiaries (>21 years) are excluded from this benefit.	Acc: No
D13	**NON-SURGICAL PROCEDURES AND TESTS (See B4)**				
D13.1	**In Hospital**	• No limit. • 150% of the Bonitas Tariff for the medical specialist. • 100% of the Bonitas Tariff for the general practitioner. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• No limit. • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• No limit. • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	Subject to the relevant managed healthcare programme and its prior authorisation in hospital only. This benefit excludes: • Psychiatry and psychology (D12); • Optometric examinations (D15); • Pathology (D18); • Radiology (D21). Acc: No
D13.2	**Out of hospital**	Subject to available savings and/or threshold.	• Limited to R5 540 per beneficiary. • R9 000 per family.	Subject to available savings and/or above threshold benefit.	Acc: Yes

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D13.2.1	· **Routine diagnostic upper and lower gastro-intestinal fibre-optic endoscopy (excluding rigid sigmoidoscopy and anoscopy)** · **24 hr oesophageal PH studies** · **Breast fine needle biopsy** · **Circumcision** · **Cystoscopy** · **Laser tonsillectomy** · **Oesophageal motility studies** · **Vasectomy** · **Prostate needle biopsy** **(See B4)**	• No limit • 100% of the Bonitas Tariff for the general practitioner or medical specialist.	• No limit • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	• No limit • 130% of the Bonitas Tariff for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	Includes related consultation, materials, pathology and radiology if done in the rooms on the same day. On BonComprehensive, the medical specialist will be reimbursed at 150% of the Bonitas Tariff if done in hospital and pre-authorised by the relevant healthcare programme. Acc: No
D13.3	**Sleep studies** **(See B4)**				Subject to registration on the relevant managed healthcare programme and to its prior authorisation.
D13.3.1	**Diagnostic Polysomnograms** **In and out of hospital**	No limit.	No limit.	No limit.	If authorised by the relevant managed healthcare programme for dyssomnias e.g. central sleep apnoea, obstructive sleep apnoea, parasomnias or medical or psychiatric sleep disorders as part of neurological investigations by a relevant specialist.
D13.3.2	**CPAP Titration**	No limit.	No limit.	No limit.	If authorised by the relevant managed healthcare programme for patents with obstructive sleep apnoea who meet the criteria for CPAP and where requested by the relevant specialist.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D14	**ONCOLOGY (See B4)**				Acc: No
D14.1	**Pre active, active & post active treatment period**	• R618 500 per family, unless PMB. • 150% of the Bonitas Tariff for services rendered by the medical specialist. • The Bonitas Oncology Network medical specialist is the preferred provider for oncology services at the negotiated rate. • 100% of the Bonitas tariff for services rendered by non oncology network medical specialists. • Above benefit, limited to PMBs and 40% copay for the voluntary use of services rendered by non oncology network medical specialists.	• R410 400 per family, unless PMB. • The Bonitas Oncology Network medical specialist is the preferred provider for oncology at the negotiated rate. • 100% of the Bonitas tariff for services rendered by non oncology network medical specialists. • Above benefit, limited to PMBs and 40% copay for the voluntary use of services rendered by non oncology network medical specialists.	• R344 500 per family, unless PMB. • The Bonitas Oncology Network medical specialist is the preferred provider for oncology at the negotiated rate. • 100% of the Bonitas tariff for services rendered by non oncology network medical specialists. • Above benefit, limited to PMBs and 40% copay for the voluntary use of services rendered by non oncology network medical specialists.	• Subject to the relevant managed healthcare programme and to its prior authorisation. • Treatment for long-term chronic conditions that may develop as a result of chemotherapy and radiotherapy is not included in this benefit. • Benefit for Oncologists, haematologists and accredited medical practitioners for consultations, visits, treatment and consumable material used in radiotherapy and chemotherapy. • The Specialist Network is the DSP for related oncology services at the Specialist Network (DSP) rate.
D14.1.1	**Medicine (See B5)**	• Limited to and included in D14.1 and subject to the DSP. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to MPL and preferred product list.	• Limited to and included in D14.1 and subject to the DSP. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to MPL and preferred product list.	• Limited to and included in D14.1 and subject to the DSP. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to MPL and preferred product list.	Subject to the Bonitas Oncology Medicine Network.
D14.1.2	**Radiology and pathology (See B4)**	Limited to and included in D14.1.	Limited to and included in D14.1.	Limited to and included in D14.1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D14.1.2.1	**PET and PET – CT (See B4)**	Limited to and included in D14.1 and one per family per annum restricted to staging of malignant tumours.	No benefit.	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation. Specific authorisations are required in addition to any authorisation that may have been obtained for hospitalisation. Only in a credentialed specialist practice.
D14.1.3	**Specialised Drugs (See B5)**				This list includes but is not limited to targeted therapies e.g. biologicals, tyrosine kinase inhibitors, and other non genericised chemotherapeutic agents. Subject to published list. Unless otherwise stated below, any other diseases where the use of the drug is deemed appropriate by the managed health care organization, drugs will be funded from this benefit.
D14.1.3.1	**Biological drugs**	R245 400 per family, limited to and included in D14.1.	No benefit, unless PMB.	No benefit, unless PMB.	
D14.1.3.2	**Unregistered chemotherapeutic agents**	Limited to and included in D14.1.3.1.	No benefit, unless PMB.	No benefit, unless PMB.	Subject to Section 21 approval by the South African Health Products Regulatory Authority (SAHPRA) and pre-authorisation by the relevant managed healthcare programme.
D14.1.3.3	**Proteasome Inhibitors**	Limited to and included in D14.1.3.1.	No benefit, unless PMB.	No benefit, unless PMB.	
D14.1.3.4	**Certain Pyrimidine Analogues**	Limited to and included in D14.1.3.1.	No benefit, unless PMB.	No benefit, unless PMB.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D14.1.4	**Flushing of a J line and/or Port (See B4)**	Limited to and included in D14.1.	Limited to and included in D14.1.	Limited to and included in D14.1.	Subject to the relevant managed healthcare programme
D14.1.5	**Brachytherapy materials (including seeds and disposables) and equipment (See B4)**	Limited to R51 000 per beneficiary and included in D14.1.	Limited to R51 000 per beneficiary and included in D14.1.	Limited to R51 000 per beneficiary and included in D14.1.	Subject to the relevant managed healthcare programme and to its prior authorisation, for services rendered by oncologists, radiotherapists and credentialed medical practitioners.The Specialist Network is the DSP for oncology related services at the Specialist Network (DSP) rate.
D14.2	**Post active treatment period (See B4)**	Limited to and included in D14.1 during the remission period following the active treatment period, except for Prescribed Minimum Benefits.	Limited to and included in D14.1 during the remission period following the active treatment period, except for Prescribed Minimum Benefits.	Limited to and included in D14.1 during the remission period following the active treatment period, except for Prescribed Minimum Benefits.	
D14.2.1	**Flushing of a J line and/or Port (See B4)**	Limited to and included in D14.1.	Limited to and included in D14.1.	Limited to and included in D14.1.	Subject to the relevant managed healthcare programme.
D14.3	**Oncology Social worker (OSW) benefit**	• Limited to R2 950 per family and subject to the Bonitas Oncology (OSW) network. • Limited to and included in D14.1.	• Limited to R2 950 per family and subject to the Bonitas Oncology (OSW) network. • Limited to and included in D14.1.	• Limited to R2 950 per family and subject to the Bonitas Oncology (OSW) network. • Limited to and included in D14.1.	Subject to the relevant managed healthcare protocols and its prior authorisation.
D14.4	**Palliative Care**	• No limit. • Subject to pre-authorisation. • Managed care protocols apply.	• 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D15	**OPTOMETRY (In and Out of Network) (See B4)**	• Subject to available savings and/or above threshold benefit. • Limited to R3 500 per beneficiary. • 100% of the network tariff. • Biennial Benefit. • Benefit availability is subject to a 24 month cycle from last date of service. • No benefit for lens enhancements (tints and coatings).	• Limited to R5 845 per family. • Biennial benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• Subject to available savings and/or above threshold benefit. • Biennial Benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• Subject to pre-authorisation by the contracted provider and subject to clinical protocols. • Failure to obtain pre-authorisation will result in no benefits. • Out-of-network benefits are available as an alternative to network benefits and not an additional benefit. • Frames and/or lenses are mutually exclusive to contact lenses. Acc: Yes
D15.1	**Optometric refraction test, re-exam and/or composite exam, tonometry and visual field test**	• One per beneficiary per benefit cycle, at network tariff. • R350 out of network. • Limited to and included in D15.	• One per beneficiary per benefit cycle, at network rates. • R350 out of network. • Limited to and included in D15.	• One per beneficiary per benefit cycle, at network tariff. • R350 out of network. • Limited to and included in D15.	
D15.2	**Frames**	Limited to and included in D15.	• R1 110 per beneficiary in network. • R833 per beneficiary out of network • Limited to and included in D15.	• R855 per beneficiary in and out of network. • Limited to and included in D15.	On the BonClassic and BonComplete options, the frame value may be used towards frames and/or lens enhancements.
D15.3	**Lenses**				

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D15.3.1	**Single vision lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R210 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R210 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R210 per lens per beneficiary out of network. • Limited to and included in D15; or	Subject to contracted providers protocols.
D15.3.2	**Bifocal lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R445 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R445 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R445 per lens per beneficiary out of network. • Limited to and included in D15; or	
D15.3.3	**Multifocal lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R770 per lens per beneficiary out of network. • Limited to and included in D15.	• 100% towards the cost of clear lenses at network rates. • Limited to R770 per lens per beneficiary out of network. • Limited to and included in D15.	• 100% towards the cost of clear lenses at network rates. • Limited to R770 per lens per beneficiary out of network. • Limited to and included in D15.	
D15.3.4	**Contact lenses**	• Limited to and included in D15. • Limited and included in D15 except for Keratoconus where it is limited to R2 500 included in D3.1.1.	• Limited to R1 880 per beneficiary. • Limited and included in D15.	• Limited to R2 105 per beneficiary. • Limited and included in D15.	
D15.4	**Low vision appliances**	Limited to and included in D3.1.1.	Limited to and included in D3.1.1.	Limited to and included in D3.1.1.	When prescribed by a registered optometrist, ophthalmologist, medical practitioner or supplementary optical practitioner.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D15.5	**Ocular prostheses**	Limited to and included in D20.2.	Limited to and included in D20.2.	Limited to and included in D20.2.	When prescribed by a registered optometrist, ophthalmologist, medical practitioner or supplementary optical practitioner.
D15.6	**Diagnostic procedures**	Limited to and included in D15.	Limited to and included in D15.	Limited to and included in D15.	
D15.7	**Readers**				
D15.7.1	**From a registered optometrist, ophthalmologist or supplementary optical practitioner**	Limited to and included in D15.	No benefit	Limited to and included in D15.	
D15.7.2	**From a registered pharmacy**	Limited to and included in D15.	No benefit.	Limited to and included in D15.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D16	**ORGAN AND HAEMOPOIETIC STEM CELL (BONE MARROW) TRANSPLANTATION AND IMMUNO-SUPPRESIVE MEDICATIONINCLUDING CORNEAL GRAFTS) (See B4)**	• No limit. • 150% of the Bonitas Tariff for services rendered by medical specialists. • 100% of the Bonitas Tariff for the general practitioner. • Corneal grafts are limited to R34 520 per beneficiary for local or imported grafts. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• No limit • 130% of the Bonitas Tariff for services rendered by network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Corneal grafts are limited to R34 520 per beneficiary for local and imported grafts. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• No limit. • 130% of the Bonitas Tariff for services rendered by network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Corneal grafts are limited to R34 520 per beneficiary for local or imported grafts. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme to its prior authorisation. • No benefits will be granted for hospitalisation, treatments and associated clinical procedures if prior authorisation is not obtained. • Organ harvesting is limited to the Republic of South Africa excluding donor cornea. Acc: No
D16.1	**Haemopoietic stem cell (bone marrow transplantation (See B4)**	Limited to and included in D16.	Limited to and included in D16.	Limited to and included in D16.	Haemopoietic stem cell (bone marrow) transplantation is limited to allogenic grafts and autologous grafts derived from the South African Bone Marrow Registry.
D16.2	**Immuno-suppressive medication (See B5)**	Limited to and included in D16.	Limited to and included in D16 and subject to the DSP.	Limited to and included in D16 and subject to the DSP.	
D16.3	**Post transplantation biopsies and scans (See B4)**	Limited to and included in D16.	Limited to and included in D16.	Limited to and included in D16.	
D16.4	**Radiology and pathology (See B4)**	Limited to and included in D16.	Limited to and included in D16.	Limited to and included in D16.	For specified radiology and pathology services, performed by pathologists, radiologists and haematologists, associated with the transplantation treatment.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D17	**PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS) (See B4)**				
D17.1	**In hospital**	No limit.	No limit.	No limit.	Subject to referral by the treating practitioner. Acc: No
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.	100% of BonitasTariff. 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.	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.	100% of Bonitas Tariff. Limited to and included in D17.1.	
D17.2	**Out of hospital**	Subject to available savings and/or above threshold benefit.	Subject to available savings.	Subject to available savings and/or above threshold benefit.	Acc: Yes
D17.2.1	**Audiology**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.2	**Chiropractics**	Limited to and included in D17.2.	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.	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.	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.	Limited to and included in D17.2.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D17.2.6	**Occupational therapy**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.7	**Orthoptics**	Limited to and included in D17.2.	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.	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.	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.	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.	Limited to and included in D17.2.	
D18	**PATHOLOGY AND MEDICAL TECHNOLOGY (See B4)**				Subject to the relevant managed healthcare programme.
D18.1	**In hospital**	• No limit. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• No limit. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• No limit. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	Acc: No

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D18.2	**Out of hospital**	• Subject to the available savings and/or above threshold benefit. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• Limited to R3 410 per beneficiary and to a maximum of R7 550 per family. • 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 and/or above threshold benefit. • 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), • the oncology benefit during the active and/or post active treatment period, (D14); • organ and haemopoietic stem cell transplantation benefit,(D16) • and the renal dialysis chronic benefit, (D22). Acc: Yes
D19	**PHYSICAL THERAPY (See B4)**				
D19.1	**In hospital Physiotherapy Biokinetics**	No limit. 100% of Bonitas Tariff.	No limit. 100% of Bonitas Tariff.	No limit. 100% of Bonitas Tariff.	Subject to referral by the treating practitioner. Physiotherapy is not covered for mental health admissions. See D12. Acc: No
D19.2	**Out of hospital physiotherapy Biokinetics Podiatry**	Subject to available savings and/or above threshold benefit.	Limited to and included in D17.2.	Subject to available savings and/or above threshold benefit.	Acc: Yes

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D20	**PROSTHESES AND DEVICES INTERNAL AND EXTERNAL (See B4)**				
D20.1	**Prostheses and devices internal(surgically implanted), including all temporary prostheses, or/and all accompanying temporary or permanent devices used to assist with the guidance, alignment or delivery of these internal prostheses and devices. This includes bone cement, bone graft substitutes, screws, pins and bone anchors**.	• R60 380 per family, unless PMB. • Sub-limit of R3 720 for a single intra-ocular lens. • R7 440 for bilateral lenses per beneficiary. • Recommend use of preferred supplier.	• R59 830 per family, unless PMB. • Sub-limit of R3 720 for a single intra-ocular lens. • R7 440 for bilateral lenses per beneficiary. • Recommend use of preferred supplier.	• R48 440 per family, unless PMB. • Sub-limit of R3 720 for a single intra-ocular lens. • R7 440 for bilateral lenses per beneficiary. • Recommend use of preferred supplier.	Subject to the relevant managed healthcare programme and to its prior authorisation. This benefit excludes Osseo-integrated implants for the purpose of replacing a missing tooth or teeth. Acc: No
D20.1.1	**Cochlear implants**	• R304 300 per family. • Recommend use of preferred supplier.	• R304 300 per family. • Recommend use of preferred supplier.	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D20.1.2	**Internal Nerve stimulator**	R181 400 per family.	No benefit.	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D20.2	**Prostheses external**	• R60 380 per family, unless PMB. • Limited to R5 760 per external breast prosthesis and limited to two per annum. • Recommend use of preferred supplier.	• Limited to and included in D20.1. • Limited to R5 760 per external breast prosthesis and limited to two per annum.	• Limited to and included in D20.1. • Limited to R5 760 per external breast prosthesis and limited to two per annum.	Subject to the relevant managed healthcare programme and to its prior authorisation. The benefit excludes consultations/fittings, which are subject to D17.2.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D21	**RADIOLOGY (See B4)**				
D21.1	**General radiology**				
D21.1.1	**In hospital**	No limit.	No limit.	No limit.	For diagnostic radiology tests and ultrasound scans. Authorisation is not required for MRI scans for low field peripheral joint examination of dedicated limb units. Acc: No
D21.1.2	**Out of hospital**	Subject to available savings and/or above threshold benefit.	Limited to and included in D18.2	Subject to available savings and/or above threshold benefit.	This benefit excludes: specified list of radiology tariff codes included in the • maternity benefit, (D10), • the oncology benefit during the active treatment and/or post active treatment period, (D14); • the organ and haemopoietic stem cell transplantation benefit, (D16), • renal dialysis chronic benefit, (D22). Authorisation is not required for MRI scans for low field peripheral joint examination of dedicated limb units. Acc: Yes.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D21.2	**Specialised radiology**				
D21.2.1	**In hospital**	• R34 340 per family. • R1 560 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.	• R31 770 per family. • R1 560 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.	• R25 570 per family. • R1 560 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 then evaluation of symptomatic patients only. Acc: No
D21.2.2	**Out of hospital**	Limited to and included in D21.2.1.	Limited to and included in D21.2.1.	Limited to and included in D21.2.1.	See D21.2.1.
D21.3	**PET and PET – CT**	See D14.1.2.1.	See D14.1.2.1.	See D14.1.2.1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D22	**RENAL DIALYSIS CHRONIC (See B4)**				Acc: No
D22.1	**Haemodialysis and peritoneal dialysis**	• No limit. • 100% of the lower of the cost or Bonitas Tariff for all services, medicines and materials associated with the cost of renal dialysis, subject to the DSP network and Regulation 8 (3). • 150% of the Bonitas Tariff for the services rendered by a medical specialist. • 20% co-payment applies for the voluntary use of a non-DSP.	• No limit. • 100% of the lower of the cost or Bonitas Tariff for all services, medicines and materials associated with the cost of renal dialysis, subject to the DSP network and Regulation 8 (3). • 130% of the Bonitas Tariff for the services rendered by a network specialist and 100% of the Bonitas Tariff for the services rendered by a non-network specialist. • Related medicine 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). • 130% of the Bonitas Tariff for the services rendered by a network specialist and 100% of the Bonitas Tariff for the services rendered by a non-network specialist. • Related medicine 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 B4)**	Limited to and included in D22.1.	Limited to and included in D22.1.	Limited to and included in D22.1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D23	**SURGICAL PROCEDURES (See B4)**				
D23.1	**In hospital and unattached operating theatres and other minor surgical procedures that can be authorised in hospital**	• Limited to and included in D7.1.1 or D7.2.1. • 150% of the Bonitas Tariff for services rendered by medical specialists. • 100% of the Bonitas Tariff for the general practitioner. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3). • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• Limited to and included in D7.1.1 or D7.2.1. • 130% of the Bonitas Tariff for services rendered by network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Co-payments apply – See paragraph D23.3 below. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3). • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• Limited to and included in D7.1.1 or D7.2.1. • 130% of the Bonitas Tariff for services rendered by network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Co-payments apply – See paragraph D23.3 below. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3). • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	This benefit excludes: • Osseo-integrated implants (D6); • Orthognathic and oral surgery (D6); • Maternity (D10); • Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16). Acc: No

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D23.1.1	**Refractive surgery**	• R22 760 per family at 100% of the Bonitas Tariff for refractive surgery such as Lasik, Radial Keratotomy and Phakic Lens Insertion. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	No benefit.	No benefit.	Acc: No
D23.1.2	**Maxillo-facial surgery**	• Limited to and included in D7.1.1 or D7.2.1. • 150% of the Bonitas Tariff for services rendered by the medical specialist.	• Limited to and included in D7.1.1 or D7.2.1. • 100% of the Bonitas Tariff for services rendered by the medical specialist.	• Limited to and included in D7.1.1 or D7.2.1. • 100% of the Bonitas Tariff for services rendered by the medical specialist.	Subject to the relevant managed healthcare programme and to its prior authorisation. For the surgical removal of • tumours • neoplasms • sepsis, • trauma, • congenital birth defects and other surgery not specifically mentioned in (D6). This benefit excludes: • Osseo-integrated implantation (D6); • Orthognathic surgery (D6); • Oral surgery (D6); • Impacted wisdom teeth (D6).
D23.2	**Out of hospital in practitioners rooms**	Subject to available savings and/or above threshold benefit.	Subject to available savings.	Subject to available savings and/or above threshold benefit.	Acc: Yes

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D23.3	**PROCEDURES THAT WILL ATTRACT A DEDUCTIBLE**				
D23.3.1	**Procedures which will attract a deductible:** **Hip or knee arthroplasty**	Subject to a R31 170 co-payment: • when hip or knee arthroplasty is performed by a non-DSP	• Subject to a R31 170 co-payment: • when hip or knee arthroplasty is performed by a non-DSP.	• Subject to a R31 170 co-payment: • when hip or knee arthroplasty is performed by 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.
	Spinal surgery	Subject to a R15 590 co-payment : • when spinal surgery is performed without prior assessment and/or intervention by the contracted conservative back programme.	Subject to a R15 590 co-payment • when spinal surgery is performed without prior assessment and/or intervention by the contracted conservative back programme.	Subject to a R15 590 co-payment • when spinal surgery is performed without prior assessment and/or intervention by the contracted conservative back programme.	
	Cataract Surgery	Subject to a R6 230 co-payment: • For voluntary use of a non-DSP.	Subject to a R6 230 co-payment • For voluntary use of a non-DSP.	Subject to a R6 230 co-payment • For voluntary use of a non-DSP.	
D23.4	**Day Surgery Procedures**	• Subject to the Day Surgery Network. • R2 290 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the Day Surgery Network. • R2 290 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the Day Surgery Network. • R2 290 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)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D24	**PREVENTATIVE CARE BENEFIT (See B4)**				Acc: No
D24.1	**Women's Health Breast Cancer Screening** **Cervical Cancer Screening**	• Mammogram Females age >40 years Once every 2 years. • Pap Smear Females 21-65 years Once every 3 years.	• Mammogram Females age >40 years Once every 2 years. • Pap Smear Females 21-65 years Once every 3 years.	• Mammogram Females age >40 years Once every 2 years. • Pap Smear Females 21-65 years Once every 3 years.	
D24.2	**Men's Health PSA test**	Men 45-69 years, 1 per annum.	Men 45-69 years, 1 per annum.	Men 45-69 years, 1 per annum.	
D24.3	**General Health**	• HIV test annually. • Flu vaccine annually, including the administration fee of the nurse practitioner.	• HIV test annually. • Flu vaccine annually, including the administration fee of the nurse practitioner.	• HIV test annually. • Flu vaccine annually, including the administration fee of the nurse practitioner.	HIV test is limited to one (1) per beneficiary per annum, either as part of Preventative Care or Health Risk Assessment. See D27.1
D24.4	**Cardiac health: Cholesterol**	• Full Lipogram From age 20 years Once every 5 years.	• Full Lipogram From age 20 years Once every 5 years.	• Full Lipogram From age 20 years Once every 5 years.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D24.5	**Elderly Health**	• Pneumococcal Vaccination, including the administration fee of the nurse practitioner. Age >65 Once every 5 years. • Faecal Occult Blood Test Ages 50 - 75 annually. • Bone Densitometry Screening Females >Age 65 Once every 5 years and Males >Age 70 Once every 5 years.	• Pneumococcal Vaccination, including the administration fee of the nurse practitioner. Age >65 Once every 5 years. • Faecal Occult Blood Test Ages 50 - 75 annually. • Bone Densitometry Screening Females >Age 65 Once every 5 years and Males >Age 70 Once every 5 years.	• Pneumococcal Vaccination, including the administration fee of the nurse practitioner. Age >65 Once every 5 years. • Faecal Occult Blood Test Ages 50 - 75 annually.	
D24.6	**Children's health Hypothyroidism** **Infant Hearing Screening**	• 1 TSH Test Age <1 month • One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	• 1 TSH Test Age <1 month • One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	• 1 TSH Test Age <1 month • One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	
	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.	• Various Vaccinations, including the administration fee of the nurse practitioner for children up to the age of 12 years.	As per State EPI protocols.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D25	**INTERNATIONAL TRAVEL BENEFIT** **Leisure travel:** **Business Travel:**	• For medical emergencies when travelling outside the borders of South Africa. ○ 90 days excluding USA - R5 million per Member, R10 million for Member and Dependants ○ 45 days including USA – Maximum cover R500,000 for Member and Dependants ○ 45 days excluding USA - R5 million per Member, 10 million for Member and Dependants ○ 45 days including USA - Maximum cover R500,000 for Member and Dependants. Subject to approval protocols prior to departure.	• For medical emergencies when travelling outside the borders of South Africa. ○ 90 days excluding USA - R5 million per Member, R10 million for Member and Dependants ○ 45 days including USA – Maximum cover R500,000 for Member and Dependants ○ 45 days excluding USA - R5 million per Member, 10 million for Member and Dependants ○ 45 days including USA - Maximum cover R500,000 for Member and Dependants. • Subject to approval protocols prior to departure.	• For medical emergencies when travelling outside the borders of South Africa. ○ 90 days excluding USA - R5 million per Member, R10 million for Member and Dependants ○ 45 days including USA – Maximum cover R500,000 for Member and Dependants ○ 45 days excluding USA - R5 million per Member, 10 million for Member and Dependants ○ 45 days including USA - Maximum cover R500,000 for Member and Dependants. Subject to approval protocols prior to departure.	Subject to authorisation, prior to departure. Acc: No • The three months' age limit will not apply. • Emergency medical expenses incurred in connection with cardiac, cardiovascular, vascular, cerebrovascular illness or conditions consequence or complications related to persons 70 years and older are restricted to a limit of R500 000 (five hundred thousand). • 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)
D26	**AFRICA BENEFIT**	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	The Fund's liability will not exceed the global amount the Fund would in the ordinary course pay for such healthcare services given the Fund's claims experience in South Africa, subject to the benefits as per benefit plan. Acc: No

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D27	**WELLNESS BENEFIT**				Acc: No
D27.1	**Health Risk Assessment (HRA) which includes** **Lifestyle questionnaire** **Wellness screening**	Wellness screening. One assessment per beneficiary per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to: • blood pressure test • glucose test • cholesterol test • body mass index • hip to waist ratio • HIV counselling and testing.	Wellness screening. One assessment per beneficiary per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to: • blood pressure test • glucose test • cholesterol test • body mass index • hip to waist ratio • HIV counselling and testing.	Wellness screening. One assessment per beneficiary per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to: • blood pressure test • glucose test • cholesterol test • body mass index • hip to waist ratio • HIV counselling and testing.	HIV test is limited to one (1) per beneficiary per annum, either as part of Preventative Care or Health Risk Assessment. See D24.3.

REGISTERED BY ME ON
2021/10/25
Mashilo Leboho
26/10/2021 15:48:33 (UTC+02:00)
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SIGNIFLOW.COM
REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D27.2	**Benefit Booster (including out of hospital day-to-day services as mentioned in D1, D5.1.3, D5.1.4, D5.2, D11.1, D11.2, D13.2, D17.2, D18.2, D19.2, D21.1.2, D24 and virtual consultations).**	Subject to completion of a Health Risk Assessment or the completion of an online wellness assessment per beneficiary. Limited to R2 730 per family. Limited to: • Alternative Health: D1 • GP consultations: D5.1.3 & D5.1.4. • Medical specialists: D5.2 • Acute medication: D11.1 • Pharmacy advised therapy: D11.2 • Non-surgical procedures: D13.2 • Paramedical services: D17.2 • Pathology: D18.2 • Physical therapy : D19.2 • General radiology: D21.1.2	Subject to completion of a Health Risk Assessment or the completion of an online wellness assessment per beneficiary. Limited to R1 880 per family. Limited to: • Alternative Health: D1 • GP consultations: D5.1.3 & D5.1.4. • Medical specialists: D5.2 • Acute medication: D11.1 • Pharmacy advised therapy: D11.2 • Non-surgical procedures: D13.2 • Paramedical services: D17.2 • Pathology: D18.2 • Physical therapy: D19.2 • General radiology: D21.1.2	Subject to completion of a Health Risk Assessment or the completion of an online wellness assessment per beneficiary. Limited to R1 880 per family. Limited to: • Alternative Health: D1 • GP consultations: D5.1.3 & D5.1.4. • Medical specialists: D5.2 • Acute medication: D11.1 • Pharmacy advised therapy: D11.2 • Non-surgical procedures: D13.2 • Paramedical services: D17.2 • Pathology: D18.2 • Physical therapy: D19.2 • General radiology: D21.1.2	• Child dependants will qualify for the Benefit Booster once the main member or an adult beneficiary has completed a Health Risk Assessment or an online wellness assessment. • Valid qualifying claims will pay first from the benefit booster and thereafter from the relevant benefits as described in D1 – D24.