FEDHEALTH MEDICAL SCHEME

BLUE DOOR PLUS

ANNEXURE B10 – BENEFITS AND LIMITS

2017

(TO BE READ IN CONJUNCTION WITH ANNEXURE C AND D)

[EFFECTIVE 1 JANUARY 2017 UNLESS OTHERWISE STATED BELOW]

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FEDHEALTH MEDICAL SCHEME – BLUE DOOR^PLUS

ANNEXURE B10

BENEFITS AND LIMITS

[Effective 1 January 2017 unless otherwise stated below]

A ENTITLEMENT TO BENEFITS

A1 “**Entitlement to Benefits**” rules applicable to all Fedhealth options are listed in Annexure E, to be read in conjunction with Annexure B, C and D for each option.

“Entitlement to Benefits” rules specific to this option (Blue Door^Plus) are listed in the paragraphs to follow.

A2 In respect of legally prescribed medicine, the following is applicable:

100% of the lower of:

i) the cost to the supplier plus the negotiated mark-up; or
ii) the single exit price plus the negotiated dispensing fee to a maximum fee of either the negotiated dispensing fee, or, in the absence of a negotiated fee, 26% capped at a maximum of R26 (VAT exclusive). In addition, no dispensing fee may exceed the maximum fee as dictated by legislation.

Both subject to the reimbursement limit, i.e., Maximum Generic Price or Medicine Price List. Levies and co-payments to apply where relevant.

A3 Hospital Network Blue Door^{Plus}:

A Hospital Network is included as the Designated Service Provider ("DSP"), for all benefits including Prescribed Minimum Benefits, (See Paragraph 7.4.6 of Annexure D) on this option.

A R10 000 co-pay will apply outside of Designated Service Provider, unless such use is involuntary.

A4 Providers In and Out of Hospital:

A4.1 **A Specialist Network**, appointed as the Scheme's DSP for PMB's on Blue Door^{Plus} (refer Annexure D, paragraph 7.4.3), is applicable for all In and Out of Hospital consultations and procedures.

The Specialist Network includes, but is not limited to, the following specialists:

- Anaesthetists
- Dermatology
- Independent Practice Specialist Obstetrics and Gynaecology
- Pulmonology
- Independent Practice Specialist Medicine
- Gastroenterology
- Neurology
- Cardiology
- Psychiatry
- Independent Practice Specialist Neurosurgery
- Ophthalmology
- Orthopaedics
- Otorhinolaryngology (ENT)
- Rheumatology
- Paediatrics Independent Practice Specialist
- Plastic and Reconstructive Surgery
- Surgery/Paediatric surgery Independent Practice Specialist
- Cardio Thoracic Surgery

- Urology
- Maxillo-facial and Oral Surgery.

A4.2 In Specialist Network for Blue Door[Plus], rates applicable as follows:

- Funded in full at negotiated rate, including Anaesthetists.

All consultations and procedures within the Specialist Network will be charged at the negotiated rate, with no co-payments applicable.

A4.3 Out of Specialist Network:
100% of the Fedhealth Rate, subject to a combined limit of R2 000 for GPs and Specialist Consultations..

A4.4 GPs in Hospital:

A **GP network**, appointed as the Scheme's DSP for PMBs is applicable for all in hospital consultations and procedures.

GPs In Network In Hospital:

Funded in full at the negotiated rate for all options.

GPs Out of Network In Hospital:

100% of the Fedhealth Rate, subject to a combined limit of R2 000 for GPs and Specialist Consultations.

A4.5 Other Healthcare Providers (excluding GP's) not mentioned in A4.1, A4.2 and A4.3 in and out of Hospital:
100% of Fedhealth Rate, only where specific benefits are provided for, as stipulated in paragraph D below.

A5 Providers Out of Hospital:
Limited to and included in paragraph D5.2, D5.3 and D5.4 below.

A6 Co-payments are applicable, on the hospital/ facility bill as listed in the co-payment schedule contained in Annexure E. Procedural co-payments as listed in Annexure E, are applicable in addition to the Hospital Benefits co-payments (where/ if applicable) listed in paragraph A3 above.

B CHARGING OF BENEFITS, LIMITS INCLUDING OVERALL ANNUAL LIMITS AND MEMBERSHIP CATEGORY

B1 Benefits covered at 100% of Fedhealth Rate or contracted rates where applicable.

B2 The column headed **"Benefits"** shows how the cost of a valid claim shall be determined for the purpose of reimbursing the member or the supplier and the share of such cost that the Scheme will bear. The balance of the share of costs to make up 100% thereof shall be the member's responsibility, except for prescribed minimum benefits.

B3 The column headed **"Limits"** shows the extent to which the benefit is limited annually (or every 24 months where indicated) or sub-limited in monetary or other terms.

B4 Prescribed Minimum Benefits above limits are covered in Designated Service Provider. A 40% co-pay will apply outside of Designated Service Provider.

B5 There is no overall annual limit.

All benefits as shown in paragraph D1 – D9 and D11 to D23 are limited to and included in the above amount.

C PRESCRIBED MINIMUM BENEFITS (PMB's)

Prescribed Minimum Benefits as shown in Annexure A of the General Regulations, made in terms of the Medical Schemes Act 131 of 1998, override all benefit limits indicated in this annexure, where applicable. PMB's are payable at 100% of cost, or at 100% of cost at the relevant Designated Service Provider (as indicated in Annexure D, where applicable).

The Prescribed Minimum Benefits are available in conjunction with the Scheme's contracted managed care programmes, which include the application of treatment protocols, medicine formularies, pre-authorisation and case management. These measures have been implemented to ensure appropriate and effective delivery of Prescribed Minimum Benefits.

See Annexure D – Paragraph 7 for a full explanation.

D ANNUAL BENEFITS LIMITS

See contents of table below.

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D1 ALTERNATIVE HEALTHCARE		
D1.1 Homeopathic consultations and medicine	No benefit.	No benefit.
D2 AMBULANCE SERVICES		
	100% of cost if authorised by the preferred provider. Unlimited. Only on inter-hospital transfer per event.	Subject to the contracted ambulance services and prior authorisation. Benefits shall apply in respect of services provided within the Republic of South Africa, Namibia, Botswana, Zimbabwe, Lesotho, Swaziland and Mozambique (below the 22nd degree parallel).
D3 APPLIANCES, EXTERNAL ACCESSORIES AND ORTHOTICS		
D3.1 In Hospital	No benefit, unless PMB. Subject to B5 for PMBs only.	Subject to the relevant managed healthcare programme and its prior authorisation.
D3.1.1 General medical and surgical appliances (including glucometers)	Limited to and included in D3.1.	Diabetic accessories and appliances (with the exception of glucometers) to be preauthorised and claimed from the chronic medicine benefit D11.4.
D3.2 Out of Hospital	No benefit.	
D4 BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS		
	Limited to and included in the overall annual limit.	Use of blood equivalents is subject to prior authorisation by the relevant managed healthcare programme.

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals and/ or single exit price plus dispensing fee.	Transportation of blood is included. Authorised Erythropoietin is included. (See D22.1.)
D5 CONSULTATIONS AND VISITS BY MEDICAL PRACTITIONERS		
D5.1 In hospital	Limited to and included in the overall annual limit. Paragraph A4 applicable. 100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals, for medical and dental specialists or general practitioners. Subject to a combined limit of R2 000 per family for non-network GP and Specialist consultations and procedures in hospital.Hospital admissions will require a referral from a General Practitioner, subject to D5.2, D5.3 and D5.4, as well as pre-authorisation. Where the hospital admission is requested by a Specialist, a referral from a contracted General Practitioner, or non-contracted General Practitioner (subject to D5.4) to the Specialist is required, as well as pre-authorisation. If no	Subject to the relevant managed healthcare programme and its prior authorisation. Paragraph A3 applicable. All radiology and pathology investigations will be limited to basic protocols and limited to a specified list of tariff codes – tests and procedures must be referred by a Medical Practitioner, as referred to in D5.2, D5.3 and D5.4. This benefit excludes: • Alternative healthcare practitioners (D1) • Dental practitioners, technologists and Therapists (D6) • Ante-natal visits and consultations (D10) • Psychiatrists, psychologists, psychometrists and registered counsellors (D12) • Oncologists, haematologists and credentialed medical practitioners, during active and post-active treatment periods (D14) • Additional Medical

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
	referral is received from a GP a 40% co-payment will apply on the specialists account.	Services (D17)
D5.2 Out of Hospital	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals, for medical and dental specialists or general practitioners. Unlimited if clinically appropriate and subject to the use of the nominated contracted General Practitioner's and relevant managed healthcare programmes. 2 x Psychiatric consultations per family per annum. Paragraph D5.3 and D5.4 applicable. A Specialist requires a referral from a contracted General Practitioner, or non-contracted General Practitioner (subject to D5.4), and is further subject to the relevant managed healthcare programme. Consultations with Nurse Practitioners in the Nurses Network, where applicable, limited to the Fedhealth negotiated rate.	Subject to the relevant managed healthcare programme and its prior authorisation. Utilisation monitoring protocols and monitoring become effective after 6 visits per beneficiary. All radiology and pathology investigations will be limited to basic protocols and limited to a specified list of codes – tests and procedures must be referred by contracted Medical Practitioner. This benefit excludes: • Alternative healthcare practitioners (D1) • Dental practitioners, technologists and therapists (D6) • Psychiatrists, psychologists, psychometrists and Registered counsellors (D12) • Oncologists, haematologists and credentialed medical practitioners, during active and post-active treatment periods (D14) • Additional Medical Services (D17) • Physical therapy (D19)

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D5.2.1 Dispensing General Practitioner	100% of the negotiated fee, or in the absence of such fee, 100% of the lower of the cost or Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals. Unlimited if clinically appropriate and subject to the use of the nominated contracted dispensing General Practitioners and relevant managed healthcare programmes.	Subject to the relevant managed healthcare programme and its prior authorisation. Utilisation monitoring protocols and monitoring become effective after 6 visits per beneficiary.
D5.2.2 Non-dispensing General Practitioner	100% of the negotiated fee, or in the absence of such fee, 100% of the lower of the cost or Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals Unlimited if clinically appropriate and subject to the use of the nominated contracted non-dispensing General Practitioners and relevant managed healthcare programmes.	Subject to the relevant managed healthcare programme and its prior authorisation. Utilisation monitoring protocols and monitoring become effective after 6 visits per beneficiary.
D5.3 Specialist consultations Out of Hospital		
D5.3.1 Specialists In Network	100% of the negotiated fee, or in the absence of such fee, 100% of the lower of the cost or Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals. 2 x Network Specialist consultations per family. Paragraph A3 applicable.	

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
	Prescribed Minimum Benefits above these benefits are covered in Designated Service Provider and managed according to managed healthcare protocols. A Specialist requires a referral from a General Practitioner, subject to D5.2 and D5.4, and is further subject to the relevant managed healthcare programme, including D11.2.	
D5.3.2 Specialists Out of Network	No benefit.	
D5.4 General Practitioners Not contracted	Cost or the agreed Fedhealth Rate of non-contracted General Practitioner or out of area usage. 2 x visits per family per year.	Member will be liable for payment for acute medication dispensed by a General Practitioner not contracted.
D6 DENTISTRY		
	100% of the negotiated fee, or in the absence of such fee, 100% of the lower of the cost or Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals. Subject to the Dental Risk Company Provider Network and limited to a list of approved procedures and dental tariff codes.	

SERVICE SUBJECT TO PMB	BLUE DOOR[PLUS] BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D6.1 Basic	100% of the negotiated fee, or in the absence of such fee, 100% of the lower of the cost or Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals. Subject to the Dental Risk Company Provider Network and limited to a list of approved procedures and dental tariff codes.	Subject to the relevant managed healthcare programme. General anaesthetics, conscious analgo sedation and hospitalisation for dental work under the age of 8 years = no benefit. All general anaesthetics and conscious analgo sedation for dentistry, regardless of where it is performed, must be pre-authorised. Surgical extraction of wisdom teeth are excluded. Lingual and labial frenectomies under GA granted for members under the age of 8, subject to the relevant managed healthcare programme and its prior authorization.
D6.2 Advanced dentistry, Oral Medical Procedures by Maxillo Facial Surgeons, Orthognathic Surgery and Osseo-Integrated Implants	No benefit.	
D7 HOSPITALISATION		
D7.1 Private hospitals and unattached operating theatres		

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D7.1.1. In Hospital	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of cost or Fedhealth Rate, for accommodation, use of the operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. Limited to and included in the overall annual limit. **Hospital Network:** A Hospital Network is the Designated Service Provider ("DSP"), for all benefits including Prescribed Minimum Benefits, see paragraph A4. A R10 000 co-pay will apply outside of Designated Service Provider, unless such use is involuntary. Hospital admissions will require a referral from a contracted General Practitioner, subject to D5.2, D5.3 and D5.4, as well as pre-authorisation. Where the hospital admission is requested by a Specialist, a referral from a contracted General Practitioner, or non-contracted General Practitioner (subject to D5.4) to the Specialist is required, as well as pre-authorisation. Prescribed Minimum Benefits above these benefits are covered at cost in Designated Service Provider and managed according to managed healthcare protocols. 40% co-pay is applicable outside of Designated Service Provider.	Subject to the relevant contracted managed healthcare programme(s) which include the application of treatment protocols, formularies pre-authorisation and case management. Paragraph A3 applicable. For accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. Benefits for the cost of private wards are paid at the same rate as for general wards, unless there is acceptable medical motivation. No benefits will be granted if prior authorisation requirements are not complied with. This benefit excludes Hospitalisation for: • Osseo-integrated implants and orthognathic surgery (Advanced dentistry (D6) • Maternity (D10) • Mental Health (D12) • Organ and Haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16) • Refractive surgery (D23) • Dentistry (D6) • Obesity

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
		• Skin disorders • Investigations and diagnostic work-up • Functional nasal surgery • Elective Caesarean Section, except if medically necessary • Surgery for oesophageal reflux and hiatus hernia • Spinal and neck treatment or surgery • Joint replacements, including but not limited to hips, knees, shoulders and elbows, excluding trauma • Cochlear implants • Auditory brain implants • Internal nerve stimulators, including procedures, devices and processors • Healthcare services that should be provided out of hospital and for which an admission to hospital is not necessary • Brachytherapy for Prostate Cancer • Non-cancerous breast conditions • Renal dialysis chronic (D22) • Healthcare Services outside of the Republic of South Africa.
D7.1.2 Medicine on discharge from hospital (TTO)	Limited to and included in D7.1.1. Limited to and included in the overall annual limit and limited to 7 days supply.	See D11.3. Except for anti-coagulants were more than seven (7) days supply can be authorised reimbursement of anti-coagulants is subject to prior authorisation by the relevant managed healthcare programme.

SERVICE SUBJECT TO PMB	BLUE DOOR^PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D7.2 Public Hospitals		
D7.2.1 In Hospital	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of cost or Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals for accommodation, use of the operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. Limited to an included in the overall annual limit.	Subject to the relevant contracted managed healthcare programme(s) which include the application of treatment protocols, formularies pre-authorisation and case management. Paragraph A3 applicable. This benefit excludes Hospitalisation for benefits listed in D.7.1.1.
D7.2.2 Medicine on discharge from hospital (TTO)	Limited to and included in D7.1.1. Limited to and included in the overall annual limit and limited to 7 days supply	See D11.3. Except for anti-coagulants were more than seven (7) days supply can be authorised reimbursement of anti-coagulants is subject to prior authorisation by the relevant managed healthcare programme.
D7.2.3 Medicine	Limited to and included in D11.1 and D11.4.	
D7.3 Alternatives to hospitalisation	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or Fedhealth Rate. No benefit, unless prescribed minimum benefit. Benefits for clinical procedures and treatment during stay in an alternative facility will be subject to the same benefits that apply to hospitalisation.	Subject to the relevant managed healthcare programme and to its prior authorisation and further limited to paragraphs A4, A5 and B5, where applicable. Limited to PMB level of care.

SERVICE SUBJECT TO PMB	BLUE DOOR^PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D7.3.1 Physical rehabilitation facilities	Limited to PMB level of care.	
D7.3.2 Sub-acute facilities	Limited to PMB level of care.	
D7.3.3 Terminal Care Benefit	No benefit, unless prescribed minimum benefit.	
D7.3.4 Nursing Services		
D7.3.4.1 Nursing Agencies	No benefit.	
D7.3.4.2 Private Nurse Practitioners	No benefit.	
D7.4 Casualty/ Emergency rooms	No benefit.	
D7.4.1 Trauma Treatment in Casualty	A co-payment of R500 is applicable on the Casualty Benefit. 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost of Fedhealth Rate.	D24 also applicable. Will be included in the hospital benefit if a retrospective authorisation is given by the relevant managed healthcare.
D8 IMMUNE DEFICIENCY SYNDROME RELATED TO HIV INFECTION		
	100% of the negotiated fee, or, in the absence of such fee, 100% of the cost, or Uniform Patient Fee Schedule for public hospitals and paragraph 7.2 of Annexure D.	

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
	Unlimited, subject to the Scheme's contracted managed healthcare programme which include the application of treatment protocols, medicine formularies, pre-authorisation and case management. Subject to State protocols.	
D8.1 Anti-retroviral medicine	Limited to and included in D8 and subject to State protocols.	
D8.2 Related medicine	Limited to and included in D8 and subject to State protocols.	
D8.3 Related pathology	Limited to and included in D8.	Pathology as specified by the relevant managed healthcare programme.
D8.4 HIV Counselling and Testing ((HCT)	Limited to and included in D8.	
D8.5 All other services	Limited to and included in D1 to D7 and D9 to D23.	
D9 INFERTILITY		
	100% of the negotiated fee, or, in the absence of such fee, 100% of the cost, or Uniform Patient Fee Schedule for public hospitals. Limited to and included in paragraphs A4 and B5.	Subject to the relevant managed healthcare programme and to its prior authorisation. Paragraph A3 applicable.

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB

	Prescribed Minimum Benefits covered in Designated Service Provider and managed according to managed healthcare protocols and further limited to interventions and investigations as prescribed by the Regulations to the Medical Schemes Act 131 of 1998 in Annexure A, paragraph 9, Code 902M.	This benefit includes the following procedures or interventions:
		• Hysterosalpingo-gram
		• The following blood tests:
		  ○ Day 3 FSH/ LH
		  ○ Day 3 Oestradiol
		  ○ Thyroid function (TSH)
		  ○ Prolactin
		  ○ Rubella
		  ○ HIV
		  ○ VDRL
		  ○ Chlamydia
		  ○ Day 21 Progesterone
		• Laparoscopy
		• Hysteroscopy
		• Surgery (uterus and tubal
		• Manipulation of ovulation defects and deficiencies
		• Semen analysis (volume; count; mobility; morphology; MAR test)
		• Basic counselling and advice on sexual behaviour, temperature charts, etc.
		• Treatment of local infections

D10 MATERNITY		
D10.1 Confinement in hospital	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals, for accommodation, use of	Subject to the relevant contracted managed healthcare programme(s) which include the application of treatment protocols, formularies pre-authorisation and case management. Strict protocols will apply.

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
	operating theatres and hospital equipment, medicine, pharmaceuticals and surgical items. Subject to PMB level of care Hospital admissions will require a referral from a contracted General Practitioner, subject to D5.2, D5.3 and D5.4, as well as pre-authorisation. Where the hospital admission is requested by a Specialist, a referral from a contracted General Practitioner, or non-contracted General Practitioner (subject to D5.4), to the Specialist is required, as well as pre-authorisation. If no referral is received from a GP a 40% co-payment will apply on specialist account.	Delivery by a contracted general practitioner and/ or referral by contracted General Practitioner for medical specialist and the services of the attendant paediatrician and/ or anaesthetists are included. Elective non-PMB caesarean sections as mode of delivery are subject to a R10 000 co-payment. Included in global obstetric fee is post-natal care by a general practitioner and a medical specialist up to an including the six week post-natal consultation. Paragraphs A3 and A4 applicable. Benefits for the cost of private wards are paid at the same rate as for general wards, unless there is acceptable medical motivation.
D10.1.1 Medicine on discharge from hospital (TTO)	See D11.3. Limited to and included in the overall annual limit and limited to 7 days supply.	
D10.1.2 Confinement in a registered birthing unit	Limited to and included in D10.1. Includes the following: 4 x post-natal midwife consultations per event, in and out of hospital.	Delivery by a midwife. Hire of water bath included in D3.1.
D10.2 Confinement out of hospital	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or	Subject to the relevant managed healthcare programme and to its prior authorisation.

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
	Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals for the delivery by a general practitioner or midwife. Limited to and included in D10.1. 4 x post natal midwife consultations per event, in and out of hospital.	Hire of water bath and oxygen cylinder included in D3.1.
D10.2.1 Consumables and pharmaceuticals	Limited to and included in D10.1.	Registered medicine, dressings and materials supplied by a midwife out of hospital.
D10.3 Related maternity services	100% of the negotiated fee, or in the absence of such fee, 100% of the lower of the cost or Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals. Limited to and included in D10.1. Includes the following: 2 x 2D scans per beneficiary per maternity event.	These may be requested directly by the Specialist.
D11 MEDICINE AND INJECTION MATERIAL		
D11.1 Routine (acute) medicine for dispensing GP	Contracted General Practitioner must either dispense the acute medicine or have an arrangement with a pharmacy where the contracted General Practitioner pays the pharmacy for the cost of the acute medicine scripted.	This benefit excludes: • In-hospital medicine (D7) • Anti-retroviral medicine (D8) • Oncology medicine (D14)

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
	Acute medicine forms part of the fixed fee for consultations and no acute medicine will be paid additional to this fee. Acute medicine prescribed by DRC Network Dentists are subject to the acute medicine formulary. Limited acute formulary medication as prescribed or dispensed by Contracted General Practitioner and/ or prescribed by a Specialist.	• Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16)
D11.2 Routine (acute) medicine for non-dispensing GPs (including Specialists, Dentists and Optometrists)	In respect of legally prescribed medicine. 100% of the lower of: (i) the cost to the supplier plus the negotiated mark-up, or (ii) the single exit price plus the negotiated dispensing fee to a maximum fee as dictated by legislation. Both subject to the reimbursement limit, i.e., Maximum Generic Price or Medicine Price List. Levies and co-payments to apply where relevant. Unlimited according to the scheme's managed healthcare acute formulary.	Subject to the relevant managed healthcare programme. The Medicine Exclusion List and the Pharmacy Products Management Document, relevant managed healthcare programmes and protocols applicable. This benefit excludes: • In-hospital medicine (D7) • Anti-retroviral medicine (D8) • Organ and haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16)

SERVICE SUBJECT TO PMB	**BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB**	**CONDITIONS/ REMARKS SUBJECT TO PMB**
	Acute medicine prescribed by DRC Network Dentists are subject to the acute medicine formulary.	
D11.3 Medicine on discharge from hospital (TTO)	100% of the lower of: (i) the cost to the supplier plus the negotiated mark-up, or (ii) the single exit price plus the negotiated dispensing fee to a maximum fee as dictated by legislation. Both subject to the reimbursement limit, i.e., Maximum Generic Price or Medicine Price List. Levies and co-payments to apply where relevant. Limited to and included in the overall annual limit and limited to 7 days supply.	Except for anti-coagulants were more than seven (7) days supply can be authorised reimbursement of anti-coagulants is subject to prior authorisation by the relevant managed healthcare programme. Anticoagulants post-surgery: subject to D7.1.1.
D11.4 Chronic medicine	In respect of legally prescribed medicine. 100% of the lower of: (i) the cost to the supplier plus the negotiated mark-up, or (ii) the single exit price plus the negotiated dispensing fee to a maximum fee as dictated by legislation.	Subject to the relevant managed healthcare programme and to its prior authorisation and applicable formularies. Prescribed Minimum Benefits (Chronic Disease Lists) and Diagnostic Treatment Pairs chronic conditions only. Restricted to a maximum of one month’s supply, unless specifically pre-authorised. Medicine Price List applies.

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
	Both subject to the reimbursement limit, i.e., Maximum Generic Price or Medicine Price List. Levies and co-payments to apply where relevant. Prescribed Minimum Benefits conditions – unlimited benefit, provided through Designated Service Provider, according to a strict and basic formulary. A co-payment of 40% will apply to voluntary use of non-formulary medicines and/ or voluntary use of non-Designated Service Providers, unless involuntary.	(Includes diabetic disposables such as syringes, needles, strips and lancets.) This benefit excludes: • In hospital medicine (D7) • Anti-retroviral drugs (D8) • Oncology medicine (D14) • Organ and Haemopoietic stem (bone marrow) transplantation and immunosuppressive medication (D16)
D11.5 Specialised Drugs for Non Oncology	No benefit.	Except for Beta-Interferon for the treatment of Multiple Sclerosis as per the Prescribed Minimum Benefits Algorithm and subject to Regulation 15(H) and 15 (I) and the relevant managed healthcare programme and to its prior authorisation.
D11.6 Specialised Drugs	See D14.1.3.	
D11.7 Female Health Benefit • **Oral Contraceptives** • **Contraceptive Injections**	Oral and injectable contraceptives payable from Major Medical Benefit. Limited to acute formulary.	Subject to a list of contraceptives. Excluding oral contraceptives prescribed for other conditions. Excluding consultations and procedural costs.

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D12 MENTAL HEALTH		
D12.1 In Hospital Consultations and visits, procedures, assessments, therapy, treatment and/ or counselling	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or the Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals for accommodation, use of operating theatres and hospital equipment, medicine, pharmaceuticals and surgical procedures performed by general practitioners and psychologists and psychiatrists. A R10 000 co-pay will apply outside of Designated Service Provider, unless such use is involuntary R8 010 per family, per year limited to and included in paragraphs A4 and B5. Unlimited for prescribed minimum benefits. Hospital admissions will require a referral from a General Practitioner as well as pre-authorisation. Where the hospital admission is requested by a Specialist, a referral from a contracted General Practitioner to the Specialist is required, as well as pre-authorisation.	Subject to the relevant contracted managed healthcare programme(s) which include the application of treatment protocols, formularies pre-authorisation and case management. Paragraph A3 applicable. Additional hospitalisation to be motivated by the contracted medical practitioner and pre-authorised by the relevant managed healthcare programme. Benefits for the cost of private wards are paid at the same rate as for general wards, unless there is acceptable medical motivation.
D12.1.1 Medicine on discharge from hospital (TTO)	Limited to and included in D7.1.1. Limited to and included in the overall annual limit and limited to 7 days supply.	See D11.3. Except for anti-coagulants were more than seven (7) days supply can be authorised reimbursement of anti-

SERVICE SUBJECT TO PMB	BLUE DOOR^{PLUS} BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
		coagulants is subject to prior authorisation by the relevant managed healthcare programme.
D12.2 Out of Hospital Consultations and visits, procedures, assessments, therapy, treatment and/or counselling	Limited to and included in D5.3.	Unless, for Prescribed Minimum Benefits, as per Regulations.
D12.2.1 Medicine	Limited to and included in D11.4.	For Prescribed Minimum Benefits.
D12.3 Rehabilitation for substance abuse	100% of the negotiated fee, or, in the absence of such fee, 100% of cost or Uniform Patient Fee Schedule for public hospital for accommodation, use of hospital equipment pharmaceutical, surgical items and medicine supplied during treatment programme. Limited to D12.1 and D12.2.1. Prescribed Minimum covered in Designated Service Provider and managed healthcare protocols.	Subject to the relevant contracted managed healthcare programme(s) which include the application of treatment protocols, formularies pre-authorisation and case management. Limited to one rehabilitation programme per beneficiary per annum, subject to pre-authorisation in hospital. Rehabilitation programme includes hospital-based management up to 21 days per beneficiary, per benefit year. Benefits for the cost of private wards are paid at the same rate as for general wards, unless there is acceptable medical motivation.
D12.3.1 Medicine on discharge from hospital (TTO)	Limited to and included in D7.1.1.	See D1.3.

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
	Limited to and included in the overall annual limit and limited to 7 days supply.	Except for anti-coagulants were more than seven (7) days supply can be authorised reimbursement of anti-coagulants is subject to prior authorisation by the relevant managed healthcare programme.
D13 NON SURGICAL TESTS AND PROCEDURES		
		Paragraphs A3 and A4 applicable.
D13.1 In hospital	100% of the negotiated fee, or, in the absence of such fee, 100% of cost or Uniform Patient Fee Schedule for public hospital for all non-surgical procedures performed by a general practitioner, medical specialists or clinical technologists. Limited to and included in the overall annual limit. Hospital admissions will require a referral from a General Practitioner, subject to D5.2, D5.3 and D5.4, as well as pre-authorisation. Where the hospital admission is requested by a Specialist, a referral from a contracted General Practitioner, or non-contracted General Practitioner (subject to D5.4) to the Specialist is required, as well as pre-authorisation.	Subject to the relevant contracted managed healthcare programme(s) which include the application of treatment protocols, formularies pre-authorisation and case management, in hospital only. This benefits excludes: • Psychiatrists and Psychology (D12) • Optometric examinations (D15) • Pathology (D18) • Radiology (D21)
D13.2 Out of hospital	100% of the negotiated fee, limited to a list of approved procedures by a contracted General Practitioner.	

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D13.2.1 Non-surgical procedures in practitioner's rooms	See D13.2.	
D13.2.1.1 Specified non-surgical procedures in practitioner's rooms	See D13.2.	
D14 ONCOLOGY		
D14.1 Active treatment period	100% of the negotiated fee, or, in the absence of such fee, 100% of cost or Uniform Patient Fee Schedule for public hospital for oncologists, haematologists and credentialed medical practitioners, consultation, visit, treatment and materials used in radiotherapy and chemotherapy. Prescribed Minimum Benefits covered with Designated Service Provider and managed according to managed healthcare protocols. 40% co-pay outside of Designated Service Provider, unless involuntary.	Subject to the relevant managed healthcare programme and to its prior authorisation. ICON is the DSP for Blue Door. A 40% co-payment is applicable, for voluntary non-DSP utilisation. Entry-level ICON Protocols apply. Treatment for long-term chronic conditions that may develop as a result of chemotherapy and radiotherapy is not included in this benefit. Excluding Specialised Drugs. See D14.1.3. Paragraphs A3 and A4 applicable, unless otherwise stated.
D14.1.2 Radiology and pathology	100% of the negotiated fee, or, in the absence of such fee, 100% of cost or Uniform Patient Fee Schedule for public hospital for specified radiologists and haematologists associated with Oncology treatment. Limited to and included in D14.1.	Subject to the relevant managed healthcare programme, protocols and to its prior authorisation. Paragraph A3 not applicable.

SERVICE SUBJECT TO PMB	BLUE DOOR^PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D14.1.2.1 PET and PET-CT	No benefit.	
D14.1.3 Specialised Drugs for Oncology	No benefit.	No benefit provided for facility fees.
D14.2 Pre and Post active treatment (surgical resection of tumour, chemotherapy and radiotherapy)	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or the Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals for consultations by oncologists, haematologists and credentialed medical practitioners, specified radiology and pathology service, performed by pathologists, radiologists and haematologists during the specified remission period. Limited to and included in D14.1 for life following the active treatment period, except for prescribed minimum benefits.	Should the condition regress the active treatment benefit D14.1 will be re-instated.
D15 OPTOMETRY		
	100% of the negotiated fee. Subject to the contract with the Designated Service Provider, per beneficiary, based on a two year benefit cycle.	
D15.1 Consultations	See D15.	

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
	Limited to one comprehensive examination per beneficiary, based on a two year benefit cycle.	
D15.2 Frames	See D15. Limited to R182 per beneficiary every two years.	
D15.3 Lenses	See D15. Limited to 1 pair of clear CR39 single vision spectacle lenses; OR 1 pair of clear CR39 Bifocal lenses.	
D16 ORGAN, TISSUE AND HAEMOPOIETIC STEM CELL (BONE MARROW) TRANSPLANTATION AND IMMUNOSUPPRESSIVE MEDICATION		
	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or the Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals for the work up and harvesting of the organ/s or haemopoietic stem cells (bone marrow) and the transplantation thereof. Prescribed Minimum Benefits covered in Designated Service Provider and managed healthcare protocols and at 100% of the cost	Haemopoietic stem cell (bone marrow) transplantation is limited to allogenic graft and autologous grafts derived from the South African Bone Marrow Registry. Organ harvesting is limited to the Republic of South Africa. Paragraphs A3, A4 and A5 applicable, where relevant.

SERVICE SUBJECT TO PMB		BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D16.1	**Haemopoietic Stem Cell (Bone Marrow) Transplantation**	Limited to and included in D16.	Haemopoietic stem cell (bone marrow) transplantation is limited to allogenic grafts and autologous grafts derived from the South Africa Bone Marrow Registry.
D16.2	**Immuno-suppressive medication**	See D11.4. Limited to and included in D16.	See D16.
D16.3	**Post transplantation biopsies and scans**	Limited to and included in D16.	See D16.
D16.4	**Radiology and pathology**	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or the Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals for specified radiology and pathology services, performed by pathologists, radiologists and haematologists, associated with the transplantation treatment. Limited to and included in D16.	See D16. Paragraph A3 not applicable.
D17	**ADDITIONAL MEDICAL SERVICES**		
(IN AND OUT OF HOSPITAL)		No benefit, unless PMB.	
D18	**PATHOLOGY AND MEDICAL TECHNOLOGY**		
D18.1	**In hospital**	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or the Fedhealth Rate, or Uniform Patient Fee Schedule	All radiology and pathology investigations will be limited to basic protocols and limited to specified list

SERVICE SUBJECT TO PMB	**BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB**	**CONDITIONS/ REMARKS SUBJECT TO PMB**
	for public hospitals for all tests performed by a pathologist or medical technologists. Limited to and included in the overall annual limit. Hospital admissions will require a referral from a General Practitioner, subject to D5.2, D5.3 and D5.4, as well as pre-authorisation. Where the hospital admission is requested by a Specialist, a referral from a contracted General Practitioner, or non-contracted General Practitioner (subject to D5.4) to the Specialist is required, as well as pre-authorisation.	of tariff codes-tests and procedures must be referred by a contracted General Practitioner. Subject to the relevant managed healthcare programme.
D18.2 Out of hospital	100% of the negotiated fee, unlimited, subject to basic protocols and a limited list of procedures and specified tariff codes. Subject to referral from nominated Network GP.	This benefit excludes a specified list of pathology tariff codes included: • maternity benefit (D10) • the oncology benefit during the active and/or post active treatment period(D14) • the organ and haemopoeitic stem cell transplantation benefit (D16) • the renal dialysis chronic benefit (D22)
D19 PHYSICAL THERAPY		
D19.1 In Hospital	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or the Fedhealth Rate, limited to and included in the overall annual limit.	Subject to referral by the treating provider. Subject to the relevant managed healthcare programme and to its prior authorisation before commencement of treatment.

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D19.2 Out of hospital	No benefit.	
D20 PROSTHESES AND DEVICES INTERNAL AND EXTERNAL		
	Prescribed Minimum Benefits covered in Designated Service Provider and managed according to managed healthcare protocols. Prescribed Minimum Benefits only covered only in State.	Subject to the relevant managed healthcare programme and to its prior approval.
D21 RADIOLOGY		
D21.1 General radiology		
D21.1.1 In Hospital	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or the Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals for diagnostic radiology tests and ultrasound scans. Limited to and included in the overall annual limit. Hospital admissions will require a referral from a General Practitioner, subject to D5.2, D5.3 and D5.4, as well as pre-authorisation. Where the hospital admission is requested by a Specialist, a referral from a contracted General Practitioner, or non-contracted General Practitioner (subject to D5.4) to the Specialist is required, as well as pre-authorisation.	Authorisation is not required for MRI scan for peripheral joint examination or dedicated limb units.

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D21.1.2 Out of hospital	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or the Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals. Unlimited, subject to basic protocols and a limited list of procedures and specified tariff codes. Subject to referral by a medical practitioner.	This benefit excludes a specified list of radiology tariff codes included in: • the maternity benefit (D10) • the oncology benefit during the active and/or post active treatment period (D14) • the organ and haemopoietic stem cell transplantation benefit (D16) • the renal dialysis chronic benefit (D22)
D21.2 Specialised Radiology		
D21.2.1 In Hospital	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or the Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals. Limited to R12 100 per beneficiary and a limit of R24 400 per member family and included in the overall annual limit.	Subject to the relevant contracted managed healthcare programme and pre-authorisation. Oncology requests will be limited and included in D14.1.2. 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 This benefit excludes:

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
		• CT colonography (virtual colonoscopy) (no benefits) • MDCT Coronary angiography)(no benefits)
D21.2.2 Out of Hospital	No benefit, unless PMB.	
D22 RENAL DIALYSIS CHRONIC		
	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or the Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals for all services, medicine and materials associated with the cost of renal dialysis. Prescribed Minimum Benefits only covered only in State.	Paragraphs A3 and A4 applicable, unless otherwise stated.
D22.1 Haemodialysis and peritoneal dialysis	Limited to and included in D22.	Subject to the relevant managed healthcare programme and to its prior authorisation. Authorised Erythropoietin is included in D4. This benefit excludes acute renal dialysis and included in D7.
D22.2 Radiology and pathology	Limited to and included in D22.	As specified by the relevant managed healthcare programme. Paragraph A3 not applicable.

SERVICE SUBJECT TO PMB	BLUE DOOR[PLUS] BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D23 SURGICAL PROCEDURES		
D23.1 In Hospital	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or the Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals for surgical procedures performed by a general practitioner or medical specialist. Limited to and included in the overall annual limit. Hospital admissions will require a referral from a General Practitioner as well as pre-authorisation. Where the hospital admission is requested by a Specialist, a referral from a contracted General Practitioner, or non-contracted General Practitioner (subject to D5.4) to the Specialist is required, as well as pre-authorisation.	Subject to the relevant contracted managed healthcare programme(s) which include the application of treatment protocols, formularies pre-authorisation and case management. Paragraphs A3, A4 and A5 applicable, where relevant. This benefit excludes: • Osseo-integrated implants(D6) • Orthognathic and oral surgery (D6) • Advanced dentistry (D6) • Maternity (D10) • Organ Haemopoietic stem cell (bone marrow) transplantation and immunosuppressive medication (D16) Surgical extraction of wisdom teeth are excluded on this option.
D23.1.1 Refractive surgery	No benefit.	
D23.1.2 Maxillo facial surgery	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or the Fedhealth Rate, or Uniform Patient Fee Schedule for public hospitals for the surgical removal of	Subject to the relevant managed healthcare programme and to its prior authorisation. This benefit excludes:

SERVICE SUBJECT TO PMB	BLUE DOOR PLUS BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
	tumours and neoplasms, sepsis, trauma, congenital birth defects and other surgery not specifically mentioned in D6. Prescribed Minimum Benefits only covered only in State. Limited to and included in the overall annual limit.	• Osseo-integrated implantation (D6) • Orthognathic surgery (D6) • Oral surgery (D6) • Impacted wisdom teeth (D6) • Advanced dentistry (D6)
D23.2 Out of hospital in practitioner's rooms	100% of the negotiated fee, limited to a list of approved procedures by a contracted General Practitioner.	Limited to and included in D7.3 and overall annual limit. Paragraph A3 applicable. This benefit excludes; • Osseo-integrated implants (D6) • Maternity (D10) • Orthognathic and oral surgery (D6) • Organ and Haemopoietic stem cell(bone marrow) transplantation and immunosuppressive medication (D16) • Advanced dentistry (D6) Includes related consultation, materials, pathology and radiology if done same day.
D23.2.1 Specific surgical procedures in practitioner's rooms	Limited to and included in D23.2.	

SERVICE SUBJECT TO PMB	BLUE DOOR^{PLUS} BENEFITS/ LIMITS SUBJECT TO PMB	CONDITIONS/ REMARKS SUBJECT TO PMB
D24 SURGICAL AND NON SURGICAL PROCEDURES WITH SPECIFIC CONDITIONS AND EXCLUSIONS		
All conditions and exclusions are included in paragraphs D1 to D23 above.		
D25 WELLNESS BENEFIT		
	100% of the lower of the cost or Fedhealth Rate for listed procedures and tests, limited to and payable from Risk Excludes consultations and costs for all procedures within this programme. For medicines and injection materials: See D11.1. All benefits subject to the use of the contracted wellness network provider.	
D25.1 Flu Immunisation	1 every year for all lives.	
D25.2 HIV Test	1 every year for all lives.	
D26 HEALTH RISK ASSESSMENTS		
	100% of the lower of the cost or Fedhealth Rate for listed procedures and tests, limited to and payable from Risk For medicines and injection materials: See D11.1. Excludes consultations and costs for all procedures within this programme. All benefits subject to the use of the contracted wellness network provider.	
D26.1 Wellness Screening • **Blood pressure;** • **Finger prick cholesterol;** • **Glucose test**	1 test per beneficiary per annum.	

D26.2 Preventative Screening • **Hip to waist ratio;** • **Body fat percentage;** • **Flexibility;** • **Posture; and** • **Fitness**	1 test per beneficiary per annum.
D26.3 Additional Biokineticists Assessments	Limited to 3 tests per beneficiary per annum, for high risk and emerging risk members.

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