2018 PRODUCT BROCHURE

Bonitas

INDEX

WHY **BONITAS**

- Affordable, quality healthcare for all South Africans
- A wide range of plans including savings, traditional, income based and hospital options
- Largest GP network and a specialist network to give more value for money
- Simple, easy to use benefits
- Separate benefits for dentistry and optometry on several options, paid from risk
- Cover for up to 60 chronic conditions and free medicine delivery
- Preventative care and wellness benefits paid from risk so benefits last longer
- Partnerships with quality service providers and healthcare professionals
- Additional benefits for maternity and children, including access to 24/7 paediatric telephonic advice, 365 days a year
- Managed Care programmes to help members manage a range of conditions including cancer, mental health, HIV/AIDS and diabetes

IMPORTANT **INFORMATION**

PREFERRED PROVIDERS AND DESIGNATED SERVICE PROVIDERS

We negotiate rates with preferred providers and Designated Service Providers to ensure that they do not charge you more than the agreed rate. This will ensure that your benefits last as long as possible and give you more value for money.

Please note: Where you are required to use a Designated Service Provider and you do not do so, a significant co-payment will apply.

You can call us on **0860 002 108** or log in to **www.bonitas.co.za** to view the list of preferred providers and Designated Service Providers.

UNDERSTANDING THE BONITAS RATE

The Bonitas Rate is the rate at which we reimburse healthcare providers.

Where we pay 100% of the Bonitas Rate and your healthcare provider charges more than this, you will have to pay the outstanding amount. For example, if you visit a healthcare provider that charges 200% of the medical aid rate and you receive a bill of R1 000, we will only pay R500.

If you visit a healthcare provider that charges the Bonitas Rate, we will pay the bill in full (provided that you have benefits available).

On some options we pay more than 100% of the Bonitas Rate.

UNDERSTANDING THE SELF-PAYMENT GAP

On BonComprehensive and BonComplete, once you have finished your savings for the year, you will reach the self-payment gap. The self-payment gap shows an amount for out-of-hospital expenses you must pay before you can access the above threshold benefit.

PROVIDERS ON THE NETWORK WILL BE PAID IN FULL

We encourage all our members to use providers on our network, as this will ensure that providers are paid in full (provided that you have benefits available).

DEPENDANTS

An *adult dependant* is any dependant on your medical aid who is 21 years or older.

A *child dependant* is any dependant on your medical aid who is under 21 years.

If your child is a student and is registered on your medical aid, child rates will apply up to and including the last day of the month in which he/she turns 24 years old. We will require valid proof of registration from a recognised tertiary institution for child rates to apply to a student.

UNDERWRITING

Late-joiner penalties and waiting periods may apply to your membership. This is a requirement of the Medical Schemes Act 131 of 1998.

A *late-joiner* penalty applies to members 35 years of age or older, who have had a break in medical aid membership for more than 3 months from 1 April 2001. Late-joiner penalties will result in your premium being increased. This is based on a specific calculation considering the number of years you have not been a member of a medical aid.

A *general waiting period* lasts 3 months. During this period you and your dependants are not entitled to claim any benefits, except, Prescribed Minimum Benefits (PMB) in some circumstances.

A *condition-specific waiting period* lasts 12 months. During this period you and your dependants are not entitled to claim benefits related to a specific condition.

Please refer to Annexure D of the Scheme Rules for more information. Visit **www.bonitas.co.za** for the latest version.

PRORATION OF BENEFITS

If you join Bonitas during the year, benefits will automatically be prorated. This means that you will only have access to a percentage of your benefits, based on the month you join us, until the next benefit year begins. For example, if you join in July, you will have access to six months' worth of benefits, which is 50% of the total benefits.

HOW OUR **PLANS WORK**

SAVINGS OPTION

OUT-OF-HOSPITAL
Day-to-day medical expenses
Use as you choose ⟷ Carry over each year

Self-payment gap

Above threshold benefits

Additional benefits
(giving you more value, does not affect other benefit limits or savings)
- Maternity
- Preventative care
- Wellness
- Childcare

Chronic benefits
(including PMBs)

IN-HOSPITAL
Unlimited, at Bonitas Rate

Network | Non-network

BONITAS SAVINGS OPTION
- **BonComprehensive**, **BonClassic**, **BonComplete** and **BonSave** - No hospital network
- **BonFit** - Hospital network
- Above threshold benefit available on **BonComprehensive** and **BonComplete**

TRADITIONAL OPTION

OUT-OF-HOSPITAL
Day-to-day benefits
Set benefit limits for daily medical expenses ⟷ Does not carry over each year

Additional benefits
(giving you more value, does not affect other benefit limits or savings)
- Maternity
- Preventative care
- Wellness
- Childcare

Chronic benefits
(including PMBs)

IN-HOSPITAL
Unlimited, at Bonitas Rate

Network | Non-network

BONITAS TRADITIONAL OPTION
- **Standard** and **Primary** - No hospital network
- **Standard Select** - Hospital network

INCOME BASED OPTION

OUT-OF-HOSPITAL
Set benefit limits for daily medical expenses

Additional benefits
(giving you more value, does not affect other benefit limits or savings)
- Maternity
- Preventative care
- Wellness
- Childcare

Chronic benefits
For 27 PMBs

IN-HOSPITAL
Unlimited, at Bonitas Rate
Network

BONITAS INCOME BASED OPTION
- **BonCap** - Hospital network

Please note: Contributions for BonCap are income-based. Income will be verified once a year.

HOSPITAL OPTION

OUT-OF-HOSPITAL
N/A

Additional benefits
(giving you more value, does not affect other benefit limits or savings)
- Maternity
- Preventative care
- Wellness
- Childcare

Chronic benefits
For 27 PMBs

IN-HOSPITAL
Unlimited, at Bonitas Rate
Non-network

BONITAS HOSPITAL OPTION
- **Hospital Plus**, **Hospital Standard** and **BonEssesntial** - No hospital network

OVERVIEW OF **OUR PLANS**

	BonComprehensive	BonClassic	BonComplete	BonSave	BonFit	Standard
In-hospital benefits						
Unlimited hospital cover	✓	✓	✓	✓	✓	✓
Bonitas Rate for hospital cover*	300%	100%	100%	150%	100%	100%
Hospital network	x	x	x	x	✓	x
Prostheses	✓	✓	✓	✓	x	✓
Oncology	✓	✓	✓	✓	✓	✓
Mental health	✓	✓	✓	✓	✓	✓
Out-of-hospital benefits						
Day-to-day, GP consultations/Savings	✓	✓	✓	✓	✓	✓
Chronic conditions covered	60	47	31	27	27	45
Specialist consultations	✓	✓	✓	✓	✓	✓
Blood and lab tests	✓	✓	✓	✓	✓	✓
Specialised radiology (CT scans, MRIs) with no co-payments	✓	✓	✓	✓	✓	✓
X-rays	✓	✓	✓	✓	✓	✓
Basic dentistry	✓	✓	✓	✓	✓	✓
Specialised dentistry	✓	✓	✓	x	x	✓
Optometry	✓	✓	✓	✓	✓	✓
Mental health consultations	✓	✓	✓	✓	✓	✓
Additional benefits						
Maternity benefits	✓	✓	✓	✓	✓	✓
24/7 Baby advice line for children under 3	✓	✓	✓	✓	✓	✓
Separate benefit for paediatric consultations	✓	x	✓	✓	✓	✓
Wellness benefits	✓	✓	✓	✓	✓	✓
Preventative care	✓	✓	✓	✓	✓	✓
International travel benefit	✓	✓	✓	✓	✓	✓

* **Please note:** Network specialists will be covered in full.
** Contributions for BonCap are income-based. Income will be verified once a year.

Standard Select	Primary	BonCap**	Hospital Plus	Hospital Standard	BonEssential
✓	✓	✓	✓	✓	✓
100%	**100%**	**100%**	**200%**	**100%**	**100%**
✓	x	✓	x	x	x
✓	✓	x	✓	✓	x
✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	✓	✓
✓	✓	✓	x	x	x
45	**27**	**27**	**27**	**27**	**27**
✓	✓	✓	x	x	x
✓	✓	✓	x	x	x
✓	✓	✓	✓	✓	x
✓	✓	✓	x	x	x
✓	✓	✓	x	x	x
✓	x	x	x	x	x
✓	✓	✓	x	x	x
✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	✓	✓
✓	✓	x	✓	✓	x
✓	✓	✓	✓	✓	✓
✓	✓	✓	✓	✓	✓
✓	✓	x	✓	✓	✓

BONCOMPREHENSIVE

SAVINGS OPTION

This first-class savings plan offers ample savings, an above threshold benefit and extensive hospital cover.

In-hospital

Unlimited, consultations & treatment at 300%

R589 000 **cancer benefit** per family - R233 700 of this can be used for **specialised drugs**

No co-payment for **scans**

Unlimited blood tests, scans & x-rays at 100%

Cochlear implants R264 500 per family

Internal nerve stimulators R157 700 per family

Internal prosthesis R52 480 per family

External prosthesis R52 480 per family

Cover for refractive **laser eye surgery**

Unlimited terminal care benefit

Out-of-hospital

Rich savings & unlimited above threshold benefit

No co-payments in threshold

R15 130 **mental health** benefit for **consultations** paid from risk

R29 840 for **MRIs & CT scans** with no co-payments

Chronic benefits

60 **conditions** covered

R26 240 **chronic benefit** per family

Comprehensive medicine list

Can **use any pharmacy** for prescribed medicine

Managed Care programmes to help members manage a range of conditions including cancer, mental health, HIV/AIDS and diabetes

Additional benefits

R1 500 per family for **contraceptives**

12 **maternity** consultations, **a private room**, antenatal classes, **amniocentesis** & 2 x **2D scans**

Wellness screening & R2 420 **wellness extender** per family

Preventative care for mammograms, pap smears, lipograms, prostate screening, flu vaccines & more

Childcare benefits including paediatrician & GP consultations, **newborn hearing screening, congenital hypothyroidism screening, Babyline** & cover for **childhood immunisations**

International travel benefit of up to R10 million per family per trip

Contributions

Main member	Adult dependant	Child dependant
R5 774	R5 446	R1 175

Your 4th and subsequent children will be covered free of charge.

Savings

	Main member	Adult dependant	Child dependant
Savings	R13 068	R12 324	R 2 664
Self-payment gap	R 3 810	R 3 150	R 1 450
Threshold level	R16 878	R15 474	R 4 114
Above threshold benefit	Unlimited	Unlimited	Unlimited

IN-HOSPITAL BENEFITS

Cover for major medical events that result in a beneficiary being admitted into hospital.

Pre-authorisation is required. Managed Care protocols apply.

We negotiate extensively with hospitals to ensure the best possible value for our members. Members have access to all private hospitals. A 30% co-payment may apply to admissions at specific hospitals. Please call us on **0860 002 108** or log in to **www.bonitas.co.za** for a list of these hospitals.

Specialist consultations/ treatment	Unlimited, covered at 300% of the Bonitas Rate
GP consultations/treatment	Unlimited, covered at 300% of the Bonitas Rate
Blood tests and other laboratory tests	Unlimited, covered at 100% of the Bonitas Rate
X-rays and ultrasounds	Unlimited, covered at 100% of the Bonitas Rate
MRIs and CT scans (specialised radiology)	Unlimited Pre-authorisation required
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Unlimited, covered at 100% of the Bonitas Rate Your therapist must get a referral from the doctor treating you in hospital
Internal prosthesis	R52 480 per family
External prosthesis	R52 480 per family Sublimit of R5 000 per breast prosthesis (limited to 2 per year)
Internal nerve stimulators	R157 700 per family
Deep brain stimulation (excluding prosthesis)	R222 200 per beneficiary
Cochlear implants	R264 500 per family You must use a preferred supplier
Mental health hospitalisation	R44 650 per family No cover for physiotherapy for mental health admissions You must use a Designated Service Provider
Take-home medicine	R520 per beneficiary, per hospital stay
Physical rehabilitation	R47 250 per family
Alternatives to hospital (hospice, step-down facilities)	R15 760 per family
Terminal care	Unlimited Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
Cancer treatment	R589 000 per family R233 700 of this can be used for specialised drugs (including biological drugs) Sublimit of R42 110 per beneficiary for Brachytherapy
Non-cancer specialised drugs (including biological drugs)	R186 900 per family
Organ transplants	Unlimited Sublimit of R30 000 per beneficiary for corneal grafts
Kidney dialysis	Unlimited You must use a Designated Service Provider, or a 20% co-payment will apply
HIV/AIDS	Unlimited, if you register on the HIV/AIDS programme

OUT-OF-HOSPITAL BENEFITS

These benefits provide cover for consultations with your GP or specialist, acute medicine, x-rays, blood tests and other out-of-hospital medical expenses.

	Main member	Adult dependant	Child dependant
Savings	R13 068	R12 324	R 2 664
Self-payment gap	R 3 810	R 3 150	R 1 450
Threshold level	R16 878	R15 474	R 4 114
Above threshold benefit	Unlimited	Unlimited	Unlimited

Once your savings for the year are finished, you will need to pay for day-to-day medical expenses out of your own pocket until you have paid the full self-payment gap. You will then reach the threshold level and have access to your above threshold benefit. Please submit all claims you have paid while in the self-payment gap to us, so that we can keep a record. Claims accumulate at the Bonitas Rate. Not all claims accumulate to the threshold level.

Please note: You must get a GP referral for specialist consultations (excluding consultations with oncologists and ophthalmologists; maternity consultations and consultations with paediatricians for children under age 2).

GP consultations	Paid from available savings and/or above threshold benefit
Specialist consultations	Paid from available savings and/or above threshold benefit You must get a referral from your GP
Blood tests and other laboratory tests	Paid from available savings and/or above threshold benefit
X-rays and ultrasounds	Paid from available savings and/or above threshold benefit

MRIs and CT scans (specialised radiology)	R29 840 per family Pre-authorisation required
Acute medicine	Paid from available savings and/or above threshold benefit
Over-the-counter medicine	Paid from available savings and/or above threshold benefit
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Paid from available savings and/or above threshold benefit
Mental health consultations	R15 130 per family In and out-of-hospital consultations (included in the mental health hospitalisation benefit) No cover for educational psychologists for beneficiaries older than 21 years
Refractive laser eye surgery	R19 780 per family Pre-authorisation required
General medical appliances (such as wheelchairs and crutches)	R7 990 per family An additional R5 870 per family will apply should Stoma care and CPAP machines exceed the general medical appliances limit You must use a preferred supplier
Hearing aids	R24 550 per family, once every 2 years (based on the date of your previous claim) 10% co-payment applies You must use a preferred supplier
Optometry	Limited to R2 880 per beneficiary Subject to available savings and/or above threshold benefit
Basic dentistry	Paid from available savings and/or above threshold benefit
Consultations	Once per beneficiary, every 6 months
X-rays: Intra-oral	Managed Care protocols apply
X-rays: Extra-oral	1 per beneficiary, every 3 years Additional benefits may be considered where specialist dental treatment is required
Oral hygiene	Once per beneficiary, every 6 months Fissure sealants are only covered for children under 16 years Fluoride treatments are only covered for children from age 5 and younger than 16 years
Fillings	Benefit for fillings is granted once per tooth, in 365 days Benefit for re-treatment of a tooth is subject to Managed Care protocols A treatment plan and x-rays may be required for multiple fillings
Root canal therapy and extractions	Managed Care protocols apply
Plastic dentures and associated laboratory costs	1 set of plastic dentures (an upper and a lower) per beneficiary, once every 4 years
Specialised dentistry	Paid from available savings and/or above threshold benefit
Partial metal frame dentures and associated laboratory costs	2 partial frames (an upper and a lower) per beneficiary, once every 5 years Managed Care protocols apply
Crowns, bridges and associated laboratory costs	3 crowns per family, per year Benefit for crowns will be granted once per tooth, every 5 years A treatment plan and x-rays may be requested Pre-authorisation required
Implants and associated laboratory costs	2 implants per beneficiary, once every 5 years Cost of implant components is limited to R2 490 per implant Managed Care protocols apply Pre-authorisation required
Orthodontics and associated laboratory costs	Orthodontic treatment is granted once per beneficiary, per lifetime Pre-authorisation cases will be clinically assessed by using an orthodontic needs analysis Benefit allocation is subject to the outcome of the needs analysis and funding can be granted up to 100% of the Bonitas Dental Tariff Benefit for orthodontic treatment will be granted where function is impaired (not granted for cosmetic reasons) Only 1 family member may begin orthodontic treatment in a calendar year Benefit for fixed comprehensive treatment is limited to beneficiaries from age 9 and younger than 18 years Managed Care protocols apply Pre-authorisation required
Periodontics	Benefit is limited to conservative, non-surgical therapy only and will only be applied to members who are registered on the Periodontal Programme Managed Care protocols apply Pre-authorisation required

Maxillo-facial surgery and oral pathology	
Surgery in the dental chair	Managed Care protocols apply
Hospitalisation (general anaesthetic)	General anaesthetic is only available to children under the age of 5 for extensive dental treatment General anaesthetic benefit is available for the removal of impacted teeth Managed Care protocols apply Pre-authorisation required
Laughing gas in dental rooms	Managed Care protocols apply
IV conscious sedation in rooms	Limited to extensive dental treatment Managed Care protocols apply Pre-authorisation required

CHRONIC BENEFITS

BonComprehensive offers extensive cover for the 60 chronic conditions listed below. This is limited to R13 170 per beneficiary and R26 240 per family on the applicable formulary. Pre-authorisation is required. If you choose to use medicine that is not on the formulary, you will have to pay a 40% co-payment.

You can get your medicine from any pharmacy.

Once the amount above is finished, you will still be covered for the 27 Prescribed Minimum Benefits, listed below.

Prescribed Minimum Benefits covered

1.	Addison's Disease	10.	Crohn's Disease	19.	Hyperlipidaemia
2.	Asthma	11.	Diabetes Insipidus	20.	Hypertension
3.	Bipolar Mood Disorder	12.	Diabetes Type 1	21.	Hypothyroidism
4.	Bronchiectasis	13.	Diabetes Type 2	22.	Multiple Sclerosis
5.	Cardiac Failure	14.	Dysrhythmias	23.	Parkinson's Disease
6.	Cardiomyopathy	15.	Epilepsy	24.	Rheumatoid Arthritis
7.	Chronic Obstructive Pulmonary Disease	16.	Glaucoma	25.	Schizophrenia
8.	Chronic Renal Disease	17.	Haemophilia	26.	Systemic Lupus Erythematosus
9.	Coronary Artery Disease	18.	HIV/AIDS	27.	Ulcerative Colitis

Additional conditions covered

28.	Acne	39.	Dermatomyositis	50.	Obsessive Compulsive Disorder
29.	Allergic Rhinitis	40.	Depression	51.	Osteoporosis
30.	Alzheimer's Disease (early onset)	41.	Eczema	52.	Paget's Disease
31.	Ankylosing Spondylitis	42.	Gastro-Oesophageal Reflux Disease (GORD)	53.	Panic Disorder
32.	Anorexia Nervosa	43.	Generalised Anxiety Disorder	54.	Polyarteritis Nodosa
33.	Attention Deficit Disorder (in children aged 5-18)	44.	Gout	55.	Post-Traumatic Stress Disorder
34.	Barrett's Oesophagus	45.	Huntington's Disease	56.	Pulmonary Interstitial Fibrosis
35.	Behcet's Disease	46.	Hyperthyroidism	57.	Psoriatic Arthritis
36.	Bulimia Nervosa	47.	Myaesthenia Gravis	58.	Systemic Sclerosis
37.	Cystic Fibrosis	48.	Narcolepsy	59.	Tourette's Syndrome
38.	Dermatitis	49.	Neuropathies	60.	Zollinger-Ellison Syndrome

ADDITIONAL BENEFITS

We believe in giving you more value. These additional benefits will not affect your other benefit limits or savings.

Contraceptives	
For women aged up to 50	R1 500 per family
Maternity care	
Per pregnancy	Private ward after delivery 12 antenatal consultations with a gynaecologist, GP or midwife 2 2D ultrasound scans R1 160 for antenatal classes 1 amniocentesis 4 consultations with a midwife after delivery A Bonitas baby bag (you must register for this after obtaining pre-authorisation for the delivery)

Childcare	
Hearing screening	For newborns, in or out of hospital
Congenital hypothyroidism screening	For infants under 1 month old
Babyline	Access to telephone helpline for 24/7 medical advice (including weekends and holidays for children under 3 years)
Paediatric consultations	3 consultations per child under 1 year 2 consultations per child between ages 1 and 2
GP consultations	2 consultations per child between ages 2 and 12
Immunisations	According to Expanded Programme on Immunisation in South Africa 1 flu vaccine per child
Preventative care	
General health	1 HIV test per beneficiary 1 flu vaccine per beneficiary
Cardiac health	1 full lipogram every 5 years, for members aged 20 and over
Women's health	1 mammogram every 2 years, for women between ages 40 and 74 1 pap smear every 3 years, for women between ages 21 and 65
Men's health	1 prostate screening antigen test for men between ages 55 and 69, who are considered to be at high risk for prostate cancer
Elderly health	1 pneumococcal vaccine every 5 years, for members aged 65 and over 1 stool test for colon cancer, for members between ages 50 and 75 1 bone density screening every 5 years, for women aged 65 and over and men aged 70 and over

Wellness benefits	
Wellness screening	1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day Wellness screening includes the following tests: • Blood pressure • Glucose • Cholesterol • Body mass index • Waist-to-hip ratio
Wellness extender	R2 420 per family Once each adult beneficiary has completed a wellness screening, you may choose from the following additional benefits: • GP consultation(s) • Biokineticist consultation(s) • Dietician consultation(s) • Physiotherapy consultation(s) • A programme to stop smoking All claims are paid at the Bonitas Rate Child dependants will qualify once an adult beneficiary has completed a wellness screening
International travel benefit	
Per trip	R5 million per beneficiary R10 million per family Including cover for mandatory vaccines You must register for this benefit

BONCLASSIC

SAVINGS OPTION

This generous savings option offers a wide range of medical benefits, in and out of hospital.

In-hospital

Unlimited, consultations & treatment at 100% - network doctors and specialists paid in full

R390 900 **cancer benefit** per family

R116 800 benefit for non-oncology **specialised drugs**

Unlimited blood tests, scans & x-rays at 100%

No co-payment for **scans**

Cochlear implants R264 500 per family

Internal & external prosthesis R52 000 per family

Unlimited terminal care benefit

Out-of-hospital

Rich savings

R15 130 **mental health** benefit for **consultations** paid from risk

R27 610 for **MRIs & CT scans** with no co-payments

Separate R4 590 **x-rays** benefit & R6 560 **blood tests** benefit per family

Separate benefit for **paramedical services** (eg occupational therapy and dieticians)

Optical and dental benefits (specialised and basic) in addition to savings

Chronic benefits

47 **conditions** covered

R22 320 **chronic benefit** per family

Chronic medicine delivery to your doorstep through the Designated Service Provider

Managed Care programmes to help members manage a range of conditions including cancer, mental health, HIV/AIDS and diabetes

Additional benefits

R1 500 per family for **contraceptives**

12 **maternity** consultations, antenatal classes, **amniocentesis** & 2 x **2D scans**

Wellness screening & R1 670 **wellness extender** per family

Preventative care for mammograms, pap smears, lipograms, bone density screening for men and women, flu vaccines & more

Childcare benefits including **newborn hearing screening, congenital hypothyroidism screening** & **Babyline**

International travel benefit of up to R10 million per family per trip

Contributions

Main member	Adult dependant	Child dependant
R4 009	R3 442	R 990

Your 4th and subsequent children will be covered free of charge.

Savings

	Main member	Adult dependant	Child dependant
Savings	R 6 804	R 5 844	R 1 680

IN-HOSPITAL BENEFITS

Cover for major medical events that result in a beneficiary being admitted into hospital.

Pre-authorisation is required. Managed Care protocols apply.

We negotiate extensively with hospitals to ensure the best possible value for our members. Members have access to all private hospitals. A 30% co-payment may apply to admissions at specific hospitals. Please call us on **0860 002 108** or log in to **www.bonitas.co.za** for a list of these hospitals.

Specialist consultations/ treatment	Unlimited, network specialists covered in full Unlimited, non-network specialists paid at 100% of the Bonitas Rate
GP consultations/treatment	Unlimited, covered at 100% of the Bonitas Rate
Blood tests and other laboratory tests	Unlimited, covered at 100% of the Bonitas Rate
X-rays and ultrasounds	Unlimited, covered at 100% of the Bonitas Rate
MRIs and CT scans (specialised radiology)	R27 610 per family, in and out of hospital Pre-authorisation required
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Unlimited, covered at 100% of the Bonitas Rate Your therapist must get a referral from the doctor treating you in hospital
Internal and external prostheses	R52 000 per family Managed Care protocols apply Sublimit of R5 000 per breast prosthesis (limited to 2 per year) You must use a preferred supplier
Spinal surgery	You will have to pay a R5 650 co-payment if you do not go for an assessment through the back and neck programme
Hip and knee replacements	You will have to pay a R5 650 co-payment if you do not use the preferred provider
Cochlear implants	R264 500 per family You must use a preferred supplier
Mental health hospitalisation	R39 250 per family No cover for physiotherapy for mental health admissions You must use a Designated Service Provider
Take-home medicine	R445 per beneficiary, per hospital stay
Physical rehabilitation	R47 250 per family
Alternatives to hospital (hospice, step-down facilities)	R15 760 per family
Terminal care	Unlimited Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
Cancer treatment	R390 900 per family You must use a preferred provider Sublimit of R42 110 per beneficiary for Brachytherapy
Non-cancer specialised drugs (including biological drugs)	R116 800 per family 10% co-payment applies Managed Care protocols apply
Organ transplants	Unlimited Sublimit of R30 000 per beneficiary for corneal grafts
Kidney dialysis	Unlimited You must use a Designated Service Provider, or a 20% co-payment will apply
HIV/AIDS	Unlimited, if you register on the HIV/AIDS programme Chronic medicine must be obtained from the Designated Service Provider

OUT-OF-HOSPITAL BENEFITS

These benefits provide cover for consultations with your GP or specialist, acute medicine, x-rays, blood tests and other out-of-hospital medical expenses.

	Main member	Adult dependant	Child dependant
Savings	R 6 804	R 5 844	R 1 680

GP consultations	Paid from available savings	
Specialist consultations	Paid from available savings You must get a referral from your GP	
Blood tests and other laboratory tests	R2 960 per beneficiary R6 560 per family	
X-rays and ultrasounds	R2 960 per beneficiary R4 590 per family	
MRIs and CT scans (specialised radiology)	R27 610 per family, in and out of hospital Pre-authorisation required	
Acute medicine	Paid from available savings	
Over-the-counter medicine	Paid from available savings	
Paramedical/Allied medical professionals (such as occupational therapists and dieticians)	Main member only Main member + 1 dependant Main member + 2 dependants Main member + 3 dependants Main member + 4 or more dependants	R2 820 R4 330 R4 990 R5 330 R5 710

Physical therapy (such as physiotherapists and biokineticists)	R1 460 per beneficiary R2 960 per family
Mental health consultations	R15 130 per family In and out-of-hospital consultations (included in the mental health hospitalisation benefit) No cover for educational psychologists for beneficiaries older than 21 years
General medical appliances (such as wheelchairs and crutches)	R7 410 per family
Hearing aids	R16 080 per family, once every 3 years (based on the date of your previous claim) 10% co-payment applies You must use a preferred supplier
Optometry	R5 300 per family, once every 2 years (based on the date of your previous claim) Each beneficiary can choose glasses or contact lenses
Eye tests	1 per beneficiary, once every 2 years at a network provider, at network rates **OR** R350 per beneficiary, at a non-network provider
Single vision lenses (Clear) **or**	100% towards the cost of lenses at network rates R150 per lens, per beneficiary, out of network
Bifocal lenses (Clear) **or**	100% towards the cost of lenses at network rates R325 per lens, per beneficiary, out of network
Multifocal lenses (Clear)	100% towards the cost of lenses at network rates R700 per lens, per beneficiary, out of network
Frames	R740 per beneficiary, once every 2 years
Contact lenses	R1 790 per beneficiary, included in family limit
Basic dentistry	R4 450 per family, per year Covered at the Bonitas Dental Tariff
Consultations	2 annual check-ups per beneficiary (once every 6 months)
X-rays: Intra-oral	Managed Care protocols apply
X-rays: Extra-oral	1 per beneficiary, every 3 years Additional benefits may be considered if specialist dental treatment is required

Oral hygiene	2 annual scale and polish treatments per beneficiary (once every 6 months) Fissure sealants are only covered for children under 16 years Fluoride treatments are only covered for children from age 5 and younger than 16 years
Fillings	Benefit for fillings is granted once per tooth, in 365 days Benefit for re-treatment of a tooth is subject to Managed Care protocols A treatment plan and x-rays may be required for multiple fillings
Root canal therapy and extractions	Managed Care protocols apply
Plastic dentures and associated laboratory costs	1 set of plastic dentures (an upper and a lower) per beneficiary, once every 4 years Managed Care protocols apply
Specialised dentistry	R5 350 per family, per year Covered at the Bonitas Dental Tariff
Partial metal frame dentures and associated laboratory costs	2 partial frames (an upper and a lower) per beneficiary, once every 5 years Managed Care protocols apply
Crowns, bridges and associated laboratory costs	1 crown per family, per year Benefit for crowns will be granted once per tooth, every 5 years A treatment plan and x-rays may be requested Pre-authorisation required
Implants and associated laboratory costs	No benefit
Orthodontics and associated laboratory costs	Orthodontic treatment is granted once per beneficiary, per lifetime Pre-authorisation cases will be clinically assessed by using an orthodontic needs analysis Benefit allocation is subject to the outcome of the needs analysis and funding can be granted up to 100% of the Bonitas Dental Tariff Benefit for orthodontic treatment will be granted where function is impaired (not granted for cosmetic reasons) Only 1 family member may begin orthodontic treatment in a calendar year Benefit for fixed comprehensive treatment is limited to beneficiaries from age 9 and younger than 18 years Managed Care protocols apply Pre-authorisation required

Periodontics	Benefit is limited to conservative, non-surgical therapy only and will only be applied to members who are registered on the Periodontal Programme Managed Care protocols apply Pre-authorisation required
Maxillo-facial surgery and oral pathology	
Surgery in the dental chair	Managed Care protocols apply
Hospitalisation (general anaesthetic)	A co-payment of R3 000 per hospital admission and admission protocols apply General anaesthetic is only available to children under the age of 5 for extensive dental treatment General anaesthetic benefit is available for the removal of impacted teeth Managed Care protocols apply Pre-authorisation required
Laughing gas in dental rooms	Managed Care protocols apply
IV conscious sedation in rooms	Limited to extensive dental treatment Managed Care protocols apply Pre-authorisation required

CHRONIC BENEFITS

BonClassic offers generous cover for 47 chronic conditions. Cover is limited to R10 790 per beneficiary and R22 320 per family on the applicable formulary. If you choose to use medicine that is not on the formulary, you will have to pay a 40% co-payment.

Pre-authorisation is required. You can get your medicine from any pharmacy on our network.

Once the amount above is finished, you will still be covered for the 27 Prescribed Minimum Benefits, listed below, from our Designated Service Provider. If you choose not to use the Designated Service Provider, you will have to pay a 40% co-payment.

Please note: For HIV/AIDS medicine, you must use the Designated Service Provider or you will have to pay a 40% co-payment.

Prescribed Minimum Benefits covered

1	Addison's Disease	10.	Crohn's Disease	19.	Hyperlipidaemia
2.	Asthma	11.	Diabetes Insipidus	20.	Hypertension
3.	Bipolar Mood Disorder	12.	Diabetes Type 1	21.	Hypothyroidism
4.	Bronchiectasis	13.	Diabetes Type 2	22.	Multiple Sclerosis
5.	Cardiac Failure	14.	Dysrhythmias	23.	Parkinson's Disease
6.	Cardiomyopathy	15.	Epilepsy	24.	Rheumatoid Arthritis
7.	Chronic Obstructive Pulmonary Disease	16.	Glaucoma	25.	Schizophrenia
8.	Chronic Renal Disease	17.	Haemophilia	26.	Systemic Lupus Erythematosus
9.	Coronary Artery Disease	18.	HIV/AIDS	27.	Ulcerative Colitis

Additional conditions covered

28.	Alzheimer's Disease (early onset)	35.	Gastro-Oesophageal Reflux Disease (GORD)	42.	Polyarteritis Nodosa
29.	Ankylosing Spondylitis	36.	Generalised Anxiety Disorder	43.	Pulmonary Interstitial Fibrosis
30.	Attention Deficit Disorder (in children aged 5-18)	37.	Gout	44.	Post-Traumatic Stress Disorder
31.	Barrett's Oesophagus	38.	Obsessive Compulsive Disorder	45.	Scleroderma
32.	Benign Prostatic Hypertrophy	39.	Osteoporosis	46.	Tourette's Syndrome
33.	Depression	40.	Paget's Disease	47.	Zollinger-Ellison Syndrome
34.	Eczema	41.	Panic Disorder		

ADDITIONAL BENEFITS

We believe in giving you more value. These additional benefits will not affect your other benefit limits and savings.

Contraceptives	
For women aged up to 50	R1 500 per family You must use the Designated Service Provider for pharmacy-dispensed contraceptives
Maternity care	
Per pregnancy	12 antenatal consultations with a gynaecologist, GP or midwife 2 2D ultrasound scans R1 160 for antenatal classes 1 amniocentesis 4 consultations with a midwife after delivery A Bonitas baby bag (you must register for this after obtaining pre-authorisation for the delivery)
Childcare	
Hearing screening	For newborns, in or out of hospital
Congenital hypothyroidism screening	For infants under 1 month old
Babyline	Access to telephone helpline for 24/7 medical advice (including weekends and holidays for children under 3 years)
Immunisations	1 flu vaccine per child
Preventative care	
General health	1 HIV test per beneficiary 1 flu vaccine per beneficiary
Cardiac health	1 full lipogram every 5 years, for members aged 20 and over
Women's health	1 mammogram every 2 years, for women between ages 40 and 74 1 pap smear every 3 years, for women between ages 21 and 65
Elderly health	1 pneumococcal vaccine every 5 years, for members aged 65 and over 1 stool test for colon cancer, for members between ages 50 and 75 1 bone density screening every 5 years, for women aged 65 and over and men aged 70 and over
Wellness benefits	
Wellness screening	1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day Wellness screening includes the following tests: • Blood pressure • Glucose • Cholesterol • Body mass index • Waist-to-hip ratio
Wellness extender	R1 670 per family Once each adult beneficiary has completed a wellness screening, you may choose from the following additional benefits: • GP consultation(s) • Biokineticist consultation(s) • Dietician consultation(s) • Physiotherapy consultation(s) • A programme to stop smoking All claims are paid at the Bonitas Rate Child dependants will qualify once an adult beneficiary has completed a wellness screening
International travel benefit	
Per trip	R5 million per beneficiary R10 million per family Including cover for mandatory vaccines You must register for this benefit

BONCOMPLETE

SAVINGS OPTION

This savings option offers generous savings, an above threshold benefit and rich hospital cover.

In-hospital

Unlimited, consultations & treatment at 100% - network doctors and specialists paid in full

R328 100 **cancer benefit** per family

Unlimited blood tests & x-rays at 100%

Internal & external prosthesis R42 100 per family

MRI and CT scans R22 220 per family in and out of hospital with no co-payments

Unlimited terminal care benefit

Out-of-hospital

Savings & above threshold benefit

R15 130 **mental health** benefit for **consultations** paid from risk

Dental benefits in addition to savings - including orthodontics

Chronic benefits

31 **conditions** covered

Cover for Acne, Allergic Dermatitis/Eczema, Allergic Rhinitis and Attention Deficit Disorder **for children**

Chronic medicine delivery to your doorstep through the Designated Service Provider

Managed Care programmes to help members manage a range of conditions including cancer, HIV/AIDS and diabetes

Additional benefits

R1 500 per family for **contraceptives**

6 **maternity** consultations, antenatal classes, **amniocentesis** & 2 x **2D scans**

Wellness screening & R1 670 **wellness extender** per family

Preventative care for mammograms, pap smears, lipograms, flu vaccines & more

Childcare benefits including paediatrician & GP consultations, **newborn hearing screening**, **congenital hypothyroidism screening** & **Babyline**

International travel benefit of up to R10 million per family per trip

Contributions

Main member	Adult dependant	Child dependant
R 3 212	R 2 572	R 873

Your 4th and subsequent children will be covered free of charge.

Savings

	Main member	Adult dependant	Child dependant
Savings	R 5 772	R 4 620	R 1 572

IN-HOSPITAL BENEFITS

Cover for major medical events that result in a beneficiary being admitted into hospital.

Pre-authorisation is required. Managed Care protocols apply.

We negotiate extensively with hospitals to ensure the best possible value for our members.

Members have access to all private hospitals. A 30% co-payment may apply to admissions at specific hospitals. Please call us on **0860 002 108** or log in to **www.bonitas.co.za** for a list of these hospitals.

Specialist consultations/ treatment	Unlimited, network specialists covered in full Unlimited, non-network specialists paid at 100% of the Bonitas Rate
GP consultations/treatment	Unlimited, covered at 100% of the Bonitas Rate
Blood tests and other laboratory tests	Unlimited, covered at 100% of the Bonitas Rate
X-rays and ultrasounds	Unlimited, covered at 100% of the Bonitas Rate
MRIs and CT scans (specialised radiology)	R22 220 per family, in and out of hospital Pre-authorisation required
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Unlimited, covered at 100% of the Bonitas Rate Your therapist must get a referral from the doctor treating you in hospital
Internal and external prostheses	R42 100 per family Managed Care protocols apply Sublimit of R5 000 per breast prosthesis (limited to 2 per year) You must use a preferred supplier
Spinal surgery	You will have to pay a R5 650 co-payment if you do not go for an assessment through the back and neck programme
Hip and knee replacements	You will have to pay a R5 650 co-payment if you do not use the preferred provider
Mental health hospitalisation	R30 680 per family No cover for physiotherapy for mental health admissions You must use a Designated Service Provider
Take-home medicine	R390 per beneficiary, per hospital stay
Physical rehabilitation	R47 250 per family
Alternatives to hospital (hospice, step-down facilities)	R15 760 per family
Terminal care	Unlimited Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
Cancer treatment	R328 100 per family You must use a preferred provider Sublimit of R42 110 per beneficiary for Brachytherapy
Organ transplants	Unlimited Sublimit of R30 000 per beneficiary for corneal grafts
Kidney dialysis	Unlimited You must use a Designated Service Provider, or a 20% co-payment will apply
HIV/AIDS	Unlimited, if you register on the HIV/AIDS programme Chronic medicine must be obtained from the Designated Service Provider

OUT-OF-HOSPITAL BENEFITS

These benefits provide cover for consultations with your GP or specialist, acute medicine, x-rays, blood tests and other out of hospital medical expenses.

	Main member	Adult dependant	Child dependant
Savings	R5 772	R4 620	R1 572
Self-payment gap	R1 660	R1 400	R 355
Threshold level	R7 432	R6 020	R1 927
Above threshold benefit	R4 390	R2 590	R1 120

Once your savings for the year are finished, you will need to pay for day-to-day medical expenses out of your own pocket until you have paid the full self-payment gap. You will then reach the threshold level and have access to your above threshold benefit. Please submit all claims you have paid while in the self-payment gap to us, so that we can keep a record. Claims accumulate at the Bonitas Rate. Not all claims accumulate to the threshold level.

Please note: You must get a GP referral for specialist consultations (excluding consultations with oncologists and ophthalmologists; maternity consultations and consultations with paediatricians for children under age 2).

GP consultations	Paid from available savings and/or above threshold benefit
Specialist consultations	Paid from available savings and/or above threshold benefit You must get a referral from your GP
Blood tests and other laboratory tests	Paid from available savings and/or above threshold benefit
X-rays and ultrasounds	Paid from available savings and/or above threshold benefit
MRIs and CT scans (specialised radiology)	R22 220 per family, in and out of hospital Pre-authorisation required
Acute medicine	Paid from available savings and/or above threshold benefit
Over-the-counter medicine	Paid from available savings and/or above threshold benefit
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Paid from available savings and/or above threshold benefit
Mental health consultations	R15 130 per family In and out of hospital consultations (included in the mental health hospitalisation benefit) No cover for educational psychologists for beneficiaries older than 21 years
General medical appliances (such as wheelchairs and crutches)	Paid from available savings and/or above threshold benefit You must use a preferred supplier
Hearing aids	Paid from available savings and/or above threshold benefit Available once every 2 years (based on the date of your previous claim) You must use a preferred supplier
Optometry	Paid from available savings, once every 2 years (based on the date of your previous claim) Each beneficiary can choose glasses or contact lenses
Eye tests	1 per beneficiary, once every 2 years at a network provider at network rates **OR** R365 per beneficiary, once every 2 years at a non-network provider
Single vision lenses (Clear) **or**	100% towards the cost of clear lenses, limited to R215 per lens, per beneficiary
Bifocal lenses (Clear) **or**	100% towards the cost of clear lenses, limited to R500 per lens, per beneficiary
Multifocal lenses (Clear)	100% towards the cost of clear lenses, limited to R865 per lens, per beneficiary
Frames	R740 per beneficiary, once every 2 years
Contact lenses	R1 820 per beneficiary
Basic dentistry	Covered at the Bonitas Dental Tariff
Consultations	2 annual check-ups per beneficiary (once every 6 months)
X-rays: Intra-oral	Managed Care protocols apply
X-rays: Extra-oral	1 per beneficiary, every 3 years Additional benefits may be considered if specialist dental treatment is required
Oral hygiene	2 annual scale and polish treatments per beneficiary (once every 6 months) Fissure sealants are only covered for children under 16 years Fluoride treatments are only covered for children from age 5 and younger than 16 years
Fillings	Benefit for fillings is granted once per tooth, in 365 days Benefit for re-treatment of a tooth is subject to Managed Care protocols A treatment plan and x-rays may be required for multiple fillings
Root canal therapy and extractions	Managed Care protocols apply
Plastic dentures and associated laboratory costs	1 set of plastic dentures (an upper and a lower) per beneficiary, once every 4 years
Specialised dentistry	Covered at the Bonitas Dental Tariff
Partial metal frame dentures and associated laboratory costs	1 partial frame (an upper or a lower) per beneficiary, once every 5 years Managed Care protocols apply
Crowns, bridges and associated laboratory costs	1 crown per family, per year Benefit for crowns will be granted once per tooth, every 5 years A treatment plan and x-rays may be requested Pre-authorisation required
Implants and associated laboratory costs	No benefit

Orthodontics and associated laboratory costs	Orthodontic treatment is granted once per beneficiary, per lifetime Pre-authorisation cases will be clinically assessed by using an orthodontic needs analysis Benefit allocation is subject to the outcome of the needs analysis and funding can be granted up to 65% of the Bonitas Dental Tariff Benefit for orthodontic treatment will be granted where function is impaired (not granted for cosmetic reasons) Only 1 family member may begin orthodontic treatment in a calendar year Benefit for fixed comprehensive treatment is limited to beneficiaries from age 9 and younger than 18 years Managed Care protocols apply Pre-authorisation required
Periodontics	Benefit is limited to conservative, non-surgical therapy only and will only be applied to members who are registered on the Periodontal Programme Managed Care protocols apply Pre-authorisation required
Maxillo-facial surgery and oral pathology	
Surgery in the dental chair	Managed Care protocols apply
Hospitalisation (general anaesthetic)	A co-payment of R3 000 per hospital admission and admission protocols apply General anaesthetic is only available to children under the age of 5 for extensive dental treatment General anaesthetic benefit is available for the removal of impacted teeth Managed Care protocols apply Pre-authorisation required
Laughing gas in dental rooms	Managed Care protocols apply
IV conscious sedation in rooms	Limited to extensive dental treatment Managed Care protocols apply Pre-authorisation required

CHRONIC BENEFITS

BonComplete offers cover for 31 chronic conditions, using the applicable formulary. Pre-authorisation is required.

You must use our Designated Service Provider to get your medicine. If you choose not to use the Designated Service Provider or if you choose to use medicine that is not on the formulary, you will have to pay a 40% co-payment.

Please note: For HIV/AIDS medicine, you must use the Designated Service Provider or you will have to pay a 40% co-payment.

Prescribed Minimum Benefits covered

1.	Addison's Disease	10.	Crohn's Disease	19.	Hyperlipidaemia
2.	Asthma	11.	Diabetes Insipidus	20.	Hypertension
3.	Bipolar Mood Disorder	12.	Diabetes Type 1	21.	Hypothyroidism
4.	Bronchiectasis	13.	Diabetes Type 2	22.	Multiple Sclerosis
5.	Cardiac Failure	14.	Dysrhythmias	23.	Parkinson's Disease
6.	Cardiomyopathy	15.	Epilepsy	24.	Rheumatoid Arthritis
7.	Chronic Obstructive Pulmonary Disease	16.	Glaucoma	25.	Schizophrenia
8.	Chronic Renal Disease	17.	Haemophilia	26.	Systemic Lupus Erythematosus
9.	Coronary Artery Disease	18.	HIV/AIDS	27.	Ulcerative Colitis

Additional conditions covered

28.	Acne (children up to 21 years)	30.	Allergic Dermatitis/ Eczema (children up to 21 years)	31.	Attention Deficit Disorder (in children aged 5-18)
29.	Allergic Rhinitis (children up to 21 years)				

ADDITIONAL BENEFITS

We believe in giving you more value. These additional benefits will not affect your other benefit limits or savings.

Contraceptives	
For women aged up to 50	R1 500 per family You must use the Designated Service Provider for pharmacy-dispensed contraceptives
Maternity care	
Per pregnancy	6 antenatal consultations with a gynaecologist, GP or midwife R1 160 for antenatal classes 2 2D ultrasound scans 1 amniocentesis 4 consultations with a midwife after delivery A Bonitas baby bag (you must register for this after obtaining pre-authorisation for the delivery)
Childcare	
Hearing screening	For newborns, in or out of hospital
Congenital hypothyroidism screening	For infants under 1 month old
Babyline	Access to telephone helpline for 24/7 medical advice (including weekends and holidays for children under 3 years)
Paediatric consultations	2 consultations per child under 1 year 1 consultation per child between ages 1 and 2
GP consultations	1 consultation per child between ages 2 and 12
Immunisations	1 flu vaccine per child
Preventative care	
General health	1 HIV test per beneficiary 1 flu vaccine per beneficiary
Cardiac health	1 full lipogram every 5 years, for members aged 20 and over
Women's health	1 mammogram every 2 years, for women between ages 40 and 74 1 pap smear every 3 years, for women between ages 21 and 65
Elderly health	1 pneumococcal vaccine every 5 years, for members aged 65 and over 1 stool test for colon cancer, for members between ages 50 and 75
Wellness benefits	
Wellness screening	1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day Wellness screening includes the following tests: • Blood pressure • Glucose • Cholesterol • Body mass index • Waist-to-hip ratio
Wellness extender	R1 670 per family Once each adult beneficiary has completed a wellness screening, you may choose from the following additional benefits: • GP consultation(s) • Biokineticist consultation(s) • Dietician consultation(s) • Physiotherapy consultation(s) • A programme to stop smoking All claims are paid at the Bonitas Rate Child dependants will qualify once an adult beneficiary has completed a wellness screening
International travel benefit	
Per trip	R5 million per beneficiary R10 million per family Including cover for mandatory vaccines You must register for this benefit

BONSAVE

SAVINGS OPTION

This savings option offers savings to use as you choose for medical expenses and extensive hospital cover.

In-hospital

Unlimited, consultations & treatment at 150% - network doctors and specialists paid in full

R328 100 **cancer benefit** per family

Unlimited blood tests & x-rays at 100%

Co-payments apply to 22 elective procedures

Internal prosthesis R30 000 per family

MRI & CT scans R22 220 per family in and out of hospital with no co-payments

Unlimited terminal care benefit

Out-of-hospital

Savings

R15 130 **mental health** benefit for **consultations** paid from risk

Basic dental benefits in addition to savings

Chronic benefits

27 **conditions** covered

Chronic medicine delivery to your doorstep through the Designated Service Provider

Managed Care programmes to help members manage a range of conditions including cancer, HIV/AIDS and diabetes

Additional benefits

3 **GP consultations** per beneficiary and 6 per family **when savings are finished**

R1 500 per family for **contraceptives**

6 **maternity** consultations, antenatal classes, **amniocentesis** & 2 x **2D scans**

Wellness screening & R1 210 **wellness extender** per family

Preventative care for mammograms, pap smears, flu vaccines & more

Childcare benefits including paediatrician & GP consultations, **newborn hearing screening**, **congenital hypothyroidism screening** & **Babyline**

International travel benefit of up to R10 million per family per trip

Contributions

Main member	Adult dependant	Child dependant
R 2 304	R 1 785	R 690

Your 4th and subsequent children will be covered free of charge.

Savings

	Main member	Adult dependant	Child dependant
Savings	R 4 428	R 3 432	R 1 332

IN-HOSPITAL BENEFITS

Cover for major medical events that result in a beneficiary being admitted into hospital.

Pre-authorisation is required. Managed Care protocols apply.

We negotiate extensively with hospitals to ensure the best possible value for our members.

Members have access to all private hospitals. A 30% co-payment may apply to admissions at specific hospitals. Please call us on **0860 002 108** or log in to **www.bonitas.co.za** for a list of these hospitals.

Specialist consultations/ treatment	Unlimited, covered at 150% of the Bonitas Rate
GP consultations/treatment	Unlimited, covered at 150% of the Bonitas Rate
Blood tests and other laboratory tests	Unlimited, covered at 100% of the Bonitas Rate
X-rays and ultrasounds	Unlimited, covered at 100% of the Bonitas Rate
MRIs and CT scans (specialised radiology)	R22 220 per family, in and out of hospital
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Unlimited, covered at 100% of the Bonitas Rate Your therapist must get a referral from the doctor treating you in hospital
Internal prostheses	R30 000 per family (excluding joint replacement prostheses) Managed Care protocols apply You must use a preferred supplier
Mental health hospitalisation	R30 680 per family No cover for physiotherapy for mental health admissions You must use a Designated Service Provider
Take-home medicine	R360 per beneficiary, per hospital stay
Physical rehabilitation	R47 250 per family
Alternatives to hospital (hospice, step-down facilities)	R15 760 per family
Terminal care	Unlimited Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
Cancer treatment	R328 100 per family You must use a preferred provider Sublimit of R42 110 per beneficiary for Brachytherapy
Organ transplants	Unlimited Sublimit of R30 000 per beneficiary for corneal grafts
Kidney dialysis	Unlimited You must use a Designated Service Provider, or a 20% co-payment will apply
HIV/AIDS	Unlimited, if you register on the HIV/AIDS programme Chronic medicine must be obtained from the Designated Service Provider

A co-payment will apply to the following procedures in hospital

R1 380 co-payment	R3 500 co-payment	R6 900 co-payment
1. Colonoscopy	1. Arthroscopy	1. Back Surgery including Spinal Fusion
2. Conservative Back Treatment	2. Diagnostic Laparoscopy	2. Joint Replacements
3. Cystoscopy	3. Laparoscopic Hysterectomy	3. Laparoscopic Pyeloplasty
4. Facet Joint Injections	4. Laparoscopic Appendectomy	4. Laparoscopic Radical Prostatectomy
5. Flexible Sigmoidoscopy	5. Percutaneous Radiofrequency Ablations (Percutaneous Rhizotomies)	5. Nissen Fundoplication (Reflux Surgery)
6. Functional Nasal Surgery		
7. Gastroscopy		
8. Hysteroscopy (not Endometrial Ablation)		
9. Myringotomy		
10. Tonsillectomy and Adenoidectomy		
11. Umbilical Hernia Repair		
12. Varicose Vein Surgery		

OUT-OF-HOSPITAL BENEFITS

These benefits provide cover for consultations with your GP or specialist, acute medicine, x-rays, blood tests and other out-of-hospital medical expenses.

	Main member	Adult dependant	Child dependant
Savings	R4 428	R3 432	R1 332

GP consultations	Paid from available savings
Specialist consultations	Paid from available savings You must get a referral from your GP
Acute medicine and over-the-counter medicine	Paid from available savings
X-rays and ultrasounds	Paid from available savings
MRIs and CT scans (specialised radiology)	R22 220 per family, in and out of hospital Pre-authorisation required
Blood tests and other laboratory tests	Paid from available savings
Mental health consultations	R15 130 per family In and out-of-hospital consultations (included in the mental health hospitalisation benefit) No cover for educational psychologists for beneficiaries older than 21 years
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Paid from available savings
General medical appliances (such as wheelchairs and crutches)	R6 560 per family An additional R6 240 per family will apply should Stoma care and CPAP machines exceed the general medical appliances limit You must use a preferred supplier
Optometry	Paid from available savings
Basic dentistry	Covered at the Bonitas Dental Tariff
Consultations	2 annual check-ups per beneficiary (once every 6 months)
X-rays: Intra-oral	Managed Care protocols apply
X-rays: Extra-oral	1 per beneficiary, every 3 years Additional benefits may be considered if specialist dental treatment is required
Oral hygiene	2 annual scale and polish treatments per beneficiary (once every 6 months) Fissure sealants are only covered for children under 16 years Fluoride treatments are only covered for children from age 5 and younger than 16 years
Fillings	Benefit for fillings is granted once per tooth, in 365 days Benefit for re-treatment of a tooth is subject to Managed Care protocols A treatment plan and x-rays may be required for multiple fillings
Root canal therapy and extractions	Benefit for root canal includes all teeth except primary teeth and permanent molars Managed Care protocols apply
Plastic dentures and associated laboratory costs	1 set of plastic dentures (an upper and a lower) per beneficiary, once every 4 years
Specialised dentistry	No benefit
Maxillo-facial surgery and oral pathology	
Surgery in the dental chair	Managed Care protocols apply
Hospitalisation (general anaesthetic)	A co-payment of R3 000 per hospital admission and admission protocols apply General anaesthetic is only available to children under the age of 5 for extensive dental treatment General anaesthetic benefit is available for the removal of impacted teeth Managed Care protocols apply Pre-authorisation required
Laughing gas in dental rooms	Managed Care protocols apply
IV conscious sedation in rooms	Limited to extensive dental treatment Managed Care protocols apply Pre-authorisation required

CHRONIC BENEFITS

BonSave ensures that you are covered for the 27 Prescribed Minimum Benefits listed below on the applicable formulary. Pre-authorisation is required. If you choose not to use the Designated Service Provider or if you choose to use medicine that is not on the formulary, you will have to pay a 40% co-payment.

Please note: For HIV/AIDS medicine, you must use the Designated Service Provider or you will have to pay a 40% co-payment.

Prescribed Minimum Benefits covered

1.	Addison's Disease	10.	Crohn's Disease	19.	Hyperlipidaemia
2.	Asthma	11.	Diabetes Insipidus	20.	Hypertension
3.	Bipolar Mood Disorder	12.	Diabetes Type 1	21.	Hypothyroidism
4.	Bronchiectasis	13.	Diabetes Type 2	22.	Multiple Sclerosis
5.	Cardiac Failure	14.	Dysrhythmias	23.	Parkinson's Disease
6.	Cardiomyopathy	15.	Epilepsy	24.	Rheumatoid Arthritis
7.	Chronic Obstructive Pulmonary Disease	16.	Glaucoma	25.	Schizophrenia
8.	Chronic Renal Disease	17.	Haemophilia	26.	Systemic Lupus Erythematosus
9.	Coronary Artery Disease	18.	HIV/AIDS	27.	Ulcerative Colitis

ADDITIONAL BENEFITS

We believe in giving you more value. These additional benefits will not affect your other benefit limits or savings.

Additional GP consultations	If you use all your savings for the year, your family will still get a maximum of 6 GP consultations (limited to 3 per beneficiary) paid at the Bonitas Rate
Contraceptives	
For women aged up to 50	R1 500 per family You must use the Designated Service Provider for pharmacy-dispensed contraceptives
Maternity care	
Per pregnancy	6 antenatal consultations with a gynaecologist, GP or midwife R1 160 for antenatal classes 2 2D ultrasound scans 1 amniocentesis 4 consultations with a midwife after delivery A Bonitas baby bag (you must register for this after obtaining pre-authorisation for the delivery)
Childcare	
Hearing screening	For newborns, in or out of hospital
Congenital hypothyroidism screening	For infants under 1 month old
Babyline	Access to telephone helpline for 24/7 medical advice (including weekends and holidays for children under 3 years)
Paediatric consultations	2 consultations per child under 1 year 1 consultation per child between ages 1 and 2
GP consultations	1 consultation per child between ages 2 and 12
Immunisations	1 flu vaccine per child
Preventative care	
General health	1 HIV test per beneficiary 1 flu vaccine per beneficiary
Women's health	1 mammogram every 2 years, for women between ages 40 and 74 1 pap smear every 3 years, for women between ages 21 and 65
Elderly health	1 pneumococcal vaccine every 5 years, for members aged 65 and over 1 stool test for colon cancer, for members between ages 50 and 75
Wellness benefits	
Wellness screening	1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day Wellness screening includes the following tests: • Blood pressure • Glucose • Cholesterol • Body mass index • Waist-to-hip ratio
Wellness extender	R1 210 per family Once each adult beneficiary has completed a wellness screening, you may choose from the following additional benefits: • GP consultation(s) • Biokineticist consultation(s) • Dietician consultation(s) • Physiotherapy consultation(s) • A programme to stop smoking All claims are paid at the Bonitas Rate Child dependants will qualify once an adult beneficiary has completed a wellness screening
International travel benefit	
Per trip	R5 million per beneficiary R10 million per family Including cover for mandatory vaccines You must register for this benefit

BONFIT

SAVINGS OPTION

This savings plan offers basic cover for day-to-day medical needs and essential hospital cover.

In-hospital

Unlimited, consultations & treatment at 100% - network doctors and specialists paid in full

Hospital network applies

R328 100 **cancer benefit** per family

Unlimited blood tests, scans & x-rays at 100%

Co-payments apply to 22 elective procedures

MRI & CT scans R15 000 per family in-hospital with no co-payments

Unlimited terminal care benefit

Out-of-hospital

Savings

Basic dental benefits in addition to savings

Chronic benefits

27 **conditions** covered

Chronic medicine delivery to your doorstep through the Designated Service Provider

Managed Care programmes to help members manage a range of conditions including cancer, HIV/AIDS & diabetes

Additional benefits

R1 500 per family for **contraceptives**

6 **maternity** consultations, **amniocentesis** & 2 x **2D scans**

Wellness screening & R1 210 **wellness extender** per family

Preventative care for pap smears, flu vaccines & more

Childcare benefits including paediatrician & GP consultations, **newborn hearing screening**, **congenital hypothyroidism screening** & **Babyline**

International travel benefit of up to R10 million per family per trip

Contributions

Main member	Adult dependant	Child dependant
R 1 930	R 1 495	R 578

Your 4th and subsequent children will be covered free of charge.

Savings

	Main member	Adult dependant	Child dependant
Savings	R 3 480	R 2 700	R 1 044

IN-HOSPITAL BENEFITS

Cover for major medical events that result in a beneficiary being admitted into hospital.

Pre-authorisation is required. Managed Care protocols apply.

Please note: You must use a hospital on the BonFit network or you will have to pay a 30% co-payment.

Specialist consultations/ treatment	Unlimited, network specialists covered in full Unlimited, non-network specialists paid at 100% of the Bonitas Rate
GP consultations/treatment	Unlimited, covered at 100% of the Bonitas Rate
Blood tests and other laboratory tests	Unlimited, covered at 100% of the Bonitas Rate
X-rays and ultrasounds	Unlimited, covered at 100% of the Bonitas Rate
MRIs and CT scans (specialised radiology)	R15 000 per family Pre-authorisation required
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Unlimited, covered at 100% of the Bonitas Rate Your therapist must get a referral from the doctor treating you in hospital
Internal and external prostheses	PMB only Managed Care protocols apply You must use a preferred supplier
Mental health hospitalisation	R30 680 per family No cover for physiotherapy for mental health admissions You must use a Designated Service Provider
Take-home medicine	R360 per beneficiary, per hospital stay
Physical rehabilitation	R47 250 per family
Alternatives to hospital (hospice, step-down facilities)	R15 760 per family
Terminal care	Unlimited Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
Cancer treatment	R328 100 per family You must use a preferred provider Sublimit of R42 110 per beneficiary for Brachytherapy
Organ transplants	Unlimited
Kidney dialysis	Unlimited You must use a Designated Service Provider, or a 20% co-payment will apply
HIV/AIDS	Unlimited, if you register on the HIV/AIDS programme Chronic medicine must be obtained from the Designated Service Provider

A co-payment will apply to the following procedures in hospital

R1 380 co-payment	R3 500 co-payment	R6 900 co-payment
1. Colonoscopy	1. Arthroscopy	1. Back Surgery including Spinal Fusion
2. Conservative Back Treatment	2. Diagnostic Laparoscopy	2. Joint Replacements
3. Cystoscopy	3. Laparoscopic Hysterectomy	3. Laparoscopic Pyeloplasty
4. Facet Joint Injections	4. Laparoscopic Appendectomy	4. Laparoscopic Radical Prostatectomy
5. Flexible Sigmoidoscopy	5. Percutaneous Radiofrequency Ablations (Percutaneous Rhizotomies)	5. Nissen Fundoplication (Reflux Surgery)
6. Functional Nasal Surgery		
7. Gastroscopy		
8. Hysteroscopy (not Endometrial Ablation)		
9. Myringotomy		
10. Tonsillectomy and Adenoidectomy		
11. Umbilical Hernia Repair		
12. Varicose Vein Surgery		

OUT-OF-HOSPITAL BENEFITS

These benefits provide cover for consultations with your GP or specialist, acute medicine, x-rays, blood tests and other out-of-hospital medical expenses.

	Main member	Adult dependant	Child dependant
Savings	R3 480	R2 700	R1 044

GP consultations	Paid from available savings
Specialist consultations	Paid from available savings You must get a referral from your GP
Blood tests and other laboratory tests	Paid from available savings
X-rays and ultrasounds	Paid from available savings
MRIs and CT scans (specialised radiology)	Paid from available savings Pre-authorisation required
Acute medicine	Paid from available savings
Over-the-counter medicine	Paid from available savings
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Paid from available savings
Mental health consultations	PMB consultations only In and out-of-hospital consultations (included in the mental health hospitalisation benefit) No cover for educational psychologists for beneficiaries older than 21 years
General medical appliances	Paid from available savings
Optometry	Paid from available savings
Basic dentistry	Covered at the Bonitas Dental Tariff
Consultations	2 annual check-ups per beneficiary (once every 6 months)
X-rays: Intra-oral	Managed Care protocols apply
X-rays: Extra-oral	1 per beneficiary, every 3 years Additional benefits may be considered if specialist dental treatment is required
Oral hygiene	2 annual scale and polish treatments per beneficiary (once every 6 months) Fissure sealants are only covered for children under 16 years Fluoride treatments are only covered for children from age 5 and younger than 16 years
Fillings	Benefit for fillings is granted once per tooth, in 365 days Benefit for re-treatment of a tooth is subject to Managed Care protocols A treatment plan and x-rays may be required for multiple fillings
Root canal therapy and extractions	Benefit for root canal includes all teeth except primary teeth and permanent molars Managed Care protocols apply
Plastic dentures and associated laboratory costs	No benefit
Specialised dentistry	No benefit

CHRONIC BENEFITS

BonFit ensures that you are covered for the 27 Prescribed Minimum Benefits listed below on the applicable formulary. Pre-authorisation is required. If you choose not to use the Designated Service Provider or if you choose to use medicine that is not on the formulary, you will have to pay a 40% co-payment.

Please note: For HIV/AIDS medicine, you must use the Designated Service Provider or you will have to pay a 40% co-payment.

Prescribed Minimum Benefits covered

1.	Addison's Disease	10.	Crohn's Disease	19.	Hyperlipidaemia
2.	Asthma	11.	Diabetes Insipidus	20.	Hypertension
3.	Bipolar Mood Disorder	12.	Diabetes Type 1	21.	Hypothyroidism
4.	Bronchiectasis	13.	Diabetes Type 2	22.	Multiple Sclerosis
5.	Cardiac Failure	14.	Dysrhythmias	23.	Parkinson's Disease
6.	Cardiomyopathy	15.	Epilepsy	24.	Rheumatoid Arthritis
7.	Chronic Obstructive Pulmonary Disease	16.	Glaucoma	25.	Schizophrenia
8.	Chronic Renal Disease	17.	Haemophilia	26.	Systemic Lupus Erythematosus
9.	Coronary Artery Disease	18.	HIV/AIDS	27.	Ulcerative Colitis

ADDITIONAL BENEFITS

We believe in giving you more value. These additional benefits will not affect your other benefit limits or savings.

Contraceptives	
For women aged up to 50	R1 500 per family You must use the Designated Service Provider for pharmacy-dispensed contraceptives
Maternity care	
Per pregnancy	6 antenatal consultations with a gynaecologist, GP or midwife 2 2D ultrasound scans 1 amniocentesis 4 consultations with a midwife after delivery A Bonitas baby bag (you must register for this after obtaining pre-authorisation for the delivery)
Childcare	
Hearing screening	For newborns, in or out of hospital
Congenital hypothyroidism screening	For infants under 1 month old
Babyline	Access to telephone helpline for 24/7 medical advice (including weekends and holidays for children under 3 years)
Paediatric consultations	2 consultations per child under 1 year 1 consultation per child between ages 1 and 2
GP consultations	1 consultation per child between ages 2 and 12
Immunisations	1 flu vaccine per child
Preventative care	
General health	1 HIV test per beneficiary 1 flu vaccine per beneficiary
Women's health	1 pap smear every 3 years, for women between ages 21 and 65
Elderly health	1 pneumococcal vaccine every 5 years, for members aged 65 and over 1 stool test for colon cancer, for members between ages 50 and 75

Wellness benefits	
Wellness screening	1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day Wellness screening includes the following tests: • Blood pressure • Glucose • Cholesterol • Body mass index • Waist-to-hip ratio
Wellness extender	R1 210 per family Once each adult beneficiary has completed a wellness screening, you may choose from the following additional benefits: • GP consultation(s) • Biokineticist consultation(s) • Dietician consultation(s) • Physiotherapy consultation(s) • A programme to stop smoking All claims are paid at the Bonitas Rate Child dependants will qualify once an adult beneficiary has completed a wellness screening
International travel benefit	
Per trip	R5 million per beneficiary R10 million per family Including cover for mandatory vaccines You must register for this benefit

STANDARD

TRADITIONAL OPTION

This traditional option offers rich day-to-day benefits and comprehensive hospital cover.

In-hospital

Unlimited, consultations & treatment at 100% - network doctors and specialists paid in full

R328 100 **cancer benefit** per family

No co-payment for scans

Unlimited blood tests, scans & x-rays at 100%

Cochlear implants R264 500 per family

Internal nerve stimulators R157 700 per family

Internal & external prosthesis R42 100 per family

Unlimited terminal care benefit

Out-of-hospital

Rich **day-to-day & GP benefits**

Separate **benefit for tests & consultations for PMB** treatment plans (excluding GP consultations)

R15 130 **mental health** benefit for **consultations** paid from risk

Optical and dental benefits (basic & specialised) in addition to day-to-day benefits

Chronic benefits

45 **conditions** covered

R18 360 **chronic benefit** per family

Comprehensive medicine list

Must **use a network** for prescribed medicine

Managed Care programmes to help members manage a range of conditions including cancer, mental health, HIV/AIDS and diabetes

Additional benefits

R1 500 per family for **contraceptives**

12 **maternity** consultations, antenatal classes, **amniocentesis** & 2 x **2D scans**

Wellness screening & R1 670 **wellness extender** per family

Preventative care for mammograms, pap smears, lipograms, flu vaccines & more

Childcare benefits including paediatrician & GP consultations, **newborn hearing screening**, **congenital hypothyroidism screening** & **Babyline**

International travel benefit of up to R10 million per family per trip

Contributions

Main member	Adult dependant	Child dependant
R 3 265	R 2 831	R 958

Your 4th and subsequent children will be covered free of charge.

IN-HOSPITAL BENEFITS

Cover for major medical events that result in a beneficiary being admitted into hospital.

Pre-authorisation is required. Managed Care protocols apply.

We negotiate extensively with hospitals to ensure the best possible value for our members.

Members have access to all private hospitals. A 30% co-payment may apply to admissions at specific hospitals. Please call us on **0860 002 108** or log in to **www.bonitas.co.za** for a list of these hospitals.

Specialist consultations/ treatment	Unlimited, network specialists covered in full Unlimited, non-network specialists paid at 100% of the Bonitas Rate
GP consultations/treatment	Unlimited, covered at 100% of the Bonitas Rate
Blood and other laboratory tests	Unlimited, covered at 100% of the Bonitas Rate
X-rays and ultrasounds	Unlimited, covered at 100% of the Bonitas Rate
MRIs and CT scans (specialised radiology)	R24 860 per family, in and out of hospital Pre-authorisation required
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Unlimited, covered at 100% of the Bonitas Rate Your therapist must get a referral from the doctor treating you in hospital
Internal and external prostheses	R42 100 per family Managed Care protocols apply Sublimit of R5 000 per breast prosthesis (limited to 2 per year) You must use a preferred supplier
Spinal surgery	You will have to pay a R5 650 co-payment if you do not go for an assessment through the back and neck programme
Hip and knee replacements	You will have to pay a R5 650 co-payment if you do not use the preferred provider
Internal nerve stimulators	R157 700 per family
Cochlear implants	R264 500 per family You must use a preferred supplier
Mental health hospitalisation	R38 670 per family No cover for physiotherapy for mental health admissions You must use a Designated Service Provider
Take-home medicine	R445 per beneficiary, per hospital stay
Physical rehabilitation	R47 250 per family
Alternatives to hospital (hospice, step-down facilities)	R15 760 per family
Terminal care	Unlimited Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
Cancer treatment	R328 100 per family You must use a preferred provider Sublimit of R42 110 per beneficiary for Brachytherapy
Organ transplants	Unlimited Sublimit of R30 000 per beneficiary for corneal grafts
Kidney dialysis	Unlimited You must use a Designated Service Provider, or a 20% co-payment will apply
HIV/AIDS	Unlimited, if you register on the HIV/AIDS programme Chronic medicine must be obtained from the Designated Service Provider

OUT-OF-HOSPITAL BENEFITS

Out-of-hospital claims will be paid from available day-to-day benefits. There is a separate benefit for GP consultations.

GP consultations

If you do not use a GP on our network, your benefit for GP consultations will be limited to the non-network GP consultation benefit. This is shown in the table below.

Main member only	R3 970 (R1 290 of this can be used for non-network GP consultations)
Main member + 1 dependant	R5 820 (R1 990 of this can be used for non-network GP consultations)
Main member + 2 dependants	R6 450 (R2 170 of this can be used for non-network GP consultations)
Main member + 3 dependants	R6 770 (R2 270 of this can be used for non-network GP consultations)
Main member + 4 or more dependants	R7 350 (R2 450 of this can be used for non-network GP consultations)

Day-to-day benefits

These benefits provide cover for consultations with your specialist, acute medicine, x-rays, blood tests and other out-of-hospital medical expenses.

Please note: You must get a GP referral for specialist consultations (excluding consultations with oncologists and ophthalmologists; maternity consultations and consultations with paediatricians for children under age 2).

There is a separate benefit for tests and consultations for PMB treatment plans (excluding GP consultations). Therefore this will not affect your day-to-day benefits.

Main member only	R 5 540
Main member + 1 dependant	R 8 430
Main member + 2 dependants	R 9 750
Main member + 3 dependants	R10 650
Main member + 4 or more dependants	R11 600

Specialist consultations	Paid from available day-to-day benefits You must get a referral from your GP
Blood tests and other laboratory tests	Paid from available day-to-day benefits
X-rays and ultrasounds	Paid from available day-to-day benefits
MRIs and CT scans (specialised radiology)	R24 860 per family, in and out of hospital Pre-authorisation required
Acute medicine	Paid from available day-to-day benefits
Over-the-counter medicine	R740 per beneficiary R2 240 per family Paid from available day-to-day benefits
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Paid from available day-to-day benefits
Mental health consultations	R15 130 per family In and out-of-hospital consultations (included in the mental health hospitalisation benefit) No cover for educational psychologists for beneficiaries older than 21 years
General medical appliances (such as wheelchairs and crutches)	R7 300 per family An additional R6 240 per family will apply should Stoma care and CPAP machines exceed the general medical appliances limit You must use a preferred supplier
Hearing aids	R15 240 per family, once every 2 years (based on the date of your previous claim) 20% co-payment applies You must use a preferred supplier
Optometry	R5 550 per family, once every 2 years (based on the date of your previous claim) Each beneficiary can choose glasses or contact lenses
Eye tests	1 per beneficiary, once every 2 years at a network provider, at network rates **OR** R350 per beneficiary, once every 2 years at a non-network provider
Single vision lenses (Clear) **or**	100% towards the cost of lenses at network rates R150 per lens, per beneficiary, out of network
Bifocal lenses (Clear) **or**	100% towards the cost of lenses at network rates R325 per lens, per beneficiary, out of network
Multifocal lenses (Clear)	100% towards the cost of lenses at network rates R700 per lens, per beneficiary, out of network
Frames	R850 per beneficiary, once every 2 years
Contact lenses	R1 850 per beneficiary (included in the family limit)
Basic dentistry	Covered at the Bonitas Dental Tariff
Consultations	2 annual check-ups per beneficiary (once every 6 months)
X-rays: Intra-oral	Managed Care protocols apply
X-rays: Extra-oral	1 per beneficiary, every 3 years Additional benefit may be considered if specialist dental treatment planning/follow up is required
Oral hygiene	2 annual scale and polish treatments per beneficiary (once every 6 months) Fissure sealants are only covered for children under 16 years Fluoride treatments are only covered for children from age 5 and younger than 16 years
Fillings	Benefit for fillings is granted once per tooth, in 365 days Benefit for re-treatment of a tooth is subject to Managed Care protocols A treatment plan and x-rays may be required for multiple fillings
Root canal and extractions	Managed Care protocols apply
Plastic dentures and associated laboratory costs	1 set of plastic dentures (an upper and a lower) per beneficiary, once every 4 years

Specialised dentistry	Covered at the Bonitas Dental Tariff
Partial metal frame dentures and associated laboratory costs	1 partial frame (an upper or lower) per beneficiary, once every 5 years Managed Care protocols apply
Crowns, bridges and associated laboratory costs	1 crown per family, per year Benefit for crowns will be granted once per tooth, every 5 years A treatment plan and x-rays may be requested Pre-authorisation required
Implants and associated laboratory costs	No benefit
Orthodontics and associated laboratory costs	Orthodontic treatment is granted once per beneficiary, per lifetime Pre-authorisation cases will be clinically assessed by using an orthodontic needs analysis Benefit allocation is subject to the outcome of the needs analysis and funding can be granted up to 80% of the Bonitas Dental Tariff Benefit for orthodontic treatment will be granted where function is impaired (not granted for cosmetic reasons) Only 1 family member may begin orthodontic treatment in a calendar year Benefit for fixed comprehensive treatment is limited to beneficiaries from age 9 and younger than 18 years Managed Care protocols apply Pre-authorisation required
Periodontics	Benefit is limited to conservative, non-surgical therapy only and will only be applied to members who are registered on the Periodontal Programme Managed Care protocols apply Pre-authorisation required
Maxillo-facial surgery and oral pathology	
Surgery in the dental chair	Managed Care protocols apply
Hospitalisation (general anaesthetic)	A co-payment of R3 000 per hospital admission and admission protocols apply General anaesthetic is only available to children under the age of 5 for extensive dental treatment General anaesthetic benefit is available for the removal of impacted teeth Managed Care protocols apply Pre-authorisation required
Laughing gas in dental rooms	Managed Care protocols apply
IV conscious sedation in rooms	Limited to extensive dental treatment Managed Care protocols apply Pre-authorisation required

CHRONIC BENEFITS

The Standard Option offers cover for 45 chronic conditions. Cover is limited to R9 150 per beneficiary and R18 360 per family on the applicable formulary. Pre-authorisation is required. If you choose to use medicine that is not on the formulary, you will have to pay a 40% co-payment. You can get your medicine from any pharmacy on our network.

Once the amount above is finished, you will still be covered for the 27 Prescribed Minimum Benefits, listed below, through the Designated Service Provider. If you choose not to use the Designated Service Provider, you will have to pay a 40% co-payment.

Please note: For HIV/AIDS medicine, you must use the Designated Service Provider or you will have to pay a 40% co-payment.

Prescribed Minimum Benefits covered

1.	Addison's Disease	10.	Crohn's Disease	19.	Hyperlipidaemia
2.	Asthma	11.	Diabetes Insipidus	20.	Hypertension
3.	Bipolar Mood Disorder	12.	Diabetes Type 1	21.	Hypothyroidism
4.	Bronchiectasis	13.	Diabetes Type 2	22.	Multiple Sclerosis
5.	Cardiac Failure	14.	Dysrhythmias	23.	Parkinson's Disease
6.	Cardiomyopathy	15.	Epilepsy	24.	Rheumatoid Arthritis
7.	Chronic Obstructive Pulmonary Disease	16.	Glaucoma	25.	Schizophrenia
8.	Chronic Renal Disease	17.	Haemophilia	26.	Systemic Lupus Erythematosus
9.	Coronary Artery Disease	18.	HIV/AIDS	27.	Ulcerative Colitis

Additional conditions covered

28. Acne	34. Dermatitis	40. Narcolepsy
29. Allergic Rhinitis	35. Depression	41. Obsessive Compulsive Disorder
30. Ankylosing Spondylitis	36. Eczema	42. Panic Disorder
31. Attention Deficit Disorder (in children aged 5-18)	37. Gastro-Oesophageal Reflux Disease (GORD)	43. Post-Traumatic Stress Disorder
32. Barrett's Oesophagus	38. Generalised Anxiety Disorder	44. Tourette's Syndrome
33. Behcet's Disease	39. Gout	45. Zollinger-Ellison Syndrome

ADDITIONAL BENEFITS

We believe in giving you more value. These additional benefits will not affect your other benefit limits.

Contraceptives	
For women aged up to 50	R1 500 per family You must use the Designated Service Provider for pharmacy-dispensed contraceptives
Maternity care	
Per pregnancy	12 antenatal consultations with a gynaecologist, GP or midwife 2 2D ultrasound scans R1 160 for antenatal classes 1 amniocentesis 4 consultations with a midwife after delivery A Bonitas baby bag (you must register for this after obtaining pre-authorisation for the delivery)
Childcare	
Hearing screening	For newborns, in or out of hospital
Congenital hypothyroidism screening	For infants under 1 month old
Babyline	Access to telephone helpline for 24/7 medical advice (including weekends and holidays for children under 3 years)
Paediatric consultations	2 consultations per child under 1 year 2 consultations per child between ages 1 and 2
GP consultations	2 consultations per child between ages 2 and 12
Immunisations	1 flu vaccine per child
Preventative care	
General health	1 HIV test per beneficiary 1 flu vaccine per beneficiary
Cardiac health	1 full lipogram every 5 years, for members aged 20 and over
Women's health	1 mammogram every 2 years, for women between ages 40 and 74 1 pap smear every 3 years, for women between ages 21 and 65
Elderly health	1 pneumococcal vaccine every 5 years, for members aged 65 and over 1 stool test for colon cancer, for members between ages 50 and 75
Wellness benefits	
Wellness screening	1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day Wellness screening includes the following tests: • Blood pressure • Glucose • Cholesterol • Body mass index • Waist-to-hip ratio
Wellness extender	R1 670 per family Once each adult beneficiary has completed a wellness screening, you may choose from the following additional benefits: • GP consultation(s) • Biokineticist consultation(s) • Dietician consultation(s) • Physiotherapy consultation(s) • A programme to stop smoking All claims are paid at the Bonitas Rate Child dependants will qualify once an adult beneficiary has completed a wellness screening
International travel benefit	
Per trip	R5 million per beneficiary R10 million per family Including cover for mandatory vaccines You must register for this benefit

STANDARD **SELECT**

TRADITIONAL OPTION

This traditional option uses a quality provider network to offer rich day-to-day benefits and hospital cover.

In-hospital

Unlimited, consultations & treatment at 100% - network doctors and specialists paid in full

Hospital network applies

R328 100 **cancer benefit** per family

No co-payment for scans

Unlimited blood tests, scans & x-rays at 100%

Cochlear implants R264 500 per family

Internal nerve stimulators R157 700 per family

Internal & external prosthesis R42 100 per family

Unlimited terminal care benefit

Out-of-hospital

Rich **day-to-day & GP benefits**

Must **nominate a network GP** per beneficiary

Separate **benefit for tests & consultations for PMB** treatment plans (excluding GP consultations)

R15 130 **mental health** benefit for **consultations** paid from risk

Optical and dental benefits (basic and specialised) in addition to day-to-day benefits

Chronic benefits

45 **conditions** covered

R18 360 **chronic benefit** per family

Comprehensive medicine list

Chronic medicine delivery to your doorstep through the Designated Service Provider

Managed Care programmes to help members manage a range of conditions including cancer, mental health, HIV/AIDS and diabetes

Additional benefits

R1 500 per family for **contraceptives**

12 **maternity** consultations, antenatal classes, **amniocentesis** & 2 x **2D scans**

Wellness screening & R1 670 **wellness extender** per family

Preventative care for mammograms, pap smears, lipograms, flu vaccines & more

Childcare benefits including paediatrician & GP consultations, **newborn hearing screening**, **congenital hypothyroidism screening** & **Babyline**

International travel benefit of up to R10 million per family per trip

Contributions

Main member	Adult dependant	Child dependant
R 2 828	R 2 447	R 828

Your 4th and subsequent children will be covered free of charge.

IN-HOSPITAL BENEFITS

Cover for major medical events that result in a beneficiary being admitted into hospital.

Pre-authorisation is required. Managed Care protocols apply.

Please note: You must use a hospital on the Standard Select network or you will have to pay a 30% co-payment.

Specialist consultations/ treatment	Unlimited, network specialists covered in full Unlimited, non-network specialists paid at 100% of the Bonitas Rate
GP consultations/treatment	Unlimited, covered at 100% of the Bonitas Rate
Blood and other laboratory tests	Unlimited, covered at 100% of the Bonitas Rate
X-rays and ultrasounds	Unlimited, covered at 100% of the Bonitas Rate
MRIs and CT scans (specialised radiology)	R24 860 per family, in and out of hospital Pre-authorisation required
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Unlimited, covered at 100% of the Bonitas Rate Your therapist must get a referral from the doctor treating you in hospital
Internal and external prostheses	R42 100 per family Managed Care protocols apply Sublimit of R5 000 per breast prosthesis (limited to 2 per year) You must use a preferred supplier
Spinal surgery	You will have to pay a R5 650 co-payment if you do not go for an assessment through the back and neck programme
Hip and knee replacements	You must use the Designated Service Provider
Internal nerve stimulators	R157 700 per family
Cochlear implants	R264 500 per family You must use a preferred supplier
Mental health hospitalisation	R38 670 per family No cover for physiotherapy for mental health admissions You must use a Designated Service Provider
Take-home medicine	R445 per beneficiary, per hospital stay
Physical rehabilitation	R47 250 per family
Alternatives to hospital (hospice, step-down facilities)	R15 760 per family
Terminal care	Unlimited Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
Cancer treatment	R328 100 per family You must use a preferred provider Sublimit of R42 110 per beneficiary for Brachytherapy
Organ transplants	Unlimited Sublimit of R30 000 per beneficiary for corneal grafts
Kidney dialysis	Unlimited, You must use a Designated Service Provider, or a 20% co-payment will apply
HIV/AIDS	Unlimited, if you register on the HIV/AIDS programme Chronic medicine must be obtained from the Designated Service Provider

OUT-OF-HOSPITAL BENEFITS

Out-of-hospital claims will be paid from available day-to-day benefits. There is a separate benefit for GP consultations.

GP consultations

You must choose 1 GP on our network for each beneficiary. This is your nominated GP for the year. If you do not use your nominated GP, your benefit will be limited to the non-nominated GP consultation benefit as indicated in the table below.

Main member only	R3 970 (R1 290 of this can be used for non-nominated GP consultations)
Main member + 1 dependant	R5 820 (R1 990 of this can be used for non-nominated GP consultations)
Main member + 2 dependants	R6 450 (R2 170 of this can be used for non-nominated GP consultations)
Main member + 3 dependants	R6 770 (R2 270 of this can be used for non-nominated GP consultations)
Main member + 4 or more dependants	R7 350 (R2 450 of this can be used for non-nominated GP consultations)

Day-to-day benefits

These benefits provide cover for consultations with your specialist, acute medicine, x-rays, blood tests and other out-of-hospital medical expenses.

Please note: You must get a GP referral for specialist consultations (excluding consultations with oncologists and ophthalmologists; maternity consultations and consultations with paediatricians for children under age 2).

There is a separate benefit for tests and consultations for PMB treatment plans (excluding GP consultations). Therefore this will not affect your day-to-day benefits.

Main member only	R 5 540
Main member + 1 dependant	R 8 430
Main member + 2 dependants	R 9 750
Main member + 3 dependants	R10 650
Main member + 4 or more dependants	R11 600

Specialist consultations	Paid from available day-to-day benefits You must get a referral from your GP
Blood tests and other laboratory tests	Paid from available day-to-day benefits
X-rays and ultrasounds	Paid from available day-to-day benefits
MRIs and CT scans (specialised radiology)	R24 860 per family, in and out of hospital Pre-authorisation required
Acute medicine	Paid from available day-to-day benefits
Over-the-counter medicine	R740 per beneficiary R2 240 per family Paid from available day-to-day benefits
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Paid from available day-to-day benefits
Mental health consultations	R15 130 per family In and out-of-hospital consultations (included in the mental health hospitalisation benefit) No cover for educational psychologists for beneficiaries older than 21 years
General medical appliances (such as wheelchairs and crutches)	R7 300 per family An additional R6 240 per family will apply should Stoma care and CPAP machines exceed the general medical appliances limit You must use a preferred supplier
Hearing aids	R15 240 per family, once every 2 years (based on the date of your previous claim) 20% co-payment applies You must use a preferred supplier
Optometry	R5 550 per family, once every 2 years (based on the date of your previous claim) Each beneficiary can choose glasses or contact lenses
Eye tests	1 per beneficiary, once every 2 years at a network provider, at network rates **OR** R350 per beneficiary, once every 2 years at a non-network provider
Single vision lenses (Clear) **or**	100% towards the cost of lenses at network rates R150 per lens, per beneficiary, out of network
Bifocal lenses (Clear) **or**	100% towards the cost of lenses at network rates R325 per lens, per beneficiary, out of network
Multifocal lenses (Clear)	100% towards the cost of lenses at network rates R700 per lens, per beneficiary, out of network
Frames	R850 per beneficiary, once every 2 years
Contact lenses	R1 850 per beneficiary (included in the family limit)
Basic dentistry	Covered at the Bonitas Dental Tariff
Consultations	2 annual check-ups per beneficiary (once every 6 months)
X-rays: Intra-oral	Managed Care protocols apply
X-rays: Extra-oral	1 per beneficiary, every 3 years Additional benefit may be considered if specialist dental treatment planning/follow up is required
Oral hygiene	2 annual scale and polish treatments per beneficiary (once every 6 months) Fissure sealants are only covered for children under 16 years Fluoride treatments are only covered for children from age 5 and younger than 16 years
Fillings	Benefit for fillings is granted once per tooth, in 365 days Benefit for re-treatment of a tooth is subject to Managed Care protocols A treatment plan and x-rays may be required for multiple fillings
Root canal and extractions	Managed Care protocols apply
Plastic dentures and associated laboratory costs	1 set of plastic dentures (an upper and a lower) per beneficiary, once every 4 years

Specialised dentistry	Covered at the Bonitas Dental Tariff
Partial metal frame dentures and associated laboratory costs	1 partial frame (an upper or lower) per beneficiary, once every 5 years Managed Care protocols apply
Crowns, bridges and associated laboratory costs	1 crown per family, per year Benefit for crowns will be granted once per tooth, every 5 years A treatment plan and x-rays may be requested Pre-authorisation required
Implants and associated laboratory costs	No benefit
Orthodontics and associated laboratory costs	Orthodontic treatment is granted once per beneficiary, per lifetime Pre-authorisation cases will be clinically assessed by using an orthodontic needs analysis Benefit allocation is subject to the outcome of the needs analysis and funding can be granted up to 80% of the Bonitas Dental Tariff Benefit for orthodontic treatment will be granted where function is impaired (not granted for cosmetic reasons) Only 1 family member may begin orthodontic treatment in a calendar year Benefit for fixed comprehensive treatment is limited to beneficiaries from age 9 and younger than 18 years Managed Care protocols apply Pre-authorisation required
Periodontics	Benefit is limited to conservative, non-surgical therapy only and will only be applied to members who are registered on the Periodontal Programme Managed Care protocols apply Pre-authorisation required
Maxillo-facial surgery and oral pathology	
Surgery in the dental chair	Managed Care protocols apply
Hospitalisation (general anaesthetic)	A co-payment of R3 000 per hospital admission and admission protocols apply General anaesthetic is only available to children under the age of 5 for extensive dental treatment General anaesthetic benefit is available for the removal of impacted teeth Managed Care protocols apply Pre-authorisation required
Laughing gas in dental rooms	Managed Care protocols apply
IV conscious sedation in rooms	Limited to extensive dental treatment Managed Care protocols apply Pre-authorisation required

CHRONIC BENEFITS

The Standard Select Option offers cover for 45 chronic conditions. Cover is limited to R9 150 per beneficiary and R18 360 per family on the applicable formulary. Pre-authorisation is required. If you choose to use medicine that is not on the formulary, you will have to pay a 40% co-payment. You must use the Designated Service Provider or you will have to pay a 40% co-payment.

Once the amount above is finished, you will still be covered for the 27 Prescribed Minimum Benefits, listed below, through the Designated Service Provider.

Please note: For HIV/AIDS medicine, you must use the Designated Service Provider or you will have to pay a 40% co-payment.

Prescribed Minimum Benefits covered

1.	Addison's Disease	10.	Crohn's Disease	19.	Hyperlipidaemia
2.	Asthma	11.	Diabetes Insipidus	20.	Hypertension
3.	Bipolar Mood Disorder	12.	Diabetes Type 1	21.	Hypothyroidism
4.	Bronchiectasis	13.	Diabetes Type 2	22.	Multiple Sclerosis
5.	Cardiac Failure	14.	Dysrhythmias	23.	Parkinson's Disease
6.	Cardiomyopathy	15.	Epilepsy	24.	Rheumatoid Arthritis
7.	Chronic Obstructive Pulmonary Disease	16.	Glaucoma	25.	Schizophrenia
8.	Chronic Renal Disease	17.	Haemophilia	26.	Systemic Lupus Erythematosus
9.	Coronary Artery Disease	18.	HIV/AIDS	27.	Ulcerative Colitis

Additional conditions covered

28. Acne	34. Dermatitis	40. Narcolepsy
29. Allergic Rhinitis	35. Depression	41. Obsessive Compulsive Disorder
30. Ankylosing Spondylitis	36. Eczema	42. Panic Disorder
31. Attention Deficit Disorder (in children aged 5-18)	37. Gastro-Oesophageal Reflux Disease (GORD)	43. Post-Traumatic Stress Disorder
32. Barrett's Oesophagus	38. Generalised Anxiety Disorder	44. Tourette's Syndrome
33. Behcet's Disease	39. Gout	45. Zollinger-Ellison Syndrome

ADDITIONAL BENEFITS

We believe in giving you more value. These additional benefits will not affect your other benefit limits.

Contraceptives	
For women aged up to 50	R1 500 per family You must use the Designated Service Provider for pharmacy-dispensed contraceptives
Maternity care	
Per pregnancy	12 antenatal consultations with a gynaecologist, GP or midwife 2 2D ultrasound scans R1 160 for antenatal classes 1 amniocentesis 4 consultations with a midwife after delivery A Bonitas baby bag (you must register for this after obtaining pre-authorisation for the delivery)
Childcare	
Hearing screening	For newborns, in or out of hospital
Congenital hypothyroidism screening	For infants under 1 month old
Babyline	Access to telephone helpline for 24/7 medical advice (including weekends and holidays for children under 3 years)
Paediatric consultations	2 consultations per child under 1 year 2 consultations per child between ages 1 and 2
GP consultations	2 consultations per child between ages 2 and 12
Immunisations	1 flu vaccine per child
Preventative care	
General health	1 HIV test per beneficiary 1 flu vaccine per beneficiary
Cardiac health	1 full lipogram every 5 years, for members aged 20 and over
Women's health	1 mammogram every 2 years, for women between ages 40 and 74 1 pap smear every 3 years, for women between ages 21 and 65
Elderly health	1 pneumococcal vaccine every 5 years, for members aged 65 and over 1 stool test for colon cancer, for members between ages 50 and 75
Wellness benefits	
Wellness screening	1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day Wellness screening includes the following tests: • Blood pressure • Glucose • Cholesterol • Body mass index • Waist-to-hip ratio
Wellness extender	R1 670 per family Once each adult beneficiary has completed a wellness screening, you may choose from the following additional benefits: • GP consultation(s) • Biokineticist consultation(s) • Dietician consultation(s) • Physiotherapy consultation(s) • A programme to stop smoking All claims are paid at the Bonitas Rate Child dependants will qualify once an adult beneficiary has completed a wellness screening
International travel benefit	
Per trip	R5 million per beneficiary R10 million per family Including cover for mandatory vaccines You must register for this benefit

PRIMARY

TRADITIONAL OPTION

This traditional option offers simple day-to-day benefits and hospital cover.

In-hospital

Unlimited, consultations & treatment at 100% - network doctors and specialists paid in full

R157 600 **cancer benefit** per family

Unlimited blood tests & x-rays at 100%

Co-payments apply to 22 elective procedures

Internal prosthesis R30 000 per family

MRI & CT scans R12 380 per family in and out of hospital with no co-payments

Unlimited terminal care benefit

Out-of-hospital

Day-to-day & GP benefits

Separate **benefit for tests & consultations for PMB** treatment plans (excluding GP consultations)

R9 100 **mental health** benefit for **consultations** paid from risk

Optical and basic dental benefits in addition to day-to-day benefits

Chronic benefits

27 **conditions** covered

Chronic medicine delivery to your doorstep through the Designated Service Provider

Managed Care programmes to help members manage a range of conditions including cancer, HIV/AIDS & diabetes

Additional benefits

R1 500 per family for **contraceptives**

6 **maternity** consultations, antenatal classes, **amniocentesis** & 2 x **2D scans**

Wellness screening & R1 210 **wellness extender** per family

Preventative care for mammograms, pap smears, flu vaccines & more

Childcare benefits including paediatrician & GP consultations, **newborn hearing screening**, **congenital hypothyroidism screening** & **Babyline**

International travel benefit of up to R10 million per family per trip

Contributions

Main member	Adult dependant	Child dependant
R 2 076	R 1 624	R 661

Your 4th and subsequent children will be covered free of charge.

IN-HOSPITAL BENEFITS

Cover for major medical events that result in a beneficiary being admitted into hospital.

Pre-authorisation is required. Managed Care protocols apply.

We negotiate extensively with hospitals to ensure the best possible value for our members.

Members have access to all private hospitals. A 30% co-payment may apply to admissions at specific hospitals. Please call us on **0860 002 108** or log in to **www.bonitas.co.za** for a list of these hospitals.

Specialist consultations/ treatment	Unlimited, network specialists covered in full Unlimited, non-network specialists paid at 100% of the Bonitas Rate
GP consultations/treatment	Unlimited, covered at 100% of the Bonitas Rate
Blood tests and other laboratory tests	Unlimited, covered at 100% of the Bonitas Rate
X-rays and ultrasounds	Unlimited, covered at 100% of the Bonitas Rate
MRIs and CT scans (specialised radiology)	R12 380 per family, in and out of hospital Pre-authorisation required
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Unlimited, covered at 100% of the Bonitas Rate Your therapist must get a referral from the doctor treating you in hospital
Internal prostheses	R30 000 per family (excluding joint replacement prostheses) Managed Care protocols apply You must use a preferred supplier
Mental health hospitalisation	R15 080 per family No cover for physiotherapy for mental health admissions You must use a Designated Service Provider
Take-home medicine	R360 per beneficiary, per hospital stay
Physical rehabilitation	R47 250 per family
Alternatives to hospital (hospice, step-down facilities)	R15 760 per family
Terminal care	Unlimited Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
Cancer treatment	R157 600 per family You must use a preferred provider Sublimit of R42 110 per beneficiary for Brachytherapy
Organ transplants	PMB only
Kidney dialysis	Unlimited You must use a Designated Service Provider, or a 20% co-payment will apply
HIV/AIDS	Unlimited, if you register on the HIV/AIDS programme Chronic medicine must be obtained from the Designated Service Provider

A co-payment will apply to the following procedures in hospital

R1 380 co-payment	R3 500 co-payment	R6 900 co-payment
1. Colonoscopy	1. Arthroscopy	1. Back Surgery including Spinal Fusion
2. Conservative Back Treatment	2. Diagnostic Laparoscopy	2. Joint Replacements
3. Cystoscopy	3. Laparoscopic Hysterectomy	3. Laparoscopic Pyeloplasty
4. Facet Joint Injections	4. Laparoscopic Appendectomy	4. Laparoscopic Radical Prostatectomy
5. Flexible Sigmoidoscopy	5. Percutaneous Radiofrequency Ablations (Percutaneous Rhizotomies)	5. Nissen Fundoplication (Reflux Surgery)
6. Functional Nasal Surgery		
7. Gastroscopy		
8. Hysteroscopy (not Endometrial Ablation)		
9. Myringotomy		
10. Tonsillectomy and Adenoidectomy		
11. Umbilical Hernia Repair		
12. Varicose Vein Surgery		

OUT-OF-HOSPITAL BENEFITS

Out-of-hospital claims will be paid from available day-to-day benefits. There is a separate benefit for GP consultations.

GP consultations

If you do not use a GP on our network, your benefit for GP consultations will be limited to the non-network GP consultation benefit. This is shown in the table below.

Main member only	R1 900 (R615 of this may be used for non-network GP consultations)
Main member + 1 dependant	R3 490 (R1 160 of this may be used for non-network GP consultations)
Main member + 2 dependants	R4 130 (R1 320 of this may be used for non-network GP consultations)
Main member + 3 dependants	R4 440 (R1 480 of this may be used for non-network GP consultations)
Main member + 4 or more dependants	R5 030 (R1 750 of this may be used for non-network GP consultations)

Day-to-day benefits

These benefits provide cover for consultations with your specialist, acute medicine, x-rays, blood tests and other out-of-hospital medical expenses.

Please note: You must get a GP referral for specialist consultations (excluding consultations with oncologists and ophthalmologists; maternity consultations and consultations with paediatricians for children under age 2).

There is a separate benefit for tests and consultations for PMB treatment plans (excluding GP consultations). Therefore this will not affect your day-to-day benefits.

Main member only	R2 010
Main member + 1 dependant	R3 600
Main member + 2 dependants	R4 230
Main member + 3 dependants	R4 550
Main member + 4 or more dependants	R4 920

Specialist consultations	Paid from available day-to-day benefits You must get a referral from your GP
Blood tests and other laboratory tests	Paid from available day-to-day benefits
X-rays and ultrasounds	Paid from available day-to-day benefits
MRIs and CT scans (specialised radiology)	R12 380 per family, in and out of hospital Pre-authorisation required
Acute medicine	Paid from available day-to-day benefits
Over-the-counter medicine	R465 per beneficiary R1 360 per family Paid from available day-to-day benefits
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Paid from available day-to-day benefits
Mental health consultations	R9 100 per family In and out-of-hospital consultations (included in the mental health hospitalisation benefit) No cover for educational psychologists for beneficiaries older than 21 years
General medical appliances (such as wheelchairs and crutches)	R6 560 per family An additional R6 240 per family will apply should Stoma care and CPAP machines exceed the general medical appliances limit You must use a preferred supplier
Optometry	R4 270 per family, once every 2 years (based on the date of your previous claim) Each beneficiary can choose glasses or contact lenses
Eye tests	1 per beneficiary, once every 2 years at a network provider at network rates **OR** R350 per beneficiary, once every 2 years at a non-network provider
Single vision lenses (Clear) or	100% towards the cost of lenses at network rates R150 per lens, per beneficiary, out of network
Bifocal lenses (Clear) or	100% towards the cost of lenses at network rates R325 per lens, per beneficiary, out of network
Multifocal lenses (Clear)	100% towards the cost of lenses at network rates R700 per lens, per beneficiary, out of network
Frames	R350 per beneficiary, once every 2 years
Contact lenses	R1 225 per beneficiary, included in the family limit
Basic dentistry	Covered at the Bonitas Dental Tariff You must use a provider on the DENIS network
Consultations	2 annual check-ups per beneficiary (once every 6 months)
X-rays: Intra-oral	Managed Care protocols apply
X-rays: Extra-oral	1 per beneficiary, every 3 years

Oral hygiene	2 annual scale and polish treatments per beneficiary (once every 6 months) Fissure sealants are only covered for children under 16 years Fluoride treatments are only covered for children from age 5 and younger than 16 years
Fillings	Benefit for fillings is granted once per tooth, in 365 days Benefit for re-treatment of a tooth is subject to Managed Care protocols A treatment plan and x-rays may be required for multiple fillings
Root canal therapy and extractions	Managed Care protocols apply Benefit for root canal includes all teeth except primary teeth and permanent molars
Plastic dentures and associated laboratory costs	1 set of plastic dentures (an upper and a lower) per beneficiary, once every 4 years
Specialised dentistry	No benefit
Maxillo-facial surgery and oral pathology	
Surgery in the dental chair	Managed Care protocols apply
Hospitalisation (general anaesthetic)	A co-payment of R3 000 per hospital admission and admission protocols apply General anaesthetic is only available to children under the age of 5 for extensive dental treatment General anaesthetic benefit is available for the removal of impacted teeth Managed Care protocols apply Pre-authorisation required
Laughing gas in dental rooms	Managed Care protocols apply
IV conscious sedation in rooms	Limited to extensive dental treatment Managed Care protocols apply Pre-authorisation required

CHRONIC BENEFITS

The Primary Option ensures that you are covered for the 27 Prescribed Minimum Benefits listed below on the applicable formulary. Pre-authorisation is required. If you choose not to use the Designated Service Provider or if you choose to use medicine that is not on the formulary, you will have to pay a 40% co-payment.

Please note: For HIV/AIDS medicine, you must use the Designated Service Provider or you will have to pay a 40% co-payment.

Prescribed Minimum Benefits covered

1.	Addison's Disease	10.	Crohn's Disease	19.	Hyperlipidaemia
2.	Asthma	11.	Diabetes Insipidus	20.	Hypertension
3.	Bipolar Mood Disorder	12.	Diabetes Type 1	21.	Hypothyroidism
4.	Bronchiectasis	13.	Diabetes Type 2	22.	Multiple Sclerosis
5.	Cardiac Failure	14.	Dysrhythmias	23.	Parkinson's Disease
6.	Cardiomyopathy	15.	Epilepsy	24.	Rheumatoid Arthritis
7.	Chronic Obstructive Pulmonary Disease	16.	Glaucoma	25.	Schizophrenia
8.	Chronic Renal Disease	17.	Haemophilia	26.	Systemic Lupus Erythematosus
9.	Coronary Artery Disease	18.	HIV/AIDS	27.	Ulcerative Colitis

ADDITIONAL BENEFITS

We believe in giving you more value. These additional benefits will not affect your other benefit limits.

Contraceptives	
For women aged up to 50	R1 500 per family You must use the Designated Service Provider for pharmacy-dispensed contraceptives
Maternity care	
Per pregnancy	6 antenatal consultations with a gynaecologist, GP or midwife 2 2D ultrasound scans 1 amniocentesis 4 consultations with a midwife after delivery A Bonitas baby bag (you must register for this after obtaining pre-authorisation for the delivery)
Childcare	
Hearing screening	For newborns, in or out of hospital
Congenital hypothyroidism screening	For infants under 1 month old
Babyline	Access to telephone helpline for 24/7 medical advice (including weekends and holidays for children under 3 years)
Paediatric consultations	1 consultation per child under 1 year 1 consultation per child between ages 1 and 2
GP consultations	1 consultation per child between ages 2 and 12
Immunisations	1 flu vaccine per child
Preventative care	
General health	1 HIV test per beneficiary 1 flu vaccine per beneficiary
Women's health	1 mammogram every 2 years, for women between ages 40 and 74 1 pap smear every 3 years, for women between ages 21 and 65
Elderly health	1 pneumococcal vaccine every 5 years, for members aged 65 and over 1 stool test for colon cancer, for members between ages 50 and 75

Wellness benefits	
Wellness screening	1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day Wellness screening includes the following tests: • Blood pressure • Glucose • Cholesterol • Body mass index • Waist-to-hip ratio
Wellness extender	R1 210 per family Once each adult beneficiary has completed a wellness screening, you may choose from the following additional benefits: • GP consultation(s) • Biokineticist consultation(s) • Dietician consultation(s) • Physiotherapy consultation(s) • A programme to stop smoking All claims are paid at the Bonitas Rate Child dependants will qualify once an adult beneficiary has completed a wellness screening
International travel benefit	
Per trip	R5 million per beneficiary R10 million per family Including cover for mandatory vaccines You must register for this benefit

BONCAP

INCOME BASED OPTION

This traditional entry-level plan offers basic day-to-day benefits and hospital cover using a network of doctors, providers and hospitals.

In-hospital

Unlimited consultations at 100% - **GP** referral required for all hospital admissions

Hospital network applies

R24 230 per family for **blood tests**

R17 600 per family for **blood transfusions**

Unlimited ultrasounds & x-rays at 100%

MRI & CT scans R11 060 per family in hospital with no co-payments

Unlimited terminal care benefit

Out-of-hospital

Unlimited GP consultations (call the BonCap call centre after the 7th consultation for approval)

Specialist benefit if referred by network GP

Separate **optical benefit** including contact lenses

Basic dentistry benefit available

Chronic benefits

27 **conditions** covered

Chronic medicine delivery to your doorstep through the Designated Service Provider

Additional benefits

R1 000 per family for **contraceptives**

Wellness screening

Preventative care for pap smears, flu vaccines & more

Childcare benefits including **newborn hearing screening**, **congenital hypothyroidism screening** & **Babyline**

Contributions

	Main member	Adult dependant	Child dependant
R0 to R7 500	R 918	R 870	R 432
R7 501 to R12 194	R1 116	R1 055	R 512
R12 195 to R16 659	R1 820	R1 620	R 689
R16 660+	R2 235	R1 990	R 847

IN-HOSPITAL BENEFITS

Hospitalisation is covered at 100% of the Bonitas Rate at all hospitals on the BonCap Network. You must get pre-authorisation for your hospital admission. You will have to pay a R6 350 co-payment if you use a non-network hospital (except for emergencies) or you do not get pre-authorisation within 48 hours of admission.

GP consultations	Unlimited, covered at 100% of the Bonitas Rate
Specialist consultations	Unlimited, covered at 100% of the Bonitas Rate
Blood tests and other laboratory tests	R24 230 per family
Blood transfusions	R17 600 per family
X-rays and ultrasounds	Unlimited, covered at 100% of the Bonitas Rate
MRIs and CT scans (specialised radiology)	R11 060 per family Pre-authorisation required
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists)	R4 130 per family Your therapist must have a referral from the doctor treating you
Surgical procedures that are not covered	Back and neck surgery Joint replacement surgery Caesarean sections done for non-medical reasons Functional nasal and sinus surgery Varicose vein surgery Hernia repair surgery Laparoscopic or keyhole surgery Gastroscopies, colonoscopies and all other endoscopies Bunion surgery In-hospital dental surgery
Internal and external prostheses	PMB only Managed Care protocols apply Pre-authorisation required You must use a preferred supplier
Mental health hospitalisation	PMB only No cover for physiotherapy for mental health admissions Subject to using the Designated Service Provider
Neonatal care	Limited to R43 220 per family, except for PMBs
Take-home medicine	R360 per beneficiary, per hospital stay
Physical rehabilitation	R47 250 per family Pre-authorisation required
Alternatives to hospital (hospice, step-down facilities)	R13 600 per family Pre-authorisation required
Terminal care	Unlimited Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
Cancer treatment	PMB only Subject to using the Designated Service Provider
Organ transplants	PMB only Pre-authorisation required
Kidney dialysis	Unlimited You must use a Designated Service Provider, or a 20% co-payment will apply Pre-authorisation required
HIV/AIDS	PMB only, if you register on the HIV/AIDS programme Chronic medicine must be obtained from the Designated Service Provider

OUT-OF-HOSPITAL BENEFITS

These benefits cover your day-to-day medical expenses at of 100% of the Bonitas Rate.

Network GP consultations	Unlimited consultations, using a maximum of 2 network GPs Pre-authorisation is required from the 8th GP consultation per beneficiary	
Non-network GP consultations	1 out-of-network consultation per beneficiary Maximum of 2 consultations per family, limited to R1 000 20% co-payment	
GP-referred acute medicine, x-rays and blood tests	Main member only Main member + 1 dependant Main member + 2 dependants Main member + 3 dependants Main member + 4 or more dependants	R1 750 R2 910 R3 490 R3 810 R4 230
Specialist consultations (this benefit includes prescribed acute medicine, blood tests, x-rays, MRIs and CT scans)	Limited to 3 visits or R2 960 per beneficiary Limited to 5 visits or R4 400 per family Subject to referral from a network GP Pre-authorisation required for MRIs and CT scans	

Maternity care	Antenatal consultations are subject to the GP consultations and specialist consultations benefits 4 consultations with a midwife after delivery
Over-the-counter medicine	Limited to R90 per event Maximum of R250 per beneficiary, per year
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	PMB only
General medical appliances (such as wheelchairs and crutches)	R5 180 per family You must use a preferred supplier
Optometry	You must use the contracted service provider Managed Care protocols apply
Basic dentistry	You must use a provider on the DENIS network Covered at the Bonitas Dental Tariff Managed Care protocols apply
Consultations	1 consultation per beneficiary, per year
Emergency consultation	1 specific (emergency) consultation for pain and sepsis per beneficiary
X-rays: Intra-oral	4 X-rays per beneficiary
X-rays: Extra-oral	1 per beneficiary, in a lifetime X-rays must be submitted to DENIS for review
Scaling and polishing	1 polish **OR** 1 scaling and polishing per beneficiary
Fluoride treatments	1 treatment for beneficiaries under 16 years
Fissure sealants	1 per tooth, once every 3 years for beneficiaries under 16 years
Infection control, instrument sterilisation and local anaesthetic	1 set per beneficiary, per visit

Laughing gas in dental rooms	Inhalation sedation limited to extensive dental treatment only
Emergency root canal therapy	For emergency treatment only Subject to DENIS treatment protocols
Pulp treatments	For amputation of pulp of primary teeth
Extractions (removal of teeth)	Subject to DENIS treatment protocols Extractions and treatment of septic sockets
Dental fillings	4 fillings per beneficiary Benefit for fillings is granted once per tooth, in 365 days Benefit for re-treatment of a tooth is subject to Managed Care protocols
Plastic dentures	1 set of plastic dentures (an upper and a lower) per family, once every 2 years for beneficiaries 21 years and over 20% co-payment Pre-authorisation required A further 20% co-payment will apply if authorisation is applied for after the treatment has been done
Denture rebase	Rebase of dentures once per family, for beneficiaries 21 years and over 20% co-payment
Denture repairs	Repairs to existing dentures twice per family, for beneficiaries 21 years and over 20% co-payment
Maxillo-facial surgery in dental chair	PMB only **Please note:** No benefit for Osseo-integrated implants and Orthognathic surgery Access to a maxillo-facial specialist by DENIS pre-authorisation ONLY Pre-authorisation from DENIS required
IV conscious sedation in the rooms	PMB only Limited to extensive dental treatment Pre-authorisation from DENIS required
Hospitalisation (general anaesthetic)	Pre-authorisation from DENIS required

CHRONIC BENEFITS

BonCap ensures that you are covered for the 27 Prescribed Minimum Benefits listed below on the applicable formulary. Pre-authorisation is required. If you do not use the Desginated Service Provider or if you use medicine that is not on the formulary, you will have to pay a 40% co-payment.

Prescribed Minimum Benefits covered

1.	Addison's Disease	10.	Crohn's Disease	19.	Hyperlipidaemia
2.	Asthma	11.	Diabetes Insipidus	20.	Hypertension
3.	Bipolar Mood Disorder	12.	Diabetes Type 1	21.	Hypothyroidism
4.	Bronchiectasis	13.	Diabetes Type 2	22.	Multiple Sclerosis
5.	Cardiac Failure	14.	Dysrhythmias	23.	Parkinson's Disease
6.	Cardiomyopathy	15.	Epilepsy	24.	Rheumatoid Arthritis
7.	Chronic Obstructive Pulmonary Disease	16.	Glaucoma	25.	Schizophrenia
8.	Chronic Renal Disease	17.	Haemophilia	26.	Systemic Lupus Erythematosus
9.	Coronary Artery Disease	18.	HIV/AIDS	27.	Ulcerative Colitis

ADDITIONAL BENEFITS

We believe in giving you more value. These additional benefits will not affect your other benefit limits.

Contraceptives	
For women aged up to 50	R1 000 per family You must use the Designated Service Provider for pharmacy-dispensed contraceptives
Childcare	
Hearing screening	For newborns, in or out of hospital
Congenital hypothyroidism screening	For infants under 1 month old
Babyline	Access to telephone helpline for 24/7 medical advice (including weekends and holidays for children under 3 years)
Immunisations	1 flu vaccine per child
Preventative care	
General health	1 HIV test per beneficiary 1 flu vaccine per beneficiary
Women's health	1 pap smear every 3 years, for women between ages 21 and 65
Elderly health	1 pneumococcal vaccine every 5 years, for members aged 65 and over 1 stool test for colon cancer, for members between ages 50 and 75
Wellness benefits	
Wellness screening	1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day Wellness screening includes the following tests: • Blood pressure • Glucose • Cholesterol • Body mass index • Waist-to-hip ratio

HOSPITAL **PLUS**

HOSPITAL OPTION

This hospital plan offers comprehensive hospital benefits with some value-added benefits.

In-hospital

Unlimited, consultations & treatment at 200%

R589 000 **cancer benefit** per family - R233 700 can be used for specialised drugs

Co-payments apply to 22 elective procedures

Unlimited blood tests, scans & x-rays at 100%

MRI & CT scans R27 610 per family in and out of hospital with no co-payments

Mental health in hospital R30 680 per family

Internal prosthesis R52 480 per family

Unlimited terminal care benefit

Out-of-hospital

Not applicable

Chronic benefits

27 **conditions** covered

Chronic medicine delivery to your doorstep through the Designated Service Provider

Managed Care programmes to help members manage a range of conditions including cancer, HIV/AIDS and diabetes

Additional benefits

R1 500 per family for **contraceptives**

6 **maternity** consultations, **amniocentesis** & 2 x **2D scans**

Wellness screening & R1 670 **wellness extender** per family

Preventative care for mammograms, pap smears, flu vaccines & more

Childcare benefits including paediatrician & GP consultations, **newborn hearing screening**, **congenital hypothyroidism screening** & **Babyline**

International travel benefit of up to R10 million per family per trip

Contributions

Main member	Adult dependant	Child dependant
R 2 897	R 2 607	R 937

Your 4th and subsequent children will be covered free of charge.

IN-HOSPITAL BENEFITS

Cover for major medical events that result in a beneficiary being admitted into hospital.

Pre-authorisation is required. Managed Care protocols apply.

We negotiate extensively with hospitals to ensure the best possible value for our members.

Members have access to all private hospitals. A 30% co-payment may apply to admissions at specific hospitals. Please call us on **0860 002 108** or log in to **www.bonitas.co.za** for a list of these hospitals.

Specialist consultations/ treatment	Unlimited, covered at 200% of the Bonitas Rate
GP consultations/treatment	Unlimited, covered at 200% of the Bonitas Rate
Blood tests and other laboratory tests	Unlimited, covered at 100% of the Bonitas Rate
X-rays and ultrasounds	Unlimited, covered at 100% of the Bonitas Rate
MRIs and CT scans (specialised radiology)	R27 610 per family, in and out of hospital Pre-authorisation required
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Unlimited, covered at 100% of the Bonitas Rate Your therapist must get a referral from the doctor treating you in hospital
Internal prosthesis	R52 480 per family Managed Care protocols apply You must use a preferred supplier
External prosthesis	PMB only Managed Care protocols apply You must use a preferred supplier
Deep brain stimulation (excluding prosthesis)	R222 200 per beneficiary
Hospitalisation for Basic Dentistry (general anaesthetic)	General anaesthetic is only available to children under the age of 5 years for extensive dental treatment General anaesthetic benefits are available for the removal of impacted teeth R3 000 co-payment for hospital admissions Managed Care protocols apply
IV conscious sedation in rooms	Limited to extensive dental treatment Managed Care protocols apply
Mental health hospitalisation	R30 680 per family Physiotherapy will be excluded for all mental health admissions You must use a Designated Service Provider
Take-home medicine	R520 per beneficiary, per hospital stay
Physical rehabilitation	R47 250 per family
Alternatives to hospital (hospice, step-down facilities)	R15 760 per family
Terminal care	Unlimited Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
Cancer treatment	R589 000 per family R233 700 of this can be used for specialised drugs including biological drugs (10% co-payment applies) Sublimit of R42 110 per beneficiary for Brachytherapy
Non-cancer specialised drugs (including biological drugs)	R186 900 per family Managed Care protocols apply 10% co-payment applies
Organ transplants	Unlimited Sublimit of R30 000 per beneficiary for corneal grafts
Kidney dialysis	Unlimited You must use a Designated Service Provider, or a 20% co-payment will apply
HIV/AIDS	Unlimited, if you register on the HIV/AIDS programme Chronic medicine must be obtained from the Designated Service Provider

A co-payment will apply to the following procedures in hospital

R1 380 co-payment	R3 500 co-payment	R6 900 co-payment
1. Colonoscopy	1. Arthroscopy	1. Back Surgery including Spinal Fusion
2. Conservative Back Treatment	2. Diagnostic Laparoscopy	2. Joint Replacements
3. Cystoscopy	3. Laparoscopic Hysterectomy	3. Laparoscopic Pyeloplasty
4. Facet Joint Injections	4. Laparoscopic Appendectomy	4. Laparoscopic Radical Prostatectomy
5. Flexible Sigmoidoscopy	5. Percutaneous Radiofrequency Ablations (Percutaneous Rhizotomies)	5. Nissen Fundoplication (Reflux Surgery)
6. Functional Nasal Surgery		
7. Gastroscopy		
8. Hysteroscopy (not Endometrial Ablation)		
9. Myringotomy		
10. Tonsillectomy and Adenoidectomy		
11. Umbilical Hernia Repair		
12. Varicose Vein Surgery		

CHRONIC BENEFITS

Hospital Plus ensures that you are covered for the 27 Prescribed Minimum Benefits listed below on the applicable formulary. Pre-authorisation is required. If you choose not to use the Designated Service Provider or if you choose to use medicine that is not on the formulary, you will have to pay a 40% co-payment.

Please note: For HIV/AIDS medicine, you must use the Designated Service Provider or you will have to pay a 40% co-payment.

Prescribed Minimum Benefits covered

1. Addison's Disease	10. Crohn's Disease	19. Hyperlipidaemia
2. Asthma	11. Diabetes Insipidus	20. Hypertension
3. Bipolar Mood Disorder	12. Diabetes Type 1	21. Hypothyroidism
4. Bronchiectasis	13. Diabetes Type 2	22. Multiple Sclerosis
5. Cardiac Failure	14. Dysrhythmias	23. Parkinson's Disease
6. Cardiomyopathy	15. Epilepsy	24. Rheumatoid Arthritis
7. Chronic Obstructive Pulmonary Disease	16. Glaucoma	25. Schizophrenia
8. Chronic Renal Disease	17. Haemophilia	26. Systemic Lupus Erythematosus
9. Coronary Artery Disease	18. HIV/AIDS	27. Ulcerative Colitis

ADDITIONAL BENEFITS

We believe in giving you more value. These additional benefits will not affect your other benefit limits.

Contraceptives	
For women aged up to 50	R1 500 per family You must use the Designated Service Provider for pharmacy-dispensed contraceptives
Maternity care	
Per pregnancy	6 antenatal consultations with a gynaecologist, GP or midwife 2 2D ultrasound scans 1 amniocentesis 4 consultations with a midwife after delivery A Bonitas baby bag (you must register for this after obtaining pre-authorisation for the delivery)
Childcare	
Hearing screening	For newborns, in or out of hospital
Congenital hypothyroidism screening	For infants under 1 month old
Babyline	Access to telephone helpline for 24/7 medical advice (including weekends and holidays for children under 3 years)
Paediatric consultations	2 consultations per child under 1 year 1 consultation per child between ages 1 and 2
GP consultations	1 consultation per child between ages 2 and 12
Immunisations	1 flu vaccine per child
Preventative care	
General health	1 HIV test per beneficiary 1 flu vaccine per beneficiary
Women's health	1 mammogram every 2 years, for women between ages 40 and 74 1 pap smear every 3 years, for women between ages 21 and 65
Elderly health	1 pneumococcal vaccine every 5 years, for members aged 65 and over 1 stool test for colon cancer, for members between ages 50 and 75

Wellness benefits	
Wellness screening	1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day Wellness screening includes the following tests: • Blood pressure • Glucose • Cholesterol • Body mass index • Waist-to-hip ratio
Wellness extender	R1 670 per family Once each adult beneficiary has completed a wellness screening, you may choose from the following additional benefits: • GP consultation(s) • Biokineticist consultation(s) • Dietician consultation(s) • Physiotherapy consultation(s) • A programme to stop smoking All claims are paid at the Bonitas Rate Child dependants will qualify once an adult beneficiary has completed a wellness screening
International travel benefit	
Per trip	R5 million per beneficiary R10 million per family Including cover for mandatory vaccines You must register for this benefit

HOSPITAL **STANDARD**

HOSPITAL OPTION

This hospital plan offers extensive hospital benefits with some value-added benefits.

In-hospital

Unlimited, consultations & treatment at 100% - network doctors and specialists paid in full

R328 100 **cancer benefit** per family

Co-payments apply to 22 elective procedures

Unlimited blood tests, scans & x-rays at 100%

MRI & CT scans R24 860 per family in and out of hospital with no co-payments

Mental health in hospital R30 680 per family

Internal prosthesis R42 100 per family

Unlimited terminal care benefit

Out-of-hospital

Not applicable

Chronic benefits

27 **conditions** covered

Chronic medicine delivery to your doorstep through the Designated Service Provider

Managed Care programmes to help members manage a range of conditions including cancer, HIV/AIDS and diabetes

Additional benefits

R1 500 per family for **contraceptives**

6 **maternity** consultations, **amniocentesis** & 2 x **2D scans**

Wellness screening & R1 210 **wellness extender** per family

Preventative care for mammograms, pap smears, flu vaccines & more

Childcare benefits including paediatrician & GP consultations, **newborn hearing screening**, **congenital hypothyroidism screening** & **Babyline**

International travel benefit of up to R10 million per family per trip

Contributions

Main member	Adult dependant	Child dependant
R 1 830	R 1 543	R 696

Your 4th and subsequent children will be covered free of charge.

IN-HOSPITAL BENEFITS

Cover for major medical events that result in a beneficiary being admitted into hospital.

Pre-authorisation is required. Managed Care protocols apply.

We negotiate extensively with hospitals to ensure the best possible value for our members.

Members have access to all private hospitals. A 30% co-payment may apply to admissions at specific hospitals. Please call us on **0860 002 108** or log in to **www.bonitas.co.za** for a list of these hospitals.

Specialist consultations/ treatment	Unlimited, network specialists covered in full Unlimited, non-network specialists paid at 100% of the Bonitas Rate
GP consultations/treatment	Unlimited, covered at 100% of the Bonitas Rate
Blood tests and other laboratory tests	Unlimited, covered at 100% of the Bonitas Rate
X-rays and ultrasounds	Unlimited, covered at 100% of the Bonitas Rate
MRIs and CT scans (specialised radiology)	R24 860 per family, in and out of hospital Pre-authorisation required
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Unlimited, covered at 100% of the Bonitas Rate Your therapist must get a referral from the doctor treating you in hospital
Internal prosthesis	R42 100 per family Managed Care protocols apply You must use a preferred supplier No benefit for joint replacements, unless PMB
External prosthesis	PMB only Managed Care protocols apply
Hospitalisation for basic dentistry (general anaesthetic)	General anaesthetic is only available to children under the age of 5 years for extensive dental treatment General anaesthetic benefits are available for the removal of impacted teeth R3 000 co-payment for hospital admissions Managed Care protocols apply
IV conscious sedation in rooms	Limited to extensive dental treatment Managed Care protocols apply
Mental health hospitalisation	R30 680 per family Physiotherapy will be excluded for all mental health admissions You must use a Designated Service Provider
Take-home medicine	R445 per beneficiary, per hospital stay
Physical rehabilitation	R47 250 per family
Alternatives to hospital (hospice, step-down facilities)	R15 760 per family
Terminal care	Unlimited Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
Cancer treatment	R328 100 per family You must use a preferred provider Sublimit of R42 110 per beneficiary for Brachytherapy
Organ transplants	Unlimited Sublimit of R30 000 per beneficiary for corneal grafts
Kidney dialysis	Unlimited You must use a Designated Service Provider, or a 20% co-payment will apply
HIV/AIDS	Unlimited, if you register on the HIV/AIDS programme Chronic medicine must be obtained from the Designated Service Provider

A co-payment will apply to the following procedures in hospital

R1 380 co-payment	R3 500 co-payment	R6 900 co-payment
1. Colonoscopy	1. Arthroscopy	1. Back Surgery including Spinal Fusion
2. Conservative Back Treatment	2. Diagnostic Laparoscopy	2. Laparoscopic Pyeloplasty
3. Cystoscopy	3. Laparoscopic Hysterectomy	3. Laparoscopic Radical Prostatectomy
4. Facet Joint Injections	4. Laparoscopic Appendectomy	4. Nissen Fundoplication (Reflux Surgery)
5. Flexible Sigmoidoscopy	5. Percutaneous Radiofrequency Ablations (Percutaneous Rhizotomies)	
6. Functional Nasal Surgery		
7. Gastroscopy		
8. Hysteroscopy (not Endometrial Ablation)		
9. Myringotomy		
10. Tonsillectomy and Adenoidectomy		
11. Umbilical Hernia Repair		
12. Varicose Vein Surgery		

CHRONIC BENEFITS

Hospital Standard ensures that you are covered for the 27 Prescribed Minimum Benefits listed below on the applicable formulary. Pre-authorisation is required. If you choose not to use the Designated Service Provider or if you choose to use medicine that is not on the formulary, you will have to pay a 40% co-payment.

Please note: For HIV/AIDS medicine, you must use the Designated Service Provider or you will have to pay a 40% co-payment.

Prescribed Minimum Benefits covered

1.	Addison's Disease	10.	Crohn's Disease	19.	Hyperlipidaemia
2.	Asthma	11.	Diabetes Insipidus	20.	Hypertension
3.	Bipolar Mood Disorder	12.	Diabetes Type 1	21.	Hypothyroidism
4.	Bronchiectasis	13.	Diabetes Type 2	22.	Multiple Sclerosis
5.	Cardiac Failure	14.	Dysrhythmias	23.	Parkinson's Disease
6.	Cardiomyopathy	15.	Epilepsy	24.	Rheumatoid Arthritis
7.	Chronic Obstructive Pulmonary Disease	16.	Glaucoma	25.	Schizophrenia
8.	Chronic Renal Disease	17.	Haemophilia	26.	Systemic Lupus Erythematosus
9.	Coronary Artery Disease	18.	HIV/AIDS	27.	Ulcerative Colitis

ADDITIONAL BENEFITS

We believe in giving you more value. These additional benefits will not affect your other benefit limits.

Contraceptives	
For women aged up to 50	R1 500 per family You must use the Designated Service Provider for pharmacy-dispensed contraceptives
Maternity care	
Per pregnancy	6 antenatal consultations with a gynaecologist, GP or midwife 2 2D ultrasound scans 1 amniocentesis 4 consultations with a midwife after delivery A Bonitas baby bag (you must register for this after obtaining pre-authorisation for the delivery)
Childcare	
Hearing screening	For newborns, in or out of hospital
Congenital hypothyroidism screening	For infants under 1 month old
Babyline	Access to telephone helpline for 24/7 medical advice (including weekends and holidays for children under 3 years)
Paediatric consultations	2 consultations per child under 1 year 1 consultation per child between ages 1 and 2
GP consultations	1 consultation per child between ages 2 and 12
Immunisations	1 flu vaccine per child
Preventative care	
General health	1 HIV test per beneficiary 1 flu vaccine per beneficiary
Women's health	1 mammogram every 2 years, for women between ages 40 and 74 1 pap smear every 3 years, for women between ages 21 and 65
Elderly health	1 pneumococcal vaccine every 5 years, for members aged 65 and over 1 stool test for colon cancer, for members between ages 50 and 75
Wellness benefits	
Wellness screening	1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day Wellness screening includes the following tests: • Blood pressure • Glucose • Cholesterol • Body mass index • Waist-to-hip ratio
Wellness extender	R1 210 per family Once each adult beneficiary has completed a wellness screening, you may choose from the following additional benefits: • GP consultation(s) • Biokineticist consultation(s) • Dietician consultation(s) • Physiotherapy consultation(s) • A programme to stop smoking All claims are paid at the Bonitas Rate Child dependants will qualify once an adult beneficiary has completed a wellness screening
International travel benefit	
Per trip	R5 million per beneficiary R10 million per family Including cover for mandatory vaccines You must register for this benefit

BONESSENTIAL

HOSPITAL OPTION

This hospital plan offers rich hospital benefits with some value-added benefits.

In-hospital

Unlimited, consultations & treatment at 100% - network doctors and specialists paid in full

R328 100 **cancer benefit** per family

Co-payments apply to 22 elective procedures

Unlimited blood tests & x-rays at 100%

MRI & CT scans R15 000 per family in hospital with no co-payments

Mental health in hospital R30 680 per family

Unlimited terminal care benefit

Out-of-hospital

Not applicable

Chronic benefits

27 **conditions** covered

Chronic medicine delivery to your doorstep through the Designated Service Provider

Managed Care programmes to help members manage a range of conditions including cancer, HIV/AIDS and diabetes

Additional benefits

R1 200 per family for **contraceptives**

6 **maternity** consultations, **amniocentesis** & 2 x **2D scans**

Wellness screening & R860 **wellness extender** per family

Preventative care for pap smears, flu vaccines & more

Childcare benefits including GP consultations, **newborn hearing screening**, **congenital hypothyroidism screening** & **Babyline**

International travel benefit of up to R10 million per family per trip

Contributions

Main member	Adult dependant	Child dependant
R 1 604	R 1 227	R 470

Your 4th and subsequent children will be covered free of charge.

IN-HOSPITAL BENEFITS

Cover for major medical events that result in a beneficiary being admitted into hospital.

Pre-authorisation is required. Managed Care protocols apply.

We negotiate extensively with hospitals to ensure the best possible value for our members.

Members have access to all private hospitals. A 30% co-payment may apply to admissions at specific hospitals. Please call us on **0860 002 108** or log in to **www.bonitas.co.za** for a list of these hospitals.

Specialist consultations/ treatment	Unlimited, network specialists covered in full Unlimited, non-network specialists paid at 100% of the Bonitas Rate
GP consultations/treatment	Unlimited, covered at 100% of the Bonitas Rate
Blood tests and other laboratory tests	Unlimited, covered at 100% of the Bonitas Rate
X-rays and ultrasounds	Unlimited, covered at 100% of the Bonitas Rate
MRIs and CT scans (specialised radiology)	R15 000 per family Pre-authorisation required
Paramedical/Allied medical professionals (such as physiotherapists, occupational therapists, dieticians and biokineticists)	Unlimited, covered at 100% of the Bonitas Rate Your therapist must get a referral from the doctor treating you in hospital
Internal and external prostheses	PMB only Managed Care protocols apply You must use a preferred supplier
Mental health hospitalisation	R30 680 per family Physiotherapy will be excluded for all mental health admissions You must use a Designated Service Provider
Take-home medicine	R360 per beneficiary, per hospital stay
Physical rehabilitation	R47 250 per family
Alternatives to hospital (hospice, step-down facilities)	R15 760 per family
Terminal care	Unlimited Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
Cancer treatment	R328 100 per family You must use a preferred provider Sublimit of R42 110 per beneficiary for Brachytherapy
Organ transplants	Unlimited
Kidney dialysis	You must use a Designated Service Provider, or a 20% co-payment will apply
HIV/AIDS	Unlimited, if you register on the HIV/AIDS programme Chronic medicine must be obtained from the Designated Service Provider

A co-payment will apply to the following procedures in hospital

R1 380 co-payment	R3 500 co-payment	R6 900 co-payment
1. Colonoscopy	1. Arthroscopy	1. Back Surgery including Spinal Fusion
2. Conservative Back Treatment	2. Diagnostic Laparoscopy	2. Joint Replacements
3. Cystoscopy	3. Laparoscopic Hysterectomy	3. Laparoscopic Pyeloplasty
4. Facet Joint Injections	4. Laparoscopic Appendectomy	4. Laparoscopic Radical Prostatectomy
5. Flexible Sigmoidoscopy	5. Percutaneous Radiofrequency Ablations (Percutaneous Rhizotomies)	5. Nissen Fundoplication (Reflux Surgery)
6. Functional Nasal Surgery		
7. Gastroscopy		
8. Hysteroscopy (not Endometrial Ablation)		
9. Myringotomy		
10. Tonsillectomy and Adenoidectomy		
11. Umbilical Hernia Repair		
12. Varicose Vein Surgery		

CHRONIC BENEFITS

BonEssential ensures that you are covered for the 27 Prescribed Minimum Benefits listed below on the applicable formulary. Pre-authorisation is required. If you choose not to use the Designated Service Provider or if you choose to use medicine that is not on the formulary, you will have to pay a 40% co-payment.

Please note: For HIV/AIDS medicine, you must use the Designated Service Provider or you will have to pay a 40% co-payment.

Prescribed Minimum Benefits covered

1.	Addison's Disease	10.	Crohn's Disease	19.	Hyperlipidaemia
2.	Asthma	11.	Diabetes Insipidus	20.	Hypertension
3.	Bipolar Mood Disorder	12.	Diabetes Type 1	21.	Hypothyroidism
4.	Bronchiectasis	13.	Diabetes Type 2	22.	Multiple Sclerosis
5.	Cardiac Failure	14.	Dysrhythmias	23.	Parkinson's Disease
6.	Cardiomyopathy	15.	Epilepsy	24.	Rheumatoid Arthritis
7.	Chronic Obstructive Pulmonary Disease	16.	Glaucoma	25.	Schizophrenia
8.	Chronic Renal Disease	17.	Haemophilia	26.	Systemic Lupus Erythematosus
9.	Coronary Artery Disease	18.	HIV/AIDS	27.	Ulcerative Colitis

ADDITIONAL BENEFITS

We believe in giving you more value. These additional benefits will not affect your other benefit limits.

Contraceptives	
For women aged up to 50	R1 200 per family You must use the Designated Service Provider for pharmacy-dispensed contraceptives
Maternity care	
Per pregnancy	6 antenatal consultations with a gynaecologist, GP or midwife 2 2D ultrasound scans 1 amniocentesis 4 consultations with a midwife after delivery A Bonitas baby bag (you must register for this after obtaining pre-authorisation for the delivery)
Childcare	
Hearing screening	For newborns, in or out of hospital
Congenital hypothyroidism screening	For infants under 1 month old
Babyline	Access to telephone helpline for 24/7 medical advice (including weekends and holidays for children under 3 years)
GP consultations	1 consultation per child between ages 2 and 12
Immunisations	1 flu vaccine per child
Preventative care	
General health	1 HIV test per beneficiary 1 flu vaccine per beneficiary
Women's health	1 pap smear every 3 years, for women between ages 21 and 65
Elderly health	1 pneumococcal vaccine every 5 years, for members aged 65 and over 1 stool test for colon cancer, for members between ages 50 and 75
Wellness benefits	
Wellness screening	1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day Wellness screening includes the following tests: • Blood pressure • Glucose • Cholesterol • Body mass index • Waist-to-hip ratio
Wellness extender	R860 per family Once each adult beneficiary has completed a wellness screening, you may choose from the following additional benefits: • GP consultation(s) • Biokineticist consultation(s) • Dietician consultation(s) • Physiotherapy consultation(s) • A programme to stop smoking All claims are paid at the Bonitas Rate Child dependants will qualify once an adult beneficiary has completed a wellness screening
International travel benefit	
Per trip	R5 million per beneficiary R10 million per family Including cover for mandatory vaccines You must register for this benefit

MANAGED CARE **PROGRAMMES**

Our managed care programmes allow you to maximise your benefits as far as possible and help you manage your condition in the most clinically-proven way, while offering you emotional and medical support.

Back and neck

- Helps manage severe back and neck pain
- Offers a personalised treatment plan for up to 6 weeks
- Includes assistance from doctors, physiotherapists and biokineticists
- Gives access to a home care plan to maintain your results long-term
- We cover the full cost of the programme so it won't impact your savings or day-to-day benefits
- Highly effective and low-risk, with an excellent success rate

To join

Call **0860 105 104** to be referred to your nearest treatment centre.

Cancer

- Puts you first, offering emotional and medical support
- Delivers cost-effective care of the highest quality
- Liaises with your doctor to ensure your treatment plan is clinically appropriate to meet your needs
- Matches the treatment plan to your benefits to ensure you have the cover you need
- Affiliated with the ICON network of oncology specialists
- Access to a social worker for you and your loved ones

To join

Call **0860 100 572** or
email **oncology@bonitas.co.za**

Chronic medicine management

- Covers you for the treatment of chronic diseases as per your plan
- Allows you to update your chronic medicine quickly and easily
- Ensures you aren't paying more than you should for your medicine
- Arranges delivery of chronic medicine to your doorstep through Pharmacy Direct

To join

Call **0860 002 108** or
email **chronicmeds@bonitas.co.za**

Diabetes

- Empowers you to make the right decisions to stay healthy
- Offers a personalised care plan for your specific needs
- Provides cover for the tests required for the management of diabetes as well as other chronic conditions
- Helps you track the results of the any required tests
- Offers access to specialised diabetes doctors, dieticians and podiatrists
- Helps you better understand your condition through diabetes education
- Gives access to a dedicated Health Coach to answer any questions you may have

To join

Call **0860 002 108** or
email **diabeticcare@bonitas.co.za**

Please note: You need to apply to join these care programmes, **visit www.bonitas.co.za** or refer to page 61.

The back and neck, diabetes, hip and knee as well as the mental wellness programmes are not available on BonCap. The mental wellness programme is only applicable on BonComprehensive, BonClassic, Standard and Standard Select.

Disease management

- Assists you to manage your condition optimally
- Ensures you understand your prescribed medicine and how to obtain it
- Offers access to trained and qualified health coaches to help you along your journey - from diagnosis until your condition is well-managed
- Works with your doctors to link all your health information for the best healthcare decisions

To join

Call **0860 002 108** or
email **queries@bonitas.co.za**

Hip and knee replacement

- Offered through Improved Clinical Pathway Services (ICPS)
- Based on the latest international standardised clinical care pathways
- Uses a multidisciplinary team, dedicated to assist with successful recovery
- Doctors ensure that your conditions are optimised before surgery to give you the best outcomes
- Treatment is covered in full

To join

Call **0861 112 666** or
visit **www.icpservices.co.za**

HIV/AIDS

- Provides you with appropriate treatment and tools to live a normal life
- Covers medicine to treat HIV (including drugs to prevent mother-to-child transmission and infection after sexual assault or needle-stick injury)
- Treatment and prevention of opportunistic infections such as pneumonia, TB and flu
- Covers regular bloods tests to monitor disease progression, response to therapy and to detect possible side-effects of treatment
- Offers HIV-related consultations to visit your doctor to monitor your clinical status
- Gives ongoing patient support via a team of trained and experienced counsellors
- Offers access to telephonic support from doctors
- Helps in finding a registered counsellor for emotional support

To join

Call **0860 100 646** or
email **afa@afadm.co.za**
to request an application form

Mental wellness

- Aims to improve your quality of life and empowers you to manage your condition
- Provides access to a dedicated case manager and specialised mental health doctors
- Offers support for your loved ones
- Gives you access to education to manage your condition more efficiently

To join

Call **0860 002 108** or
email **queries@bonitas.co.za**

EXCLUSIONS

1. PRESCRIBED MINIMUM BENEFITS

The Fund will pay in full, without co-payment or use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefits as per Regulation 8 of the Act. The Fund will employ appropriate interventions aimed at improving the efficiency and effectiveness of healthcare provision, including such techniques as requirements for pre-authorisation the application of treatment protocols and the use of formularies (Regulation 8(3)).

Where a managed health care protocol or a formulary drug preferred by the Scheme, but excluding the Prescribed Minimum Benefits (PMB) algorithm as defined in the Regulation, has been ineffective or would cause harm to a beneficiary, the Scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by Regulation 15H and 15I of the Act. DSP refers to Designated Service Providers.

2. LIMITATION AND RESTRICTION OF BENEFITS

2.1 In cases of illness of a protracted nature, the Fund shall have the right to insist upon a member or dependant of a member consulting any particular specialist the Fund may nominate in consultation with the attending practitioner.

2.2 The Fund may require a second opinion in respect of proposed treatment or medicine 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 Fund and at the cost of the Fund. In the event that the second opinion proposes different treatment or medicine to the first, the Fund may in its discretion require that the second opinion proposals be followed.

2.3 Unless otherwise decided by the Fund, 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.

2.4 If the Fund 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 with due regard to the provision of Regulations 15(H) and 15(I).

2.5 If the Fund does not have funding guidelines or protocols in respect of benefits for services and supplies referred to in Annexure B, beneficiaries will only qualify for benefits in respect of those services and supplies if the Fund or its managed healthcare organisation acknowledges them as medically necessary, and then subject to such conditions as the Fund or its managed healthcare organisation may impose.

2.5.1 They are required to restore normal function of an affected limb, organ or system;

2.5.2 No alternative exists that has a better outcome, is more cost-effective, or has a lower risk;

2.5.3 They are accepted by the relevant service provider as optimal and necessary for the specific condition and at an appropriate level to render safe and adequate care;

2.5.4 They are not rendered or provided for the convenience of the relevant beneficiary or service provider;

2.5.5 Outcome studies are available and acceptable to the Fund in respect of such services or supplies;

2.5.6 They are not rendered or provided because of personal choice or preference of the relevant beneficiary or service provider, while other medically appropriate, more cost-effective alternatives exist.

2.6 The Fund reserves the right not to pay for any new medical technology or, investigational procedures, interventions, new drugs or medicine as applied in clinical medicine, including new indications for existing medicines or technologies, unless the following clinical data relating to the above have been presented to and accepted by the Medical Advisory Committee and such data demonstrating their:

2.6.1 Therapeutic role in clinical medicine;

2.6.2 Cost-efficiency and affordability;

2.6.3 Value relative to existing services or supplies;

2.6.4 Role in drug therapy as established by the Fund's managed healthcare organisation.

2.7 In the event that (non-PMB conditions):

2.7.1 The treatment of an extended or chronic sickness condition becomes necessary; or

2.7.2 A disease or a condition (including pregnancy) requires specialised or intensive treatment; or

2.7.3 The treatment of any disease or condition becomes of a protracted nature or requires extended medicine and such treatment is given in or by a non-DSP, the case may be evaluated in terms of the relevant managed healthcare programme and, having regard to the aforementioned diseases or conditions in question, the Fund may require and arrange:

2.7.3.1 The transfer of that beneficiary to a public hospital or other DSP as arranged by the Fund where appropriate care is available, with due regard to Regulation 8(3)(c); or

2.7.3.2 The application of a limited drug formulary; or

2.7.3.3 Both such transfer and restricted drug formulary in order to conserve or maximise efficient utilisation of available benefits.

2.8 In the event that a decision has been taken in terms of paragraph 2.7 above, the following conditions shall apply:

2.8.1 In respect of PMBs, no benefit limit shall apply provided treatment is given in or by a public hospital or DSP referred to in paragraph 7.4 in Annexure D. If for any reason the beneficiary on BonCap voluntarily receives treatment in or by a non-DSP, the beneficiary shall be required to pay the difference between the DSP rate and the cost of such treatment.

2.8.2 In respect of non-PMB conditions, if the Fund or its managed healthcare organisation should determine that any annual benefit limits, as set out in Annexure B, and available to the beneficiary receiving such treatment, are likely to be exceeded in the course of the year, the beneficiary may be advised to move to a public hospital or DSP or to accept a limited drug formulary, or both, in order to conserve available benefits. In such DSP or public facility any costs incurred over and above the limit stipulated in Annexure B (excluding PMB conditions), shall be the member's responsibility. The member may elect on behalf of himself or his beneficiary, to remain in the private hospital, or remain on the full drug formulary available, or both, in which event the Fund shall pay up to the benefit limit stipulated in Annexure B, where after the member shall be responsible for payment, direct to the private hospital, for any further treatment in such hospital or for payment direct to the supplier for further medicine.

2.9 The Scheme (or contracted managed care company on behalf of the Scheme) may from time to time contract with, or pilot with, or credential specific provider groups (networks) or centres of excellence, or supplier groups as determined by the Scheme in order to ensure cost effective and appropriate care. Beneficiaries are entitled to benefits from contracted networks appointed as the Scheme's DSP for PMB benefits and other benefits (as set out in Annexure D).

The Scheme reserves the right not to fund or partially fund services acquired outside of these networks provided reasonable steps are taken by the Scheme to ensure access to the network, subject to PMBs. The Fund reserves the right not to pay for procedures performed by non-recognised providers (where applicable). Certain procedures may be associated with a significant learning curve and/or are not taught routinely at local universities and/or require special training and experience, including that aimed at maintenance of expertise, and/or need access to certain infrastructure for quality outcomes. Where such procedures have been identified by the Scheme's managed care provider, recognised providers are those who have been acknowledged by same as meeting minimum training and practice criteria for the safe and effective performance of such procedures. Recognition occurs as

a result of a formal application process by interested providers and adjudication of relevant information against competency guidelines by the managed care provider and/or appointed credentialing body. Criteria for formal recognition are informed by clinical evidence, clinical guidelines and/or expert opinion.

3. BENEFITS EXCLUDED INSOFAR AS THESE ARE NOT PRESCRIBED UNDER THE PMBs

3.1 General exclusions

The Fund will pay in full, without co-payment or use of deductibles, the diagnosis, treatment and care costs of the PMBs as per Regulation 8 of the Act. The Fund will employ appropriate interventions aimed at improving the efficiency and effectiveness of healthcare provision, including such techniques as requirements for pre-authorisation, the application of treatment protocols, and the use of formularies (Regulation 8(3).

Where a managed health care protocol or a formulary drug preferred by the Scheme, but excluding the PMB algorithm as defined in the Regulation, has been ineffective or would cause harm to a beneficiary the Scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by Regulation 15H and 15I of the Act.

Unless otherwise decided by the Fund (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 Fund:

3.1.1 All costs that exceed the annual or biennial maximum allowed for the particular category as set out in Annexure B, for the benefits to which the member is entitled in terms of the rules;

3.1.2 All costs for operations, medicines, treatments and procedures for cosmetic and aesthetic purposes or for personal reasons and not directly caused by or related to illness, accident or disease;

3.1.3 All costs for healthcare services if, in the opinion of the medical or dental adviser, such healthcare services are not appropriate and necessary based on current practice, evidence based medicine, cost effectiveness and affordability;

3.1.4 All costs for medicines for the treatment of chronic conditions not on the list of diseases covered, with the exception of medicines for the treatment of an excluded chronic condition which the Chronic Medicine Programme has specifically determined should be treated to achieve overall cost effective treatment of the beneficiary;

3.1.5 Futility of care: for members in a persistent vegetative state, where there has been no significant improvement and where the underlying cause is irreversible. Subject to an opinion from an independent panel of ethics experts.

3.2 Exclusions and indemnity in regard to third party claims

3.2.1 It is recorded that the relationship between the Fund and its members shall at all times be deemed to be one of the utmost good faith. The member therefore acknowledges and agrees that, notwithstanding anything to the contrary or not specifically set out in the rules or Annexures of the Fund, the member is under a duty of care to disclose all and any information or matters to the Fund.

3.2.2 The Fund shall be liable for the payment of any costs, subject to the Fund's rules, incurred by a member, which arose or may have arisen, as a result of the actions or omissions of another party. In the event of claims reimbursed on behalf of the member which arose from the actions or omissions of any other party, the member shall:

3.2.2.1 Be liable to repay to the Fund all amounts paid by the Fund and recovered by or on behalf of the member from the party responsible to compensate such member, free of any legal costs or deductions that may have been incurred in the recovery of such amount;

3.2.2.2 Ensure that, prior to the settlement of any claim instituted against such other party, all the amounts set out above and paid by the Fund, are included in such claim and form part of any settlement amount, whether globular or separately;

3.2.2.3 Disclose to the Fund, alternatively, instruct his legal representative to disclose to the Fund, the full extent of any compensation awarded in respect of past and future medical expenses;

3.2.2.4 Sign all documentation as may be required by the Fund to obtain copies of all such information not in the Fund's possession, relating to the member's medical accounts and records from the relevant practitioners and/or medical institutions;

3.2.2.5 Sign all such documentation as may be required by the Fund, to proceed with a claim in the member's name to recover any amounts expended by the Fund, subject to the Fund indemnifying the member against any costs which may arise as a result of the institution of such claim, if the Fund is satisfied that a valid claim exists and the member elects not to proceed with it;

3.2.2.6 Be deemed to be liable to repay all amounts expended by the Fund, as above, in the event of the member's claim being finalized and paid in circumstances where no specific or separate award is made for the payment of medical or hospital expenses incurred;

3.2.2.7 Either personally or through his/her legal representative keep the Fund informed, whether called upon by the Fund to do so or not, as to the ongoing progress of his/her claim;

3.2.2.8 When requested by the Fund, whether prior to or subsequent to the Fund effecting any payments as referred to above, provide the Fund with a written undertaking signed by both the member and his/her legal representative so as to give full effect to what is contained in paragraphs 3.2.1 and 3.2.2.1 to 3.2.2.7 above;

3.3 Exclusions in regard to non-registered service providers

The Fund shall not pay the costs for services rendered by:

3.3.1 Persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or

3.3.2 Any institution, nursing home or similar institution, except a state or provincial hospital, not registered in terms of any law.

3.4 Specific exclusions

All costs for services rendered in respect of the following:

3.4.1 Alternative Health Practitioners

All services not listed in paragraph D1 of Annexure B:

3.4.1.1 Acupuncture on BonCap
3.4.1.2 Aromatherapy
3.4.1.3 Ayurvedics
3.4.1.4 Herbalists
3.4.1.5 Homoeopathy on BonCap
3.4.1.6 Iridology
3.4.1.7 Naturopathy on BonCap
3.4.1.8 Osteopathy on BonCap
3.4.1.9 Phytotherapy on BonCap
3.4.1.10 Reflexology
3.4.1.11 Therapeutic Massage Therapy (Masseurs)

3.4.2 Ambulance services

3.4.2.1 Services not authorised or included in the preferred provider contract (subject to Regulation 8(3).

3.4.3 Appliances, external accessories and orthotics

3.4.3.1 Appliances, devices and procedures not scientifically proven or appropriate;
3.4.3.2 Back rests and chair seats;
3.4.3.3 Bandages and dressings (except medicated dressings);
3.4.3.4 Beds and mattresses, pillows and overlays;
3.4.3.5 Long term implantable ventricular assist devices and total artificial hearts" – e.g. Heart Ware and Berlin heart.

3.4.3.6 Diagnostic kits, agents and appliances unless otherwise stated except for diabetic accessories;
3.4.3.7 Electric tooth brushes;
3.4.3.8 Humidifiers;
3.4.3.9 Ionisers and air purifiers;
3.4.3.10 Orthopaedic shoes and, inserts/levelers and boots unless specifically authorised and/or PMB;
3.4.3.11 Pain relieving machines, e.g. TENS and APS;
3.4.3.12 Stethoscopes and sphygmomanometers (blood pressure monitors);
3.4.3.13 Portable cylinders are excluded on all options. Portable oxygen concentrators will be excluded on all options except for BonComprehensive, and BonClassic, subject to preauthorisation and available appliance benefit;
3.4.3.14 Electric wheelchairs and scooters.

3.4.4 Blood, blood equivalents and blood products
3.4.4.1 Hemopure (bovine blood).

3.4.5 Dentistry
3.4.5.1 Appointments not kept;
3.4.5.2 Orthodontic treatment for individuals 18 years and older;
3.4.5.3 Dental procedures or devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable;
3.4.5.4 Orthognathic (jaw correction) surgery, other orthodontic related surgery and the associated laboratory cost;
3.4.5.5 Instruction for oral hygiene;
3.4.5.6 Nutrition and tobacco counseling;
3.4.5.7 Caries susceptibility and microbiological tests;
3.4.5.8 Oral hygiene evaluation;
3.4.5.9 Crown and bridge procedures where there is no extensive tooth structure loss and associated laboratory costs;
3.4.5.10 Electrognathographic recordings, pantographic recordings and other such electronic analyses;
3.4.5.11 Fissure sealants on patients 16 years and older;
3.4.5.12 Pulp tests and pulp capping (direct and indirect);
3.4.5.13 Polishing of restorations;
3.4.5.14 Ozone therapy;
3.4.5.15 Metal base to full dentures, including the laboratory cost;
3.4.5.16 The clinical fee of dental repairs, denture tooth replacements and the addition of a soft base to new dentures.(The laboraroty fee will be covered at the scheme dental tariff where managed care protocols apply.);
3.4.5.17 Diagnostic dentures and associated laboratory costs;
3.4.5.18 Provisional crowns, including laboratory cost;
3.4.5.19 Resin bonding for restorations charged as a separate procedure to the restoration;
3.4.5.20 Dental bleaching;
3.4.5.21 Porcelain veneers and inlays/onlays and associated laboratory costs;
3.4.5.22 Pontics on second molars;
3.4.5.23 Laboratory fabricated crowns on primary teeth;
3.4.5.24 Fixed prosthodontics used to repair occlusal wear;
3.4.5.25 Gold foil restorations;
3.4.5.26 Surgical periodontics, which includes gingivectomies, periodontal flap surgery, tissue grafting and hemisection of a tooth;
3.4.5.27 Perio chip;
3.4.5.28 Emergency crowns that are not placed for immediate protection in tooth injury and the associated laboratory costs;
3.4.5.29 Orthodontic re-treatment and the associated laborartory costs;
3.4.5.30 Lingual orthodontics;
3.4.5.31 Implants on wisdom teeth (3rd molars);
3.4.5.32 Orthodontic treatment for cosmetic reasons and associated laboratory costs;
3.4.5.33 Sinus lifts;
3.4.5.34 Bone augmentations;
3.4.5.35 Bone and other tissue regeneration procedures;
3.4.5.36 Dolder bars and associated abutments on implants including the laboratory cost;
3.4.5.37 Laboratory cost where the associated dental treatment is not covered;
3.4.5.38 Laboratory cost associated with mouth guards;
3.4.5.39 Snoring appliances;
3.4.5.40 High impact acrylic;
3.4.5.41 Cost of mineral trioxide;
3.4.5.42 Cost of gold, precious metal, semi-precious metal and platinum foil;
3.4.5.43 Cost of invisible retainer material;
3.4.5.44 Cost of bone regeneration material;
3.4.5.45 Cost of prescribed toothpastes, mouth washes (e.g Corsodyl) and ointments;
3.4.5.46 Topical application of fluoride in patients 16 years and older;
3.4.5.47 Cost of dental materials in hospital;
3.4.5.48 Fillings to restore teeth damaged due to toothbrush abrasion, attrition, erosion and fluorosis;
3.4.5.49 Crowns or crown retainers on wisdom teeth (3rd molars);
3.4.5.50 Crown and bridge procedures of cosmetic reasons and associated laboratory costs;
3.4.5.51 Occlussal rehabilitations and associated laboratory costs;
3.4.5.52 Provisional dentures and associated laboratory costs;
3.4.5.53 Root canal therapy on wisdom teeth and primary (milk) teeth;
3.4.5.54 Enamel microabrasion;
3.4.5.55 Behaviour management;
3.4.5.56 Intramuscular or subcutaneous injection;
3.4.5.57 Special reports and dental testimony including dento-legal fees;
3.4.5.58 The auto-transplantation of teeth;
3.4.5.59 The closure of an oral-antral opening (item code 8909) when claimed during the same visit with impacted teeth (item code 8941, 8943 and 8945);
3.4.5.60 Hospitalisation (general anaesthetic): where the reason for admission to hospital is dental fear or anxiety; multiple hospital admissions; where the only reason for admission to hospital is to acquire a sterile facility;
3.4.5.61 Hospital and anaethetist claims will not be covered for the following procedures when performed under general anaesthesia: apicectomies, dentectomies, frenectomies, conservative dental treatment (fillings, extractions and root canal therapy) in hospital for adults, professional oral hygiene procedures, implantology and associated surgical procedures and surgical tooth exposure for orthodontic reasons;
3.4.5.62 Treatment plan completed (currently code 8120);
3.4.5.63 Procedures that are defined as unusual circumstances and procedures that are defined as unlisted procedures;
3.4.5.64 Laboratory delivery fees.

3.4.6 Hospitalisation
3.4.6.1 If application for a pre-authorisation reference number (PAR) for a clinical procedure, treatment or specialised radiology is not made or is refused, no benefits are payable (refer to paragraphs 4.1, 4.5.6 and 4.5.7 of Annexure D);
3.4.6.2 Accommodation and services provided in a geriatric hospital, old age home, frail care facility or similar institution (unless specifically provided for in Annexure B).

3.4.7 Infertility

3.4.7.1 Medical and surgical treatment , which is not included in the Prescribed Minimum Benefits in the Regulations to Act 131 of 1998, Annexure A, Paragraph 9, Code 902M, including:

- Assisted Reproductive Technology (ART),
- In-vitro fertilisation (IVF);
- Gamete Intrafallopian tube transfer (GIFT);
- Zygote Intrafallopian tube transfer (ZIFT); and
- Intracytoplasmic sperm injection (ICS).

3.4.7.2 Vasovasostomy (reversal of vasectomy).

3.4.8 Maternity

3.4.8.1 3D and 4D scans;

3.4.8.2 2D scans in excess of 2, unless motivated for an appropriate medical condition;

3.4.8.3 Antenatal classes/exercises except on BonComprehensive, BonClassic, BonSave, Standard, Standard Select and BonComplete.

3.4.9 Medicine and injection material

3.4.9.1 Anabolic steroids and immunostimulants unless Prescribed Minimum Benefits;

3.4.9.2 Contraceptives, oral, parenteral, foams, IUCDS and when used for skin conditions;

3.4.9.3 Cosmetic preparations, emollients, moisturisers, medicated or otherwise, soaps, scrubs and other cleansers, sunscreen and sun tanning preparations, medicated shampoos and conditioners, except for the treatment of lice, scabies and other microbial infections and coal tar products for the treatment of psoriasis;

3.4.9.4 Erectile dysfunction and loss of libido medical treatment;

3.4.9.5 Patented and nutritional supplements including baby food and special milk preparations unless formalabsorptive disorders and if registered by the relevant managed health care programme or MTCT prophylaxis and registered on the appropriate disease management programme or when used during and authorised hospital admission, subject to the relevant health care program;

3.4.9.6 Injection and infusion material, except for outpatient parenteral treatment (OPAT), diabetes and other prescribed minimum benefits;

3.4.9.7 The following medicines, unless they form part of the public sector protocols and specifically provided for in annexure B and are authorised by the relevant managed healthcare programme:

3.4.9.7.1 Maintenance Rituximab (or other monoclonal antibodies) in the first line setting for haematological malignancies;

3.4.9.7.2 Liposomal amphotericin B for fungal infections;

3.4.9.7.3 Any specialised drugs that have not convincingly demonstrated a median overall survival advantage of more than 3 months in locally advanced or metastatic solid organ malignant tumours. (for example sorafenib for hepatocellular carcinoma, bevacizumab for colorectal and metastatic breast cancer). This does not include drugs that are deemed cost-effective for the specific setting, compared to standard therapy (excluding specialised drugs) as defined in established and generally accepted treatment protocols (for example, erlotinib in the second line treatment setting for non small cell lung cancer);

3.4.9.7.4 Trastuzumab for the treatment of HER2-positive early breast cancer and metastatic cancer on BonComplete, BonClassic, Standard, Standard Select, BonSave, BonFit, Primary, BonEssential, BonCap and Hospital Standard Options;

3.4.9.7.5 Carmustine wafers for the treatment of malignant gliomas;

3.4.9.7.6 Any new chemotherapeutic drug that has not convincingly demonstrated a survival advantage of more than 3 months in advanced or metastatic malignancies, unless pre-authorised by the managed care organisation as a cost effective alternative to standard chemotherapy.

3.4.9.8 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);

3.4.9.9 Medicines for intestinal flora;

3.4.9.10 Medicines defined as exclusions by the relevant managed healthcare programme;

3.4.9.11 Medicines not approved by the Medicine Control Council unless Section 21 approval is obtained and pre-authorised by the relevant managed healthcare programme;

3.4.9.12 Medicines not authorised by the relevant managed healthcare programme based on evidence based medicine, taking into consideration cost-effectiveness and affordability;

3.4.9.13 Patent medicines, household remedies and proprietary preparations and preparations not otherwise classified;

3.4.9.14 Slimming preparations for obesity;

3.4.9.15 Smoking cessation and anti-smoking preparations, unless authorised as part of the wellness extender benefit. Excluded on BonCap;

3.4.9.16 Tonics, evening primrose oil, fish liver oils, multi-vitamin preparations and/or trace elements and/or mineral combinations (except for registered products that include haemotonics and those for use by infants and pregnant mothers);

3.4.9.17 Biological drugs except on BonComprehensive, BonClassic and Hospital Plus and Beta-Interferon for the treatment of Multiple Sclerosis as per the PMB algorithm unless specifically provided for in Annexure B;

3.4.9.18 All benefits for clinical trials and all treatment/admission costs relating to complications of trial drugs, unless pre-authorised by the relevant managed healthcare programme;

3.4.9.19 Diagnostic agents, unless authorised;

3.4.9.20 Growth hormones, unless pre-authorised;

3.4.9.21 Immunoglobulins and immune stimulants, oral and parenteral, unless pre-authorised;

3.4.9.22 Medicines used specifically to treat alcohol and drug addiction, unless PMB.

3.4.10 Mental health

3.4.10.1 Sleep therapy;

3.4.10.2 Educational psychology visits for adult beneficiaries.

3.4.11 Non-surgical procedures and tests

3.4.11.1 Epilation – treatment for hair removal;

3.4.11.2 Hyperbaric oxygen therapy except for PMBs;

3.4.11.3 Facet joint injections and percutaneous radiofrequency ablations (percutaneous rhizotomies) on BonCap only.

3.4.12 Optometry

3.4.12.1 Coloured and other cosmetic effect contact lenses, and contact lens accessories and solutions;

3.4.12.2 Optical devices which are not regarded by the relevant managed healthcare programme, as clinically essential or clinically desirable except on BonSave, BonFit, BonClassic and BonComprehensive;

3.4.12.3 Sunglasses and prescription sunglasses.

3.4.13 Organs and Haemopoietic Stem Cell (Bone Marrow) Transplantation and Immunosuppressive Medication

3.4.13.1 Organs and haemopoietic stem cell (bone marrow) donations to any person other than to a member or dependant of a member on this Fund.

3.4.14 Paramedical Services

3.4.14.1 Pharmacy services

3.4.15 Pathology and Medical Technology

3.4.15.1 Gene sequencing

3.4.16 Physical therapy

3.4.16.1 X-rays performed by chiropractors;

3.4.16.2 Chiropractor benefits in hospital;

3.4.16.3 Physiotherapy for mental health admissions.

3.4.17 Prostheses internal and external

3.4.17.1 Cochlear implants, unless specifically provided for in Annexure B;

3.4.17.2 Osseo-integrated implants for dental purposes to replace missing teeth, unless specifically provided for in Annexure B;

3.4.17.3 Total ankle replacement on BonEssential, BonSave, BonFit, Primary, BonCap and Hospital Standard;

3.4.17.4 Implantable defibrillators on BonEssential, BonSave, BonFit, Primary, BonCap and Hospital Standard.

3.4.18 Radiology and radiography

3.4.18.1 MRI scans ordered by a general practitioner, unless there is no reasonable access to a specialist;

3.4.18.2 Positron Emission Tomography, except for appropriate diagnosis, staging, the monitoring of response to treatment and investigation of residual tumour or suspected recurrence (restaging) e.g. Metatastic breast cancer on all options except on BonComprehensive and Hospital Plus, and PET plus PET-CT for screening;

3.4.18.3 Bone densitometry performed by a general practitioner or specialist not included in the Fund credentialed list;

3.4.18.4 CT colonography (virtual colonoscopy) for screening;

3.4.18.5 MDCT Coronary Angiography for screening;

3.4.18.6 If application for a pre-authorisation reference number (PAR) for specialised radiology procedures is not made or is refused, no benefits are payable (refer to paragraphs 4.1, 4.5.6 and 4.5.7 of Annexure D);

3.4.18.7 All screening that has not been pre-authorised or is not in accordance with the Fund's policies and protocols.

3.4.19 Surgical procedures

3.4.19.1 Abdominoplasties and the repair of divarication of the abdominal muscles;

3.4.19.2 Balloon sinuplasty on BonCap, BonEssential, BonFit, BonSave, Primary and Hospital Standard;

3.4.19.3 Bilateral gynaecomastia;

3.4.19.4 Blepharoplasties unless causing demonstrated functional visual impairment and pre-authorised;

3.4.19.5 Breast augmentation;

3.4.19.6 Breast reconstruction - unless mastectomy following cancer and pre-authorised;

3.4.19.7 Breast reductions,

3.4.19.8 All costs for cosmetic surgery performed over and above the codes authorised for admission;

3.4.19.9 Deep brain stimulation for Parkinson's and intractable epilepsy on BonCap, BonClassic, BonComplete, BonEssential, BonFit, BonSave, Primary and Hospital Standard;

3.4.19.10 Erectile dysfunction surgical procedures;

3.4.19.11 Gender reassignment medical or surgical treatment;

3.4.19.12 Genioplasties as an isolated procedure;

3.4.19.13 Custom made hip arthroplasty for inflammatory and degenerative joint disease;

3.4.19.14 Keloid surgery except for functional impairment;

3.4.19.15 Laparoscopic unilateral primary inguinal hernia repair on BonCap, BonEssential, BonSave, BonFit, Primary and Hospital Standard;

3.4.19.16 Obesity- surgical treatment or bariatric surgery;

3.4.19.17 Otoplasties;

3.4.19.18 Pectus excavatum/carinatum;

3.4.19.19 Percutaneous valve replacement, including transcatheter aortic valve implantation and repairs on BonCap, BonEssential, BonSave, BonFit, Primary and Hospital Standard;

3.4.19.20 Refractive surgery, unless specifically provided for in Annexure B;

3.4.19.21 Revision of scars except for functional impairment;

3.4.19.22 Rhinoplasties for cosmetic purposes;

3.4.19.23 Robotic surgery, other than for radical prostatectomy where authorized by the managed care organisation; additional costs relating to the use of the robot during such pre-authorised surgery, and including additional fees pertaining to theatre time, disposables and equipment fees remain excluded. Excluded on BonCap;

3.4.19.24 Uvulo palatal pharyngoplasty (UPPP and LAUP).

3.5 Items not mentioned in Annexure B

3.5.1 Appointments which a beneficiary fails to keep;

3.5.2 Autopsies;

3.5.3 Cryo-storage of foetal stem cells and sperm;

3.5.4 Holidays for recuperative purposes;

3.5.5 Nuclear or radio-active material or waste;

3.5.6 Travelling expenses;

3.5.7 Veterinary products;

3.5.8 Delivery charges or fees.

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