Bonitas

BONITAS MEDICAL FUND

ANNEXURE B

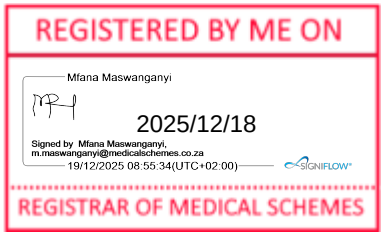
OPTIONS:

BONCOMPREHENSIVE

BONCLASSIC

BONCOMPLETE

2026



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A ENTITLEMENT OF BENEFITS

A1 The Bonitas Fund Tariff is defined as the Bonitas monetary tariffs applicable in 2025 increased by an average of 4.0%.

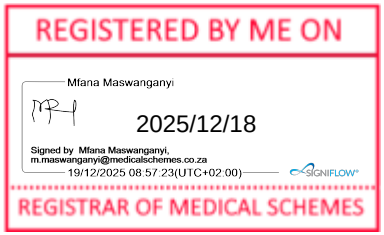
A2 Beneficiaries are entitled to benefits as shown in this Annexure B, subject to the monetary limits and implementation restrictions set out herein, to the exclusions referred to in Annexure C of the Rules, to the general limitation and restriction of benefits set out in Annexure D of the Rules and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

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

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

B1 On the 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.

B4.1 Sequence of payments for out-of-hospital claims:
Valid out of hospital claims will pay as set out in the Benefits table in paragraph D below.
Where an out of hospital claim is a Prescribed Minimum Benefit, cover will be concurrently from the Above Threshold Benefit and the approved aPMB protocols.on BonComprehensive and BonComplete.

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. Drug Reference Price List and applicable formularies. Co-payments to apply where relevant.

B6 MEMBERSHIP CATEGORY

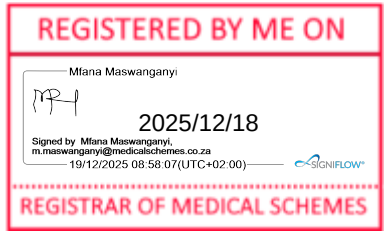
Member	=	M0
Member plus 1 dependant	=	M1
Member plus 2 dependants	=	M2
Member plus 3 dependants	=	M3
Member plus 4 or more dependants	=	M4

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 932	R14 230
Add per adult dependant	=	R25 718	R11 506
Add per child dependant	=	R6 634	R3 726



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.

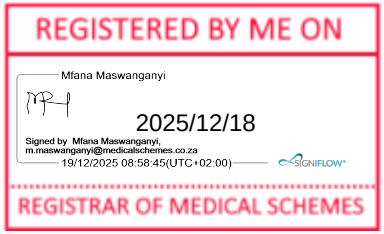
Threshold Level

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.~~

Rejected

The following exceptions are applicable:

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

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: R6 250 A: R3 660 C: R1 600	
	General Practitioner Network	Not applicable.	Not applicable.	Not applicable.	
D1	**ALTERNATIVE HEALTHCARE**				
D1.1	**In and Out of Hospital (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
D1.1.1	**Homeopathic Consultations and/or treatment**	Limited to and included in D1.1.	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.2	**Homeopathic Medicines**	• Limited to and included in D1.1. • Paid at 80% of tariff when paid from the above threshold benefit.	Limited to and included in D1.1.	• Limited to and included in D1.1. • Paid at 80% of tariff when paid from the above threshold benefit.	
D1.1.3	**Acupuncture**	Limited to and included in D1.1.	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.4	**Naturopathy Consultations and/or treatment and medicines.**	• Limited to and included in D1.1. • Medicines are paid at 80% of tariff when paid from the above threshold benefit.	Limited to and included in D1.1.	• Limited to and included in D1.1. • Medicines are paid at 80% of tariff when paid	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
				from the above threshold benefit.	
D1.1.5	**Phytotherapy**	Limited to and included in D1.1.	Limited to and included in D1.1.	Limited to and included in D1.1.	
D1.1.6	**Osteopathy**	Limited to and included in D1.1.	Limited to and included in D1.1.	Limited to and included in D1.1.	
D2	**AMBULANCE SERVICES**				
D.2.1	**Emergency Medical Transport (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**				
D3.1	**In and Out of Hospital (See B4)**	REGISTERED BY ME ON Mfana Maswanganyi 2025/12/18 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 19/12/2025 09:00:19(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES			• Diabetic accessories and appliances - (with the exception of glucometers, continuous glucose monitoring devices and consumables) to be pre-authorised and claimed from the chronic medicine benefits D11.3. • Subject to frequency limits as per managed care protocols. • The benefit excludes consultations/fittings which are subject to D17.2.
D3.1.1	**General medical and surgical appliances, including wheelchairs and repairs, and large orthopaedic appliances**	• Subject to available savings. • Blood pressure monitors for high risk beneficiaries, registered for Hypertension, are limited to R1 250 per family, subject to available	• Subject to available savings. • Blood pressure monitors for high risk beneficiaries, registered for Hypertension, are limited to R1 250 per family, subject to	• Subject to available savings and/or above threshold benefit. • Blood pressure monitors for high risk beneficiaries, registered for Hypertension, are limited to R1 250 per family, subject to	Hiring or buying medical or surgical aids as prescribed by a medical practitioner. Acc: Yes

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		savings, once every 2 years.	available savings, once every 2 years.	available savings and/or above threshold benefit, once every 2 years.	
D3.1.2	**Audiology Benefit Management Benefit including Hearing Aids and repairs**	• Limited to R11 340 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 R10 090 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 R10 090 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.	Subject to the Hearing Loss Management Programme (HLM). Acc: Yes, when paid from savings
D3.1.2.1	**Audiology Services**	• Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). • Non-network: Limited to and included in D17.2.	• Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). • Non-network: Limited to and included in D17.2.	• Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). • Non-network: Limited to and included in D17.2	• Subject to the Hearing Loss Management Programme. • The Benefit Booster (D27.2) does not apply.
D3.1.2.2	**Hearing Aid Acoustic Services**	• Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). • Non-network: Limited to and included in D17.2.	• Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). • Non-network: Limited to and included in D17.2.	• Network: All tests and consultations limited to the Hearing Loss Management Programme (HLM). • Non-network: Limited to and included in D17.2.	• Subject to the Hearing Loss 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
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 unless PMB.	Subject to available savings. unless PMB.	Subject to available savings unless PMB.	Foot orthotics are not payable from the above threshold benefit on BonComprehensive and BonComplete.
D3.1.5.5	**Insulin Pump Therapy Continuous Glucose Infusion Monitor (CGM)**	• R65 000 per family for insulin pump • Limited to one device per Type 1 Diabetic for beneficiaries younger than 18 years every 5 years; and • R28 000 per annum per CGM device for Type 1 Diabetic beneficiaries younger than 18 years. • R93 000 per family for insulin pump or CGM consumables for Type 1 Diabetic beneficiaries younger than 18 years.	• R65 000 per family for insulin pump • Limited to one device per Type 1 Diabetic for beneficiaries younger than 18 years every 5 years; and • R28 000 per annum per CGM device for Type 1 Diabetic beneficiaries younger than 18 years. • R93 000 per family for insulin pump or CGM consumables for Type 1 Diabetic beneficiaries younger than 18 years	• R65 000 per family for insulin pump . • Limited to one device per Type 1 Diabetic for beneficiaries younger than 18 years every 5 years; and • R28 000 per annum per CGM device for Type 1 Diabetic beneficiaries younger than 18 years. • R93 000 per family for insulin pump or CGM consumables for Type 1 Diabetic beneficiaries younger than 18 years	• 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D4	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS**				
D4.1	**In and Out of Hospital (See B4)**	No limit if specifically authorised.	No limit if specifically authorised.	No limit if specifically authorised.	Subject to the relevant managed healthcare programme and to its prior authorisation and if the treatment forms part of the relevant managed healthcare programme, out of hospital.
D5	**CONSULTATIONS AND VISITS BY MEDICAL PRACTITIONERS**				
D5.1	**General Practitioners (Including Virtual Consultations) (See B4)**				This benefit excludes the following as they are covered under services mentioned elsewhere in this Annexure: • Dental Practitioners and Therapists (D6), • Ante-natal visits and consultations (D10); • Psychiatrists, Psychologists, Psychometrists and Registered Counsellors (D12); • Oncologists, Haematologists and 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**				Acc: No

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REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		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.	
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. • 150% of Bonitas Tariff for medical and dental specialists.	• No limit. • The contacted rate applies for network specialists. • 100% of Bonitas Tariff for non-network specialists.	• No limit. • The contracted rate applies for network specialists. • 100% of Bonitas Tariff for non-network specialists.	This benefit excludes the following as they are covered under services mentioned elsewhere in this Annexure: • Dental Practitioners and Therapists (D6), • Ante-natal visits and consultations (D10); • Psychiatrists, Psychologists, Psychometrists and Registered Counsellors (D12); • Oncologists, Haematologists and Credentialed Medical Practitioners during active and post-active treatment periods (D14); • Paramedical Services (D17); • Physiotherapists and Biokineticists in hospital (D19.1). • All consultations and procedures within the Specialist Network will be paid at the negotiated Tariff,

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
					with no co-payment applicable. Acc: No
D5.2.2	**Out of Hospital (See A3)**	• 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. • Psychologist to Psychiatrist referral. • Follow-up visits with one of the treating specialists within 8 weeks of discharge from hospital for the same condition. • One (1) Urologist visit/consultation per annum for male beneficiaries; Acc: Yes

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D5.2.3	**Infant Paediatric Benefit (Consultation with a GP or Paediatrician)**	• 3 Paediatric consultations per beneficiary for children aged 0 - 12 months within the age bracket. • 2 Paediatric consultations per beneficiary for children aged 13 - 24 months within the age bracket, included in the OAL.	No benefit.	• 2 Paediatric consultations per beneficiary for children aged 0 - 12 months within the age bracket. • 1 Paediatric consultation per beneficiary for children aged 13 - 24 months within the age bracket, included in the OAL.	Acc: No
D6	**DENTISTRY**				
D6.1	**BASIC DENTISTRY (SEE B4)**		Limited to R6 400 per family per annum.		Subject to the Dental Management Programme. Acc: Yes, when paid from savings.
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 and included in D6.1.	• 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. • Limited to and included in D6.1.	• Covered at 100% of the BDT. • Fillings are granted once per tooth every 2 years. Benefit for re-treatment of a tooth is subject to managed care protocols.	• Benefits for fillings are granted once per tooth every 2 years. • Benefits for re-treatment of a tooth are subject to managed care protocols. • A treatment plan and x-rays may be required for multiple fillings.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D6.1.3	**Plastic dentures and associated Laboratory costs**	• One set of plastic dentures (an upper and a lower) per beneficiary in a 4 year period. • Subject to available savings and/or above threshold benefit. • Subject to pre-authorisation. • Covered at 100% of the BDT.	• 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. • Limited to and included in D6.1.	Covered at 100% of the BDT and managed care protocols apply.	Subject to managed care protocols.
D6.1.5	**Root Canal therapy**	• Subject to available savings and/or above threshold benefit. • Covered at 100% of the BDT.	• Covered at 100% of BDT and managed care protocols apply. • Limited to and included in D6.1.	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**	• 2 Annual scale and polish treatments per beneficiary (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. • Limited to and included in D6.1.	• 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**	• Certain maxillo-facial procedures are covered in hospital. Admission protocols apply.	• Covered at 100% of the BDT. • Certain maxillo-facial procedures are covered in hospital.	• Covered at 100% of the BDT • Certain maxillo-facial procedures are covered in hospital.	• Subject to pre-authorisation. • Pre-authorisation is required for moderate/deep sedation in the rooms and is limited to extensive dental treatment

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		• 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 available savings and/or above threshold benefit for the dental account.	• Admission protocols apply. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. o A co-payment of R3 640 aplies per hospital admission or R2 600 if treatment is done in a Day Clinic. • ~~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 the BonClassic Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. o A co-payment R5 200 applies per hospital admission or R2 600 if treatment is done in a Day Clinic.	• Admission protocols apply. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. o A co-payment of R3 640 aplies per hospital admission or R2 600 if treatment is done in a Day Clinic. • ~~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 the BonComplete Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. o A co-payment of R5 200 applies per hospital admission or R2 600 if treatment is done in a Day Clinic.	where managed care protocols apply. • The co-payments on BonClassic and BonComplete to be waived if the cost of the service falls within the co-payment amount. Rejected
D6.1.8	**Inhalation Sedation in dental rooms**	• Covered at 100% of the BDT. • Subject to available savings and/or above threshold benefit.	• Covered at 100% of the BDT. • Subject to managed care protocols.	• Covered at 100% of the BDT. • Subject to managed care protocols.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D6.1.9	**X-rays**	• Covered at 100% of the BDT for intra-oral x-rays. Extra-oral x-rays will be covered at 100% of the BDT subject to 1 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 R7 710 per family per annum.	No benefit unless otherwise specified.	Subject to pre-authorisation and dental management protocols.
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	• 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		• savings and/or above threshold benefit. • Subject to pre-authorisation.			
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 710 per implant. • No benefit for orthognathic surgery. • Subject to available savings and/or above threshold benefit.	No benefit.	No benefit.	• Includes all stages of treatment required to achieve the end result of placing an implant supported tooth or teeth into spaces left by previous removal of natural teeth and surgical placement and exposure of implants. • Hospital and Anaesthetist accounts will not attract benefit if treatment is done In Hospital.
D6.2.4	**Oral Surgery**	• Surgery in the dental chair. • Covered at 100% of BDT.	• Surgery in the dental chair. • Covered at 100% of BDT.	• Surgery in the dental chair. • Covered at 100% of BDT.	Benefits for Tempero-mandibular joint therapy are limited to non-surgical interventions/treatments.
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	• 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	• 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	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).

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		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.	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.	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.	
D6.2.6	**Maxillo-facial surgery**	See D23.1.2.	See D23.1.2.	See D23.1.2.	
D6.2.7	**Periodontal treatment**	• Benefits are limited to conservative, non-surgical therapy only. • Benefits will be applied to members who are registered on the Periodontal Programme. Surgical treatment is excluded. • Subject to available savings and/or above threshold benefit. • 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-authorisation • 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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D7	**HOSPITALISATION**				
D7.1	**Private Hospitals and unattached operating theatres (See B4)**				Subject to the relevant managed healthcare programme and its prior authorisation.
D7.1.1	**In Hospital**	• No limit. • Deep Brain Stimulation Implantation for Parkinson's and intractable epilepsy is limited to R298 000 per beneficiary (excluding the prosthesis benefit). • Hip and Knee arthroplasties are subjected to the DSP. • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• No limit. • No benefit for Deep Brain Stimulation Implantation, unless PMB • Subject to the BonClassic Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • Hip and knee arthroplasties are subject to the DSP. • Day Surgery Network applies for defined procedures. (See paragraph D23.4)	• No limit. • No benefit for Deep Brain Stimulation Implantation, unless PMB • Subject to the BonComplete Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions. • Hip and knee arthroplasties are subject to the DSP. • 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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
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 R670 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 R605 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 R535 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 without prior authorisation is maximum 2 emergency 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. 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 t to available savings and/or above threshold benefit.	• Will be included in the hospital benefit if a retrospective authorisation is given by the relevant managed healthcare programme for bona fide emergencies. • Acc: Yes, when paid from savings.
D7.1.3.2	**Consultations**	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • Subsequent emergency consultations without pre-authorisation or	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • Subsequent emergency consultations without	• Limited to 2 consultations per family, limited to and included in the OAL for bona fide emergencies. • Subsequent emergency consultations without	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		non-emergency consultations are limited to and included in D5.1.2 and D5.2.2.	pre-authorisation or non-emergency consultations are limited to and included in D5.1.2 and D5.2.2.	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 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 R670 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant	• Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R605 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant	• Limited to and included in the OAL. • Up to 7 days' supply, to a maximum of R535 per beneficiary per admission, except anticoagulants post surgery which will be subject to the relevant	• Where the script amount exceeds the benefit, the balance will be subject to available savings. • Acc: Yes, when paid from savings.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		managed healthcare programme. • See D7.1.2.	managed healthcare programme. • See D7.1.2.	managed healthcare programme. • See D7.1.2.	
D7.2.3	**Casualty/emergency room visits**				The risk benefit without prior authorisation is maximum 2 emergency 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 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.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.	
D7.2.3.3	**Medicine**	See D11.1.	D11.1.	See D11.1.	
D7.2.4	**Outpatient services**				

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
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**	R63 340 per family for all services.	R67 270 per family for all services.	R67 270 per family for all services.	See D7.3.
D7.3.2	**Sub-acute facilities including Hospice**	R21 570 per family.	R21 570 per family.	R21 570 per family.	This benefit includes psychiatric nursing but excludes midwifery services. See D7.3.
D7.3.3	**Homebased Care including private nursing and Outpatient antibiotic therapy in lieu of hospitalisation**	• No limit. • Subject to pre-authorisation.	• No limit. • Subject to pre-authorisation.	• No limit. • Subject to pre-authorisation.	Subject to the relevant managed healthcare programme.
D7.3.4	**Conservative Back Programme (Including treatment for shoulders and knees and a physiotherapy network where the nearest centre of excellence is greater ~~than 30kms away).~~**	Subject to the Contracted Provider. Rejected	Subject to the Contracted Provider.	Subject to the Contracted Provider.	• Subject to one treatment protocol per beneficiary per annum. • Subject to the relevant managed healthcare programme.
D7.3.5	**Terminal Care (Non-oncology)**	Limited to and included in D7.3.2 and above limits, subject to pre-authorisation.	Limited to and included in D7.3.2 and above limits, subject to pre-authorisation.	Limited to and included in D7.3.2 and above limits, subject to pre-authorisation.	Subject to the relevant managed healthcare programme.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D8	**IMMUNE DEFICIENCY SYNDROME RELATED TO HIV INFECTION**				
D8.1	**Treatment for Immune Deficiency Syndrome related to HIV (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
D8.1.1	**Anti-retroviral medicine**	Limited to and included in D8.1.	Limited to and included in D8.1 and subject to the DSP.	Limited to and included in D8.1 and subject to the DSP.	
D8.1.2	**Related medicine**	Limited to and included in D8.1.	Limited to and included in D8.1 and subject to the DSP.	Limited to and included in D8.1 and subject to the DSP.	
D8.1.3	**Related pathology**	Limited to and included in D8.1.	Limited to and included in D8.1.	Limited to and included in D8.1.	Pathology as specified by the relevant managed healthcare programme, out of hospital.
D8.1.4	**Related consultations**	Limited to and included in D8.1.	Limited to and included in D8.1.	Limited to and included in D8.1.	
D8.1.5	**All other services**	Limited to and included in D1 - D7 and D9 – D27.	Limited to and included in D1 - D7 and D9 – D27.	Limited to and included in D1 - D7 and D9 – D27.	
D9	**INFERTILITY**				
D9.1	**Treatment related to 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**				
D10.1	**Confinement (See A3 & B4)**				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
					Acc: No
D10.1.1	**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.
D10.1.2	**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.	
D10.1.3	**Confinement in a registered birthing unit**	• Limited to and included in D10.1.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) can be used for a consultation with an accredited lactation specialist, out of hospital.	• Limited to and included in D10.1.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) can be used for a consultation with an accredited lactation specialist, out of hospital. • Subject to the BonClassic Hospital Network.	• Limited to and included in D10.1.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) can be used for a consultation with an accredited lactation specialist, 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.

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.	• One of the post-natal midwife consultations can be used for a consultation with an accredited lactation specialist out of hospital.
D10.2	**Confinement out of hospital**	• Limited to and included in D10.1.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) can be used for a consultation with an accredited lactation specialist.	• Limited to and included in D10.1.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) can be used for a consultation with an accredited lactation specialist.	• Limited to and included in D10.1.1. • 4 x post-natal midwife consultations per pregnancy, of which one (1) can be used for a consultation with an accredited lactation specialist.	• Subject to the relevant managed healthcare programme and its prior authorisation. • Delivery by a midwife • Hire of water bath and oxygen cylinder limited to and included in OAL. This must be hired from a practitioner who has a registered practice number. • One of the post-natal midwife consultations may be used for a consultation with an accredited lactation specialist.
D10.2.1	**Consumables and pharmaceuticals**	Limited to and included in D10.1.1.	Limited to and included in D10.1.1.	Limited to and included in D10.1.1.	Registered medicine, dressings and materials supplied by a midwife out of hospital.
D10.3	**Related maternity services**	Limited to and included in D10.1.1.	Limited to and included in D10.1.1.	Limited to and included in D10.1.1.	
D10.3.1	**Ante-natal consultations**	• 12 ante-natal consultations by a specialist, general practitioner or midwife. • R1 640 for ante-natal classes/exercises per pregnancy.	• 12 ante-natal consultations by a specialist, general practitioner or midwife. • R1 580 for ante-natal classes /exercises per pregnancy.	• 6 ante-natal consultations by a specialist, general practitioner or midwife. • R1 580 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**				
D11.1	**Routine/ (acute) medicine (See B4 and B5)**	• Subject to available savings and above threshold benefit, limited to R18 560 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, Drug Reference Pricing 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 R2 050 per family. • ~~Limited to females up to the age of 50 years~~.	• Limited to R2 050 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 R2 050 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 Rejected
D11.1.3	**Registered ante-natal vitamins during pregnancy**	• Limited to and included in D11.1. • Limited to R200 per beneficiary per month.	• Limited to and included in D11.1 and D27.2. • Limited to R200 per beneficiary per month.	• Limited to and included in D11.1 and D27.2. • Limited to R200 per beneficiary per month.	Acc: Yes, when paid from savings.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		• Subject to the medicine formulary.	• Subject to the medicine formulary.	• Subject to the medicine formulary.	
D11.2	**Pharmacy Advised therapy Schedules 0, 1, 2 and medicine advised and dispensed by a pharmacist.**	Limited to and included in D11.1.	Limited to and included in D11.1.	Limited to and included in D11.1.	• Subject to the relevant managed healthcare programme. • Subject to the Bonitas Pharmacy Network. • The Medicine Exclusion List, Drug Reference Pricing, and the Pharmacy Products Management Document are applicable. Acc: Yes
D11.3	**Chronic medicine (See B4)**	• R37 360 per family. • R18 760 per beneficiary. • As specified in Annexure D paragraph 6.4.3. • Subject to the Bonitas Pharmacy Network. • Above limits, PMBs apply. • 30% co-payment applies for non formulary drugs used voluntarily and use of a pharmacy outside the Bonitas Pharmacy Network.	• R31 770 per family. • R15 370 per beneficiary. • As specified in Annexure D paragraph 6.4.3. • Subject to the Bonitas Pharmacy Network. • Above limits, PMBs and DSP apply. • 30% 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. • 30% co-payment applies for non-formulary drugs used voluntarily and for the voluntary use of a non-DSP. • Subject to the Bonitas Pharmacy Network. • R165 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. Subject to Drug Reference Pricing. Restricted to a maximum of one month's supply unless pre-authorised. Includes diabetic disposables such as • syringes, • needles, • strips • lancets for patients not registered on the Diabetic Management Programme. This benefit excludes: • In hospital medicine (D7); • Anti-retroviral drugs (D8); • Oncology medicine (D14); • Organ and haemopoietic stem cell (bone marrow) transplantation immunosuppressive medication (D16). Acc: No

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D11.3.1	**MDR and XDR-TB**	• No limit. • Subject to managed care protocols. • Subject to the DSP.	• No limit. • Subject to managed care protocols. • Subject to the DSP.	• No limit. • Subject to managed care protocols. • Subject to the DSP.	Acc: No
D11.4	**Specialised Drugs (See B4)**				• The non oncology specialised drug list is a continuously evolving list of high cost drugs, not listed on the National Department of Health Essential Drug List (EDL), used for the treatment of chronic conditions. • This list includes but is not limited to biological drugs (biological therapy for inflammatory arthritides, inflammatory bowel disease, chronic demyelinating polyneuropathies, chronic hepatitis, botulinum toxin, palivizumab). • Unless otherwise stated below, any other diseases where the use of the drug is deemed appropriate by the managed health care organization, drugs will be funded from this benefit. • Subject to published list. • Drug Reference Pricing applies.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
					Acc: No
D11.4.1	**Non Oncology Biological Drugs applicable to monoclonal antibodies interleukins**	• R257 300 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**	• R68 850 per family. Limited to and included in D11.4.1. • Subject to clinical protocols.	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation for the treatment of Retinal disorders.
D11.4.3	**Iron chelating agents for chronic use**	Limited to and included in D11.4.1.	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D11.4.4	**Human Immunoglobulin for chronic use**	Limited to and included in D11.4.1.	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D11.4.5	**Non calcium phosphate binders and calcimimetics**	Limited to and included in D11.4.1.	No benefit, unless PMB.	No benefit, unless PMB.	Subject to the relevant managed healthcare programme and to its prior authorisation of renal osteodystrophy as a result of chronic kidney disease. The co-payment will be applicable to the non-PMB diseases.
D12	**MENTAL HEALTH**				
D12.1	**Treatment and care related to Mental Health (See B4 and B9)**	R59 920 per family, unless PMB.	R52 670 per family, unless PMB.	R41 190 per family, unless PMB.	• Subject to the relevant managed healthcare programme. • Physiotherapy is not covered for mental health admissions. Acc: No

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D12.1.1	**In Hospital**	Limited to and included in D12.1.	• Limited to and included in D12.1. • Subject to the BonClassic Hospital Network. • 30% co-payment to apply to all voluntary non-network admissions.	• Limited to and included in D12.1. • 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.)
D12.1.2	**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 D12.1. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	• Limited to and included in D12.1. • Subject to the DSP. • 30% co-payment applies to the voluntary use of a non-DSP.	• Limited to and included in D12.1. • 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.
D12.4	**Consultations and visits, procedures, assessments, therapy, treatment and/or counselling, in and out of hospital. (See B4)**	• R20 310 per family, limited to and included in D12.1. • Educational psychology visits and psychometry	• R20 310 per family, limited to and included in D12.1. • Educational psychology visits and psychometry	• R20 310 per family, limited to and included in D12.1. • Educational psychology visits and psychometry	Acc: No

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	assessments for learning and education for adult beneficiaries (>21 years) are excluded from this benefit.	
D12.5	**Mental Health Programme, as managed via Active Disease Risk Management in Annexure D, paragraph 6.10**	• Limited to R14 400 per beneficiary. • Subject to enrolment on the relevant managed healthcare programme,	• Limited to R14 400 per beneficiary. • Subject to enrolment on the relevant managed healthcare programme,	• Limited to R14 400 per beneficiary. • Subject to enrolment on the relevant managed healthcare programme,	• Subject to the relevant managed healthcare programme and its prior authorisation for out of hospital treatment only. • PMB treatment and the Mental Health Programme claims will not pay concurrently.
D13	**NON-SURGICAL PROCEDURES AND TESTS**				
D13.1	**In Hospital (See B4)**	• 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.	• Subject to available savings.		Acc: Yes

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
				Subject to available savings and/or above threshold benefit.	
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)**	REGISTERED BY ME ON Mfana Maswanganyi 2025/12/18 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 19/12/2025 09:09:37(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES			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	• No limit. • The contracted rate applies for network specialists.	• No limit. • The contracted rate applies for network specialists.	If authorised by the relevant managed healthcare programme for patents with obstructive sleep apnoea who meet the criteria for

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		practitioner or medical specialist.	• 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	• 100% of the Bonitas Tariff for the general practitioner or non-network specialist.	CPAP and where requested by the relevant specialist.
D14	**ONCOLOGY**				
D14.1	**Pre active, active & post active treatment period (See A4 & B4)**	• R448 200 per family for oncology. • 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).	• R336 100 per family for oncology. • 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).	• R280 100 per family for oncology. • Unlimited for PMB oncology. • Above benefit limit, non-PMB oncology is unlimited at a network provider, subject to a 20% co-payment. • The Bonitas Oncology Network 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).	• Acc: No • Subject to registration on the oncology management programme. All costs related to approved cancer treatment including PMB treatment will add up to the oncology benefit limit. • Treatment for long-term chronic conditions that may develop as a result of chemotherapy and radiotherapy is not included in this benefit. • The benefit is for Oncologists, Haematologists and approved providers for consultations, visits, treatment and consumable material used in radiotherapy and chemotherapy. • The Oncology Network is the DSP for related oncology services at the Oncology Network (DSP) rate. • Pre-active, active and post-active consultations and investigations are subject to Cancer Care Plans. • Where more than one co-payment applies, the lower of the co-payments will be

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
					waived and the highest will be the member's liability.
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. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to Drug Reference Pricing and preferred product list.	• Limited to and included in D14.1 and subject to the Oncology Medicine DSP Network. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to Drug Reference Pricing and preferred product list.	• Limited to and included in D14.1 and subject to the Oncology Medicine DSP Network. • 20% co-payment applies for the voluntary use of a non-DSP. • Subject to Drug Reference Pricing and preferred product list.	Subject to the Bonitas Oncology Medicine DSP Network.
D14.1.2	**Radiology and pathology (See B4)**	Limited to and included in D14.1.	Limited to and included in D14.1.	Limited to and included in D14.1.	• Subject to the relevant managed healthcare programme and to its prior authorisation. • Limited to Cancer Care Plans in pre-active, active and post-active setting. • 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 two per family per annum. • Subject to the use of a provider on the PET-CT scan network at the contracted rate. • Services rendered by a non-network provider	• Limited to and included in D14.1 and one per family per annum. • Subject to the use of a provider on the PET-CT scan network at the contracted rate. • Services rendered by a non-network provider	• PMB only, subject to the use of a provider on the PET-CT scan network at the contracted rate. • Services rendered by a non-network provider at 100% of the Bonitas Tariff, subject to a 25%	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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		pay at 100% of the Bonitas Tariff, subject to a 25% non-network co-payment.	pay at 100% of the Bonitas Tariff, subject to a 25% non-network co-payment.	non-network co-payment.	
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 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, immunologic and targeted therapy**	• R448 200 per family, limited to and included in D14.1. • No benefit applies above the Specialised Drug benefit limit, unless PMB. • Identified innovative drugs will be funded at 70%, conditional to clinical criteria being met, and subject to the specialised drug benefit limit of R448 200.	• R164 100 per family, limited to and included in D14.1. • No benefit applies above the Specialised Drug benefit limit, unless PMB.	No benefit, unless PMB.	• Innovative drugs include but are not limited to high cost therapies, such as biologicals, certain enzyme inhibitors, immunomodulatory antineoplastic agents and other targeted therapies. • Subject to published list.
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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D14.1.4	**Flushing of a J line and/or Port (See B4)**	Limited to and included in D14.1.	Limited to and included in D14.1.	Limited to and included in D14.1.	Subject to the relevant managed healthcare programme
D14.1.5	**Brachytherapy materials (including seeds disposablesand equipment) (See B4)**	Limited to R63 110 per beneficiary and included in D14.1.	Limited to R63 110 per beneficiary and included in D14.1.	Limited to R63 110 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 640 per family. • Limited to and included in D14.1.	• Limited to R3 640 per family. • Limited to and included in D14.1.	• Limited to R3 640 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.
D15	**OPTOMETRY**				
D15.1	**(In and Out of Network) (See B4)**	• Subject to available savings and/or above threshold benefit. • Limited to R4 225 per beneficiary. • 100% of the network tariff. • Biennial Benefit. • Benefit availability is subject to a 24 month cycle from last date of service.	• 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 clinical protocols. • 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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		• No benefit for lens enhancements (tints and coatings).			
D15.1.1	**Optometric refraction test, re-exam and/or composite exam, tonometry and visual field test**	• One per beneficiary per benefit cycle, at network tariff. • R420 out of network. • Limited to and included in D15.1.	• One per beneficiary per benefit cycle, at network rates. • R420 out of network. • Limited to and included in D15.1.	• One per beneficiary per benefit cycle, at network tariff. • R420 out of network. • Limited to and included in D15.1.	• 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 D15.1.	• R1 410 per beneficiary in network. • R1 058 per beneficiary out of network • Limited to and included in D15.1.	• R1 040 per beneficiary in and out of network. • Limited to and included in D15.1.	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 R225 per lens per beneficiary out of network. • Limited to and included in D15.1; or	• 100% towards the cost of clear lenses at network rates. • Limited to R225 per lens per beneficiary out of network. • Limited to and included in D15.1; or	• 100% towards the cost of clear lenses at network rates. • Limited to R225 per lens per beneficiary out of network. • Limited to and included in D15.1; or	Subject to contracted providers protocols.
D15.3.2	**Bifocal lenses**	• 100% towards the cost of clear lenses at network rates. • Limited to R485 per lens per beneficiary out of network. • Limited to and included in D15.1; or	• 100% towards the cost of clear lenses at network rates. • Limited to R485 per lens per beneficiary out of network. • Limited to and included in D15.1; or	• 100% towards the cost of clear lenses at network rates. • Limited to R485 per lens per beneficiary out of network. • Limited to and included in D15.1; or	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D15.3.3	**Multifocal lenses**	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R850 per base lens and R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.1.	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R850 per base lens and R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.1.	• 100% towards the cost of base lenses plus group 1 branded lens add-ons at network rates. • Limited to R850 per base lens and R50 per branded lens add-on per beneficiary out of network. • Limited to and included in D15.1.	
D15.3.4	**Contact lenses**	• Limited to and included in D15.1. • Limited and included in D15 except for Keratoconus where it is limited to R3 035 included in D3.1.1.	• Limited to R2 190 per beneficiary. • Limited and included in D15.1.	• Limited to R2 555 per beneficiary. • Limited and included in D15.1.	
D15.4	**Low vision appliances**	Limited to and included in D3.1.1.	Limited to and included in D3.1.1.	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 D15.1.	Limited to and included in D15.1.	Limited to and included in D15.1.	
D15.7	**Readers**				
D15.7.1	**From a registered optometrist, ophthalmologist or supplementary optical practitioner**	Limited to and included in D15.1.	No benefit	Limited to and included in D15.1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D15.7.2	**From a registered pharmacy**	Limited to and included in D15.1.	No benefit.	Limited to and included in D15.1.	
D16	**ORGAN TRANSPLANTATION**				
D16.1	**ORGAN AND HAEMOPOIETIC STEM CELL (BONE MARROW) TRANSPLANTATION AND IMMUNO-SUPPRESIVE MEDICATION, INCLUDING 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 R40 220 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 R42 710 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 R42 710 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
D16.2	**Haemopoietic stem cell (bone marrow transplantation) (See B4)**	Limited to and included in D16.1.	Limited to and included in D16.1.	Limited to and included in D16.1.	Haemopoietic stem cell (bone marrow) transplantation is limited to allogenic grafts and autologous grafts derived from Bone Marrow Registries in accordance with managed care protocols
D16.3	**Immuno-suppressive medication (See B5)**	Limited to and included in D16.1.	Limited to and included in D16.1 and subject to the DSP.	Limited to and included in D16.1 and subject to the DSP.	
D16.4	**Post transplantation biopsies and scans**	Limited to and included in D16.1.	Limited to and included in D16.1.	Limited to and included in D16.1.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
	(See B4)				
D16.5	**Radiology and pathology (See B4)**	Limited to and included in D16.1.	Limited to and included in D16.1.	Limited to and included in D16.1.	For specified radiology and pathology services, performed by Pathologists, Radiologists and Haematologists, associated with the transplantation treatment.
D17	**PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS)**				
D17.1	**In hospital (See B4)**	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.	
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.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
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**				
D18.1	**In hospital (See B4)**	• 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.	Subject to the relevant managed healthcare programme. 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 rendered by non-DSP providers.	• Subject to available savings. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• Subject to the available savings and/or above threshold benefit. • Subject to the DSP for pathology at negotiated rates. • 100% of the Bonitas Tariff for services rendered by non-DSP providers.	• Subject to the Pathology Management Program. • The specified list of pathology • tariff codes included in the • Maternity benefit, (D10.1), • The oncology benefit during the active and/or post active treatment period, (D14.1); • Organ and haemopoietic stem cell transplantation benefit,(D16.1) • Renal dialysis chronic benefit, (D22).

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
					Acc: Yes
D19	**PHYSICAL THERAPY**				
D19.1	**In hospital Physiotherapy Biokinetics (See B4)**	• 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 D12.1. 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**				
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. (See B4)**	• R67 640 per family, unless PMB. • Sub-limit of R4 340 for a single intra-ocular lens. • R8 660 for bilateral lenses per beneficiary.	• R67 640 per family, unless PMB. • Sub-limit of R4 610 for a single intra-ocular lens. • R9 210 for bilateral lenses per beneficiary.	• R57 630 per family, unless PMB. • Sub-limit of R4 610 for a single intra-ocular lens. • R9 210 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

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D20.1.1	**Cochlear implants**	R354 600 per family.	R376 600 per family.	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D20.1.2	**Internal Nerve stimulator**	R211 300 per family.	No benefit.	No benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation.
D20.2	**Prostheses external**	• R67 640 per family, unless PMB. • Limited to R6 710 per external breast prosthesis and limited to two per annum.	• Limited to and included in D20.1. • Limited to R7 130 per external breast prosthesis and limited to two per annum.	• Limited to and included in D20.1. • Limited to R7 130 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**				
D21.1	**General radiology (See B4)**				
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.	• Subject to available savings. • 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, (D14.1);

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
					• Organ and haemopoietic stem cell transplantation benefit, (D16.1), • Renal dialysis chronic benefit, (D22). 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**	• R38 470 per family. • 100% of the Bonitas Tariff. • R2 800 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.	• R37 800 per family. • 100% of the Bonitas Tariff. • R2 800 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.	• R30 430 per family. • 100% of the Bonitas Tariff. • R2 800 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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D21.3	**PET and PET – CT**	See D14.1.2.1.	See D14.1.2.1.	See D14.1.2.1.	
D22	**RENAL DIALYSIS CHRONIC**				
D22.1	**Haemodialysis and peritoneal dialysis (See B4)**	• 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 (D4.1). • Acute renal dialysis is included in hospitalisation costs. • See D7. Acc: No
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**				
D23.1	**In hospital and unattached operating theatres and other minor surgical procedures that can be authorised in hospital (See B4)**	• 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 (D10.1); • Organ and haemopoietic • stem cell (bone marrow) transplantation and immunosuppressive medication (D16.1). Acc: No
D23.1.1	**Refractive surgery**	R26 520 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,

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
					• congenital birth defects • and other surgery not • specifically mentioned in (D6). This benefit excludes: • Osseo-integrated implantation (D6); • Orthognathic surgery (D6); • Oral surgery (D6); • Impacted wisdom teeth (D6).
D23.2	**Out of hospital procedures in 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 rate applies 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)			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: Repeat – Limited: (2317) • Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread: (2318) • Evacuation of uterus: Incomplete abortion: Before 12 weeks gestation: (2445) • Evacuation: Missed abortion: Before 12 weeks gestation: (2449) • Excision of benign lip lesion: (1485) • Excision of malignant lip lesion (1487) • Excision of superficial eyelid tumour: (3163) • Extensive resection for malignant soft tissue tumour including muscle: (0313) • Flap repairs (large, complicated): 0295 • Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.: (1676) • 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 applies 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**	Subject to a R38 560 co-payment: • when hip or knee arthroplasty is performed by a non-DSP	Subject to a R38 560 co-payment: • when hip or knee arthroplasty is performed by a non-DSP.	• Subject to a R38 560 co-payment: • when hip or knee arthroplasty is performed by a non-DSP.	• Subject to the relevant managed healthcare programme and to its prior authorisation. • The co-payment to be waived if the cost of the service falls within the co-payment amount.
	Cataract Surgery	Subject to a R7 420 co-payment: • For voluntary use of a non-DSP.	Subject to a R7 420 co-payment • For voluntary use of a non-DSP.	Subject to a R7 420 co-payment • For voluntary use of a non-DSP.	
D23.4	**Day Surgery Procedures**	Subject to the Day Surgery Network. • R5 440 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	Subject to the Day Surgery Network. • R5 440 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	Subject to the Day Surgery Network. • R5 440 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the relevant managed healthcare programme and to its prior authorisation and subject to a defined list of procedures. • The co-payment to be waived if the cost of the service falls within the co-payment amount.
D24	**PREVENTATIVE CARE BENEFIT**				
D24.1	**Women's Health Breast Cancer Screening (See B4)**	Mammogram • Females age >40 years • Once every 2 years.	Mammogram • Females age >40 years • Once every 2 years.	Mammogram • Females age >40 years • Once every 2 years.	
	Cervical Cancer Screening	Pap Smear • Females 21-65 years • Once every 3 years.	Pap Smear • Females 21-65 years • Once every 3 years.	Pap Smear • Females 21-65 years • Once every 3 years.	Eligible beneficiaries may choose between the basic cytology test once every 3 years or HPV PCR test once every 5 years. Acc: No
	Cervical Cancer Screening in HIV infection	Pap Smear • Females 21-65 years	Pap Smear • Females 21-65 years	Pap Smear • Females 21-65 years	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		• 1 basic cytology test per annum or the HPV PCR once every 5 years.	• 1 basic cytology test per annum or the HPV PCR once every 5 years.	• 1 basic cytology test per annum or the HPV PCR once every 5 years.	
	Human Papilloma Virus (HPV) Vaccine	Limited to 3 doses for females between 15 – 26 years. • One course per lifetime. • Limited to R1 140 per vaccine.	Limited to 3 doses for females between 15 – 26 years. • One course per lifetime. • Limited to R1 140 per vaccine.	Limited to 3 doses for females between 15 – 26 years. • One course per lifetime. • Limited to R1 140 per vaccine.	
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, either as part of Preventative Care or Health Risk Assessment. See D27.1. • Upon a positive diagnosis, the HIV basket of care applies, subject to registration on the relevant managed healthcare programme.
D24.4	**Cardiac health: 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.	Pneumococcal Vaccination, including the administration fee of the nurse practitioner. • Age >65 Once every 5 years.	Pneumococcal Vaccination, including the administration fee of the nurse practitioner. • Age >65 Once every 5 years.	
		Faecal Occult Blood Test Ages 45 - 75 annually.	Faecal Occult Blood Test Ages 45 - 75 annually.	Faecal Occult Blood Test Ages 45 - 75 annually.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
		Bone Densitometry Screening: Females >Age 65 • Once every 5 years and Males >Age 70 • Once every 5 years.	Bone Densitometry Screening: Females >Age 65 • Once every 5 years and Males >Age 70 • Once every 5 years.		
D24.6	**Children's health Hypothyroidism**	1 TSH Test • Age <1 month	1 TSH Test • Age <1 month	1 TSH Test • Age <1 month	
	Infant Hearing Screening	One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	One infant hearing screening test for newborns up to 8 weeks, in or out of hospital, performed by an audiologist or speech therapist.	
	Neonatal Vision Screening: (For Retinopathy of prematurity (ROP) in neonates (<32 weeks gestational age and very low birth (<1500g))	• Two vision screening tests per beneficiary for newborns up to 6 weeks, in or out of hospital, performed by an ophthalmologist.	• Two vision screening tests per beneficiary for newborns up to 6 weeks, in or out of hospital, performed by an ophthalmologist.	• Two vision screening tests per beneficiary for newborns up to 6 weeks, in or out of hospital, performed by an ophthalmologist.	Screening should be performed at 4 – 6 weeks chronological age or 31 – 33 weeks post-conceptional age (whichever comes later).
	Human Papilloma Virus (HPV) Vaccine	Limited to two doses for girls aged between 9 – 14years. • One course per lifetime. • Limited to R1 140 per vaccine.	Limited to two doses for girls aged between 9 – 14years. • One course per lifetime. • Limited to R1 140 per vaccine.	Limited to two doses for girls aged between 9 – 14years. • One course per lifetime. • Limited to R1 140 per vaccine.	
	Extended Program on Immunisation (EPI)	Various Vaccinations, including the administration fee of the nurse practitioner for children up to the age of 12 years.	Various Vaccinations, including the administration fee of the nurse practitioner for children up to the age of 12 years.	Various Vaccinations, including the administration fee of the nurse practitioner for children up to the age of 12 years.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
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.	
D24.9	**Weight Management Programme, as managed via Active Disease Risk Management in Annexure D, paragraph 6.10**	Limited to 1 enrolment per beneficiary, subject to qualifying criteria and successful enrolment on the programme.	Limited to 1 enrolment per beneficiary, subject to qualifying criteria and successful enrolment on the programme.	Limited to 1 enrolment per beneficiary, subject to qualifying criteria and successful enrolment on the programme.	Subject to the contract with the preferred provider.
D24.10	**Smoking Cessation (GoSmokefree)**	Subject to available savings.	Subject to available savings and the Benefit Booster in D27.2.	Subject to available savings and the Benefit Booster in D27.2.	
D25	**INTERNATIONAL TRAVEL BENEFIT**				
D25.1	**Leisure travel: (Travelling for recreation, holiday or visiting family and friends)**	For medical emergencies when travelling outside the borders of South Africa. • 60 days excluding USA – R1.2 million per Member, R1.2 million for Member and Dependants • 60 days including USA – Maximum cover R500,000 for Member and Dependants.	For medical emergencies when travelling outside the borders of South Africa. • 60 days excluding USA – R1.2 million per Member, R1.2 million for Member and Dependants • 60 days including USA – Maximum cover R500,000 for Member and Dependants.	For medical emergencies when travelling outside the borders of South Africa. • 60 days excluding USA – R1.2 million per Member, R1.2 million for Member and Dependants • 60 days including USA – Maximum cover R500,000 for Member and Dependants.	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.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
					• The cover will only apply if a beneficiary tested positive.
D25.2	**Business Travel: (Primarily for attending meetings, conferences, visiting suppliers and for administrative purposes)**	For medical emergencies when travelling outside the borders of South Africa. • 30 days excluding USA – R1.2 million per MemberR1.2 million for Member and Dependants • 30 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. • 30 days excluding USA – R1.2 million per Member, R1.2 million for Member and Dependants • 30 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. • 30 days excluding USA – R1.2 million per Member, R1.2 million for Member and Dependants • 30 days including USA - Maximum cover R500,000 for Member and Dependants. • Subject to approval protocols prior to departure.	Subject to authorisation, prior to departure. • Additional benefits for Covid-19: ◦ additional costs for compulsory medical quarantine limited to R1 000 per day to a maximum of R10 000 for accommodation and PCR testing up to R1 000. ◦ The cover will only apply if a beneficiary tested positive. • Manual labour excluded - refers to any occupation or activity involving physical labour (use of hands or machinery).
D26	**AFRICA BENEFIT**				
D26.1	**In and Out of Hospital (See B4)**	• 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

REGISTERED BY ME ON
Mfana Maswanganyi
2025/12/18
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REGISTRAR OF MEDICAL SCHEMES

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	BONCOMPREHENSIVE	BONCLASSIC	BONCOMPLETE	CONDITION/REMARKS SUBJECT TO PMB
D27	**WELLNESS BENEFIT**				
D27.1	**Health Risk Assessment (HRA) which includes Lifestyle questionnaire and Wellness screening**	Wellness screening. • One assessment per beneficiary over the age of 21 years per annum by a registered provider, (wellness day or participating pharmacy.) • Payable from OAL. Limited to: • blood pressure test • glucose test • cholesterol test • body mass index • hip to waist ratio • HIV counselling and testing.	Wellness screening. • One assessment per beneficiary over the age of 21 years per annum by a registered provider, (wellness day or participating pharmacy • Payable from OAL. Limited to: • blood pressure test • glucose test • cholesterol test • body mass index • hip to waist ratio • HIV counselling and testing.	Wellness screening. • One assessment per beneficiary over the age of 21 years per annum by a registered provider, (wellness day or participating pharmacy.) • Payable from OAL. Limited to: • blood pressure test • glucose test • cholesterol test • body mass index • hip to waist ratio • HIV counselling and testing.	• HIV test, either as part of Preventative Care or Health Risk Assessment. See D24.3. • Upon a positive diagnosis, the HIV basket of care applies, subject to registration on the relevant managed healthcare programme. Acc: No

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, D11.1.3, D11.2, D13.2, D17.2, D18.2, D19.2, D21.1.2, D24 and virtual consultations).**	• No benefit.	Subject to completion of a physical Health Risk Assessment and the completion of the mental health questionnaire per beneficiary over the age of 21 years at a preferred provider network pharmacy or wellness day. • 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 • Registered ante-natal vitamins during pregnancy: D11.1.3 • Pharmacy advised therapy: D11.2 • Non-surgical procedures: D13.2 • Paramedical services: D17.2 • Pathology: D18.2 • Physical therapy: D19.2 • General radiology: D21.1.2 • Smoking cessation: D24.10	Subject to completion of a physical Health Risk Assessment and the completion of the mental health questionnaire per beneficiary over the age of 21 years at a preferred provider network pharmacy or wellness day. • 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 • Registered ante-natal vitamins during pregnancy: D11.1.3 • Pharmacy advised therapy: D11.2Non-surgical procedures: D13.2 • Paramedical services: D17.2 • Pathology: D18.2 • Physical therapy: D19.2 • General radiology: D21.1.2 • Smoking cessation: D24.10	• Child dependants under the age of 21 years will qualify for the Benefit Booster once the main member or an adult beneficiary has completed a physical Health Risk Assessment and the mental health questionnaire at a preferred provider network pharmacy or wellness day. • Valid qualifying claims will pay first from the Benefit Booster and thereafter from the relevant benefits as described in D1 – D24. • When a main member or adult beneficiary completes the physical health risk assessment (HRA) and mental health questionnaire at a preferred provider the Benefit Booster will become available. • 20% co-payment will apply to all non-network GP consultations (the 20% co-payment may be paid from available savings) • 20% co-payment applies to medicines on the acute out-of-formulary list and for the voluntary use of non-DSP. • Homeopathic medicines are excluded from the benefit.