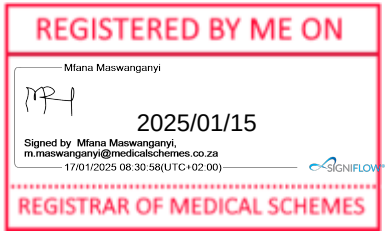


BANKMED

ANNEXURE B6: BANKMED PLUS PLAN (WITH SAVINGS)

Schedule of benefits with effect from 1 January 2025

STATUTORY PRESCRIBED MINIMUM BENEFITS

Notwithstanding any provisions to the contrary in this schedule, the Scheme will fund:

- 100% of the diagnosis, treatment and care costs of the Statutory Prescribed Minimum Benefits (PMBs), subject to PMB regulations, if those services are obtained from a Designated Service Provider (DSP) in South Africa; or
  - the relevant Scheme Rate for the diagnosis, treatment and care costs of the Statutory Prescribed Minimum Benefits if a beneficiary voluntarily accesses PMBs via a non-DSP in South Africa, when provision is made for a DSP according to this schedule; or
  - 100% of cost for involuntary use of a non-DSP in South Africa, subject to PMB regulations

Pre-authorisation, medicine formularies and Scheme protocols (previously known as “Care Plans” and now known as “Baskets of Care”) may apply

Diagnosis costs are only regarded as a PMB if the result of diagnostic investigations confirms a PMB diagnosis

When insured limits are specified in this schedule, the limit will first be utilised for the payment of the relevant claims, and thereafter continued funding will apply for PMB claims only, subject to PMB regulations

Where a benefit is indicated as “payable from Savings” or as “no benefit” in this schedule, insured benefits shall nevertheless be provided for PMBs in South Africa, subject to PMB regulations

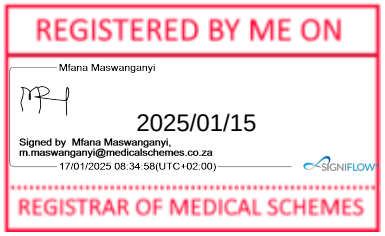
PMB claims shall not be funded from Savings

Additional arrangements pertaining to PMBs (subject to PMB regulations) are set out in the Preamble to Annexure B and in Annexure D (Claims Procedure and General Provisions Regarding Benefits)

STATUTORY PRESCRIBED MINIMUM BENEFITS

PRO RATING OF BENEFITS FOR MEMBERS JOINING DURING THE COURSE OF A FINANCIAL YEAR

Beneficiaries admitted during the course of a financial year are entitled to the benefits set out in this schedule, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the financial year (rule 16.1.5), except for stated wellness and preventative care benefits, which shall not be subject to pro-ration



EXPLANATION OF ANNUAL THRESHOLD AND ABOVE THRESHOLD BENEFITS

The Above Threshold Benefit (ATB) provides continued cover for non-PMB day-to-day claims, as an insured benefit, once a member has depleted his available Savings for the year.

The Above Threshold Benefit can only be accessed once the Annual Threshold has been reached and is limited as indicated in this section.

Accumulation of Claims (paid from Savings) towards the Annual Threshold:

Where indicated, day-to-day claims are first paid from available Savings, until the Annual Threshold is reached, and thereafter from the Above Threshold Benefit (ATB).

Relevant claims that are payable from Savings accumulate towards the Annual Threshold at 100% of Scheme Rate. Any difference between the cost of an account and the Scheme Rate will not accumulate towards the Annual Threshold, although this difference may be covered from available Savings.

The Annual Threshold is set at R26 800 for a Principal Member + R19 900 per adult dependant + R6 600 per child dependant (limited to three children). The Annual Threshold is a combined family threshold and is calculated by adding the Threshold value for each family member together.

EXAMPLE:
For a family consisting of a member, one adult dependant and one child dependant, the Annual Threshold will be R53 300 (R26 800 + R19 900 + R6 600).
The Annual Threshold is pro-rated (reduced) if a member joins after 1 January each year, by dividing the total Threshold for the year by 12 and multiplying this amount by the remaining number of months in the year.
The Annual Threshold is re-calculated when a dependant is added or removed during the year, or when a child dependant becomes an adult dependant (paying the rate for an adult dependant).

Above Threshold Benefits:

Once the Annual Threshold has been reached, continued benefits apply for claims that are subject to Above Threshold Benefit (ATB), as indicated in this schedule. ATB claims are funded at 100% of Scheme Rate as an insured benefit, until the Above Threshold Benefit (ATB) is depleted.

The Above Threshold Benefit (limit) is set at R24 000 for a Principal Member + R18 100 per adult dependant + R6 000 per child dependant (limited to three children). This is a combined (family) limit and is calculated by adding the individual limits per family member together. The Above Threshold Benefit can only be accessed when the total (combined) Annual Threshold for the family has been reached.
EXAMPLE:
For a family consisting of a member, one adult dependant and one child dependant, the ATB will be R48 100 (R24 000 + R18 100 + R6 000).

The difference between the Scheme Rate and the cost of an account, may be paid from available Savings (e.g. if there is an unused Savings balance from previous years), however, this excludes any and all shortfalls that may arise on a PMB claim.

The ATB is pro-rated (reduced) if a member joins after 1 January each year, by dividing the total Threshold for the year by 12 and multiplying this amount by the remaining number of months in the year.

The ATB is re-calculated when a dependant is added or removed during the year, or when a child dependant becomes an adult dependant (paying the rate for an adult dependant).

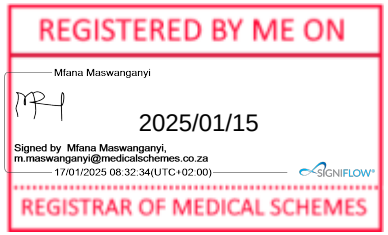
There is no clawback (debt owing to the Scheme) on overspend on ATB due to the removal of a dependant or the resignation of a member during the year.

A self-payment gap will occur when Savings is depleted, and the member has not yet reached the Annual Threshold. The member will need to self-fund claims during the self-funding gap, until the Annual Threshold is reached. The member must, however, continue to submit claims to the Scheme as these will accumulate towards the Annual Threshold (at 100% of Scheme Rate) until the Annual Threshold is reached.

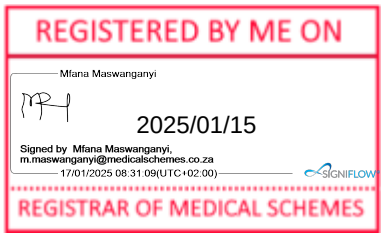
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
ANNUAL THRESHOLD (Accumulation)	100% of Scheme Rate	Combined Threshold of R26 800 (principal member) + R19 900 per adult + R6 600 per child dependant (but limited to three children)	Accumulation towards Annual Threshold at 100% of Scheme Rate for claims payable from Savings. See Explanation of Annual Threshold and Above Threshold Benefits.
ABOVE THRESHOLD BENEFIT (ATB)	100% of Scheme Rate	Combined ATB of R24 000 (principal member) + R18 100 per adult + R6 000 per child dependant (but limited to three children)	Specified claims are paid from Above Threshold Benefit (ATB) at 100% of Scheme Rate after Annual Threshold is reached. See Explanation of Annual Threshold and Above Threshold Benefits.
OVERALL ANNUAL LIMIT		Unlimited	This plan has no overall annual limit.
HOSPITAL NETWORK/DSPs REGISTERED BY ME ON Mfana Maswanganyi 2025/01/15 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 17/01/2025 08:34:02(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES	Hospital Network DSPs are applicable on this plan. Reduced benefits apply for accommodation and associated fees charged by non-DSP hospitals, subject to PMB regulations. Hospital Network DSPs on this plan are: • Contracted private hospitals/facilities (restricted network) as communicated to members from time to time.		

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
HOSPITALISATION **Hospital Network DSPs** Deductibles apply to a specified list of conditions/procedures as set out in Appendix 3			Benefits subject to pre-authorisation and PMB regulations. Emergencies must be authorised within 24 hours of admission.
All admissions at network DSP	100% of cost	Unlimited (at general and private ward rates)	
Other hospitals (non-DSPS)			
PMB admission: involuntary use of non-DSP (deductible does not apply)	100% of cost	Unlimited (at general and private ward rates)	
PMB admission: voluntary use of non-DSP (deductible applies to all admissions)	100% of Scheme Rate	Unlimited (at general and private ward rates)	
Non-PMB admission (deductible applies to all admissions)	100% of Scheme Rate	Unlimited (at general and private ward rates)	
Deductibles payable on admission Healthcare services reflected in Appendix 3	Beneficiary responsible for a Deductible in respect of the hospital account for certain hospital events, unless the admission is related to a Prescribed Minimum Benefit diagnosis typically as a result of an emergency. The Deductible will apply regardless of the whether the procedure attracting the deductible was the primary reason for the admission or not.		

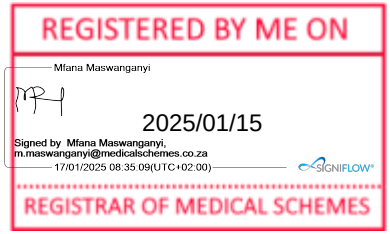
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Benefits provided on admission to:			
1. Hospital Network DSPs • Ward Fees (general and private ward rate) • ICU and high care unit fees • Theatre fees • Ward and theatre drugs, dressings, materials and equipment consumed / utilised in hospital • Outpatient services • Recovery beds	100% of cost	Unlimited	In accordance with a per diem or negotiated rate. Facility fees charged by hospitals for outpatient visits that do not result in authorised admissions to be paid from out of hospital specialist consultations and procedures limit.
• Ward and theatre drugs, dressings, materials, equipment and disposables consumed / utilised in the theatre (at hospital network DSPs)	100% of cost	Unlimited	
2. Other hospitals (non-DSPs) • Ward Fees (general and private ward rate) • ICU and high care unit fees • Theatre fees • Outpatient services • Recovery beds	100% of Scheme Rate	Unlimited	PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations. Facility fees charged by hospitals for outpatient visits that do not result in authorised admissions to be paid from out of hospital specialist consultations and procedures limit.
• Ward and theatre drugs, dressings, materials, equipment and disposables consumed / utilised in hospital (at non-DSP hospitals)	100% of Scheme Rate	Unlimited	
3. Unattached Theatre Units (Private) • Theatre fees • Recovery beds	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	The unattached theatre must be registered with the Department of Health.
• Ward and theatre drugs, dressings, materials, equipment and disposables consumed / utilised in hospital (at unattached theatre unit)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	

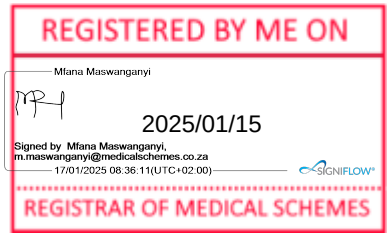
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
OUTPATIENT CONSULTATIONS WITH GPs/SPECIALISTS AT HOSPITAL EMERGENCY ROOMS AND OUTPATIENT UNITS	See General Practitioners/ Specialists: out of hospital consultations in rooms	See General Practitioners/ Specialists: out of hospital consultations in rooms	Regarded as out of hospital GP/Specialist consultations in rooms, unless resulting in an authorised hospital admission.
HOME-BASED HEALTHCARE **For clinically appropriate chronic and acute treatment and conditions, where treatment is possible at home**	100% of Scheme Rate	Subject to the Scheme's preferred provider (where applicable) and the treatment meeting the Scheme's treatment guidelines and clinical and benefit criteria.	Subject to pre-authorisation and PMB regulations. Basket of care as set by the Scheme.
TO TAKE OUT DRUGS	100% of cost	Limited to PMBs and a maximum of 7 days' supply per admission	Benefit for medicine supplied by the hospital when a patient is discharged. 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.
AMBULANCE SERVICES	100% of cost via the Scheme's DSP 100% of Scheme Rate through a non-DSP	Unlimited	Subject to pre-authorisation and PMB regulations. No benefit for services outside the borders of South Africa.
BLOOD TRANSFUSIONS **Blood products, materials, apparatus and operator's fees** 	100% of cost	Unlimited	Subject to pre-authorisation and PMB regulations.

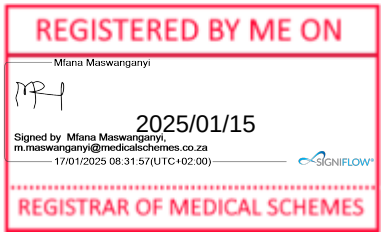
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
ORGAN AND BONE MARROW TRANSPLANTS			Subject to pre-authorisation and PMB regulations.
Hospitalisation, and organ and patient preparation	Benefits as for hospitalisation	Benefits as for hospitalisation	The organ recipient must be a Bankmed beneficiary for benefits to apply.
Medication (in and out of hospital)			Benefits for Specialists will be as specified elsewhere this schedule.
• Medication via designated pharmacy (DSP)	100% of cost	Unlimited	No benefit for travelling and non-hospital accommodation expenses.
• Medication via non-DSP (voluntary use of non-DSP)	80% of Scheme Medicine Reference Price plus dispensing fee	Unlimited	
• Medication via non-DSP (involuntary use of non-DSP)	100% of cost	Unlimited	
Harvesting and transporting of organs, and other donor costs	100% of cost	Unlimited	
ONCOLOGY (CHEMOTHERAPY AND RADIOTHERAPY)			
In and out of hospital consultations, treatment and materials	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	Subject to: - Pre-authorisation and PMB regulations - Evidence-based medicine, cost-effectiveness and affordability - Scheme's oncology baskets of care, formularies and/or protocols - Meeting Scheme's Clinical Entry Criteria - Peer-review by external panel of specialists as appointed by the Scheme



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Associated Medicine/Drugs **For medicines administered in-rooms:** (Injectable and infusional chemotherapy) • Medication via the Oncology Pharmacy Designated Service Provider (DSP) (Courier pharmacy) • Medication via a non-DSP (voluntary use of non-DSP) • Medication via a non-DSP (involuntary use of non-DSP) Excludes medicines administered in-hospital and medicines administered in-rooms by a dispensing provider. **For medicines scripted and dispensed at a retail pharmacy or via a courier pharmacy (scripted by treating provider):** (Supportive medication, oral chemotherapy and hormonal therapy) • Medication via the Oncology Pharmacy Designated Service Provider (DSP) • Medication via a non-DSP (voluntary use of non-DSP) • Medication via a non-DSP (involuntary use of non-DSP)	100% of cost 80% of Scheme Medicine Reference Price plus dispensing fee 100% of cost 100% of cost 80% of Scheme Medicine Reference Price plus dispensing fee 100% of cost	Unlimited Unlimited Unlimited Unlimited Unlimited Unlimited	Subject to: - Pre-authorisation and PMB regulations - Evidence-based medicine, cost-effectiveness and affordability - Scheme's oncology baskets of care, 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 a designated service provider. 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)



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
RENAL DIALYSIS **Procedures and Treatment** **Associated Medicine/Drugs** • Medication via designated courier pharmacy (DSP) • Medication via non-DSP (voluntary use of non-DSP) • Medication via non-DSP (involuntary use of non-DSP)	 100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost 100% of Scheme Medicine Reference Price plus dispensing fee 100% of cost	 Unlimited Unlimited Unlimited Unlimited	 Subject to pre-authorisation and PMB regulations. 
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: Out-of-hospital healthcare services related to COVID-19: - Screening consultation with a nurse or GP - Defined basket of pathology - Defined basket of x-rays and scans - Consultations with a nurse or GP - Supportive treatment - Contact tracing	Over and above the PMB requirements. Up to a maximum of 100% of the Scheme Rate. Cover for testing is subject to NICD protocol and referral. Subject to the Scheme's preferred provider (where applicable), protocols and the condition and treatment meeting the Scheme's entry criteria and guidelines.	Up to a 100% of the Scheme Rate for registered healthcare providers.	Basket of care as set by the Scheme 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 providers except where covered as PMB.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
PREGNANCY AND CHILDBIRTH			
Hospitalisation and associated in hospital services (hospital network rules apply)	As specified elsewhere in this schedule	As specified elsewhere in this schedule	Subject to pre-authorisation and PMB regulations. Benefits for hospitalisation and other in hospital services as specified elsewhere in this schedule.
Midwife care and delivery	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	Subject to pre-authorisation and PMB regulations.
Birthing facilities	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited (Cost of disposables limited to R1 440 per case)	Subject to pre-authorisation and PMB regulations. Only available where hospital services are not used (except for registered active birthing units).
GPs and Specialists	As specified elsewhere in this schedule	As specified elsewhere in this schedule	Benefits for General Practitioners and Specialists as specified elsewhere in this schedule.
Radiology and Pathology	As specified elsewhere in this schedule	As specified elsewhere in this schedule	Benefits for Radiology and Pathology specified elsewhere in this schedule.
ALTERNATIVES TO HOSPITALISATION			
Frail Care Facilities 	100% of cost	R575 per beneficiary per day	Frail care facilities: Subject to pre-authorisation. Available to permanently chronic sick or geriatric patients for accommodation in a registered nursing home or hospital. No Benefits for accommodation in old age homes. Available as alternative to home nursing not in addition hereto.

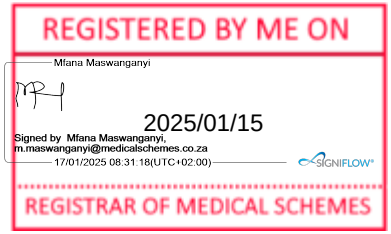
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Step-down facilities	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	Step-down facilities: Subject to pre-authorisation and available only as an alternative to hospitalisation. Such service follows pre-authorised hospitalisation or operation and is in lieu of further hospitalisation. The facility must be registered with the Department of Health.
Home nursing services	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R455 per beneficiary per day	Home nursing services: Subject to pre-authorisation. Rendered at the patient's residence by a registered nurse or a person from a registered nursing institution. For such periods as the Scheme may determine as reasonable.
REGISTERED PRIVATE NURSE PRACTITIONERS (registered with the S. A. Nursing Council or its legal successor)			
Procedures	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	For procedures not requiring admission to a day surgery facility or hospital.
Consultations	300% of Scheme Rate	Three pbpa from the Insured Benefit Thereafter subject to available Savings ATB applies once the Threshold is reached	Includes the cost of vaccination and injection material administered by the Practitioner.
HomeCare Services	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	For procedures not requiring admission to a day surgery facility or hospital. Scheme Entry Criteria Applies. Subject to preauthorisation.
ADVANCED ILLNESS BENEFIT	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	Subject to pre-authorisation and the treatment meeting the Scheme's guidelines and managed care criteria.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
WELLNESS AND PREVENTATIVE CARE BENEFITS (VACCINATIONS AND SCREENING)			Benefits in this section do not contribute to the depletion of any insured limits specified elsewhere in this schedule. Associated consultation fees are not provided for in this section, unless indicated. See General Practitioners (GPs): out of hospital consultations and procedures in rooms for consultation benefits.
Contraception: oral contraceptives, devices and injectables	100% of Scheme Medicine Reference Price	R2 510 pbpa	For female beneficiaries only. Oral contraceptives limited to one prescription or repeat prescription per beneficiary per month.
Influenza vaccine	100% of Scheme Medicine Reference Price	One pbpa	
Human Papilloma Virus (HPV) vaccine	100% of Scheme Medicine Reference Price	Three doses pb	For male and female beneficiaries aged 9 to 25 years and limited to a total course of three doses (depending on product and age).
Cholesterol screening, blood sugar screening and blood pressure measurements	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R400 pbpa	At clinics, pharmacies or Bankmed GP Network GPs' consulting rooms.
HIV Counselling and Testing (HCT)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	HCT DSPs: Bankmed GP Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering onsite services at employer groups, subject to PMB regulations.
Mammogram	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa	For beneficiaries aged 40 years and older; Benefits for beneficiaries younger than 40 years, subject to motivation and prior approval.

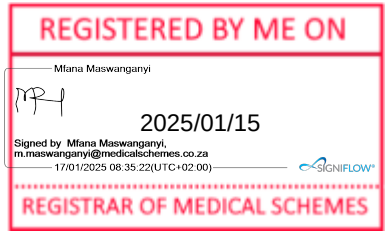
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Breast MRI (breast cancer risk only)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa	For high-risk beneficiaries only. Subject to clinical entry criteria and pre-authorisation.
Pap smear	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa	One associated nurse, Bankmed GP Network GP or Bankmed Specialist Network consultation per beneficiary covered as an additional insured benefit, limited to R630 pbpa.
Bone densitometry **Prostate specific antigen** **Faecal occult blood test**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa One pbpa One pbpa	For beneficiaries aged 50 years and older; Benefits for beneficiaries younger than 50 years, subject to motivation and prior approval. Should member not meet clinical entry criteria, and they are younger than age 50, the member may claim the bone densitometry test from their Radiology Benefit. Where the Radiology Benefit is exhausted, this test may be claimed from available Medical Savings Account.
Tuberculosis (TB) screening	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One chest x-ray pbpa	For TB screening requested by private nurse practitioners rendering onsite services at employer groups; All other TB screenings subject to available out of hospital radiology and/or pathology benefits, and PMB regulations.
Childhood vaccinations (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	Subject to EPI guidelines	For immunisations administered in accordance with the Department of Health's Expanded Programme on Immunisation (EPI) guidelines for children up to 12 years.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Pneumococcal vaccine	100% of Scheme Medicine Reference Price	Limited as follows:	• One vaccination every five years for adults 60 years and older. • One vaccination every five years for beneficiaries younger than 60 years, who have been diagnosed with Asthma, Chronic Obstructive Pulmonary Disease, Diabetes, Cardiovascular Disease, or HIV/Aids.
Herpes Zoster Virus vaccine **(Reduces the rate of herpes zoster [shingles])**	100% of Scheme Medicine Reference Price	Limited as follows:	One vaccination every five years for adults 60 years and older.
Personal Health Assessment (PHA)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one pbpa	One assessment pbpa. Benefit limited to Bankmed GP Network GPs, Bankmed Pharmacy Network and contracted providers rendering onsite services at employer groups; subject to completion and follow up of the assessment. Applies to members and beneficiaries aged 16 years and older only.
Post-Personal Health Assessment (PHA): Additional Consultations for Dietician and Biokineticist	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to two dietician visits per year plus two Biokineticist visits per year First visit to dietician and biokineticist to take place within 6 weeks of the PHA and second visit within 12 months of the PHA, otherwise funded from day-to-day benefits	Limited to medium and high-risk members and/or members with a Body Mass Index (BMI) of 30 and more. Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA. Clinical Entry Criteria applies. Applies to members and beneficiaries aged 16 years and older only.

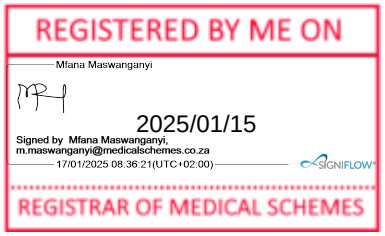
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Post-Personal Health Assessment (PHA): Additional Consultation for Bankmed Network GP	100% of cost at a DSP Not covered at a non-DSP	Limited to one Bankmed Network GP visit pbpa Visit to Bankmed Network GP to take place within 6 weeks of the PHA, otherwise funded from day-to-day benefits.	Limited to high-risk members. Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA. Clinical Entry Criteria applies. Applies to members and beneficiaries aged 16 years and older only.
Bankmed Mental Wellbeing Assessments			Free online assessment via www.bankmed.co.za; There is no limit on the number of assessments per beneficiary per annum.
Mental Health 'At Risk' Benefit: Additional Consultation for Bankmed Network GP or Network Psychologist	100% of cost at a DSP Not covered at a non-DSP	Limited to one consultation per qualifying beneficiary Visit to Bankmed Network GP or Network Psychologist to take place within 6 weeks of the Online Mental Wellbeing Assessment, otherwise funded from day-to-day benefits.	Limited to high-risk members. Consultations limited to Bankmed Network GPs and Bankmed Network psychologists. Members identified and risk-rated using results from the Online Mental Wellbeing Assessment, therefore subject to completion of the Online Mental Wellbeing Assessment. Clinical Entry Criteria applies.
New-born Screening Test	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one per beneficiary	Testing limited to services provided within the borders of South Africa. Test funded only if performed within 72 hours of birth.



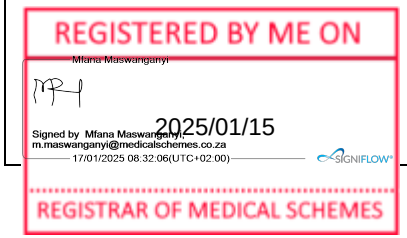
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
New-born Hearing Test	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one per beneficiary	Testing limited to service provided by a registered Audiologist. Only the test is funded. Should the provider charge a consultation fee, the consultation fee will be funded from available consultation benefits. Test only funded if performed within eight weeks of birth. Thereafter funded from standard benefits.
Amniocentesis	100% of cost for DSP 100% of Scheme Rate for non-DSP	Limited to one per pregnancy	Subject to gynaecologist referral. One assessment per beneficiary per pregnancy. Testing limited to services provided within the borders of South Africa.
T21 Chromosome Test or Non-Invasive Prenatal Test (NIPT) **(Member may have either of the two tests, not both)**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one per pregnancy	Subject to the Scheme's protocols and clinical entry criteria. One assessment per beneficiary per pregnancy. Testing limited to services provided within the borders of South Africa. Applies to high-risk beneficiaries aged 35 years and older at delivery. If member does not meet clinical entry criteria, the screening test is covered from the available balance in the member's Medical Savings Account on this Plan.



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Dementia Screening and Assessment Benefit	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one consultation and comprehensive cognitive assessment per qualifying beneficiary per year	One assessment per qualifying pbpa. Testing limited to service provided by a registered Occupational Therapist. Where an Occupational Therapist is not available, the member may consult a Bankmed Network psychologist for the assessment. Only the consultation and assessment are funded. Should the provider charge for additional services, these services will be funded from standard available benefits, where relevant. Applies to members and beneficiaries aged 65 years and older only.
Child Obesity Screening	100% of cost at a DSP Not covered at a non-DSP	Limited to one pbpa	One assessment pbpa. Applies to beneficiaries who are 9 years old to 15 years old only.
Child Obesity Screening: Additional Consultations for Dietician and Biokineticist	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to two dietician visits per year plus two Biokineticist visits per year First visit to dietician and biokineticist to take place within 6 weeks of the Child Obesity Screening and second visit within 12 months of the Child Obesity Screening, otherwise funded from day-to-day benefits	Limited to medium and high-risk beneficiaries based on Body Mass Index (BMI). Beneficiaries identified and risk-rated using results from the Child Obesity Screening, therefore subject to completion of the Child Obesity Screening. Clinical Entry Criteria applies. Applies to beneficiaries who are aged 9 years to 15 years only.

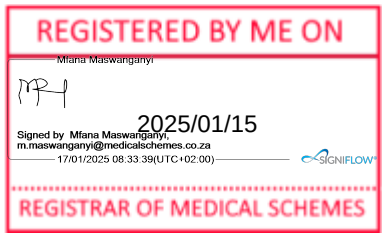


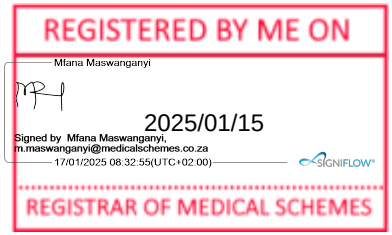
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Child Obesity Screening: Additional Consultation for Bankmed Network GP	100% of cost at a DSP Not covered at a non-DSP	Limited to one Bankmed Network GP visit. Visit to Bankmed Network GP to take place within 6 weeks of the Child Obesity Screening, otherwise funded from day-to-day benefits.	Limited to high-risk beneficiaries. Beneficiaries identified and risk-rated using results from the Child Obesity Screening, therefore subject to completion of the Child Obesity Screening. Clinical Entry Criteria applies. Applies to beneficiaries who are 9 years old to 15 years old only.
DIABETES MANAGEMENT For members registered on the Scheme's Disease Management Programme	100% of cost for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP and member utilises the Scheme's DSP as their service provider. 100% of Scheme Rate if non-DSP used.	Unlimited	Basket of Care set by the Scheme, subject to PMB regulations.
Continuous Glucose Monitoring Device (CGM) Available to Type 1 and Type 2 diabetics meeting the Scheme's clinical entry criteria	Subject to authorisation and/or approval and the member meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.	Unlimited	Subject to the Scheme's protocols and clinical entry criteria. Members with a CGM device have limited glucose strip benefits, where approved.
DISEASE MANAGEMENT FOR CARDIO-METABOLIC RISK SYNDROME Disease Management for cardiometabolic risk syndrome for members registered on the Scheme's Disease Management Programme	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.	Limited to the basket of care set by the Scheme.	Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
RADIOLOGY AND PATHOLOGY **In Hospital** **Out of hospital**	 100% of cost at a DSP 100% of Scheme Rate at a non-DSP 300% of Scheme Rate	 Unlimited Subject to available Savings	Subject to Annual Threshold and ATB. The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an Above Threshold Benefit, subject to the availability of Above Threshold Benefits, is R8 010 per family per annum (irrespective of family size)
MRI / CT SCANS AND RADIONUCLIDE SCANS **In Hospital and out of hospital**	 100% of cost at a DSP 100% of Scheme Rate at a non-DSP	 Unlimited	 Subject to pre-authorisation (both in and out of hospital).
HIV/AIDS PROGRAMME Additional benefits subject to registration on HIV/Aids Programme. These additional benefits do not contribute to the depletion of other insured benefits provided by the Scheme. **Consultations and pathology** **Associated Medicine/Drugs** • Medication via Bankmed Pharmacy Network (DSP) • Medication via non-DSP (voluntary use of non-DSP) • Medication via non-DSP (involuntary use of non-DSP)	 100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost 80% of Scheme Medicine Reference Price plus contracted dispensing fee 100% of cost	 Subject to benefits available in Scheme's Basket of Care Unlimited Unlimited Unlimited	Beneficiaries who do not register on the HIV/Aids Programme will be entitled to all other benefits as specified in this schedule, with continued funding for PMBs, subject to PMB regulations, after depletion of the relevant sub-limits. Bankmed Pharmacy Network for HIV/Aids medication: as communicated to registered beneficiaries from time to time. A motivation is required for the use of a non-DSP for medication. Subject to Scheme's approved formulary. Reference pricing applies to non-formulary medication.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
INTERNAL PROSTHESIS			Benefits subject to clinical motivation, the application of clinical / funding protocols, Scheme approval and PMB regulations. Defined as appliances placed in the body as an internal adjuvant, during an operation. Combined limit for all internal prosthesis items, excluding pacemakers and defibrillators; Sub-limits may apply depending on the prosthesis required. All sub-limits as indicated are further subject to the combined limit for all internal prosthesis items, excluding pacemakers, defibrillators. The sub-limits are not “in addition to” the combined limit. Dental implants of any nature are not included in the definition of internal prosthesis.
Combined limit for all internal prostheses items	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R91 190 pbpa	
Internal prosthesis sub-limits:			
Hip joint prostheses, knee joint prostheses and shoulder joint prostheses	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R60 685 per prosthesis per admission if prosthesis is not supplied by the Scheme's network provider. If supplied by the Schemes network provider, unlimited (not subject to combined limit for all internal prosthesis items)	
Spinal fusions	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R61 440	The prostheses accumulate to the limit. The balance of the hospital and related accounts do not accumulate to the annual limit.
Cardiac stents	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R90 830	
Grafts	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R49 170	
Cardiac Valves	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R51 715	
Non-specified items	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R28 335	

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
SPINAL CARE (SPINAL 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	Unlimited	Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria. Subject to PMB regulations. Unlimited at a network provider for in-hospital treatment Basket of care as set by the Scheme for out-of-hospital conservative treatment
PACEMAKERS AND DEFIBRILLATORS	100% of cost of device if preferred provider used 100% of Scheme Rate if non-preferred provider used to purchase device	Unlimited	Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval.
INTRAOCCULAR LENSES FOR CATARACT SURGERY (Permanent, implantable lenses, inclusive of basic and specialised lens varieties)	Up to a maximum of 100% of the Scheme Rate Scheme Rate is equal to the negotiated and agreed lens price plus 25% mark-up		Subject to pre-authorisation and the treatment meeting the Scheme's criteria. Covered in full when supplied by the Scheme's preferred suppliers, otherwise covered up to the Scheme Rate for the lens. Scheme Rate is equal to the negotiated and agreed lens 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.
EXTERNAL PROSTHESIS Artificial limbs and eyes	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R31 110 pfpa	Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval. Benefit includes the repair of the prosthesis.

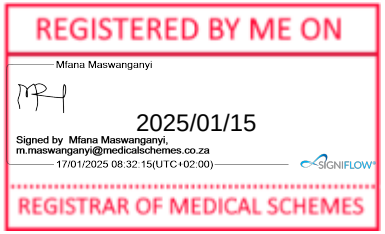
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
MEDICAL AND SURGICAL APPLIANCES **Post-surgery appliances** • Purchase or hire of: Braces, Splints, Slings, Corsets, Cervical collars, Post-op footwear (sandals and boots), Air-casts, Pressure garments, Compression hose, Cushions, Mastectomy brassiere/breast prosthesis. • Hire of: Wheelchairs, Walking frames, Crutches, Traction equipment, Toilet/bath riser, Bath swivel stool **Chronic appliances** • Oxygen and oxygen delivery systems, i.e. items required for its delivery and administration (e.g. delivery tube, nasal cannulas and mask) **Chronic appliances** • Stoma products, including indwelling catheters and colostomy bags **Other chronic appliances** • Other chronic appliances include Braces/Callipers/Surgical boots (in combination), Lumbar Sacral Corsets, Splints, Compression hose, "Be-sure" products, Heel pads/insoles/metatarsal bars, CPAP machines, Sleep apnoea monitor for infants (hire thereof), Suction machine and catheters, Nebulisers, Glucometers, Peak flow meters • Purchase of: Crutches, Wheelchairs, Walking frames, Toilet/bath risers, Commodes, Urinal bottles, Bed pans	100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost at a DSP 100% of Scheme Rate at a non-DSP 	R9 145 pbpa R28 720 pbpa R28 720 pbpa R9 145 pbpa Limit may be extended to R13 380 for beneficiaries requiring a CPAP machine Sub-limits apply as follows: R1 125 for arch supports (per pair) R1 695 for shoe insoles (per pair)	Benefits subject to a doctor's prescription, the application of clinical and funding protocols, and Scheme approval. Additional benefits may be provided for wheelchairs, subject to motivation, from occupational therapist and/or physiotherapist, a minimum of two cost quotations and Scheme approval. **Frequency limits apply:** Surgical/moonboot: one every 24 months Crutches: one set every 24 months Brace callipers: one set every 24 months Rigid back brace: one every 24 months Wig: one every 24 months Breast prosthesis bra: no limit on number of bras that may be purchased in 12 months; Rand limit applies for post-surgery appliances Breast prosthesis: one/two per 24 months (one/two is patient dependent) Commodes: one every 36 months Wheelchairs: one every 36 months Walking frames: one every 24 months Surgical compression stockings: two pairs per 12-month period Sling/clavicle brace: one every 24 months Portable oxygen: one every 48 months Arch supports: one pair every 24 months Shoe insoles: one pair every 24 months CPAP machine: one every 36 months Humidifier: one every 36 months

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Appliances for acute conditions	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Subject to available Savings	Appliances for acute conditions subject to Annual Threshold and ATB. For conditions not covered under the post-surgery appliance benefit and the chronic surgical appliances benefit. Repairs and maintenance of any appliances provided under any of these benefit categories.
BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS (Combined limit with medical and surgical appliances: other chronic appliances)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R9 145 pbpa Sub-limits apply as follows: R1 540 pbpa for blood pressure monitors R2 175 pbpa for nebulisers R1 085 pbpa for glucometers	Benefits available on doctor's prescription without additional motivation or Scheme approval. **Frequency limits apply:** Blood pressure monitors: one every 36 months Nebulisers: one every 36 months Glucometers: one every 36 months
HEARING AIDS (SUPPLY AND FITMENT)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R42 540 per beneficiary every 24 months	**Frequency limits apply:** Benefit only available where the beneficiary has not claimed for hearing aid/s in the previous calendar year. Rolling limit every 24 months. No benefit for replacement batteries.
HEARING AID REPAIRS	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R1 885 pbpa	
BONE ANCHORED HEARING AIDS	90% of Scheme Rate	R194 345 pfpa	

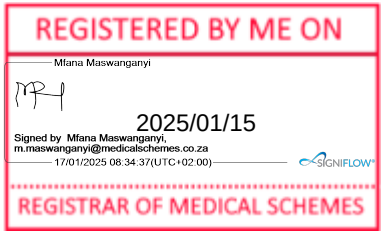
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
COCHLEAR IMPLANTS			Once in a lifetime benefit.
Hospitalisation	Benefits for hospitalisation as specified elsewhere in this schedule	As specified	Subject to pre-authorisation and Scheme protocols.
Pre-operative evaluation and associated preparation costs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R21 605 pb per lifetime	Funding only available in recognised Centres of Excellence.
Cochlear implant device	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R452 990 pb per lifetime	Once in a lifetime benefit available to: • Children under 8 years of age • Persons over the age of 8 diagnosed as suffering from profound bilateral sensory neural hearing loss
Intra-operative audiology testing	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R1 125 pb per lifetime	
Post-operative evaluation costs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R45 370 pb per lifetime	
UPGRADE OR REPLACEMENT OF SPEECH PROCESSORS	100% of Scheme Rate	R169 140 pb over a three-year cycle	Subject to clinical motivation, the application of clinical / funding protocols and Scheme approval.
PSYCHIATRY, CLINICAL PSYCHOLOGY, & RELATED OCCUPATIONAL THERAPY			
Hospitalisation: **Hospital Network DSPs** All admissions at network DSP	100% of cost for Bankmed Network Psychiatric facilities (DSPs)	R85 215 pbpa (Combined limit with occupational therapy: psychiatric consultations /sessions in hospital)	Subject to pre-authorisation. Continued benefits for PMBs subject to pre-authorisation and PMB regulations. PMBs limited to 80% of Scheme Rate for non-DSPs, subject to PMB regulations. Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the rand limit.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Other hospitals (non-DSPS)			
PMB admission: involuntary use of non-DSP	100% of cost		
PMB admission: voluntary use of non-DSP	80% of Scheme Rate for non-DSPs		Out of hospital benefits subject to Annual Threshold and ATB.
Non-PMB admission	80% of Scheme Rate for non-DSPs		The maximum amount that can jointly accumulate towards reaching the Annual Threshold and/or be paid as an Above Threshold Benefit (subject to the availability of Above Threshold Benefits) is R18 850 per family per annum (irrespective of family size)
In-hospital consultations / sessions	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSPs		
Out of hospital consultations / sessions	300% of Scheme Rate	Subject to available Savings	for out of hospital mental health benefits (psychiatry, clinical psychology and related occupational therapy). PMBs covered at 100% of cost (from insured benefit) at Bankmed Prestige A&B Specialist Network: DSPs and limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations. Cover for 15 out-of-hospital psychotherapy sessions for PMBs.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Post-hospital psychiatric consultation within 30 days of discharge from hospital (excluding day cases) for a psychiatric admission (Related to Major Depression, Schizophrenia and Bipolar Mood Disorder only)	100% of cost for Bankmed Prestige A&B Specialist Network 100% of Scheme Rate for non-DSP Psychiatrist	Limited to three consultations per beneficiary per annum	An additional consultation will be granted as an insured benefit, per beneficiary visiting a psychiatrist within 30 days of discharge, following an authorised psychiatric hospital admission (excluding day cases). PMBs limited to 100% of Scheme rate for non-DSPs, subject to PMB regulations. In the event that the member exceeds the three-consultation limit (following three hospital admissions), the consultations will be subject to the standard psychiatry, clinical psychology and related occupational therapy benefit limits, thereafter, available funds in the Medical Savings Account.
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, up to 100% of the Scheme Rate for services covered in the Scheme's basket of care if referred by the Scheme's DSP. 100% of Scheme Rate for services performed by the Scheme's DSP.	Limited to the basket of care set by the Scheme.	Subject to the treatment meeting the Scheme's treatment guidelines and managed care criteria. Subject to PMB regulations.



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
OCCUPATIONAL THERAPY: PSYCHIATRIC CONSULTATIONS / SESSIONS			
Hospitalisation and in-hospital consultations / sessions	See Psychiatry, clinical psychology and related occupational therapy – hospitalisation and in-hospital consultations / sessions	See Psychiatry, clinical psychology and related occupational therapy – hospitalisation and in-hospital consultations / sessions	In-hospital benefits subject to pre-authorisation. Continued benefits for PMBs subject to pre-authorisation and PMB regulations. PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.
Out of hospital	See Psychiatry, clinical psychology and related occupational therapy - out of hospital consultations / sessions	See Psychiatry, clinical psychology and related occupational therapy - out of hospital consultations / sessions	
OCCUPATIONAL THERAPY: NON-PSYCHIATRIC CONSULTATIONS / SESSIONS			
In hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	Subject to pre-authorisation
Out of hospital	300% of Scheme Rate	Subject to available Savings	Out of hospital benefit subject to Annual Threshold and ATB. The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an Above Threshold Benefit, subject to the availability of Above Threshold Benefits, is R9 505 per family per annum (irrespective of family size) for occupational therapy: non-psychiatric consultations out of hospital PMBs covered at 100% of cost (from insured benefit) at Bankmed Prestige A&B Specialist Network: DSPs, and limited to

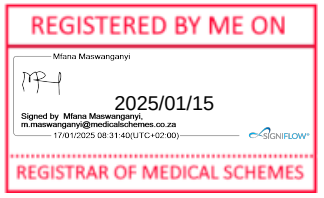


HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
			100% of Scheme Rate for non-DSPs, subject to PMB regulations.
PHYSIOTHERAPY **In hospital** **Out of hospital physiotherapy (including post hospitalisation treatment or an approved day surgery facility)**	 100% of cost at a DSP 100% of Scheme Rate at a non-DSP 300% of Scheme Rate	 Unlimited Subject to available Savings	 Subject to pre-authorisation Subject to Annual Threshold and ATB The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an Above Threshold Benefit, subject to the availability of Above Threshold Benefits, is R3 795 per beneficiary per annum.
SPEECH THERAPY, AUDIO THERAPY AND AUDIOLOGY **In and out of hospital**	 300% of Scheme Rate	 Subject to available Savings	Subject to Annual Threshold and ATB The maximum amount that can jointly accumulate towards reaching the annual threshold (at 100% of Scheme Rate) and/or be paid as an Above Threshold Benefit, subject to the availability of Above Threshold Benefits, is R2 835 per family per annum (irrespective of family size).

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
ADDITIONAL BENEFITS FOR BENEFICIARIES WITH NEURODEVELOPMENTAL DISORDERS • Occupational therapy: psychiatric consultations/sessions (out of hospital) • Occupational therapy: non-psychiatric consultations/sessions (out of hospital) • Physiotherapy (out of hospital) • Speech therapy (out of hospital)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	As approved	Additional discretionary insured benefits 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 100% of the Scheme Rate or contracted rate, whichever applies. These discretionary benefits are in addition to any other insured benefits normally applicable to these services, as specified elsewhere in this schedule.
OTHER AUXILIARY SERVICES **In and out of hospital** • Chiropody/Podiatry • Dietetics/Nutritional Assessments • Orthotics • Massage • Chiropractors • Herbalists • Naturopaths • Family planning clinics • Homeopaths • Biokineticists (fitness assessments)	300% of Scheme Rate	Subject to available Savings	**Frequency limits apply:** Foot orthotics: one every 24 months If prescribed by a medical practitioner and provided that the supplier of service is registered as such in terms of any law. The fees must have been incurred for a definite complaint and treatment must be for curative purposes only. Subject to Annual Threshold and ATB; The maximum amount that can jointly accumulate towards the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an Above Threshold Benefit, subject to the availability of Above Threshold Benefits, is R4 005 per family per annum (irrespective of family size).

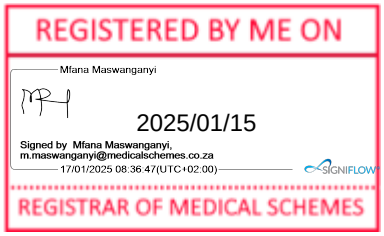
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
CHRONIC MEDICATION **Medication via DSP** (Bankmed Network GP and Bankmed Pharmacy Network) **Medication via non-DSP** (voluntary use of non-DSP) **Medication via non-DSP** (involuntary use of non-DSP)	Subject to Scheme approved Chronic Medicine List 100% of Scheme Medicine Reference Price 80% of Scheme Medicine Reference Price 100% of cost	R34 215 pbpa	Benefits for chronic medication, drugs and injection material subject to: • Prior application and approval of 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 medical practitioners, as are required by the Scheme • Scheme approved Chronic Medicine List • 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.
PRESCRIBED ACUTE MEDICATION	100% of Scheme Medicine Reference Price plus contracted dispensing fee	Subject to available Savings	Subject to Annual Threshold and ATB. Dispensing fee limited to the contracted fee as for Bankmed Network GPs and Bankmed Pharmacy Network (DSPs). The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an Above Threshold Benefit (subject to the availability of Above Threshold Benefits) is set at R22 730 per annum for a single member and R34 430 per annum for a member with dependants.
SELF-MEDICATION (OVER THE COUNTER MEDICINE) AND PHARMACY ADVISED THERAPY (PAT)	100% of Scheme Medicine Reference Price	Subject to available Savings	Self-medication/PAT does not accumulate towards the annual threshold and is not covered as an Above Threshold Benefit (ATB)

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
HOMEOPATHIC MEDICATION	Benefits as for prescribed acute/ chronic medication	Benefits as for prescribed acute/ chronic medication	On doctor's prescription only and limited to items with NAPPI codes. No self-medication /PAT benefit for homeopathic medicines.
SPECIALISTS			
In hospital consultations, operations and procedures	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 300% of Scheme Rate for non-DSPs	Unlimited	Subject to pre-authorisation. PMBs limited to 300% of Scheme Rate for non-DSPs, subject to PMB regulations.
Out-of-hospital consultations in rooms	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 300% of Scheme Rate for non-DSPs	Subject to available Savings	Subject to Annual Threshold and available ATB.
Out-of-hospital procedures in rooms	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 300% of scheme Rate for non-DSPs	Unlimited	Benefit includes the cost of vaccination and injection material administered by the Specialist, except where indicated as a specified benefit under Vaccinations and Screening. PMBs limited to 300% of Scheme Rate for non-DSPs, subject to PMB regulations.
GENERAL PRACTITIONERS (GPs)			In-hospital benefits are subject to pre-authorisation.
In hospital consultations	100% of cost for Bankmed Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.
In hospital operations and procedures	100% of cost for Bankmed Network GPs: DSPs 300% of Scheme Rate for non-DSPs	Unlimited	
Out of hospital consultations in rooms	100% of cost for Bankmed Network GPs: DSPs 300% of Scheme Rate for non-DSPs	Subject to available Savings	Subject to Annual Threshold and ATB Includes the cost of vaccination and injection material administered by the GP.



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Out of hospital procedures in rooms	100% of cost for Bankmed Network GPs: DSPs 300% of Scheme Rate for non-DSPs	Unlimited	
Post hospital GP consultation within 30 days of discharge from hospital (excluding day cases)	100% of cost for Bankmed Network GPs: DSPs 100% of Scheme Rate for non-DSPs	One per authorised admission (excluding day cases)	An additional consultation will be granted as an insured benefit, per beneficiary visiting a GP within 30 days of discharge, following an authorised hospital admission (excluding day cases). PMBs limited to 100% of Scheme rate for non-DSPs, subject to PMB regulations.
Virtual GP consultation	100% of cost for Bankmed Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Limited to three consultations pbpa	Subject to member and/or beneficiary having a prior consulting relationship with the GP. Verification notes to be submitted by claiming GP.
MAXILLO FACIAL AND ORAL SURGERY **Primary Treatment** Benefits cover: • Treatment of cysts, tumours and salivary gland conditions including complications. • Intra and extra-oral drainage of abscesses and surgery to infected bone • Treatment of trauma including fractures of jaws and facial structures as well as associated skeletal complications. • Treatment of conditions of the tempero-mandibular (jaw) joint, excluding orthognatic surgery • Surgical extraction of teeth, removal of roots, and associated complications where there is no need for reflecting of a flap and removing of bone including suturing • Surgical extraction and exposure of impacted teeth	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	Subject to pre-authorisation. Hospital and general anaesthesia costs associated with dental treatment and oral surgery are subject to pre-authorisation and PMB regulations.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
• Repair of cleft palate, cleft lip and associated soft tissue repair **Elective Treatment** Benefits cover: • Orthognatic surgery (surgical repositioning of jaws) • Surgical placement and exposure of implants excluding the cost of all components and transmucosal healing abutments • Surgical preparation of jaws for prosthetics • Functional corrections of malocclusions	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	Subject to pre-authorisation.
DENTAL SERVICES **Preventive and Basic Dentistry** **Advanced Dentistry** Caps, crowns, bridges and cost of endosteal and ossea-integrated implants **Orthodontics** **All other dental services**	300% of Scheme Rate 300% of Scheme Rate 300% of Scheme Rate 300% of Scheme Rate	Subject to available Savings Subject to available Savings Subject to available Savings Subject to available Savings	Subject to Annual Threshold and ATB The maximum amount that can jointly accumulate towards reaching the Annual Threshold and/or be paid as an Above Threshold Benefit, subject to the availability of Above Threshold Benefits, is R22 730 per annum for a single member R34 430 per annum for a member with dependants (in and out of hospital).



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
OPTOMETRY **Subject to the Optometry Benefit Management program and clinical necessity**			
Consultations	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Subject to available Savings	Subject to Annual Threshold and ATB (except for frames and extras, which shall not accumulate towards the Annual Threshold or be covered as an insured benefit from ATB).
Frames and Extras	100% of cost at a DSP 100% of Scheme Rate at a non-DSP		
Prescription Lenses	100% of cost at a DSP 100% of Scheme Rate at a non-DSP		
Readymade Readers	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Two pairs at R125 a pair, pb every two years paid from available Savings	Readymade readers via optometrists and Pharmacies as an OTC benefit subject to benefit availability
Contact Lenses	100% of cost at a DSP 100% of Scheme Rate at a non-DSP		
Fitting of contact lenses	100% of cost at a DSP 100% of Scheme Rate at a non-DSP		
Other optometric services Refractive surgery/excimer laser treatment, hospitalisation and associated costs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP		Accumulation towards Annual Threshold and/or payment of Above Threshold Benefits (at 100% of Scheme Rate) limited to a combined maximum of R5 740 per beneficiary per annum.
Sunglasses	No benefit	No benefit	No benefit for sunglasses / prescription sunglasses / spectacles with a tint > 35%.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
CLAIMS FOR SERVICES RENDERED OUTSIDE THE BORDERS OF SOUTH AFRICA	As per Annexure D	As per Annexure D	Foreign claims covered at the relevant Scheme Rate and/or Rand limit normally allowed for an equivalent non-PMB claim in South Africa. In the case of internal prosthesis and/or medical and surgical appliances, funding will be limited to the amount or rate at which the Scheme would normally fund or procure such device within the borders of South Africa. No benefits for emergency/ambulance transport outside the borders of South Africa. Medical motivation and prior approval required for elective/non-emergency surgery outside the borders of South Africa.
BENEFIT LIMITS EXHAUSTED/ ABOVE SCHEME RATE PORTIONS OF CLAIMS			All benefits are covered at the specified rate (percentage benefit) up to the annual limit, as per this schedule. Once specified limits are exceeded, continued benefits are paid at the specified rate (percentage benefit), from available Savings (except for PMBs, which are covered at 100% of cost, unlimited, after specified sub-limits are depleted). Above Scheme Rate portions of claims are not automatically paid from Savings. Members may, however, apply in writing to have the above Scheme Rate portions of claims automatically paid from available Savings.

LEGEND:

Contracted rate	=	The rate determined in terms of an agreement between the Scheme and a service provider or group of service providers in respect of payment of relevant services
Cost	=	The net cost (after discount) charged for a relevant health service or, in respect of a contracted or negotiated service, the contracted rate. In respect of surgical items and procedures provided in hospital, "cost" shall be the nett acquisition price (also see Annexure B)
DSP	=	Designated Service Provider (may also be referred to as Preferred Provider or Contracted Provider in this schedule): A healthcare provider or group of providers contracted by the Scheme as preferred provider/s to provide diagnosis, treatment and care to beneficiaries in respect of one or more prescribed minimum benefit conditions
M	=	Member without dependants
M+	=	Member plus dependants
pb	=	per beneficiary
pbpa	=	per beneficiary per annum
pfpa	=	per family per annum
pmpa	=	per member per annum
PMB	=	Prescribed Minimum Benefits - a set of minimum benefits to be funded by all medical schemes as per the Medical Schemes Act and Regulations, in respect of the Prescribed Minimum Benefit Conditions (A Prescribed Minimum Benefit Condition is "a condition contemplated in the Diagnosis and Treatment Pairs and Chronic Disease List conditions listed in Annexure A of the Regulations, or any emergency medical condition")
Scheme Medicine Reference Price	=	the maximum price that the Scheme shall pay for a drug or a class of drugs, where cost-effective alternatives exist. In the event that a member voluntarily chooses a drug that is more expensive than an alternative available drug that falls within the Scheme Medicine Reference Price, the price difference shall be a co-payment payable by the member at point of sale, subject to PMB regulations, where applicable
Scheme Rate	=	the rate at which health services are reimbursed by the Scheme in accordance with the applicable benefit schedule and shall be determined by the Scheme from time to time