PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D5.1	**General Practitioners (Including Virtual Consultations)**			This benefit excludes • Dental Practitioners and Therapists (D6), • Oncologists, Haematologists and Credentialed Medical Practitioners during active and post-active treatment periods (D14); • Paramedical Services (D17); • Physiotherapists and Biokineticists in hospital (D19.1).
D5.1.1	**In Hospital**	• No limit. • 100% of Bonitas Tariff for general practitioners.	• No limit. • 100% of Bonitas Tariff for general practitioners.	
D5.1.2.	**Out of Hospital**	Subject to the General Practitioner benefit in D5.1.3 and D5.1.4.	Subject to the General Practitioner benefit in D5.1.3 and D5.1.4.	
D5.1.3	**In Network General Practitioners/Nominated General Practitioners for Standard Select (including virtual consultations)**	M : R4 390 M+1: R6 440 M+2: R7 140 M+3: R7 500 M+4+: R8 140	M : R4 390 M+1: R6 440 M+2: R7 140 M+3: R7 500 M+4+: R8 170 Subject to GP Nomination from the GP Network.	On Standard Select, subject to nominating a maximum of two GPs from the GP Network and submitting the claim from the nominated GP.
D5.1.4	**Non-Network General Practitioners/Non Nominated, for Standard Select**	M : R1 430 M+1: R2 200 M+2: R2 410 M+3: R2 510 M+4+: R2 710 Limited to and included in the General Practitioner Network benefit D5.1.3. 30% co-payment applies to non-network GP consultations.	• Limited to 2 out of area visits per family for non-nominated GPs or non-network GP visits • Limited to and included in D5.1.3. • 30% co-payment applies to non-network GP consultations.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D6.1.5	Root canal therapy	Covered at 100% of BDT. Root canal therapy on wisdom teeth (3rd molars) and primary (milk) teeth is not covered.	Covered at 100% of BDT. Root canal therapy on wisdom teeth (3rd molars) and primary (milk) teeth is not covered.	Subject to managed care protocols.
D6.1.6	Preventative Care	2 Annual scale and polish treatments per beneficiary once every 6 months.	2 Annual scale and polish treatments per beneficiary once every 6 months.	No benefit for oral hygiene instructions. Benefit for fluoride is limited to beneficiaries from age 5 and younger than 16 years of age. Benefit for fissure sealants is limited to beneficiaries younger than 16 years of age.
D6.1.7	Hospitalisation (general anaesthetic) and Moderate/Deep Sedation in the rooms	• Co-payment of R3 500 per hospital admission applies for children younger than 5 years and R5 000 for any other admission, including removal of impacted teeth or medical condition. • Subject to pre-authorisation. • Admission protocols apply. • Certain maxillo-facial procedures are covered in hospital. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. • Multiple hospital admissions are not covered. • General anaesthetic benefits are available for the removal of impacted teeth. Benefit is subject to managed care protocols. • Specific facilities may be contractually excluded and will incur a 30% co-payment, subject to Regulation 8 (3).	• Co-payment of R3 500 per hospital admission applies for children younger than 5 years and R5 000 for any other admission, including removal of impacted teeth or medical condition. • Subject to pre-authorisation. • Subject to the Standard Select Hospital Network. • Admission protocols apply. • Certain maxillo-facial procedures are covered in hospital. • General anaesthetic benefits are available for children under the age of 5 years for extensive dental treatment. • Multiple hospital admissions are not covered. • General anaesthetic benefits are available for the removal of impacted teeth. Benefit is subject to managed care protocols.	Pre-authorisation is required for Moderate/Deep Sedation in the rooms and is limited to extensive dental treatment where managed care protocols apply. The co-payment to be waived if the cost of the service falls within the co-payment amount

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D21.1.2	Out of hospital	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	This benefit excludes: specified list of radiology tariff codes included in the • maternity benefit, (D10), • the oncology benefit during the active treatment and/or post active treatment period, (D14); • the organ and haemopoietic stem cell transplantation benefit, (D16), • renal dialysis chronic benefit, (D22). Authorisation is not required for MRI scans for low field peripheral joint examination of dedicated limb units. Out of hospital general radiology, as specified in the aPMB care templates, will only accrue to the Day-to-Day benefits once the aPMB entitlements are depleted.
D21.2	Specialised radiology			
D21.2.1	In hospital	• R27 530 per family. • R1 500 co-payment applies per scan event, unless PMB or nuclear radio-isotope studies. • The co-payment to be waived if the cost of the service falls within the co-payment amount	• R27 530 per family. • R1 500 co-payment applies per scan event, unless PMB or nuclear radio-isotope studies. • The co-payment to be waived if the cost of the service falls within the co-payment amount	Subject to the relevant managed healthcare programme and to its prior authorisation. Specific authorisations are required in addition to any authorisation that may have been obtained for hospitalisation, for the following: • CT scans • MUGA scans • MRI scans • Radio isotope studies • CT colonography (virtual colonoscopy, limited to one per beneficiary per annum restricted to the evaluation of symptomaticpatients only). • MDCT coronary angiography, limited to one per beneficiary, restricted to the evaluation of symptomatic patients only. The applicable co-payment to be paid from the day-to-day benefit first.

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D23.2	Out of hospital in practitioner's rooms	Limited to and included in the Day-to-Day benefit.	Limited to and included in the Day-to-Day benefit.	Subject to the relevant managed healthcare programme and to its prior authorisation. Only where a hospital procedure is performed in the practitioner's rooms and is approved, will it be limited to and included in (D7) and OAL. This benefit excludes services as above as well as Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication. (D16). No co-payment applies if the procedure is done in the practitioner's rooms.
D23.3	PROCEDURES WHICH WILL ATTRACT A DEDUCTIBLE:			Subject to the relevant managed healthcare programme and to its prior authorisation.
D23.3.1	Procedures which will attract a deductible: Hip and knee arthroplasty Spinal surgery Cataract Surgery	• Subject to a R30 000 co-payment: • when hip or knee arthroplasty is performed by a non-DSP. Subject to a R15 000 co-payment: • when spinal surgery is performed without prior assessment and/or intervention by the contracted conservative back programme. Subject to a R6 000 co-payment: • For the voluntary use of a non-DSP.	• Subject to a R30 000 co-payment for: • when hip or knee arthroplasty is performed by a non-DSP. Subject to a R15 000 co-payment: • when spinal surgery is performed without prior assessment and/or intervention by the contracted conservative back programme. Subject to a R6 000 co-payment: • For the voluntary use of a non-DSP.	The co-payment to be waived if the cost of the service falls within the co-payment amount

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D23.4	Day Surgery Procedures	• Subject to the Day Surgery Network. • R2 200 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	• Subject to the Day Surgery Network. • R4 400 co-payment to apply to all non-network admissions and subject to Regulation 8 (3).	Subject to the relevant managed healthcare programme and to its prior authorisation and subject to a defined list of procedures. The co-payment to be waived if the cost of the service falls within the co-payment amount
D24	PREVENTATIVE CARE BENEFIT (See B3)			
D24.1	Women's Health Breast Cancer Screening Cervical Cancer Screening	• Mammogram Females age >40 years Once every 2 years. • Pap Smear Females 21-65 years Once every 3 years	• Mammogram Females age >40 years Once every 2 years. • Pap Smear Females 21-65 years Once every 3 years	
D24.2	Mens Health PSA test	• Men 45-69 years, 1 per annum.	• Men 45-69 years, 1 per annum.	
D24.3	General Health	• HIV test annually • Flu vaccine annually.	• HIV test annually • Flu vaccine annually.	HIV test is limited to one (1) per beneficiary per annum, either as part of Preventative Care or Health Risk Assessment. See D27.1.
D24.4	Cardiac Health	Full Lipogram From age 20 years Once every 5 years	Full Lipogram From age 20 years Every 5 years	
D24.5	Elderly Health	• Pneumococcal Vaccination Age >65 once every 5 years. • Faecal Occult Blood Test Ages 50-75 annually.	• Pneumococcal Vaccination Age >65 once every 5 years. • Faecal Occult Blood Test Ages 50-75 annually.	

PARA GRAPH	BENEFIT (EXCEPT FOR PMBs)	STANDARD	STANDARD SELECT	CONDITIONS/REMARKS SUBJECT TO PMB
D26	**AFRICA BENEFIT**	• 100% of the usual, reasonable cost for in-and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	• 100% of the usual, reasonable cost for in- and out-of-hospital treatment routinely available in South Africa received in Africa. • Subject to authorisation.	The Fund's liability will not exceed the global amount the Fund would in the ordinary course pay for such healthcare services given the Fund's claims experience in South Africa, subject to the benefits as per benefit plan.
D27	**WELLNESS BENEFIT**			
D27.1	**Health Risk Assessment (HRA) which includes** **Lifestyle questionnaire** **Wellness screening**	Wellness screening. One assessment per beneficiary per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to • blood pressure test • glucose test • cholesterol test • body mass index. • hip to waist ratio • HIV counselling and testing.	Wellness screening. One assessment per beneficiary per annum by a registered provider, (wellness day, participating pharmacy or biokineticists). Payable from OAL. Limited to • blood pressure test • glucose test • cholesterol test • body mass index • hip to waist ratio • HIV counselling and testing.	HIV test is limited to one (1) per beneficiary per annum, either as part of Preventative Care or Health Risk Assessment. See D24.3.
D27.2	**Wellness extender**	Subject to completion of a Health Risk Assessment per beneficiary. Limited to R1 810 per family for services rendered by: • Family practitioner • Dietician • Biokineticist • Physiotherapist • Smoking cessation programme • Basic radiology and • GP referred pathology	Subject to completion of a Health Risk Assessment per beneficiary. Limited to R1 810 per family for services rendered by: • Family practitioner • Dietician • Biokineticist • Physiotherapist • Smoking cessation programme • Basic radiology and • GP referred pathology	• Child dependants will qualify for the wellness extender benefit once the main member or an adult beneficiary has completed a Health Risk Assessment. • The benefit includes specified general radiology performed by radiologists and radiographers and GP referred pathology services, performed by pathologists.