6.10 Active Disease Risk Management

A coordinated system of health care interventions aimed at beneficiaries with chronic diseases with the emphasis being placed on the prevention of exacerbation and or complications utilising evidence based protocols and formularies. Essential components include the risk stratification of the beneficiary population so that interventions can be targeted; coordination of care, services and interventions; education and coaching with a focus on behaviour modification and self-management; and the ongoing monitoring of outcomes (quality, clinical and financial). The service may extend (but is not limited) to beneficiaries who fall within the following groups:

- High risk beneficiaries as identified through data analytics
- Emerging risk beneficiaries as identified through data analytics
- Beneficiaries with mental illness
- Diabetics
- Beneficiaries with chronic back and neck pain
- Beneficiaries with cardiovascular disease
- Beneficiaries who meet criteria for assistance with weight management

6.11 Specialist Referral Management

A programme adopted by the Fund, for all beneficiaries of the Fund, for the co-ordination of care whereby specialist referrals will need to be obtained through a family practioner, prior to consultation with a specialist. Failure to obtain referral authorization prior to consultation with a specialist, will result in non-payment of claims except for the exceptions listed in Annexure B.

6.12 Virtual Care Consultations

A programme adopted by the Fund, where members can consult with a network of registered practitioners using telehealth services.

6.13 Audiology Benefit Management

A programme adopted by the Fund to provide digital audiology pre-screening as well as screening for hearing loss, using peer-reviewed clinical pathways and treatment protocols for hearing loss, and providing appropriate hearing devices to members of the Fund.

7. PRESCRIBED MINIMUM BENEFITS

This section includes the membership benefits that relate to PMBs and non-PMB benefits and service entitlements.

Members and their registered dependants shall be entitled to prescribed minimum benefits for relevant health services, and each case shall be assessed individually with reference to Regulation 8 and Annexure A to the Regulations published in terms of the Act and the scheme's healthcare programmes and protocols.

7.1 Prescribed minimum benefits will be paid at cost and or the negotiated rate for medical specialists within the specialist network.

Select and the preferred provider for spinal surgery on the aforementioned options.

7.3.9 Designated service providers for chronic renal dialysis on all options.

7.3.10 Denis as the contracted service provider for dentistry on all options;

7.3.11 Preferred Provider Negotiators (PPN) for Optometry on all options, except Hospital Standard, BonEssential and BonEssential Select;.

7.3.12 Documentation Based Care (DBC) for conservative back and neck rehabilitation on all options except BonCap, BonStart and BonStart Plus.

7.3.13 Preferred supplier agreements for appliances and prostheses as specified in Annexure B paragraphs D3.1.1 and D20.1;

7.3.14 Ampath, Lancet, Pathcare and Vermaak for Pathology services.

7.3.15 Contracted provider for international cover on all options, except BonCap,.

7.3.16 Contracted Day Surgery Network for specified day procedures

7.3.17 Contracted Cataract Surgery Network

7.3.1.8 Alignd for oncology related palliative care services

7.3.1.9 Private Health Administrators (PHA) for the provision of healthcare services to members on the BonCap option.

7.3.1.10 Private Health Administrators (PHA) for the provision of audiology benefit management services.

7.4 Prescribed minimum benefits obtained from designated service providers

100% of negotiated cost in respect of diagnosis, treatment and care of prescribed minimum benefit conditions if those services are obtained from a designated service provider.

7.5 Prescribed minimum benefits voluntarily obtained from other providers

If a beneficiary voluntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition during the applicable waiting period or when benefits are exceeded from a provider other than a designated service provider, the member shall be required to pay the 40% co-payment on all options including BonComprehensive, where applicable.

7.6 Prescribed minimum benefits involuntarily obtained from other providers

7.6.1 If a beneficiary involuntarily obtains diagnosis, treatment and care in respect of a Prescribed Minimum Benefit condition from a provider other than a