TRADITIONAL

STANDARD
STANDARD SELECT

2024

Bonitas

Medical Aid for South Africa

WHAT YOU PAY

STANDARD

MAIN MEMBER	R4 922
ADULT DEPENDANT	R4 267
CHILD DEPENDANT	R1 444

STANDARD PROVIDES ACCESS TO **ANY PRIVATE HOSPITAL** AND USES A LINKED FORMULARY OF CHRONIC MEDICATION.

STANDARD SELECT

MAIN MEMBER	R4 448
ADULT DEPENDANT	R3 849
CHILD DEPENDANT	R1 302

STANDARD SELECT USES A LIST OF **SPECIFIC PRIVATE HOSPITALS** AND LINKED FORMULARY OF CHRONIC MEDICATION.

YOU ONLY PAY FOR A MAXIMUM OF THREE CHILDREN. DEPENDANTS UP TO AGE 24 YEARS PAY CHILD RATES. NEW

All benefits and limits are per calendar year, unless otherwise stated. Managed Care protocols apply. Benefits are subject to approval by the Council for Medical Schemes. **PMB =** Prescribed Minimum Benefits

OUT-OF-HOSPITAL BENEFITS

Remember to unlock the Benefit Booster which can be used to pay for out-of-hospital expenses first (See page 8 for more information). Simply follow the steps below.
- To activate Level 1, complete an online wellness questionnaire (on the Bonitas app or website)
- To activate Level 2 and get the rest of the amount, complete a wellness screening (at a participating pharmacy, biokineticist or Bonitas wellness day)
- To activate the total amount from the get-go, simply complete a wellness screening from the start

OVERALL DAY-TO-DAY LIMIT

The day-to-day benefits provide cover for consultations with your GP and specialist, acute medicine, X-rays, blood tests and other out-of-hospital medical expenses up to the overall day-to-day limit, subject to the relevant sublimit per category. There is a separate benefit for tests and consultations for PMB treatment plans so this will not affect your day-to-day benefits.

	STANDARD DAY-TO-DAY BENEFITS	STANDARD SELECT DAY-TO-DAY BENEFITS
MAIN MEMBER ONLY	R12 780	R12 780
MAIN MEMBER + 1 DEPENDANT	R19 170	R19 170
MAIN MEMBER + 2 DEPENDANTS	R21 300	R21 300
MAIN MEMBER + 3 OR MORE DEPENDANTS	R23 430	R23 430

DAY-TO-DAY SUBLIMITS

The sublimits below are the maximum available for each category, subject to the overall day-to-day limit.

	STANDARD & STANDARD SELECT			
	GP & SPECIALIST CONSULTATIONS	ACUTE AND OVER-THE-COUNTER MEDICINE	X-RAYS & BLOOD TESTS	AUXILIARY SERVICES
	For specialist consultations you must get a referral from your GP. (Including virtual care consultations) On **Standard Select:** • You must nominate 2 GPs on our network for each beneficiary for the year • 2 non-nominated network GP visits allowed per family per year • Consultations with non-network GPs are limited to PMBs only	• Avoid a 20% co-payment by using a Bonitas Pharmacy Network • Avoid a 20% co-payment by using medicine that is on the formulary • Over-the-counter medicine is limited to R850 per beneficiary and R2 660 per family	This category applies to blood and other laboratory tests as well as X-rays and ultrasounds.	This category applies to physiotherapy, podiatry and biokinetics, allied medical professionals (such as dieticians, speech and occupational therapists) and alternative healthcare (20% co-payment applies to homoeopathic medicine).
MAIN MEMBER ONLY	R3 200	R3 200	R3 200	R3 200
MAIN MEMBER + 1 DEPENDANT	R4 790	R4 790	R4 790	R4 790
MAIN MEMBER + 2 DEPENDANTS	R5 330	R5 330	R5 330	R5 330
MAIN MEMBER + 3 OR MORE DEPENDANTS	R6 390	R6 390	R6 390	R6 390

GENERAL MEDICAL APPLIANCES (SUCH AS WHEELCHAIRS AND CRUTCHES)	Subject to the available overall day-to-day limit	Subject to frequency limits as per Managed Care protocols
	R8 130 per family for Stoma Care and CPAP machines (Note: CPAP machines subject to Managed Care protocols)	
NON-SURGICAL PROCEDURES	Subject to the available overall day-to-day limit	Subject to the available overall day-to-day limit

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These benefits are in addition to your overall day-to-day limit.

	STANDARD	STANDARD SELECT
ADDITIONAL GP CONSULTATIONS (NEW) (WHEN THE GP & SPECIALIST CONSULTATIONS DAY-TO-DAY SUBLIMIT IS REACHED)	2 network GP consultations per family	2 network GP consultations per family
ADDITIONAL SPECIALIST CONSULTATIONS (NEW)	2 network specialist consultations per family You must get a referral from your GP	2 network specialist consultations per family You must get a referral from your network GP
EMERGENCY ROOM BENEFIT (NEW) (FOR EMERGENCIES ONLY)	2 emergency consultations per family at a casualty ward or emergency room facility of a hospital 2 emergency consultations at a casualty ward or emergency room facility of a hospital for children under the age of 6 If it is not classified as an emergency, it will be paid from the available GP & specialist day-to-day benefit	2 emergency consultations per family at a casualty ward or emergency room facility of a hospital 2 emergency consultations at a casualty ward or emergency room facility of a hospital for children under the age of 6 If it is not classified as an emergency, it will be paid from the available GP & specialist day-to-day benefit
AUDIOLOGY (HEARING AIDS, CONSULTATIONS AND TESTS) *(ALSO SEE CARE PROGRAMMES PAGE 12)*	R8 650 per device (maximum two devices per family), once every 3 years (based on the date of your previous claim) Avoid a 25% co-payment by using a Designated Service Provider All tests and consultations limited to the Audiology Benefit Management Programme and use of a network provider Claims outside the Audiology Benefit Management Programme paid from the auxiliary services day-to-day benefit	R8 650 per device (maximum two devices per family), once every 3 years (based on the date of your previous claim) Avoid a 25% co-payment by using a Designated Service Provider All tests and consultations limited to the Audiology Benefit Management Programme and use of a network provider Claims outside the Audiology Benefit Management Programme paid from the auxiliary services day-to-day benefit
MRIs AND CT SCANS (SPECIALISED RADIOLOGY)	R32 340 per family, in and out-of-hospital Pre-authorisation required R1 770 co-payment per scan event except for PMB	R32 340 per family, in and out-of-hospital Pre-authorisation required R1 770 co-payment per scan event except for PMB
MENTAL HEALTH CONSULTATIONS *(ALSO SEE CARE PROGRAMMES PAGE 11)*	In and out-of-hospital consultations (included in the mental health hospitalisation benefit) Limited to R19 310 per family	In and out-of-hospital consultations (included in the mental health hospitalisation benefit) Limited to R19 310 per family
INSULIN PUMP OR CONTINUOUS GLUCOSE MONITOR *(ALSO SEE CARE PROGRAMMES PAGE 11)*	R85 000 per family every 5 years Consumables limited to R85 000 per family Limited to one device per type 1 diabetic for beneficiaries younger than 18	R85 000 per family every 5 years Consumables limited to R85 000 per family Limited to one device per type 1 diabetic for beneficiaries younger than 18
IN-ROOM PROCEDURES	Cover for a defined list of approved procedures performed in the specialist's rooms Pre-authorisation required	Cover for a defined list of approved procedures performed in the specialist's rooms Pre-authorisation required
OPTOMETRY	R7 385 per family, once every 2 years (based on the date of your previous claim) Each beneficiary can choose glasses **OR** contact lenses	R7 385 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 composite consultation per beneficiary, at a network provider **OR** R380 per beneficiary for an eye examination, at a non-network provider	1 composite consultation per beneficiary, at a network provider **OR** R380 per beneficiary for an eye examination, at a non-network provider

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	STANDARD		STANDARD SELECT	
SINGLE VISION LENSES (CLEAR) OR	100% towards the cost of lenses at network rates	R215 per lens, per beneficiary, out of network	100% towards the cost of lenses at network rates	R215 per lens, per beneficiary, out of network
BIFOCAL LENSES (CLEAR) OR	100% towards the cost of lenses at network rates	R460 per lens, per beneficiary, out of network	100% towards the cost of lenses at network rates	R460 per lens, per beneficiary, out of network
MULTIFOCAL LENSES	100% towards the cost of base lenses at a network provider, or limited to a maximum of R860 per designer lens, per beneficiary, in and out of network		100% towards the cost of base lenses at a network provider, or limited to a maximum of R860 per designer lens, per beneficiary, in and out of network	
FRAMES (AND/OR LENS ENHANCEMENTS)	R1 340 per beneficiary at a network provider **OR**	R1 005 per beneficiary at a non-network provider	R1 340 per beneficiary at a network provider **OR**	R1 005 per beneficiary at a non-network provider
CONTACT LENSES	R2 060 per beneficiary (included in the family limit)		R2 060 per beneficiary (included in the family limit)	
BASIC DENTISTRY	Covered at the Bonitas Dental Tariff	Subject to the Bonitas Dental Management Programme	Covered at the Bonitas Dental Tariff	Subject to the Bonitas Dental Management Programme and a Designated Service Provider
CONSULTATIONS	2 annual check-ups per beneficiary (once every 6 months)		2 annual check-ups per beneficiary (once every 6 months)	
X-RAYS: INTRA-ORAL	Managed Care protocols apply		Managed Care protocols apply	
X-RAYS: EXTRA-ORAL	1 per beneficiary, every 3 years		1 per beneficiary, every 3 years	
PREVENTATIVE CARE	2 annual scale and polish treatments per beneficiary (once every 6 months)	Fissure sealants are only covered for children under 16 years	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		Fluoride treatments are only covered for children from age 5 and younger than 16 years	
FILLINGS	Benefit for fillings is granted once per tooth, every 2 years	Benefit for re-treatment of a tooth is subject to Managed Care protocols	Benefit for fillings is granted once per tooth, every 2 years	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		A treatment plan and X-rays may be required for multiple fillings	
ROOT CANAL THERAPY AND EXTRACTIONS	Managed Care protocols apply		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	Pre-authorisation required	1 set of plastic dentures (an upper and a lower) per beneficiary, once every 4 years	Pre-authorisation required
SPECIALISED DENTISTRY	Covered at the Bonitas Dental Tariff		Covered at the Bonitas Dental Tariff	
PARTIAL CHROME COBALT FRAME DENTURES AND ASSOCIATED LABORATORY COSTS	1 partial frame (an upper or lower) per beneficiary, once every 5 years	Managed Care protocols apply	1 partial frame (an upper or lower) per beneficiary, once every 5 years	Managed Care protocols apply
	Pre-authorisation required		Pre-authorisation required	
CROWNS, BRIDGES AND ASSOCIATED LABORATORY COSTS	1 crown per family, per year	Benefit for crowns will be granted once per tooth, every 5 years	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	A treatment plan and X-rays may be requested	Pre-authorisation required

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	STANDARD		STANDARD SELECT	
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	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)	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	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	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	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		Pre-authorisation required	
MAXILLO-FACIAL SURGERY AND ORAL PATHOLOGY				
SURGERY IN THE DENTAL CHAIR	Managed Care protocols apply		Managed Care protocols apply	
HOSPITALISATION (GENERAL ANAESTHETIC)	A co-payment of R3 500 per admission applies for children under the age of 5 and R5 000 for any other admission, including removal of impacted teeth or any other medical condition OR A R2 500 upfront co-payment if the dental treatment is done in a day hospital	General anaesthetic is only available to children under the age of 5 for extensive dental treatment once per lifetime	A co-payment of R3 500 per admission applies for children under the age of 5 and R5 000 for any other admission, including removal of impacted teeth or any other medical condition OR A R2 500 upfront co-payment if the dental treatment is done in a day hospital	General anaesthetic is only available to children under the age of 5 for extensive dental treatment once per lifetime
	General anaesthetic benefit is available for the removal of impacted teeth	Managed Care protocols apply	Avoid a 30% co-payment by using a hospital on the applicable network	General anaesthetic benefit is available for the removal of impacted teeth
	Pre-authorisation required		Pre-authorisation required	Managed Care protocols apply
INHALATION SEDATION IN DENTAL ROOMS (LAUGHING GAS)	Managed Care protocols apply		Managed Care protocols apply	
MODERATE/DEEP SEDATION IN DENTAL ROOMS (IV CONSCIOUS SEDATION)	Limited to extensive dental treatment	Managed Care protocols apply	Limited to extensive dental treatment	Managed Care protocols apply
	Pre-authorisation required		Pre-authorisation required	

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CHRONIC BENEFITS

STANDARD

Standard offers cover for the **45** chronic conditions listed below, limited to **R11 910** per beneficiary and **R23 900** 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. You must get your medicine from a Bonitas Network Pharmacy or Pharmacy Direct, our Designated Service Provider. If you choose to use a non-network pharmacy, you will have to pay a 40% co-payment. Pre-authorisation is required.

Once the amount above is finished, you will still be covered for the **27** Prescribed Minimum Benefits, listed below – through a Bonitas Network Pharmacy or Pharmacy Direct, our Designated Service Provider. If you choose to use a non-network pharmacy or medicine that is not on the formulary, you will have to pay a 40% co-payment.

& STANDARD SELECT

Standard Select offers cover for the **45** chronic conditions listed below, limited to **R11 910** per beneficiary and **R23 900** per family on the applicable formulary. You must use Pharmacy Direct, our Designated Service Provider, to get your medicine. If you choose not to use Pharmacy Direct or 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.

Once the amount above is finished, you will still be covered for the **27** Prescribed Minimum Benefits, listed below – through Pharmacy Direct, our Designated Service Provider. If you choose not to use Pharmacy Direct or if you choose to 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
2.	Asthma
3.	Bipolar Mood Disorder
4.	Bronchiectasis
5.	Cardiac Failure
6.	Cardiomyopathy
7.	Chronic Obstructive Pulmonary Disease
8.	Chronic Renal Disease
9.	Coronary Artery Disease

10.	Crohn's Disease
11.	Diabetes Insipidus
12.	Diabetes Type 1
13.	Diabetes Type 2
14.	Dysrhythmias
15.	Epilepsy
16.	Glaucoma
17.	Haemophilia
18.	HIV/AIDS

19.	Hyperlipidaemia
20.	Hypertension
21.	Hypothyroidism
22.	Multiple Sclerosis
23.	Parkinson's Disease
24.	Rheumatoid Arthritis
25.	Schizophrenia
26.	Systemic Lupus Erythematosus
27.	Ulcerative Colitis

ADDITIONAL CONDITIONS COVERED

28.	Acne
29.	Allergic Rhinitis
30.	Ankylosing Spondylitis
31.	Attention Deficit Disorder (in children aged 5-18)
32.	Barrett's Oesophagus
33.	Behcet's Disease

34.	Dermatitis
35.	Depression
36.	Eczema
37.	Gastro-Oesophageal Reflux Disease (GORD)
38.	Generalised Anxiety Disorder
39.	Gout

40.	Narcolepsy
41.	Obsessive Compulsive Disorder
42.	Panic Disorder
43.	Post-Traumatic Stress Disorder
44.	Tourette's Syndrome
45.	Zollinger-Ellison Syndrome

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BENEFIT BOOSTER

GET UP TO R5 000 EXTRA BENEFITS TO PAY FOR ANY OUT-OF-HOSPITAL CLAIMS

WHAT IS THE BENEFIT BOOSTER?

It's an extra out-of-hospital benefit amount in addition to your day-to-day or savings amount, that you get after completing an online wellness questionnaire and/or wellness screening. Once activated, out-of-hospital claims like GP visits, over-the-counter medicine, X-rays and blood tests will then first pay from the available Benefit Booster amount – helping your day-to-day benefit/savings last longer.

Annual amount available per family

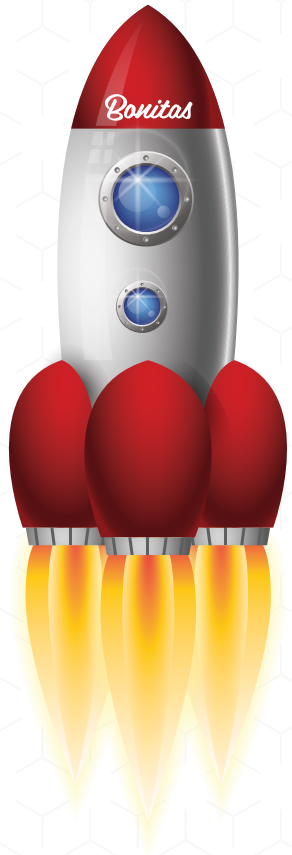
IF YOU ARE ON		YOUR BENEFIT BOOSTER AMOUNT
STANDARD & STANDARD SELECT	Level 1	R1 000
	Level 2	R4 000
	Total	R5 000

HOW TO ACTIVATE IT

- To activate **Level 1**, complete an online wellness questionnaire (on the Bonitas app or website)
- To activate **Level 2** and get the rest of the amount, complete a wellness screening (at a participating pharmacy, biokineticist or Bonitas wellness day)
- To activate the **total amount** from the get-go, simply complete a wellness screening from the start

Ts & Cs apply. Child dependants can access the Benefit Booster once an adult beneficiary has completed a wellness screening or online wellness questionnaire.

(All claims are paid at the Bonitas Rate)



MOTHER & CHILD CARE

NEW

MATERNITY CARE

- 12 antenatal consultations with a gynaecologist, GP or midwife
- R1 500 for antenatal classes
- 2 2D ultrasound scans
- 1 amniocentesis
- 4 consultations with a midwife after delivery (1 of these can be used for a consultation with a lactation specialist)

MATERNITY PROGRAMME

Register for the maternity programme and get:

- Access to 24/7 maternity advice line
- Dedicated maternity nurse/midwife to support and advise you throughout your pregnancy
- Access to articles regarding common pregnancy concerns
- Pregnancy education emails and SMSs sent to you weekly
- Online antenatal classes to prepare you for the birth and what to expect when you get home
- Baby bag including baby care essentials

CHILDCARE

- Hearing screening for newborns, in or out-of-hospital up to 8 weeks
- Congenital hypothyroidism screening for infants under 1 month old
- Babyline: 24/7 helpline for medical advice for children under 3 years
- 2 Paediatrician or GP consultations per child under 1 year
- 2 Paediatrician or GP consultation per child between ages 1 and 2
- 2 GP consultations per child between ages 2 and 12
- Immunisation according to the Private Vaccination schedule in South Africa up to the age of 12

NEW

BE BETTER BENEFIT

PREVENTATIVE CARE

- 1 HIV test and counselling per beneficiary
- 1 flu vaccine per beneficiary
- 1 full lipogram every 5 years, for members aged 20 and over
- 1 mammogram every 2 years, for women over 40
- 1 pap smear every 3 years, or 1 HPV PCR test every 5 years, for women between ages 21 and 65
- 1 prostate screening antigen test for men between ages 55 and 69
- 1 pneumococcal vaccine every 5 years, for members aged 65 and over
- 1 stool test for colon cancer, for members between ages 45 and 75
- Dental fissure sealants to prevent tooth decay on permanent teeth for children under 16
- 1 whooping cough booster vaccine every 10 years, for members between ages 7 and 64
- 2 doses of the human papillomavirus (HPV) vaccine for female beneficiaries between ages 9 and 14 (limited to 1 course per lifetime)
- 3 doses of the human papillomavirus (HPV) vaccine for female beneficiaries between ages 15 and 26 (limited to 1 course per lifetime)
- Free online hearing screening for beneficiaries aged 18 and over

WELLNESS BENEFIT

- 1 wellness screening per beneficiary at a participating pharmacy, biokineticist or a Bonitas wellness day

Wellness screening includes the following tests:

- Blood pressure
- Glucose
- Waist-to-hip ratio
- Cholesterol
- Body Mass Index

CONTRACEPTIVES

- R1 950 per family (for women aged up to 50)

STANDARD:

- You must use a Bonitas Network Pharmacy or Pharmacy Direct, our Designated Service Provider, for pharmacy-dispensed contraceptives
- If you choose not to use a network pharmacy or the Designated Service Provider, a 40% co-payment applies

STANDARD SELECT:

- You must use Pharmacy Direct, our Designated Service Provider for pharmacy-dispensed contraceptives
- If you choose not to use the Designated Service Provider, a 40% co-payment applies

CARE PROGRAMMES

MENTAL HEALTH PROGRAMME

- Available to members who suffer from depression, anxiety, post-traumatic stress disorder and alcohol abuse
- Access to a Care Manager who will work with you, your treating doctor and where appropriate, with other healthcare professionals to assist in improving your condition
- Your Care Manager will help you understand the importance of preventative care and the use of wellness benefits as well as resolve queries related to any other health condition
- Provides educational material on mental health which empowers you to manage your condition
- A digital platform designed to give members easy access to mental health information, community support and expert help

DIABETES MANAGEMENT

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

CANCER

- Puts you first, offering emotional and medical support
- Liaises with your doctor to ensure your treatment plan is clinically appropriate to meet your needs
- Access to a social worker for you and your loved ones
- Uses the Bonitas Oncology Medicine Network (20% co-payment applies for use of a non-network provider)
- Matches the treatment plan to your benefits to ensure you have the cover you need
- Uses the Bonitas Oncology Network of specialists

BACK AND NECK

- Assessment of back and neck pain to determine the level of care required before surgery to give you the best outcome
- Offers a personalised treatment plan for up to 6 weeks
- Includes treatment from doctors, physiotherapists and biokineticists
- Gives access to a home care plan to maintain long-term results and helps manage severe back and neck pain
- Highly effective and low-risk, with an excellent success rate
- We cover the cost of the programme, excluding X-rays
- Uses the DBC network

CARE PROGRAMMES

HIV/AIDS

- Provides you with appropriate treatment and tools to live your best life
- Offers HIV-related consultations to visit your doctor to monitor your clinical status
- Offers access to telephonic support from doctors
- Covers medicine to treat HIV (including drugs to prevent mother-to-child transmission and infection after sexual assault or needle-stick injury)
- Covers regular blood tests to monitor disease progression, response to therapy and to detect possible side-effects of treatment
- Offers 1 annual pap smear for members who had a positive cytology test
- Gives ongoing patient support via a team of trained and experienced counsellors
- Treatment and prevention of opportunistic infections such as pneumonia, TB and flu
- Helps in finding a registered counsellor for face-to-face emotional support

HIP AND KNEE REPLACEMENT

- Based on the latest international standardised clinical care pathways
- Doctors evaluate and treat your condition before surgery to give you the best outcome
- Uses a multidisciplinary team, dedicated to assist with successful recovery
- Treatment is covered in full at a Designated Service Provider for joint replacement surgery

HOSPITAL-AT-HOME

- Care for any acute condition deemed appropriate by your treating provider i.e., pneumonia, Covid-19
- An alternative to general ward admission and stepdown facilities, allowing you to receive quality, safe healthcare in the comfort of your home
- Remote patient monitoring including 24/7 vital signs monitoring from our clinical command centre, continuous virtual visits and clinical support, continuous care from a doctor, short-term oxygen (as prescribed) and emergency ambulance services
- Our hospital setup at home also includes remote patient monitoring, daily visits, laboratory services, blood tests, wound dressings, medication/fluids via a drip, allied healthcare services and physiotherapy (as prescribed)
- A team of trained healthcare professionals, including skilled nurses, that will bring all the essential elements of hospital care to your home
- A transitional care programme to minimise re-admissions
- Hospital-at-Home is subject to pre-authorisation

NEW

AUDIOLOGY BENEFIT MANAGEMENT

- Available to members who are experiencing hearing loss
- Offers members quality treatment and hearing devices
- Uses the latest in audiological technology and the highest standard of clinical expertise
- Tests and consultations are fully covered by using an audiologist on the hearConnect Audiology Network
- No co-payments for prescribed hearing aids should you use an in-network service provider
- Hearing aid benefit will renew every 3 years

IN-HOSPITAL BENEFITS

This benefit offers cover for major medical events that result in a beneficiary being admitted to hospital. Members have access to cover at a private hospital. Pre-authorisation is required. A co-payment may apply to specific admissions and/or procedures. Managed Care protocols apply.

Please note: On the Standard Select option you can avoid a 30% co-payment by using a hospital on the applicable network.

	STANDARD		STANDARD SELECT	
SPECIALIST CONSULTATIONS/TREATMENT	Unlimited, network specialists covered in full at the Bonitas Rate	Unlimited, non-network specialists paid at 100% of the Bonitas Rate	Unlimited, network specialists covered in full at the Bonitas Rate	Unlimited, non-network specialists paid at 100% of the Bonitas Rate
GP CONSULTATIONS/TREATMENT	Unlimited, covered at 100% of the Bonitas Rate		Unlimited, covered at 100% of the Bonitas Rate	
BLOOD TESTS AND OTHER LABORATORY TESTS	Unlimited, covered at 100% of the Bonitas Rate		Unlimited, covered at 100% of the Bonitas Rate	
X-RAYS AND ULTRASOUNDS	Unlimited, covered at 100% of the Bonitas Rate		Unlimited, covered at 100% of the Bonitas Rate	
MRIs AND CT SCANS (SPECIALISED RADIOLOGY)	R32 340 per family, in and out-of-hospital	Pre-authorisation required	R32 340 per family, in and out-of-hospital	Pre-authorisation required
	R1 770 co-payment per scan event except for PMB		R1 770 co-payment per scan event except for PMB	
ALLIED MEDICAL PROFESSIONALS (SUCH AS DIETICIAN, SPEECH AND OCCUPATIONAL THERAPIST)	Subject to the auxiliary services benefit sublimit, unless PMB	Subject to referral by the treating practitioner	Subject to the auxiliary services benefit sublimit, unless PMB	Subject to referral by the treating practitioner
PHYSIOTHERAPY, PODIATRY AND BIOKINETICS	Subject to the auxiliary services benefit sublimit, unless PMB	Subject to referral by the treating practitioner	Subject to the auxiliary services benefit sublimit, unless PMB	Subject to referral by the treating practitioner
INTERNAL AND EXTERNAL PROSTHESES	R54 780 per family	Managed Care protocols apply	R54 780 per family	Managed Care protocols apply
	Sublimit of R6 520 per breast prosthesis (limited to 2 per year)		Sublimit of R6 520 per breast prosthesis (limited to 2 per year)	
SPINAL SURGERY (*ALSO SEE CARE PROGRAMMES PAGE 11*)	Subject to an assessment and/or conservative treatment by the Designated Service Provider		Subject to an assessment and/or conservative treatment by the Designated Service Provider	
HIP AND KNEE REPLACEMENTS (*ALSO SEE CARE PROGRAMMES PAGE 12*)	Avoid a R35 250 co-payment by using the Designated Service Provider		Avoid a R35 250 co-payment by using the Designated Service Provider	
INTERNAL NERVE STIMULATORS	R205 100 per family		R205 100 per family	
COCHLEAR IMPLANTS	PMB only		PMB only	
CATARACT SURGERY	Avoid a R7 050 co-payment by using the Designated Service Provider		Avoid a R7 050 co-payment by using the Designated Service Provider	
MENTAL HEALTH HOSPITALISATION (*ALSO SEE CARE PROGRAMMES PAGE 11*)	R49 330 per family	No cover for physiotherapy for mental health admissions	R49 330 per family	No cover for physiotherapy for mental health admissions
			Avoid a 30% co-payment by using a hospital on the applicable network	

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	STANDARD		STANDARD SELECT	
TAKE-HOME MEDICINE	Limited to a 7-day supply up to R575 per hospital stay		Limited to a 7-day supply up to R575 per hospital stay	
PHYSICAL REHABILITATION	R61 480 per family		R61 480 per family	
ALTERNATIVES TO HOSPITAL (HOSPICE, STEP-DOWN FACILITIES)	R20 500 per family	Managed Care protocols apply	R20 500 per family	Managed Care protocols apply
PALLIATIVE CARE (CANCER ONLY)	Unlimited, subject to using the Designated Service Provider	Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support	Unlimited, subject to using the Designated Service Provider	Including hospice/private nursing, home oxygen, pain management, psychologist and social worker support
CANCER TREATMENT (*ALSO SEE CARE PROGRAMMES PAGE 11*)	Unlimited for PMBs	Avoid a 30% co-payment by using a Designated Service Provider	Unlimited for PMBs	Avoid a 30% co-payment by using a Designated Service Provider
	R266 300 per family for non-PMBs. Paid at 80% at a Designated Service Provider and no cover at a non-Designated Service Provider, once limit is reached.		R266 300 per family for non-PMBs. Paid at 80% at a Designated Service Provider and no cover at a non-Designated Service Provider, once limit is reached.	
	Sublimit of R57 680 per beneficiary for Brachytherapy	Sublimit of R150 000 can be used for specialised drugs (including biological drugs)	Sublimit of R57 680 per beneficiary for Brachytherapy	Sublimit of R150 000 can be used for specialised drugs (including biological drugs)
CANCER MEDICINE	Subject to Medicine Price List and preferred product list	Avoid a 20% co-payment by using a Designated Service Provider	Subject to Medicine Price List and preferred product list	Avoid a 20% co-payment by using a Designated Service Provider
ORGAN TRANSPLANTS	Unlimited	Sublimit of R39 040 per beneficiary for corneal grafts	Unlimited	Sublimit of R39 040 per beneficiary for corneal grafts
KIDNEY DIALYSIS	Unlimited	Avoid a 20% co-payment by using a Designated Service Provider	Unlimited	Avoid a 20% co-payment by using a Designated Service Provider
HIV/AIDS (*ALSO SEE CARE PROGRAMMES PAGE 12*)	Unlimited, if you register on the HIV/AIDS programme	Chronic medicine must be obtained from the Designated Service Provider	Unlimited, if you register on the HIV/AIDS programme	Chronic medicine must be obtained from the Designated Service Provider
DAY SURGERY PROCEDURES (APPLIES TO SELECTED PROCEDURES)	Avoid a R2 590 co-payment by using a network day hospital		Avoid a R5 170 co-payment by using a network day hospital	

ADDITIONAL BENEFITS

INTERNATIONAL TRAVEL BENEFIT	Up to R10 million cover per family for medical emergencies when you travel outside South Africa	Additional benefit for medical quarantine up to R10 000 per beneficiary if tested positive for Covid-19
	You must register for this benefit prior to departure	
AFRICA BENEFIT	In and out-of-hospital treatment covered at 100% of the Bonitas Rate	Subject to authorisation

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NOTES

MAKE THE MOST OF YOUR BONITAS MEMBERSHIP WITH THE NEW MEMBER INFORMATION PAGE ON OUR WEBSITE!

We know that medical aid can be confusing at times, but we've made it easy for you to quickly access essential medical aid information. And there is no need to log in, just info at the click of a button, like:

- How to get your claims paid quickly
- Effortlessly getting hospital authorisations
- Registering your chronic medicine
- Accessing our Maternity programme
- Getting more benefits with the Benefit Booster
- Going for a free wellness screening
- And much more

TO JOIN SPEAK TO YOUR **FINANCIAL ADVISOR**, OR VISIT **BONITAS.CO.ZA**

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