B.GAP FOR Bonitas MEMBERS

The first step to take before benefiting from partner offers of the B Value and Well-being Programme, such as BGap is to join the B Value programme.
Visit www.bvalue.co.za to register for the programme at no cost.

Shortfalls in medical aid cover can easily become a burden. As a Bonitas member, BGAP Gap Cover should be part of your financial planning for unforeseen circumstances. It provides a cost-effective solution to unexpected medical expenses and in-hospital co-payments in times when you need to focus on your health and not your pocket.

WHAT IS BGAP?

BGAP is not a medical scheme benefit option, it is a short-term insurance product that helps you provide for medical expense shortfalls incurred when the charges for the medical care specified in this brochure exceed the medical scheme rate or the level of cover provided.

To qualify for BGAP, you must be an active member of Bonitas Medical Fund. BGAP should never be considered a substitute for your medical aid.

THREE OPTIONS TO CHOOSE FROM:

B.GAP START

Only available to members on BonCore, BonStart, BonStart Plus, BonEssential Select, BonEssential and BonFit members

Starting at R140

B.GAP PRIMARY

Available to all Bonitas benefit options

Starting at R238

B.GAP SUPREME

Available to all Bonitas benefit options

Starting at R289

To join, **SMS BGAP to 43366** or visit **www.bvalue.co.za**, and one of our consultants will contact and assist you. SMSs are charged at R1.50, free SMSs do not apply.

B.GAP START

Even as a member of a medical scheme, co-payments and shortfalls in medical cover can catch you off guard. To support career starters and young families, **BGAP START** offers core gap cover and steps in to cover those unforeseen medical expenses at less than R200 per month for a family.

MONTHLY CONTRIBUTIONS

Monthly contributions are based on age and family composition

	SINGLE	FAMILY
0-30 years	R140	R182
31-55 years	R220	R286
56-64 years	R350	R455
65+	R440	R572

Family rates apply when there are one or more dependants covered on your medical scheme. All registered dependants on your medical aid will be covered.

A discounted group rate will apply to employer groups of 35 members and more.

BENEFITS

BGAP start is only available to members on the following benefit options: BonCore, BonStart, BonStart Plus, BonEssential Select, BonEssential, and BonFit.

Description	Benefit
Overall Annual Limit (OAL R219 800 per person per year)	
Shortfalls in medical practitioner costs in-hospital and certain out-of-hospital procedures	Covers the shortfall between what is charged, and the medical scheme pays up to 200% of the Scheme rate
Shortfalls in certain elective medical procedures performed out-of-hospital or in a day clinic	Up to 200% of the Scheme rate
In-hospital co-payments	Covers co-payments on services rendered by Designated Service Providers
Casualty benefit for accidents and emergencies	R1 200 per policy year
Assist benefit – not subject to the OAL	
Trauma counselling for victims of violent crimes or traumatic accidents/bereavement counselling for death of immediate family members	R2 000 per family per year

Individual underwriting: A 12-month condition-specific waiting period applies to any pre-existing conditions.
Group underwriting: Compulsory: No underwriting. Voluntary: Underwriting applies.

Ts & Cs apply – All of the benefits offered are subject to the terms and conditions of the policy. A comprehensive description of the terms and conditions, as well as the exclusions are available upon request or in the policy document.

B.GAP PRIMARY

Although you already have medical cover, additional medical costs when a healthcare provider charges more than what your medical aid pays, can cause financial pressure on your family. You can close that gap with **BGAP Primary.**

MONTHLY CONTRIBUTIONS

34 YEARS AND YOUNGER	SINGLE	
B GAP PRIMARY	R238	
64 YEARS AND YOUNGER	**SINGLE**	**FAMILY**
B GAP PRIMARY	R311	R354
65 YEARS AND OLDER	**SINGLE**	
B GAP PRIMARY	R778	

Family rates apply when there are one or more dependants covered on your medical scheme. All registered dependants on your medical aid will be covered. Members over the age of 65 cannot add dependants.

A discounted group rate will apply to employer groups of 35 members and more.

BENEFITS

Description	**Benefit**
Overall Annual Limit R219 800 per person per year	
Shortfalls in medical practitioner costs in-hospital and certain out-of-hospital procedures	Covers the shortfall between what is charged, and the medical scheme pays up to 3 times the Scheme rate
Shortfalls in certain elective medical procedures performed out-of-hospital or in a day clinic	Up to 3 times the Scheme rate
In-hospital co-payments and deductibles	Covers co-payments on services rendered by Designated Service Providers

Individual underwriting: A 12-month condition-specific waiting period applies to any pre-existing conditions.
Group underwriting: Compulsory: No underwriting. Voluntary: Underwriting applies.

B.GAP SUPREME

BGAP Supreme gives comprehensive cover against unexpected medical costs incurred when healthcare professionals charge more than what your medical aid covers.It also provides additional support for life-changing events such as a pregnancy or accidental death

MONTHLY CONTRIBUTIONS

34 YEARS AND YOUNGER	SINGLE	
B GAP SUPREME	R289	
64 YEARS AND YOUNGER	**SINGLE**	**FAMILY**
B GAP SUPREME	R388	R446
65 YEARS AND OLDER	**SINGLE**	
B GAP SUPREME	R823	

Family rates apply when there are one or more dependants covered on your medical scheme. All registered dependants on your medical aid will be covered. Members over the age of 65 cannot add dependants.

A discounted group rate will apply to employer groups of 35 members and more.

BENEFITS

Description	Benefit
Overall Annual Limit - R219 800 per person per year	
Shortfalls in medical practitioner costs in-hospital and certain out-of-hospital procedures	Covers the shortfall between what is charged, and the medical scheme pays up to 3 times the Scheme rate
Shortfalls in certain Elective Medical Procedures performed out-of-hospital or in a day clinic	Up to 3 times the Scheme rate
In-hospital co-payments and deductibles	Covers co-payments on services rendered by Designated Service Providers
Shortfalls on Allied Professionals Services rendered during hospitalisation	Shortfalls up to R2 500 per policy per year
Co-payment on Oncology Treatment	Covers the 20% co-payment after depletion of the Bonitas oncology treatment limit
Shortfalls on Internal Prosthesis Benefit: • Internal Prosthesis	Up to R35 000 per year
• Stents and pacemakers	R8 000 per event – Aggregates to the R35 000 limit
Casualty Benefit for accidents and emergencies	R24 000 per year (subject to 5 visits)
Emergency Only Benefit for children 8 years and younger	Sub-limit: R5 000 per year (subject to 3 visits)
Sub-limit Benefit	R16 000 per year when MRI, CT scans and scopes limits are applied
Robotic Procedures shortfalls	Co-payments covered at R12 000 per family per year. Shortfalls covered at 3 times the Scheme rate

Assist benefit – not subject to the OAL	
Accidental Death and Disability Benefit: Accidental death or accidental permanent or total disability	R55 000 – Once per insured per lifetime
Accidental death or disability due to a violent crime	Double the accidental benefit (R110 000)
Medical Scheme and Gap Policy Premium Waiver in case of accidental death or permanent or total disability	R36 000 to cover the cost of dependents' medical scheme and gap cover premiums
Cancer Assist Benefit: • First-time Stage II Localised and Malignant Cancer	R8 000 per insured, per lifetime
• Stage II REGIONAL and malignant cancer	R20 000 per insured, per lifetime
• Additional payout when R200 000 of the medical schemes' oncology treatment costs are reached	R15 000 per insured, per lifetime
Cosmetic breast reconstruction for the non-affected breast due to a mastectomy	R15 000 per family per year
Trauma counselling for victims of a violent crimes or traumatic accidents/ bereavement counselling for death of immediate family member	R30 000 per year Up to R800 per session at a registered councillor
Baby Bump Benefit	R2 500 per foetus in a confirmed pregnancy

Individual underwriting: A 12-month condition-specific waiting period applies to any pre-existing conditions.
Group underwriting: Compulsory: No underwriting. Voluntary: Underwriting applies.

T's & Cs apply – All of the benefits offered are subject to the terms and conditions of the policy. A comprehensive description of the terms and conditions, as well as the exclusions are available upon request or in the policy document.

TERMS AND CONDITIONS

All benefits are subject to the terms and conditions of the policy. A comprehensive description of the terms and conditions as well as the exclusions, are available upon request or in the policy wording.

WAITING PERIODS

Individual underwriting:
A 12-month condition-specific waiting period applies on any pre-existing conditions at the time of applying for cover.
Group underwriting:

- Compulsory: No underwriting
- Voluntary: 12-month condition-specific waiting period will apply.

WHAT IS NOT COVERED

All the benefits offered are subject to the terms and conditions of the policy. Additional information on the below exclusions is available upon request or in the policy wording.

EXCLUSIONS

MEDICAL EXPENSE SHORTFALL BENEFIT

- Shortfalls where your medical scheme has not paid the first portion of costs
- Hospital and day clinic fees including theatre charges, ward charges or any other hospital or day clinic costs
- Pre-admission or out-of-hospital consultation costs
- Materials or medicine used during a procedure
- External prostheses or dental implants
- Appliances (wheelchairs, crutches, braces, etc)
- Out-of-hospital dental procedures
- Home and private nursing
- Procedures for cosmetic purposes
- Investigative procedures such as blood tests, pap smears, ultrasounds, laboratory tests etc.
- Procedures that are paid for by your medical scheme on an exception or ex-gratia basis
- Elective procedures performed for religious or cultural reasons
- Procedures performed specifically for the treatment of obesity
- Any costs levied as a direct result of the patient's Body Mass Index (BMI) or bodily weight
- Shortfalls on medical practitioners contracted with the medical scheme
- Hospice or step-down facilities
- Medical examinations performed annually or routinely such as pap smears, annual check-ups, etc
- Anxiety disorders, mood disorders, psychotic disorders, dementia and eating disorders
- Transportation costs (including resuscitation) in an emergency vehicle or aircraft and emergency medical service costs
- Any other cost charged for for auxiliary or paramedical services not listed. Shortfalls where your medical practitioner is contracted to your medical scheme on a preferential pricing basis and your medical scheme statement indicates that you are not liable for the amount.

ALLIED PROFESSIONALS SHORTFALL COVER

- We will not pay your claim under this benefit if the medical scheme plan option that you have selected does not include cover under your major medical benefit for the procedure that you are claiming for.
- We will not pay your claim under this benefit if your allied professional is not on our list of covered allied professionals
- We will not cover any allied professional services once you have been discharged from hospital or day clinic.

ROBOTIC PROCEDURE SHORTFALL/CO-PAYMENT BENEFIT

- Any other shortfalls related to the procedure with exception of the medical practitioner costs
- Any amount exceeding the R12 000 annual amount

CO-PAYMENT BENEFIT

- Co-payments levied by a medical practitioner, hospital or day clinic
- Percentage co-payments applied on any part of the account, for the use of a non-Designated Service Provider (non-DSP)

- Co-payments applied for not adhering to the medical scheme's protocols (e.g. not being referred to a specialist by a GP, not obtaining a pre-authorisation for a procedure, etc)
- Co-payments applied for use of a private ward or any other special request not covered by the medical scheme
- Co-payments applied to a condition in a waiting period

ONCOLOGY CO-PAYMENT BENEFIT

- Co-payments applied prior to reaching the medical scheme oncology benefit limit
- Co-payments applied for undergoing treatment with a non-DSP
- All oncology co-payments that are approved by the scheme as ex-gratia, experimental or as an exception even though they are approved as part of the members' oncology treatment plan
- Any speciality cancer treatment or medicine that is accessible before your oncology limit has been depleted and exceeds a co-payment of 20% co-payment

INTERNAL PROSTHESIS BENEFIT

- Shortfalls where the medical scheme has not paid the first portion of costs
- Devices that are placed inside a body to assist with the functioning of a body part, with the exception of stents and pacemakers
- External prostheses or dental implants

CASUALTY BENEFIT

- Elective procedures undertaken at a casualty ward
- Casualty ward visits due to illness, unless it is due to an emergency only, for a dependant 8 years or younger
- Visits to the casualty ward that exceeds 24 hours from the incident
- Follow up visits to a casualty ward more than 24 hours after the initial casualty visit.
- Accidental death/disability assist benefit
- Death or permanent and total disablement which is not directly due to an accident as defined in the policy
- Disability which is not total and permanent as defined in the policy

SUB-LIMIT BENEFIT

- Cover for sub-limits exhausted other than for MRI/CT scans and scopes

RECONSTRUCTION OF NON-AFFECTED BREAST BENEFIT

- Any treatment for prophylactic measures
- Any reconstruction that is not directly due to a cancer diagnosis within the current policy period
- Any procedure not being performed in the same surgery as the mastectomy of the affected breast

CANCER ASSIST BENEFIT

- Any diagnosis which does not meet the minimum criteria for eligibility of the benefit
- Any diagnosis which is not a first-time diagnosis
- All skin cancers
- All cancers diagnosed and treated by primary biopsy

VIOLENT CRIME BENEFIT

- Accidental death or disability claims which have been rejected
- Death or disability that was not due to violent crime as defined in the policy

BENEFIT FOR TRAUMA COUNSELLING

- Any counselling that is not related to an act of violence or a traumatic accident
- Any counselling not undertaken by a counsellor as defined in the policy

PREMIUM WAIVER BENEFIT

- Death or disability that is not due to an accident as defined in the policy
- Death or disability of a person that is not the premium payer
- Disability that does not meet the criteria of permanent and total disability

TRAUMA AND BEREAVEMENT COUNSELLING BENEFIT

- Any counselling that is not related to an act of violence or a traumatic accident
- Any counselling not undertaken by a counsellor as defined in the policy
- Co-payments applied for not adhering to the medical scheme's protocols (e.g. not being referred to a specialist by a GP, not obtaining a pre-authorisation for a procedure, etc)
- Co-payments applied for use of a private ward or any other special request not covered by the medical scheme
- Co-payments applied to a condition in a waiting period

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- Death or disability that is not due to an accident as defined in the policy
- Death or disability of a person that is not the premium payer
- Disability that does not meet the criteria of permanent and total disability

TRAUMA AND BEREAVEMENT COUNSELLING BENEFIT

- Any counselling that is not related to an act of violence or a traumatic accident
- Any counselling not undertaken by a counsellor as defined in the policy
- Bereavement counselling for anyone who does not meet the definition of immediate family member as defined in policy

BABY BUMP

- Any pregnancy diagnosis which occurs before cover has begun
- Any pregnancy diagnosis not confirmed with the required blood tests or evidence of registration on the medical schemes maternity programme
- The benefit will not be paid after the birth of the baby

GENERAL EXCLUSIONS

Any claims that arise from the below events are not covered:

- Participation in war, invasion, terrorist activity, rebellion, active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike or the activities of locked out workers
- Nuclear weapons, nuclear material, ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the burning of nuclear fuel, including any self-sustaining process of nuclear fission (the splitting of an atomic nucleus into small parts)
- Taking of any legal drug unless it has been prescribed by a registered medical practitioner (other than you) and you are following the instructions of the medical practitioner in your taking of the drug
- Taking of any illegal drug
- Illegal behaviour or as a result of breaking any law of the Republic of South Africa
- Suicide, attempted suicide, intentional self-injury or any form of exposure to danger
- Aviation except if you are on a commercial flight as a fare-paying passenger

CLAIMS

Medical practitioner shortfall and co-payment claims will be paid through the seamless claim process, and no claim form or documentation is needed as this is handled on your behalf. All claims that do not form part of the seamless claims process must be submitted manually. Your claim form and all related documents must be submitted within 180 days from the date of treatment. Claim forms are obtainable by emailing **info@bgapcover.co.za** or calling **0860 102 936.**

ENQUIRIES

New business
Tel: 0860 102 936 I info@bgapcover.co.za

GUARDRISK
TAILORED RISK SOLUTIONS

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