



PEACE OF MIND
THROUGH AFFORDABLE HEALTHCARE

STANDARD OPTION 2017 BENEFITS

General disclaimers

The information in this brochure is subject to approval by the Council of Medical Schemes. This brochure is intended for marketing purposes and contains only a summary of the COMMED benefits. In terms of the Medical Schemes Act, medical schemes may apply waiting periods and/or late joiner penalties to new members joining. The member will be notified in writing should a waiting period or late joiner penalty apply.

GLOSSARY of terms

CDL	Chronic Disease List of 25 chronic conditions.	Clinical Protocols	These are used to manage benefits for specific conditions.
PMB	Prescribed Minimum Benefits. List of benefits in term of the Medical Schemes Act No. 131 of 1998	Co-Payments	A payment made by an individual who has health insurance, usually at the time a service is received, to offset some of the cost of care.
EMC	An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation.	Pre-Authorisation	Pre-Authorisation is important. Failure to authorise could result in your account not being covered in full.
Tariff	Claims are paid at Scheme/Negotiated Tariffs	DSP	A Designated Service Provider (DSP) is a healthcare provider (doctor, pharmacist, hospital, etc.) that is a medical scheme's first choice when its members need diagnosis, treatment or care for a PMB condition.
Limits	Limits are per annum unless otherwise indicated.	FRP	Formulary Reference Price.
Formulary	Approved List of Medication based on Clinical Protocols.	Out of Hospital Procedures	Procedures performed in the doctor's rooms.

Standard Option Benefits

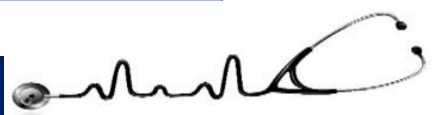
<p>Overall Annual Limit</p> <ul style="list-style-type: none"> Limited to R 730,000 per person Limited to R1 460,000 per family <p>Authorised admissions to Hospital</p>	<p>Pharmacy</p> <p>Acute Medicine</p> <ul style="list-style-type: none"> 100% of Scheme/Negotiated Tariff Subject to Medical Savings Account and Formulary Reference Price <p>Chronic Medicine</p> <ul style="list-style-type: none"> 100% of cost to a maximum of Single Exit Price plus the Preferred Provider dispensing fee Subject to Chronic programme protocols Unlimited for CDL conditions at 100% of cost Non CDL conditions are not covered <p>Pharmacist Advised Therapy (Over the Counter)</p> <ul style="list-style-type: none"> 100% of Scheme/Negotiated Tariff Subject to Medical Savings Account One script every 5 days
<p>Medical Savings Account</p> <p>Medical Savings Account:</p> <ul style="list-style-type: none"> 12, 5% of total contribution will be credited into members savings account 	
<p>Consultations</p> <p>General Practitioners and Specialist Consultations</p> <ul style="list-style-type: none"> 100% of Scheme/Negotiated Tariff Subject to Medical Savings Account, except for PMB <p>Emergency Room Treatment</p> <ul style="list-style-type: none"> 100% of Scheme/Negotiated Tariff Subject to Medical Savings Account, except for PMB 	
<p>Dentistry</p> <p>Conservative Dentistry (Including Dental Therapist)</p> <ul style="list-style-type: none"> 100% of Scheme/Negotiated Tariff Subject to Medical Savings Account, except for PMB <p>Specialised Dentistry</p> <ul style="list-style-type: none"> 100% of Scheme/Negotiated Tariff Subject to Medical Savings Account, except for PMB <p>Pre-authorisation required</p>	<p>Maternity Benefits</p> <p>Maternity</p> <ul style="list-style-type: none"> NVD Limited to 3 days in Hospital Caesar Limited to 4 days in Hospital Limited to 2 x 2D sonars per person Subject to pre-authorisation and DSP arrangements Only medically necessary caesareans are covered <p>Ante natal consultations</p> <ul style="list-style-type: none"> 100% of Scheme/Negotiated Tariff Subject to Medical Savings Account, except for PMB
<p>Ambulance & Emergency Services</p> <p>Contact ER24 on 084 124 for all emergencies</p> <ul style="list-style-type: none"> DSP Provider only 	
<p>Cover outside of South African Borders</p> <p>Emergency cover only when travelling in SADC countries. Subject to the equivalent of Scheme tariff rates and South African Currency</p>	<p>Optical Benefits</p> <p>Optical</p> <ul style="list-style-type: none"> 100% of Scheme/Negotiated Tariff Subject to Medical Savings Account Covers eye tests, frames, lenses or contact lenses



IMPORTANT CONTACT DETAILS

Please have your membership or ID number handy when contacting the Scheme

<p>Important Telephone Numbers</p>		<p>Important Email Addresses</p>	
Commed Call Centre	0861 311 911	General Email	admin@allcare.co.za
Dental Authorisations	0861 311 911	Authorisations	auths@allcare.co.za
Ambulance - ER24	084 124	Claims	claimsqueries@allcare.co.za
Chroni-Line (Chronic Medication)	0860 113 238	Membership	membership@allcare.co.za
Lifesense (HIV)	0860 506 080	<p>Website Address</p>	
Commed Fax Number	011 290 6378	Dashboard :	http://live.allcare.co.za
		Website :	www.commed.co.za



Radiology & Pathology

Radiology

X-Rays (black and white) Out of Hospital

- 100% of Scheme/Negotiated Tariff
- Subject to Medical Savings Account

X-Rays (black and white) in Hospital

- 100% of Scheme/Negotiated Tariff

MRI and CT Scans Only (In and Out of Hospital)

- 100% of Scheme/Negotiated Tariff
- Limited to R8,000 per person per year, with a co-payment of R2,000 per event on all procedures except for PMB
- Out-of-Hospital Benefit subject to Medical Savings Account

Mammogram Benefit

- 100% of Scheme Tariff, per female beneficiary over the age of 49 years, once every 2 years
- Limited to R2,500 with co-payment of R500 – except for PMB

Pathology

Out of Hospital

- 100% of Scheme/Negotiated Tariff
- Subject to Medical Savings Account

In Hospital

- 100% of Scheme/Negotiated Tariff, except for PMB

All the above benefits are subject to pre-authorization

External Appliances

Crutches, Wheelchairs, Hearing Aids and Artificial Limbs

- Limited to R10,000 per family per year
- Wheelchairs every 36 months
- Hearing Aids every 24 months, subject to Medical Savings Account
- Stoma Care, subject to Medical Savings Account

Subject to pre-authorization

Oncology

Oncology

- Limited to R275,000 per person
- Must be pre-authorized
- Designated Service Provider
- Use of SAOCA protocols

Supplementary Services

Physiotherapy, Occupational and Speech Therapy, Dieticians and Podiatrists

- 100% of Scheme/Negotiated Tariff
- Subject to Medical Savings Account, except for PMB

Hospitalisation

Hospital

- General Ward, High Care, ICU, Theatre and Medicine (formulary reference price)
- 100% of Scheme/Negotiated Tariff
- Subject to pre-authorization

R5,000 penalty will be levied if an out of network hospital is voluntarily used

Specialists

- 100% of Scheme/Negotiated Tariff, except for PMB
- Failure to obtain services from a network service provider will result in a co-payment of 30% of the specialists claim

Allied Healthcare Service (Occupational, Physiotherapists, Speech therapist and dieticians)

- 100% of Scheme/Negotiated Tariff
- Subject to pre-authorization

Prostheses and implants including hearing devices

- Limited to R35,000 per family per year
- Subject to pre-authorization

Mental Illness, Alcoholism and Drug Abuse

- No cover, except for PMB
- Limited to 21 days per annum
- Subject to pre-authorization

Step Down facilities, hospices, registered nurses and rehabilitation centres

- Limited to 14 days combined per person per year, except for PMB
- Hospice – 100% of cost
- Subject to pre-authorization

Co-payments apply to specific procedures

HIV/AIDS Management Programme

HIV/AIDS

- Hospitalisation in a private hospital
- Education and Counselling
- Monitoring
- ARV therapy
- Treatment of Opportunistic Infections

List of Chronic Conditions

Addison's Disease	Arthroscopy – except of diagnostic	2,500
Asthma	Circumcision – except when medically indicated	1,500
Bipolar Mood Disorder	Colonoscopy, Sigmoidoscopy, proctoscopy	2,000
Bronchiectasis	Cystoscopy	1,500
Cardiac Failure	Dental Admissions	1,500
Cardiomyopathy	Hospital and Anaesthetist	Part of Dental Limit
Chronic Renal Disease	Excision Nailbed	1,500
Chronic Obstructive Pulmonary Disease	Gastroscopy	2,000
Coronary Artery Disease	Hernia Repair	2,000
Crohn's Disease	Hysterectomy	3,000
Diabetes Insipidus	Hysteroscopy	3,000
Diabetes Mellitus Type 1 & 2	Joint replacements	5,500
Dysrhythmias	Laparoscopic procedures	3,000
Epilepsy	Myringotomy	1,500
Glaucoma	Nasal surgery (including endoscopy)	2,000
Haemophilia	Reflux Surgery	3,000
Hyperlipidaemia	Skin Lesions	1,500
Hypertension	Spinal surgery	5,500
Hypothyroidism	Urinary incontinence repair	3,500
Multiple Sclerosis	Varicose Veins	3,500
Parkinson's Disease		
Rheumatoid Arthritis		
Schizophrenia		
Systemic Lupus Erythematosus		
Ulcerative Colitis		

RATE TABLE - STANDARD OPTION

Salary Band	Member	Adult	Child
SALARY R0 - R6 000			
Risk Contribution	2,578	2,111	517
Savings - 12.5% of Gross	368	302	74
Gross Contribution	2,946	2,413	591
Annual Savings - Phase 1	4,419	3,620	887
SALARY R6 001 – R7 000			
Risk Contribution	2,783	2,281	558
Savings - 12.5% of Gross	398	326	80
Gross Contribution	3,181	2,607	638
Annual Savings - Phase 1	4,772	3,911	957
SALARY R7 001+			
Risk Contribution	3,005	2,463	604
Savings - 12.5% of Gross	429	352	86
Gross Contribution	3,434	2,815	690
Annual Savings - Phase 1	5,151	4,223	1,035

LATE JOINER PENALTIES

Premium penalties for persons joining late in life:

Premium penalties will be applied in respect of persons over the age of 35 years, who were without medical scheme cover for the period indicated hereunder after the age of 35 years as follows:

1 - 4	@	0.05 multiplied by the relevant contribution above
5 - 14	@	0.25 multiplied by the relevant contribution above
15 - 24	@	0.50 multiplied by the relevant contribution above
25+ years	@	0.75 multiplied by the relevant contribution above



IMPORTANT INFORMATION

All Benefits are subject to PMB guidelines and protocols

Where pre-authorization is required, failure to do so may result in a 30% penalty or non-payment of claims

All pre-authorization must be obtained **before** undergoing a procedure and/or admission.

All claims must be submitted within 120 days from date of treatment. **Claims submitted after 120 days will be rejected.** Please note that it remains the member's responsibility to ensure that claims are received by the Scheme for processing.

PMBs are defined by law. They are the minimum level of diagnosis, treatment and care that your Medical Scheme must cover and it must pay for your PMB condition/s. A designated service provider (DSP) is a healthcare provider (e.g. doctor, pharmacist, hospital) that is your medical scheme's first choice when you need treatment or care for a PMB condition. PMBs include 270 serious health conditions, any emergency condition and 26 chronic diseases, they can be found on our website by accessing the link provided below:-

www.medicalschemes.com/medical_schemes_pmb/index.htm

LIMITATIONS AND RESTRICTIONS OF BENEFITS

- The Scheme may require a second opinion in respect of proposed treatment or medication which may result in a claim for benefits and for that purpose the relevant beneficiary shall consult a dental or medical practitioner nominated by the Scheme and at the cost of the Scheme. The procedure to be followed in obtaining a second opinion is outlined in the relevant Scheme protocol (Protocol Regarding Requests for Second Opinions).
- Unless otherwise decided by the Scheme, benefits in respect of medicines obtained on a prescription are limited to one month's supply (or to the nearest unbroken pack) for every such prescription or repeat thereof.
- If the Scheme or its managed healthcare organisation has funding guidelines or protocols in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies with reference to the available funding guidelines and protocols irrespective of clinical guidelines.
- If the Scheme does not have funding guidelines or protocols in respect of benefits for services and supplies referred to in Annexure A, beneficiaries will only qualify for benefits in respect of those services and supplies if the Scheme or its managed healthcare organisation acknowledges them as medically necessary, and then subject to such conditions as the Scheme or its managed healthcare organisation may impose.
- "Medical necessity" is defined in the Scheme policy: Definition of Medical Necessity.
- The Scheme reserves the right not to pay for any new technology. Coverage of new technology will be assessed by the Scheme with due consideration given to:
 - Medical necessity;
 - Clinical evidence of its use in clinical medicine including outcome studies;
 - Its cost-effectiveness; Its affordability; Its safety.
 - Its value relative to existing services or supplies;
 - New technology is defined as any clinical intervention of a novel nature as well as those that the Scheme has not had previous experience with.
- A 10% co-payment will be applied on the following procedure codes:
 - 1034 - Autogenous nasal bone transplant: Bone removal included
 - 1035 - Functional endoscopic sinus surgery: Unilateral
 - 1036 - Functional endoscopic sinus surgery: Bilateral
 - 1087 - Sub-total reconstruction consisting of any two of the following: Septum plasty, osteotomy and nasal tip reconstruction
- Mirena Device - Fund according to scheme protocol:
 - 40 years of age. Not covered if used for contraception. Cover for abnormal uterine bleeding.
 - Insertion in rooms no co-payment applicable
 - Insertion in theatre – co-payment R800.00 even if done in conjunction with another procedure
 - Mirena device – cost from acute medicine benefit
- The Scheme reserves the right to impose and apply exclusions and limits to the benefits that will be paid for medicines/ procedures/interventions which have been accepted into the practice of clinical medicine through a process of health technology assessment/evaluation.
- Benefits in respect of the cost of emergency medical treatment, whilst abroad, are covered at the applicable South African tariff rates and RSA currency;
- High myopia – payable as per scheme protocols

- Biologicals and polygams will be subject to a 30% co-payment by the member. Subject to overall limit and preauthorization required from designated service provider
- In the event of an emergency, the Scheme shall be notified of such emergency within two working days after ADMISSION. Failing which, a levy of 10% or R 500 (whichever is higher) will be levied.
- In the case of a PMB, the scheme will pay according to the Scheme's protocols and at the Scheme's rates.
- In the case of a non PMB, the Scheme has the right to repudiate the claim.
- All costs which in the opinion of the Scheme's medical advisor are not medically necessary and appropriate and necessary to meet the health care needs of the patient, consistent with the diagnosis or condition; rendered in a cost effective manner and type of setting appropriate to the supply of the service required for purposes other than comfort or convenience; and consistent in type, frequency and duration of treatment with scientifically based guidelines of medical practice and of demonstrated medical value.
- The benefits covered include:
- Accommodation in hospital (ward fees i.e. for ICU, high care, general wards), theatre fees, medicines and disposables used in theatre, medicines and disposables used in the ward. surgical procedures including GP and specialist consultations whilst in hospital, approved diagnostic investigations, blood transfusions, physiotherapy and biokinetics, renal dialysis (if pre-authorization is obtained in writing from the Scheme's Medical Advisor) and emergency ambulance services.
- The benefits specifically excluded:
 - Oncology treatment, sterilization/vasectomy, internal prosthesis (unless pre-authorization is obtained in writing from the Scheme's Medical Advisor), dental hospitalisation, back surgery, outpatient visits (which are covered in 2 below), private nursing (unless pre-authorization is obtained in writing from the Scheme's Medical Advisor and only for the period granted by the Medical Advisor).

BENEFITS EXCLUDED

- General exclusions mentioned in this paragraph are not affected by any specific exclusion. Unless otherwise decided by the Scheme (and with the express exception of medicines or treatment approved and authorised in terms of any relevant managed healthcare programme), expenses incurred in connection with any of the following will not be paid by the Scheme:
- All costs that exceed the annual or biennial maximum allowed for the particular category as set out in Annexure A, for the benefits to which the member is entitled in terms of the rules;
 - All costs for operations, medicines, treatments and procedures for cosmetic purposes or for personal reasons;
 - If, in the opinion of the medical advisor, the healthcare service in respect of which a claim is made, is not appropriate and necessary for any aspect of the management of the medical condition at an affordable level of service and cost;
 - All costs for treatment, if the efficacy and safety of such treatment cannot be proved;
 - Cost incurred from a member which arose or may have arisen as a result of the actions or omission of another party.
 - Where such cost is a result of an injury sustained by the member the scheme will require a full injury report.
 - If such cost results from a work related injury the scheme will cover it and will be referred to the COID commissioner and any amounts paid out will be refunded to the Scheme.

- Where such cost result from negligence of another party that may result in a public liability insurance claim the scheme will cover the cost arising, subject to PMBs and annual benefits available in terms of the rules of the scheme.
- Where such cost result from a motor vehicle accident the following will apply in term of the Regulations of the RAF Act.:
 - Member and attorney must submit to the scheme a signed letter of undertaking that, if there is a successful RAF claim, all money paid with respect to medical expenses will be reimbursed in full to the medical scheme.
 - If a valid RAF claim exists and the member opts not to claim from the RAF the scheme will only cover medical expenses related to the accident, up to and including PMBs and annual benefits available.
 - The cost of any injury not covered by the RAF will be borne by the scheme at UPFS (Uniform Patient Fee Schedule) rates.
 - Cost for emergency treatment will be covered at the tariff published by the RAF in the regulations.
 - All costs for services rendered by:
 - Persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
 - Any institution, nursing home or similar institution, except a state or provincial hospital, not registered in terms of any law;
 - Abdominoplasties (including the repair of divarication of the abdominal muscles);
 - Accommodation and services provided in a geriatric hospital, old age home, frail care facility or the like (unless specifically provided for in Annexure A);
 - Acupuncture;
 - Anabolic steroids, immunostimulants (except for immunoglobulins and growth hormones, which are subject to pre-authorization by the relevant managed healthcare programme);
 - Ante and postnatal exercises;
 - Appointments which a beneficiary fails to keep;
 - Appliances, devices and procedures deemed by the Scheme not to be scientifically proven or appropriate;
 - Arch supports including shoe inserts and foot orthotics
 - Aromatherapy;
 - Autopsies;
 - Appliances
 - Back rests, chair seats and transfer boards unless motivated by a doctor
 - Toilet seat raisers unless motivated by a doctor
 - Bandages and dressings (except medicated dressings subject to authorisation by the relevant managed healthcare programme);
 - Beds and mattresses;
 - Ayurvedics medicine and related cost
 - Bilateral gynaecomastia in beneficiaries under the age of 18 years (in beneficiaries over 18 years Scheme protocol will apply);
 - Blepharoplasties;
 - Breast augmentation;
 - Breast reconstruction (unless necessitated by pre-authorized surgical mastectomy, traumatic mastectomy or congenital unilateral absence of a breast which is subject to Scheme protocol);
 - Breast reductions;
 - Nasal surgery done by a plastic surgeon, nasal cautery (procedure code 1069) if done with other intranasal procedures;
 - External cardiac assistive devices;
 - Coloured or cosmetic effect contact lenses, and contact lens accessories and contact lens solutions;

- Cosmetic preparations, emollients, moisturisers, medicated or otherwise, soaps, scrubs and other cleansers, sunscreen and sun tanning preparations, medicated shampoos and conditioners, not including coal tar products and the treatment of lice infestation, scabies and other microbial infections (subject to PMB regulations);
- Dental procedures or devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable; and costs for:
 - Anaesthetics in respect of dental services:
 - general anaesthetics, conscious analgo-sedation and hospitalisation for dental work except in the case of patients under the age of 7 years and bony impaction of third molars;
 - Labial frenectomies in respect of beneficiaries under the age of 12 years;
 - Orthodontic treatment over the age of 18 years;
 - Periodontal plastic procedures for cosmetic reasons;
 - Use of high impact acrylic and precious metal in dentures or the cost of precious metal as an alternative to semi-precious or non-precious metal in dental prosthesis;
 - Osseo-integrated tooth implants; genioplasty and dental osteotomy
 - Contraception other than oral contraceptives, IUD's for contraceptive purposes, contraceptive foams and barrier contraceptive methods;
 - Diagnostic kits, agents and appliances unless otherwise stated except for diabetic accessories (subject to PMB regulations and Scheme protocols);
 - Electric tooth brushes;
 - Treatment for erectile dysfunction and loss of libido;
 - Food and nutritional supplements including baby food and special milk preparations;
 - Sleep therapy for the treatment of depression;
 - Gender re-assignment treatment;
 - Genioplasty except as a consequence of major maxillofacial injury
 - Headaches: oral appliances and the ligation of temporal artery and its branches for the treatment of headaches;
 - Hirsutism;
 - Holidays for recuperative purposes;
 - Humidifiers;
 - Hyperbaric oxygen therapy subject to PMB regulations and Scheme protocols;
 - Infertility treatment, subject to PMB regulations;
 - Ionizers and air purifiers;
 - Iridology;
 - Surrogate pregnancy;
 - Keloid surgery, except for those resulting from burns and functional impairment deemed by the Scheme to medically necessary;
 - Laxatives, subject to Scheme protocols
 - Medical, surgical and orthopaedic appliances, devices and products, including oxygen hire or purchase and attachments, subject to PMB regulations and Scheme protocols;
 - Medication in respect of substance abuse treatment unless specifically authorised by the relevant managed healthcare programme, subject to PMB regulations;
 - Medicines not included in a prescription from a medical practitioner or other healthcare professional who is legally entitled to prescribe such medicines (except for schedule 0,1 and 2 medicines supplied by a registered pharmacist);
 - Medicine not approved by the Medicines Control Council or other statutory body empowered to approve/register medications;
 - MRI scans ordered by a general practitioner, subject to Scheme protocols;
 - Obesity treatment;

- Parenteral contraceptives;
- Optical devices excluded by the Scheme;
- Orthopaedic shoes and boots, subject to Scheme protocols;
- Osteopathy;
- Otoplasties;
- Pain relieving machines e.g. TENS, APS;
- Medicines, household remedies and propriety preparations and preparations not otherwise classified;
- Positron Emission Tomography (PET) scans ;
- Refractive surgery;
- Excimer laser treatment;
- Reflexology;
- Revision of scars ;
- Rhinoplasties;
- Smoking cessation and anti-smoking preparations;
- Stethoscopes;
- Sphygmomanometers/blood pressure monitors;
- Sunglasses and repairs to spectacle frames;
- Counselling, subject to prescribed minimum benefits;
- Telephone consultations;
- Tonics, evening primrose oil, fish liver oils, nutritional supplements, multivitamin preparations and minerals except prenatal vitamins as approved by the Scheme's pharmacy benefit management programme;
- Topical preparations excluding topical steroid and acne preparations;
- Travelling expenses ;
- Uvulo-palatal pharyngoplasty (UPPP and LAUP);
- Veterinary products;
- Pharmacy service fees, except for services related to the Schemes preventative benefit which requires pre-authorization;
- Facility fees;
- Fentonplasty;
- Insulin pumps except for children 7 years or younger subject to Scheme protocols ;
- Services rendered during any waiting periods that are imposed on the member or any dependent joining the Scheme;
- Medical expenses resulting from the treatment of occupational diseases and injuries;
- All claims where ICD-10 codes are missing, invalid or incomplete will be rejected;
- Allergy tests ordered by general practitioners
- Radiotherapy for non-malignant conditions
- Bone substitutes
- Nasal tip reconstructions
- Private isolation in ICU and High Care and barrier not covered
- Bariatric surgery
- Virtual colonoscopy
- Somatostatins except after medically necessary surgical intervention

- Hypnosis therapy
- Preoperative day admission with exception of invasive preoperative preparation
- Surgical treatment for hyperhidrosis
- Examination and tests for purposes of visa or insurance application
- Interest and legal costs on outstanding account
- Professionally applied topical fluoride in adults
- Root canal treatment on third molars
- Pulp capping
- Bleaching
- Crowns on third molars
- Pontics on second molars
- Crowns used to repair teeth damaged due to bruxism erosion or fluorosis
- Crowns used to restore teeth for cosmetic reasons
- Fixed prosthodontics (crowns) where a reasonable attempt has not been made to restore or replace the tooth conservatively
- Fixed prosthodontics (crowns) where the member is periodontally compromised
- Crowning of teeth involving failed root canal treatment
- PerioChip
- Orthodontic re-treatment
- Cost of implant component
- Cost of gold, precious metal or semi-precious metal
- Full series peri-apical radiographs
- Porcelain/ceramic crowns
- Metal, porcelain or resin inlays
- Treatment of attrition or abrasion
- Temporary crown/emergency crown
- Oral/facial image for dentist work
- Special report
- Cosmetic dentistry
- Composite veneer
- Orthodontic/removable appliance repairs
- Cantilever bridges
- Veneer
- Orthognathic and associated hospitalization
- Mouth protectors/gum guards
- Ozone therapy
- Lingual orthodontics/ceramic brackets
- Snoring appliances including dental laboratory and material costs
- Storing/caring case for intra-oral appliances
- Resin bonding for restoration
- Alveola augmentation



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