Bankmed
Yours in good health

BENEFIT & CONTRIBUTION SCHEDULE 2024

MORE THAN A MEMBER. MORE **WITH BANKMED**.

CONTENTS

The Bankmed Benefit & Contribution Schedule is a summary of the benefits and features of your Plan. The registered Scheme Rules are on the website under 'About Us', 'Scheme Rules'. In all instances, the Scheme Rules apply as registered by the Council for Medical Schemes, and supersede any errors or omissions contained herein. Benefit access and use may be subject to clinical entry criteria, Scheme-determined protocols, limitations on funding, network provider utilisation, and so forth. Prescribed Minimum Benefit (PMB) regulations apply in all instances. Bankmed is administered by Discovery Health (Pty) Ltd.

We are constantly improving our communication and the latest version of the Benefit & Contribution Schedule is available on our website (www.bankmed.co.za).

TERMINOLOGY EXPLAINED

A

ABOVE THRESHOLD BENEFIT (ATB)

Plus Plan members have access to the Above Threshold Benefit (ATB). This gives you extra cover when your claims add up to a set amount called the Annual Threshold. Once the claims you have sent to us add up to the Annual Threshold, we pay specific benefit claims from the ATB, at the Scheme Rate or a portion of it.

ADDITIONAL DISEASE LIST (ADL)

Depending on your Plan, and your approval for the CIB, you have cover for medication for an additional list of life-threatening or degenerative conditions, as defined by Bankmed.

ANNUAL THRESHOLD

We set the Annual Threshold amount at the beginning of each year. The number and type of dependants (spouse, adult, or child) on your Plan determines the amount. The Annual Threshold is the amount that your claims must add up to before we pay your day-to-day claims from the ATB.

B

BOARD OF HEALTHCARE FUNDERS (BHF)

All Healthcare Professionals seeking reimbursement from a medical scheme, are required to register with the BHF and obtain a practice number.

C

CHRONIC DISEASE LIST (CDL)

A defined list of chronic conditions we cover according to the PMBs.

CHRONIC ILLNESS BENEFIT (CIB)

The CIB covers you for a defined list of chronic conditions. You need to apply to have your medication and treatment covered for your chronic condition.

CONNECTED CARE

Connected Care is an integrated ecosystem of benefits, services, and digital capabilities to help you manage your health and wellness.

CO-PAYMENT

This is an amount that you may have to pay towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service or if the amount the Healthcare Professional charges is higher than the rate we cover. If the co-payment amount is higher than the amount charged for the healthcare service, you will have to pay this amount yourself.

COVER

Cover refers to the benefits you have access to and how we pay for these healthcare services such as consultations, medication, and hospitals, on your Plan.

CARE NAVIGATORS

A dedicated team who will help you to:

- Understand your diabetes-specific benefits
- Register on our digital tools
- Choose and engage with Healthcare Professionals on the full-care team (podiatrist, dietitian etc.)
- Get the most out of the programme by using the benefits available

CARE COORDINATION NETWORK

The network of GPs and Specialists who have contracted with the Scheme to provide you with coordinated care for the Diabetes Care Programme.

COUNCIL FOR MEDICAL SCHEMES (CMS)

All medical schemes need to be registered with the CMS, which is a statutory body established by the Medical Schemes Act 131 of 1998 and regulates private health financing through medical schemes.

D

DAY-TO-DAY BENEFITS

These are the available funds allocated to your MSA and ATB or defined benefits for day-to-day healthcare services. The level of day-to-day benefits depends on your Plan.

DEDUCTIBLE

A deductible is an upfront payment that you pay to a hospital, day clinic or other healthcare facility before you can receive treatment. The facility will not admit you until you pay the deductible. If the upfront amount is higher than the amount charged for the healthcare service, you will have to pay for the cost of the healthcare service.

DEPENDANT

A dependant is a spouse, partner, child, or special dependant. Applications must be submitted to Bankmed for membership.

TERMINOLOGY EXPLAINED

DESIGNATED SERVICE PROVIDER (DSP) OR NETWORK

We negotiate tariffs for you with hospitals, pharmacies, GPs, and specialists. When these Healthcare Professionals agree to charge the Scheme Rate, we contract with these Healthcare Professionals as network Healthcare Professionals or DSPs. These Healthcare Professionals must meet our quality standards and charge you the agreed contracted rates. Visit **www.bankmed.co.za** or the Bankmed App and click on 'Find a Healthcare Professional' to view the full list of DSPs.

HomeCare

Home Care is an additional service offering quality home-based care in the comfort of your home for healthcare services like IV infusions, wound care, post-natal care, and advanced illness care.

E EMERGENCY MEDICAL CONDITION

An emergency medical condition (also referred to as an emergency) is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical and/or surgical treatment, where failure to provide medical and/or surgical treatment would result in serious impairment to bodily functions, or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy. An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency.

F FIND A HEALTHCARE PROFESSIONAL TOOL

Our 'Find a Healthcare Professional' tool is a medical and provider search tool which is available on the Bankmed App or website.

FIND A BENEFIT PLAN TOOL

This tool assists you to better understand your benefits and select a Plan that best meets your needs. Plan selection and quotes are based on your individual needs. This is not a benefit comparison tool.

H HEALTHID

HealthID is an online platform that gives your Healthcare Professional fast, up-to-date access to your health information. Once you provide consent, your Healthcare Professional can use HealthID to access your medical history, make referrals to other Healthcare Professionals and check your relevant test results.

I ICD-10 CODE

A clinical code that describes diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organisation (WHO).

INSURED BENEFIT

This is a benefit Bankmed pays from pooled contributions, instead of using your personal MSA, if you have one.

M MEDICAL SAVINGS ACCOUNT (MSA)

The MSA is an amount allocated to you at the beginning of each year or when you join the Scheme. You pay this amount back in equal portions as part of your monthly contribution. We pay your day-to-day medical expenses such as GP and specialist consultations, acute medication, radiology, and pathology from the available funds allocated to your MSA.

You can choose to have your claims paid from the MSA either at the Scheme Rate, or at cost. Any unused MSA funds will carry over to the next year. Should you leave the Scheme or change your Plan partway through the year, and if you have used more of the MSA than you have contributed, you will need to pay the difference to us. PMB claims cannot be funded from the MSA.

MEDICATION LIST (FORMULARY)

A list of medication we cover in full for the treatment of approved chronic condition(s). This list is also known as a 'formulary'.

MEMBERSHIP OR MEMBER

The Principal Member is the main member and membership contract holder, and is responsible for ensuring the monthly contribution is paid. In the case of Bankmed, the Principal Member is an employee of a participating employer or bank that has an agreement with Bankmed. Alternatively, membership may extend to continuation members such as retirees or surviving dependants.

MEDICAL SCHEMES ACT AND REGULATIONS (ACT)

The Medical Schemes Act 131 of 1998 and its regulations consolidates the laws relating to registered medical schemes, serves to protect the interests of members of medical schemes, and provides measures to coordinate medical schemes.

TERMINOLOGY EXPLAINED

N

NETWORKS

Depending on your chosen Plan, you may need to make use of specific hospitals, pharmacies, doctors, specialists, or allied Healthcare Professionals in a network. We have payment arrangements with these Healthcare Professionals to ensure you get access to quality care at an affordable cost. By using network Healthcare Professionals, you can avoid having to pay additional costs and co-payments yourself.

P

PARTICIPATING EMPLOYER

Rule 4.25 of the Bankmed main body rules defines an "Employer" as any bank as defined in the Banks Act (Act 94 of 1990), the Mutual Banks Act (Act 124 of 1993), or the Development Bank of Southern Africa Act (Act 13 of 1997), or a co-operative bank as defined in Section 1(1) of the Co-operative Banks Act (Act 40 of 2007), or any registered financial service provider as defined in the Financial Advisory and Intermediary Services Act (Act 37 of 2002), and any subsidiary or an associated company in which there is a shareholding by an organisation referred to above.

PAYMENT ARRANGEMENTS

The Scheme has payment arrangements with various Healthcare Professionals and service providers to ensure that you can get full cover with no co-payments.

PERSONAL HEALTH ASSESSMENT (PHA)

The PHA measures health indicators like blood pressure, cholesterol, blood sugar, waist circumference, and BMI.

The PHA is paid by Bankmed and its results used to unlock additional benefits, where appropriate.

PREMIER PLUS GP

A Premier Plus GP is a network GP who has contracted with us to provide you with coordinated care and enrolment onto one of our Care Programmes for defined chronic conditions.

PRESCRIBED MINIMUM BENEFITS (PMB)

According to the Medical Schemes Act, all medical schemes must pay for a minimum level of care for a list of defined medical conditions.

R

RELATED ACCOUNTS

Any account besides the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology.

S

SCHEME RATE

Healthcare Professionals in our network charge the Scheme Rate. If you visit a Healthcare Professional who is not in our network, they can charge you more than the Scheme Rate and you will have to pay the difference.

SCHEME MEDICATION RATE

Like the Scheme Rate but applies to medication. Pharmacies in our network charge the Scheme Medication Rate. If you claim for medication that costs more than the Scheme Medication Rate, you will have to pay the difference yourself. The Scheme Medication Rate is made up of the SEP of medication plus the relevant dispensing fee.

SINGLE EXIT PRICE (SEP)

The SEP is the price at which a manufacturer must sell to all pharmacies, irrespective of volume sold. The introduction of the SEP ensured that no person shall supply any medication according to a bonus system, rebate system or any other incentive scheme including sampling of medications. This price is regulated by the government and a medication may not be sold by a wholesaler at less than the published SEP. Pharmacies and dispensers may charge an additional dispensing fee depending on the price of the medication.

SELF-PAYMENT GAP (SPG)

If your MSA funds are depleted, you go into an SPG where you will have to pay all claims from your own pocket. These claims will go towards closing the SPG so that you can eventually access the ATB. Continue submitting claims to close the SPG and access the ATB.

W

WHO GLOBAL OUTBREAK BENEFIT

The WHO Global Outbreak Benefit provides cover for approved global disease outbreaks recognised by the World Health Organisation (WHO) such as COVID-19 and Mpox. This benefit provides access to a defined Basket-of-Care per disease outbreak, which includes cover for the administration of vaccines, where applicable, and relevant out-of-hospital treatment.

ABOUT **BANKMED**

Who we are

Bankmed Medical Scheme (“Bankmed” or “the Scheme”) is an exclusive medical scheme and non-profit organisation that operates under the guidance of the Medical Schemes Act 131 of 1998, as amended, and is regulated by the CMS. Membership is limited to employees at participating employer groups. Participating employers are made up of registered banks and financial service providers that have partnered with Bankmed to provide health and wellness benefits for their employees.

The Scheme is governed by a Board of Trustees (BOT), which is appointed by the members of the Scheme. These dedicated individuals manage the affairs of the Scheme in accordance with the Act and the Scheme Rules. At least 50% of the BOT members are elected from the Scheme's members and they must be capable of fulfilling their duties responsibly. Their primary objective is to safeguard the interests of the members and ensure proper administration of the Scheme. Any misconduct or reckless trading on their part may result in their being held accountable for any losses incurred by the Scheme. The day-to-day operations of the Scheme are overseen by a Principal Officer (PO), who reports to the BOT.

Bankmed exists solely for the benefit of its members, with all funds pooled and protected to cover claims in accordance with the Scheme's Rules. Our utmost priority is to provide fair and compassionate care to all members, based on their chosen Plan.

WHAT DOES IT MEAN TO BE ADMINISTERED BY DISCOVERY HEALTH (PTY) LTD?

Discovery Health (Pty) Ltd (Discovery Health), a registered medical scheme administrator and managed care organisation, has been entrusted by Bankmed to oversee the management of administration and managed care services. Guided by Bankmed's rules, policies, and protocols, Discovery Health effectively executes these responsibilities. With expertise in developing efficient claims systems and staffing a dedicated call centre to address inquiries, Discovery Health manages the operational aspects of the Scheme.

WHAT IS THE DIFFERENCE BETWEEN BANKMED, DISCOVERY HEALTH (PTY) LTD AND DISCOVERY HEALTH MEDICAL SCHEME?

Bankmed and Discovery Health Medical Scheme are both registered medical schemes under the Medical Schemes Act 131 of 1998. They are regulated by the Council for Medical Schemes.

Bankmed is a restricted-access medical scheme, limited to people employed by a participating employer group in the banking or financial services industry.

Discovery Health Medical Scheme is an open medical scheme available to the public. It's important to note that Bankmed and Discovery Health Medical Scheme are separate legal entities and have no relationship with each other.

Discovery Health (Pty) Ltd is a registered medical scheme administrator and managed care organisation, also regulated by the Council for Medical Schemes. Discovery Health provides administration and managed care services to Bankmed, Discovery Health Medical Scheme, and numerous other restricted access medical schemes.

WHAT MAKES **BANKMED SPECIAL**

Bankmed Medical Scheme: your partner in health and wellness

Bankmed's commitment to your health and wellness spans over a century, combining the expertise of the banking and healthcare industries. We understand that every individual has unique health needs and are here to provide you with tailored medical cover that prioritises your wellbeing.

ACCESS TO QUALITY HEALTHCARE

Bankmed takes part in an annual survey commissioned by the Health Quality Assessment. The 2022 findings revealed that Bankmed members enjoy superior healthcare quality across various clinical indicators.

BALANCE — BANKMED'S BESPOKE WELLNESS PROGRAMME

As a Bankmed member you have access to Balance at no cost. Balance makes choosing to lead a healthy lifestyle even more rewarding because it offers you a science-based behaviour change programme that helps you keep track of your progress towards a healthier you. It then rewards you for making better choices with a range of health, lifestyle, and leisure benefits. Join **Balance** today.

INNOVATION, UNRIVALLED VALUE, AND QUALITY

Bankmed offers exceptional quality of care through carefully designed networks and Centres of Excellence, providing unrivalled Wellness and Preventative Care benefits, innovative digital tools, and access to a vast array of Disease Management Programmes designed to improve your health.

COMPETITIVE CONTRIBUTIONS

Contributions remain exceptionally competitive, whilst continuing to offer innovative and enhanced benefits and services each year.

POWERFUL DIGITAL TOOLS

Bankmed has created a digital world inside our website and Bankmed App bringing our members a superior user experience. Our digital tools and communication channels are expertly designed to provide seamless and effortless access to information, wellness benefits, rewards, and Healthcare Professionals.

35% MORE VALUE, BECAUSE YOU DESERVE MORE

Not all medical schemes are created equal. At Bankmed, we pride ourselves on offering our members an average of 35% more value due to lower contributions and/or richer benefits. This means you receive a superior member experience with consistently lower contributions, stable increases, and continuously enhanced benefits. We invest in you through innovative programmes like Hospital@Home, Advanced Illness Support, and Diabetes and Wellness Management, demonstrating our commitment to being there for you and your loved ones when you need us the most.

FINANCIAL STRENGTH AND SUSTAINABILITY: WE'VE GOT YOU COVERED

Choosing a medical scheme is not just about healthcare; it's about financial strength and sustainability. Bankmed's robust financial control and risk management ensure the Scheme maintains required solvency reserve levels, guaranteeing our ability to cover claims, even during unexpected peaks. A remarkable 94.98% of member contributions are dedicated to funding benefits.

SIX PLANS TO SUIT YOUR UNIQUE NEEDS

Bankmed offers a range of Plans to suit everyone's healthcare needs and pockets. Have a look at our Plan Comparison Tool and Find a Benefit Tool for more information.

AA+ GLOBAL CREDIT RATING: SOLID FOUNDATION FOR YOUR HEALTH

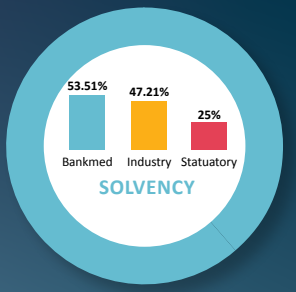
For fourteen consecutive years, Bankmed has been awarded the prestigious AA+ Global Credit Rating, a testament to our solid financial foundation. As one of the few closed medical schemes in South Africa with this rating, this allows us to provide you with more benefits and/or lower contributions compared to the market. Your financial wellbeing is as important to us as your physical health.

YOUR INVESTMENT IN MEMBERSHIP TAKES CARE OF YOU

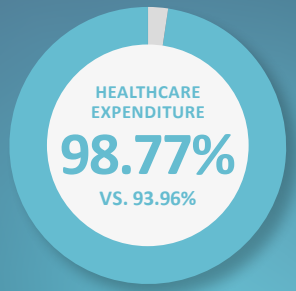
Bankmed operates as a non-profit organisation, solely funded by member contributions and investment returns. The Scheme pools all contributions to cover members' claims and any additional funds go into Scheme reserves for the security and benefit of our members. When setting contributions, we ensure they can cover all claims, generate a modest surplus for regulatory solvency, and provide a cushion against unexpected costs.

Bankmed gives you better benefits

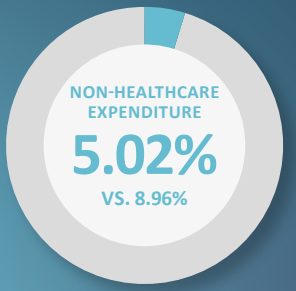
35% more value than the average comparable open scheme due to lower contributions and/or richer benefits



Bankmed's solvency ratio 53.51% *(as at 31 December 2022)* compared to the industry average of 47.21% *(CMS Annual Report 2023)*; 25% statutory requirement



Relevant healthcare expenditure, expressed as a percentage of risk contribution income, was 98.77% for 2022 *(as at 31 December 2022)* compared to the industry average of 93.96% *(CMS Annual Report 2023)*



Bankmed non-healthcare expenditure limited to 5.02% of gross contribution income *(as at 31 December 2022)* compared to the industry average of 8.96% *(CMS Annual Report 2023)*

We offer a variety of Plans to suit our members' healthcare needs and pockets

For fourteen consecutive years, Bankmed has been awarded the prestigious AA+ Global Credit Rating

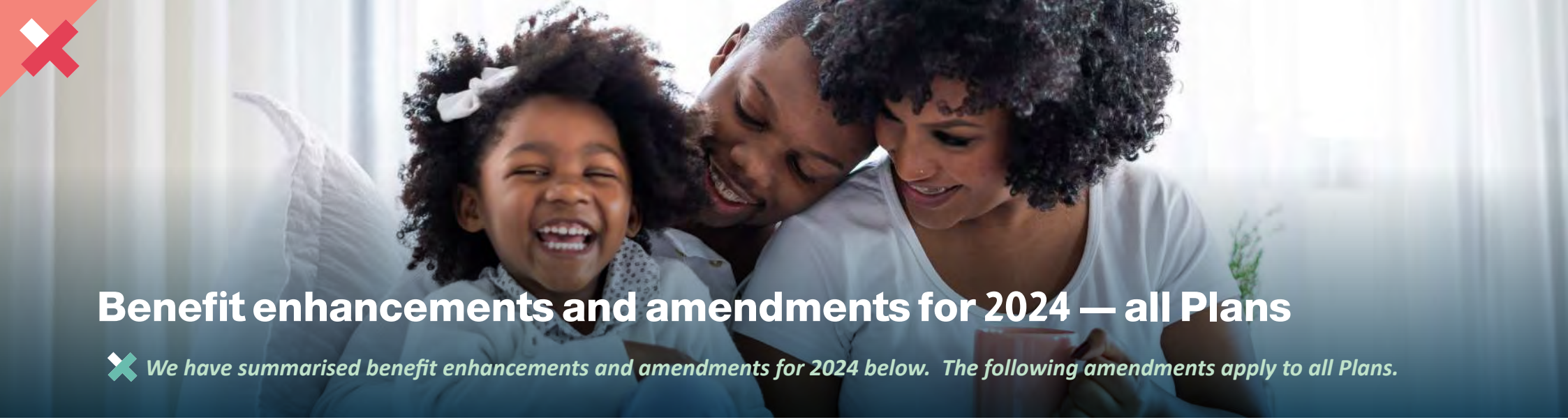
WHAT'S NEW IN 2024

2024 Contribution increases

Medical inflation, demographic changes, legislative requirements, and the performance of each Plan type all influence contribution increases.

On average, contribution increases have been limited to **8.5% across all Plans in 2024**, keeping contribution increases to a minimum while still improving benefits. Your individual Plan increase has been included in your Plan Guide.

Bankmed's contribution increases remain consistently more stable and lower than the industry average. This means you're still getting an average of 35% more value than the average comparable open medical scheme, thanks to better benefits and/or lower contributions.



Benefit enhancements and amendments for 2024 — all Plans

We have summarised benefit enhancements and amendments for 2024 below. The following amendments apply to all Plans.

BENEFIT LIMIT INCREASES

Benefit limits across our Plans will see an average increase of 5.5%, ensuring you have the coverage you need, when you need it.

ENHANCED POST-ENGAGEMENT WELLNESS MANAGEMENT PROGRAMME

If you are identified as a moderate- to high-risk member after completing the PHA, you will have access to two dietitian and two biokineticist consultations to support you in managing and improving your lifestyle and health.

- The benefit is being enhanced to include members with a BMI of ≥ 30.
- The dietitian consultation is being extended to 30 minutes for more personalised support.

DISEASE PREVENTION PROGRAMME

If you are identified as a member with a high risk of developing diabetes, you may be eligible for enrolment on the Disease Prevention Programme.

- The programme is designed to help you avoid progression to diabetes with the help of a clinical care team consisting of your Premier Plus GP, a dietitian, and a Bankmed Health Coach.
- The Bankmed Health Coach will support you with behavioural change for the duration of the programme.
- You have access to a Basket-of-Care for specified consultations and pathology tests.

ACCESS TO DIGITAL THERAPEUTICS — INTERNET-BASED COGNITIVE BEHAVIOURAL THERAPY (iCBT)

Digital therapeutics (DTx) is an emerging category of medical care where medical interventions (to treat, manage, and prevent a broad spectrum of diseases and disorders) are delivered directly to patients using evidence-based, clinically evaluated software (Digital Therapeutics Alliance).

- Introducing internet-based cognitive behavioural therapy (iCBT) for members diagnosed with depression, recommended by a Healthcare Professional . [1]
- Members must register on the Mental Health Care Programme to access this benefit.

NEW ONCOLOGY MEDICATION PHARMACY DSP

Bankmed has partnered with a leading Oncology Medication Pharmacy DSP to manage costs while ensuring comprehensive oncology benefits.

- Implementation in 2024, with no penalties for using a non-network pharmacy this year.
- A 20% co-payment applies to non-network pharmacies in 2025.

BANKMED DAY SURGERY DEDUCTIBLE

Bankmed's Day Surgery Network includes a defined list of contracted day surgery facilities and acute hospitals that provide day surgery facilities at day surgery rates.

- Benefit from our Day Surgery Network for 27 procedures without a deductible.
- Choose non-network facilities where a deductible of R4 100 per admission applies in 2024, increasing to R6 300 in 2025.

ADDITIONAL DAY SURGERY PROCEDURES

We've expanded our day surgery procedures, including eye procedures, gynaecological procedures, orthopaedic procedures, and more. The list of day surgery procedures is available in the Day Surgery section of this guide.

READMISSIONS BENEFIT

Hospital readmissions are increasing worldwide with up to 20%[2] of hospital patients being readmitted within 30 days of discharge. In South Africa readmission generally occurs within the first week of discharge.

- The Readmissions Benefit focusses on high-risk patients to prevent hospital readmissions for a defined list of conditions.
- Hospital Benefit Specialists (HBS) intervene during admission and discharge.
- Components of this benefit include homecare, Healthcare Professional's follow-up, and medication reconciliation within the first 10-14 days post-discharge.

SPINAL CONSERVATIVE CARE PROGRAMME

The programme is targeted at members who have had multiple consultations with a diagnosis of back pain, have been admitted for medical treatment for back pain or who are referred by their neurosurgeon or orthopaedic surgeon. In 2024, the benefit is being expanded to allow network GP referral for members with back pain.

[1] Where diagnosis and treatment of depression are within their scope of practice (psychiatrist, psychologist, GP, and clinical social worker).

[2] International Trend

Benefit enhancements & amendments for 2024: specific Plans

We have summarised specific benefit enhancements and amendments for 2024 according to Plan type

ESSENTIAL PLAN AMENDMENTS FOR 2024

New Advanced Illness Benefit (End-of-Life Care Benefit)

We are introducing the Advanced Illness Benefit (AIB) as part of your end-of-life care benefits. This provides comprehensive out-of-hospital benefits to manage your palliative care needs in the comfort of your home.

- Facilitates optimal palliative care through proactive care coordination.
- Offers high-touch, high-care benefits where our care coordinators support you and your family during vulnerable times.

New Advanced Illness Member Support Programme

The Advanced Illness Benefit (AIB) is complemented by the Advanced Illness Member Support Programme (AIMSP).

- Supports members facing advanced disease progression.
- Provides access to a team of social workers, counsellors, or palliatively trained GPs to assist you in understanding your illness, navigating appropriate care, and creating a personalised care plan.

Spinal Conservative Care Programme

This targeted programme is designed for members with back pain diagnoses.

- If you've had multiple consultations, medical treatment, or referrals related to back pain, you may qualify.
- Referral by your neurosurgeon, orthopaedic surgeon, or network GP.
- Receive treatment from a physiotherapist or chiropractor specialised in conservative back pain treatment, under the supervision of a specialist.
- Aims to minimise the risk of future back surgery.

BASIC PLAN AMENDMENTS FOR 2024

Access to Bankmed's Baby-and-Me Programme

Bankmed's Baby-and-Me Programme provides you with access to:

- Six ante-natal consultations per pregnancy.
- Three 2D ultrasounds per pregnancy.
- R1 690 per pregnancy for ante-natal and post-natal classes.
- Additional insured pathology benefits subject to the Baby-and-Me Programme Basket-of-Care.

Enhanced specialist benefits

We've boosted the Basic Plan Specialist sublimit, improving your access to specialist care when you are not in hospital. The limits are now as follows:

Out-of-hospital consultations and procedures in rooms		
	2023 Limit	**2024 Limit**
Single Member	R2 270	R4 260
Family	R3 550	R6 670

COMPREHENSIVE PLAN AMENDMENTS FOR 2024

Enhanced pathology limits

Insured Benefits for out-of-hospital pathology have increased substantially, with the limit doubling in 2024.

PLUS PLAN AMENDMENTS FOR 2024

ATB

The ATB and Annual Thresholds are increasing to provide you with even more coverage.

Annual Threshold			
	Member (M)	**Adult (A)**	**Child (C)**
Threshold Level	R24 600	R18 300	R6 100
Threshold Amount	R22 900	R17 200	R5 700

KEY FEATURES & PLAN OVERVIEWS

Plan	Wellness and Preventative Care Benefits Determine your risk, detect conditions early, and improve your health	Networks For full cover, PMBs, and other treatment	Major medical expenses and hospital cover	Chronic medication	PMBs
Plus Plan	• PHA • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Female contraception • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Herpes Zoster vaccine for members aged 60+ • Post-engagement Wellness Management Programme	• Bankmed GP Network • Bankmed Prestige A and B Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network	• Comprehensive cover for hospitalisation and most hospital care • Any private hospital • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 300% of the Scheme Rate	• R32 665 a year per member • We pay less for the medication you collect from pharmacies that are not in our network • You might have to pay part of the cost yourself	• We pay the full cost of PMBs for network Healthcare Professionals • Reduced benefits if you use Healthcare Professionals who are not in our network • You may have to pay part of the treatment cost yourself
Comprehensive Plan	• PHA • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Female contraception • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Herpes Zoster vaccine for members aged 60+ • Post-engagement Wellness Management Programme	• Bankmed GP Network • Bankmed Prestige A and B Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network	• Comprehensive cover for hospitalisation and most hospital care • Any private hospital • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 100% of the Scheme Rate	• R27 395 a year per member • We pay less for the medication you collect from pharmacies that are not in our network • You might have to pay part of the cost yourself	• We pay the full cost of PMBs for network Healthcare Professionals • Reduced benefits if you use Healthcare Professionals who are not in our network • You may have to pay part of the treatment cost yourself
Traditional Plan	• PHA • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Female contraception • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Herpes Zoster vaccine for members aged 60+ • Post-engagement Wellness Management Programme	• Traditional Plan Hospital Network • Bankmed GP Network • Bankmed Prestige A and B Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network	• Comprehensive cover for hospitalisation and most hospital care • Restricted hospital network • More extensive hospital network than the Essential and Basic Plans • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 100% of the Scheme Rate	• R25 300 a year per member • We pay less for the medication you collect from pharmacies that are not in our network • You might have to pay part of the cost yourself	• We pay the full cost of PMBs for network Healthcare Professionals • Reduced benefits if you use Healthcare Professionals who are not in our network • You may have to pay part of the treatment cost yourself

Plan	Wellness and Preventative Care Benefits Determine your risk, detect conditions early, and improve your health	Networks For full cover, PMBs, and other treatment	Major medical expenses and hospital cover	Chronic medication	PMBs
Core Saver	• PHA • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Female contraception • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Herpes Zoster vaccine for members aged 60+ • Post-engagement Wellness Management Programme	• Bankmed GP Network • Bankmed Prestige A and B Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network	• Comprehensive cover for hospitalisation and most hospital care • Any private hospital • Organ transplants and oncology treatment is limited to PMBs • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 100% of the Scheme Rate	• No overall limit, but benefits subject to Core Saver medication list (formulary) for PMB conditions only • We pay less for the medication you collect from pharmacies that are not in our network • You might have to pay part of the cost yourself	• We pay the full cost of PMBs for network Healthcare Professionals • Reduced benefits if you use Healthcare Professionals who are not in our network • You may have to pay part of the treatment cost yourself
Basic	• PHA • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Female contraception • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Herpes Zoster vaccine for members aged 60+ • Post-engagement Wellness Management Programme	• Basic Plan Hospital Network • Bankmed Entry Plan GP Network • Bankmed Entry Plan Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network • Bankmed Dental Network	• Comprehensive cover for hospitalisation and most hospital care from a restricted hospital network • Hospital network more limited than the Traditional Plan • Organ transplants, oncology treatment and renal dialysis, are limited to PMBs • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 100% of the Scheme Rate	• No overall limit, but benefits subject to CIB medication list (formulary) • Network Healthcare Professionals only • We pay less for the medication you collect from pharmacies that are not in our network • You might have to pay part of the cost yourself	• We pay the full cost of PMBs for network Healthcare Professionals • Reduced benefits if you use Healthcare Professionals who are not in our network • You may have to pay part of the treatment cost yourself
Essential	• PHA • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Herpes Zoster vaccine for members aged 60+ • Post-engagement Wellness Management Programme	• Essential Plan Hospital Network • Bankmed Entry Plan GP Network • Bankmed Entry Plan Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network	• Limited to PMBs from a restricted hospital network • Hospital network more limited than the Traditional Plan • Organ transplants, oncology treatment and renal dialysis, are limited to PMBs • Specific categories subject to rand limits • In-hospital procedures limited to PMBs	• No overall limit, but limited to PMBs • Covered at 100% of cost at Bankmed Entry Plan GP network • Subject to CIB medication list (formulary)	• We pay the full cost of PMBs for network Healthcare Professionals • Reduced benefits if you use Healthcare Professionals who are not in our network • You may have to pay part of the treatment cost yourself

MAXIMISING **YOUR PLAN'S BENEFITS**

Strategies for extracting the best value from your Plan and reducing out-of-pocket expenditure

USE BANKMED'S EXTENSIVE NETWORKS

- Look out for information in this guide to help you choose a network option wherever possible. This helps you avoid co-payments and helps your benefits last longer.

USE BANKMED'S 'FIND A HEALTHCARE PROFESSIONAL' TOOL

- Find a Healthcare Professional who has agreed to only charge you the Scheme Rate.
- We pay them in full.

SAVE YOUR MEDICAL SAVINGS ACCOUNT (MSA)

- Manage your MSA wisely.
- Strategise your spending and take advantage of our Wellness and Preventative Care Benefits that are paid by Bankmed to help your MSA last longer.

REGISTER ON THE CIB PROGRAMME

- Use chronic medication on our formulary list.
- Avoid using your day-to-day benefits by registering on the CIB for chronic medication. Use medication on the formulary list (where applicable) to ensure you don't pay co-payments.

BABY-AND-ME PROGRAMME

- Maximise your benefits with the Baby-and-Me Programme.
- If you're pregnant, consider enrolling in our Baby-and-Me Programme to preserve your out-of-hospital benefits for other medical treatments.

USE THE BANKMED DAY SURGERY NETWORK

- Extensive day surgery network.
- Use a facility in Bankmed's Day Surgery Network and avoid paying a deductible for a defined list of procedures and treatments.

JOIN OUR CARE PROGRAMMES

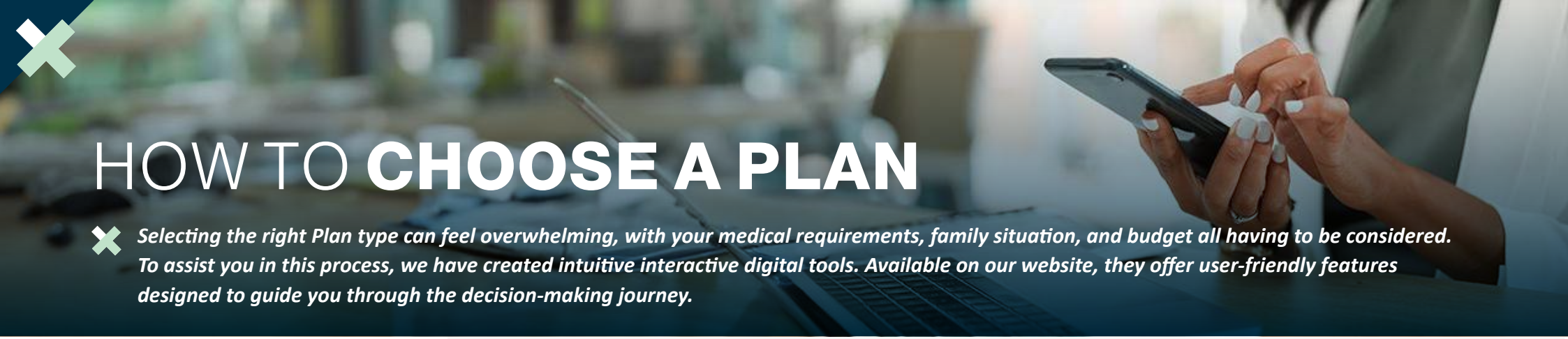
- Participate in our Care Programmes and Wellness Programmes.
- Bankmed's Disease Management Programmes, Care Programmes, Wellness and Preventative Care Benefits, and Chronic Baskets-of-Care provide benefits and support without using your day-to-day benefits.

OBTAIN PRE-AUTHORISATION BEFORE HAVING A PROCEDURE

- Confirm your benefits beforehand to avoid possible non-payment for a procedure or treatment.

AVOID DEDUCTIBLES

- The deductible is an upfront payment that you must pay to a hospital, day surgery or other healthcare facility before you can receive treatment. You must contact us to get pre-authorisation before you go to a day surgery or hospital for a procedure. Specific procedures can be performed in a day surgery instead of in a hospital.
- By using our Day Surgery Network, you can avoid having to pay a deductible.



HOW TO **CHOOSE A PLAN**

Selecting the right Plan type can feel overwhelming, with your medical requirements, family situation, and budget all having to be considered. To assist you in this process, we have created intuitive interactive digital tools. Available on our website, they offer user-friendly features designed to guide you through the decision-making journey.

DIGITAL TOOLS

PLAN COMPARISON TOOL

Compare Bankmed Plans.

Side-by-side tabular summary of three Plans' main benefits.

FIND A BENEFIT PLAN TOOL

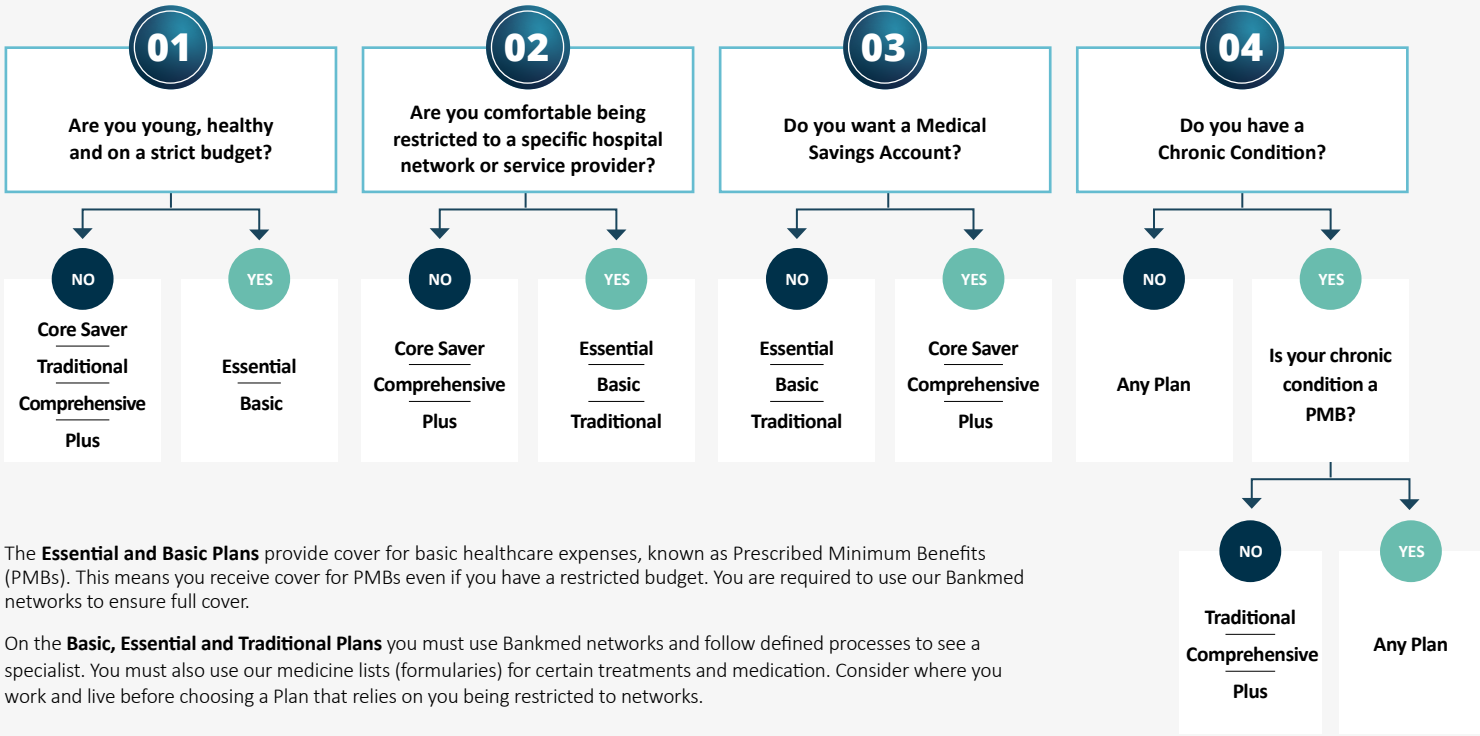
This tool was developed to assist members to better understand their benefits and how to select a Plan that best meets their needs. Plan selection and quote based on individual needs. This is not a comparison tool.

LOOK-UP PLAN BENEFITS TOOL

This page allows you to search the Benefit & Contribution Schedule to find details of the benefits provided. Plan-specific benefit table with limits presented in single web page. This is not a comparison tool.

WHAT TO CONSIDER WHEN CHOOSING A PLAN

Make sure your healthcare cover suits your needs and budget.This infographic gives a broad overview of things you need to keep in mind when choosing your Plan.



The **Essential and Basic Plans** provide cover for basic healthcare expenses, known as Prescribed Minimum Benefits (PMBs). This means you receive cover for PMBs even if you have a restricted budget. You are required to use our Bankmed networks to ensure full cover.

On the **Basic, Essential and Traditional Plans** you must use Bankmed networks and follow defined processes to see a specialist. You must also use our medicine lists (formularies) for certain treatments and medication. Consider where you work and live before choosing a Plan that relies on you being restricted to networks.

EMERGENCY **COVER**

What is a medical emergency?

The Medical Schemes Act provides the criteria for what qualifies as a medical emergency. To ensure full cover from us, a medical condition must meet the following criteria:

- It must have a sudden and unexpected onset.
- Immediate treatment, potentially including surgery, is necessary.
- Failure to receive immediate treatment could result in weakened bodily functions, serious organ damage, impairment of limbs or body parts, or even death.

If you experience a sudden health issue, it may be unclear whether it constitutes a medical emergency. To ensure coverage under the PMB, we may request evidence that the situation indeed qualified as a medical emergency.

ASSISTANCE DURING OR AFTER TRAUMA EVENTS

Should you experience a traumatic incident or find yourself dealing with the aftermath of trauma, know that dedicated assistance is available to you. By reaching out to Bankmed Emergency Services, you and your family can access 24-hour trauma support, including counselling and ambulance services.

Bankmed Emergency Services offers real-time emergency care for all members. Our 24/7 helpline is staffed by highly qualified emergency personnel who assess each case and provide immediate feedback and assistance.

If you require medically-equipped transport within South Africa, our Emergency Services will arrange for an ambulance or helicopter to transport you to hospital. This cost is covered by your Hospital Benefit, regardless of whether you are admitted. In an emergency you can obtain care at any hospital. We will cover your emergency hospital admission, even if it is not within our network.

WHAT WE COVER

We provide cover for all necessary medical services during emergencies, including:

- Ambulance or other forms of medical transport.
- Hospital expenses.
- Fees from the attending Healthcare Professional.
- Anaesthetist fees.
- Services provided by other approved Healthcare Professionals.

If you are admitted to hospital in an emergency, kindly reach out to us within 48 hours for authorisation.

PRESCRIBED MINIMUM BENEFITS (PMBs)

What are PMBs?

PMBs are essential medical services that medical schemes in South Africa are obligated to provide to all their members under the Medical Schemes Act number 131 of 1998. These benefits include the diagnosis, treatment, and ongoing care costs for life-threatening emergency medical conditions, a specified set of 270 medical conditions (defined in the Diagnosis Treatment Pairs), and 27 chronic conditions (defined in the CDL).

HOW BANKMED FUNDS PMBs AND NON-PMBs

- PMBs are covered in full from the Insured Benefit when treatment is received from a DSP.
- Treatment from non-DSPs may involve co-payments if charges exceed the funded amount.
- Non-PMB claims are funded from available day-to-day benefits according to the selected Plan.

IMPORTANT POINTS TO REMEMBER

- PMBs only apply to claims in South Africa. If you receive care or treatment outside of South Africa for a healthcare service that is listed as a PMB in South Africa, it will be treated as an ordinary claim and paid according to your Plan's benefits.
- To qualify for PMB cover, you must obtain pre-authorisation, use medication from our medication list (formulary), and receive the recommended treatment stated in your claim.
- Diagnostic tests or scans may not be covered as PMBs if they do not confirm that the medical condition being diagnosed is indeed a PMB.
- When this schedule sets out insured limits, we pay claims (including PMBs) up to the limit.
- Once the limit is reached, we will only pay for treatment as a PMB if you meet the criteria for cover.
- PMBs have specific conditions and treatment protocols, and exceeding limits may result in non-coverage.
- The CMS prohibits medical schemes from paying PMBs from your MSA. Once you register for a chronic PMB condition, we will not pay for treatment from your MSA.
- Even if we typically pay for care or treatment from your MSA or do not offer a particular benefit, we will still pay for PMBs if you meet the conditions for cover.
- Waiting periods may apply before accessing PMBs.

REQUIREMENTS FOR PMB COVERAGE

To benefit from PMBs, certain criteria must be met:

- The condition must be on the list of defined PMB conditions.
- The required treatment must match treatments in the defined benefits on the PMB list.
- Bankmed's DSPs should be used unless there is no applicable DSP for the selected Plan.

REGISTERING CHRONIC AND PMB CONDITIONS

- Members on Essential or Basic Plans need to register for out-of-hospital PMB or chronic conditions, by obtaining and submitting the prescribed form.
- Other Plans (Core Saver, Traditional, Comprehensive, and Plus) do not require application for in-hospital PMB cover.

WHAT CONDITIONS ARE COVERED AS PRESCRIBED MINIMUM BENEFITS?

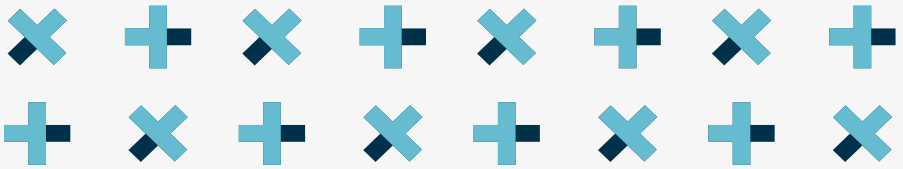
A Healthcare Professional must diagnose you with a condition within the list of 270 PMB diagnoses for us to cover your healthcare costs. This diagnosis must include the correct ICD-10 code for the condition.

For chronic medical conditions, we offer coverage through our CIB. If you are diagnosed with a chronic PMB condition, you must register before gaining access to cover. Failure to register will result in us paying for your treatment from your day-to-day benefits. Once authorised, cover is available from date of authorisation. Benefit authorisation will not be backdated.

The CDL specifies the medication and treatment for the 27 chronic conditions covered under the PMBs.

- Addison's Disease
- Epilepsy
- Asthma
- Glaucoma
- Bipolar Mood Disorder
- Haemophilia
- Bronchiectasis
- Hyperlipidaemia
- Cardiac Failure
- Hypertension
- Cardiomyopathy
- Hypothyroidism
- Chronic Renal Disease
- Multiple Sclerosis
- Chronic Obstructive Pulmonary Disease
- Parkinson's Disease
- Coronary Artery Disease
- Rheumatoid Arthritis
- Crohn's Disease
- Schizophrenia
- Diabetes Insipidus
- Systemic Lupus Erythematosus
- Diabetes Mellitus Type 1 & 2
- Ulcerative Colitis
- Dysrhythmias
- HIV/AIDS (anti-retroviral therapy)

You must obtain pre-authorisation, ensure your treatment follows clinical protocols, and register on our CIB to gain access to PMB cover. Failure to do so means your treatment will be funded from your day-to-day benefits. After reaching the limit for chronic medication, we will only provide funding for medication for PMB conditions, in accordance with PMB regulations.



AUTHORISATION AND FUNDING GUIDELINES FOR YOUR HEALTH CONDITIONS

It is important to obtain pre-authorisation before hospital visits or specific medical procedures. Only claims for procedures and consultations listed in the PMB treatment baskets will be paid from the CIB. These are pro-rated based on the approval date of your chronic condition.

If you have recently been diagnosed and approved for a CDL condition, we will fully cover the tests, procedures, and consultation in the diagnostic basket. This coverage is provided if you were an active and eligible member at the time of diagnosis, and the relevant ICD-10 diagnosis codes are included on the claim.

Ongoing management of your condition, involving Healthcare Professionals such as radiologists, dietitians, and podiatrists, is fully covered from the treatment baskets. Claims from pathologists are paid in full, up to the agreed rate or up to the Scheme Rate if there is no payment arrangement. Claims from Diabetes Educators are covered up to the agreed rate, subject to the limit and network Healthcare Professional criteria.

- **Plus Plan:** GP and specialist consultations are paid at agreed rates for network Healthcare Professionals.
- **Comprehensive Plan:** GP and specialist consultations are covered at the agreed rates for network Healthcare Professionals.
- **Traditional and Core Saver Plans:** coverage is up to the Scheme Rate.
- **Basic and Essential Plans:** consultations are paid at agreed rates for network Healthcare Professionals or up to the Scheme Rate if not part of the network.

Claims must have the appropriate ICD-10 diagnosis codes for correct processing. Ensure your Healthcare Professionals include these codes on claims and referral forms. Failure to do so may result in non-payment from the CIB.

Designated Service Providers (DSP)

A DSP is a Healthcare Professional with whom we have an agreement, otherwise referred to as a network or network Healthcare Professional. While you are allowed to use a non-DSP, please keep in mind that you may have to pay part of the claim yourself. By using DSPs, your PMB treatment is paid in full.

There are situations where we will pay for PMBs in full, even if you do not use a Healthcare Professional within our network, if you contact us for pre-authorisation beforehand. These situations include when the healthcare service is not available from someone in the Bankmed network, if there is an unreasonable wait for treatment or service, or if there is no network Healthcare Professional within reasonable proximity of your home or work.

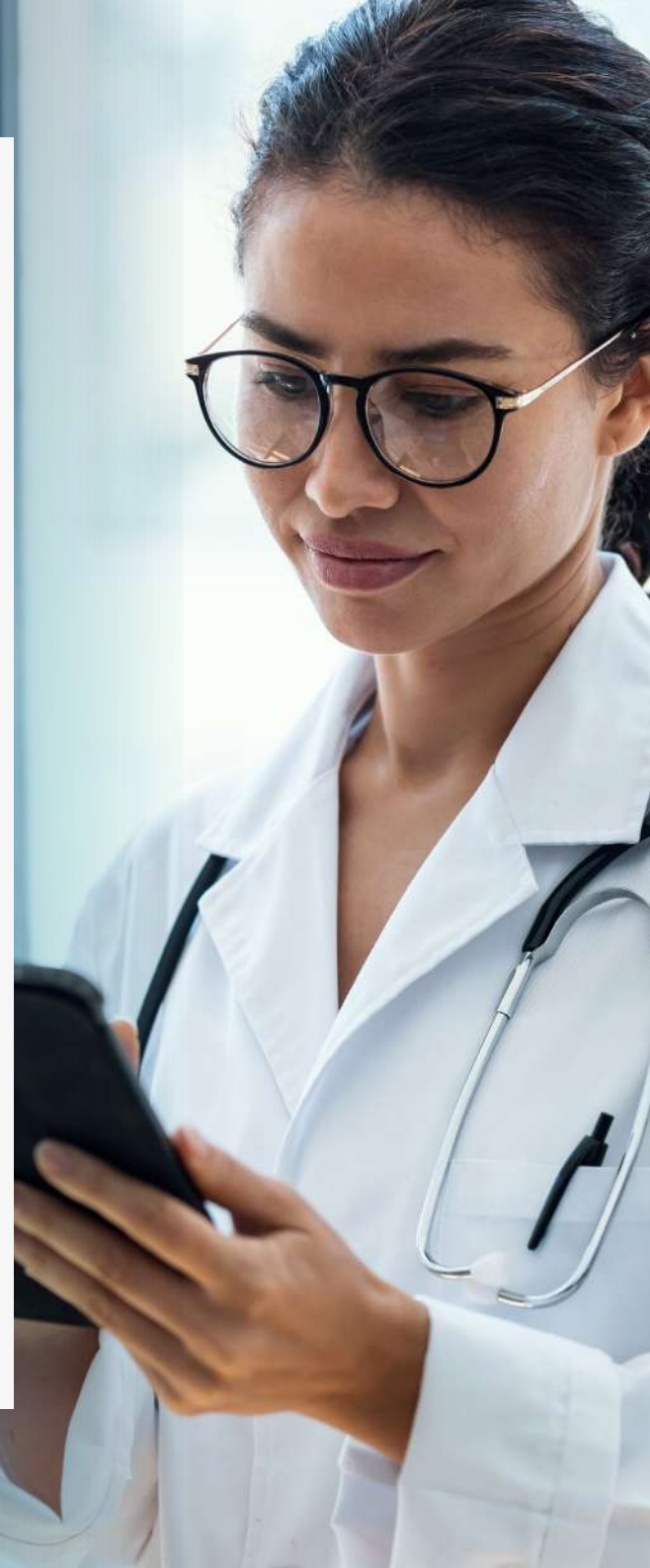
WHAT IF I CANNOT USE A DSP?

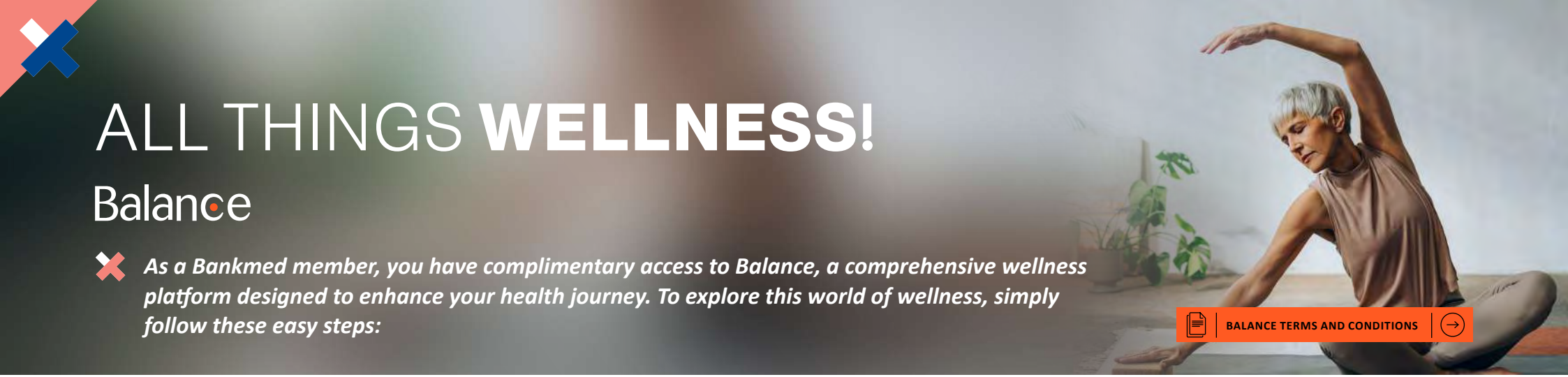
If you find yourself unable to use a network Healthcare Professional, please remember; in a medical emergency, head straight to the nearest hospital. For non-emergencies, it is recommended that you use a Healthcare Professional, pharmacy, or hospital in our network for PMB care to ensure full cover.

WHAT IF I CHOOSE TO USE A HEALTHCARE PROFESSIONAL THAT IS NOT IN THE NETWORK OR A DSP?

If it is not a medical emergency and a network Healthcare Professional (DSP) is available, and you choose to use a non-DSP, we will cover the diagnosis, treatment, and care of PMBs at the Scheme Rate.

Additionally, if you need to go to the hospital and it isn't a medical emergency, we will only cover claims if you contacted us and arranged pre-authorisation before being hospitalised.





ALL THINGS **WELLNESS!**

Balance

As a Bankmed member, you have complimentary access to Balance, a comprehensive wellness platform designed to enhance your health journey. To explore this world of wellness, simply follow these easy steps:

BALANCE TERMS AND CONDITIONS

1 KNOW YOUR HEALTH

- Start your health journey by completing the health assessments provided by Balance.
- These assessments are the first steps toward identifying areas for improvement and guiding you on the journey to better health.

2 IMPROVE YOUR HEALTH

- Use the Bankmed App to get personalised, weekly physical activity targets through the Active Rewards feature.
- Track your physical activity with a compatible fitness device, monitoring your progress towards the set weekly goals.

3 GET REWARDED

- As a valued Balance member, you qualify for a variety of rewards that recognise and celebrate your commitment to a healthy lifestyle.
- Rewards range from weekly incentives to exclusive discounts and savings, making your journey towards wellness both fulfilling and rewarding.

Balance focusses on incentivising your efforts to lead a healthier life through these three straightforward steps. The Bankmed App allows you to access and navigate the Balance platform, for a holistic approach to a healthier you.

Earn points by getting healthier

Earn points by getting active, eating well and doing all your health checks. You'll enjoy a variety of rewards at each status level and the healthier you get, the higher your Balance status.

	BLUE STATUS	BRONZE STATUS	SILVER STATUS	GOLD STATUS	DIAMOND STATUS
Single member	You start at Blue Balance status	7,500	25,000	40,000	50,000
Main member +1 member 18 years or older		15,000	50,000	80,000	100,000
Main member +2 members 18 years or older		18,750	62,000	100,000	125,000
For each additional member 18 years or older		+ 3,750	+ 12,500	+20,000	+ 25,000

All these points add towards reaching the next status level. You'll enjoy a variety of rewards at each status level and the healthier you get, the higher your status. At the start of every year, your points reset to zero, but you keep the rewards and status level that you earned the previous year. So, if you ended the year on Gold status, you start the new year on Gold status too. This is to encourage you to stay healthy year-on-year.

Your rewards in a snapshot

Balance makes a healthier lifestyle more accessible than ever before. Through the programme, you have access to a comprehensive network of healthy-lifestyle partners at significantly reduced costs.

Up to 15%
back on HealthyFood at Pick n Pay or Woolworths.

Pick n Pay
WOOLWORTHS

Up to 15%
back on thousands of HealthyCare items at Clicks or Dis-Chem stores.

CLICKS
Dis-Chem PHARMACIES

You get exclusive access to **Active Rewards** for free. Active Rewards is a free in-app wellness programme that encourages you to get active and rewards you for doing so.

Up to 15%
upfront discount on qualifying sports gear and equipment from Sportsmans Warehouse and Totalsports.

Sportsmans Warehouse winning starts here
TOTALSPORTS

30% off
your monthly gym fees from Virgin Active or Planet Fitness.

Virgin active
planetfitness

Up to 80% off
Allen Carr's Easyway To Stop Smoking.

Allen Carr's Easyway To Stop Smoking

Track your workouts through Active Rewards using your device and earn points for step count, heart rate and speed. You may link multiple devices to your profile, however, we'll only award points for the highest points-earning fitness and health activity for the day.

Activate your Balance benefit today, get healthy and get rewarded. Visit **www.balancesa.co.za** for more.

**Terms and conditions apply*

Important information about Balance:
Bankmed Medical Scheme (Bankmed), registration number 1279, is an independent non-profit organisation registered with the Council for Medical Schemes. Balance is a separate health-management and wellness product developed specifically for Bankmed, offered to its members at no extra cost, and is administered by Discovery Vitality (Pty) Ltd (Vitality), registration number 1999/007736/07. Neither Balance nor Vitality are part of Bankmed.

Active Rewards

As a Balance member, you get exclusive access to Active Rewards for free. Balance makes choosing to lead a healthy lifestyle even more rewarding. It offers you a science-based behaviour-change programme that helps you keep track of your progress towards a healthier you. All while rewarding you for making better choices with a range of health, lifestyle and leisure benefits.

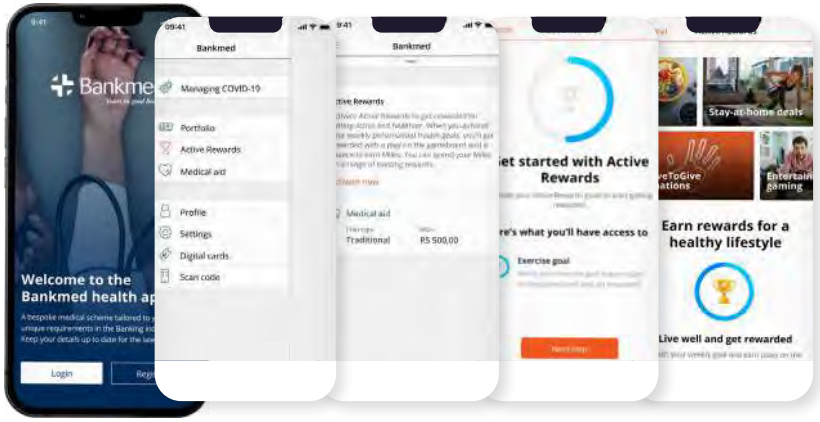
How Active Rewards works

Each week, you'll get a personalised exercise goal tailored to your unique fitness level.

When you achieve your exercise goal, you'll get a play on your gameboard to reveal Miles.

You can then redeem your Miles on a range of exciting rewards, from coffees, smoothies and snacks, to shopping and rewards.

Follow these steps to activate active rewards



Step 01
Log into the Bankmed App

Step 02
Select Active Rewards

Step 03
Click "Get Started"

Step 04
Get Active and start earning points

Step 05
Reach your personalised exercise goals to earn rewards

Wellness and Preventative Care benefits

We firmly believe that health is wealth, and the foundation of good health lies in understanding your health status. Regular screening plays a pivotal role in early detection of medical conditions, ensuring prompt and effective medical care for positive outcomes.

Optimal health is more than the absence of symptoms, as the body may hide early signs of a medical condition. Untreated conditions or symptoms overlooked without addressing the root cause can progress to a stage needing significant intervention, such as costly surgeries and intensive medical care. Our Wellness and Preventative Care Benefits provide members with access to crucial screenings for early diagnosis and preventative care.

Key Points Regarding Wellness and Preventative Care Benefits:

COVERAGE UNDER INSURED BENEFIT

- The Wellness and Preventative Care Benefits are covered by your Insured Benefit.
- These benefits do not deplete your out-of-hospital insured sub-limits or your MSA, where applicable.
- Using a DSP ensures that you do not incur any out-of-pocket expenses.
- This benefit excludes the cost of a consultation if billed by the Healthcare Professional. The consultation will be paid from your available day-to-day benefits.

ESSENTIAL SCREENING AND PREVENTATIVE CARE BENEFITS

- This benefit covers specific tests designed to detect early warning signs of serious illnesses.
- Screening tests include blood glucose, cholesterol, HIV, Pap smear for cervical screening, mammograms and/or ultrasounds, and prostate screenings.
- Tests are covered by the Screening and Preventative Care Benefit, ensuring proactive health management.
- Consultations not falling under PMBs are paid from available day-to-day benefits.

Our Wellness and Preventative Care Benefits give you the tools to proactively manage your health, ensuring early detection and intervention. These comprehensive screening benefits are part of our commitment to your long-term health.

We have summarised our screening benefits on the next page.

POSITIVE IMPACT OF WELLNESS INITIATIVES

- Beyond enhancing longevity and overall mental and physical wellbeing, wellness initiatives contribute to reducing healthcare costs.
- These initiatives lower absenteeism, boost productivity, decrease injuries, compensation, and disability-related costs.
- They foster a positive organisational culture by enhancing morale and loyalty.

Important:
It is important to note that the Wellness and Preventative Care benefits are a proactive screening intervention to prevent and assist with early detection of an underlying medical condition. Bankmed Medical Scheme and our Administrator, Discovery Health (Pty) Ltd make every effort to ensure treatment and Disease Management Programmes are available to you post-screening based on your Plan of choice. Therefore, the Scheme, the Administrator or any other Healthcare Professional cannot accept responsibility or be held liable for any consequences that may result from neglect, non-compliance, and non-adherence to treatment. Participation is voluntary and at your own risk and therefore, Bankmed Medical Scheme, the Administrator, or any other Healthcare Professional will not be liable for any loss, damage, liability, claim, expense, or injury suffered or incurred by any person as a result of their participation in our Wellness and Preventative Care screening benefits.

Wellness and Preventative Screening benefit summary

Lifestyle Screening

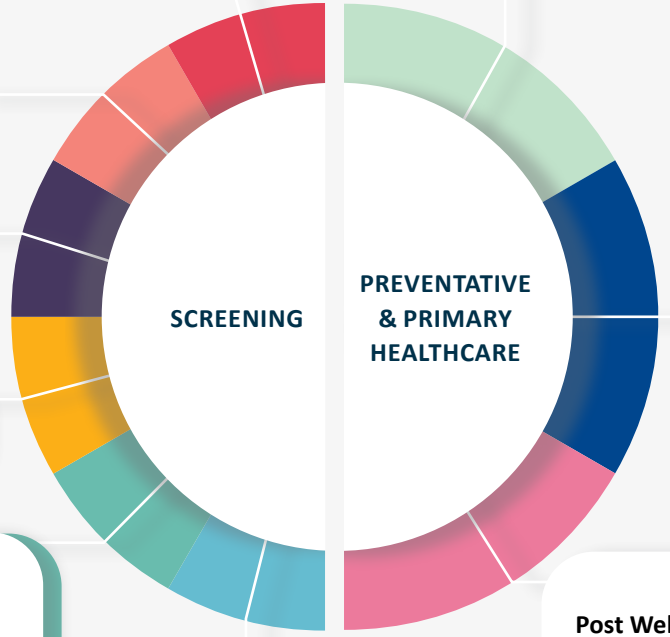
- Personal Health Assessment (PHA)
  - PHA measures health indicators like blood pressure, cholesterol, blood sugar, waist circumference, and BMI
- HIV Counselling and Testing (HCT)
- Bone Density

Primary Healthcare

- Three x nurse consultations
- Contraceptive Benefit (Family Planning)
- Intra-muscular Injection

Cancer Screening

- Mammogram
- Breast MRI
- Prostate-Specific Antigen (PSA)
- Faecal Occult Blood
- Pap Smear Pathology
- Pap Smear Consultation



Mental Health Screening

- Mental Wellbeing Online Assessment

Occupational Health Screening

- Tuberculosis (TB)

Vaccinations

- Flu Vaccination
- HPV Vaccination
- Pneumococcal Vaccine
- Herpes Zoster Virus Vaccine
- COVID-19 Vaccine
- Childhood Vaccines

Maternity & Newborn Screening

- Ultrasounds under the Baby-and-Me Programme
- Newborn Screening
  - Tests for the presence of certain metabolic and endocrine disorders
- Newborn Hearing Test
- Antenatal Screening
  - T21 Chromosome Test, or
  - Non-invasive Prenatal Testing (NIPT), or
  - Amniocentesis, to test for chromosomal abnormalities

Post Wellness Screening Programme

- PHA Basket (Bio & Dietician consult post PHA) – Medium- to High-Risk Members
- Lifestyle Preventative Screening – Cholesterol, BP & Blood Glucose
- Diabetes Management

World Health Organisation (WHO) Outbreak Screening

- COVID-19
  - COVID-19 Risk Assessment
  - COVID-19 Diagnostic PCR and Rapid Antigen screening test
  - Defined basket of x-rays and scans for COVID-19 positive members
  - Home monitoring device to track oxygen saturation levels for at-risk members
- Mpox
  - Mpox diagnostic PCR
  - Consultations with a dermatologist

As a Bankmed member you have access to health screenings as well as preventative and wellness benefits. Through preventative healthcare it is possible to diagnose underlying health issues before they become a risk.

WELLNESS TOOLKIT/EXPERIENCE

Day-to-day benefits and cover

We cover your day-to-day benefits from your Day-to-Day Insured Benefits, MSA and ATB, according to your Plan type.

WHAT ARE DAY-TO-DAY BENEFITS?

Day-to-day expenses include items such as medication, visits to your GP, X-rays, and blood tests.

- On the Plus, Comprehensive, and Core Saver Plans, we pay these expenses from your MSA.
- On the Traditional, Basic, and Essential Plans, we cover these expenses from the Insured Benefits, subject to limits.

WHAT ARE INSURED BENEFITS?

These are funded from the pool of member contributions, instead of using your personal MSA, if you have one.

MEDICAL SAVINGS ACCOUNT (MSA)

Available on Core Saver, Comprehensive and Plus Plans

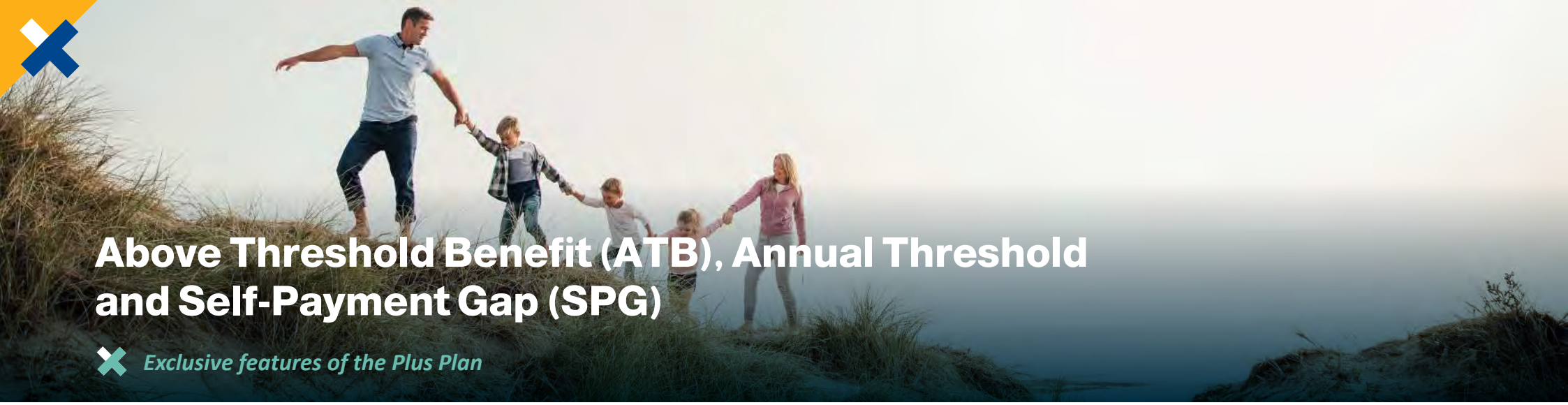
The MSA is used to pay for day-to-day medical costs like GP visits, X-rays (radiology), medication and blood tests.

At the start of each year, we give you full access to a yearly amount.

You pay the amount back without interest as part of your monthly contributions.

If you join Bankmed after 1 January 2024, we calculate your MSA amount for the rest of the year by multiplying the monthly amount you contribute towards your MSA, by the number of months left in the year.

If you leave Bankmed and have spent more of your MSA than what you have contributed during the year, you will need to pay a portion of the MSA back to Bankmed. We call this a clawback.



Above Threshold Benefit (ATB), Annual Threshold and Self-Payment Gap (SPG)

Exclusive features of the Plus Plan

ATB

- Provides cover for out-of-hospital treatment for Plus Plan members who reach the Annual Threshold.
- This is an Insured Benefit which is accessed only after reaching the Annual Threshold with specified limits.
- ATB offers additional cover when the yearly MSA amount is depleted.

ANNUAL THRESHOLD

- Calculated based on the number of dependants on the membership, limited to three children.
- We use the Scheme Rate instead of the cost of medication or treatment to calculate when you reach the Annual Threshold. When claims are paid at 100% of the Scheme Rate from your MSA and add up to the Annual Threshold, you can access the ATB.
- Claims at 100% of the Scheme Rate from the MSA contribute to reaching the Annual Threshold, unlocking the ATB.

SPG

- An SPG will occur when your MSA is depleted, and you have not yet reached your Annual Threshold.
- You will need to pay claims during the SPG from your own pocket, until the Annual Threshold is reached.
- You must continue to submit claims to the Scheme during this period as these will accumulate towards reaching the Annual Threshold.
- Remember that claims accumulate to the Annual Threshold at 100% of the Scheme Rate. However, you can choose to fund claims at cost from your MSA. If your Healthcare Professional charges more than the Scheme Rate, the difference between the claimed amount and the paid amount contributes to your SPG.

LIMITS TO AMOUNTS ADDING UP AND BENEFIT CATEGORIES

There is a limit to how much of your MSA you can use to pay for specific categories of treatments, which adds up to the Annual Threshold. Some of the categories are:

- Prescribed acute medication (short-term medication).
- Claims for tooth and gum care (including preventative and basic dentistry, advanced dentistry, and all other dental services).
- Optometry consultations, prescription lenses and ready-made readers, contact lenses, fitting of contact lenses and other eye care such as refractive surgery. Ask your Healthcare Professional about the available DSP lens options which are covered in full.

Your general limits for the categories can be more than the limits for the ATB. However, we do not pay out more than your family limit for the ATB.

IMPORTANT

Both the Annual Threshold and the ATB are pro-rated (reduced) if a member joins after 1 January each year. This is calculated by dividing the total Annual Threshold and ATB for the year by 12 and multiplying these amounts by the remaining number of months in the year. These amounts are recalculated when a dependant is added or removed during the year, or when a child dependant becomes an adult dependant (and will have to pay the rate for an adult dependant). There is no clawback (debt owing to the Scheme) on overspend on ATB if a dependant is removed or a member resigns during the year.

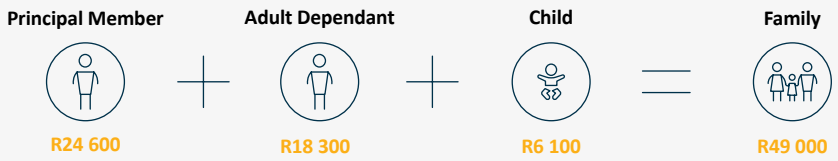
2024 ATB AND ANNUAL THRESHOLD

Annual Threshold			
	M	**A**	**C**
Threshold Level	R24 600	R18 300	R6 100
Threshold Amount	R22 900	R17 200	R5700

Limited to three children.

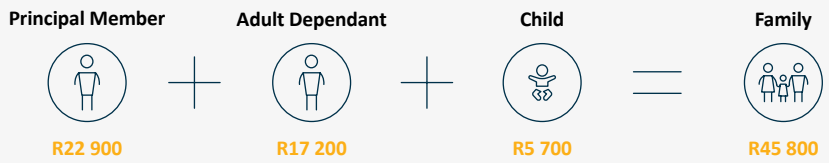
How to calculate the Annual Threshold

The Annual Threshold is a combined family threshold and is calculated by adding the threshold level amount for each family member together. See example below:



How to calculate the ATB

The ATB is a combined (family) limit and is calculated by adding the threshold amount for each family member together. See example below:



Day-to-day benefits and cover

DAY-TO-DAY BENEFITS PER PLAN

	Medical Savings Account (MSA)	Benefit Funding	How the Funding Works
Plus Plan	Yes	MSA ATB	• All day-to-day claims paid from your MSA until you reach the Annual Threshold. • Once you reach the Annual Threshold, you gain access to the ATB, which gives more cover if you have high out-of-hospital expenses. • This encompasses payments for GP and specialist consultations, procedures performed in rooms, acute medication (short-term prescriptions), blood tests (pathology), X-rays (radiology), basic dentistry (including dentist consultations, teeth cleaning, and fillings), advanced dentistry, orthodontics, hearing aids, and other specified categories. • Network Healthcare Professionals receive full payment. If you opt for a non-network Healthcare Professional, we pay up to the Scheme Rate, and you pay any shortfalls.
Comprehensive Plan	Yes	MSA	• Day-to-day claims are settled through your MSA, encompassing GP and specialist consultations, acute medication (short-term prescriptions), blood tests (pathology), and X-rays (radiology). Procedures performed by GPs or specialists in their rooms, as well as basic dentistry (including dentist consultations, teeth cleaning, and fillings), are funded from Insured Benefit with no set limits. • Coverage for advanced dentistry, orthodontics, hearing aids, and specific categories is limited under the Insured Benefit. Once this limit is reached, expenses are covered from the available funds in your MSA. • Network Healthcare Professionals receive full payment. If you opt for a non-network Healthcare Professional, we pay up to the Scheme Rate, and you pay any shortfalls.
Traditional Plan	No	Insured Benefits	• We pay day-to-day benefits from the Insured Benefit for GP and specialist consultations, acute medication (short-term medication), X-rays (radiology), blood tests (pathology), basic dentistry (including dentist consultations, teeth cleaning, and fillings), advanced dentistry and orthodontics, hearing aids, and other specified categories up to the Plan limits. • Unlimited cover from the Insured Benefit for procedures performed by GPs and specialists in their rooms. • Limited cover for an eye test, and glasses or contact lenses, every two years. • Network Healthcare Professionals receive full payment. If you opt for a non-network Healthcare Professional, we pay up to the Scheme Rate, and you pay any shortfalls.
Core Saver Plan	Yes	MSA Insured Benefits	• Unlimited cover for PMBs if you use GPs or specialists in our networks and get the recommended care for the condition. • Registration on the Chronic Illness Benefit is required for chronic conditions. • Two consultations for non-PMB conditions are covered by the Insured Benefit. Once exhausted, day-to-day benefits are covered from the available funds in your Medical Savings Account (MSA). • Available funds are utilized to cover non-PMBs, including dentistry, orthodontics, eye care, and acute medication (short-term prescriptions) prescribed by a Healthcare Professional. • Limited coverage from the Insured Benefit is available for acute medication prescribed by a pharmacist. • Network Healthcare Professionals receive full payment. If you opt for a non-network Healthcare Professional, we pay up to the Scheme Rate, and you pay any shortfalls.
Basic Plan	No	Insured Benefits	• Unlimited coverage for primary healthcare services, including GP consultations, acute medication (short-term prescriptions) listed on our medication formulary, and basic dentistry provided by Healthcare Professionals in our Dental Network (preferred provider). • Claims for basic dentistry administered by non-preferred providers or not listed on the formulary will not be reimbursed. No coverage is provided for advanced dentistry or orthodontic treatment. • Limited benefits for eye care are available through the Bankmed Optometry Network every two years. • Additional benefits are extended up to a specified limit when obtained from a Bankmed Entry Plan Network GP or upon referral by this GP to another Healthcare Professional within our network (supported by a referral letter). Network Healthcare Professionals receive full payment. If you opt for a non-network Healthcare Professional, we pay up to the Scheme Rate, and you pay any shortfalls.
Essential Plan	No	Insured Benefits	• Cover limited to PMBs

MATERNITY BENEFITS

Cover for pregnancy and childbirth

IN-HOSPITAL COVER GUIDELINES

Hospitalisation and associated in-hospital services require pre-authorisation. Failure to obtain pre-authorisation may result in the loss of benefits or incurring co-payments.

- Hospitalisation and associated in-hospital services require pre-authorisation. Failure to obtain pre-authorisation may result in the loss of benefits or incurring co-payments.
- You must use a DSP to ensure full coverage at the contracted rate. If you do not use a DSP, claims may not be paid in full. Prior authorisation for admission is essential, and you should contact us at 0800 BANKMED (0800 226 5633).

Maternity benefits covered by Bankmed

- Midwife care and delivery.
- Birthing facilities as an alternative to hospitalisation.
- Cost of disposables are limited to R1 375 for each case.
- Out-of-hospital cover includes certain pregnancy-related expenses based on your Plan benefits.
- Antenatal and post-natal care includes services of GPs, specialist consultations, and procedures performed in the Healthcare Professional's rooms.
- Ultrasonic investigations are limited per Plan type.
- Pathology tests.
- Newborn screening test:
  - Available to all newborns to detect certain metabolic and endocrine disorders.
  - Clinical entry criteria and Plan limitations apply.
- Newborn hearing test:
  - Funding only covers the test, provided by a registered Audiologist.
- Plan limitations apply.
- T21 chromosome test or non-invasive prenatal test (NIPT):
  - Clinical entry criteria and Plan limitations apply; applicable to high-risk beneficiaries aged 35 years and older at delivery.
  - If a T21 test is positive, the Healthcare Professional may refer for NIPT, and Bankmed will fund both tests, subject to pre-authorisation.
- Amniocentesis:
  - Clinical entry criteria and Plan limitations apply.
  - Any registered pathologist may perform the test, subject to gynaecologist referral.

Items not covered

Items not covered:

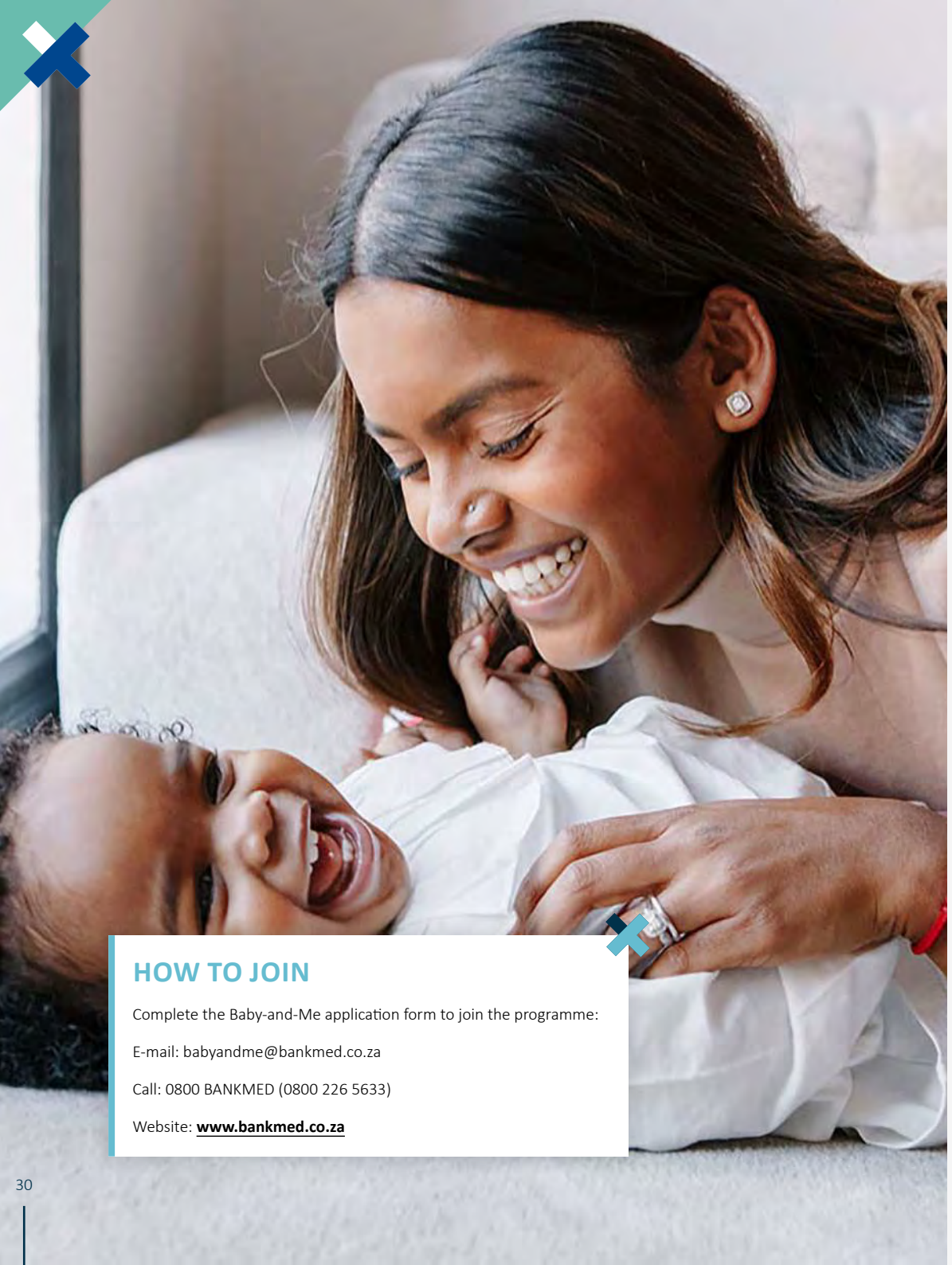
- Mother and baby packs supplied by the hospital.
- Bed-booking fees required by certain hospitals.
- Lodger or boarder fees if your baby needs an extended stay in the hospital and you choose to stay on.

Additional Insured Benefits

Additional Insured Benefits are subject to registration on the Bankmed Baby-and-Me Programme.

Important:

Please refer to the Plan Tables for specific limitations and requirements pertaining to maternity benefits on your Plan.



HOW TO JOIN

Complete the Baby-and-Me application form to join the programme:

E-mail: babyandme@bankmed.co.za

Call: 0800 BANKMED (0800 226 5633)

Website: **www.bankmed.co.za**

BANKMED'S BABY-AND-ME PROGRAMME

Bankmed's dedicated maternity programme, Baby-and-Me, offers enhanced coverage for pregnancy and childbirth. Access to this programme is exclusive to members on the **Basic, Core Saver, Traditional, and Comprehensive Plans.** Unfortunately, members on the Essential and Plus Plans are not eligible for the additional coverage provided by the Insured Benefit.

Key benefits and reasons to join

- Additional coverage from the Insured Benefit during pregnancy, for services such as ultrasounds and consultations.
- Guidance and support from a client relationship manager throughout your pregnancy and postpartum period.

Upon registration, you receive:

- A Bankmed baby hamper*, redeemable at any Toys R Us or Babies R Us store nationally.
- Extra coverage beyond the standard benefits.
- Regular communication at different milestones throughout your pregnancy.
- Assistance with hospital pre-authorisation.
- A comprehensive hospital checklist to prepare you for your hospital stay.

**Note: The contents of the Bankmed baby hamper are subject to change without notice, based on stock availability.*

Additional Insured Benefits

Additional Insured Benefits are subject to registration on the Bankmed Baby-and-Me Programme. All additional Insured Benefits require a referral from a GP within the Bankmed GP Network.

Coverage details for Basic, Core Saver, Traditional, and Comprehensive Plans

Coverage Details for Basic, Core Saver, Traditional, and Comprehensive Plans

- Six antenatal consultations per pregnancy at applicable rates for both GP and specialist in-room consultations.
- Three 2D ultrasounds covered at 100% of the Scheme Rate.
- A reimbursement of R1 690 (per pregnancy) for antenatal and postnatal classes.
- Additional pathology tests covered at 100% of the Scheme Rate.

HIV NUTRITIONAL & MOTHER-TO-CHILD FORMULARY →

CHRONIC ILLNESS BENEFIT

You are covered for 27 chronic conditions (including HIV and AIDS).

You must register on the CIB. Once approved we will start paying for your chronic medication.

If you do not register, we pay for your chronic medication from your day-to-day benefits.

MEDICINE ADVISORY SERVICES

Core Saver, Traditional, Comprehensive and Plus Plans

Our aim is to provide structure and make sure your chronic medication works for you. We provide an efficient pre-authorisation process for you when taking chronic medication and combine advanced technology with pharmacological and medical expertise to assess applications for medication in line with clinical guidelines.

HOW TO REGISTER

We ask your treating Healthcare Professional about your medical condition and may require test results or additional proof to confirm that your medical condition qualifies for cover.

Core Saver, Traditional, Comprehensive or Plus Plans

To get authorisation for immediate chronic medication, your Healthcare Professional or pharmacist can contact Bankmed on 0800 13 23 45. Alternatively, ask your treating Healthcare Professional to fill in a registration form. E-mail the completed form to chronic@bankmed.co.za or fax it to 011 770 6247.

Essential and Basic Plans

Ask your treating Healthcare Professional to fill in a registration form. E-mail the completed form to chronicbasicessential@bankmed.co.za or fax it to 011 539 7000.

TIPS FOR EXTENDING YOUR BENEFITS

When you apply to join the CIB, and Bankmed reviews your application, we suggest that your treating Healthcare Professional prescribes the generic version of the medication.

Using generics can reduce the cost of your claim, make your benefits last longer and reduce the risk of having to pay a co-payment at the pharmacy. By law, only you and your treating Healthcare Professional can decide what treatment is best for you. We will not change your medication without your Healthcare Professional's permission.

Essential and Basic Plans

You must use medication on our medication list (formulary) for it to be covered. Please speak to your Healthcare Professional and consult the Bankmed website or App to check if the medication is on our formulary.

Core Saver, Traditional, Comprehensive and Plus Plans

Should the medication you require not be included in our approved medication list (formulary), you may be responsible for a portion of the expenses, even if it is a generic drug. Please speak to your Healthcare Professional and consult the Bankmed website or App to check if the medication is on our formulary.

CHOOSE MEDICATION WISELY

As per the International Generic Pharmaceutical Alliance, generics are 20 to 90 percent more cost-effective than original medications. When obtaining your medication from the pharmacy, ask your pharmacist about the availability of a generic option and its associated costs. You can save further by choosing a single medication that addresses multiple symptoms. For instance, a specific type of medication may effectively relieve a runny nose, congestion, and headache.

What is generic medication?

A generic medication consists of identical active ingredients to the original, but is presented in distinct packaging. It shares the same dosage, strength, quality, performance characteristics, and intended use as the original product. Generally, generics are more affordable than the original medication. The higher cost of the original is due to exclusive selling rights held by the developing company immediately after production. Generics become available when the patent expires, allowing other companies to produce the medication.

Medications prescribed for the treatment of the PMB conditions are paid at 100% of the Scheme Medication Reference Price, when the medication is obtained via the Scheme's DSP (Bankmed Network GP and Bankmed Pharmacy Network). This medication is paid at 80% of the Scheme Medicine Reference Price when the medication is obtained via a non-DSP on a voluntary basis. If the medication is obtained via a non-DSP on an involuntary basis, the medication will be funded at cost, subject to the Scheme's review of a valid motivation. Medication is subject to the Scheme's approved Condition Medication List (CML).

The CDL covers specific conditions

The CDL specifies the medication and treatment for the 27 chronic conditions covered under the PMBs. This list applies to all members on all Bankmed Plans.

- Addison's Disease
- Epilepsy
- Asthma
- Glaucoma
- Bipolar Mood Disorder
- Haemophilia
- Bronchiectasis
- Hyperlipidaemia
- Cardiac Failure
- Hypertension
- Cardiomyopathy
- Hypothyroidism
- Chronic Renal Disease
- Multiple Sclerosis
- Chronic Obstructive Pulmonary Disease
- Parkinson's Disease
- Coronary Artery Disease
- Rheumatoid Arthritis
- Crohn's Disease
- Schizophrenia
- Diabetes Insipidus
- Systemic Lupus Erythematosus
- Diabetes Mellitus Type 1 & 2
- Ulcerative Colitis
- Dysrhythmias
- HIV/AIDS (anti-retroviral therapy)

You must obtain pre-authorisation, ensure your treatment follows clinical protocols, and register on our CIB for PMB cover. If you do not, your treatment will be funded from your day-to-day benefits. After reaching the limit for chronic medication, we will only provide funding for medication for PMB conditions, in accordance with PMB regulations.

Additional Disease List (ADL): Applies to Traditional, Comprehensive and Plus Plans

Prescribed medication will be covered in terms of the Scheme rules of the above mentioned Plans' ADL if the required criteria are met:

- Acne
- Allergic Rhinitis
- Ankylosing Spondylitis
- Anxiety Disorder (Chronic)
- Atopic Dermatitis (Eczema)
- Attention deficit disorder
- Cystic Fibrosis
- Depression
- Gastro-oesophageal reflux disease
- Gout
- Motor neuron disease
- Osteoarthritis
- Osteoporosis
- Paget's disease
- Psoriasis
- Alzheimer's Disease (covered on Comprehensive and Plus Plans only)
- Meniere's Disease (covered on Comprehensive and Plus Plans only)
- Interstitial Lung Fibrosis (covered on Comprehensive and Plus Plans only)

Benefits for chronic medication, drugs, and injection material subject to:

- Prior application and approval by the Scheme.
- The conditions applicable to the Medicine Management Programme.
- Each prescription or repeat prescription being limited to one month's supply per beneficiary.
- Such motivations and reports by appropriate Healthcare Professionals, as are required by the Scheme.
- PMB regulations.
- Scheme-approved Condition Medication List (CML).

Dispensing fee limited to the contracted dispensing fee applicable to Bankmed GP Network GPs and Bankmed Pharmacy Network (DSPs). Continued benefits for PMBs, subject to PMB Regulations. Benefits for non-PMB conditions are detailed in the applicable annexures, subject to PMB Regulations.

Additional Disease List (covered on the Basic Plan only)

- Major Depression

Medication prescribed for the treatment of the PMB conditions are paid at 100% of Scheme Medicine Reference Price when the medication is obtained via the Scheme's DSP (Bankmed GP Entry Plan Network GP and Bankmed Pharmacy Network). This medication is paid at 80% of the Scheme Medicine Reference Price when the medication is obtained via a non-DSP on a voluntary basis. If the medication is obtained via a non-DSP on an involuntary basis, the medication will be funded at cost, subject to Scheme's review of a valid motivation. Medication is subject to the Scheme's approved Formulary/Condition Medication List.

Benefits for chronic medication, drugs, and injection material subject to:

- Prior application and approval by the Scheme.
- The conditions applicable to the Medicine Management Programme.
- Each prescription or repeat prescription being limited to one month's supply per beneficiary.
- Such motivations and reports by appropriate Healthcare Professionals, as are required by the Scheme.
- PMB regulations.
- Scheme-approved Formulary/Condition Medication List.

Dispensing fee limited to the contracted dispensing fee applicable to Bankmed GP Entry Plan Network GPs and Bankmed Pharmacy Network (DSPs).

BANKMED'S **CARE PROGRAMMES**

SPINAL CONSERVATIVE CARE PROGRAMME

Overview

Back pain is one of the most common medical conditions experienced by our members. Appropriate out-of-hospital conservative management for back pain has proven to deliver good outcomes and could prevent the need for surgery. This programme will help you manage your condition with the support of a network of Healthcare Professionals that specialise in the treatment and rehabilitation of back and neck pain. The Spinal Conservative Care Programme is available on all Bankmed Plans from 2024.

Access to the programme subject to clinical entry criteria

There are two ways in which you could qualify as a possible candidate for the Spinal Conservative Care Programme:

- If you meet clinical entry criteria after a recent hospital stay or request for a spinal-related hospital admission and are deemed to be at high risk for spinal surgery. You are then eligible for an assessment, which will be performed by a chiropractor or physiotherapist in the conservative care network.
- If a GP refers you to a Spinal surgeon in the conservative care network, and the surgeon recommends you for non-surgical conservative treatment.
- The Healthcare Professional will enrol you on the programme using HealthID if you meet the clinical entry criteria after assessment .

For your chosen Healthcare Professional to view your medical records on HealthID you must give consent for them to access your Electronic Health Record, under 'Digital Tools' and 'Provide Your Doctor Consent'. Through the programme, you and your treating Healthcare Professional can agree on key goals and track your progress.

Your Chiropractor or Physiotherapist will work with you to manage your condition

The Spinal Conservative Care Programme gives you access to a defined Basket-of-Care for consultations with a network of conservative care Healthcare Professionals over a period of six to 12 weeks. These sessions can be conducted face-to-face or through the Bankmed Connected Care online platform. You can choose to consult either a network Physiotherapist or a network Chiropractor for your treatment.

Your treating Healthcare Professional will decide what is best for you and your condition. Once enrolled, we cover the consultation fee with your Healthcare Professional in full — this will not affect your day-to-day benefits, where applicable. Any additional conservative healthcare services outside of the sessions approved as part of the defined Basket-of-Care, will be covered in accordance with the benefits on your chosen Plan.

Find a Physiotherapist or Chiropractor in the network

1. Bankmed Website

On the Bankmed website **www.bankmed.co.za** under 'Digital Tools' go to 'Find a Healthcare Professional'. Type in the name or category of Healthcare Professional you would like to find closest to you e.g. Physiotherapist, and your address and select the 'Search' icon. To filter your results for Physiotherapists or Chiropractors in the Spinal Conservative Care Programme, select Care Programmes under the search filters, and tick the box for 'Spinal Conservative Care'.

2. Log on to your Bankmed App

On the Bankmed App, navigate to 'Digital Tools' and go to 'Find a Healthcare Professional'. Type in the name or category of Healthcare Professional you would like to see e.g. Chiropractor. Select 'Filters', then 'Care Programmes', 'Spinal Conservative Care' and then navigate back to the search page and select 'Apply'.

Your cover on the programme

If you are enrolled on the Spinal Conservative Care Programme:

- Any additional conservative healthcare services, outside of the sessions approved as part of the defined Basket-of-Care, will be covered in accordance with your chosen Plan benefits.
- If you change conservative care network Healthcare Professionals, we continue counting the sessions from where you left off with your first Healthcare Professional. Your cover does not reset with the new Healthcare Professional.
- If you stop the programme, we do not pay further costs.
- Where clinically appropriate, your conservative care network Healthcare Professional can refer you for further assessment with a network Spinal surgeon. If you need to have surgery, the Spinal Conservative Care Programme will end.
- You are eligible for the Spinal Conservative Care Programme only once per year, even if your condition recurs or a new area of concern arises.
- If you have had spinal surgery in the past 24 months, you do not qualify for the programme.

ADVANCED ILLNESS BENEFIT (AIB)

The AIB provides access to comprehensive palliative care for members who have an advanced illness. A multidisciplinary team provides care in the comfort of the member's own home or in a hospice facility. The AIB is available on all Plans in 2024.

ENROLLING IN THE AIB

Your Healthcare Professional is responsible for initiating your enrolment in the AIB. To begin the registration process, they need to complete the AIB application form, available on our website **www.bankmed.co.za** and e-mail it to **AIB@bankmed.co.za**. Please be aware that access to the AIB is voluntary and you must meet certain clinical entry criteria.

KEY FEATURES OF THE AIB

The AIB is designed to provide funding for palliative care for members in advanced stages of illness, specifically where curative treatment has ceased. The benefit includes a comprehensive palliative care plan aimed at treating symptoms related to the illness. Once your application is approved, you gain access to the benefits offered by the AIB.

BENEFITS OVERVIEW

Support from a dedicated care coordinator:

Upon registration, a registered nurse, serving as a dedicated care coordinator, will liaise with you or your family member. This coordinator offers support, collaborates with your GP and/or specialist, and ensures optimal care.

Personalised support and counselling:

Members and their families enrolled in the AIB receive access to counselling services to provide essential support during challenging times.

Comprehensive home-based care:

Those registered on the AIB qualify for personalised home-based services, including medical care by palliative care-trained Healthcare Professionals, rental of home oxygen concentrators, pain management, psychosocial support, and limited bereavement counselling for the family.

Specialised telephonic support:

Enrolled members can contact 011 529 6797 during working hours for assistance with AIB-related authorisations, oxygen, or benefit and claims-related inquiries.

COVER DETAILS

- The AIB covers services provided by a multidisciplinary team and will not impact day-to-day benefits. Payments are made at the Scheme Rate from your Hospital Benefit.
- Palliative care services must be provided by registered Healthcare Professionals with valid Board of Healthcare Funders (BHF) registration numbers (practice number) and appropriate tariff codes for services.
- Ensure that accounts contain the relevant and correct ICD-10 codes (diagnosis codes) for palliative care, to facilitate seamless claims processing.

NOMINATION AND ASSISTANCE

- You have the option to nominate someone to assist in managing your medical aid by completing a **Third-Party Consent** application form available on **www.bankmed.co.za**

ADVANCED ILLNESS MEMBER SUPPORT PROGRAMME (AIMSP)

The primary goal of the AIMSP is to afford members with advanced diseases the opportunity to engage with a team comprising a social worker, counsellor, and palliatively-trained GP. This team is dedicated to aiding members in understanding their illness, navigating appropriate care avenues, and devising a personalised care plan. Research indicates that initiating discussions about care plans at an earlier stage significantly enhances the likelihood that members will seek and receive suitable end-of-life care when needed.

DISEASE PREVENTION PROGRAMME

The Disease Prevention Programme aims to enhance access and quality of care, anticipating improvements in health outcomes. All adult dependents on all Plans are eligible – they are identified proactively after completing a PHA. If you are identified as a member with a high risk of developing diabetes, you may be eligible for enrolment on the Disease Prevention Programme.

Enrolment process

Our predictive model uses your PHA results, health claim patterns, family history and other relevant information to determine if you are at risk of developing diabetes. Eligible members are contacted by a Health Coach and referred to a Premier Plus GP for risk confirmation. If you are one of these eligible members, and you are referred to your Premier Plus GP, your Premier Plus GP will register you on HealthID, and refer you to a Dietitian. The programme's clinical care team – the Premier Plus GP, Dietitian, and Health Coach – will support you in preventing Diabetes progression.

The Health Coach will support you with behavioural change for the duration of the programme. You will also be granted access to a Basket-of-Care for specified consultations and pathology tests.

Cover is subject to the Scheme's clinical entry criteria, treatment guidelines, protocols, and preferred providers (where applicable) and is paid up to a maximum of the Scheme Rate.

KIDNEY CARE PROGRAMME

Chronic kidney disease manifests when the kidneys operate below expected levels, impacting crucial functions such as waste excretion, electrolyte balance, and hormone production. This condition can be congenital (you were born with it) or acquired due to factors like high blood pressure, diabetes, HIV, or ageing. Chronic kidney disease often progresses silently, without prominent symptoms. Diagnosis typically occurs at advanced stages, hindering early intervention.

How to register

If you are diagnosed with kidney disease, you must apply for Bankmed's CIB. The application form must be completed by your treating Healthcare Professional and can be returned to Bankmed via e-mail or via HealthID.

Cover for Renal Dialysis services

Coverage for renal dialysis services varies based on your chosen Plan type and is payable up to the Scheme Rate. By using Healthcare Professionals in the dialysis network, you can ensure full coverage and avoid co-payments. However, you can receive dialysis at any dialysis Healthcare Professional. We will pay your claims up to the Scheme Rate if you have pre-authorised your treatment.

Kidney Care Programme

Recognising the challenges of managing chronic kidney disease, Bankmed's Kidney Care Programme aligns with international best practice for enhanced care and quality of life. The programme benefits include:

- A calendar-based blood test schedule
- Yearly reports with essential clinical information
- An informative booklet for understanding and managing the condition
- Additional support

CARDIO CARE PROGRAMME

What is Cardiovascular Disease

Cardiovascular disease (CVD) is a leading cause of death globally. Individuals at risk of CVD may have raised blood pressure, raised glucose levels, high cholesterol or be overweight or obese. Four lifestyle factors increase the risk of fatal complications of CVDs: tobacco use, physical activity, an unhealthy diet, and increased alcohol use.

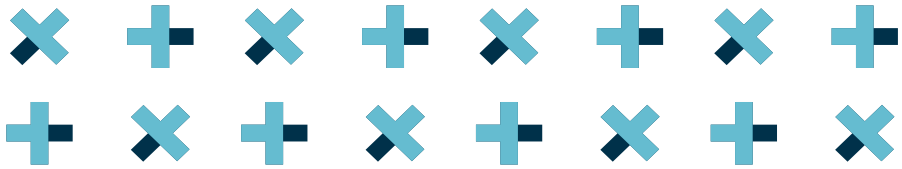
The Cardio Care Programme

The Cardio Care Programme is designed to offer you optimal cover that ensures the best quality care and outcomes. The Cardio Care Programme enables your Premier Plus GP to diagnose and initiate appropriate treatment, while managing your risk factors with the support of a high- functioning, multidisciplinary care team. To access the programme, you must consult with a Premier Plus GP and be registered for at least one of the following conditions as part of the CIB:

- Hypertension
- Ischaemic heart disease
- Hyperlipidaemia.

Note to Basic Plan members

You must choose a Healthcare Professional who is on both the Bankmed Entry Plan and Premier Plus GP networks.



COVER **FOR CANCER**

Bankmed's Oncology Programme: accessing cancer treatment coverage

If you receive a cancer diagnosis and your cancer treatment is approved, the Oncology Programme provides comprehensive coverage. To benefit from this offering, you must enrol on the Oncology Programme.

THE SCHEME COVERS APPROVED AND REGISTERED TREATMENT METHODS AND MEDICATION

The Scheme provides coverage for treatment methods and medications that are approved and registered. Cover excludes cancer treatment and related services that lack approval. Unapproved or unregistered medications and treatments, as determined by the South African Health Products Regulatory Authority (SAHPRA), are not covered by the Scheme. This includes treatments that haven't undergone sufficient testing and includes herbal or traditional remedies. In unique circumstances where members may require such treatments, the Scheme allows for requests through an exception management process.

COVERAGE DETAILS ACCORDING TO PLAN

Essential, Basic, and Core Saver Plans

- Cover is extended only for approved PMB cancer treatments.
- Submission of your treatment Plan is required for cover approval.

Traditional, Comprehensive, and Plus Plans

- Unlimited cover ensures continuous support for approved treatments.
- Submission of your treatment Plan is necessary for cover approval before your Healthcare Professional starts treatment.

COVERED TREATMENTS

We follow the guidelines established by the South African Oncology Consortium (SAOC), ensuring access to the most suitable treatment for your specific cancer stage. Our coverage encompasses proven-effective treatments such as chemotherapy, radiotherapy, and other evidence-based healthcare services that align with cost-effectiveness.

AVOID CO-PAYMENTS BY USING OUR DSP NETWORKS AND NETWORK PROVIDERS

You can benefit by using Healthcare Professionals and other healthcare service providers such as hospitals, pharmacies, radiologists, and pathologists on our network, because the Scheme will cover their approved procedures/services in full. If your Healthcare Professional charges more than the amount the Scheme pays, you will need to pay the difference.

NEW ONCOLOGY MEDICATIONS PHARMACY DSP

Bankmed has partnered with a leading Oncology Medications Pharmacy DSP to manage costs while ensuring comprehensive oncology benefits.

Please use our pharmacy Oncology Medications Pharmacy DSP for approved oncology medications to avoid a co-payment. Speak to your treating Healthcare Professional and confirm that they are using our Oncology Medications Pharmacy DSP for your medication for **treatment in their rooms or in a treatment facility**.

For approved oncology-related medication **where your Healthcare Professional has provided a prescription**, please use the Oncology Medications Pharmacy DSP. To find an Oncology Medications Pharmacy DSP, visit **www.bankmed.co.za** and click on 'Find a Healthcare Professional' or access the 'Find a Healthcare Professional' tool on the Bankmed App. Our Oncology Medications Pharmacy DSP is a convenient medication-ordering service that allows you to order prescribed medication via SMS, the Bankmed website, and the Bankmed App.

CO-PAYMENTS IN 2024 AND 2025

Bankmed has implemented the Oncology Medications Pharmacy DSP for approved oncology medications in 2024 for the first time. If you do not use the Oncology Medications Pharmacy DSP for your oncology medication in 2024, you will not incur a non-network penalty of 20%. Bankmed will pay up to the Scheme Medicine Reference Price.

In 2025 the Oncology Medications Pharmacy DSP will be enforced and failure to make use of the Oncology Medications Pharmacy DSP for oncology medication will attract a co-payment of **20%**.

Important note

We strictly adhere to predefined criteria and do not provide payment for healthcare services that fail to meet all established criteria.

To register or learn more

For additional information or to initiate registration, please reach out to us through the following channels:

E-mail: **oncology@bankmed.co.za**

Call: 0800 BANKMED (0800 226 5633)

Fax: 011 539 5417

BANKMED'S **MENTAL HEALTH CARE PROGRAMME**

Make mental wellbeing part of your holistic approach to health

When you look after your body, you can ward off illness. The same goes for looking after your mind. Not taking care of your mental health could lead to the development of chronic illnesses such as diabetes, hypertension, anxiety, and depression, leaving you with long-term health damage.

Stress is a normal part of your daily life. However, stress left unmanaged over time can damage your mental and physical health and can impact on your family and work performance. Given the enormous role your mental health plays in your ability to function, it's important that you nurture your mental health.

Scientific research and data tell us that we are much more productive, effective, happy, and healthy when we prioritise our own wellbeing. Bankmed offers you a comprehensive online Mental Wellbeing Assessment which includes:

- A psychological wellbeing assessment.
- A social support assessment.
- A stressor assessment.

Bankmed's Mental Health Care Programme, together with your Healthcare Professional, will help you actively manage episodes of Major Depression. This programme gives you and your Healthcare Professional access to tools and benefits to monitor and manage your condition and ensure you get high-quality, coordinated healthcare and the best outcomes. This programme is available on all Bankmed Plans.

Bankmed's Mental Health Care Programme

COMPLETE THE ONLINE MENTAL WELLBEING ASSESSMENT

Our online Mental Wellbeing Assessment is available at the click of a button on our website. Simply log in to **www.bankmed.co.za** and click on 'Manage your Plan' and then on 'Mental Wellbeing Assessment' to complete your Mental Wellbeing Assessment. If you are a Balance member, you can earn a total of 1 000 points — 500 points each time you do the assessment up to twice a year.

ONLINE MENTAL WELLBEING ASSESSMENT

HOW TO JOIN THE MENTAL HEALTH CARE PROGRAMME

A Premier Plus GP or a Psychologist in the Mental Health Care Programme network can enrol you on the programme, provided you give consent. Visit **www.bankmed.co.za** to find a Healthcare Professional on the network.

FIND A HEALTHCARE PROFESSIONAL IN OUR NETWORK

THE BANKMED MENTAL HEALTH CARE PROGRAMME OFFERING

On the Mental Health Care Programme, you and your Healthcare Professional have access to tools and benefits to monitor and manage your condition and to ensure you have access to coordinated care. Your Healthcare Professional can track your progress on a personalised dashboard on HealthID. This will help to identify which areas may need attention so that your Healthcare Professional can improve the management of your condition.

The Mental Health Care Programme runs over a six-month period but can be extended to 12 months, where clinically appropriate.

BENEFITS AVAILABLE ON THE MENTAL HEALTH CARE PROGRAMME

When enrolled on the Mental Health Care Programme you will have access to the following benefits:

- Up to three consultations (virtual or face-to-face) with your enrolling Premier Plus GP.
- Psychotherapy consultations.
- When enrolled by a Premier Plus GP, you have access to antidepressant medication if you are on the Comprehensive, Traditional, Plus and Basic Plans. Members on the Essential and Core Saver Plans do not have access to antidepressant medication from this Programme.
- Members on the Comprehensive, Traditional and Plus Plans need to follow the MediKredit authorisation process so that their antidepressant medication can be funded from the Additional Disease List benefit.
- Members on the Basic Plan have access to selective serotonin re-uptake inhibitor (SSRI) antidepressant medication up to a monthly amount of R110.00.

Digital therapeutics: internet-based cognitive behavioural therapy (iCBT)

To improve access and quality of care, Bankmed introduces iCBT in 2024 for all members diagnosed with depression. Digital therapeutics (DTx) is an emerging category of medical care where medical interventions, to treat, manage, and prevent a broad spectrum of diseases and disorders, are delivered directly to patients using evidence-based, clinically evaluated software (Digital Therapeutics Alliance).

Initially, the service will only be made available to members with diagnosed depression and on the recommendation of a Healthcare Professional, where the diagnosis and treatment of depression are within their scope of practice (Psychiatrist, Psychologist, GP, and Clinical social worker). Benefits will be subject to your mental health benefits. You must be registered on the Mental Health Care Programme to access this benefit. Please refer to the Benefit Tables in this guide for details about limits.

BANKMED'S **HIV CARE PROGRAMME**

Bankmed's HIV Care Programme offers you comprehensive disease management if you are living with HIV and AIDS. Registration with the HIV Care Programme is required for access.

ACCESS TO CLINICALLY SOUND AND COST-EFFECTIVE TREATMENT

Bankmed's HIV protocols are based on the guidelines of the Southern African HIV Clinicians' Society and the South African Department of Health. Approval of HIV-related services is subject to PMB guidelines and individual benefits.

PREFERRED PHARMACY PROVIDER NETWORK FOR HIV MEDICATION

When registered on the HIV Care Programme you can obtain your monthly HIV medication from pharmacies within the preferred pharmacy provider network. Dispensing GPs are also an option. Any charges beyond the Scheme's coverage will require that you pay the difference.

CONFIDENTIALITY AND HOSPITALISATION

The HIV healthcare team ensures complete confidentiality in handling any HIV and AIDS-related queries or cases. When you register on the HIV Care Programme there are no limits on hospitalisation, but approval is necessary, and payment is governed by Bankmed Rules.

BANKMED COVERS A SPECIFIED NUMBER OF CONSULTATIONS AND HIV-SPECIFIC BLOOD TESTS

- **GP and specialist consultations**

  When you register on the HIV Care Programme, Bankmed pays for four GP consultations and one specialist consultation per member per year for the management of HIV.

- **HIV monitoring blood tests**

  Bankmed also pays for HIV-specific blood tests for you when you are registered on the HIV Care Programme. These tests measure how many copies of HIV (viral load) are present in the blood and how well the immune system is functioning and are instrumental in managing your response to treatment.

ANTIRETROVIRAL MEDICATION AND SUPPORTIVE TREATMENT

Bankmed covers antiretroviral medication from the HIV medication list (formulary) up to the Scheme Medication Rate or 100% of the MMAP (or Scheme Medication Rate if MMAP is unavailable). Supportive medication is funded based on clinical criteria.

HIV SUPPORTIVE FORMULARY

HIV BASKET OF CARE FORMULARY

HIV ANTIRETROVIRAL FORMULARY

PREVENTIVE TREATMENT WITHOUT WAITING PERIODS

You have cover for preventative treatment in cases like sexual assault, mother-to-child transmission, trauma, or workmen's compensation without HIV waiting periods, provided treatment is pre-authorised.

NUTRITIONAL FEEDS FOR MOTHER-TO-CHILD PREVENTION

Bankmed covers nutritional feeds for babies born to HIV-positive mothers, following the HIV nutritional and mother-to-child prevention medication list (formulary).

PREMIER PLUS HIV GP NETWORK AND FULL COVER FOR HEALTHCARE PROFESSIONALS

Choosing a Premier Plus HIV GP within the network ensures additional cover, including social workers. Full cover is provided for GPs on the Premier Plus HIV GP Network and specialists with payment arrangements.

APPROVED MEDICATION AND PRESCRIPTION REQUIREMENTS

Bankmed covers approved medication on its HIV medication list, and you are responsible for any shortfall for unlisted medication or charges exceeding specified rates. Medication must be approved for coverage.

PRESCRIBED MINIMUM BENEFITS

HIV is a PMB condition. Full cover is ensured when using a DSP. Specific requirements must be met for accessing PMBs, and an appeals process is available for additional cover.

OUT-OF-HOSPITAL TREATMENTS AND APPEALS

Basic out-of-hospital treatments related to HIV infection are covered as PMBs. Additional cover can be appealed through a process outlined by Bankmed. Other out-of-hospital treatments are covered from available day-to-day benefits.

TO REGISTER OR LEARN MORE

For registration or additional information, please contact us through the following channels:

E-mail: **hiv@bankmed.co.za**

Call: 0800 BANKMED (0800 226 5633)

Fax: 011 539 3151

HIV PROGRAMME APPLICATION FORM

Disclaimer

The HIV/AIDS Programme is governed by Scheme Rules, and members must be familiar with these. Any medication instructions or advice should complement, not substitute, professional judgment. The Scheme retains the right to determine treatment coverage at any time.

HIV self-testing

In line with the 1 December 2016 recommendation by the World Health Organisation that HIV self-testing be encouraged to help reach first-time testers and people with undiagnosed HIV, Bankmed provides you with access to an HIV self-testing screening benefit.

WHAT IS AN HIV SELF-TEST?

Self-testing is a quick, convenient, and confidential HIV-testing option which allows you to know your status in the privacy of your own home. HIV self-testing does not provide a final diagnosis or result. Instead, it is a screening test. A self-test is accurate, but a positive test needs to be verified with another blood-based test (confirmatory test). This can be done at a laboratory or with your Healthcare Professional. Order your kit on the **website now.**

ORDER KIT NOW

DIABETES CARE PROGRAMME

Comprehensive Diabetes Care Programme

Living with diabetes involves daily challenges that demand ongoing management. Our Diabetes Care Programme is designed to assist with these challenges through a team of Healthcare Professionals dedicated to providing high-quality coordinated care, ultimately contributing to improved health outcomes.

Key Features:

- **Dedicated healthcare team:** A specialised team of Healthcare Professionals collaborates to deliver comprehensive care, tailored to your diabetes management needs.
- **Tools and additional benefits:** A range of tools and supplementary benefits aimed at monitoring and effectively managing your condition.
- **Dedicated care navigators:** Our programme includes dedicated care navigators, ready to assist with all your diabetes-related enquiries and needs.

ENROLLING IN THE DIABETES CARE PROGRAMME

If you are currently registered on the CIB for diabetes, access to our Diabetes Care Programme is a straightforward process facilitated by your chosen Premier Plus GP. For those not yet registered, simply approach your Healthcare Professional to enrol you.

YOUR HEALTHCARE PROFESSIONAL WILL WORK WITH YOU TO MANAGE YOUR CONDITION

The Diabetes Care Programme follows internationally and locally -recognised clinical and lifestyle guidelines.

By collaborating with your Healthcare Professional, who must be part of our network, you can:

- Establish key goals.
- Monitor your progress through a personalised dashboard on HealthID (a dedicated system for Healthcare Professionals).
- Generate your Diabetes Management Score, for insights on important areas needing attention to stabilise your condition and improve your overall health.

We are dedicated to supporting you on your journey to effective diabetes management.

DIABETES CARE NAVIGATORS

Our Care Navigators guide you through your diabetes benefits

Managing diabetes takes more than measuring your blood glucose. The condition comes with many challenges. To make managing these challenges easier, Bankmed offers a **Diabetes Care Programme.** This programme gives members living with diabetes more benefits and tools than those only registered for diabetes on the Chronic Illness Benefit.

Studies have shown that patients have the best health outcomes when one Healthcare Professional leads their care and coordinates with other Healthcare Professionals, like dietitians and foot specialists (podiatrists). By receiving care from a team who work together and follow the same plan, you get the best possible advice suited to your condition.

Managing diabetes is complicated. Using our care programme for diabetes-related care doesn't have to be. We have a dedicated call centre available to help you.

How can your Care Navigator help you?

Our dedicated Care Navigator call centre is here to help you:

- Understand your cover for diabetes and diabetes-related care.
- Register for our digital tools and maximise your rewards.
- Choose and engage with allied Healthcare Professionals (such as Dietitians and foot specialists- Podiatrists).
- Remind you what benefits you have available.

To register, learn more, contact a care navigator, or check if your GP is on our network

E-mail: **Members_DCP@bankmed.co.za**

Call: 0860 444 439

Please save these contact details if you are already registered for the Diabetes Care Programme.

FIND A HEALTHCARE PROFESSIONAL IN OUR NETWORK

COVER FOR CONTINUOUS GLUCOSE MONITORING (CGM) SENSORS

CGM automatically tracks blood glucose levels, giving you the ability to test your glucose level at any time to better manage your condition. When appropriately prescribed by a Healthcare Professional in our network, members with type-1 Diabetes have cover for continuous glucose monitoring sensors. Cover depends on your chosen Plan.

HOSPITAL BENEFITS & GOING TO HOSPITAL

Hospital care and procedures

HOSPITAL BUILDING VERSUS BEING IN HOSPITAL

We cover the costs of your treatment and care during a hospital stay through the Hospital Benefit. It's important to note that not all healthcare received within a hospital building is covered by the Hospital Benefit. A distinction is made between being hospitalised and visiting a Healthcare Professional with an office on the hospital premises.

When we refer to being 'in hospital', 'admitted to hospital', or 'hospitalised', it means you formally checked into the hospital at reception and have a designated hospital bed. In such cases, we cover the expenses for procedures and your entire hospital stay through the Hospital Benefit, without using your day-to-day benefits.

However, if you receive healthcare services within the hospital building (such as visits to the casualty unit, consultations with specialists, scans, and blood tests) without occupying a hospital bed, these are covered by your day-to-day benefits.

HOSPITAL PREAUTHORISATION

In case of an emergency hospital admission, please reach out to us for authorisation within 48 hours of the emergency admission. For planned procedures requiring hospitalisation, pre-authorisation is mandatory. As soon as you and your Healthcare Professional have finalised the admission date, contact us for pre-authorisation through one of the channels provided below:

Call: 0800 BANKMED (0800 226 5633)

E-mail: **treatment@bankmed.co.za**

Fax: 021 527 1928

You must provide the following information from your treating Healthcare Professional when you contact us for pre-authorisation:

- Your treating Healthcare Professional's practice number.
- Name of the hospital to which you or your dependant will be admitted.
- The date of admission.
- The diagnosis code (ICD-10 code).
- Any tariff and procedure codes.

We send you and the hospital an authorisation letter as soon as the admission is approved. If we have your cell phone number, we also send you an SMS with pre-authorisation details.

Pre-authorisation does not imply full coverage of all expenses during your hospital stay.

While pre-authorisation confirms that your hospital admission meets our clinical guidelines for funding, actual coverage depends on your Plan's limits and whether you use a Healthcare Professional within our network. It's essential that you review your Plan's limits in this Benefit & Contribution Schedule and refer to the Scheme Rules on the **website** where required. If uncertain, please contact us at 0800 BANKMED (0800 226 5633) for benefit confirmation.

It is your responsibility to obtain pre-authorisation

If your Healthcare Professional obtains authorisation on your behalf, it is important to ensure that you receive comprehensive information about the authorisation directly from the Healthcare Professional. **Bankmed cannot be held responsible if your Healthcare Professional fails to share this information with you**. This includes information about:

- If your treating Healthcare Professional is a network Healthcare Professional or DSP.
- What we cover and what we do not cover.
- Upfront payments (deductibles) that need to be paid to the hospital before you receive treatment.
- How much you must pay yourself (co-payments and shortfalls).

HOW WE PAY YOUR TREATING HEALTHCARE PROFESSIONAL

The specifics of your benefits, including the rate of cover and limits, are outlined in this Benefit & Contribution Schedule. You must discuss the costs of the treatment with your treating Healthcare Professional and enquire if they charge the Scheme Rate. In instances where they charge more than the Scheme Rate, you are responsible for covering the difference, known as a co-payment. Also, clarify whether other Healthcare Professionals, such as an anaesthetist or assistant, will be involved in your treatment and if they also charge the Scheme Rate.

PRE-ASSESSMENTS AHEAD OF PROCEDURES

Bankmed can assist you with a claim pre-assessment if you send us detailed quotes provided by your treating Healthcare Professional well in advance of your procedure. We can only assist you with a pre-assessment if your quote contains all the information pertaining to your procedure. Whilst a pre-assessment is not a guarantee of cover, it can provide you with a sense of the difference in cost between what your treating Healthcare Professional plans to charge for the procedure and the Bankmed Scheme Rate, highlighting potential shortfalls and co-payments.

To avoid unexpected financial burdens, we suggest you negotiate tariffs upfront. In cases where multiple procedures are performed under one anaesthetic, industry guidelines stipulate that Healthcare Professionals should apply lower fees for subsequent procedures. Your treating Healthcare Professional should be aware of these guidelines and discuss the planned charges with you before the procedure, to ensure you are not billed the full amount for multiple procedures under one anaesthetic.

If you negotiate tariffs upfront, you can avoid paying unexpected shortfalls and co-payments.

MAKE SURE YOUR CONTACT DETAILS ARE ALWAYS UP TO DATE

We send pre-authorisation letters to both you (the member) and your Healthcare Professional when pre-authorisation is granted. If your dependant is 18 years or older, they receive their own pre-authorisation communication. These letters contain important information about what Bankmed will cover and what it will not. Make sure we have your correct e-mail address on record, and if applicable, ensure that we have the correct e-mail address for your dependant. **Bankmed cannot be held responsible for any consequences if you or your dependants don't receive letters due to inaccurate contact details.**

DISCHARGE PLANNING

During your hospital stays, your Healthcare Professional and the hospital regularly inform us of any changes to your treatment plan and update your authorisation. If you require rehabilitation in other settings like step-down facilities or home nursing, a case manager will guide the transition. Cover for these services are based on your Plan's benefits.

DEDUCTIBLES

UPFRONT PAYMENT (DEDUCTIBLE)

You may have to pay an amount to a hospital or a day surgery facility before certain procedures, or if you do not use a network hospital if you are on a Plan that makes use of hospital networks. We call this amount 'an upfront payment' or 'deductible'. The facility will not admit you until you pay the amount. You do not have any upfront payments for emergency admissions, readmissions within six weeks of discharge, or childbirth.

THE DAY SURGERY NETWORK DEDUCTIBLE

How the Day Surgery Procedure List and Day Surgery Network operate

- **Procedure performed is listed on the Bankmed Day Surgery Procedure List and is performed at a Bankmed Day Surgery Network Facility**

  If you have one of the procedures listed on Bankmed's Day Surgery Procedure list performed in the Bankmed Day Surgery Network, you do not pay a deductible.

- **Procedure performed is listed on the Bankmed Day Surgery Procedure List and is NOT performed at a Bankmed Day Surgery Network Facility**

  If you have one of the procedures listed on the Bankmed's Day Surgery Procedure list performed at a facility that is **not** in the Bankmed Day Surgery Network, you will pay a deductible of R4 100 per admission. This deductible will increase to R6 300 in 2025.

Important note for Essential Plan members:

If you are an Essential Plan member, you do not have access to the full list of treatments/ procedures, as your cover is limited to PMB cover. As an Essential Plan member, if you have the PMB procedure/treatment performed at a facility not in the Bankmed Day Surgery Network (day surgery facility or hospital), you will be liable for a R4 100 deductible per admission.

Other hospitals (non-DSPS)

- PMB admission: involuntary use of a non-DSP: No deductible
- PMB admission: voluntary use of a non-DSP: R4 100 per admission
- Non-PMB admission: R4 100 per admission

The deductible is payable on admission.

Day surgery pre-authorisation

For planned procedures, pre-authorisation is mandatory. As soon as you and your Healthcare Professional have finalised the admission date, contact us for pre-authorisation through one of the channels provided below:

Call: 0860 444 439

E-mail: **treatment@bankmed.co.za**

Fax: 021 527 1928

UPFRONT PAYMENT (DEDUCTIBLE) FOR NOT USING A NETWORK FACILITY

Unless it is a medical emergency, you have an upfront payment before you can receive treatment or care in a day clinic or hospital that is not in our network.

This deductible applies to all procedures not listed in the Bankmed Day Surgery Procedure List:

BASIC, CORE SAVER, COMPREHENSIVE AND PLUS PLANS

- Day clinic: R310 for each admission
- Hospital: R775 for each admission

TRADITIONAL PLAN

- Day clinic: R310 for each admission
- Hospital: R6 425 for each admission

ESSENTIAL PLAN

- No cover outside our hospital and day clinic networks

FIND A HEALTHCARE PROFESSIONAL IN OUR NETWORK

UPFRONT PAYMENTS (DEDUCTIBLES) FOR DENTAL ADMISSIONS

Cover for in-hospital tooth and gum (dental) treatment is only provided on the Traditional, Comprehensive, and Plus Plans. If you are on any other Plan, you are responsible for covering all procedure and associated costs.

TRADITIONAL, COMPREHENSIVE AND PLUS PLANS

- Day clinic: R310 for each admission
- Hospital: R2 295 for each admission

BASIC, ESSENTIAL AND CORE SAVER PLANS

- No cover for dentistry performed in a hospital or day clinic.

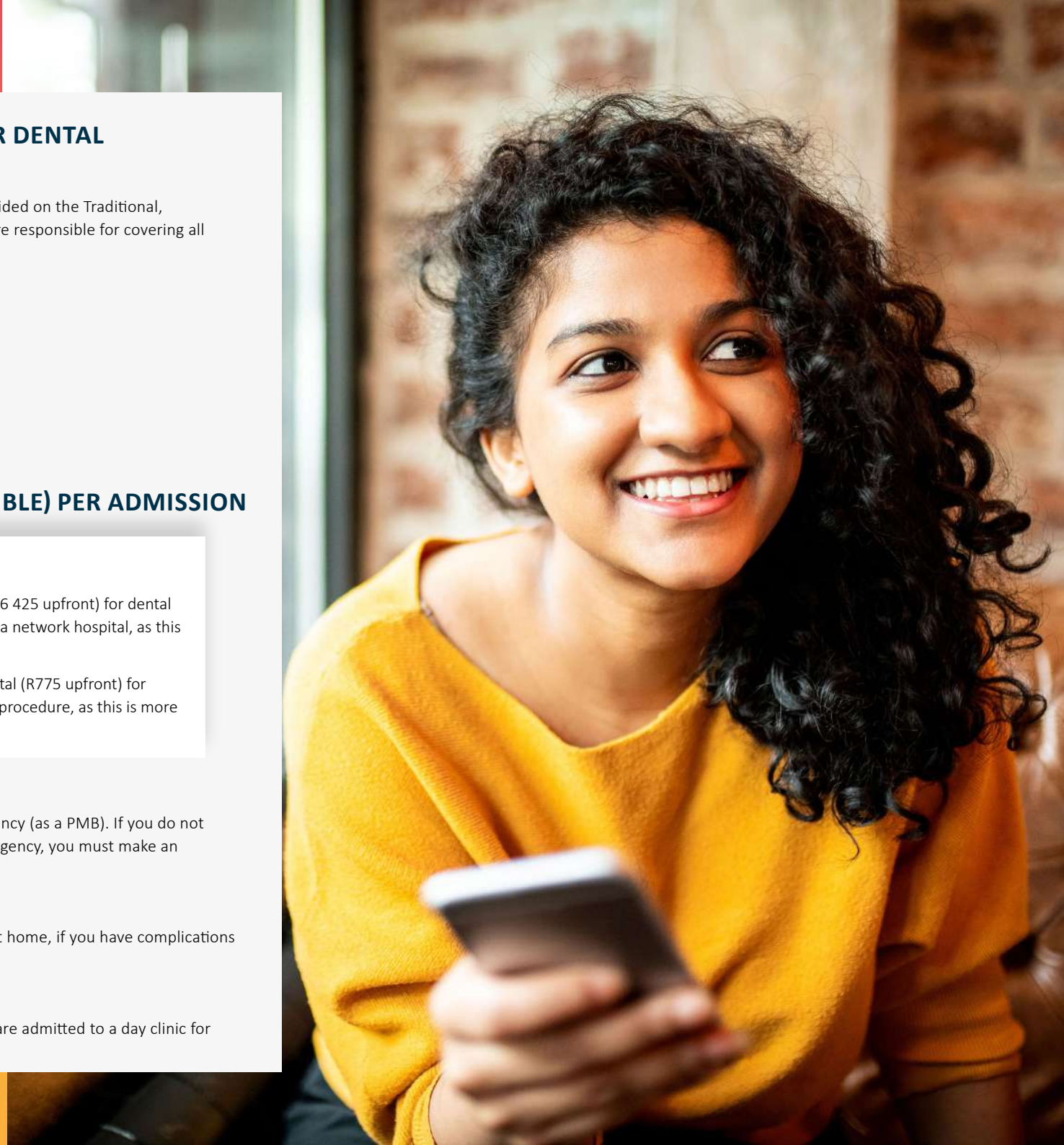
ONLY ONE UPFRONT PAYMENT (DEDUCTIBLE) PER ADMISSION

EXAMPLE:

- A Traditional Plan member going to a non-network hospital (R6 425 upfront) for dental treatment (R2 295 upfront) pays R6 425 upfront for not using a network hospital, as this is more than the dental upfront payment
- A Comprehensive Plan member going to a non-network hospital (R775 upfront) for dental treatment (R2 295) pays R2 295 upfront for the dental procedure, as this is more than the non-network upfront payment

You do not have to pay an amount upfront if:

- You are admitted to a non-network hospital in a medical emergency (as a PMB). If you do not use a network hospital or day clinic, and it is not a medical emergency, you must make an upfront payment.
- You are admitted to hospital for childbirth.
- You are admitted to hospital again within six weeks of being sent home, if you have complications from a procedure that you already paid an amount upfront for.
- You are admitted to a state hospital.
- We inform you that you do not have an upfront payment if you are admitted to a day clinic for specific procedures.



DAY **SURGERY**

Hospital costs are one of the main drivers of medical inflation. Determining the setting of care helps schemes to manage these costs while ensuring the most appropriate healthcare delivery mechanism. Having certain elective procedures in appropriate day surgery settings results in cost savings for the Scheme, less impact on your contribution increases, better quality outcomes, and an enhanced member experience.

BANKMED HAS CREATED AN ENHANCED DAY SURGERY NETWORK

Bankmed's Day Surgery Network has been enhanced to include a defined list of contracted day surgery facilities as well as contracted acute hospitals providing day surgery facilities at day surgery rates. You now have more choice when choosing a healthcare facility in our network. Within the network, you have access to a defined list of medical and surgical procedures that can be performed on a same-day basis. A clinical exceptions process applies to all complex cases and those procedures that may need an extended length of stay. Find a facility in our Day Surgery Network by using our 'Find a Healthcare Professional' tool on the website.

Bankmed's list of day surgery procedures:

- Adenoidectomy
- Arthrocentesis
- Cataract Surgery
- Cautery of vulva warts
- Circumcision
- Colonoscopy
- Cystourethroscopy
- Diagnostic D and C
- Gastroscopy
- Hysteroscopy
- Myringotomy
- Myringotomy with intubation (grommets)
- Nasal cautery
- Nasal plugging for nose bleeds
- Proctoscopy
- Prostate biopsy
- Removal of pins and plates
- Sigmoidoscopy
- Tonsillectomy
- Treatment of Bartholins cyst/gland
- Vasectomy
- Vulva/cone biopsy
- Oesophagoscopy
- Simple abdominal hernia repair
- Eye procedures
  - Other eye procedures: removal of foreign body, vitrectomy
- Gynaecological procedures
  - Laparoscopic gynaecological procedures
- Orthopaedic procedures
  - Arthroscopy, arthrotomy, knee, shoulder, elbow, hand, wrist), arthrodesis (hand, wrist)
  - Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty)
  - Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy)
  - Treatment of simple closed fractures and/or dislocations, removal of pins and plates
  - Incision and drainage/excision of abscess and/or cyst/tumour: subcutaneous tissue, soft tissue, bone, bursa
  - Biopsies: subcutaneous tissue, soft tissue, muscle, bone
  - Treatment of closed fractures and/or dislocations, removal of pins and plates

BANKMED'S DAY SURGERY PROCEDURE LIST

Please go to the **Deductibles** page to view Bankmed's Day Surgery Procedure List. If you have one of the procedures listed on Bankmed's Day Surgery Procedure list performed in the Bankmed Day Surgery Network, you do not pay a deductible. However, if you have one of the procedures listed on the Bankmed's Day Surgery Procedure list performed at a facility that is not in the Bankmed Day Surgery Network, you will **pay a deductible of R4 100 per admission. This deductible will increase to R6 300 in 2025.**

Read more about deductibles in the **Deductible** section of this Benefit & Contribution Schedule.

DAY SURGERY PRE-AUTHORISATION

For planned procedures, pre-authorisation is mandatory. As soon as you and your Healthcare Professional have finalised the admission date, contact us for pre-authorisation through one of the channels provided below:

Call: 0860 444 439

E-mail: **treatment@bankmed.co.za**

Fax: 021 527 1928

DIGITAL **HEALTHCARE**

We've gone digital!

Bankmed has created a digital world to meet the changing needs of our members. Our Bankmed App and website have been designed to provide easy access to forms, information, and claim submissions at a click of a button!

BANKMED APP

Download the Bankmed App. On the 'Health' tab in the Bankmed App, select 'Doctor(s) Consent' and follow the prompts on the screen to give permission to view your medical record.

GET IT ON Google Play Download on the App Store

BANKMED WEBSITE

Log in to **www.bankmed.co.za**

FIND A BENEFIT PLAN TOOL

Selecting the right Plan type can feel overwhelming with your medical requirements, family situation, and budget all having to be considered. To assist you, we have created interactive digital tools. Available on our website, they offer user-friendly features designed to guide you through the decision-making journey.

Use the 'Find a Benefit' tool to help you select a Plan. This tool helps members to better understand their benefits and to select a Plan that best meets their needs. Plan selections and quotes are based on individual needs. This is not a comparison tool.

FIND A BENEFIT PLAN TOOL

Online interactive tool that helps you choose a Plan

ASK FOR HELP

We have consolidated a list of our most popular topics along with their links. Choose from the popular links on our website to help you.

FIND A DOCTOR, HOSPITAL, OR PHARMACY

MY MEDICAL AID CLAIMS

FIND A DOCUMENT

VIEW RECENT INTERACTIONS

GET INSTANT HELP FROM OUR CHATBOT, ASK BANKMED

Choose one of the popular questions below to start a conversation with 'Ask Bankmed' or ask your own question.

- Get my membership certificate
- Get my medical aid tax certificate
- What are my monthly contributions?
- What benefits do I have on my Plan?
- How do I get hospital authorisation?
- Membership card
- Pregnancy and childbirth
- COVID-19 Vaccination

ASK BANKMED FOR HELP

KNOWLEDGE CENTRE

Our knowledge centre is updated with information about topical issues like Gender-Based Violence, Emergency Services, and articles about health and wellness.

KNOWLEDGE CENTRE

INTERACTIVE PLAN GUIDE

This page helps you to find a Plan that best suits you and your family's financial and healthcare needs. You must select a Plan when you apply to join Bankmed and if you decided to change your Plan during the Plan change period.

INTERACTIVE PLAN GUIDE

PLAN COMPARISON TOOL

Side-by-side summary of three Plans' main benefits.

COMPARE MEDICAL AID PLANS

LOOK-UP PLAN BENEFITS TOOL

Search the Benefit & Contribution Schedule for details of the benefits provided. This is not a comparison tool.

LOOK-UP PLAN BENEFITS

CONTRIBUTION CALCULATOR

Use the 'Contribution Calculator' to calculate your contributions on another Plan type or understand what it would cost to add another dependant.

CONTRIBUTION CALCULATOR

DIGITAL MEMBERSHIP CARD

Do your bit for the environment- access your digital membership card on the Bankmed App.

DIGITAL CLAIMING

Healthcare Professionals, hospitals and pharmacies in our networks usually send us your claims directly. If you use a network Healthcare Professional, you do not have to send us a claim.

Submitting Claims

- You must submit your claim within four months from the date of service. After this, the claim expires, and you will not be refunded.
- Make sure your membership number and Healthcare Professional's details (including their practice number) are clear on the claim.
- Submit a detailed claim and not just a receipt. We need the details of the treatment or medication for which you are claiming.

How to Claim

1. Bankmed App

Download the Bankmed App and:

- Use the camera on your smartphone to take a photo of the claim and submit it using the App.
- Be sure to send us a high-resolution image. If you send a low-resolution image, we cannot read and process your claim.
- Use your smartphone to scan the claim or QR code on the claim (if the claim has a block QR code).

2. Bankmed website

- Log in to **www.bankmed.co.za**
- Go to 'Claims' and click on 'Submit a claim'.
- Once there, go to 'Upload' and click on 'Upload now'.
- Select the file you want to upload and then click on 'Send claim'.
- Once the claim has been successfully uploaded, you should receive a reference number.
- Please ensure that your image is a high-resolution image so that we can read the detail of the claim and are able to process it.

3. E-mail

SUBMIT A CLAIM

FIND A HEALTHCARE PROFESSIONAL TOOL

You can use our website or the Bankmed App to find a Healthcare Professional close to you or in a specific area and find out if they are part of our network.

Bankmed website

Check whether Healthcare Professional is on a Bankmed network

- 1. Log in to **www.bankmed.co.za**
- 2. Under 'Digital Tools' click on 'Find a Healthcare Professional'.
- Type their name under '1. Who or what'.
- Select their name from the drop-down list.
- If the system shows 'Partial cover' or the search does not find them, they are not part of our network.

If you want to find a specific kind of Healthcare Professional like a Dentist or GP

- Under'1. Who or what', click on or choose a category of provider. This opens a list of categories.
- Select the category and specific kind of Healthcare Professional you need.
- Under '2. Where' start typing the area and click on the area you're looking for.
- Select 'Search' and scroll down to the results.
- If the system shows 'Full network' cover, the Healthcare Professional is part of our network

SOCIAL MEDIA

KNOWLEDGE LIBRARY

Our knowledge library has been created to empower you with medical health information at your fingertips.

KNOWLEDGE LIBRARY

ELECTRONIC HEALTH RECORD

Once you give consent, your Healthcare Professional can use the Electronic Health Record to access your medical history, gain insight into the benefits of your Plan, refer you to other Healthcare Professionals, study your blood test results and write electronic prescriptions and referrals.

Consent

Healthcare Professionals need your permission to view your confidential medical information. Your personal information is protected. We only give Healthcare Professionals access to your medical records.

When you give consent, you agree that you understand the Electronic Health Record contains details about any chronic conditions you may have, as well as pathology results (such as blood tests). Our **privacy statement** explains how we use and protect your personal information.

ELECTRONIC HEALTH RECORD

SMART DEVICES: SMART HEALTH

Wearable fitness devices and applications can inspire you to take charge of your health and fitness.

Different devices offer different features, but a basic step tracker counts how many steps you take a day. These devices synchronise with an application on your smartphone. More advanced devices can monitor your heart rate and detect what kind of activity you are doing.

You do not need to buy an additional device to track your health. Any smartphone can be converted into a fitness-tracking and health-monitoring device. Some smart devices come with a pre-installed health and fitness application, but there are many free applications you can download to help you track your health. Fitness devices and applications make sure that you have an accurate record of your physical activity.

Smartphones can help support good health

Applications have changed how people view and engage with their health and fitness. Applications are available to improve diet (for example the MyFitnessPal App) and track moods. Some applications also give exercise advice. Productivity applications are becoming popular because they allow users to set realistic goals about eating, exercise, remembering to take medication, and sleep. While some of these applications are free, some require that you pay a subscription fee. Search the App Store or Google Play for fitness applications. Read the descriptions and reviews carefully before downloading to find the right app for you.

CONNECTED CARE

Access Connected Care in your browser or download it to your phone home screen. Bankmed members already have access to Connected Care - simply log in.

COVID-19 Vaccination Navigator

Register and book your COVID-19 vaccination, track your journey, and stay updated with Connected Care.

In-App booking

Book in-person, telephonic or online consultations in-app and easily keep track of your appointments.

Online consultations

Book an online Healthcare Professional consultation from the comfort of your home. Online consultations with a Healthcare Professional in the Connected Care GP network are covered by the available day-to-day benefits or Insured Benefits, depending on your Plan choice. Connected Care users can also access Healthcare Professionals who are online immediately, without having to make a booking.

Electronic Health Record (EHR)

Access and share records

With Connected Care you can access and share your Electronic Health Record with Healthcare Professionals. Receive your diagnosis, instructions, and clinical readings, all in one place. Once you give consent, your Healthcare Professional can use the Electronic Health Record to access your medical history, gain insight into your Plan benefits, refer you to other Healthcare Professionals, study your blood test results and write electronic prescriptions and referrals.

E-scripting

Electronic prescriptions, seamless e-scripting to give you easy access to your medication.

CONNECTED CARE

CONTRIBUTIONS 2024

Schedule of monthly contributions with effect from 1 January 2024.

ESSENTIAL PLAN (No MSA)

	2024 Total Contribution		
	M	A	C
> R5 000	R850	R763	R213
R5 001 – R6 000	R929	R837	R243
R6 001 – R7 000	R1 027	R924	R264
R7 001 – R8 000	R1 128	R1 014	R290
R8 001 – R9 000	R1 288	R1 162	R319
R9 001 – R10 000	R1 433	R1 288	R361
R10 000+	R1 632	R1 471	R412

BASIC PLAN (No MSA)

	2024 Total Contribution		
	M	A	C
> R5 000	R1 320	R987	R332
R5 001 – R6 000	R1 450	R1 087	R374
R6 001 – R7 000	R1 598	R1 193	R412
R7 001 – R8 000	R1 753	R1 333	R452
R8 001 – R9 000	R2 003	R1 518	R502
R9 001 – R10 000	R2 229	R1 687	R560
R10 000+	R2 538	R1 902	R636

CORE SAVER PLAN (With MSA)

	2024 Total Contribution			2024 Risk Contribution			2024 MSA Contribution		
	M	A	C	M	A	C	M	A	C
> R5 000	R2 092	R1 575	R525	R1 782	R1 342	R448	R310	R233	R77
R5 001 – R6 000	R2 242	R1 684	R561	R1 912	R1 435	R481	R330	R249	R80
R6 001 – R7 000	R2 400	R1 801	R599	R2 047	R1 535	R508	R353	R266	R91
R7 001 – R8 000	R2 521	R1 891	R633	R2 149	R1 611	R537	R372	R280	R96
R8 001 – R9 000	R2 716	R2 042	R686	R2 314	R1 741	R585	R402	R301	R101
R9 001 – R10 000	R2 856	R2 147	R716	R2 435	R1 833	R612	R421	R314	R104
R10 000+	R3 149	R2 357	R791	R2 687	R2 009	R675	R462	R348	R116

We acknowledge that selecting the right Plan type can be overwhelming due to various considerations, such as your medical requirements, family situation, and budget for medical scheme coverage. To assist you in navigating this intricate decision-making process, we have created intuitive interactive digital tools. These tools, available on our website, offer user-friendly features designed to guide you through the decision-making journey. Use the 'Find a Benefit' tool to help you select a Plan.

FIND A BENEFIT PLAN TOOL

This tool was developed to assist members to better understand their benefits and how to select a Plan that best meets their needs. Plan selection and quote based on individual needs. This is not a comparison tool.

TRADITIONAL PLAN (No MSA)

	2024 Total Contribution		
	M	A	C
> R5 000	R3 489	R2 612	R871
R5 001 – R10 000	R4 066	R3 047	R1 021
R10 000+	R4 232	R3 178	R1 060

COMPREHENSIVE PLAN (With MSA)

	2024 Total Contribution			2024 Risk Contribution			2024 MSA Contribution		
	M	A	C	M	A	C	M	A	C
R0 – R10 000	R4 648	R3 481	R1 169	R3 828	R2 868	R962	R820	R613	R207
R10 000+	R4 840	R3 628	R1 211	R3 986	R2 988	R998	R854	R640	R213

PLUS PLAN (With MSA)

	2024 Total Contribution			2024 Risk Contribution			2024 MSA Contribution		
	M	A	C	M	A	C	M	A	C
All Incomes	R8 200	R6 139	R2 052	R6 281	R4 703	R1 572	R1 919	R1 436	R480

LATE-JOINER PENALTY

The Medical Schemes Act recommends that medical schemes charge a late-joiner penalty if someone joins a medical scheme for the first time at the age of 35 or older, or if someone isn't a member and has a break in coverage for more than three months and then wants to join a medical scheme again. The Act calls this person a late joiner. This does not apply to members or their dependants who were members of a medical scheme before 1 April 2001 and who have not had a break in coverage for more than three months. The Board of Trustees can decide to charge a late joiner an extra percentage of their contribution depending on how long they have not belonged to a medical scheme. The penalty is permanent and will apply for the duration of the membership.

Penalty bands	Maximum penalty
1 to 4 uncovered years	**5%**
5 to 14 uncovered years	**25%**
15 to 24 uncovered years	**50%**
25+ uncovered years	**75%**

If you can prove that you've been a member of a South African medical scheme before, we subtract those years of membership from your current age when we calculate your late joiner penalty.

Important

Contributions for child dependants are limited to a maximum of three children

EXCLUSIONS

The following are examples of items typically not covered by Bankmed:

- Operations, treatment, and procedures for cosmetic purposes.
- Examinations, consultations, and treatment related to obesity.
- Sunscreens and tanning agents.
- Travel expenses.
- Accommodation in retirement homes or similar institutions.
- Sunglasses.
- Accommodation and/or treatment in headache or stress-relief clinics.
- The cost of holidays for recuperative purposes (for example spas and health resorts).
- Telephone consultations with Healthcare Professionals.
- Costs associated with vocational guidance, child guidance, marriage guidance or counselling, sex therapy, school readiness, school therapy or attendance at remedial education schools or clinics.

View the complete list of the **Scheme exclusions** in accordance with Bankmed's Rules.

BANKMED PRIVACY STATEMENT

HOW WE WILL PROCESS AND DISCLOSE YOUR PERSONAL INFORMATION AND COMMUNICATE WITH YOU

The security of your personal information is extremely important to us. The Privacy Statement explains how we obtain, use, disclose and process your information in a manner that is compliant, ethical, adheres to industry best practice and the Protection of Personal Information legislation.

Access the **full Statement**.

COMPLAINTS PROCESS

If you have a complaint about your membership, please let us know in writing:

E-mail for members: enquiries@bankmed.co.za

E-mail for pensioners: pensioners@bankmed.co.za

Post: Complaints Bankmed, Private Bag X2, Rivonia, 2128

By law, we must respond to written complaints within 30 days, but we always try to respond much sooner.

LODGE A FORMAL COMPLAINT

If you have given us a reasonable chance to address your concerns and you are still not satisfied with the outcome of the process, you can lodge a formal complaint with the Council for Medical Schemes:

Customer Care Line: 0861 123 267

ShareCall from a Telkom landline

Reception: 012 431 0500

Fax: 086 673 2466

E-mail: complaints@medicalschemes.co.za

Post: Council for Medical Schemes, Block A, Eco Glades 2 Office Park, 420 Witch Hazel Avenue, Eco Park, Centurion, 0157 or Council for Medical Schemes, Private Bag X34, Hatfield, 0028

CONTACTS

Medical Emergencies
0860 999 911

GENERAL INFORMATION

Website: www.bankmed.co.za

Call: 0800 BANKMED (0800 226 5633)

Toll-free on a Telkom landline

E-mail for members: enquiries@bankmed.co.za

E-mail for pensioners: pensioners@bankmed.co.za

Fax: 021 527 1926

Post: Bankmed Customer Services, Private Bag X2, Rivonia 2128

DIGITAL TOOLS

View information about your membership and update your contact details

Website: Log in to the member portal at www.bankmed.co.za

Bankmed App: Download from your App store and log in

Your username and password are the same for the website, mobile site, and App.

CLAIMS

Include your membership number and make sure the claim is easy to read

Bankmed App: download from the App Store or Google Play Store

E-mail: claims@bankmed.co.za

Fax: 021 527 1940

Post: Bankmed Claims, Private Bag X2, Rivonia 2128

SUBMIT A CLAIM

PRE-AUTHORISATION

For Hospital or Day Surgery facility admissions, MRI, CT scan or radionuclide scan

Call: 0800 BANKMED (0800 226 5633)

Toll-free on a Telkom landline

Fax: 021 527 1928

E-mail: treatment@bankmed.co.za

HOSPITAL CARE AND PROCEDURES

REPORT FRAUD

Call: 0800 004 500 / 0800 007 788

SMS: 43477

E-mail: bankmed@tip-offs.com

Post: Freepost DN298, Umhlanga Rocks 4320

CHRONIC MEDICATION AUTHORISATION

Register to gain access to these benefits

Call: 0800 BANKMED (0800 226 5633)

Toll-free on a Telkom landline

Core Saver, Traditional, Comprehensive and Plus Plans

E-mail: chronic@bankmed.co.za

Fax: 011 770 6247

Your pharmacist can call 0800 BANKMED (0800 226 5633)

Healthcare Professionals can call 0800 132 345

Essential and Basic Plans

E-mail: chronicbasicessential@bankmed.co.za

Fax: 011 539 7000

Your pharmacist can call 0800 BANKMED (0800 226 5633)

HIV PROGRAMME (CONFIDENTIALITY GUARANTEED)

BABY-AND-ME PROGRAMME FOR PREGNANCY AND CHILDBIRTH

ONCOLOGY PROGRAMME

CHRONIC ILLNESS BENEFIT

BENEFIT TABLES 2024

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
Does this Plan have an MSA?	No	No	No	Yes	Yes	Yes
Percentage of gross contribution allocated to MSA	N/A	N/A	N/A	14.7%*	17.6%*	23.4%*
				*Percentage of Gross Contribution allocated to the MSA is not fixed and varies by dependant type, income band, rounding of values and way contribution increases have been calculated. The percentage published in this schedule is an aggregated value.		
1. OVERALL ANNUAL LIMIT						
1.1	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
2. CLAIMS FOR SERVICES RENDERED OUTSIDE THE BORDERS OF SOUTH AFRICA (FOREIGN CLAIMS) Consider purchasing comprehensive travel insurance before travelling abroad as not all foreign claims may receive full coverage						
2.1	• PMB conditions and life-threatening emergencies only • No benefits for emergency/ ambulance transport outside the borders of South Africa • No benefits for services not normally covered at the Scheme's preferred provider network (Bankmed Entry Plan GP Network) for out-of-hospital consultations, medication, and treatment (except via Bankmed Entry Plan GP Network providers in Lesotho) • Medical motivation and prior approval required for non-emergency surgery outside the borders of South Africa	• Foreign claims covered at the relevant Scheme Rate and/or Rand limit subject to benefits available on your selected Plan • No benefits for emergency/ ambulance transport outside the borders of South Africa • No benefits for services not normally covered at the Scheme's preferred provider network (Bankmed Entry Plan GP Network) for out-of-hospital consultations, medication, and treatment (except via Bankmed Entry Plan GP Network providers in Lesotho) • Medical motivation and prior approval required for non-emergency surgery outside the borders of South Africa	• Foreign claims covered at the relevant Scheme Rate and/or Rand limit subject to benefits available on your selected Plan • No benefits for emergency/ambulance transport outside the borders of South Africa • Medical motivation and prior approval required for non-emergency surgery outside the borders of South Africa			

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
3.	**WELLNESS AND PREVENTATIVE CARE BENEFITS (INSURED BENEFITS)** Wellness and Preventative Care Benefits are additional Insured Benefits and do not deplete other Insured Benefits or MSA. Consultation costs related to these benefits are not covered					
3.1	**Flu vaccine**	• 100% of Scheme Medicine Reference Price Limited to one vaccine pbpa				
3.2	**Human Papilloma Virus (HPV) vaccine**	• 100% of Scheme Medicine Reference Price • Limited three course dose (product and age dependent) per male or female beneficiary, aged nine to 25 years				
3.3	**Childhood vaccines** BCG, oral polio, rotavirus, diphtheria, tetanus, acellular pertussis, inactivated polio and haemophilus influenza type B, hepatitis B, measles, pneumococcal vaccine	• 100% of Scheme Medicine Reference Price • For children up to age 12 • Limited to immunisations per the Department of Health's Expanded Programme on Immunisation (EPI) guidelines				
3.4	**Pneumococcal vaccine**	• 100% of Scheme Medicine Reference Price, limited as follows: • One vaccine every five years for adults 60 years and older • One vaccine every five years for beneficiaries younger than 60 years, diagnosed with asthma, chronic obstructive pulmonary disease, diabetes, cardiovascular disease, or HIV/AIDS				
3.5	**Herpes Zoster Virus vaccine** Reduces the rate of herpes zoster (shingles)	• 100% of Scheme Medicine Reference Price as follows: • One vaccination every five years for adults 60 years and older				
3.6	**Mammogram**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa age 40 years and older • Benefits for beneficiaries younger than 40 years subject to motivation and prior approval				
3.7	**Breast MRI** Limited to high-risk breast cancer beneficiaries Subject to clinical entry criteria Pre-authorisation required	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa • Breast Cancer Risk Calculator available on website				
3.8	**Bone densitometry**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa aged 50 years and older • Benefits for beneficiaries younger than 50 years subject to motivation and prior approval • Where clinical entry criteria not met and member under age 50, test can be claimed from available radiology benefit or MSA, where applicable				
3.9	**Prostate-specific antigen**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa aged 50 years and older • Benefits for beneficiaries younger than 50 years subject to motivation and prior approval				

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		

3.10	**Faecal occult blood test**	• 100% of cost at DSP
		• 100% of Scheme Rate at non-DSP
		  • Limited to one pbpa aged 50 years and older
		  • Benefits for beneficiaries younger than 50 years subject to motivation and prior approval					

3.11	**Tuberculosis (TB) screening**	• 100% of cost at DSP
		• 100% of Scheme Rate at non-DSP
		  • Limited to one x-ray pbpa
		  • For TB screening requested by onsite registered private nurse at Employer Groups
		  • All other TB screenings subject to available out-of-hospital radiology and/or pathology benefits					

3.12	**Bankmed mental wellbeing assessment**	• Unlimited online Mental Wellbeing Assessments					

3.13	**Cholesterol screening, blood sugar screening and blood pressure measurements**	• 100% of cost at DSP
		• 100% of Scheme Rate at non-DSP
		  • Limited to R380 pbpa at DSP
		  • DSP: clinics, pharmacies, or Bankmed Entry Plan GP Network consulting rooms
				• 100% of cost at DSP
				• 100% of Scheme Rate at non-DSP
				  • Limited to R380 pbpa at DSP
				  • DSP: clinics, pharmacies, or Bankmed Network GPs' consulting rooms			

3.14	**HIV counselling and testing (HCT)**	• Unlimited • 100% of cost for HCT DSP • DSP: Bankmed Entry Plan GP Network, Bankmed Pharmacy Network, contracted onsite HCT providers at Employer Groups • 100% of Scheme Rate at non-DSP • Subject to PMB regulations		• Unlimited • 100% of cost for HCT DSP • DSP: Bankmed GP Network, Bankmed Pharmacy Network, contracted onsite HCT providers at Employer Groups • 100% of Scheme Rate at non-DSP			

3.15	**Pap smear**	• 100% of cost at DSP
		• 100% of Scheme Rate at non-DSP
		  • Limited to one pbpa
		  • One associated nurse, Bankmed Entry Plan GP Network GP, or Bankmed Entry Plan Specialist Network consultation pb covered as an additional Insured Benefit limited to R600 pbpa
				• 100% of cost at DSP
				• 100% of Scheme Rate at non-DSP
				  • Limited to one pbpa
				  • One associated nurse, Bankmed GP Network, or Bankmed Prestige A and B Specialist Network consultation pb covered as an additional Insured Benefit limited to R600 pbpa			

3.16	**Personal Health Assessment (PHA)**
	Limited to members and beneficiaries aged 18 years and older
		• 100% of cost at DSP only
		  • DSP: Bankmed Entry Plan GP Network, Bankmed Pharmacy Network and contracted onsite providers at Employer Groups
		  • Not covered at non-DSP
		  • Limited to one assessment pbpa
				• 100% of cost at DSP only
				  • DSP: Bankmed GP Network, Bankmed Pharmacy Network and contracted onsite providers at Employer Groups
				  • Not covered at non-DSP
				  • Limited to one assessment pbpa			

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		

3.17	**Personal Health Assessment (PHA) Post-engagement Wellness Management Programme**
	• Limited to members and beneficiaries aged 18 years and older
	• Additional consultations for Dietician and Biokineticist subject to clinical entry criteria
	• Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA
		• 100% of cost at DSP only
		• Not covered at non-DSP
		• Benefit includes two 30-minute Dietician consultations pbpa and two Biokineticist consultations pbpa
		
		• **Limited to:**
		  • Medium- and high-risk members identified via the PHA
		  • Members with a BMI ≥ 30
		
		• **Benefit use requirements:**
		  • Within 6 weeks of PHA: first visit to Dietician and Biokineticist
		  • Within 12 months of PHA: second visit to Dietician and Biokineticist
		  • Otherwise funded from day-to-day benefits				

3.18	**Contraception**
	Oral Contraceptives, Devices and Injectables
		• No benefit	• 100% of Scheme Medicine Reference Price
			  • Limited to R2 395 per female beneficiary per annum
			  • Oral contraceptives limited to one prescription/repeat prescription pbpm				

3.19	**Antenatal screening**
	
	• **T21 chromosome test or non-invasive prenatal testing (NIPT)**
	To test for chromosomal abnormalities
	(South African testing only)
	
	• **Amniocentesis**
	(South African testing only)
		• 100% of cost at DSP
		• 100% of Scheme Rate at non-DSP
		  • Limited to one test pb per pregnancy
		  • Test to be conducted at 10 – 12 weeks of pregnancy
		  • Subject to clinical entry criteria
		  • Applies to high-risk beneficiaries only, who are aged 35 years and older at time of delivery
		  • If member does not meet clinical entry criteria, the screening test is not covered by the Scheme
		
		• 100% of cost at DSP
		• 100% of Scheme Rate at non-DSP
		  • Limited to one test pb per pregnancy
		  • Subject to gynaecologist referral and pre-authorisation				

3.20	**Newborn screening**
	To test for the presence of certain metabolic and endocrine disorders
	(South African testing only)
		• 100% of cost at DSP
		• 100% of Scheme Rate at non-DSP
		  • Limited to one test pb per pregnancy
		  • Test to be carried out within 72 hours of birth					

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		

3.21	**Newborn hearing test**
	• Only hearing test covered from this benefit
	• Consultation costs related to this benefit covered from available consultation benefits
		• 100% of cost at DSP
		• 100% of Scheme Rate at non-DSP
		  • Limited to one test pb and must be carried out within eight weeks of birth
		  • Test to be performed by a registered Audiologist					

3.22	**Diabetes management** For members registered on the Scheme's Disease Management Programme BOC set by the Scheme, subject to PMB regulations	• Unlimited • 100% of cost for services covered in the Scheme's BOC if referred by the Scheme's DSP and member utilises the Scheme's DSP as their Healthcare Professional • 100% of Scheme Rate at non-DSP	• Unlimited • 100% of cost for services covered in the Scheme's BOC if referred by the Scheme's DSP and member utilises the Scheme's DSP as their Healthcare Professional • 100% of Scheme Rate at non-DSP • The 'Out-of-network GP Benefit' limit applies if the Healthcare Professional is not the member's nominated GP	• Unlimited • 100% of cost for services covered in the Scheme's BOC if referred by the Scheme's DSP and member utilises the Scheme's DSP as their Healthcare Professional • 100% of Scheme Rate at non-DSP			
3.23	**Disease Prevention Programme** Programme designed to support members identified as being at risk of developing diabetes • Clinical entry criteria apply • BOC as specified by the Scheme • Subject to PMB regulations	• Limited to BOC determined by Scheme • 100% of Scheme Rate • Subject to authorisation and/or approval • Limited to PMBs		• Limited to BOC determined by Scheme • 100% of Scheme Rate • Subject to authorisation and/or approval			
4.	**HIV/AIDS CARE PROGRAMME** Enrollment in the Scheme's HIV/AIDS Care Programme grants extra benefits that do not diminish any other Insured Benefits. Unregistered beneficiaries retain access to all standard benefits outlined in the Benefit Tables, including PMB coverage in accordance with regulations, even after respective sub-limits have been reached						
4.1	**Consultations and pathology**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to benefits available in Scheme's BOC					

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
4.2	**Medication via DSP** Bankmed Pharmacy Network	• Unlimited • 100% of cost at DSP • 100% of Scheme Medicine Reference Price for non-formulary medication • Subject to Scheme Medication Formulary (medicine list) • Motivation is required for the use of a non-DSP					
4.3	**Medication via non-DSP** Voluntary use of a non-DSP	• Unlimited • 80% of Scheme Medicine Reference Price • Subject to Scheme Medication Formulary (medicine list) • 100% of Scheme Medicine Reference Price for non-formulary medication • Motivation is required for the use of a non-DSP					
4.4	**Medication via non-DSP** Involuntary use of a non-DSP	• Unlimited • 100% of cost • 100% of Scheme Medicine Reference Price for non-formulary medication • Subject to Scheme Medication Formulary (medicine list) • Motivation is required for the use of a non-DSP					
5.	**24-HOUR MEDICAL ADVICE LINE (CALL 0860 999 911)** Free service to Bankmed members						
5.1	Call 0860 999 911 for 24-hour medical advice from a registered nurse						
6.	**AMBULANCE SERVICES (CALL 0860 999 911 FOR PRE-AUTHORISATION)** Subject to pre-authorisation and PMB regulations						
6.1	**BENEFITS FOR EMERGENCY SERVICES ARE SUBJECT TO USE OF THE SCHEME'S DSP. FAILURE TO USE THE DSP MAY LEAD TO CO-PAYMENTS BEING APPLIED** **CALL 0860 999 911 – 24 HOURS A DAY, SEVEN DAYS A WEEK AND YOU WILL BE CONNECTED WITH HIGHLY QUALIFIED INDIVIDUALS WHO WILL ASSIST WITH YOUR EMERGENCY** • Unlimited • 100% of cost via the Scheme's DSP • 100% of Scheme Rate via non-DSP • No benefit outside the borders of South Africa						
7.	**HOSPITALISATION** Subject to pre-authorisation and PMB regulations. Bankmed reserves the right to obtain a second opinion prior to granting authorisation for spinal surgery						
	HOSPITALISATION AND ASSOCIATED IN-HOSPITAL BENEFITS ARE SUBJECT TO PRE-AUTHORISATION AND PMB REGULATIONS **FAILURE TO OBTAIN PRE-AUTHORISATION MAY LEAD TO CO-PAYMENTS BEING APPLIED OR BENEFITS BEING DECLINED UPON REVIEW** **CONTACT US ON 0800 226 5633 FOR AUTHORISATION PRIOR TO ANY PLANNED HOSPITAL ADMISSION, DAY SURGERY PROCEDURE, MRI SCAN, CT SCAN OR RADIONUCLIDE SCAN, OR WITHIN 24 HOURS OF AN EMERGENCY ADMISSION** • Pre-authorisation for a hospital admission **does not guarantee** that all claims related to the hospital event will be **covered in full** • **The onus is on you, as the member, to ensure that the hospital, treatment facility or day surgery facility, as well as treating Healthcare Professionals are DSPs or in the Bankmed network to avoid co-payments** • Benefits and limitations applicable to your Plan are set out in these Benefit Tables as well as in the Scheme Rules available on the Bankmed website. The benefits under the 'Hospitalisation' benefit section refer only to the hospital account • Any Healthcare Professionals attending to you during your hospital stay must submit a valid account for payment • The payment will be subject to the benefits, limits and/or any special conditions set out in these Benefit Tables and Scheme Rules under the relevant benefit categories • **You are responsible for ensuring the claims are submitted for payment by the Healthcare Professional**						

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
	• Please take care to determine the limits for your Plan (if any) and the rate at which the Scheme will reimburse your claims • Always understand the fees to be charged by your Healthcare Professional, and where necessary, negotiate fees with your attending Healthcare Professionals before incurring costs to avoid out-of-pocket payments • Please log in to the website for a list of procedures that can be safely performed in the doctor's rooms as an alternative to hospitalisation						
7.1	**Hospitalisation overall annual limit**	• No overall annual limit • Limited to PMBs	• No overall annual limit				
7.2	**Hospital network (DSP) applicable**	• Bankmed Hospital Network DSP for the Essential Plan	• Bankmed Hospital Network DSP for the Basic Plan	• Bankmed Hospital Network DSP for the Traditional Plan	• All contracted Netcare, National Hospital Network (NHN), Life Healthcare, Mediclinic and Clinix hospitals, and any other independent private hospitals contracted to the Scheme		
7.3	**Hospitalisation at a DSP** All admissions	• 100% of cost					
7.4	**Hospitalisation at non-DSP for PMB admission** Involuntary use of non-DSP	• 100% of cost					
7.5	**Hospitalisation at non-DSP for PMB admission** Voluntary use of non-DSP	• 80% of Scheme Rate • Deductible applies		• 100% of Scheme Rate • Deductible applies			
7.6	**Hospitalisation at non-DSP for non-PMB admission**	• No benefit	• 80% of Scheme Rate • Deductible applies	• 100% of Scheme Rate • Deductible applies			
7.7	**Ward rate**	• General ward					• General and private wards
7.8	**Referral requirement**	• Benefits only available on referral from GP in Bankmed Entry Plan GP Network, or referred specialist subject to PMB regulations		• Not applicable			
7.9	**Other**	• No benefit for dental surgery and auxiliary services, except for PMBs		• Not applicable			
7.10	**To-take-out (TTO) medication** Supplied by the hospital when a patient is discharged	• 100% of cost • Limited to PMBs and a maximum of a seven-day supply per admission • Must be charged on the hospital account where a hospital event has taken place • Not payable if obtained via a pharmacy after discharge • If procedure took place in a day surgery facility, a maximum of a seven-day supply will be funded from Insured Benefits if obtained from a retail pharmacy on the date of discharge only					
8.	**DEDUCTIBLES (UPFRONT PAYMENT)** A beneficiary will be responsible for a deductible in respect of the hospital or day surgery account for certain hospital and day surgery events, unless the admission is related to a PMB diagnosis, typically as a result of an emergency. This applies even if the procedure is not the main reason for admission. Payment is due directly to the facility at the time of admission						
8.1	**Deductibles** Deductible waiver conditions: • PMB conditions where admission to a non-DSP is on an involuntary basis. In the case of other PMB conditions, where a DSP has been used on a voluntary basis, the deductible will be applied • Confinements are excluded from deductibles • Re-admissions to hospital within six weeks of discharge following complications directly related to a prior admission in respect of which a deductible was levied • Admissions to a State hospital or facility • Authorised day surgery admissions for specified procedures						

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
8.2	**Day Surgery Network deductible** Bankmed's Day Surgery Network comprises a defined list of contracted day surgery facilities as well as contracted acute hospitals providing day surgery facilities at day surgery rates					
	Day surgery deductible waiver conditions • Applicable to Day Surgery Procedure List • Treatment/procedure performed at Bankmed Day Surgery Network facility	• Refer to 'Bankmed Day Surgery Procedure List' in 8.3 below • No deductible • Limited to PMBs		• Refer to 'Bankmed Day Surgery Procedure List' in 8.3 below • No deductible		
	PMB admission • Treatment/procedure NOT performed at Bankmed Day Surgery Network facility • Involuntary use of non-DSP	• Refer to 'Bankmed Day Surgery Procedure List' in 8.3 below • No deductible • Limited to PMBs		• Refer to 'Bankmed Day Surgery Procedure List' in 8.3 below • No deductible		
	PMB admission • Treatment/procedure NOT performed at Bankmed Day Surgery Network facility • Voluntary use of non-DSP	• Refer to 'Bankmed Day Surgery Procedure List' in 8.3 below • R4 100 per admission • Limited to PMBs		• Refer to 'Bankmed Day Surgery Procedure List' in 8.3 below • R4 100 per admission		
	Non-PMB admission • Treatment/procedure NOT performed at Bankmed Day Surgery Network facility	• No benefit		• Refer to 'Bankmed Day Surgery Procedure List' in 8.3 below • R4 100 per admission		
8.3	**Bankmed Day Surgery Procedure List** Bankmed's Day Surgery Procedure List comprises a defined list of procedures/treatments that can be safely performed at a contracted facility in the Bankmed Day Surgery Network without incurring a deductible					

	• Adenoidectomy
	• Arthrocentesis
	• Cataract Surgery
	• Cautery of vulva warts
	• Circumcision
	• Colonoscopy
	• Cystourethroscopy
	• Diagnostic D and C
	• Gastroscopy
	• Hysteroscopy
	• Myringotomy
	• Myringotomy with intubation (grommets)
		• Nasal cautery
		• Nasal plugging for nose bleeds
		• Proctoscopy
		• Prostate biopsy
		• Removal of pins and plates
		• Sigmoidoscopy
		• Tonsillectomy
		• Treatment of Bartholins cyst/gland
		• Vasectomy
		• Vulva/cone biopsy
		• Oesophagoscopy
			• Simple abdominal hernia repair
			• Eye procedures
			  • Other eye procedures: removal of foreign body, vitrectomy
			• Gynaecological procedures
			  • Laparoscopic gynaecological procedures
			• Orthopaedic procedures
			  • Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty)
			  • Biopsies: subcutaneous tissue, soft tissue, muscle, bone
			  • Treatment of simple closed fractures and/or dislocations, removal of pins and plates.
				• Orthopaedic procedures continued
				  • Arthroscopy, arthrotomy, knee, shoulder, elbow, hand, wrist), arthrodesis (hand, wrist,)
				  • Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy).
				  • Incision and drainage/excision of abscess and/or cyst/tumour: subcutaneous tissue, soft tissue, bone, bursa
				  • Treatment of closed fractures and/or dislocations, removal of pins and plates	

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
8.4	**Dental admission deductible** Deductible applies to dental admissions at private hospitals and day surgery facilities (both DSPs and non-DSPs)						

	Dental admission deductible	• No benefit for in-hospital dental treatment, except PMBs		• Deductible:
				  • Day surgery: R310
				  • Hospital: R2 295
					• No benefit for in-hospital dental treatment, except PMBs	• Deductible:
						  • Day surgery: R310
						  • Hospital: R2 295	

8.5	**Non-DSP facility deductible** Deductible applicable to a use of a non-DSP facility Applies to all procedures NOT listed in the Bankmed Day Surgery Procedure List in 8.3						
	PMB admission • Treatment/procedure NOT performed at Bankmed Network Facility • Involuntary use of non-DSP	• No deductible payable for PMBs	• No deductible payable for PMBs	• No deductible payable for PMBs	• No deductible payable for PMBs		

	PMB admission
	• Treatment/procedure NOT performed at Bankmed Network Facility
	• Voluntary use of non-DSP
		• Applies to all admissions
		• Deductible:
		  • Day surgery: R310
		  • Hospital: R775
			• Applies to all admissions
			• Deductible:
			  • Day surgery: R310
			  • Hospital: R775
				• Applies to all admissions
				• Deductible:
				  • Day surgery: R310
				  • Hospital: R6 425
					• Applies to all admissions
					• Deductible:
					  • Day surgery: R310
					  • Hospital: R775		

	Non-PMB admission
	• Treatment/procedure NOT performed at Bankmed Network Facility
		• No benefit	• Applies to all admissions
			• Deductible:
			  • Day surgery: R310
			  • Hospital: R775
				• Applies to all admissions
				• Deductible:
				  • Day surgery: R310
				  • Hospital: R6 425
					• Applies to all admissions
					• Deductible:
					  • Day surgery: R310
					  • Hospital: R775		

9.	**OUTPATIENT CONSULTATIONS AND FACILITY FEES FOR OUTPATIENT VISITS**						
9.1	**Casualty and outpatient consultations** GP or specialist consultation at hospital emergency unit, casualty unit or outpatient unit	• Regarded as an out-of-hospital GP/specialist consultation in rooms, unless resulting in an authorised hospital admission • Refer to 'GP Consultations In-room or out-of-hospital', and 'Specialist Consultations In-room or out-of-hospital' benefit sections					
9.2	**Facility fees** For casualty and outpatient consultations at a hospital emergency unit, casualty unit, or outpatient unit	• Facility fees not covered, unless resulting in an authorised hospital admission	• Facility fees subject to 'Specialist Consultations In-room or out-of-hospital' benefit, unless resulting in an authorised hospital admission				

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
10.	**GP CONSULTATION WITHIN 30 DAYS OF DISCHARGE FROM HOSPITAL**					
10.1	**Post-hospital GP consultation within 30 days of discharge from hospital**	• Additional Insured Benefit • Refer to '30-Day Post-hospital GP Consultation Benefit' section				
11.	**BLOOD TRANSFUSIONS** Subject to pre-authorisation and PMB regulations					
11.1	**Blood transfusions**	• 100% of cost • Limited to PMBs	• 100% of cost • Unlimited			
12.	**ORGAN AND BONE MARROW TRANSPLANTS** Subject to pre-authorisation and PMB regulations. Organ recipient must be a Bankmed beneficiary for benefits to apply. No benefits for travelling and non-hospital accommodation expenses					
12.1	**Hospitalisation/organ and patient preparation**	• Refer to 'Hospitalisation' benefit section • Limited to PMBs	• Refer to 'Hospitalisation' benefit section	• Refer to 'Hospitalisation' benefit section • Limited to PMBs	• Refer to 'Hospitalisation' benefit section	
12.2	**Medication** In- and out-of-hospital	• Limited to PMBs	• Unlimited	• Limited to PMBs	• Unlimited	
	Medication via DSP Designated pharmacy	• 100% of cost	• 100% of cost	• 100% of cost	• 100% of cost	
	Medication via non-DSP Voluntary use of non-DSP	• 80% of Scheme Medicine Reference Price plus dispensing fee	• 80% of Scheme Medicine Reference Price plus dispensing fee	• 80% of Scheme Medicine Reference Price plus dispensing fee	• 80% of Scheme Medicine Reference Price plus dispensing fee	
	Medication via non-DSP Involuntary use of non- DSP	• 100% of cost	• 100% of cost	• 100% of cost	• 100% of cost	
12.3	**Harvesting and transporting organs and other donor costs**	• 100% of cost, limited to PMBs	• 100% of cost, unlimited	• 100% of cost, limited to PMBs	• 100% of cost, unlimited	
13.	**ONCOLOGY**					
	Subject to: • Pre-authorisation and PMB regulations • Evidence-based medicine, cost-effectiveness and affordability • Scheme's oncology BOC, formularies and/or protocols • Meeting Scheme's Clinical Entry Criteria • Peer-review by external panel of specialists as appointed by the Scheme • Medication must be dispensed through the DSP. Where a non-network provider is used, funding will be approved up to a maximum of 80% of the Scheme Medicine Reference Price and the balance will be for the member's own pocket • Generic substitution and/or switching to cost-effective therapeutic equivalents (drug utilisation review)					

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
13.1	**Consultations, treatment, and materials** In- and out-of-hospital	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	
13.2	**Radiotherapy fees, chemotherapy facility, and professional fees**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	
13.3	**Associated medication and drugs**						
	For medicines administered in-rooms • Injectable and infusional chemotherapy • Excludes medicines administered in-hospital and medicines administered in-rooms by a dispensing provider						
	Medication via DSP Bankmed's Oncology Pharmacy DSP (courier pharmacy)	• Limited to PMBs • 100% of cost, limited to PMBs		• Unlimited • 100% of cost	• Limited to PMBs • 100% of cost, limited to PMBs	• Unlimited • 100% of cost	
	Medication via a non-DSP Voluntary use of non-DSP	• 80% of Scheme Medicine Reference Price plus dispensing fee, limited to PMBs		• 80% of Scheme Medicine Reference Price plus dispensing fee	• 80% of Scheme Medicine Reference Price plus dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus dispensing fee	
	Medication via non-DSP Involuntary use of non- DSP	• 100% of cost, limited to PMBs		• 100% of cost	• 100% of cost, limited to PMBs	• 100% of cost	
	For medicines scripted and dispensed at a retail pharmacy (scripted by treating provider) • Supportive medication, oral chemotherapy and hormonal therapy						
	Medication via DSP Bankmed's Oncology Pharmacy DSP	• Limited to PMBs • 100% of cost, limited to PMBs		• Unlimited • 100% of cost	• Limited to PMBs • 100% of cost, limited to PMBs	• Unlimited • 100% of cost	
	Medication via a non-DSP Voluntary use of non-DSP	• 80% of Scheme Medicine Reference Price plus dispensing fee, limited to PMBs		• 80% of Scheme Medicine Reference Price plus dispensing fee	• 80% of Scheme Medicine Reference Price plus dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus dispensing fee	
	Medication via non-DSP Involuntary use of non- DSP	• 100% of cost, limited to PMBs		• 100% of cost	• 100% of cost, limited to PMBs	• 100% of cost	

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
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pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
14.	**RENAL DIALYSIS** Subject to pre-authorisation and PMB regulations					
14.1	**Procedures and treatment**	• Limited to PMBs • 100% of cost at DSP • 100% of Scheme Rate at non-DSP		• Unlimited • 100% of cost at DSP • 100% of Scheme Rate at non-DSP		
14.2	**Medication** In- and out-of-hospital	• Limited to PMBs		• Unlimited		
	Medication via DSP Bankmed Pharmacy Network	• 100% of cost, limited to PMBs		• 100% of cost		
	Medication via a non-DSP Voluntary use of non-DSP	• 80% of Scheme Medicine Reference Price plus dispensing fee, limited to PMBs		• 80% of Scheme Medicine Reference Price plus dispensing fee		
	Medication via non-DSP Involuntary use of non-DSP	• 100% of cost, limited to PMBs		• 100% of cost		
15.	**PREGNANCY AND CHILDBIRTH** Subject to pre-authorisation and PMB regulations					
15.1	**Baby-and-Me Programme for expectant mothers**	• No benefit	• Call 0800 BANKMED (0800 226 5633) to register			
15.2	**Hospitalisation and associated in-hospital services** Subject to pre-authorisation	• Refer to 'Hospitalisation' benefit section • Hospital network rules apply • Limited to PMBs	• Refer to 'Hospitalisation' benefit section • Hospital network rules apply			
15.3	**Midwife care and delivery** Subject to pre-authorisation	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited		
15.4	**Birthing facilities as an alternative to hospitalisation** Subject to pre-authorisation • Only available where hospital services are not used, except registered active birthing units	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs • Cost of disposables limited to R1 375 per case		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited • Cost of disposables limited to R1 375 per case		

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
15.5	**Antenatal and postnatal care** GP and specialist consultations and procedures in-rooms	• Refer to 'GP Consultations In-room or out-of-hospital', and 'Specialist Consultations In-room or out-of-hospital' benefit sections • Limited to PMBs	• Refer to 'GP Consultations In-room or out-of-hospital', and 'Specialist Consultations In-room or out-of-hospital' benefit sections • Refer to additional Insured Benefits under Baby-and-Me Programme				• Refer to 'GP Consultations In-room or out-of-hospital', and 'Specialist Consultations In-room or out-of-hospital' benefit sections
15.6	**Antenatal and postnatal care** Ultrasonic investigations Radiology	• Refer to 'Radiology and pathology' benefit section • Limited to PMBs	• Refer to 'Radiology and pathology' benefit section • Refer to additional Insured Benefits under Baby-and-Me Programme				• Refer to 'Radiology and pathology' benefit section
15.7	**Antenatal and postnatal care** Pathology	• Refer to 'Radiology and pathology' benefit section • Limited to PMBs	• Refer to 'Radiology and pathology' benefit section • Refer to additional Insured Benefits under Baby-and-Me Programme				• Refer to 'Radiology and pathology' benefit section

15.8	**Additional Insured Benefits**
	Subject to registration on the Baby-and-Me Programme
		• No benefit	• Additional Insured Benefits subject to referral by GP in Bankmed Entry Plan GP Network (Basic Plan member) or GP in Bankmed GP Network (Core Saver, Traditional and Comprehensive Plan members)
			  • Six antenatal consultations per pregnancy at the contracted rate for Bankmed's GP Network and Prestige A and B Specialist Network
			  • Refer to 'GP Consultations In-room or out-of-hospital', and 'Specialist Consultations In-room or out-of-hospital' benefit sections
			  • Three 2D ultrasounds at 100% of Scheme Rate
			  • R1 690 per pregnancy for antenatal and postnatal classes at 100% of Scheme Rate
			  • Additional pathology at 100% of Scheme Rate, subject to Baby-and-Me approved BOC
							• Additional Insured Benefits not applicable on this Plan
							  • Members may register on the programme to obtain information, guidance and support throughout the pregnancy

16.	**RADIOLOGY AND PATHOLOGY**						
16.1	**Radiology** In-hospital	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited				
16.2	**Pathology** In-hospital	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited				
16.3	**MRI/CT scans, radionuclide scans** In- and out-of-hospital Subject to pre-authorisation and PMB regulations **In-hospital**	• 100% of cost for radiology facilities at hospital network DSP	• 100% of cost at DSP	• 100% of cost at DSP			

Terminology Reminders:

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pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
	Out-of-hospital	• Limited to 100% of Scheme Rate for voluntary use of radiology facilities at non-DSP • Limited to PMBs • Subject to pre-authorisation in-hospital • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to pre-authorisation out-of-hospital • Limited to PMBs	• 100% of Scheme Rate at non-DSP • Unlimited • Subject to pre-authorisation in-hospital • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to pre-authorisation out-of-hospital • Limited to PMBs	• 100% of Scheme Rate at non-DSP • Unlimited • Subject to pre-authorisation in-hospital • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to pre-authorisation out-of-hospital • Unlimited			
16.4	**Radiology and pathology** Out-of-hospital	• Limited to PMBs • 100% of cost for PMBs • Benefits subject to a CDL (BOC) registration for PMB conditions	• Unlimited via DSP • 100% of cost at DSP • DSP: Bankmed Entry Plan GP Network • Subject to Scheme Radiology and Pathology Formulary • Specialist requested/performed radiology/pathology subject to available 'Specialist Consultations In-room or out-of-hospital' benefit	• 100% of cost at DSP for PMB • 100% of Scheme Rate, limited to R7 180 pfpa for non-DSP or non-PMB • Combined limit for 'Radiology and pathology out-of-hospital'	• 100% of cost at DSP for PMB • Subject to referral by GP in Bankmed GP Network (DSP) • 100% of Scheme Rate, subject to a CDL (BOC) and referral by GP in Bankmed GP Network (DSP) • Benefits approved for beneficiaries registered for PMB CDL conditions • Non-CDL benefits subject to available MSA	**Radiology:** • 100% of cost at DSP for PMB • 100% of Scheme Rate, limited to R4 810 pfpa (including a sub-limit of R3 050 pfpa for out-of-hospital pathology) • Thereafter subject to available MSA **Pathology:** • 100% of cost at DSP for PMB • 100% of Scheme Rate, limited to R3 050 pfpa (included in the annual limit of R4 810 pfpa for out-of-hospital radiology) • Thereafter subject to available MSA	• 100% of cost at DSP for PMB • 300% of Scheme Rate, subject to available MSA • ATB applies once Annual Threshold is reached • The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an ATB (always subject to available ATB) is R7 645 pfpa

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
17.	**ALTERNATIVES TO HOSPITALISATION** Subject to pre-authorisation and PMB regulations					
17.1	**Step-down facilities**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited			
17.2	**Advanced Illness Benefit** End-of-life treatment Subject to pre-authorisation and PMB regulations and the treatment meeting the Scheme's guidelines and managed care criteria	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited		
17.3	**Frail care facilities**	• No benefit		• 100% of cost, limited to R550 pb per day	• No benefit	• 100% of cost, limited to R550 pb per day
17.4	**Home nursing**	• No benefit		• 100% of cost, limited to R435 pb per day	• No benefit	• 100% of cost, limited to R435 pb per day
17.5	**HomeCare services** For procedures not requiring admission to a day surgery or hospital. Subject to clinical entry criteria, pre-authorisation, and PMB regulations	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited			
17.6	**Spinal Conservative Care Programme** • In-hospital and out-of-hospital management for spinal care and surgery • Limited to a defined list of clinically appropriate procedures which include Lumbar Fusion, Cervical Fusion, Laminectomy, Laminotomy	• 100% of cost for the hospital account at a network facility • Network does not apply to any admissions related to trauma • 100% of the Scheme Rate for the hospital account if performed at a non-network facility • 100% of cost for related accounts at a DSP • 100% of Scheme Rate for related accounts at a non-DSP • Limited to PMBs • Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria • Subject to PMB regulations • BOC as set by the Scheme for out-of-hospital conservative treatment		• 100% of cost for the hospital account at a network facility • Network does not apply to any admissions related to trauma • 100% of the Scheme Rate for the hospital account if performed at a non-network facility • 100% of cost for related accounts at a DSP • 100% of Scheme Rate for related accounts at a non-DSP • Unlimited • Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria • Subject to PMB regulations • BOC as set by the Scheme for out-of-hospital conservative treatment		

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
18.	**INTERNAL PROSTHESIS** Subject to clinical motivation, the application of clinical and funding protocols and Scheme approval. Bankmed reserves the right to obtain further quotations prior to granting approval. The prostheses accumulate to the limit and not the hospital and related accounts. All sub-limits are subject to the combined Internal Prosthesis limit of R87 055 pbpa (excluding pacemakers and defibrillators)					
18.1	**Internal prosthesis**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to the combined 'Internal prosthesis' limit of R87 055 pbpa for all internal prosthesis items		
18.2	**Spinal fusions**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of Scheme Rate for device • Limited to R58 655 pbpa • Subject to the combined 'Internal prosthesis' limit		
18.3	**Cardiac stents**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of Scheme Rate for device • Limited to R86 710 pbpa • Subject to the combined 'Internal prosthesis' limit		
18.4	**Grafts**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of Scheme Rate for device • Limited to R46 940 pbpa • Subject to the combined 'Internal prosthesis' limit		
18.5	**Cardiac valves**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of Scheme Rate for device • Limited to R49 370 pbpa • Subject to the combined 'Internal prosthesis' limit		
18.6	**Hip, knee and shoulder joints**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of Scheme Rate for device • If prosthesis is not supplied by Scheme's network provider (DSP): Limited to R57 935 per prosthesis per admission • If prosthesis is supplied by the Scheme's network provider (DSP): Unlimited and not subject to the combined 'Internal prosthesis' limit		
18.7	**Non-specified Items**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of Scheme Rate for device • Limited to R27 050 pbpa • Subject to the combined 'Internal prosthesis' limit		
19.	**PACEMAKERS AND DEFIBRILLATORS** Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval. Bankmed reserves the right to obtain further quotations prior to granting approval					
19.1	**Pacemakers and defibrillators**	• Limited to PMBs • 100% of cost at hospital network DSP • 80% of cost at non-DSP		• 100% of cost, unlimited, if preferred provider used • 100% of Scheme Rate if non-preferred provider used to purchase device		

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
20.	**INTRAOCULAR LENSES FOR CATARACT SURGERY** Subject to pre-authorisation and PMB regulations and the treatment meeting the Scheme's criteria. Covered in full when supplied by the Scheme's preferred suppliers, otherwise covered up to 100% of the Scheme Rate for the lens					
20.1	**Intraocular lenses for cataract surgery** Permanent, implantable lenses, inclusive of basic and specialised lens varieties	• 100% of cost, unlimited, if preferred supplier's lens is used • 100% of Scheme Rate if lens used is not a preferred supplier lens • Scheme Rate is equal to the lens base price/lens reference price, plus 25% mark-up • Where the provider marks up the lens cost in excess of the agreed rate, the Scheme will not be responsible for the shortfall • Limited to PMBs	• 100% of cost, unlimited, if preferred supplier's lens is used • 100% of Scheme Rate if lens used is not a preferred supplier lens • Scheme Rate is equal to the lens base price/lens reference price, plus 25% mark-up • Where the provider marks up the lens cost in excess of the agreed rate, the Scheme will not be responsible for the shortfall			
21.	**COCHLEAR IMPLANT** Subject to pre-authorisation and PMB regulations and Scheme protocols. Once in a lifetime benefit. Funding only available in recognised Centres of Excellence. Bilateral cochlear implant benefits may be awarded to children under the age of 5 years where clinical entry criteria are met. Subject to special motivation, clinical review and authorisation					
21.1	**Hospitalisation**	• No benefit	• Refer to 'Hospitalisation' benefit section	• No benefit	• Refer to 'Hospitalisation' benefit section	
21.2	**Pre-operative evaluation and associated preparation costs**	• No benefit	• R20 625 pb per lifetime • 100% of Scheme Rate	• No benefit	• R20 625 pb per lifetime • 100% of Scheme Rate	
21.3	**Cochlear implant device**	• No benefit	• R432 450 pb per lifetime • 100% of Scheme Rate	• No benefit	• R432 450 pb per lifetime • 100% of Scheme Rate	
21.4	**Intra-operative audiology testing**	• No benefit	• R1 075 pb per lifetime • 100% of Scheme Rate	• No benefit	• R1 075 pb per lifetime • 100% of Scheme Rate	
21.5	**Post-operative evaluation costs**	• No benefit	• R43 315 pb per lifetime • 100% of Scheme Rate	• No benefit	• R43 315 pb per lifetime • 100% of Scheme Rate	
22.	**SPEECH PROCESSORS** Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval					
22.1	**Upgrade or replacement of speech processors**	• No benefit	• 80% of Scheme Rate • Limited to R161 470 pb over a three-year cycle	• No benefit	• 80% of Scheme Rate • Limited to R161 470 pb over a three-year cycle	
23.	**HEARING AIDS**					
23.1	**Hearing aids** Supply and fitment	• No benefit, except for PMBs	• 100% of Scheme Rate, limited to R34 685 pb every second year (rolling 24 months)	• 100% of Scheme Rate, subject to available MSA	• 100% of Scheme Rate, limited to R34 685 pb every second year (rolling 24 months)	• 100% of Scheme Rate, limited to R40 610 pb every second year (rolling 24 months)
23.2	**Hearing aid repairs**	• No benefit	• 100% of Scheme Rate • Limited to R1 800 pbpa	• 100% of Scheme Rate • Subject to available MSA	• 100% of Scheme Rate • Limited to R1 800 pbpa	
23.3	**Bone anchored hearing aids**	• No benefit	• 90% of Scheme Rate • Limited to R185 530 pfpa	• 100% of Scheme Rate • Subject to available MSA	• 90% of Scheme Rate • Limited to R185 530 pfpa	

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
24.	**EXTERNAL PROSTHESIS, MEDICAL AND SURGICAL APPLIANCES, BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS** Benefit includes the repair of the prosthesis					
24.1	**External prosthesis** Benefit for limbs and eyes	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R3 825 pfpa • Combined limit with 'Blood pressure monitors, nebulisers and glucometers' benefits	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R29 700 pfpa	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R3 825 pfpa • Combined limit with 'Medical and surgical appliances', 'Blood pressure monitors, nebulisers and glucometers', and 'Arch supports and shoe insoles' benefits	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R29 700 pfpa	
24.2	**Medical and surgical appliances** Refer to claim 'Frequency limits' in 24.6 below	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs • No benefit for wheelchairs and large orthopaedic appliances on this Plan, except for PMBs • Only payable if claimed from a service provider with a valid BHF practice number	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs • Combined limit of R3 825 pfpa with 'External prosthesis', 'Blood pressure monitors', 'Nebulisers and glucometers' benefits • Subject to pre- authorisation and PMB regulations • No benefit for wheelchairs and large orthopaedic appliances on this Plan, except for PMBs • Only payable if claimed from a service provider with a valid BHF practice number	**Post-surgery appliances:** • 100% of Scheme Rate • Limited to R8 730 pbpa **Chronic appliances:** • 100% of cost • Limited to: • R27 420 pbpa for oxygen/ oxygen delivery systems • R27 420 pbpa for stoma products • R8 730 pbpa for 'Other chronic appliances', including wheelchairs • Sub-limits as follows: • R1 075 arch supports (Per pair) • R1 620 shoe insoles (Per pair) • 'Other chronic appliances' limit extended to R12 775 for beneficiaries requiring a CPAP machine	• Limit of R3 825 pfpa • Combined limit with 'External prosthesis', 'Blood pressure monitors, nebulisers and glucometers', and 'Arch supports and shoe insoles' benefits • Benefits for wheelchairs and large orthopaedic appliances at 100% of Scheme Rate, subject to available MSA • Only payable if claimed from a service provider with a valid BHF practice number	**Post-surgery appliances:** • 100% of Scheme Rate • Limited to R8 730 pbpa **Chronic appliances:** • 100% of cost • Limited to: • R27 420 pbpa for oxygen/ oxygen delivery systems • R27 420 pbpa for stoma products • R8 730 pbpa for 'Other chronic appliances', including wheelchairs • Sub-limits as follows: • R1 075 arch supports (Per pair) • R1 620 shoe insoles (Per pair) • 'Other chronic appliances' limit extended to R12 775 for beneficiaries requiring a CPAP machine	**Post-surgery appliances:** • 100% of Scheme Rate • Limited to R8 730 pbpa **Chronic appliances:** • 100% of cost • Limited to: • R27 420 pbpa for oxygen/ oxygen delivery systems • R27 420 pbpa for stoma products • R8 730 pbpa for 'Other chronic appliances', including wheelchairs • Sub-limits as follows: • R1 075 arch supports (Per pair) • R1 620 shoe insoles (Per pair) • 'Other chronic appliances' limit extended to R12 775 for beneficiaries requiring a CPAP machine

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
			Appliances for acute conditions: • 100% of Scheme Rate • Limited to R8 730 pbpa • Combined limit with 'Other chronic appliances' benefits • Additional discretionary benefits may be granted for wheelchairs, subject to occupational therapist or physiotherapist motivation, at least two cost quotations and Scheme approval • Only payable if claimed from a service provider with a valid BHF practice number		**Appliances for acute conditions:** • 100% of Scheme Rate • Subject to available MSA • Additional discretionary benefits may be granted for wheelchairs, subject to occupational therapist or physiotherapist motivation, at least two cost quotations and Scheme approval • Only payable if claimed from a service provider with a valid BHF practice number	**Appliances for acute conditions:** • 100% of Scheme Rate • Subject to available MSA • ATB applies once the Annual Threshold is reached • 100% of Scheme Rate in ATB • Additional discretionary benefits may be granted for wheelchairs, subject to occupational therapist or physiotherapist motivation, at least two cost quotations and Scheme approval • Only payable if claimed from a service provider with a valid BHF practice number

24.3	**Blood pressure monitors (BPM), nebulisers and glucometers**
	Refer to claim 'Frequency limits' in 24.6 below
		• Subject to pre-authorisation and PMB regulations
		• 100% of cost at DSP
		• 100% of Scheme Rate at non-DSP
		• Limited to PMBs
			• Subject to pre-authorisation and PMB regulations
			• 100% of Scheme Rate
			• Limit of R3 825 pfpa
			• Combined limit with 'External prosthesis' and 'Medical and surgical appliances' benefits
			• Sub-limits as follows:
			  • BPM: R1 470 pbpa
			  • Nebulisers: R2 075 pbpa
			  • Glucometers: R1 035 pbpa
			• Only payable if claimed from a service provider with a valid BHF practice number
				• Available on prescription without additional motivation or Scheme approval
				• 100% of Scheme Rate
				• Limit of R8 730 pbpa
				• Combined limit with 'Other chronic appliances' under 'Medical and surgical appliances' benefits
				• Sub-limits as follows:
				  • BPM: R1 470 pbpa
				  • Nebulisers: R2 075 pbpa
				  • Glucometers: R1 035 pbpa
				• Only payable if claimed from a service provider with a valid BHF practice number
					• Available on prescription without additional motivation or Scheme approval
					• 100% of Scheme Rate
					• Limit of R3 825 pfpa
					• Combined limit with 'External prosthesis', 'Medical and surgical appliances', and 'Arch supports and shoe insoles' benefits
					• Sub-limits as follows:
					  • BPM: R1 470 pbpa
					  • Nebulisers: R2 075 pbpa
					  • Glucometers: R1 035 pbpa
					• Only payable if claimed from a service provider with a valid BHF practice number
						• Available on prescription without additional motivation or Scheme approval
						• 100% of Scheme Rate
						• Limit of R8 730 pbpa
						• Combined limit with 'External prosthesis' and 'Medical and surgical appliances' benefits
						• Sub-limits as follows:
						  • BPM: R1 470 pbpa
						  • Nebulisers: R2 075 pbpa
						  • Glucometers: R1 035 pbpa
						• Only payable if claimed from a service provider with a valid BHF practice number

Important information

- Claims for medical and surgical appliances can only be paid if the appliance has been purchased from a Healthcare Professional with a valid BHF practice number.
- Bankmed cannot refund members where the appliance has been purchased from a company or person that is not registered as a Healthcare Professional with the BHF.
- For example, members may purchase a wheelchair, breast pump, wheelchair batteries, commodes, crutches, arch supports, blood pressure monitors, nebulisers, etc., from Takealot, Gumtree, old age homes, battery suppliers, and other companies that offer these products to the public.
- These "claims" cannot be refunded by Bankmed.
- Please ensure that you have checked that the provider is registered with the BHF before ordering or paying for the appliance.

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		

24.4	**Arch supports and shoe insoles**
	Refer to claim 'Frequency limits' in 24.6 below
		• No benefit		• Refer to 24.3	• 100% of Scheme Rate
					• Limit of R3 825 pfpa
					• Combined limit with 'External prosthesis', 'Medical and surgical appliances', and 'Blood pressure monitors, nebulisers and glucometers' benefits
					• Sub-limits as follows:
					  • R1 075 arch supports (Per pair)
					  • R1 620 shoe insoles (Per pair)
					• Only payable if claimed from a service provider with a valid BHF practice number
						• Refer to 24.3	

24.5	**Breast pumps and baby monitors**	• No benefit		• Limit of R8 730 pbpa • Combined limit with 'Other chronic appliances' under 'Medical and surgical appliances' benefits • Only payable if claimed from a service provider with a valid BHF practice number	• Funded from available MSA • Only payable if claimed from a service provider with a valid BHF practice number		
24.6	**Frequency limits pertaining to medical and surgical appliances, blood pressure monitors, nebulisers, glucometers, etc.**	• Appliances may be claimed once over a specified period • The following appliances may be claimed once per the specified period below:					

Appliance/device	Frequency
Blood pressure monitor	Once every three years
Humidifier	Once every three years
CPAP machine	Once every three years
Crutches	Once every two years
Rigid back brace	Once every two years
Foot orthotics	Once every two years
Sling/clavicle brace	Once every two years

Appliance/device	Frequency
Breast prosthesis	Once every two years (single/pair)
Wheelchair	Once every three years
Compression stockings	Two per year
Portable oxygen	Once every four years
Glucometer	Once every three years
Nebuliser	Once every three years

Appliance/device	Frequency
Surgical boot/moon boot	Once every three years
Brace/callipers	Once every three years
Wig	Once every three years
Breast prosthesis bra*	Once every three years
Commode	Once every three years
Walking frame	Once every three years

- The above limits apply to members who qualify for the abovementioned benefits per their Plan Type. Should a member not qualify for the benefit, the frequency limit is not applicable

  * Where Plans have Rand limits in place, members may claim for more than two breast prosthesis bras, provided that the Rand limit is not exceeded

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
25.	**PSYCHIATRY, CLINICAL PSYCHOLOGY AND RELATED OCCUPATIONAL THERAPY**					
25.1	**Hospitalisation** Subject to pre-authorisation and PMB regulations	• Limited to PMBs • Subject to referral from a Bankmed Entry Plan GP Network GP (DSP)		• Limited to R81 350 pbpa		
	Hospital Network DSP • All admissions at network DSP	• 100% of cost for Bankmed Network Psychiatric facilities (DSP)		• 100% of cost for Bankmed Network Psychiatric facilities (DSP)		
	Other hospitals (non-DSP) • **PMB admission** Involuntary use of non-DSP	• 100% of cost		• 100% of cost		
	• **PMB admission** Voluntary use of non-DSP	• 80% of Scheme Rate		• 80% of Scheme Rate		
	• **Non-PMB admission**	• No benefit		• 80% of Scheme Rate		

	In-hospital consultations/ sessions	• 100% of cost for Bankmed Entry Plan Specialist Network (DSP)
		• 100% of Scheme Rate for non-DSP
		  • Cover for 21 days in hospital in line with PMB regulations
				• 100% of cost for Bankmed Prestige A and B Specialist Network (DSP)
				• 100% of Scheme Rate for non-DSP
				  • Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the Rand limit
				  • Continued benefits for PMBs subject to pre-authorisation and PMB regulations
				  • Combined limit with 'Occupational therapy: psychiatric consultations/sessions in hospital' benefit		

25.2	**30-Day Post-hospital Psychiatric Consultation Benefit**
	Access to psychiatric consultation within 30 days of hospital discharge following a psychiatric admission
	
	Applies for psychiatric admissions for Major depression, Schizophrenia and Bipolar mood disorder only (excluding day cases)
		• One additional post-hospitalisation Psychiatrist consultation covered pb within 30 days of being discharged from hospital following an authorised psychiatric admission
		• Covered as an Insured Benefit
		
		• 100% of cost at DSP
		• 100% of Scheme Rate for non-DSP
		  • DSP: Bankmed Entry Plan Specialist Network for Psychiatrist only
		  • Limited to three consultations pbpa, following an authorised admission, thereafter, funded from 'Specialist Consultations In-room or out-of-hospital' benefits
				• One additional post-hospitalisation Psychiatrist consultation covered pb within 30 days of being discharged from hospital following an authorised psychiatric admission
				
				• Covered as an Insured Benefit
				
				• 100% of cost at DSP
				• 100% of Scheme Rate for non-DSP
				  • DSP: Bankmed Prestige A and B Specialist Network for Psychiatrist only
				  • Limited to three consultations pbpa, following an authorised admission, thereafter, funded from 'Specialist Consultations In-room or out-of-hospital' benefits or available MSA, as applicable per Plan		

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
25.3	**Consultations/sessions** Out-of-hospital **Important note:** Cover for 15 out-of-hospital psychotherapy sessions for PMBs	• Limited to PMBs • Benefits subject to pre-authorisation and PMB regulations and referral from a Bankmed Entry Plan GP Network GP (DSP) • 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSP) • 100% of Scheme Rate for non-DSP		• Limited to R5 100 pbpa • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP • Combined limit with 'Occupational therapy: Psychiatric consultations/ sessions out-of-hospital' benefit • Combined limit may be extended to R12 695 pbpa for Depression and/or Bipolar mood disorder, subject to pre-authorisation and PMB regulations	• Subject to available MSA • Benefits subject to pre-authorisation and PMB regulations and referral from a Bankmed Network GP (DSP) • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP, subject to available MSA	• Limited to R5 955 pbpa • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP • Combined limit with 'Occupational therapy: Psychiatric consultations/ sessions out-of-hospital' benefit • Combined limit may be extended to R14 200 pbpa for Depression and/or Bipolar mood disorder, subject to pre-authorisation and PMB regulations	• Subject to available MSA • Benefits subject to PMB regulations and Bankmed Prestige A and B Specialist Network (DSP) • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Prestige A and B Specialist Network (DSP) • 300% of Scheme Rate for non-DSP, subject to available MSA • ATB applies once Annual Threshold is reached • The maximum amount that can accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an ATB (always subject to available ATB) is R17 995 pfpa
25.4	**Mental Health Integrated Disease Management Programme** Disease Management for specified mental health conditions for members registered on the Scheme's Mental Health Integrated Disease Management Programme	• In addition to the cover provided for under the PMB regulations • 100% of the Scheme Rate for services covered in the Scheme's BOC if referred by the Scheme's DSP • 100% of Scheme Rate for services performed by the Scheme's DSP • Limited to the BOC set by the Scheme • Subject to the treatment meeting the Scheme's treatment guidelines and managed care criteria • Subject to PMB regulations					

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
26.	**OCCUPATIONAL THERAPY**					
26.1	**Psychiatric consultations/ sessions** In-hospital Subject to pre-authorisation and PMB regulations	• Refer to 'Psychiatry, clinical psychology and related occupational therapy: Hospitalisation and in-hospital consultations/sessions' benefit section				
26.2	**Psychiatric consultations/ sessions** Out-of-hospital	• Refer to 'Psychiatry, clinical psychology and related occupational therapy: Consultations/sessions out-of-hospital' benefit section				
26.3	**Non-psychiatric consultations/sessions** In-hospital Subject to pre-authorisation and PMB regulations	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	
26.4	**Non-psychiatric consultations/sessions** Out-of-hospital	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs • Subject to pre-authorisation and PMB regulations, and referral from a Bankmed Entry Plan GP Network (DSP)	• 100% of cost for PMB at DSP • 100% of Scheme Rate at non-DSP • Limited to R2 500 pfpa	• 100% of cost for PMB at DSP • 100% of Scheme Rate at non-DSP • 100% of Scheme Rate, subject to available MSA for non-PMBs	• 100% of cost for PMB at DSP • 100% of Scheme Rate at non-DSP • Limited to R2 630 pfpa, from Insured Benefits • Thereafter subject to available MSA	• 100% of cost at DSP from Insured Benefits for PMBs • 300% of Scheme Rate, subject to available MSA for non-PMBs • ATB applies once Annual Threshold is reached • The maximum amount that can accumulate towards reaching the Annual Threshold at 100% of Scheme Rate and/or be paid as an ATB (always subject to available ATB) is R9 075 pfpa. • Subject to PMB regulation
27.	**SPEECH THERAPY, AUDIO THERAPY AND AUDIOLOGY**					
27.1	**Speech therapy, audio therapy and audiology** In- and out-of-hospital	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs • Subject to pre-authorisation and PMB regulations, and referral from a Bankmed Entry Plan GP Network (DSP) • Out-of-hospital cover is subject to PMB application	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs • Subject to pre-authorisation and PMB regulations, and referral from a Bankmed Entry Plan GP Network (DSP)	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R2 500 pfpa	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to available MSA • 100% of cost paid from Insured Benefits for PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R2 705 pfpa • 100% of cost paid from Insured Benefits for PMBs • Thereafter subject to available MSA	• 100% of cost at DSP • 300% of Scheme Rate at non-DSP • Subject to available MSA • 100% of cost paid from Insured Benefits for PMBs • ATB applies once Annual Threshold is reached • The maximum amount that can jointly accumulate towards

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
							reaching the Annual Threshold at 100% of Scheme Rate and/ or be paid as an ATB (always subject to available ATB) is R2 705 pfpa
28.	**PHYSIOTHERAPY**						
28.1	**Physiotherapy** In-hospital Subject to pre-authorisation	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	
28.2	**Post-hospitalisation Physiotherapy Benefit** Applies within six weeks of discharge from hospital or approved day surgery facility, following an authorised hospital or approved day surgery facility admission	• Refer to 'Physiotherapy out-of-hospital' benefit section		• 100% of Scheme Rate • Limited to R3 625 pfpa • 100% of cost at DSP • 100% of Scheme Rate at non-DSP	• Refer to 'Physiotherapy out-of-hospital' benefit section	• 100% of Scheme Rate • Limited to R3 000 pbpa from Insured Benefits • Thereafter subject to available MSA • 100% of cost at DSP • 100% of Scheme Rate at non-DSP	• Refer to 'Physiotherapy out-of-hospital' benefit section
28.3	**Physiotherapy** Out-of-hospital	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to pre-authorisation and PMB regulations, and referral from a Bankmed Entry Plan GP Network GP (DSP) • Limited to PMBs		• 100% of Scheme Rate • Subject to 'GP Consultations In-room or out-of-hospital', and 'Specialist Consultations In-room or out-of-hospital' benefits • 100% of cost at DSP • 100% of Scheme Rate at non-DSP	• 100% of Scheme Rate • Subject to available MSA for non-PMBs • 100% of cost for PMBs • 100% of cost at DSP • 100% of Scheme Rate at non-DSP		• 300% of Scheme Rate • Subject to available MSA for non-PMBs • 100% of cost for PMBs • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • ATB applies once Annual Threshold is reached • The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/ or be paid as an ATB (always subject to available ATB) is R3 625 pbpa

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
29.	**ADDITIONAL BENEFITS FOR BENEFICIARIES WITH NEURODEVELOPMENTAL DISORDERS** Subject to approval. Additional discretionary Insured Benefits in the following categories may be granted for beneficiaries with neurodevelopmental disorders, subject to clinical motivation and Scheme approval The quantum of additional benefits, if approved, shall be decided on a case-for-case basis and granted at the applicable contracted rate or Scheme Rate as set out below					
29.1	**Occupational therapy: psychiatric consultations/ sessions** Out-of-hospital	• No benefit	• 100% of Scheme Rate or contracted rate, whichever applies			
29.2	**Occupational therapy: non-psychiatric consultations/ sessions** Out-of-hospital	• No benefit	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP			
29.3	**Physiotherapy** Out-of-hospital	• No benefit	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP			
29.4	**Speech therapy** Out-of-hospital	• No benefit	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP			
30.	**OTHER AUXILIARY SERVICES** In- and out-of-hospital					
30.1	**Auxiliary allied services** Chiropody, Podiatry, Dietetics (nutritional assessments), Orthotics, Massage, Chiropractors, Herbalists, Naturopaths, Family Planning Clinics, Homeopaths and Biokineticists (fitness assessments)	• Limited to PMBs and subject to PMB regulations • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Out-of-hospital cover is subject to PMB application, referral by GP in the Bankmed Entry Plan GP Network (DSP), and pre-authorisation • Frequency limits apply	• Limited to R3 825 pfpa • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Frequency limits apply	• Limited to available MSA for non-PMBs • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Frequency limits apply	• Limited to available MSA for non-PMBs • 100% of cost at DSP • 300% of Scheme Rate at a non-DSP • Frequency limits apply • ATB applies once Annual Threshold is reached • The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/ or be paid as an ATB (always subject to available ATB) is R3 825 pfpa

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
31.	**MAXILLOFACIAL AND ORAL SURGERY** Benefits for caps, crowns, bridges, endosteal and ossea-integrated implants are detailed under 'Advanced dentistry' whilst orthodontic benefits are detailed under 'Orthodontics'					
31.1	**Maxillofacial and oral surgery** Consultations, procedures and treatment in- and out-of-hospital Subject to pre-authorisation and PMB regulation	• Limited to PMBs • 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSP) • 100% of Scheme Rate for non-DSP	• Unlimited • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP • Benefit inclusive of elective treatment	• Limited to PMBs • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP	• Unlimited • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP • Benefit inclusive of elective treatment	
32.	**DENTISTRY** Subject to pre-authorisation and PMB regulations.					

32.1	**Preventative and basic dentistry**	• No benefit	• Unlimited
			• 100% of cost at Bankmed Dental Network (DSP)
			• Bankmed Dental Formulary applies
			• No benefits for non-DSP or non-Formulary treatment
				• Unlimited
				• 100% of cost at DSP
				• 100% of Scheme Rate at non-DSP
				• Sub-limits apply:
				  • One oral examination pbpa
				  • Amalgam and resin fillings only
				  • Plastic dentures only
				  • Two topical fluoride treatments pbpa (age 15 years and younger)
				  • One topical fluoride treatment pfpa
				  • Limited to eight molar teeth pb per lifetime
				  • Scale and polish limited to two pbpa
					• Limited to available MSA
					• 100% of cost at DSP
					• 100% of Scheme Rate at non-DSP
						• Unlimited
						• 100% of cost at DSP
						• 100% of Scheme Rate at non-DSP
						• Funded from Insured Benefit
						• Sub-limits apply:
						  • One oral examination pbpa
						  • Amalgam and resin fillings only
						  • Plastic dentures only
						  • Two topical fluoride treatments pbpa (age 15 years and younger)
						  • One topical fluoride treatment pfpa
						  • Limited to eight molar teeth pb per lifetime
						  • Scale and polish limited to two pbpa
							• 100% of cost at DSP
							• 300% of Scheme Rate, subject to available MSA
							• ATB applies once Annual Threshold is reached
							• The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an ATB (always subject to available ATB), is R21 700 for a single member and R32 870 for a family

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		

32.2	**Advanced dentistry**
	Caps, crowns, bridges and cost of endosteal and ossea-integrated implants
		• No benefit		• 100% of cost at DSP
				• 100% of Scheme Rate at non-DSP
				• Limited to:
				  • M: R8 370 pbpa
				  • M + 1 +: R12 985 pfpa
				• Combined limit for 'Advanced dentistry', 'Orthodontics' and 'All other dental services'
					• 100% of cost at DSP
					• 100% of Scheme Rate at non-DSP
					• 100% of cost for PMBs
					• Subject to available MSA for non-PMBs
						• 100% of cost at DSP
						• 100% of Scheme Rate at non-DSP
						• Limited to:
						  • M: R6 520 pbpa
						  • M + 1 +: R10 920 pfpa
						  • Thereafter subject to available MSA	

32.3	**Orthodontics** Subject to orthodontic quotation and prior approval from Scheme	• No benefit		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to 'Advanced dentistry' limit	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to available MSA	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R10 920 pfpa • Thereafter subject to available MSA	

32.4	**All other dental services**	• No benefit	• 100% of cost at Bankmed Dental Network (DSP), and
			• Bankmed Dental Formulary applies to:
			  • Second and subsequent exams in same year
			  • X-rays
				• 100% of cost at DSP
				• 100% of Scheme Rate at non-DSP
				• Subject to 'Advanced dentistry' limit
					• 100% of cost at DSP
					• 100% of Scheme Rate at non-DSP
					• Subject to available MSA		

33.	**GENERAL PRACTITIONERS (GPs)**						
33.1	**GP consultations** In-hospital	• Limited to PMBs • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Entry Plan GP Network	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Entry Plan GP Network	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed GP Network			
33.2	**GP procedures** In-hospital	• Limited to PMBs • 100% of cost at DSP • 100% of Scheme Rate for non-DSP (including PMBs) • DSP: Bankmed Entry Plan GP Network • No benefit for dental surgery, except for PMBs	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP (including PMBs) • DSP: Bankmed Entry Plan GP Network • No benefit for dental surgery, except for PMBs	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP (including PMBs) • DSP: Bankmed GP Network	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP (including PMBs) • DSP: Bankmed GP Network • No benefit for dental surgery, except for PMBs	• Unlimited • 100% of cost at DSP • 125% of Scheme Rate for non-DSP (including PMBs) • DSP: Bankmed GP Network	• Unlimited • 100% of cost at DSP • 300% of Scheme Rate for non-DSP (including PMBs) • DSP: Bankmed GP Network

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
33.3	**30-Day Post-hospital GP Consultation Benefit** Consultation within 30 days of discharge from hospital (excluding day cases)	• Limited to PMBs • One additional post-hospitalisation GP consultation covered as an Insured Benefit pb visiting a GP within 30 days of discharge, following an authorised hospital admission • 100% of cost at the contracted rate for Bankmed Entry Plan GP Network (DSP) • 100% of Scheme Rate for non-DSP	• One additional post-hospitalisation GP consultation covered as an Insured Benefit pb visiting a GP within 30 days of discharge, following an authorised hospital admission • 100% of cost at the contracted rate via Bankmed Entry Plan GP Network (DSP) • 100% of Scheme Rate for non-DSP • Subject to the 'Out-of-network GP Benefit' limit	• One additional post-hospitalisation GP consultation covered as an Insured Benefit pb visiting a GP within 30 days of discharge, following an authorised hospital admission (excluding day cases): • 100% of cost at contracted rate for Bankmed Network GPs (DSP) • 100% of Scheme Rate for non-DSP			

33.4	**GP consultations**
	In-room or out-of-hospital
		• Limited to PMBs
		• 100% of cost at DSP
		• 100% of Scheme Rate for non-DSP
		• DSP: Bankmed Entry Plan GP Network
			• Unlimited
			• 100% of cost at DSP
			• 100% of Scheme Rate for non-DSP
			• DSP: Bankmed Entry Plan GP Network
			• Member to nominate primary GP within network
			• **Out-of-network GP Benefit**
			  • Limited to three visits, to a maximum of R2 630 pfpa (at DSP rate) for consultations, procedures and medication at non-network GP
			  • When the nominated DSP GP is not available, or the beneficiary is out of town, the 'Out-of-network GP Benefit' includes all costs associated with out-of-network consultation
				• Combined limit for 'GP Consultations In-room or out-of-hospital', and 'Specialist Consultations In-room or out-of-hospital' benefits:
				  • M: R4 220 pbpa
				  • M + 1: R7 640 pfpa
				  • M + 2 +: R8 860 pfpa
				• 100% of cost at DSP
				• 100% of Scheme Rate for non-DSP
				• DSP: Bankmed GP Network
				• Unlimited if DSP used
				• Continued benefits for beneficiaries with PMB conditions, subject to PMB regulations
					• **Bankmed GP Network benefits (DSP):**
					• Unlimited for PMBs
					• 100% of cost
					• Limited to two consultations from Insured Benefits for non-PMBs, thereafter subject to available MSA
					• **Non-network GP benefits (non-DSP):**
					• 100% of Scheme Rate from Insured Benefits for PMBs
					• 100% of Scheme Rate, subject to available MSA for non-PMBs
						• **Bankmed GP Network benefits (DSP):**
						• Unlimited for PMBs
						• 100% of cost
						• Non-PMBs subject to available MSA
						• **Non-network GP benefits (non-DSP):**
						• 100% of Scheme Rate from Insured Benefits for PMBs
						• 100% of Scheme Rate, subject to available MSA for non-PMBs
							• **Bankmed GP Network benefits (DSP):**
							• Unlimited for PMBs
							• 100% of cost
							• Non-PMBs subject to available MSA/ATB
							• **Non-network GP benefits (non-DSP):**
							• 100% of Scheme Rate from Insured Benefits for PMBs
							• 300% of Scheme Rate, subject to available MSA/ATB for non-PMBs
							• ATB applies once Annual Threshold is reached

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
33.5	**GP procedures** In-room or out-of-hospital	• Limited to PMBs • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Entry Plan GP Network	• Refer to 'GP Consultations In-room or out-of-hospital' benefit section	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed GP Network	• **Bankmed GP Network benefits (DSP):** • Unlimited for PMBs • 100% of cost • Non-PMBs subject to available MSA • **Non-network GP benefits (non-DSP):** • 100% of Scheme Rate from Insured Benefits for PMBs • 100% of Scheme Rate, subject to available MSA for non-PMBs	• **Bankmed GP Network benefits (DSP):** • Unlimited for PMBs • 100% of cost • **Non-network GP benefits (non-DSP):** • 100% of Scheme Rate from Insured Benefits for PMBs • 125% of Scheme Rate from Insured Benefits for non-PMBs	• **Bankmed GP Network benefits (DSP):** • Unlimited for PMBs • 100% of cost • **Non-network GP benefits (non-DSP):** • 100% of Scheme Rate from Insured Benefits for PMBs • 300% of Scheme Rate from Insured Benefits for non-PMBs
33.6	**GP consultations** Virtual or online Subject to verification notes submitted by claiming GP Subject to Out-of-hospital GP Benefits and Limits	• 100% of cost for Bankmed Entry Plan GP Network GPs (DSP) • 100% of Scheme Rate for non-DSP • Limited to three consultations pbpa • Limited to PMBs	• 100% of cost for Bankmed Entry Plan GP Network GPs (DSP) • 100% of Scheme Rate for non-DSP • Limited to three consultations pbpa • Subject to the 'Out-of-network GP Benefit' limit if non-DSP used	• 100% of cost for Bankmed Network GPs (DSP) • 100% of Scheme Rate for non-DSP • Limited to three consultations pbpa	• 100% of cost for Bankmed Network GPs (DSP) • 100% of Scheme Rate for non-DSP • Limited to three consultations pbpa • Subject to available MSA for non-PMBs		• 100% of cost for Bankmed Network GPs (DSP) • 100% of Scheme Rate for non-DSP • Limited to three consultations pbpa • Subject to available MSA/ATB for non-PMBs
34.	**SPECIALISTS** NB: Psychiatrists, oncologists, radiologists, pathologists, maxillofacial and oral surgeons and other dental practitioners are covered elsewhere in these Benefit Tables						
34.1	**Specialist consultations and procedures** In-hospital	• Limited to PMBs • 100% of cost for Bankmed Entry Plan Specialist Network (DSP) • 100% of Scheme Rate for non-DSP	• Unlimited • 100% of cost for Bankmed Entry Plan Specialist Network (DSP) • 100% of Scheme Rate for non-DSP	• Unlimited • 100% of cost for Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP			• Unlimited • 100% of cost for Bankmed Prestige A and B Specialist Network (DSP) • 300% of Scheme Rate for non-DSP

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		

34.2	**Specialist consultations**
	In-room or out-of-hospital
	Pre-authorisation required for all Plans, excluding Comprehensive and Plus
	Make use of our DSP to limit or avoid co-payments
		• Limited to PMBs
		• Benefits subject to referral by GP in Bankmed Entry Plan GP Network and approved BOC registration for PMB conditions
		• 100% of cost for Bankmed Entry Plan Specialist Network (DSP)
		• 80% of cost if no pre-authorisation and no referral from a Bankmed Entry Plan GP Network GP (DSP)
		• 100% of Scheme Rate for non-DSP
		• 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed Entry Plan GP Network GP (DSP)
			• Limited to:
			  • M: R4 260 pbpa
			  • M + 1 +: R6 670 pfpa
			  Combined limit with 'Specialist procedures: In-room or out-of-hospital' benefit
			• Benefits subject to referral by a Bankmed Entry Plan GP Network GP
			• 100% of cost for Bankmed Entry Plan Specialist Network (DSP)
			• 80% of cost if no pre-authorisation and no referral from a Bankmed Entry Plan GP Network GP (DSP)
			• 100% of Scheme Rate for non-DSP
			• 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed Entry Plan GP Network GP (DSP)
			• Annual limit includes basic radiology, scans, and pathology prescribed by specialist/ appearing on specialist's claim
			• Continued benefits for PMBs, subject to PMB regulations and approval
				• Combined limit for GP and specialist consultations in rooms:
				  • M: R4 220 pbpa
				  • M + 1: R7 640 pfpa
				  • M + 2 +: R8 860 pfpa
				• Benefits subject to referral by a Bankmed GP Network GP
				• 100% of cost at Bankmed Prestige A and B Specialist Network (DSP)
				• 80% of cost if no pre-authorisation and no referral from Bankmed GP Network GP (DSP)
				• 100% of Scheme Rate for non-DSP (including PMBs)
				• 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed Network GP (DSP)
				• Continued benefits for PMBs, subject to PMB regulations and approval
					• Specialist consultations approved for beneficiaries registered for PMB Chronic Disease List (CDL) conditions
					• Benefits subject to approved BOC and referral by a Bankmed Network GP
					• 100% of cost for Bankmed Prestige A and B Specialist Network (DSP)
					• 80% of cost if no pre-authorisation and no referral from a Bankmed Network GP (DSP)
					• 100% of Scheme Rate for non-DSP
					• 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed Network GP (DSP)
					• Non-BOC benefits covered at 100% of Scheme Rate, subject to available MSA
					• Continued benefits for PMBs, subject to PMB regulations and approval
						• 100% of Scheme Rate, subject to available MSA
						• 100% of cost for Bankmed Prestige A and B Specialist Network (DSP)
						• 100% of Scheme Rate for non-DSP
							• 300% of Scheme Rate, subject to available MSA
							• ATB applies once Annual Threshold is reached
							• 100% of cost for Bankmed Prestige A and B Specialist Network (DSP)
							• 300% of Scheme Rate for non-DSP

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
34.3	**Specialist procedures** In-room or out-of-hospital	• Limited to PMBs • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Entry Plan Specialist Network	• Refer to 'Specialist consultations In-room or out-of-hospital' benefit section	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Prestige A and B Specialist Network	• Limited to PMBs • **Bankmed Prestige A and B Specialist Network benefits (DSP):** • 100% of cost • 80% of cost if no pre-authorisation or no referral from Bankmed GP Network GP (DSP) • Non-PMBs subject to available MSA • **Non-network GP benefits (non-DSP):** • 100% of Scheme Rate for PMBs	• Unlimited • **Bankmed Prestige A and B Specialist Network benefits (DSP):** • 100% of cost • **Non-network GP benefits (non-DSP):** • 100% of Scheme Rate for PMBs	• Unlimited • **Bankmed Prestige A and B Specialist Network benefits (DSP):** • 100% of cost • **Non-network GP benefits (non-DSP):** • 300% of Scheme Rate for PMBs
35.	**REGISTERED PRIVATE NURSE PRACTITIONERS**						
35.1.	**Consultations and procedures**	• Limited to PMBs • **Procedures:** • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • For procedures not requiring admission to a day surgery or hospital, includes the cost of vaccination and injection material administered by the Healthcare Professional • **Consultations:** • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Three consultations pbpa at 100% of Scheme Rate for PMBs	• Unlimited • **Procedures:** • 100% of Scheme Rate • **Consultations:** • Three consultations pbpa at 100% of Scheme Rate	• Unlimited • **Procedures:** • 100% of Scheme Rate • **Consultations:** • Three consultations pbpa at 100% of Scheme Rate • Thereafter, 100% of Scheme Rate, subject to out-of- hospital GP/Specialist limit	• Unlimited • **Procedures:** • 100% of Scheme Rate • **Consultations:** • Three consultations pbpa at 100% of Scheme Rate from Insured Benefits • Thereafter, subject to available MSA	• Unlimited • **Procedures:** • 100% of Scheme Rate • **Consultations:** • Three consultations pbpa at 100% of Scheme Rate from Insured Benefits • Thereafter, subject to available MSA	• Unlimited • **Procedures:** • 100% of Scheme Rate • **Consultations:** • Three consultations pbpa at 300% of Scheme Rate from Insured Benefits • Thereafter, subject to available MSA/ATB • ATB applies once the Annual Threshold is reached

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

	ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
	NON-MSA PLANS			MSA PLANS		
36.	**OPTOMETRY CONSULTATIONS, SPECTACLES, FRAMES, LENSES AND CONTACT LENSES**					

36.1	**Optometry consultations** Subject to the Optometry Benefit Management Programme and clinical necessity	• No benefit	• Limited to Iso Leso Optometry Network (DSP)
			• No benefit out of network
			• 100% of cost at DSP
			• Limited to one consultation pb every two years
			• All services and products subject to selected Iso Leso Optometry Network Scheme-approved and contracted services and products
				• 100% of Scheme Rate
				• Benefits limited to:
				  • One eye test, or
				  • One re-examination, or
				  • One composite examination pb every 24 months from previous date of service
					• 100% of Scheme Rate
					• Subject to available MSA
						• 100% of Scheme Rate
						• Benefits limited to:
						  • One eye test, or
						  • One re-examination, or
						  • One composite examination pb every 24 months from previous date of service
							• 100% of Scheme Rate
							• Subject to available MSA
							• Accumulation to the Annual Threshold is limited to 100% of the Scheme Rate for spectacle lenses, contact lenses, eye tests and all other applicable services
							• ATB applies once the Annual Threshold is reached
							• The maximum amount that can jointly accumulate towards reaching the Annual Threshold and/or be paid as an ATB (always subject to available ATB), is R5 480 pbpa

36.2	**Frames and extras**	• No benefit	• Limited to Iso Leso Optometry Network (DSP) • No benefit out of network • 100% of cost at DSP • Limited to one frame pb every two years • All services and products, including frames, subject to selected Iso Leso Optometry Network Scheme-approved and contracted services and products	• 100% of Scheme Rate • Limited to R1 150 pb every 24 months from previous date of service • One frame pb every 24 months from previous date of service • Extras subject to pre-authorisation and PMB regulations and clinical necessity	• 100% of Scheme Rate • Subject to available MSA • One frame pb every 24 months from previous date of service • Extras subject to pre-authorisation and PMB regulations and clinical necessity		• 100% of Scheme Rate • Subject to available MSA • Frames and extras do not accumulate towards reaching the Annual Threshold and are not covered as an ATB benefit • Extras subject to pre-authorisation and PMB regulations and clinical necessity

Did you know?

THE OPTICLEAR OPTOMETRY NETWORK AND HOW IT WORKS

- Bankmed members receive optometry services and material, like spectacles and contact lenses, at a preferred and discounted rate from any Opticlear Network optometrist. This means that by visiting an Opticlear Network optometrist, you will receive services and items at a guaranteed reduced rate.
- The Opticlear Network incorporates 97% of all optometry providers in South Africa, making it more likely that your chosen optometrist is a member of this network. To find your nearest Opticlear Network optometrist, please visit their website at www.opticlear.co.za

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
36.3	**Prescription lenses** Clear, standard/generic, single vision, bifocal or multi-focal lenses	• No benefit	• Limited to Iso Leso Optometry Network (DSP) • No benefit out of network • 100% of cost at DSP • Limited to one pair of prescription lenses pb every two years • All services and products, including frames, subject to selected Iso Leso Optometry Network Scheme-approved and contracted services and products	• Benefits for prescription lenses limited to one pair of lenses pb every 24 months from previous date of service • 100% of the Scheme Rate • Limited to clear, standard/ generic, single vision, bifocal or multi-focal lenses from an Opticlear Network optometrist	• 100% of Scheme Rate • Subject to available MSA	• Benefits for prescription lenses limited to one pair of lenses pb every 24 months from previous date of service • 100% of the Scheme Rate • Limited to clear, standard/ generic, single vision, bifocal or multi-focal lenses from an Opticlear Network optometrist	• 100% of Scheme Rate • Subject to available MSA
36.4	**Readymade readers**	• No benefit		• Limited to two pairs of readymade readers pb every two years • Limited to R120 per pair • 100% of Scheme Rate • Readymade readers via optometrists and pharmacies covered from the OTC benefit, subject to benefit availability	• 100% of Scheme Rate • Subject to available MSA • Readymade readers via optometrists and pharmacies covered from the OTC benefit, subject to available MSA	• Limited to two pairs of readymade readers pb every two years • Limited to R120 per pair • 100% of Scheme Rate • Subject to available MSA • Readymade readers via optometrists and pharmacies covered from the OTC benefit, subject to benefit availability	• Limited to two pairs of readymade readers pb every two years • Limited to R120 per pair • 100% of Scheme Rate • Subject to available MSA • Readymade readers via optometrists and pharmacies covered from the OTC benefit, subject to benefit availability
36.5	**Contact lenses**	• No benefit		• 100% of Scheme Rate • Limited to R1 805 pbpa at an Opticlear Network optometrist • Limited to clear contact lenses • A beneficiary may not claim for spectacles (lenses/frame) AND contact lenses in same benefit year OR contact lenses within 24 months from previous date of service after receiving spectacles (lenses/frame)	• 100% of Scheme Rate • Subject to available MSA • Limited to clear contact lenses • A beneficiary may not claim for spectacles (lenses or frame) AND contact lenses in the same benefit year	• 100% of Scheme Rate • Limited to R2 005 pbpa for an Opticlear Network optometrist, paid from Insured Benefits • Limited to clear contact lenses • A beneficiary may not claim for spectacles (lenses/frame) AND contact lenses in same benefit year OR contact lenses within 24 months from previous date of service after receiving spectacles (lenses/frame)	• Refer to 'Optometry consultation' benefit section

Be a better-informed Bankmed member

You can make a difference to your healthcare costs, so next time you receive eye care keep the following in mind:

- Always confirm your available benefits with the optometrists as well as with Bankmed before you have your consultation. Bankmed will be able to assist you with questions regarding your benefits.
- Make 100% certain of the cost of the items that will not be covered by Bankmed and check with your optometrist why these services and/or materials are necessary.

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
36.6	**Fitting of contact lenses**	• No benefit		• 100% of Scheme Rate • One contact lens dispensing and/or assessment pb every 12 months	• 100% of Scheme Rate, subject to available MSA	• 100% of Scheme Rate • One contact lens dispensing and/or assessment pb every 12 months	• Refer to 'Optometry consultation' benefit section
36.7	**Sunglasses**	• No benefit		• No benefit for sunglasses/prescription sunglasses/spectacles with a tint > 35%			
37.	**REFRACTIVE SURGERY AND ASSOCIATED COSTS (INCLUDING HOSPITALISATION)**						
37.1	**Other optometric services** Refractive surgery excimer laser treatment, hospitalisation and associated costs	• No benefit, including the cost of hospitalisation, medication and all other associated services		• 100% of Scheme Rate • Limited to R4 810 pfpa, including the cost of hospitalisation, medication and all other associated services	• 100% of Scheme Rate check for plus plan • Subject to available MSA, including the cost of hospitalisation, medication and all other associated services		
38.	**MEDICATION** NB: In the case of qualifying prescribed acute and chronic medication, each prescription or repeat prescription shall be limited to one month's supply pbpm						

38.1	**Prescribed acute medication**
	Refer to 'Contraception' benefit section for additional Insured Benefits
		• Limited to PMBs
		• Subject to Scheme Medication Formulary (medicine list)
		• 100% of cost for PMBs
		• Unlimited via Bankmed GP Entry Plan Network GP (DSP)
			• Unlimited
			• Subject to Scheme Medication Formulary (medicine list)
			• **Medication via DSP** Bankmed GP Entry Plan Network and Bankmed Pharmacy Network
			• 100% of cost plus contracted dispensing fee, unlimited
				• Limited to:
				  • M: R4 785 pbpa
				  • M + 1: R8 810 pfpa
				  • M + 2 +: R9 565 pfpa
				  • The above limits include a maximum allowance of R1 800 pfpa OTC
				• **Medication via DSP** Bankmed GP Network and Bankmed Pharmacy Network
				• 100% of Scheme Medicine Reference Price plus contracted dispensing fee for generic medication
				• 80% of Scheme Medicine Reference Price plus contracted dispensing fee for original medication (medication where a generic alternative is available)
					• 100% of Scheme Medicine Reference Price
					• Subject to available MSA
						• 100% of Scheme Medicine Reference Price
						• Subject to available MSA
							• 100% of Scheme Medicine Reference Price plus contracted dispensing fee as applicable
							• to Bankmed GP Network or Bankmed Pharmacy Network (DSP)
							• Subject to available MSA
							• ATB applies once Annual Threshold is reached
							• The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an ATB (always subject to available ATB), is R21 700 for a single member and R32 870 for a family

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
			• **Medication via non-DSP** Voluntary use of non-DSP • 100% of Scheme Medicine Reference Price • Subject to the 'Out-of-network GP Benefit' limit of R2 630 pfpa • **Medication via non-DSP** Involuntary use of non-DSP • 100% of cost plus contracted dispensing fee, unlimited • **Important note:** Medication obtained from a DSP or non-DSP, if prescribed by a non-DSP provider, will accumulate to the 'Out-of-network GP Benefit' limit of R2 630 pfpa	• **Medication via non-DSP** Voluntary use of non-DSP • 80% of Scheme Medicine Reference Price for generic medication and original medication (medication where a generic alternative is available) • **Medication via non-DSP** Involuntary use of non-DSP • 100% of Scheme Medicine Reference Price plus contracted dispensing fee for generic medication • 80% of Scheme Medicine Reference Price plus contracted dispensing fee for original medication (medication where a generic alternative is available)	**Important information** Pre-authorisation is required for PMB funding of treatment and care of the PMB Chronic Disease List (CDL) conditions. Have your Healthcare Professional and pharmacist call 0800 132 345 to register your chronic medication or send a motivation confirming your PMB diagnosis to pmb_app_forms@bankmed.co.za if chronic medication has not been prescribed for your condition.		
38.2	**Self-medication** Over-the-counter (OTC) medication/pharmacy advised therapy (PAT)	• No benefit		• 100% of Scheme Medicine Reference Price for Bankmed Pharmacy Network (DSP) • 80% of the Scheme Medicine Reference Price for non-DSP • Limited to R1 900 pfpa, and further subject to the annual limit for prescribed acute medication	• 100% of Scheme Medicine Reference Price paid from Insured Benefits for acute medication prescribed and dispensed by a pharmacist (PAT) for a limited number of conditions and events, subject to the Core Saver Formulary (medicine list) for PAT • All other acute and over-the-counter medication subject to available MSA	• 100% of Scheme Medicine Reference Price • Subject to available MSA	• 100% of Scheme Medicine Reference Price • Subject to available MSA • Self-medication/PAT does not accumulate towards the Annual Threshold and is not covered as an ATB benefit
38.3	**Homeopathic medication** On prescription only. Limited to items with NAPPI codes	• No benefit		• Refer to 'Prescribed acute medication' and 'Chronic medication' benefit sections • No self-medication benefit for homeopathic medication			

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
38.4	**Chronic medication** Subject to prior application and approval	• Limited to PMBs • 100% of cost for PMBs at DSP • Unlimited via Bankmed Entry Plan GP Network (DSP) • Subject to Scheme Medication Formulary (medicine list)	• **Medication via DSP** Bankmed GP Entry Plan Network and Bankmed Pharmacy Network • 100% of cost at DSP • Unlimited via DSP • Subject to Scheme Medication Formulary (medicine list) • **Medication via non-DSP** Voluntary use of non-DSP • 80% of Scheme Medicine Reference Price • Subject to 'Out-of-network GP Benefit' limit of R2 630 pfpa • **Medication via non-DSP** Involuntary use of non-DSP • 100% of cost plus contracted dispensing fee	• **Medication via DSP** Bankmed GP Network and Bankmed Pharmacy Network • Limited to R25 300 pbpa • 100% of Scheme Medicine Reference Price for DSP • **Medication via non-DSP** Voluntary use of non-DSP • 80% of Scheme Medicine Reference Price • **Medication via non-DSP** Involuntary use of non-DSP • 100% of cost plus contracted dispensing fee • Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations	• **Medication via DSP** Bankmed GP Network and Bankmed Pharmacy Network • Limited to Core Saver Medication Formulary (medicine list) for PMB conditions • 100% of Scheme Medicine Reference Price for DSP • **Medication via non-DSP** Voluntary use of non-DSP • 80% of Scheme Medicine Reference Price • **Medication via non-DSP** Involuntary use of non-DSP • 100% of cost plus contracted dispensing fee	• **Medication via DSP** Bankmed GP Network and Bankmed Pharmacy Network • Limited to R27 395 pbpa (Insured Benefits) • 100% of Scheme Medicine Reference Price for DSP • **Medication via non-DSP** Voluntary use of non-DSP • 80% of Scheme Medicine Reference Price • **Medication via non-DSP** Involuntary use of non-DSP • 100% of cost plus contracted dispensing fee • Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations	• **Medication via DSP** Bankmed GP Network and Bankmed Pharmacy Network • Limited to R32 665 pbpa (Insured Benefits) • 100% of Scheme Medicine Reference Price for DSP • **Medication via non-DSP** Voluntary use of non-DSP • 80% of Scheme Medicine Reference Price • **Medication via non-DSP** Involuntary use of non-DSP • 100% of cost plus contracted dispensing fee • Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

		ESSENTIAL PLAN 2024	BASIC PLAN 2024	TRADITIONAL PLAN 2024	CORE SAVER PLAN 2024	COMPREHENSIVE PLAN 2024	PLUS PLAN 2024
		NON-MSA PLANS			MSA PLANS		
38.5	**Biologic and high-cost specialised medication** Utilised in the management of PMB CDL and non-PMB chronic conditions • **Includes off-label medications** Request for medications not registered for the condition by the Medicines Control Council (MCC) • **Includes Section 21 medication** Medications not registered by the MCC for use in South Africa	• Limited to PMBs • Subject to PMB regulations	• Limited to PMBs • Subject to PMB regulations	• Includes PMBs and non-PMBs • Subject to PMB regulations	• Includes PMBs and non-PMBs • Subject to PMB regulations	• Includes PMBs and non-PMBs • Subject to PMB regulations	• Includes PMBs and non-PMBs • Subject to PMB regulations
	• **PMB algorithm medication**	• 100% of cost	• 100% of cost	• 100% of cost	• 100% of cost	• 100% of cost	• 100% of cost
	• **PMB non-algorithm medication**	• No benefit	• No benefit	• 70% of Scheme Rate	• 70% of Scheme Rate	• 100% of Scheme Rate	• 100% of Scheme Rate
	• **Non-PMB non-algorithm medication**	• No benefit	• No benefit	• 70% of Scheme Rate	• No benefit	• 100% of Scheme Rate	• 100% of Scheme Rate

39. WORLD HEALTH ORGANISATION (WHO) RECOGNISED DISEASE OUTBREAKS

Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks

39.1 Out-of-hospital healthcare services related to COVID-19:

Benefits

BENEFITS AND LIMITATIONS Benefits in excess of the PMB requirements	BENEFITS AND LIMITATIONS BOC as defined by Bankmed
• Up to a maximum of 100% of the Scheme Rate. • Cover for testing is subject to NICD protocol and referral by a Healthcare Professional. • Subject to the Scheme's preferred provider (where applicable), protocols and the • condition and treatment meeting the Scheme's entry criteria and guidelines.	Out-of-hospital healthcare services related to COVID-19: • Screening consultation with a nurse or GP: unlimited • Defined basket of pathology: unlimited tests per person per year subject to appropriate clinical referral for testing for registered Healthcare Professionals except where covered as PMB. • Defined basket of X-rays and scans • Supportive treatment • Contact tracing

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

40. PLAN SPECIFIC INFORMATION

40.1 Core Saver Pharmacy Advised Therapy (PAT) Medication Formulary (medicine list)

- Applicable to the medication on the Core Saver Plan only
- Acute medication covered at 100% of cost from Insured Benefits subject to the Core Saver Pharmacy Advised Therapy (PAT) Medication Formulary (medicine list) for the following conditions and up to the specified number of incidents pbpa, on pharmacist's recommendation (PAT) only
- Visit www.bankmed.co.za, select '2024 Plan Information' and then 'Medicine Formularies 2024' to view the Core Saver Pharmacy Advised Therapy (PAT) Medication Formulary (medicine list)
- Non-formulary medication and other acute medication subject to available MSA

Condition	Incidents covered
Abdominal pain/dyspepsia/heartburn/indigestion (includes reflux)	2
Helminthic (worms) infestation	2
Conjunctivitis, bacterial	2
Topical candidiasis (topical thrush)	2
Oral candidiasis (oral thrush)	2
Headache -analgesia	2

Condition	Incidents covered
Upper respiratory and lower respiratory tract infections	2
Gastroenteritis	2
Urticaria, insect bites and stings	2
Urinary tract infection	2
Treatment of wounds and/or infection of the skin/subcutaneous tissues (excluding post-operative wound care)	2

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