Bonitas

BONITAS MEDICAL FUND

Annexure C

2024

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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 Fund, but excluding the PMB algorithm as defined in the Regulation, has been ineffective or would cause harm to a beneficiary the Fund will cover the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by Regulation 15H and 15I of the Act.

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-designated service provider, 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 designated service provider 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 maximize efficient utilization 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 prescribed minimum benefits, no benefit limit shall apply provided treatment is given in or by a public hospital or designated service provider referred to in paragraph 7.4 in Annexure D. If for any reason the beneficiary voluntarily receives treatment in or by a non-designated service provider, 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-prescribed minimum benefit 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 designated service provider or to accept a limited drug formulary, or both, in order to conserve available benefits. In such designated service provider or public facility any costs incurred over and above the limit stipulated in Annexure B (excluding prescribed minimum benefit 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 Fund (or contracted managed care company on behalf of the Fund) may from time to time contract with or pilot with credentialed specific provider groups (networks) or centres of excellence as determined by the Fund in order to ensure cost effective and appropriate care. Beneficiaries are entitled to benefits from contracted networks appointed as the Fund's DSP for PMB benefits and other benefits (as set out in Annexure D). The Fund reserves the right to impose a co-payment for services voluntarily acquired outside of these networks provided reasonable steps are taken by the Fund to ensure access to the network, and that the member is aware of the need to use such a network for the provision of care. The application of these rules will be subject to Prescribed Minimum Benefits.

The Fund reserves the right not to pay for procedures performed by non-recognized 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 Fund's managed care provider, recognized 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 PRESCRIBED MINIMUM BENEFITS

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 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 Fund, but excluding the PMB algorithm as defined in the Regulation, has been ineffective or would cause harm to a beneficiary the Fund 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;

3.2 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, mattresses, linen savers, 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 ionizers 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 savings;

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 laboratory 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 tooth whitening;

3.4.5.21 porcelain veneers and inlays/onlays and associated laboratory costs;

3.4.5.22 laboratory fabricated crowns on primary teeth;

3.4.5.23 fixed prosthodontics used to repair occlusal wear;

3.4.5.24 gold foil restorations;

3.4.5.25 surgical periodontics, which includes gingivectomies, periodontal flap surgery, tissue grafting and hemisection of a tooth;

3.4.5.26 perio chip;

3.4.5.27 emergency crowns that are not placed for immediate protection in tooth injury and the associated laboratory costs;

3.4.5.28 orthodontic re-treatment and the associated laborartory costs;

3.4.5.29 lingual orthodontics;

3.4.5.30 implants on wisdom teeth (3rd molars);

3.4.5.31 orthodontic treatment for cosmetic reasons and associated laboratory costs;

3.4.5.32 sinus lifts;

3.4.5.33 bone augmentations;

3.4.5.34 bone and other tissue regeneration procedures;

3.4.5.35 laboratory cost where the associated dental treatment is not covered;

3.4.5.36 snoring appliances;

3.4.5.37 high impact acrylic;

3.4.5.38 cost of mineral trioxide;

3.4.5.39 cost of gold, precious metal, semi-precious metal and platinum foil;

3.4.5.40 cost of invisible retainer material;

3.4.5.41 cost of bone regeneration material;

3.4.5.42 cost of prescribed toothpastes, mouth washes (e.g Corsodyl) and ointments;

3.4.5.43 topical application of fluoride in patients 16 years and older;

3.4.5.44 cost of dental materials in hospital;

3.4.5.45 fillings to restore teeth damaged due to toothbrush abrasion, attrition, erosion and fluorosis;

3.4.5.46 crowns on wisdom teeth (3rd molars);

3.4.5.47 crown and bridge procedures of cosmetic reasons and associated laboratory costs;

3.4.5.48 occlussal rehabilitations and associated laboratory costs;

3.4.5.49 provisional dentures and associated laboratory costs;

3.4.5.50 root canal therapy on wisdom teeth and primary (milk) teeth;

3.4.5.51 enamel microabrasion;

3.4.5.52 behavior management;

3.4.5.53 intramuscular or subcutaneous injection;

3.4.5.54 special reports and dental testimony including dento-legal fees;

3.4.5.55 the auto-transplantation of teeth;

3.4.5.56 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;

3.4.5.57 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;

3.4.5.58 treatment plan completed (currently code 8120);

3.4.5.59 procedures that are defined as unusual circumstances and procedures that are defined as unlisted procedures;

3.4.5.60 laboratory delivery fees;

3.4.5.61 laboratory fabricated temporary crowns.

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 fertilization (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, unless specifically provided for in Annexure B or Annexure D;

3.4.9.3 cosmetic preparations, emollients, moisturizers, 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 liposomal amphotericin B for fungal infections;

3.4.9.7.2 Any specialised drugs, as defined by the Fund's contracted managed healthcare organisation, that have not convincingly demonstrated a median overall survival advantage of more than 3 months in locally advanced or metastatic malignancies unless deemed cost-effective for the specific setting, compared to standard therapy (excluding specialised drugs) as defined in established and generally accepted treatment protocols;

3.4.9.7.3 carmustine wafers for the treatment of malignant gliomas;

3.4.9.7.4 any new chemotherapeutic drugs that have not convincingly demonstrated a survival advantage of more than 3 months in advanced or metastatic malignancies, unless pre-authorised by the Fund's contracted managed care organisation as a cost effective alternative to standard chemotherapy, reimbursed in accordance with the managed care protocols applied.

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 South African Health Products Regulatory Authority (SAHPRA) 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 Benefit Booster 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), except on BonStart and BonStart Plus;

3.4.9.17 biological drugs except for those options where a specialised drug benefit limit applies and where a drug is deemed to be PMB level of care e.g. 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 and psychometry assessments for learning and education for beneficiaries over the age of 21 years.

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 specific conditions pre-authorised by the relevant managed healthcare programme;

3.4.11.3 facet joint injections and percutaneous radiofrequency ablations (percutaneous rhizotomies) on BonCap, BonStart and BonStart Plus 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.

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 Pathology and Medical Technology

3.4.14.1 gene sequencing.

3.4.15 Physical therapy

3.4.15.1 X-rays performed by chiropractors;

3.4.15.2 chiropractor benefits in hospital;

3.4.15.3 physiotherapy for mental health admissions.

3.4.16 Prostheses internal and external

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

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

3.4.16.3 total ankle replacement on BonEssential, BonEssential Select, BonSave, BonFit Select, Primary, Primary Select, BonCap, BonStart, BonStart Plus and Hospital Standard;

3.4.16.4 implantable defibrillators on BonEssential, BonEssential Select, BonSave, BonFit Select, Primary, Primary Select, BonCap, BonStart, BonStart Plus and Hospital Standard.

3.4.17 Radiology and radiography

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

3.4.17.2 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 PET plus PET-CT for screening;

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

3.4.17.4 CT colonography (virtual colonoscopy) for screening;

3.4.17.5 MDCT Coronary Angiography for screening;

3.4.17.6 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);

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

3.4.18 Surgical procedures

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

3.4.18.2 back and neck surgery, unless PMB on BonSave, BonFit Select, Primary, Primary Select, Hospital Standard, BonEssential, BonEssential Select, BonCap, BonStart and BonStart Plus; and
back and neck surgery, unless pre-authorised by the relevant managed healthcare programme following completion of conservative clinical pathways on BonComprehensive, BonClassic, BonComplete, Standard and Standard Select,

3.4.18.3 balloon sinuplasty on BonCap, BonEssential, BonEssential Select, BonFit Select, BonSave, Primary, Primary Select, BonStart, BonStart Plus and Hospital Standard;

3.4.18.4 bilateral gynaecomastia;

3.4.18.5 blepharoplasties unless causing demonstrated functional visual impairment and pre-authorised;

3.4.18.6 breast augmentation;

3.4.18.7 breast reconstruction - unless mastectomy following cancer and pre-authorised;

3.4.18.8 breast reductions,

3.4.18.9 all costs for cosmetic surgery performed over and above the codes authorised for admission;

3.4.18.10 deep brain stimulation for Parkinson's and intractable epilepsy on BonCap, BonClassic, BonComplete, BonEssential, BonEssential Select, BonFit Select, BonSave, Primary, Primary Select, BonStart, BonStart Plus and Hospital Standard;

3.4.18.11 erectile dysfunction surgical procedures;

3.4.18.12 gender reassignment medical or surgical treatment;

3.4.18.13 genioplasties as an isolated procedure;

3.4.18.14 custom made hip arthroplasty for inflammatory and degenerative joint disease;

3.4.18.15 keloid surgery except for functional impairment;

3.4.18.16 laparoscopic unilateral primary inguinal hernia repair on BonCap, BonEssential, BonEssential Select, BonSave, BonFit Select, Primary, Primary Select, BonStart, BonStart Plus and Hospital Standard;

3.4.18.17 obesity - surgical treatment or bariatric surgery;

3.4.18.18 otoplasties;

3.4.18.19 pectus excavatum / carinatum;

3.4.18.20 percutaneous valve replacement, including transcatheter aortic valve implantation and repairs on Boncap, BonEssential, BonEssential Select, BonSave, BonFit Select, Primary, Primary Select, BonStart, BonStart Plus and Hospital Standard;

3.4.18.21 refractive surgery, unless specifically provided for in Annexure B;

3.4.18.22 revision of scars except for functional impairment;

3.4.18.23 rhinoplasties for cosmetic purposes;

3.4.18.24 robotic surgery, other than for radical prostatectomy where authorised 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, BonStart and BonStart Plus;

3.4.18.25 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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