Bonitas

BONITAS MEDICAL FUND

ANNEXURE B

OPTIONS:

BONCOMPREHENSIVE

BONCLASSIC

BONCOMPLETE

2024

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A ENTITLEMENT OF BENEFITS

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

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

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

A3.1 Specialist Network

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

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

A3.1.2 In-Specialist Network, in hospital rates are applicable as follows:
- The contracted rate for the BonComplete and BonClassic Options.

A3.1.3 In-Specialist Network, out of hospital rates are applicable as follows:
- The contracted rate for the BonComplete and BonClassic Options.

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

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 (PMSA) account is exhausted on the BonClassic Option no further benefits are 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 Above 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) if a non-contracted pharmacy is used. Both subject to the reimbursement limit, i.e. Medicine Price List and applicable formularies. Co-payments to apply where relevant.

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		R27 258	R11 774
Add per adult dependant	=	R25 146	R9 536
Add per child dependant	=	R6 406	R3 086

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 and Haematologists
- Consultations with Ophthalmologists
- Specialist to specialist referral.

On depletion of benefits, PMB above limits will only be applicable via the contracted Designated Service Providers of the Fund (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 710 A: R3 350 C: R1 460	
	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.	
D1.6	**Osteopathy**	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
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. 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.	• Subject to available savings.	• Subject to available savings and/or above threshold benefit.	Hiring or buying medical or surgical aids as prescribed by a medical practitioner. Acc: Yes
D3.1.2	**Hearing Aids and repairs**	• Limited to R10 300 per device (maximum of two devices per beneficiary) over a three year cycle. • A 25% co-payment will apply to devices obtained from a non-DSP. • Benefit is available per beneficiary every three years based on the last claim date.	• Limited to R9 200 per device (maximum of two devices per beneficiary) over a three year cycle. • A 25% co-payment will apply to devices obtained from a non-DSP. • Benefit is available per beneficiary every three years based on the last claim date.	• Limited to R9 200 per device (maximum of two devices per beneficiary) over a three year cycle. • A 25% co-payment will apply to devices obtained from a non-DSP. • Benefit is available per family every three years based on the last claim date.	Subject to the Audiology Benefit Management Programme (ABM). Acc: Yes, when paid from savings
	Audiology Services	• Network: All tests and consultations limited to the Audiology Benefit	• Network: All tests and consultations limited to the Audiology Benefit	• Network: All tests and consultations limited to the Audiology Benefit	Subject to the Audiology Benefit Management Programme. The Benefit Booster (D27.2) does not apply.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		Management Programme (ABM). • Non-network: Limited to and included in D1.	Management Programme (ABM). • Non-network: Limited to and included in D1.	Management Programme (ABM). • Non-network: Limited to and included in D1.	
	Hearing Aid Acoustic Services REGISTERED BY ME ON Mfana Maswanganyi 2024/01/23 25/01/2024 10:44:55(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za SIGNFLOW.COM REGISTRAR OF MEDICAL SCHEMES	• Network: All tests and consultations limited to the Audiology Benefit Management Programme (ABM). • Non-network: Limited to and included in D1.	• Network: All tests and consultations limited to the Audiology Benefit Management Programme (ABM). • Non-network: Limited to and included in D1.	• Network: All tests and consultations limited to the Audiology Benefit Management Programme (ABM). • Non-network: Limited to and included in D1.	Subject to the Audiology Benefit Management Programme. The Benefit Booster (D27.2) does not apply.
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.	
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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D3.15.5	**Insulin Pump Therapy Continuous Glucose Infusion Monitor (CGM)**	• R85 000 per family per annum for insulin pump or CGM device. • Limited to one device per Type 1 Diabetic for beneficiaries younger than 18 years every 5 years; and • R85 000 per family for insulin pump or CGM consumables.	R85 000 per family per annum for insulin pump or CGM device. • Limited to one device per Type 1 Diabetic for beneficiaries younger than 18 years every 5 years; and • R85 000 per family for insulin pump or CGM consumables.	• R85 000 per family per annum for insulin pump or CGM device. • Limited to one device per Type 1 Diabetic for beneficiaries younger than 18 years every 5 years; and • R85 000 per family for insulin pump or CGM consumables.	• Subject to pre-authorisation by the relevant managed healthcare programme and its prior authorisation. • Once the benefit for consumables is exceeded the benefit for the pump or the appliance benefit may not be utilized to cover the cost.
D4	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS (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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
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
D5.1.2	**Out of Hospital GP consultations, Including virtual consultations with network GPs**	100% of 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	• No limit	• No limit	All consultations and procedures within the Specialist Network will

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		• 150% of Bonitas Tariff for medical and dental specialists.	• The contacted rate applies for network specialists. • 100% of Bonitas Tariff for non-network specialists.	• The contracted rate applies for network specialists. • 100% of Bonitas Tariff for non-network specialists.	be paid at the negotiated Tariff, with no co-payment applicable. Acc: No
5.2.2	**Out of Hospital (See A3)** REGISTERED BY ME ON Mfana Maswanganyi 2024/01/23 25/01/2024 10:39:17(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES	• 100% at Bonitas Tariff. Subject to available savings and/or above threshold benefit.	• Subject to available savings. • The contracted rate applies for network specialists. • 100% of Bonitas Tariff for non-network Specialists.	• Subject to available savings and/or above threshold benefit. • The contracted rate applies 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 Haematologists, Ophthalmologists and Oncologists. • Specialist to specialist referrals. Acc: Yes
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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D6	**DENTISTRY (SEE B4)**				Subject to the Dental Management Programme. Acc: Yes, when paid from savings.
D6.1	**BASIC DENTISTRY**		Limited to R5 812 per family per annum.		
D6.1.1	**Consultations**	• Once in 6 months • Subject to available savings and/or above threshold benefit. • Covered at 100% of the BDT	• Limited to two general check-ups (once in 6 months) per beneficiary per year. • Covered at 100% of the BDT.	• Limited to two general check-ups (once in 6 months) per beneficiary per year. • Covered at 100% of 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	• 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.
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.	• 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. • Limited to and included in D6.1.	• 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 the BDT.	Covered at 100% of the BDT and managed care protocols apply.	Covered at 100% of the BDT and managed care protocols apply.	Subject to managed care protocols.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D6.1.5	**Root Canal therapy**	• Subject to available savings and/or above threshold benefit. • Covered at 100% of the BDT.	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. • Covered at 100% of the BDT.	• 2 Annual scale and polish treatments per beneficiary (once in 6 months). • Covered at 100% of the BDT.	• 2 Annual scale and polish treatments per beneficiary (once in 6 months). • Covered at 100% of 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
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. • Covered at 100% of the BDT.	• Subject to pre-authorisation. • Covered at 100% of the BDT. • 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.	• Subject to pre-authorisation. • Covered at 100% of the BDT • 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.	• Pre-authorisation is required for moderate/deep sedation in the rooms and is limited to extensive dental treatment where managed care protocols apply. On BonClassic and BonComplete, the following co-payments will apply: • A co-payment of R3 500 per hospital admission for children younger than 5 years and R5 000 for any other admission, including removal of impacted teeth or medical admission; or • R2 500 upfront co-payment to apply for any admission, including removal of impacted teeth or medical admission if the dental treatment is done in a Day Clinic. • The co-payments on BonClassic and

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
			• Subject to the BonClassic Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• Subject to the BonComplete Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	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.	
D6.1.9	**X-rays**	• Covered at 100% of the BDT for intra-oral x-rays. Extra-oral x-rays will be covered at 100% of the BDT subject to 1 per beneficiary in a 3 year period. • 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 per beneficiary 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 per beneficiary 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	**SPECIALISED DENTISTRY (See B4)**	Subject to available savings and/or above threshold benefit.	Limited to R6 997 per family per annum.	No benefit unless otherwise specified.	Subject to pre-authorisation and dental management protocols.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D6.2.1	**Crowns**	• 3 crowns per family per year, subject to pre-authorisation. • Covered at 100% of the BDT. • 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. • Covered at 100% of the BDT. • Subject to pre-authorisation. • Benefits for crowns will be granted once per tooth in 5 years.	• 1 Crown per family per year. • Covered at 100% of the BDT. • 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.
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 R3 387 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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
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.
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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
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. • Covered at 100% of the BDT.	• 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 • Covered at 100% of the BDT.	• 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. • Covered at 100% of the BDT.	
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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D7.1.1	**In Hospital**	• No limit. • Deep Brain Stimulation Implantation for Parkinson's and intractable epilepsy is limited to R272 300 per beneficiary (excluding the prosthesis benefit). • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• No limit. • No benefit for Deep Brain Stimulation Implantation. • Subject to the BonClassic Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• No limit. • No benefit for Deep Brain Stimulation Implantation. • Subject to the BonComplete Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • 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 R635 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 R575 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.	Where the script amount exceeds the benefit, the balance will be subject to available savings. Acc: Yes, when paid from savings.
D7.1.3	**Casualty/emergency room visits**				The risk benefit is maximum 2 visits per family either in a private or public hospital setting.
D7.1.3.1	**Facility fee**	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies.	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies.	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies.	Will be included in the hospital benefit if a retrospective authorisation is given by the relevant managed healthcare

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		• Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are subject to available savings and/or above threshold benefit.	• Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are subject to available savings.	• Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are subject t to available savings and/or above threshold benefit.	programme for bona fide emergencies. Acc: Yes, when paid from savings.
D7.1.3.2	**Consultations** REGISTERED BY ME ON Mfana Maswanganyi 2024/01/23 25/01/2024 10:39:32(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.2 and D5.2.2.	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.2 and D5.2.2.	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.2 and D5.2.2.	
D7.1.3.3	**Medicine**	See D11.1.	See D11.1.	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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
					immunosuppressive medication (D16); • Renal dialysis chronic (D22); • Refractive surgery (D23.1.1). Acc: No
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 R635 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 R575 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.	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**				The risk benefit is maximum 2 visits per family either in a private or public hospital setting.
D7.2.3.1	**Facility Fee**	• Limited to 2 emergency rooms vists per family, limited to and included in the OAL for bona fide emergencies. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are subject to available savings and/or above threshold benefit.	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are subject to available savings.	• Limited to 2 emergency rooms visits per family, limited to and included in the OAL for bona fide emergencies. • Subsequent emergency rooms visits without pre-authorisation or non-emergency visits are 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**	• Limited to 2 consultations per family, limited to and	• Limited to 2 consultations per family,	• Limited to 2 consultations per family,	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		included in the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.2 and D5.2.2.	limited to and included in the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in.1.2 and D5.2.2.	limited to and included in the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or non-emergency consultations are limited to and included in D5.1.2 and D5.2.2.	
D7.2.3.3	**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.	
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**	R57 890 per family for all services.	R61 480 per family for all services.	R61 480 per family for all services.	See D7.3.
D7.3.2	**Sub-acute facilities including Hospice**	R19 310 per family.	R20 500 per family.	R20 500 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
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.
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 – D27.	Limited to and included in D1 - D7 and D9 – D27.	Limited to and included in D1 - D7 and D9 – D27.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	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.	• No limit., • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. Subject to the BonClassic Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions	• No limit. • The contacted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Subject to the BonComplete Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions	Delivery by a general practitioner or medical specialist and the services of the attendant paediatrician and/or anaesthetists are included. Included in 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.	
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.	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used for a lactation specialist consultation out of hospital. • Subject to the BonClassic Hospital Network.	• Limited to and included in D10.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) may be used for a lactation specialist consultation out of hospital. • Subject to the BonComplete Hospital Network.	• 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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
			• 30% co-payment to apply to all voluntary non-network admissions.	• 30% co-payment to apply to all voluntary non-network admissions.	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.	
D10.3.1	**Ante-natal consultations**	• 12 ante-natal consultations by a specialist, general practitioner or midwife. • R1 500 for ante-natal classes/exercises per pregnancy.	• 12 ante-natal consultations by a specialist, general practitioner or midwife. • R1 500 for ante-natal classes /exercises per pregnancy.	• 6 ante-natal consultations by a specialist, general practitioner or midwife. • R1 500 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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D11	**MEDICINE AND INJECTION MATERIAL (See B4 and B5)**				
D11.1	**Routine/ (acute) medicine**	• Subject to available savings and above threshold benefit, limited to R16 970 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.
D11.1.2	**Contraceptives**	• Limited to R1 950 per family. • Limited to females up to the age of 50 years.	• Limited to R1 950 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 950 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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D11.3	**Chronic medicine (See B4)**	• R34 140 per family. • R17 150 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.	• R29 040 per family. • R14 050 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. • R150 per beneficiary per month for Depression, subject to managed care protocols and the DSP.	Subject to registration on the relevant managed healthcare programme and to its prior authorisation and applicable formularies. Restricted to a maximum of one month's supply unless pre-authorised. Includes diabetic disposables such as • syringes, • needles, • strips • 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
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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
					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
D11.4.1	**Non Oncology Biological Drugs applicable to monoclonal antibodies interleukins**	• R235 200 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**	• R62 930 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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
					osteodystrophy as a result of chronic kidney disease. The co-payment will be applicable to the non-PMB diseases.
D12	**MENTAL HEALTH (See B4 and B9)**	• R56 960 per family, unless PMB.	• R50 070 per family, unless PMB.	• R39 150 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.	• Limited to and included in D12. • Subject to the BonClassic Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• Limited to and included in D12. • Subject to the BonComplete Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	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)**	• R19 310 per family, limited to and included in D12. • Educational psychology visits and psychometry assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	• R19 310 per family, limited to and included in D12. • Educational psychology visits and psychometry assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	• R19 310 per family, limited to and included in D12. • Educational psychology visits and psychometry assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	Acc: No REGISTERED BY ME ON Mfana Maswanganyi 2024/01/23 25/01/2024 10:35:42(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za SIGNFLOW.COM REGISTRAR OF MEDICAL SCHEMES
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.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Subject to the BonClassic Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• No limit. • The contacted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Subject to the BonComplete Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	Subject to the relevant managed healthcare programme and its prior authorisation in hospital only. This benefit excludes: • Psychiatry and psychology (D12); • Optometric examinations (D15); • Pathology (D18); • Radiology (D21). Acc: No
D13.2	**Out of hospital**	Subject to available savings and/or threshold.	• Limited to R6 260 per beneficiary. • R10 180 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	· **24 hr oesophageal PH studies** · **Breast fine needle biopsy** · **Circumcision** · **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 • The contacted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	• No limit • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	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. 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.
D13.3.1	**Diagnostic Polysomnograms** **In and out of hospital**	• No limit. • 100% of the Bonitas Tariff for the general practitioner or medical specialist.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist	If authorised by the relevant managed healthcare programme for dyssomnias e.g. central sleep apnoea, obstructive sleep apnoea, parasomnias or medical or psychiatric sleep disorders as part of neurological investigations by a relevant specialist.
D13.3.2	**CPAP Titration**	• No limit. • 100% of the Bonitas Tariff for the general practitioner or medical specialist.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	• No limit. • The contracted rate applies for network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	If authorised by the relevant managed healthcare programme for patents with obstructive sleep apnoea who meet the criteria for CPAP and where requested by the relevant specialist.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D14	**ONCOLOGY (See A4 & B4)**				Acc: No Where more than one co-payment apply, the lower of the co-payments will be waived and the highest will be the member's liability.
D14.1	**Pre active, active & post active treatment period** Rejected	• R426 000 per family for ~~PMB~~ and non-PMB oncology. • Thereafter, unlimited for PMB oncology. • Above benefit limit, non-PMB oncology, excluding specialised drugs, is unlimited at a network provider, subject to a 20% co-payment. • The Bonitas Oncology Network is the DSP for oncology services at the contracted network rate. • 100% of the Bonitas Tariff for services rendered by non-network oncology providers. • 30% co-payment applies for the voluntary use of services rendered by non-network oncology providers, subject to Regulation 8 (3).	• R319 500 per family for ~~PMB~~ and non-PMB oncology. • Thereafter, unlimited for PMB oncology. • Above benefit limit, non-PMB oncology, excluding specialised drugs, is unlimited at a network provider, subject to a 20% co-payment. • The Bonitas Oncology Network is the DSP for oncology at the contracted network rate. • 100% of the Bonitas Tariff for services rendered by non-network oncology providers. • 30% co-payment applies for the voluntary use of services rendered by non-network oncology providers, subject to Regulation 8 (3).	• R266 300 per family for ~~PMB~~ and non-PMB oncology. • Thereafter, unlimited for PMB oncology. • Above benefit limit, non-PMB oncology is unlimited at a network provider, subject to a 20% co-payment. • The Bonitas Oncology Network medical specialist is DSP for oncology at the contracted network rate. • 100% of the Bonitas Tariff for services rendered by non-network oncology providers. • 30% co-payment applies for the voluntary use of services rendered by non-network oncology providers, subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and to its prior authorisation. • All costs related to approved cancer treatment including PMB treatment will add up to the oncology benefit limit. • Treatment for long-term chronic conditions that may develop as a result of chemotherapy and radiotherapy is not included in this benefit. • Benefit is for Oncologists, Haematologists and approved providers for consultations, visits, treatment and consumable material used in radiotherapy and chemotherapy. • The Oncology Network is the DSP for related oncology services at the Oncology Network (DSP) rate. • Pre- and post-active consultations and investigations are subject to Cancer Care Plans.
D14.1.1	**Medicine (excluding Specialised Drugs) See D14.1.3 (See B5)**	• Limited to and included in D14.1 and subject to the Oncology Medicine • DSP Network.	• Limited to and included in D14.1 and subject to the Oncology Medicine DSP Network.	• Limited to and included in D14.1 and subject to the Oncology Medicine DSP Network.	Subject to the Bonitas Oncology Medicine DSP Network.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		• 20% co-payment applies for the voluntary use of a non-DSP. • Subject to MPL and preferred product list.	• 20% co-payment applies for the voluntary use of a non-DSP. • Subject to MPL and preferred product list.	• 20% co-payment applies for the voluntary use of a non-DSP. • Subject to MPL and preferred product list.	
D14.1.2	**Radiology and pathology (See 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 and to its prior authorisation. • Limited to Cancer Care Plans in pre-active and post-active setting. • Specific authorisations are required for advanced radiology in addition to any authorisation that may have been obtained for hospitalisation.
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.
D14.1.3	**Specialised Drugs (See B5)**				Specialised drugs include biological, immunologic and targeted therapies. This list includes but is not limited to targeted therapies e.g. biologicals, , and other non-genericised chemotherapeutic agents. Unless otherwise stated below, any other diseases where the

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
					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**	• R426 000 per family, limited to and included in D14.1. • No benefit applies above the Specialised Drug benefit limit, unless PMB.	• R150 000 per family, limited to and included in D14.1. • No benefit applies above the Specialised Drug benefit limit, unless PMB.	No benefit, unless PMB.	
D14.1.3.2	**Unregistered chemotherapeutic agents**	Limited to and included in D14.1.3.1.	Limited to and included in D14.1.3.1.	No benefit, unless PMB.	Subject to Section 21 approval by the South African Health Products Regulatory Authority (SAHPRA) and oncology pre-authorisation, managed care protocols and processes.
D14.1.4	**Flushing of a J line and/or Port (See 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 disposablesand equipment) (See B4)**	Limited to R57 680 per beneficiary and included in D14.1.	Limited to R57 680 per beneficiary and included in D14.1.	Limited to R57 680 per beneficiary and included in D14.1.	Subject to the relevant managed healthcare programme and to its prior authorisation, for services rendered by oncologists, radiotherapists and credentialed medical practitioners.The Oncology Network is the DSP for oncology related services at the Oncology Network (DSP) rate.
D14.2	**Oncology Social Worker (OSW) benefit**	• Limited to R3 330 per family. • Limited to and included in D14.1.	• Limited to R3 330 per family. • Limited to and included in D14.1.	• Limited to R3 330 per family. • Limited to and included in D14.1.	Subject to the relevant managed healthcare protocols and its prior authorisation.
D14.3	**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 860 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 R6 440 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. • R380 out of network. • Limited to and included in D15.	• One per beneficiary per benefit cycle, at network rates. • R380 out of network. • Limited to and included in D15.	• One per beneficiary per benefit cycle, at network tariff. • R380 out of network. • Limited to and included in D15.	• Contracted Providers – 100% of cost for a Composite Consultation inclusive of the refraction, a glaucoma screening, visual field screening and artificial intelligence screening. • Non-contracted Provider – Eye examination
D15.2	**Frames**	Limited to and included in D15.	• R1 280 per beneficiary in network. • R960 per beneficiary out of network • Limited to and included in D15.	• R945 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**				
D15.3.1	**Single vision lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R215 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R215 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R215 per lens per beneficiary out of network. • Limited to and included in D15; or	Subject to contracted providers protocols.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D15.3.2	**Bifocal lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R460 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R460 per lens per beneficiary out of network. • Limited to and included in D15; or	• 100% towards the cost of clear lenses at network rates. • Limited to R460 per lens per beneficiary out of network. • Limited to and included in D15; or	REGISTERED BY ME ON Mfana Maswanganyi 2024/01/23 25/01/2024 10:44:11(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES
D15.3.3	**Multifocal lenses**	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R810 per base lens and R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R810 per base lens and R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R810 per base lens and R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.	
D15.3.4	**Contact lenses**	• Limited to and included in D15. • Limited and included in D15 except for Keratoconus where it is limited to R2 755 included in D3.1.1.	• Limited to R2 065 per beneficiary. • Limited and included in D15.	• Limited to R2 320 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.
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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
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.	
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 R36 760 per beneficiary for local or imported grafts.	• No limit • The contracted rate applies for services rendered by network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Corneal grafts are limited to R39 040 per beneficiary for local and imported grafts. • Subject to the BonClassic Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• No limit. • The contracted rate applies for services rendered by network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist. • Corneal grafts are limited to R39 040 per beneficiary for local or imported grafts. • Subject to the BonComplete Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• Subject to the relevant managed healthcare programme to its prior authorisation. • No benefits will be granted for hospitalisation, treatments and associated clinical procedures if prior authorisation is not obtained. • Organ harvesting is limited to the Republic of South Africa excluding donor cornea and donor bone marrow. 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 Bone Marrow Registries in accordance with managed care protocols
D16.2	**Immuno-suppressive medication**	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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
	(See B5)				
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.
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. • 100% of the Bonitas Tariff.	• Subject to available savings. • 100% of the Bonitas Tariff.	• Subject to available savings and/or above threshold benefit. • 100% of the Bonitas Tariff.	Acc: Yes
D17.2.1	**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.
D17.2.2	**Dietetics**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.23	**Genetic counselling**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.4	**Occupational therapy**	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
D17.2.5	**Orthoptics**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.6	**Orthotists and Prosthetists**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.7	**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.
D17.2.8	**Speech therapy**	Limited to and included in D17.2.	Limited to and included in D17.2.	Limited to and included in D17.2.	
D17.2.9	**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
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	• Limited to R3 860 per beneficiary and to a maximum of R8 540 per family. • Subject to the DSP for pathology at negotiated rates.	• 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	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);

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		rendered by non-DSP providers.	• 100% of the Bonitas Tariff for services rendered by non-DSP providers.	rendered by non-DSP providers.	• Organ and haemopoietic stem cell transplantation benefit,(D16) • 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. • 100% of Bonitas Tariff.	• Limited to and included in D17.2. • 100% of Bonitas Tariff.	• Subject to available savings and/or above threshold benefit. • 100% of Bonitas Tariff.	Acc: Yes
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**.	• R64 300 per family, unless PMB. • Sub-limit of R3 960 for a single intra-ocular lens. • R7 920 for bilateral lenses per beneficiary.	• R67 670 per family, unless PMB. • Sub-limit of R4 210 for a single intra-ocular lens. • R8 420 for bilateral lenses per beneficiary.	• R54 780 per family, unless PMB. • Sub-limit of R4 210 for a single intra-ocular lens. • R8 420 for bilateral lenses per beneficiary.	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**	• R324 100 per family. •	• R344 200 per family.	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D20.1.2	**Internal Nerve stimulator**	R193 200 per family.	No benefit.	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D20.2	**Prostheses external**	• R64 300 per family, unless PMB. • Limited to R6 130 per external breast prosthesis and limited to two per annum.	• Limited to and included in D20.1. • Limited to R6 520 per external breast prosthesis and limited to two per annum.	• Limited to and included in D20.1. • Limited to R6 520 per external breast prosthesis and limited to two per annum.	Subject to the relevant managed healthcare programme and to its prior authorisation. The benefit excludes consultations/fittings, which are subject to D17.2.
D21	**RADIOLOGY (See B4)**	REGISTERED BY ME ON Mfana Maswanganyi 2024/01/23 25/01/2024 10:43:07(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za SIGNFLOW.COM REGISTRAR OF MEDICAL SCHEMES			
D21.1	**General radiology**				
D21.1.1	**In hospital**	• No limit. • 100% of the Bonitas Tariff.	• No limit. • 100% of the Bonitas Tariff.	• No limit. • 100% of the Bonitas Tariff.	For diagnostic radiology tests and ultrasound scans. Authorisation is not required for MRI scans for low field peripheral joint examination of dedicated limb units. Acc: No
D21.1.2	**Out of hospital**	• Subject to available savings and/or above threshold benefit. • 100% of the Bonitas Tariff.	• Limited to and included in D18.2 • 100% of the Bonitas Tariff.	• Subject to available savings and/or above threshold benefit. • 100% of the Bonitas Tariff.	This benefit excludes: specified list of radiology tariff codes included in the • Maternity benefit, (D10), • Oncology benefit during the active treatment and/or post active treatment period, (D14); • Organ and haemopoietic stem cell transplantation benefit, (D16), • Renal dialysis chronic benefit, (D22).

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		REGISTERED BY ME ON Mfana Maswanganyi 25/01/2024 10:45:42(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 2024/01/23 REGISTRAR OF MEDICAL SCHEMES			Authorisation is not required for MRI scans for low field peripheral joint examination of dedicated limb units. Acc: Yes.
D21.2	**Specialised radiology**				
D21.2.1	**In hospital**	• R36 570 per family. • 100% of the Bonitas Tariff. • R2 660 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.	• R35 930 per family. • 100% of the Bonitas Tariff. • R2 660 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.	• R28 930 per family. • 100% of the Bonitas Tariff. • R2 660 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. • 100% of the Bonitas Tariff.	• Limited to and included in D21.2.1. • 100% of the Bonitas Tariff.	• Limited to and included in D21.2.1. • 100% of the Bonitas Tariff.	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). • The contracted rate applies for the services rendered by a network specialist and 100% of the Bonitas Tariff for the services rendered by a non-network specialist. • Related medicine are subject to the DSP and Regulation 8 (3). • 20% co-payment applies for the voluntary use of a non-DSP.	• No limit. • 100% of the lower of the cost or Bonitas Tariff for all services, medicines and materials associated with the cost of renal dialysis, subject to the DSP network and Regulation 8 (3). • The contracted rate applies for the services rendered by a network specialist and 100% of the Bonitas Tariff for the services rendered by a non-network specialist. • Related medicine are subject to the DSP and Regulation 8 (3). • 20% co-payment applies for the voluntary use of a non-DSP.	Subject to the relevant managed healthcare programme and to its prior authorisation Authorised erythropoietin is included in (D4). Acute renal dialysis is included in hospitalisation costs. See D7.
D22.2	**Radiology and pathology (See 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. • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• Limited to and included in D7.1.1 or D7.2.1. • The contracted rate applies for 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. • Subject to the BonClassic Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• Limited to and included in D7.1.1 or D7.2.1. • The contracted rate applies for 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. • Subject to the BonComplete Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • 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
D23.1.1	**Refractive surgery**	• R24 240 per family at 100% of the Bonitas Tariff for refractive surgery such as Lasik, Radial Keratotomy and Phakic Lens Insertion.	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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
					specifically mentioned in (D6). This benefit excludes: • Osseo-integrated implantation (D6); • Orthognathic surgery (D6); • Oral surgery (D6); • Impacted wisdom teeth (D6).
D23.2	**Out of hospital procedures in practitioners rooms that are not mentioned in D23.2.1 or D23.2.2**	• Subject to available savings and/or above threshold benefit. • 100% of the Bonitas Tariff.	• Subject to available savings. • The contracted rate applies for services rendered by network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	• Subject to available savings and/or above threshold benefit. • The contracted rateapplies for services rendered by network specialists. • 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	Acc: Yes
D23.2.1	**General procedures performed in specialist consulting rooms**	Limited to and included in D7.1.1 or D7.2.1 at enhanced rates for: • Endometrial biopsy (excluding after-care): (2434) • Implantation hormone pellets (excluding after-care): (2565). • Insertion of intra-uterine contraceptive device (IUCD) (excluding after-care): (2442) • Punch biopsy (excluding after-care): (2399) • Removal of tag or polyp: (2271) • Removal of small superficial benign lesions: (2272) • Removal of benign vulva tumour or cyst: (2277)			Subject to pre-authorisation.
D23.2.2	**Specified procedures done in the specialist rooms or suitably equipped procedure room with correct equipment and monitoring facilities**	Limited to and included in D7.1.1 or D7.2.1 at enhanced rates for: • Biopsy during pregnancy (excluding after care): (2400) • Cervix encirclage: Removal items 2409 and 2411: without anaesthetic): (2415) • Colposcopy (excluding after-care): (2429) • Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room: (2392) • Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): Under anaesthetic: (2395) • Cystoscopy: (1949) • Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion: (2316) • Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat – Limited: (2317)			Subject to pre-authorisation.

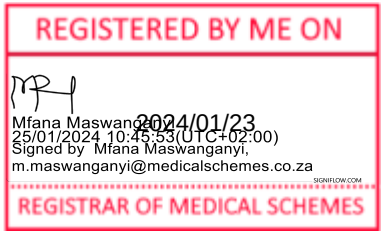
PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		• Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread: (2318) • Evacuation of uterus: Incomplete abortion: Before 12 weeks gestation: (2445) • Evacuation: Missed abortion: Before 12 weeks gestation: (2449) • Excision of benign lip lesion: (1485) • Excision of malignant lip lesion (1487) • Excision of superficial eyelid tumour: (3163) • Extensive resection for malignant soft tissue tumour including muscle: (0313) • Flap repairs (large, complicated): 0295 • Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.: (1676) • Full thickness skingraft repair: (0289) • Full thickness eyelid repair: (3189) • Full thickness lip repair: (1499) • Hymenectomy: (2283) • Hysterosalpingogram (excluding after-care): (2435) • Hysteroscopy (excluding after-care): (2436) • Hysteroscopy and polypectomy (excluding after-care): (2440) • Laser or harmonic scalpel treatment of the cervix: (2396) • Laser therapy of vulva and/or vagina (colposcopically directed): (2274) • Left-sided colonoscopy: (1656) • Termination of pregnancy before 12 weeks: (2448) • Total colonoscopy: With hospital equipment (including biopsy): (1653) • Upper gastro-intestinal endoscopy: Hospital equipment: (1587) • Vulva and introitus: drainage of abscess: (2293)			
D23.3	**PROCEDURES THAT WILL ATTRACT A CO-PAYMENT**				Where more than one co-payment apply to an admission event, the lower of the co-payments will be waived and the highest will be the member's liability.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D23.3.1	**Procedures which will attract a co-payment:** **Hip or knee arthroplasty** **Cataract Surgery**	Subject to a R35 250 co-payment: • when hip or knee arthroplasty is performed by a non-DSP Subject to a R7 050 co-payment: • For voluntary use of a non-DSP.	• Subject to a R35 250 co-payment: • when hip or knee arthroplasty is performed by a non-DSP. Subject to a R7 050 co-payment • For voluntary use of a non-DSP.	• Subject to a R35 250 co-payment: • when hip or knee arthroplasty is performed by a non-DSP. Subject to a R7 050 co-payment • For voluntary use of a non-DSP.	• Subject to the relevant managed healthcare programme and to its prior authorisation. • The co-payment to be waived if the cost of the service falls within the co-payment amount.
D23.4	**Day Surgery Procedures**	• Subject to the Day Surgery Network. • R2 590 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the Day Surgery Network. • R2 590 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the Day Surgery Network. • R2 590 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and to its prior authorisation and subject to a defined list of procedures. • The co-payment to be waived if the cost of the service falls within the co-payment amount.
D24	**PREVENTATIVE CARE BENEFIT (See B4)**				Acc: No
D24.1	**Women's Health Breast Cancer Screening** **Cervical Cancer Screening** **Cervical Cancer Screening in HIV infection**	• Mammogram Females age >40 years • Once every 2 years. • Pap Smear Females 21-65 years • Once every 3 years. • Pap Smear Females 21-65 years • 1 basic cytology test per annum or the HPV PCR once every 5 years.	• Mammogram Females age >40 years • Once every 2 years. • Pap Smear Females 21-65 years • Once every 3 years. • Pap Smear Females 21-65 years • 1 basic cytology test per annum or the HPV PCR once every 5 years.	• Mammogram Females age >40 years • Once every 2 years. • Pap Smear Females 21-65 years • Once every 3 years. • Pap Smear Females 21-65 years • 1 basic cytology test per annum or the HPV PCR once every 5 years.	Eligible beneficiaries may choose between the basic cytology test once every 3 years or HPV PCR test once every 5 years.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
	Human Papilloma Virus (HPV) Vaccine	• Limited to 3 doses for females between 15 – 26 years. • One course per lifetime.	• Limited to 3 doses for females between 15 – 26 years. • One course per lifetime.	• Limited to 3 doses for females between 15 – 26 years. • One course per lifetime.	
D24.2	**Men's Health PSA test**	Men 55-69 years, 1 per annum.	Men 55-69 years, 1 per annum.	Men 55-69 years, 1 per annum.	
D24.3	**General Health**	• HIV test annually. • Flu vaccine annually, including the administration fee of the nurse practitioner.	• HIV test annually. • Flu vaccine annually, including the administration fee of the nurse practitioner.	• HIV test 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.	
D24.5	**Elderly Health**	• Pneumococcal Vaccination, including the administration fee of the nurse practitioner. Age >65 Once every 5 years. • Faecal Occult Blood Test Ages 45 - 75 annually. • 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 45 - 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 45 - 75 annually.	
D24.6	**Children's health Hypothyroidism**	• 1 TSH Test Age <1 month	• 1 TSH Test Age <1 month	• 1 TSH Test Age <1 month	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
	Infant Hearing Screening	• One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	• One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	• One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	REGISTERED BY ME ON Mfana Maswanganyi 2024/01/23 25/01/2024 10:43:15 (UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za SIGNFLOW.COM REGISTRAR OF MEDICAL SCHEMES
	Human Papilloma Virus (HPV) Vaccine	• Limited to two doses for girls aged between 9 – 14years. • One course per lifetime.	• Limited to two doses for girls aged between 9 – 14years. • One course per lifetime.	• Limited to two doses for girls aged between 9 – 14years. • One course per lifetime.	
	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.	
D24.7	**Pertussis Booster Vaccine (Whooping Cough)**	• One booster vaccine per beneficiary between the ages of 07 and 64 years, every 10 years.	• One booster vaccine per beneficiary between the ages of 07 and 64 years, every 10 years.	• One booster vaccine per beneficiary between the ages of 07 and 64 years, every 10 years.	
D24.8	**Hearing Loss Preventative Screening**	• Unlimited digital pre-screening for potential hearing loss subject to the Audiology Benefit Management Programme.	• Unlimited digital pre-screening for potential hearing loss subject to the Audiology Benefit Management Programme.	• Unlimited digital pre-screening for potential hearing loss subject to the Audiology Benefit Management Programme.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB



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 ○ 90 days including USA – Maximum cover R500,000 for Member and Dependants ○ 45 days excluding USA - R5 million per Member, 10 million for Member and Dependants ○ 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 ○ 90 days including USA – Maximum cover R500,000 for Member and Dependants ○ 45 days excluding USA - R5 million per Member, 10 million for Member and Dependants ○ 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 ○ 90days 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 • Additional benefits for Covid-19: ○ additional costs for compulsory medical quarantine limited to R1 000 per day to a maximum of R10 000 for accommodation and PCR testing up to R1 000. ○ The cover will only apply if a beneficiary tested positive. • (Manual labour excluded) • Pre-existing medical conditions are limited to R200 000 per family when hospitalized. • Subject to pre-authorisation of Emergency Medical expenses.
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. Rejected

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D27.2	**Benefit Booster (including out of hospital non-PMB day-to-day services as mentioned in D1, D5.1.3, D5.1.4, D5.2, D11.1, D11.2, D13.2, D17.2, D18.2, D19.2, D21.1.2, D24 and virtual consultations).**	Subject to completion of a Health Risk Assessment or the completion of an online wellness questionnaire per beneficiary. Limited to R3 000 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 questionnaire per beneficiary. Limited to R2 070 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 questionnaire per beneficiary. Limited to R2 070 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 questionnaire. • Valid qualifying claims will pay first from the benefit booster and thereafter from the relevant benefits as described in D1 – D24.

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Mfana Maswanganyi
25/01/2024 10:44:32(UTC+02:00)
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