Bankmed
your good health

2018
BENEFIT AND CONTRIBUTION SCHEDULE

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PART A – OVERVIEW

With financial sustainability forming the foundation of the Bankmed Medical Scheme, we aim to provide our members with benefits that exceed the market average. We focus on our members' needs holistically. Bankmed goes beyond profit, add-ons and incentives. We are committed to meeting our members' healthcare needs.
Because Bankmed is for you. For your family. For your good health.

WHY BANKMED?

Bankmed value

As a Bankmed member, you are part of an exclusive club. Bankmed is a closed medical scheme that is tailored specifically for the banking industry. This gives us invaluable experience and insights into your specific needs, and the ability to offer you a medical scheme that gives you what you need, when you need it.

Scheme overview

Bankmed is registered in terms of the Medical Schemes Act 131 of 1998 and all rules and our benefits are approved by the Council for Medical Schemes. With more than 100 years experience as a medical scheme, we exist solely for your benefit. We don't pursue profits or try to accumulate reserves.

We are managed by a Board of Trustees, who prioritises the interests of our members and the Scheme's sustainability. Half of the Trustees are elected by members. Our unique approach to healthcare is underpinned by the ability to support employer groups with health solutions that have a measurable impact on the health of members and, by extension, the health of the organisation.

Bankmed's initiatives contribute to members' wellbeing and productivity

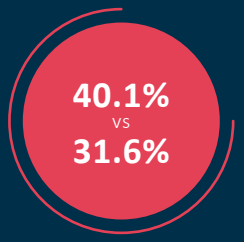
Bankmed participates in an annual survey commissioned by Health Quality Assessment (HQA). The survey measures the clinical quality of the benefit offering of medical schemes (77% of funding industry). Based on the HQA's 2016 findings, Bankmed is ahead of the industry in most clinical quality indicators.

> Bankmed is ranked among the top seven restricted medical schemes in the country – based on its sustainability. **– Alexander Forbes, 2016**

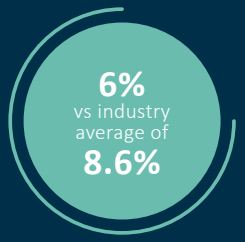
WHAT SETS BANKMED APART FROM OPEN SCHEMES?

Compared to the average open scheme*

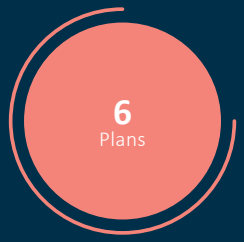
Global Credit Rating – 2017 (Highest in the industry)



Bankmed's Solvency Ratio vs Industry Average, as at end December 2016



Non-Healthcare Expenses Ratio (Administration, Managed Healthcare and General Administration Expenses)



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

Our value proposition includes:

Preventative Care and Wellness

Good health starts with knowing your health. Bankmed offers wellness initiatives, Wellness Days at your workplace and Preventative Care programmes that help us to identify your risks early. This allows you to be in your best possible health.

Prescribed Minimum Benefits (PMBs)

No matter which Plan you choose, you are covered for the Prescribed Minimum Benefits as set out in the Medical Schemes Act.

Good Governance

Bankmed is governed by a competent Board of Trustees who put members' interests and Bankmed's sustainability first.

Sexual Health

We pay for certain screening tests and procedures from the Insured Benefit, which means looking after your sexual health does not affect your day-to-day benefits. We pay for pap smears and offer a circumcision benefit on all Plans and female birth control on all Plans except the Essential Plan. Members also have cover for HIV counselling and testing as well as a full HIV treatment programme if they need it.

Always there when you need us

With our Bankmed App and website, you can always reach us, wherever you or your family happen to be.

On-site Support

Bankmed comes to your office to help you with any questions about your benefits and services.

A promise for a select few

Our commitment to you is reflected in the value we provide. We do this through Plans and benefits designed specifically for the banking industry.

Bankmed is a medical scheme that is exclusively for the banking sector

All our Plans, benefits and contributions are designed with you in mind. We are experts in designing Plans and benefits that reflect our understanding of your career, your challenges, your workplace and the risks that you face each day.

Bankmed offers incredible value for money

Apart from the six different Plans to suit every member's health needs and pocket, we have consistently shown that we are Rand-for-Rand one of the most competitive medical schemes in the market in terms of cost versus benefits offered.

*based on independent actuarial analysis.

PART B – YOUR BENEFIT OPTIONS

GETTING THE MOST OUT OF YOUR PLAN

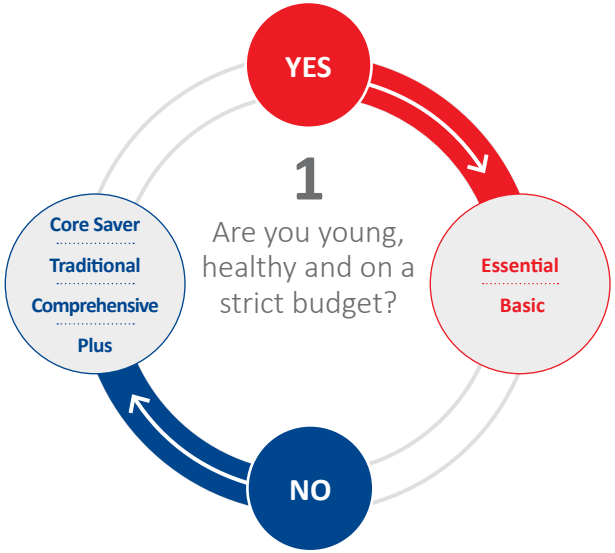
No matter which Plan you choose, you can take steps to get the most out of your benefits and the best value for your money:

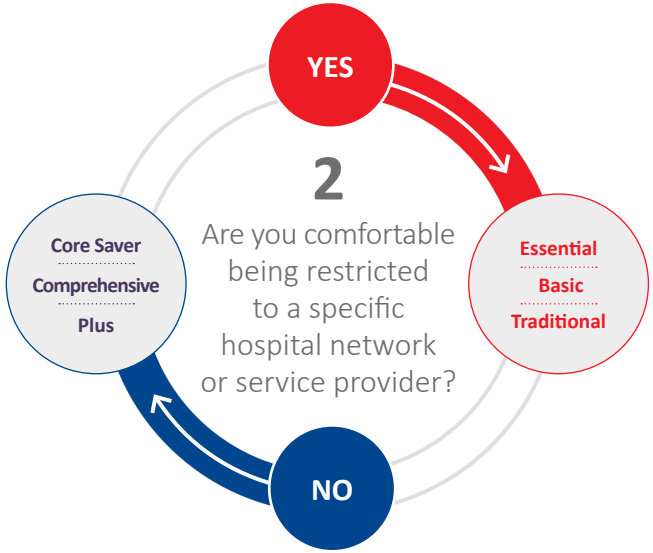
- Use a day clinic rather than an acute hospital if the procedure can be done at a day clinic to avoid out-of-pocket upfront payments (deductibles)
- Have regular health screenings. We pay for them from your Insured Benefit. What this means is that the claim won't affect your day-to-day benefits
- Make your day-to-day benefits last longer by using a Healthcare Professional we have a payment agreement with (a network provider or Designated Service Provider)
- Don't use up your day-to-day benefits if you can register for a programme that gives additional cover. Contact Medicine Advisory Services if you need cover for chronic medicine or register on the Baby-and-Me Programme if you are pregnant
- Visit our website or use the Bankmed App to keep your contact details up to date, check what benefits you have available, search for a Healthcare Professional, share your medical history with your Healthcare Professional through your Electronic Health Record (EHR), request membership and tax certificates, and more
- Keep your medical information with you by downloading the Bankmed App to your smartphone or other smart device. Visit www.bankmed.co.za for details

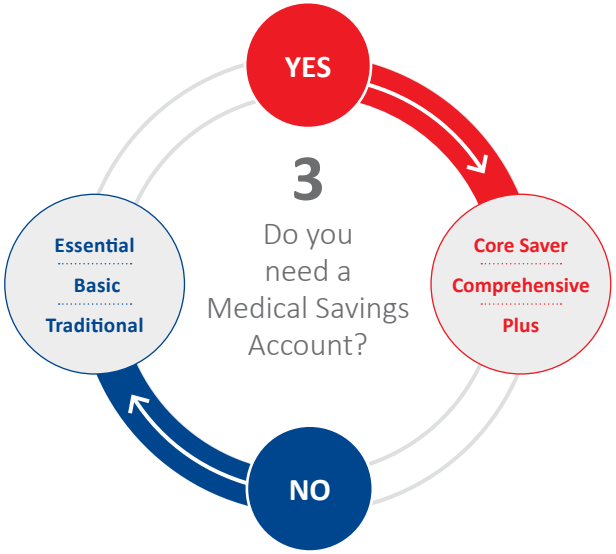
Remember: You have access to 24-hour medical transport and a medical advice helpline on 0860 999 911, as well as unlimited hospitalisation in an emergency

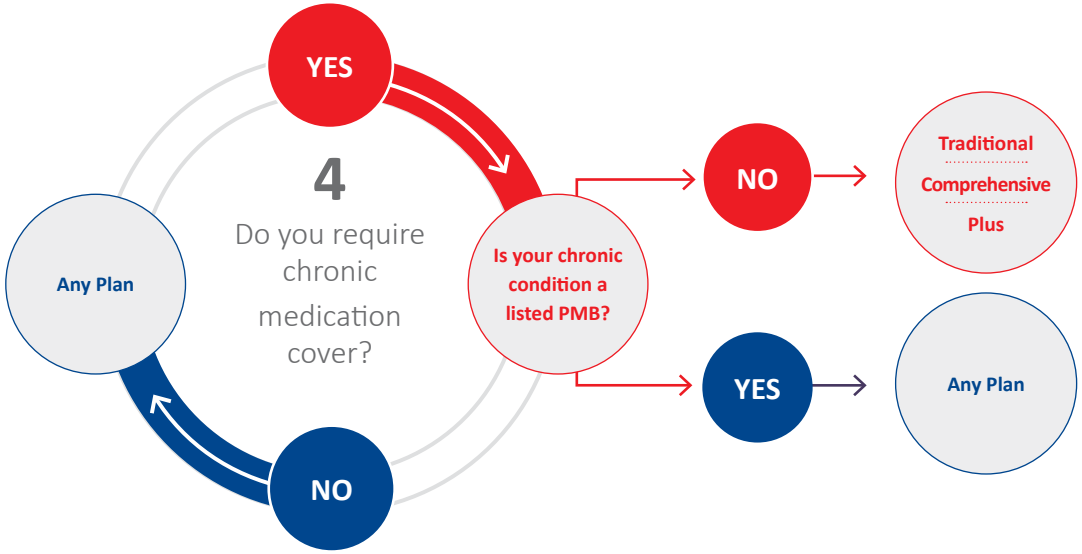
CHOOSING YOUR PLAN OR LOOKING TO CHANGE PLANS?

These four options are basic summaries to help you to select the best Plan for you. Please refer to the detailed Benefit & Contribution tables to compare benefits, costs and limits.









CALCULATE YOUR MONTHLY CONTRIBUTION

Look at the 2018 contribution tables provided on the next page and follow the steps below to calculate how much the Plan you are considering may cost. Remember to ask your employer if you qualify for any subsidies, as this may make different Plans more affordable:

STEP 1 Work out your income category

STEP 2 Write down the cost for Member in the Total Contributions column (for your income category)

STEP 3 Multiply the number of adult dependants* by the amount under Adult Dependant in the Total Monthly Contribution column

STEP 4 Multiply the number of child dependants** by the amount under Child Dependant in the Total Monthly Contribution column. You pay for your first three children you register on your Plan

STEP 5 Add the values you wrote down in step 2, 3 and 4 to calculate your total contributions***

* An adult dependant is a spouse, partner, member's child or grandchild 23 years or older or any other immediate family member for whom the member is responsible for family care and support (and who qualifies as a dependant).

** A child dependant is the member's biological child or grandchild who is dependent on the member, a stepchild, legally adopted child or any child placed in the custody of the member or the member's spouse or partner, and who is younger than 23 years.

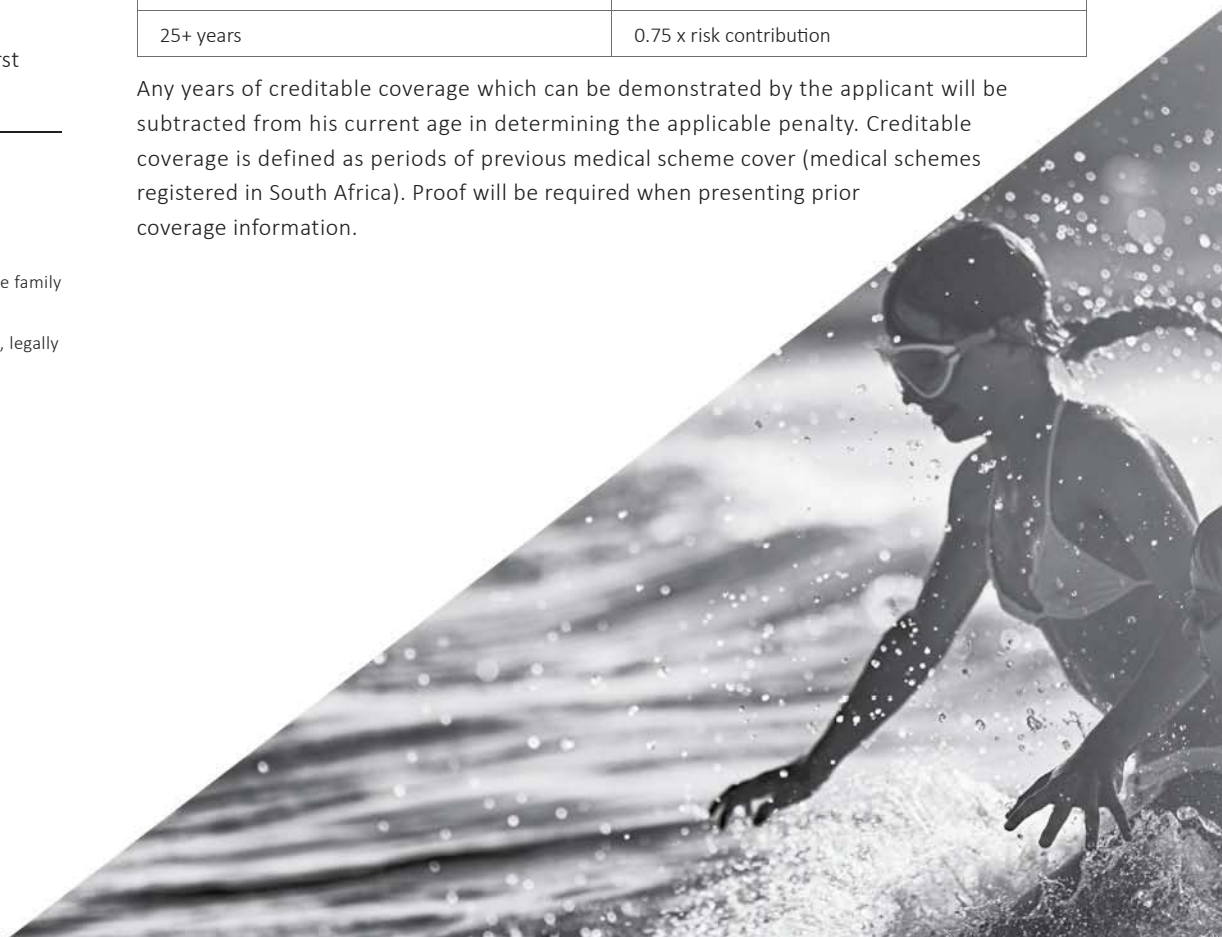
*** This calculation does not include late-joiner penalties. Please add them if they apply to you.

CONTRIBUTION PENALTIES FOR PERSONS JOINING LATE IN LIFE

The Board may, in addition to the contributions stated, impose contribution penalties up to the specified ratio for a late-joiner. A late-joiner is defined as an applicant or adult dependant of an applicant who, at the date of application for membership or admission as a dependant, as the case may be, is 35 years of age or older, but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001.

Penalty bands	Maximum penalty
1 – 4 years	0.05 x risk contribution
5 – 14 years	0.25 x risk contribution
15 – 24 years	0.50 x risk contribution
25+ years	0.75 x risk contribution

Any years of creditable coverage which can be demonstrated by the applicant will be subtracted from his current age in determining the applicable penalty. Creditable coverage is defined as periods of previous medical scheme cover (medical schemes registered in South Africa). Proof will be required when presenting prior coverage information.



CONTRIBUTIONS 2018

ESSENTIAL PLAN No Medical Savings Account

GROSS INCOME	TOTAL MONTHLY CONTRIBUTION		
	Member	Adult Dependant	Child Dependant
R0 – R5 000	R656	R589	R164
R5 001 – R6 000	R718	R646	R188
R6 001 – R7 000	R792	R713	R204
R7 001 – R8 000	R870	R783	R223
R8 001 – R9 000	R994	R897	R246
R9 001 – R10 000	R1 106	R994	R278
R10 001+	R1 260	R1 135	R317

BASIC PLAN No Medical Savings Account

GROSS INCOME	TOTAL MONTHLY CONTRIBUTION		
	Member	Adult Dependant	Child Dependant
R0 – R5 000	R989	R739	R248
R5 001 – R6 000	R1 085	R814	R281
R6 001 – R7 000	R1 196	R894	R308
R7 001 – R8 000	R1 313	R997	R337
R8 001 – R9 000	R1 500	R1 137	R376
R9 001 – R10 000	R1 669	R1 262	R419
R10 001+	R1 900	R1 425	R477

Important

Contributions for child dependants are limited to a maximum of three children, without limiting the number of children that may be registered.

CORE SAVER PLAN With Medical Savings Account

GROSS INCOME	TOTAL MONTHLY CONTRIBUTION (INCLUDING MEDICAL SAVINGS ACCOUNT)			MEDICAL SAVINGS ACCOUNT (INCLUDED IN TOTAL CONTRIBUTION)		
	Member	Adult Dependant	Child Dependant	Member	Adult Dependant	Child Dependant
R0 – R5 000	R1 450	R1 091	R364	R214	R161	R54
R5 001 – R6 000	R1 553	R1 166	R388	R229	R172	R57
R6 001 – R7 000	R1 662	R1 248	R415	R245	R184	R62
R7 001 – R8 000	R1 746	R1 310	R438	R258	R194	R66
R8 001 – R9 000	R1 882	R1 414	R475	R278	R209	R70
R9 001 – R10 000	R1 978	R1 486	R496	R291	R218	R73
R10 001+	R2 181	R1 631	R548	R320	R241	R81

TRADITIONAL PLAN No Medical Savings Account

GROSS INCOME	TOTAL MONTHLY CONTRIBUTION		
	Member	Adult Dependant	Child Dependant
R0 – R5 000	R2 416	R1 809	R603
R5 001 – R10 000	R2 817	R2 110	R708
R10 001+	R2 931	R2 201	R734

COMPREHENSIVE PLAN With Medical Savings Account

GROSS INCOME	TOTAL MONTHLY CONTRIBUTION (INCLUDING MEDICAL SAVINGS ACCOUNT)			MEDICAL SAVINGS ACCOUNT (INCLUDED IN TOTAL CONTRIBUTION)		
	Member	Adult Dependant	Child Dependant	Member	Adult Dependant	Child Dependant
R0 – R10 000	R3 150	R2 359	R792	R556	R416	R140
R10 001+	R3 280	R2 460	R821	R579	R434	R145

PLUS PLAN With Medical Savings Account

GROSS INCOME	TOTAL MONTHLY CONTRIBUTION (INCLUDING MEDICAL SAVINGS ACCOUNT)			MEDICAL SAVINGS ACCOUNT (INCLUDED IN TOTAL CONTRIBUTION)		
	Member	Adult Dependant	Child Dependant	Member	Adult Dependant	Child Dependant
ALL INCOMES	R5 518	R4 131	R1 382	R1 291	R967	R323

OVERVIEW OF PLANS

GLOSSARY OF TERMS

To help you understand the terms we use in the overview of our benefits and contributions tables.

TERM	ACRONYM	DEFINITION
Above Threshold Benefit	ATB	This is a limited out-of-hospital Insured Benefit that provides additional out-of-hospital cover. When the member's cumulative expenses equal the Annual Threshold amount, the member enters the Above Threshold Benefit. This is only available on the Plus Plan
Annual Threshold	AT	A predetermined Rand value which is calculated based on the number of people linked to a specific membership. Day-to-day claims accumulate to the Annual Threshold at 100% of the Scheme Rate and, once reached, the Above Threshold Benefit can be accessed for extended non-Prescribed Minimum Benefit out-of-hospital cover. This is only available on the Plus Plan
Approved Baskets of Care	BOC	This is a predefined set of out-of-hospital consultations, procedures and diagnostic tests which are covered to manage Prescribed Minimum Benefit conditions. A member must be registered on the Chronic Illness Benefit in order to qualify for the Basket of Care
Benefit Entry Criteria	None	Condition-specific standardised entry and verification criteria that the member must meet in order for the member's condition to be covered by the Chronic Illness Benefit and relevant PMB Baskets of Care
Board of Healthcare Funders	BHF	An industry representative body to the healthcare funding industry. Healthcare Professionals are required to register their practice numbers with BHF in order that they be recognised by medical schemes for billing purposes
Cost	None	The net cost (after discount) charged for a relevant health service or, for a contracted or negotiated service – the contracted rate. With regards to surgical items and procedures provided in hospital, "cost" refers to the net acquisition price
Designated Service Providers	DSPs	The doctors, specialists, hospitals and pharmacies with whom Bankmed has negotiated preferential rates
Emergency Medical Condition	EMC	This means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction to a bodily organ or part, or would place the person's life in serious jeopardy
Emergency Medical Services	EMS	Ambulances etc
Formulary	None	This is a comprehensive list of medications and treatments for which you are covered for a particular benefit
In-Hospital	IH	Refers to all related, approved costs during procedures (emergency or elected) which occur during a hospital stay
Insured Benefit	None	This is a benefit that pays directly from a members risk spend, instead of from the member's Medical Savings Account
Medicine Reference Price List	None	Reference pricing system that uses a benchmark or reference price for generically similar products. The fundamental principle of any reference price system is that it does not restrict a member's choice of medicine but instead limits the amount that will be paid
Member	M	Member without dependants
Member and Dependants	M+	Member with dependants
Medical Savings Account	MSA	The Medical Savings Account covers the cost of day-to-day expenses such as visits to GPs and dentists as well as the cost of medication, subject to the availability of funds in the Medical Savings Account. The full annual amount is available on 1 January every year and any leftover Medical Savings are carried over to the following year. This is only available on specific Plans
Out-of-Hospital	OH	Refers to any procedures, treatments, claims or benefits which occur without an overnight hospital stay. Also known as "day-to-day"
Preferred Providers	DSP	A provider chosen by a medical scheme to provide specific services for its members. These services may be furnished at discounted rates. Members must visit these providers to enjoy full cover
Prescribed Minimum Benefits	PMBs	A set of minimum benefits to be funded by all medical schemes as per the Medical Schemes Act and Regulations, in respect of the PMB conditions. A PMB condition is "a condition contemplated in the Diagnosis and Treatment Pairs and chronic conditions defined in the Chronic Disease List in Annexure A of the Regulations or any emergency medical condition"
Rand Value	R	This is the South African Rand amount a member would have paid if the specified service or treatment was obtained in South Africa
Scheme Rate	None	The rate determined in terms of an agreement between the Scheme and a Healthcare Professional or group of Healthcare Professionals with regards to payment for relevant services
Self-Payment Gap	SPG	The Self-Payment Gap comes into effect when a member runs out of funds in their Medical Savings Account before reaching the Annual Threshold. When a Self-Payment Gap is in force, the member is personally responsible for the payment of all day-to-day medical expenses. Members must continue to submit claims during this time as they count towards the Annual Threshold. This is only available on the Plus Plan

The table below shows an overview of the benefits and limits that apply to each Plan.

PLAN	WELLNESS AND PREVENTATIVE CARE BENEFITS TO ACCESS RISK FACTORS, PREVENT ILLNESS AND IMPROVE YOUR HEALTH	DESIGNATED SERVICE PROVIDERS (DSP)	HOSPITALISATION (IN-HOSPITAL SERVICES) AND OTHER MAJOR MEDICAL EXPENSES	CHRONIC MEDICATION	PRESCRIBED MINIMUM BENEFITS (PMBS)
PLUS	Personal Health Assessment Bankmed Stress Assessment Vaccinations and screenings Pap smear consultation Female contraception Workplace-based TB screening Human Papilloma Virus (HPV) vaccine for girls aged nine to 16	Bankmed GP Network Bankmed Specialist Network Bankmed Pharmacy Network Courier pharmacy for HIV medication Discovery 911 for Ambulance Services	Comprehensive cover for hospitalisation and most in-hospital services via an unrestricted network of hospitals Certain categories subject to Rand limits In-hospital GP/specialist procedures covered at 300% of Scheme Rate	R24 150 per beneficiary per annum Reduced rate of cover for medication via non-DSPs	PMBs covered in full via DSPs Reduced benefits for non-DSPs, subject to PMB regulations
COMPREHENSIVE	Personal Health Assessment Bankmed Stress Assessment Vaccinations and screenings Pap smear consultation Female contraception Workplace-based TB screening Human Papilloma Virus (HPV) vaccine for girls aged nine to 16	Bankmed GP Network Bankmed Specialist Network Bankmed Pharmacy Network Courier pharmacy for HIV medication Discovery 911 for Ambulance Services	Comprehensive cover for hospitalisation and most in-hospital services via an unrestricted network of hospitals Certain categories subject to Rand limits In-hospital GP/specialist procedures covered at 125% of Scheme Rate	R20 250 per beneficiary per annum Reduced rate of cover for medication via non-DSPs	PMBs covered in full via DSPs Reduced benefits for non-DSPs, subject to PMB regulations
TRADITIONAL	Personal Health Assessment Bankmed Stress Assessment Vaccinations and screenings Pap smear consultation Female contraception Workplace-based TB screening Human Papilloma Virus (HPV) vaccine for girls aged nine to 16	Hospital Network DSPs Bankmed GP Network Bankmed Specialist Network Bankmed Pharmacy Network Courier pharmacy for HIV medication Discovery 911 for Ambulance Services	Comprehensive cover for hospitalisation and most in-hospital services via a restricted hospital network (DSPs) Certain categories subject to Rand limits Wider hospital network than for Essential and Basic Plans In-hospital GP procedures covered at 125% of Scheme Rate In-hospital specialist procedures covered at 100% of Scheme Rate	R18 700 per beneficiary per annum Reduced rate of cover for medication via non-DSPs	PMBs covered in full via DSPs Reduced benefits for non-DSPs, subject to PMB regulations
CORE SAVER	Personal Health Assessment Bankmed Stress Assessment Vaccinations and screenings Pap smear consultation Female contraception Workplace-based TB screening Human Papilloma Virus (HPV) vaccine for girls aged nine to 16	Bankmed GP Network Bankmed Specialist Network Bankmed Pharmacy Network Courier pharmacy for HIV medication Discovery 911 for Ambulance Services	Comprehensive cover for hospitalisation and most in-hospital services via an unrestricted network of hospitals Certain categories subject to Rand limits Organ transplants and oncology limited to PMBs In-hospital GP/specialist procedures covered at 100% of Scheme Rate	No overall limit, but benefits subject to Core Saver medicine list (formulary) for PMB conditions only Reduced rate of cover for medication via non-DSPs	PMBs covered in full via DSPs Reduced benefits for non-DSPs, subject to PMB regulations
BASIC	Personal Health Assessment Bankmed Stress Assessment Vaccinations and screenings Pap smear consultation Female contraception Workplace-based TB screening Human Papilloma Virus (HPV) vaccine for girls aged nine to 16	Hospital Network DSPs Bankmed GP Entry Plan Network Bankmed Specialist Network Bankmed Pharmacy Network Courier pharmacy for HIV medication Discovery 911 for Ambulance Services	Comprehensive cover for hospitalisation and most in-hospital services via a restricted hospital network (DSPs) Certain categories subject to Rand limits Hospital network more restricted than for the Traditional Plan Organ transplants, oncology and renal dialysis limited to PMBs In-hospital GP/specialist procedures covered at 100% of Scheme Rate	No overall limit, but benefits via Bankmed Network providers and subject to Scheme-approved medicine list (formulary)	PMBs covered in full via DSPs Reduced benefits for non-DSPs, subject to PMB regulations
ESSENTIAL	Personal Health Assessment Bankmed Stress Assessment Vaccinations and screenings Pap smear consultation Workplace-based TB screening Human Papilloma Virus (HPV) vaccine for girls aged nine to 16	Hospital Network DSPs Bankmed GP Entry Plan Network Bankmed Specialist Network Bankmed Pharmacy Network Courier pharmacy for HIV medication Discovery 911 for Ambulance Services	Limited to PMBs (minimum benefits) via a restricted hospital network (DSPs) Hospital network more restricted than for the Traditional Plan In-hospital GP/specialist procedures limited to PMBs	Limited to PMBs, covered at 100% of cost via Bankmed GP Entry Plan Network and subject to Scheme-approved medicine list (formulary).	PMBs covered in full via DSPs Reduced benefits for non-DSPs, subject to PMB regulations

PLAN	MEDICAL SAVINGS ACCOUNT	OUT-OF-HOSPITAL (DAY-TO-DAY) BENEFITS
PLUS	Yes	Day-to-day claims first paid from the Medical Savings Account, until the Annual Threshold is reached. Once the Annual Threshold is reached, Insured Benefits are provided in the form of the Above Threshold Benefit (ATB), which acts as a safety net for members with unexpectedly high out-of-hospital expenses.
COMPREHENSIVE	Yes	GP and Specialist consultations, acute medication and some other benefit categories payable from the Medical Savings Account. Unlimited Insured Benefits for GP and specialist procedures and basic dentistry. Limited rates of cover for non-DSPs, subject to PMB regulations. Insured limits for advanced dentistry, orthodontics and other specified categories (thereafter subject to available funds in the Medical Savings Account).
TRADITIONAL	No	Insured Benefits for GP and specialist consultations, acute medication, radiology, pathology, basic dentistry, advanced dentistry and orthodontics, subject to Plan limits. Unlimited Insured Benefits for GP and specialist procedures. Limited rates of cover for non-DSPs, subject to PMB regulations. Limited optometry benefits available every two years.
CORE SAVER	Yes	Unlimited cover for PMB conditions only, via Bankmed Network GPs and Bankmed Network Specialists and subject to approved baskets of care (where applicable). Two insured consultations for non-PMB conditions via Bankmed Network GP only. Non-PMB services including dentistry, orthodontics, optometry and acute medication all payable from the Medical Savings Account (MSA), plus limited Insured Benefits for acute medication prescribed and dispensed by a pharmacist.
BASIC	No	Unlimited cover for primary healthcare services, such as GP consultations, acute medication and basic dentistry via Bankmed Network Providers (DSPs) and subject to Scheme-approved formularies (medicine list). Limited optometry benefits via Iso Leso Optometry Network every two years. Other specified benefits subject to Plan limits and available via or on referral by a Bankmed GP Entry Plan Network GP. No benefit for advanced dentistry or orthodontic treatment.
ESSENTIAL	No	Limited to PMBs

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
Does this Plan have a Medical Savings Account (MSA)?		No	No	Yes	No	Yes	Yes
1	OVERALL ANNUAL LIMIT						
		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
2	CLAIMS FOR SERVICES RENDERED OUTSIDE THE BORDERS OF SOUTH AFRICA (FOREIGN CLAIMS) It is recommended that you consider taking out comprehensive travel insurance prior to journeying abroad, as not all foreign claims will be covered (or covered in full)						
2.1		Cover available for 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 GP Entry Plan Network) for out-of-hospital consultations, medication and treatment (except via Bankmed GP Entry Plan 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 GP Entry Plan Network) for out-of-hospital consultations, medication and treatment (except via Bankmed GP Entry Plan 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	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	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	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
3	WELLNESS AND PREVENTATIVE CARE BENEFITS (INSURED BENEFITS)						
	Wellness and Preventative Care Benefits are provided as additional Insured Benefits, which do not contribute towards the depletion of any other insured limits (or Medical Savings Account) specified elsewhere in these Benefit Tables. The cost of associated consultations is not included in the Wellness and Preventative Care Benefits.						
3.1	Flu Vaccine	100% of the Scheme's Medicine Reference Price, limited to one vaccine pbpa					
3.2	Human Papilloma Virus (HPV) Vaccine	100% of the Scheme's Medicine Reference Price, limited to a total course of three doses (depending on product and age) per female beneficiary aged nine to 16 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 the Scheme's Medicine Reference Price, for immunisations administered in accordance with the Department of Health's Expanded Programme on Immunisation (EPI) guidelines for children up to 12 years					

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
3.4	Pneumococcal Vaccine	100% of the Scheme's 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, who have been diagnosed with asthma, chronic obstructive pulmonary disease, diabetes, cardiovascular disease or HIV/AIDS					
3.5	Mammogram	100% of Scheme Rate, limited to one pbpa age 40 years and older (benefits for beneficiaries younger than 40 years subject to motivation and prior approval)					
3.6	Bone Densitometry	100% of Scheme Rate, limited to one pbpa age 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, if applicable to their Plan type					
3.7	Prostate-Specific Antigen	100% of Scheme Rate, limited to one pbpa age 50 years and older (benefits for beneficiaries younger than 50 years subject to motivation and prior approval)					
3.8	Faecal Occult Blood Test	100% of Scheme Rate, limited to one pbpa age 50 years and older (benefits for beneficiaries younger than 50 years subject to motivation and prior approval)					
3.9	Tuberculosis (TB) Screening	100% of Scheme Rate, limited to one chest X-ray pbpa For TB screening requested by registered private nurse practitioners providing on-site services at Employer Groups All other TB screenings subject to out-of-hospital radiology and/or pathology benefits as indicated elsewhere in these Benefit Tables					
3.10	Bankmed Stress Assessment	Visit www.bankmed.co.za to complete your free online Bankmed Stress Assessment. There is no limit on the number of assessments per beneficiary per annum					
3.11	Cholesterol Screening, Blood Sugar Screening and Blood Pressure Measurements	100% of cost, limited to R280 pbpa at clinics, pharmacies or Bankmed GP Entry Plan Network GPs' consulting room	100% of cost, limited to R280 pbpa at clinics, pharmacies or Bankmed GP Entry Plan Network GPs' consulting room	100% of cost, limited to R280 pbpa at clinics, pharmacies or doctors' consulting room	100% of cost, limited to R280 pbpa at clinics, pharmacies or doctors' consulting room	100% of cost, limited to R280 pbpa at clinics, pharmacies or doctors' consulting room	100% of cost, limited to R280 pbpa at clinics, pharmacies or doctors' consulting room
3.12	HIV Counselling and Testing (HCT)	Unlimited, covered at 100% of cost for HCT DSPs namely Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering onsite services at Employer Groups, subject to PMB regulations	Unlimited, covered at 100% of cost for HCT DSPs namely Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering onsite services at Employer Groups, subject to PMB regulations	100% of cost, unlimited, for DSPs: Bankmed Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering on-site services at Employer Groups	100% of cost, unlimited, for DSPs: Bankmed Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering on-site services at Employer Groups	100% of cost, unlimited, for DSPs: Bankmed Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering on-site services at Employer Groups	100% of cost, unlimited, for DSPs: Bankmed Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering on-site services at Employer Groups
3.13	Pap Smear	100% of Scheme Rate, limited to one pbpa One associated nurse, Bankmed GP Entry Plan network GP or Bankmed Specialist Network consultation pb covered as an additional Insured Benefit limited to R445 pbpa	100% of Scheme Rate, limited to one pbpa One associated nurse, Bankmed GP Entry Plan network GP or Bankmed Specialist Network consultation pb covered as an additional Insured Benefit limited to R445 pbpa	100% of Scheme Rate, limited to one pbpa One associated nurse, Bankmed network GP or Bankmed Specialist Network consultation pb covered as an additional Insured Benefit limited to R445 pbpa	100% of Scheme Rate, limited to one pbpa One associated nurse, Bankmed network GP or Bankmed Specialist Network consultation pb covered as an additional Insured Benefit limited to R445 pbpa	100% of Scheme Rate, limited to one pbpa One associated nurse, Bankmed network GP or Bankmed Specialist Network consultation pb covered as an additional Insured Benefit limited to R445 pbpa	100% of Scheme Rate, limited to one pbpa One associated nurse, Bankmed network GP or Bankmed Specialist Network consultation pb covered as an additional Insured Benefit limited to R445 pbpa
3.14	Personal Health Assessment (PHA)	100% of cost, limited to one assessment pbpa Benefit limited to Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted providers rendering on-site services at Employer Groups	100% of cost, limited to one assessment pbpa Benefit limited to Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted providers rendering on-site services at Employer Groups	100% of cost, limited to one assessment pbpa Benefit limited to Bankmed Network GPs, Bankmed Pharmacy Network and contracted providers rendering on-site services at Employer Groups	100% of cost, limited to one assessment pbpa Benefit limited to Bankmed Network GPs, Bankmed Pharmacy Network and contracted providers rendering on-site services at Employer Groups	100% of cost, limited to one assessment pbpa Benefit limited to Bankmed Network GPs, Bankmed Pharmacy Network and contracted providers rendering on-site services at Employer Groups	100% of cost, limited to one assessment pbpa Benefit limited to Bankmed Network GPs, Bankmed Pharmacy Network and contracted providers rendering on-site services at Employer Groups

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
3.15	**Contraception: Oral Contraceptives, Devices and Injectables**	No benefit	100% of cost, limited to R1 765 per female beneficiary per annum Oral contraceptives limited to one prescription or repeat prescription pb per month	100% of cost, limited to R1 765 per female beneficiary per annum Oral contraceptives limited to one prescription or repeat prescription pb per month	100% of cost, limited to R1 765 per female beneficiary per annum Oral contraceptives limited to one prescription or repeat prescription pb per month	100% of cost, limited to R1 765 per female beneficiary per annum Oral contraceptives limited to one prescription or repeat prescription pb per month	100% of cost, limited to R1 765 per female beneficiary per annum Oral contraceptives limited to one prescription or repeat prescription pb per month
3.16	**Antenatal Screening** Non-invasive Prenatal Testing (NIPT) to test for chromosomal abnormalities Clinical entry criteria applies South African testing only Mother must be aged 35 years at the time of delivery	100% of Scheme Rate Limited to one test pb per pregnancy Test to be conducted at 10 - 12 weeks of pregnancy	100% of Scheme Rate Limited to one test pb per pregnancy Test to be conducted at 10 - 12 weeks of pregnancy	100% of Scheme Rate Limited to one test pb per pregnancy Test to be conducted at 10 - 12 weeks of pregnancy	100% of Scheme Rate Limited to one test pb per pregnancy Test to be conducted at 10 - 12 weeks of pregnancy	100% of Scheme Rate Limited to one test pb per pregnancy Test to be conducted at 10 - 12 weeks of pregnancy	100% of Scheme Rate Limited to one test pb per pregnancy Test to be conducted at 10 - 12 weeks of pregnancy
3.17	**New-born Screening** To test for the presence of certain metabolic and endocrine disorders South African testing only	100% of Scheme Rate Limited to one test pb per pregnancy Test to be carried out within 72 hours of birth	100% of Scheme Rate Limited to one test pb per pregnancy Test to be carried out within 72 hours of birth	100% of Scheme Rate Limited to one test pb per pregnancy Test to be carried out within 72 hours of birth	100% of Scheme Rate Limited to one test pb per pregnancy Test to be carried out within 72 hours of birth	100% of Scheme Rate Limited to one test pb per pregnancy Test to be carried out within 72 hours of birth	100% of Scheme Rate Limited to one test pb per pregnancy Test to be carried out within 72 hours of birth
3.18	**Diabetes Management** For members registered on the Scheme's Disease Management Programme Basket of Care set by the Scheme, subject to PMB regulations.	Unlimited and 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 and 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. Out-of-network GP benefit limit applies if the doctor is not the member's nominated GP	Unlimited and 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 and 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 and 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 and 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

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
4	**HIV/AIDS PROGRAMME**						
	Additional benefits subject to registration on the Scheme's HIV/AIDS Programme. These additional benefits do not contribute to the depletion of other Insured Benefits provided by the Scheme. Beneficiaries who do not register on the HIV/AIDS Programme will be entitled to all other benefits as specified in these Benefit Tables, with continued funding for PMBs, subject to PMB regulations, after depletion of the relevant sub-limits						
4.1	**Consultations and Pathology**	Subject to benefits available in Scheme's Basket of Care 100% of cost at a DSP 100% of Scheme Rate at a non-DSP					
4.2	**Medication via Designated Courier Pharmacy (DSP)**	Unlimited 100% of cost via Designated Courier Pharmacy (DSP), 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					
4.3	**Medication via non-DSP: Voluntary use of a non-DSP**	Unlimited 80% of Scheme Medicine Reference Price plus contracted dispensing fee 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					
4.4	**Medication via non-DSP: Involuntary use of a non-DSP**	Unlimited 100% of cost, unlimited 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					
5	**24-HOUR MEDICAL ADVICE LINE (CALL 0860 999 911)** **Free service to Bankmed members (cost of calls not claimable from the Scheme)**						
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)** **Benefits through preferred provider only (Discovery 911) and subject to pre-authorisation**						
6.1	100% of cost, unlimited. No benefit outside the borders of South Africa Call 0860 999 911 - 24 hours a day, seven days a week for pre-authorisation and you will be connected with highly qualified (Discovery 911) emergency personnel						
7	**HOSPITALISATION** **Subject to pre-authorisation. 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; FAILING TO OBTAIN A 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, 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 • Benefits available for your Plan, as well as annual limits for individual benefit categories, are set out in these Benefit Tables. The benefits under "hospitalisation" refer only to the hospital account • Any Healthcare Professionals attending to you during your hospital stay must submit a valid accounts for payment. The payment will be subject to the benefits, limits and/or any special conditions set out in these Benefit Tables under the relevant benefit categories. The onus is on the member to ensure that the Healthcare Professional has submitted the account for payment • Please take care to determine the limits for your Plan (if any) and at what rate the Scheme will cover your claims. Always negotiate fees with your attending doctors before incurring costs to avoid out-of-pocket payments. Please refer to Bankmed's website at www.bankmed.co.za for a list of procedures that can be safely performed in a doctor's rooms as an alternative to hospitalisation						
7.1	**Hospital Network (DSP)**	Bankmed Hospital Network DSPs for the Essential Plan	Bankmed Hospital Network DSPs for the Basic Plan	All Netcare, National Hospital Network (NHN), Life Healthcare, Mediclinic and Clinix hospitals, any other independent private hospitals contracted to the Scheme	Bankmed Hospital Network DSPs for the Traditional Plan	All Netcare, National Hospital Network (NHN), Life Healthcare, Mediclinic and Clinix hospitals, any other independent private hospitals contracted to the Scheme	All Netcare, National Hospital Network (NHN), Life Healthcare, Mediclinic and Clinix hospitals, any other independent private hospitals contracted to the Scheme

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
7.2	**Hospitalisation** (subject to pre-authorisation)	Limited to PMBs • 100% of cost at network DSPs • 80% of Scheme Rate for voluntary use of a non-DSPs • 100% of cost for involuntary use of non-DSP • No benefit for non-PMB admissions Benefits limited to general ward rate No benefit for dental surgery, except for PMBs Benefits only available on referral from a Bankmed GP Entry Plan Network GP or referred specialist subject to PMB regulations No benefit for auxiliary services except for PMBs	Benefits for PMBs and non-PMBs • 100% of cost at contracted rate in-hospital network DSPs • 80% of Scheme Rate in non-DSPs • 100% of cost for involuntary use of non-DSP Benefits limited to general ward rate No benefit for dental surgery, except for PMBs Benefits only available on referral from a Bankmed GP Entry Plan Network GP or referred specialist	Benefit unlimited • 100% of cost in contracted private hospitals (DSPs) • 100% of cost in non-contracted private hospitals for a PMB admission (involuntary use of a non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a PMB admission (voluntary use of non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a non-PMB admission Benefits limited to general ward rate No benefit for dental surgery, except for PMBs	Benefit unlimited • 100% of cost in contracted private hospitals (DSPs) • 100% of cost in non-contracted private hospitals for a PMB admission (involuntary use of a non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a PMB admission (voluntary use of non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a non-PMB admission Benefits limited to general ward rate	Benefit unlimited • 100% of cost in contracted private hospitals (DSPs) • 100% of cost in non-contracted private hospitals for a PMB admission (involuntary use of a non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a PMB admission (voluntary use of non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a non-PMB admission Benefits limited to general ward rate	Benefit unlimited • 100% of cost in contracted private hospitals (DSPs) • 100% of cost in non-contracted private hospitals for a PMB admission (involuntary use of a non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a PMB admission (voluntary use of non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a non-PMB admission Benefits limited to general and private ward rates
7.3	**Deductibles** A Beneficiary will be 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. Member to pay hospital or day clinic directly upon admission. Deductibles are payable for all specified hospital admissions, except under the following circumstances: 1. Prescribed Minimum Benefit conditions where admission to a non-DSP is on an involuntary basis. In the case of other PMB conditions, were a DSP has been used on a voluntary basis, the deductible will be applied 2. Confinements are excluded from deductibles 3. Re-admissions to hospital within 6 weeks of discharge following complications directly related to a prior admission in respect of which a deductible was levied 4. Admissions to a State Hospital 5. Authorised day clinic admissions for specified procedures, as communicated to members from time to time **Detailed deductible information is set out on page 54 of the Benefit and Contribution Schedule.**						

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
7.3.1	**Deductible applicable to a use of a non-DSP Facility** A deductible will apply to all beneficiaries on the below Plans when the beneficiary chooses to utilise a non-DSP facility (both hospital and day clinics). The deductible applies upfront and will need to be settled at the facility prior to admission						
	PMB admission: Involuntary use of non-DSP	No deductible payable for PMBs	No deductible	No deductible	No deductible	No deductible	No deductible
	PMB admission: Voluntary use of non-DSP (applies to all admissions)		Day clinic: R227 deductible Hospital: R570 deductible	Day clinic: R227 deductible Hospital: R570 deductible	Day clinic: R227 deductible Hospital: R4 750 deductible	Day clinic: R227 deductible Hospital: R570 deductible	Day clinic: R227 deductible Hospital: R570 deductible
	Non-PMB admission (applies to all admissions)		Day clinic: R227 deductible Hospital: R570 deductible	Day clinic: R227 deductible Hospital: R570 deductible	Day clinic: R227 deductible Hospital: R4 750 deductible	Day clinic: R227 deductible Hospital: R570 deductible	Day clinic: R227 deductible Hospital: R570 deductible
7.3.2	**Deductible applicable to a specific list of treatment/procedures carried out in a Day Surgery Network** The following conditions/procedures will NOT attract a deductible at a Day Surgery Network (list of conditions/ procedures applies to DSP only): 1. Adenoidectomy 2. Arthrocentesis 3. Cataract Surgery 4. Cautery of vulva warts 5. Circumcision 6. Colonoscopy 7. Cystourethroscopy 8. Diagnostic D and C 9. Gastroscopy 10. Hysteroscopy 11. Myringotomy 12. Myringotomy with intubation (grommets) 13. Nasal cautery 14. Nasal plugging for nose bleeds 15. Proctoscopy 16. Prostate biopsy 17. Removal of pins and plates 18. Sigmoidoscopy 19. Tonsillectomy 20. Treatment of Bartholins cyst/gland 21. Vasectomy 22. Vulva/cone biopsy If the member chooses to have the abovementioned procedures/treatments performed in a non-network Day Surgery facility or in a hospital, the member will be liable for a deductible per admission Important note for Essential Plan members: No access to full list of treatments/procedures listed above. Cover is limited to PMBs. If underlying diagnosis is a PMB, member qualifies for treatment						
	PMB admission: Involuntary use of a non-DSP	No deductible	No deductible	No deductible	No deductible	No deductible	No deductible
	PMB admission: Voluntary use of non-DSP (applies to all admissions)	Non-DSP: R1 500 deductible	Non-DSP: R1 500 deductible	Non-DSP: R1 500 deductible	Non-DSP: R1 500 deductible	Non-DSP: R1 500 deductible	Non-DSP: R1 500 deductible
	Non-PMB admission (applies to all admissions)	No benefit	Non-PMB: R1 500 deductible	Non-PMB: R1 500 deductible	Non-PMB: R1 500 deductible	Non-PMB: R1 500 deductible	Non-PMB: R1 500 deductible
7.3.3	**Deductible applicable to Dental Admissions to Private Hospitals and Day Clinics** A deductible will apply to all beneficiaries on the below Plans when the beneficiary is admitted to hospital or a day clinic for dental treatment. The deductible applies upfront and will need to be settled at the facility prior to admission						
	Applies to both DSP and non-DSP Facilities	No benefit for in-hospital dental treatment, except PMBs	No benefit for in-hospital dental treatment, except PMBs	No benefit for in-hospital dental treatment, except PMBs	Day clinic: R227 deductible Hospital: R1 690 deductible	Day clinic: R227 deductible Hospital: R1 690 deductible	Day clinic: R227 deductible Hospital: R1 690 deductible
7.3.4	**Deductible applicable to a specific list of treatment/procedures performed in Hospital Network DSPs** A deductible will apply to all beneficiaries on the below Plans when the beneficiary obtains treatment for the specified treatment/procedures set out below. The deductible applies when the beneficiary is admitted to hospital or a day clinic that falls within the list of DSP/network providers. The deductible applies upfront and will need to be settled at the facility prior to admission						
	The following procedures will always attract a deductible at a hospital/day clinic at a DSP facility: 1. **Oesophagoscopy** 2. **Simple abdominal hernia repair** (applies to all admissions)	No deductible payable for PMBs	Day clinic: R227 deductible Hospital: R570 deductible	Day clinic: R227 deductible Hospital: R570 deductible	Day clinic: R227 deductible Hospital: R570 deductible	Day clinic: R227 deductible Hospital: R570 deductible	Day clinic: R227 deductible Hospital: R570 deductible

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
7.4	**To-take-out drugs supplied by the hospital when a patient is discharged**	100% of cost, limited to PMBs and a maximum of seven days' supply per admission Must be charged on the hospital account. Not payable if obtained via a pharmacy after discharge					
8	OUTPATIENT CONSULTATIONS AND FACILITY FEES FOR OUTPATIENT VISITS						
8.1	**Outpatient consultations with GPs and Specialists at hospital emergency rooms and outpatient units**	Regarded as an out-of-hospital GP/specialist consultation in rooms, unless resulting in an authorised hospital admission See "GPs: Consultations in rooms'' and "Specialists: Consultations in rooms'', set out in the Benefit Table					
8.2	**Facility fees for outpatient visits to hospital emergency rooms**	Facility fees for outpatient visits not covered, unless resulting in an authorised hospital admission	Facility fees for outpatient visits subject to out-of-hospital specialist consultations in rooms limit, unless resulting in an authorised hospital admission	Facility fees for outpatient visits subject to available Medical Savings Account, unless resulting in an authorised hospital admission	Facility fees for outpatient visits subject to out-of-hospital GP and specialist consultations in rooms limit, unless resulting in an authorised hospital admission	Facility fees for outpatient visits subject to available Medical Savings Account, unless resulting in an authorised hospital admission	Facility fees for outpatient visits subject to available Medical Savings Account, unless resulting in an authorised hospital admission
9	GP CONSULTATION WITHIN 30 DAYS OF DISCHARGE FROM HOSPITAL						
9.1	**Post-hospital GP consultation within 30 days of discharge from hospital**	Additional Insured Benefits. See "General Practitioners (GPs): Post-hospital GP consultation within 30 days of discharge from hospital (excluding day cases) as set out in the Benefit Table					
10	BLOOD TRANSFUSIONS						
10.1	**Blood Transfusions**	Limited to PMBs 100% of cost for PMBs	100% of cost, unlimited	100% of cost, unlimited	100% of cost, unlimited	100% of cost, unlimited	100% of cost, unlimited
11	ORGAN AND BONE MARROW TRANSPLANTS Subject to pre-authorisation. Organ recipient must be a Bankmed beneficiary for benefits to apply; no benefits for travelling and non-hospital accommodation expenses						
11.1	**Hospitalisation/Organ and patient preparation**	Benefits for hospitalisation as specified elsewhere in these Benefit Tables, limited to PMBs	Benefits for hospitalisation as specified elsewhere in these Benefit Tables, limited to PMBs	Benefits for hospitalisation as specified elsewhere in these Benefit Tables, limited to PMBs	Benefits for hospitalisation as specified elsewhere in these Benefit Tables	Benefits for hospitalisation as specified elsewhere in these Benefit Tables	Benefits for hospitalisation as specified elsewhere in these Benefit Tables
11.2	**Medication** (in-and out-of-hospital)	Limited to PMBs	Limited to PMBs	Limited to PMBs	Unlimited	Unlimited	Unlimited
	• **Medication via designated pharmacy (DSP)**	• 100% of cost, limited to PMBs	• 100% of cost, limited to PMBs	• 100% of cost, limited to PMBs	• 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 contracted dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee
	• **Medication via non-DSP** (involuntary use of non-DSP)	• 100% of cost, limited to PMBs	• 100% of cost, limited to PMBs	• 100% of cost, limited to PMBs	• 100% of cost	• 100% of cost	• 100% of cost
11.3	**Harvesting and transporting of organs and other donor costs**	100% of cost, limited to PMBs	100% of cost, limited to PMBs	100% of cost, limited to PMBs	100% of cost, unlimited	100% of cost, unlimited	100% of cost, unlimited

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
12	ONCOLOGY Subject to pre-authorisation						
12.1	**In- and out-of-hospital consultations, treatment and materials**	Limited to PMBs, 100% of cost at a DSP or 100% of Scheme Rate at non-DSP	Limited to PMBs, 100% of cost at a DSP or 100% of Scheme Rate at non-DSP	Limited to PMBs, 100% of cost at a DSP or 100% of Scheme Rate at non-DSP	100% of cost at a DSP or 100% of Scheme Rate at non-DSP, unlimited	100% of cost at a DSP or 100% of Scheme Rate at non-DSP, unlimited	100% of cost at a DSP or 100% of Scheme Rate at non-DSP, unlimited
12.1	**Radiotherapy fees, chemotherapy facility and professional fees**	100% of Scheme Rate					
12.3	**Medication** (in-and out-of-hospital)	Limited to PMBs	Limited to PMBs	Limited to PMBs	Unlimited	Unlimited	Unlimited
	• **Medication via designated pharmacy (DSP)**	• 100% of cost, limited to PMBs	• 100% of cost, limited to PMBs	• 100% of cost, limited to PMBs	• 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 contracted dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee
	• **Medication via non-DSP** (involuntary use of non-DSP)	• 100% of cost, limited to PMBs	• 100% of cost, limited to PMBs	• 100% of cost, limited to PMBs	• 100% of cost	• 100% of cost	• 100% of cost
13	RENAL DIALYSIS Subject to pre-authorisation						
13.1	**Procedures and treatment**	Limited to PMBs, 100% of cost at a DSP or 100% of Scheme Rate at non-DSP	Limited to PMBs, 100% of cost at a DSP or 100% of Scheme Rate at non-DSP	Limited to PMBs, 100% of cost at a DSP or 100% of Scheme Rate at non-DSP	100% of cost at a DSP or 100% of Scheme Rate at non-DSP, unlimited	100% of cost at a DSP or 100% of Scheme Rate at non-DSP, unlimited	100% of cost at a DSP or 100% of Scheme Rate at non-DSP, unlimited
13.2	**Medication** (in-and out-of-hospital)	Limited to PMBs	Limited to PMBs	Limited to PMBs	Unlimited	Unlimited	Unlimited
	• **Medication via designated pharmacy (DSP)**	• 100% of cost, limited to PMBs	• 100% of cost, limited to PMBs	• 100% of cost, limited to PMBs	• 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 contracted dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee	• 80% of Scheme Medicine Reference Price plus contracted dispensing fee
	• **Medication via non-DSP** (involuntary use of non-DSP)	• 100% of cost, limited to PMBs	• 100% of cost, limited to PMBs	• 100% of cost, limited to PMBs	• 100% of cost	• 100% of cost	• 100% of cost
14	PREGNANCY AND CHILDBIRTH						
14.1	**Baby-and-Me Programme for expectant mothers**	No benefit	No benefit	Call 0800 BANKMED (0800 226 5633) to register	Call 0800 BANKMED (0800 226 5633) to register	Call 0800 BANKMED (0800 226 5633) to register	Call 0800 BANKMED (0800 226 5633) to register

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
14.2	**Hospitalisation and associated in-hospital services** (subject to pre-authorisation)	Benefits as specified elsewhere in these Benefit Tables Hospital network rules apply Limited to PMBs	Benefits as specified elsewhere in these Benefit Tables Hospital network rules apply	Benefits as specified elsewhere in these Benefit Tables Hospital network rules apply	Benefits as specified elsewhere in these Benefit Tables Hospital network rules apply	Benefits as specified elsewhere in these Benefit Tables Hospital network rules apply	Benefits as specified elsewhere in these Benefit Tables Hospital network rules apply
14.3	**Midwife care and delivery** (subject to pre-authorisation)	100% of Scheme Rate, unlimited					
14.4	**Birthing facilities as an alternative to hospitalisation** (subject to pre-authorisation)	100% of cost for PMBs Cost of disposables limited to R1 013 per case Limited to PMBs	100% of Scheme Rate, unlimited Cost of disposables limited to R1 013 per case	100% of Scheme Rate, unlimited Cost of disposables limited to R1 013 per case	100% of Scheme Rate, unlimited Cost of disposables limited to R1 013 per case	100% of Scheme Rate, unlimited Cost of disposables limited to R1 013 per case	100% of Scheme Rate, unlimited Cost of disposables limited to R1 013 per case
14.5	**Antenatal and postnatal care: GP and Specialist consultations and procedures in rooms**	Benefits for GPs and specialists as specified elsewhere in these Benefit Tables Limited to PMBs	Benefits for GPs and specialists as specified elsewhere in these Benefit Tables	Benefits for GPs and specialists as specified elsewhere in these Benefit Tables Additional Insured Benefits - see 14.8	Benefits for GPs and specialists as specified elsewhere in these Benefit Tables Additional Insured Benefits - see 14.8	Benefits for GPs and specialists as specified elsewhere in these Benefit Tables Additional Insured Benefits - see 14.8	Benefits for GPs and specialists as specified elsewhere in these Benefit Tables
14.6	**Antenatal and postnatal care: Ultrasonic investigations** (radiology)	Benefits for radiology as specified elsewhere in these Benefit Tables Limited to PMBs	Ultrasonic investigations limited to: • one first trimester 2D scan (per pregnancy) at contracted rate via Bankmed GP Entry Plan Network GP • one second trimester 2D scan (per pregnancy) at contracted rate via a Bankmed Specialist Network (DSP) gynaecologist/ obstetrician • Scan as per the above are covered at 100% of cost All other/additional radiology benefits as specified elsewhere in these Benefit Tables	Benefits for radiology as specified elsewhere in these Benefit Tables Additional Insured Benefits - see 14.8	Benefits for radiology as specified elsewhere in these Benefit Tables Additional Insured Benefits - see 14.8	Benefits for radiology as specified elsewhere in these Benefit Tables Additional Insured Benefits - see 14.8	Benefits for radiology as specified elsewhere in these Benefit Tables
14.7	**Antenatal and postnatal care: Pathology**	Benefits for pathology as specified elsewhere in these Benefit Tables Limited to PMBs	Benefits for pathology as specified elsewhere in these Benefit Tables	Benefits for pathology as specified elsewhere in these Benefit Tables Additional Insured Benefits - see 14.8	Benefits for pathology as specified elsewhere in these Benefit Tables Additional Insured Benefits - see 14.8	Benefits for pathology as specified elsewhere in these Benefit Tables Additional Insured Benefits - see 14.8	Benefits for pathology as specified elsewhere in these Benefit Tables

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
14.8	Additional Insured Benefits subject to registration on the Baby-and-Me Programme	No benefit	No benefit	Additional Insured Benefits at, or subject to referral by, a Bankmed Network GP: • five antenatal consultations per pregnancy, at the applicable rate/s for GP and specialist consultations in rooms as specified elsewhere in these Benefit Tables • two 2D ultrasounds at 100% of Scheme Rate • R1 245 per pregnancy for antenatal and postnatal classes • additional pathology at 100% of Scheme Rate, subject to Baby-and-Me approved basket of care	Additional Insured Benefits at, or subject to referral by, a Bankmed Network GP: • five antenatal consultations per pregnancy, at the applicable rate/s for GP and specialist consultations in rooms as specified elsewhere in these Benefit Tables • two 2D ultrasounds at 100% of Scheme Rate • R1 245 per pregnancy for antenatal and postnatal classes • additional pathology at 100% of Scheme Rate, subject to Baby-and-Me approved basket of care	Additional Insured Benefits at, or subject to referral by, a Bankmed Network GP: • five antenatal consultations per pregnancy, at the applicable rate/s for GP and specialist consultations in rooms as specified elsewhere in these Benefit Tables • two 2D ultrasounds at 100% of Scheme Rate • R1 245 per pregnancy for antenatal and postnatal classes • additional pathology at 100% of Scheme Rate, subject to Baby-and-Me approved basket of care	Additional Insured Benefits not applicable on this Plan, however, members may benefit from valuable information, guidance and support throughout the pregnancy by registering on the Baby-and-Me Programme
15	RADIOLOGY AND PATHOLOGY						
15.1	Radiology (in-hospital)	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited
15.2	Pathology (in-hospital)	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited
15.3	MRI/CT scans, Radionuclide scans in- and out-of-hospital (subject to pre-authorisation)	Limited to PMBs 100% of cost for radiology facilities at hospital network DSPs Limited to 100% of Scheme Rate for voluntary use of radiology facilities at non-DSPs	In-hospital at 100% of Scheme Rate, unlimited Out-of-hospital at 100% of cost, limited to PMBs via radiology facilities at hospital network DSPs only	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
15.4	**Radiology and Pathology** (out-of-hospital)	Limited to PMBs Benefits subject to a CDL (baskets of care) registration for PMB conditions 100% of cost for PMBs	100% of cost, unlimited via Bankmed GP Entry Plan Network and subject to Scheme-approved medicine list (formulary) For radiology/pathology requested or carried out via a specialist, the benefit will be subject to the out-of-hospital "Specialists: Consultations/ Procedures in rooms" limit, specified elsewhere in these Benefit Tables, except for one 2D scan in the second trimester via a Bankmed Specialist Network (DSP) gynaecologist/ obstetrician, as specified in 14.6	Benefits approved for beneficiaries registered for PMB Chronic Disease List (CDL) conditions: • 100% of cost, subject to a CDL (baskets of care) and referral by a Bankmed Network GP (DSP) • Non-CDL (baskets of care) benefits subject to available Medical Savings Account, except for PMBs (subject to PMB regulations)	100% of Scheme Rate, limited to R5 300 pfpa	Radiology: 100% of Scheme Rate, limited to R3 555 pfpa (including a sub-limit of R1 182 pfpa for out-of-hospital pathology); thereafter subject to available Medical Savings Account Pathology: 100% of Scheme Rate, limited to R1 182 pfpa (included in the annual limit of R3 555 pfpa for out-of-hospital radiology); thereafter subject to available Medical Savings Account	300% of Scheme Rate, subject to available Medical Savings Account 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 R5 650 pfpa
16	ALTERNATIVES TO HOSPITALISATION Subject to pre-authorisation						
16.1	**Step-down Facilities**	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate Unlimited	100% of Scheme Rate Unlimited	100% of Scheme Rate Unlimited	100% of Scheme Rate Unlimited	100% of Scheme Rate Unlimited
16.2	**Hospice** (ward fees and disposables)	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate Unlimited	See Compassionate Care Benefit as specified in 16.3	See Compassionate Care Benefit as specified in 16.3	See Compassionate Care Benefit as specified in 16.3	See Compassionate Care Benefit as specified in 16.3
16.3	**Compassionate Care Benefit: End-of-life care for non-oncology patients** (in-patient care and homecare visits)	No benefit See Hospice Benefit as specified in 16.2	No benefit See Hospice Benefit as specified in 16.2	100% of Scheme Rate Unlimited for PMB scope and level of treatment. Limited to R53 800 pb per lifetime for all claims Subject to pre-authorisation and meeting the Scheme's guidelines	100% of Scheme Rate Unlimited for PMB scope and level of treatment. Limited to R53 800 pb per lifetime for all claims Subject to pre-authorisation and meeting the Scheme's guidelines	100% of Scheme Rate Unlimited for PMB scope and level of treatment. Limited to R53 800 pb per lifetime for all claims Subject to pre-authorisation and meeting the Scheme's guidelines	100% of Scheme Rate Unlimited for PMB scope and level of treatment. Limited to R53 800 pb per lifetime for all claims Subject to pre-authorisation and meeting the Scheme's guidelines
16.4	**Advanced Illness Benefit: Defined list of out-of-hospital benefits for patients with advanced oncology conditions only** (end-of-life treatment)	No benefit See Hospice Benefit as specified in 16.2	No benefit See Hospice Benefit as specified in 16.2	100% of Scheme Rate Unlimited Subject to pre-authorisation and the treatment meeting the Scheme's guidelines and managed care criteria	100% of Scheme Rate Unlimited Subject to pre-authorisation and the treatment meeting the Scheme's guidelines and managed care criteria	100% of Scheme Rate Unlimited Subject to pre-authorisation and the treatment meeting the Scheme's guidelines and managed care criteria	100% of Scheme Rate Unlimited Subject to pre-authorisation and the treatment meeting the Scheme's guidelines and managed care criteria
16.5	**Frail Care Facilities**	No benefit	No benefit	No benefit	50% of cost, limited to R422 pb per day	50% of cost, limited to R422 pb per day	50% of cost, limited to R422 pb per day

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
16.6	**Home Nursing**	No benefit	No benefit	No benefit	100% of cost, limited to R322 pb per day	100% of cost, limited to R322 pb per day	100% of cost, limited to R322 pb per day
17	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. The balance of the hospital and related accounts do not accumulate to the annual limit. All sub-limits are further subject to the combined Internal Prosthesis limit of R64 355 pbpa, applicable to all internal prosthesis items, excluding pacemakers and defibrillators) on the specified Plans. Dental implants are not regarded as internal prosthesis, for the purpose of the Rules. See "Dentistry and orthodontics: Advanced dentistry" for available implant benefits/limits for your Plan						
17.1	**Internal Prosthesis**	Limited to PMBs 100% of cost for PMBs	100% of cost as per Internal Prosthesis List, subject to a combined limit of R64 355 pbpa for all internal prosthesis items	100% of cost as per Internal Prosthesis List, subject to a combined limit of R64 355 pbpa for all internal prosthesis items	100% of cost as per Internal Prosthesis List, subject to a combined limit of R64 355 pbpa for all internal prosthesis items	100% of cost as per Internal Prosthesis List, subject to a combined limit of R64 355 pbpa for all internal prosthesis items	100% of cost as per Internal Prosthesis List, subject to a combined limit of R64 355 pbpa for all internal prosthesis items
	Internal Prosthesis sub-limits:						
17.2	**Spinal Fusions**	Limited to PMBs 100% of cost for PMBs	100% of cost of device Limited to R43 360 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R43 360 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R43 360 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R43 360 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R43 360 pbpa Subject to the combined Internal Prosthesis limit
17.3	**Cardiac Stents**	Limited to PMBs 100% of cost for PMBs	100% of cost of device Limited to R64 100 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R64 100 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R64 100 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R64 100 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R64 100 pbpa Subject to the combined Internal Prosthesis limit
17.4	**Grafts**	Limited to PMBs 100% of cost for PMBs	100% of cost of device Limited to R34 710 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R34 710 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R34 710 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R34 710 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R34 710 pbpa Subject to the combined Internal Prosthesis limit
17.5	**Cardiac Valves**	Limited to PMBs 100% of cost for PMBs	100% of cost of device Limited to R36 500 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R36 500 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R36 500 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R36 500 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R36 500 pbpa Subject to the combined Internal Prosthesis limit

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
17.6	Hip, Knee and Shoulder Joints	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate for device Limited to R42 835 per prosthesis per admission if prosthesis is not supplied by the Scheme's network provider If supplied by the Scheme's network provider, unlimited and not subject to combined limit for all internal prosthesis items	100% of Scheme Rate for device Limited to R42 835 per prosthesis per admission if prosthesis is not supplied by the Scheme's network provider If supplied by the Scheme's network provider, unlimited and not subject to combined limit for all internal prosthesis items	100% of Scheme Rate for device Limited to R42 835 per prosthesis per admission if prosthesis is not supplied by the Scheme's network provider If supplied by the Scheme's network provider, unlimited and not subject to combined limit for all internal prosthesis items	100% of Scheme Rate for device Limited to R42 835 per prosthesis per admission if prosthesis is not supplied by the Scheme's network provider If supplied by the Scheme's network provider, unlimited and not subject to combined limit for all internal prosthesis items	100% of Scheme Rate for device Limited to R42 835 per prosthesis per admission if prosthesis is not supplied by the Scheme's network provider If supplied by the Scheme's network provider, unlimited and not subject to combined limit for all internal prosthesis items
17.7	Non-specified Items	Limited to PMBs 100% of cost for PMBs	100% of cost of device Limited to R20 000 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R20 000 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R20 000 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R20 000 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R20 000 pbpa Subject to the combined Internal Prosthesis limit
18	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						
18.1	Pacemakers and Defibrillators	Limited to PMBs • 100% of cost at hospital network DSPs • 80% of cost at non-DSPs	Limited to PMBs • 100% of cost at hospital network DSPs • 80% of cost at non-DSPs	• 100% of cost, unlimited, if preferred provider used • 100% of Scheme Rate if non-preferred provider used to purchase device	• 100% of cost, unlimited, if preferred provider used • 100% of Scheme Rate if non-preferred provider used to purchase device	• 100% of cost, unlimited, if preferred provider used • 100% of Scheme Rate if non-preferred provider used to purchase device	• 100% of cost, unlimited, if preferred provider used • 100% of Scheme Rate if non-preferred provider used to purchase device
19	SPECIALISED LENSES 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.						
19.1	Specialised Lenses (Permanent, implantable lenses, inclusive of basic and specialised lens varieties)	Limited to PMBs • 100% of cost if preferred provider used • 100% of Scheme Rate if non-preferred provider used	Limited to PMBs • 100% of cost if preferred provider used • 100% of Scheme Rate if non-preferred provider used	• 100% of cost, unlimited, if preferred provider used • 100% of Scheme Rate if non-preferred provider used	• 100% of cost, unlimited, if preferred provider used • 100% of Scheme Rate if non-preferred provider used	• 100% of cost, unlimited, if preferred provider used • 100% of Scheme Rate if non-preferred provider used	• 100% of cost, unlimited, if preferred provider used • 100% of Scheme Rate if non-preferred provider used

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
20	COCHLEAR IMPLANTS Subject to pre-authorisation and Scheme protocols. Once in a lifetime benefit. Funding only available in recognised Centres of Excellence. Visit www.bankmed.co.za; select "Network Providers" and then "Centres for Cochlear Implants 2018" for a comprehensive list						
20.1	Hospitalisation	No benefit	No benefit	No benefit	Benefits as for hospitalisation	Benefits as for hospitalisation	Benefits as for hospitalisation
20.2	Pre-operative Evaluation and Associated Preparation Costs	No benefit	No benefit	No benefit	R15 250 pb per lifetime	R15 250 pb per lifetime	R15 250 pb per lifetime
20.3	Cochlear Implant Device	No benefit	No benefit	No benefit	R319 665 pb per lifetime	R319 665 pb per lifetime	R319 665 pb per lifetime
20.4	Intra-operative Audiology Testing	No benefit	No benefit	No benefit	R800 pb per lifetime	R800 pb per lifetime	R800 pb per lifetime
20.5	Post-operative Evaluation Costs	No benefit	No benefit	No benefit	R32 000 pb per lifetime	R32 000 pb per lifetime	R32 000 pb per lifetime
21	SPEECH PROCESSORS Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval						
21.1	Upgrade or Replacement of Speech Processors	No benefit	No benefit	No benefit	80% of cost, limited to R119 375 pb over a five-year cycle	80% of cost, limited to R119 375 pb over a five-year cycle	80% of cost, limited to R119 375 pb over a five-year cycle
22	HEARING AIDS						
22.1	Hearing Aids (supply and fitment)	No benefit, except for PMBs	No benefit, except for PMBs	100% of cost, subject to available Medical Savings Account	100% of cost, limited to R25 650 per beneficiary every second year (rolling 24 months)	100% of cost, limited to R25 650 per beneficiary every second year (rolling 24 months)	100% of cost, limited to R30 000 per beneficiary every second year (rolling 24 months)
22.2	Hearing Aid Repairs	No benefit	No benefit	100% of cost, subject to available Medical Savings Account	100% of cost, limited to R1 330 pbpa	100% of cost, limited to R1 330 pbpa	100% of cost, limited to R1 330 pbpa
22.3	Bone Anchored Hearing Aids	No benefit	No benefit	100% of cost, subject to available Medical Savings Account	90% of cost, limited to R137 150 pfpa	90% of cost, limited to R137 150 pfpa	90% of cost, limited to R137 150 pfpa
23	EXTERNAL PROSTHESIS, MEDICAL AND SURGICAL APPLIANCES, BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS Benefit includes the repair of the prosthesis						
23.1	External Prosthesis: Benefit for Limbs and Eyes	Limited to PMBs 100% of cost for PMBs	100% of cost Limited to R2 830 pfpa Combined limit with medical and surgical appliances, blood pressure monitors, nebulisers and glucometers	100% of cost Limited to R2 830 pfpa Combined limit with medical and surgical appliances, blood pressure monitors, nebulisers, glucometers, arch supports and shoe insoles	100% of cost Limited to R21 950 pfpa	100% of cost Limited to R21 950 pfpa	100% of cost Limited to R21 950 pfpa

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
23.2	**Medical and Surgical Appliances** (claim frequency limits apply – refer to 23.6)	Limited to PMBs 100% of cost for PMBs No benefit for wheelchairs and large orthopaedic appliances on this Plan, except for PMBs	Combined limit of R2 830 pfpa with external prosthesis, blood pressure monitors, nebulisers and glucometers and subject to pre-authorisation No benefit for wheelchairs and large orthopaedic appliances on this Plan, except for PMBs	Combined limit of R2 830 pfpa with external prosthesis, blood pressure monitors, nebulisers, glucometers, arch supports and shoe insoles Benefits for wheelchairs and large orthopaedic appliances at 100% of cost, subject to available Medical Savings Account	Post-surgery appliances: 100% of cost, limited to R6 450 pbpa Chronic appliances 100% of cost, limited to: • R20 275 pbpa for oxygen/ oxygen delivery systems • R20 275 pbpa for stoma products • R6 450 pbpa* for other chronic appliances, including wheelchairs • Sub-limits apply as follows: - R797 arch supports (per pair) - R1 197 shoe insoles (per pair) • Appliances for acute conditions: - 100% of cost, subject to other chronic appliances limit of R6 450 pbpa *Other chronic appliances limit extended to R9 440 for beneficiaries requiring a CPAP machine Additional discretionary benefits may be granted for wheelchairs, subject to occupational therapist or physiotherapist motivation, at least two cost quotations and Scheme approval	Post-surgery appliances: 100% of cost, limited to R6 450 pbpa Chronic appliances 100% of cost, limited to: • R20 275 pbpa for oxygen/ oxygen delivery systems • R20 275 pbpa for stoma products • R6 450 pbpa* for other chronic appliances, including wheelchairs • Sub-limits apply as follows: - R797 arch supports (per pair) - R1 197 shoe insoles (per pair) • Appliances for acute conditions: - 100% of cost, subject to available Medical Savings Account *Other chronic appliances limit extended to R9 440 for beneficiaries requiring a CPAP machine Additional discretionary benefits may be granted for wheelchairs, subject to occupational therapist or physiotherapist motivation, at least two cost quotations and Scheme approval	Post-surgery appliances: 100% of cost, limited to R6 450 pbpa Chronic appliances 100% of cost, limited to: • R20 275 pbpa for oxygen/ oxygen delivery systems • R20 275 pbpa for stoma products • R6 450 pbpa* for other chronic appliances, including wheelchairs • Sub-limits apply as follows: - R797 arch supports (per pair) - R1 197 shoe insoles (per pair) • Appliances for acute conditions: - 100% of cost, subject to available Medical Savings Account - ATB applies once the Annual Threshold is reached *Other chronic appliances limit extended to R9 440 for beneficiaries requiring a CPAP machine Additional discretionary benefits may be granted for wheelchairs, subject to occupational therapist or physiotherapist motivation, at least two cost quotations and Scheme approval

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
23.3	**Blood Pressure Monitors, Nebulisers and Glucometers** (claim frequency limits apply – refer to 23.6)	Subject to pre-authorisation 100% of cost for PMBs	Subject to pre-authorisation Combined limit of R2 830 pfpa with external prosthesis and medical/surgical appliances	Available on prescription without additional motivation or Scheme approval Subject to the combined limit of R2 830 pfpa with external prosthesis and medical/surgical appliances, and further limited as follows: • Blood pressure monitors: R1 087 pfpa • Nebulisers: R1 530 pfpa • Glucometers: R770 pfpa	Available on prescription without additional motivation or Scheme approval Subject to the combined limit of R6 450 pbpa for "other chronic appliances" under medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 087 pfpa • Nebulisers: R1 530 pfpa • Glucometers: R770 pfpa	Available on prescription without additional motivation or Scheme approval Subject to the combined limit of R6 450 pbpa for "other chronic appliances" under medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 087 pfpa • Nebulisers: R1 530 pfpa • Glucometers: R770 pfpa	Available on prescription without additional motivation or Scheme approval Subject to the combined limit of R6 450 pbpa for "other chronic appliances" under medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 087 pfpa • Nebulisers: R1 530 pfpa • Glucometers: R770 pfpa
23.4	**Arch Supports and Shoe Insoles** (claim frequency limits apply – refer to 23.6)	No benefit	No benefit	Combined limit with External Prosthesis Benefit, medical and surgical appliances, blood pressure monitors, nebulisers and glucometers Subject to a combined limit of R2 830 pfpa • Sub-limits apply as follows: - R797 arch supports (per pair) - R1 197 shoe insoles (per pair)	Refer to 23.2	Refer to 23.2	Refer to 23.2
23.5	**Breast Pumps and Baby Monitors**	No benefit	No benefit	Funded from available Medical Savings Account Only payable if claimed from a service provider with a valid BHF practice number	Funded from available Other Chronic Appliances limit of R6 450 pbpa Only payable if claimed from a service provider with a valid BHF practice number	Funded from available Medical Savings Account Only payable if claimed from a service provider with a valid BHF practice number	Funded from available Medical Savings Account Only payable if claimed from a service provider with a valid BHF practice number
23.6	**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
BP 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
Breast Prosthesis	Once every two years (single/pair)
Wheelchairs	Once every three years
Compression Stockings	Two per year
Portable Oxygen	Once every four years

Appliance/Device	Frequency
Glucometer	Once every three years
Nebuliser	Once every three years
Surgical Boot/Moon Boot	Once every two years
Brace/Calipers	Once every two years
Wigs	Once every two years
Breast Prosthesis Bras	Two per annum
Commodes	Once every three years
Walking Frames	Once every two years
Sling/Clavicle Brace	Once every two 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.

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24	PSYCHIATRY, CLINICAL PSYCHOLOGY AND RELATED OCCUPATIONAL THERAPY						
24.1	**Hospitalisation:** (subject to pre-authorisation)	Limited to PMBs	Limited to PMBs	R 60 135 pbpa covered as follows:	R 60 135 pbpa covered as follows:	R 60 135 pbpa covered as follows:	R 60 135 pbpa covered as follows:
	Hospital Network DSPs • All admissions at network DSP	• 100% of cost for Bankmed Network Psychiatric facilities (DSPs)	• 100% of cost for Bankmed Network Psychiatric facilities (DSPs)	• 100% of cost for Bankmed Network Psychiatric facilities (DSPs)	• 100% of cost for Bankmed Network Psychiatric facilities (DSPs)	• 100% of cost for Bankmed Network Psychiatric facilities (DSPs)	• 100% of cost for Bankmed Network Psychiatric facilities (DSPs)
	Other Hospitals (non-DSPS) • PMB admission: involuntary use of non-DSP	• 100% of cost	• 100% of cost	• 100% of cost	• 100% of cost	• 100% of cost	• 100% of cost
	• PMB admission: voluntary use of non-DSP	• 80% of Scheme Rate for non-DSPs	• 80% of Scheme Rate for non-DSPs	• 80% of Scheme Rate for non-DSPs	• 80% of Scheme Rate for non-DSPs	• 80% of Scheme Rate for non-DSPs	• 80% of Scheme Rate for non-DSPs
	• Non-PMB admission	• No benefit	• No benefit	• 80% of Scheme Rate for non-DSPs	• 80% of Scheme Rate for non-DSPs	• 80% of Scheme Rate for non-DSPs	• 80% of Scheme Rate for non-DSPs
	In-hospital Consultations/ Sessions	• 100% of cost for Bankmed Network Specialists: DSPs • 100% of Scheme Rate for non-DSPs	• 100% of cost for Bankmed Network Specialists: DSPs • 100% of Scheme Rate for non-DSPs	• 100% of cost for Bankmed Network Specialists: DSPs • 100% of Scheme Rate for non-DSPs	• 100% of cost for Bankmed Network Specialists: DSPs • 100% of Scheme Rate for non-DSPs	• 100% of cost for Bankmed Network Specialists: DSPs • 100% of Scheme Rate for non-DSPs	• 100% of cost for Bankmed Network Specialists: DSPs • 100% of Scheme Rate for non-DSPs
				Continued benefits for PMBs subject to pre-authorisation and PMB regulations	Continued benefits for PMBs subject to pre-authorisation and PMB regulations	Continued benefits for PMBs subject to pre-authorisation and PMB regulations	Continued benefits for PMBs subject to pre-authorisation and PMB regulations
		Cover for 21 days in hospital in line with PMB regulations	Cover for 21 days in hospital in line with PMB regulations	Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the rand limit	Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the rand limit	Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the rand limit	Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the rand limit
				Combined limit with "Occupational therapy: psychiatric consultations /sessions in hospital"	Combined limit with "Occupational therapy: psychiatric consultations /sessions in hospital"	Combined limit with "Occupational therapy: psychiatric consultations /sessions in hospital"	Combined limit with "Occupational therapy: psychiatric consultations /sessions in hospital"

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
24.2	**Post-hospital Psychiatric consultation within 30 days of discharge from hospital 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 as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission: • 100% of cost at a contracted rate for Bankmed Network Specialists (Psychiatrist only) - DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission: • 100% of cost at a contracted rate for Bankmed Network Specialists (Psychiatrist only) - DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission: • 100% of cost at a contracted rate for Bankmed Network Specialists (Psychiatrist only) - DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits and/or Medical Savings Account	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission: • 100% of cost at a contracted rate for Bankmed Network Specialists (Psychiatrist only) - DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission: • 100% of cost at a contracted rate for Bankmed Network Specialists (Psychiatrist only) - DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits and/or Medical Savings Account	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission: • 100% of cost at a contracted rate for Bankmed Network Specialists (Psychiatrist only) - DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits and/or Medical Savings Account
24.3	**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, PMB regulations and referral from a Bankmed GP Entry Plan Network GP (DSP): • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs	Limited to PMBs Benefits subject to pre-authorisation, PMB regulations and referral from a Bankmed GP Entry Plan Network GP (DSP): • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs	100% of cost, subject to available Medical Savings Account • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Network Specialists (DSPs), subject to pre-authorisation, PMB regulations and referral from a Bankmed Network GP (DSPs) • 100% of Scheme Rate for non-DSPs	R3 770 pbpa covered as follows: • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs Combined limit with occupational therapy: psychiatric consultations/ sessions out-of-hospital Combined limit may be extended to R9 390 pbpa for depression and/or bipolar mood disorder, subject to pre-authorisation and PMB regulations	R4 400 pbpa covered as follows: • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs Combined limit with occupational therapy: psychiatric consultations/ sessions out-of-hospital Combined limit may be extended to R10 500 pbpa for depression and/or bipolar mood disorder, subject to pre-authorisation and PMB regulations	300% of Scheme Rate, subject to available Medical Savings Account 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 R13 300 pfpa • 100% of cost at contracted rate from Insured Benefits for PMB, subject to PMB regulations at Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs

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25	OCCUPATIONAL THERAPY						
25.1	**Psychiatric consultations/ sessions in-hospital** (subject to preauthorisation)	See "Psychiatry, clinical psychology and related occupational therapy: Hospitalisation and in-hospital consultations/sessions" in these Benefit Tables					
25.2	**Psychiatric consultations/ sessions** (out-of-hospital)	See "Psychiatry, clinical psychology and related occupational therapy: Consultations/Sessions out-of-hospital" above					
25.3	**Non-psychiatric consultations/sessions in-hospital** (subject to pre-authorisation)	Limited to PMBs 100% of cost for PMBs	Limited to PMBs and subject to pre-authorisation 100% of cost for PMBs	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited
25.4	**Non-psychiatric consultations/sessions** (out-of-hospital)	Limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP) 100% of cost for PMBs	Limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP) 100% of cost for PMBs	100% of cost, subject to available Medical Savings Account for non-PMBs 100% of cost for PMBs	100% of Scheme Rate, limited to R1 850 pfpa	100% of Scheme Rate, limited to R1 945 pfpa, from Insured Benefits Thereafter subject to available Medical Savings Account	300% of Scheme Rate, subject to available Medical Savings Account 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Network Specialists (DSPs) 100% of Scheme Rate for non-DSPs 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 R6 700 pfpa Subject to PMB regulation

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
26	SPEECH THERAPY, AUDIO THERAPY AND AUDIOLOGY						
26.1	**Speech Therapy, Audio Therapy and Audiology** (in- and out-of-hospital)	Limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP)	Limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP)	100% of cost, subject to available Medical Savings Account 100% of cost paid from Insured Benefits for PMBs	100% of Scheme Rate, limited to R1 850 pfpa	100% of Scheme Rate, limited to R2 000 pfpa Thereafter subject to available Medical Savings Account	300% of Scheme Rate, subject to available Medical Savings Account, thereafter 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 R2 000 pfpa
27	PHYSIOTHERAPY						
27.1	**Physiotherapy** (in-hospital)	Limited to PMBs 100% of cost for PMBs	Limited to PMBs 100% of cost for PMBs	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited
27.2	**Post-hospitalisation physiotherapy within six weeks of discharge from hospital, following an authorised hospital admission**	See "Physiotherapy (out-of-hospital)" below	See "Physiotherapy (out-of-hospital)" below	See "Physiotherapy (out-of-hospital)" below	100% of Scheme Rate, limited to R2 670 pfpa	100% of Scheme Rate, limited to R2 215 pbpa from Insured Benefits and thereafter subject to available Medical Savings Account	See "Physiotherapy (out-of-hospital)" below
27.3	**Physiotherapy** (out-of-hospital)	Limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP): • 100% of cost at contracted rate for Bankmed GP Entry Plan Network Physiotherapists (DSPs) • 100% of Scheme Rate for non-DSPs	Limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP): • 100% of cost at contracted rate for Bankmed GP Entry Plan Network Physiotherapists (DSPs) • 100% of Scheme Rate for non-DSPs	100% of cost, subject to available Medical Savings Account for non-PMBs 100% of cost for PMBs	100% of Scheme Rate, subject to out-of-hospital "GP and Specialists: Consultations in rooms" limits as set out in the Benefit Tables	100% of cost, subject to available Medical Savings Account	300% of Scheme Rate, subject to available Medical Savings Account 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 R2 670 pbpa
28	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						
28.1	**Occupational Therapy: Psychiatric consultations/ sessions** (out-of-hospital)	No benefit	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies
28.2	**Occupational Therapy: Non-psychiatric consultations/ sessions**	No benefit	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
	(out-of-hospital)						
28.3	**Physiotherapy** (out-of-hospital)	No benefit	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies
28.4	**Speech Therapy** (out-of-hospital)	No benefit	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies	100% of Scheme Rate or contracted rate, whichever applies
29	**OTHER AUXILIARY SERVICES** In- and out-of-hospital						
29.1	**Chiropody, Podiatry, Dietetics (nutritional assessments), Orthotics, Massage, Chiropractors, Herbalists, Naturopaths, Family Planning Clinics, Homeopaths and Biokineticists (fitness assessments)**	Limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP)	Limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP)	100% of cost, subject to available Medical Savings Account for non-PMBs 100% of cost for PMBs	100% of Scheme Rate, limited to R2 830 pfpa	100% of cost, subject to available Medical Savings Account	300% of Scheme Rate, subject to available Medical Savings Account 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 R2 830 pfpa
30	**MAXILLOFACIAL AND ORAL SURGERY** Subject to pre-authorisation. NB: Benefits for caps, crowns, bridges and endosteal and ossea-integrated implants are dealt with under dentistry and orthodontics: Advanced dentistry- see 31.2 below						
30.1	**Maxillofacial and Oral Surgery: Consultations, procedures and treatment in-and out-of-hospital**	Limited to PMBs: • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs	Limited to PMBs: • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs	Limited to PMBs: • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs Benefit inclusive of elective treatment	• 100% of cost at contracted rate, unlimited for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs Benefit inclusive of elective treatment	• 100% of cost at contracted rate, unlimited for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs Benefit inclusive of elective treatment

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
31	DENTISTRY Subject to pre-authorisation. NB: Benefits for caps, crowns, bridges and endosteal and ossea-integrated implants are dealt with under dentistry and orthodontics: Advanced dentistry- see 31.2 below						
31.1	**Preventative and Basic Dentistry**	No benefit	100% of cost unlimited via Bankmed Dental Network Subject to Scheme-approved formulary	100% of cost, subject to available Medical Savings Account	100% of Scheme Rate, unlimited Limited to: • One oral examination pbpa • Amalgam and resin fillings only • Plastic dentures only • Two topical fluoride treatments per child per year (age 15 years and younger). • One topical fluoride treatment per year for all other beneficiaries. • Limited to eight molar teeth pb per lifetime • Scale and polish limited to two pbpa	100% of Scheme Rate, unlimited; paid from Insured Benefit Limited to: • One oral examination pbpa • Amalgam and resin fillings only • Plastic dentures only • Two topical fluoride treatments per child per year (age 15 years and younger). • One topical fluoride treatment per year for all other beneficiaries. • Limited to eight molar teeth pb per lifetime • Scale and polish limited to two pbpa	300% of Scheme Rate, subject to available Medical Savings Account 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 R16 050 for a single member and R24 300 for a family
31.2	**Advanced Dentistry** (caps, crowns, bridges and cost of endosteal and osseaintegrated implants)	No benefit	No benefit	100% of cost, subject to available Medical Savings Account for non-PMBs 100% of cost for PMBs	100% of Scheme Rate, limited to: M: R6 190 pbpa M + 1 +: R9 600 pfpa Combined limit for advanced dentistry, orthodontics and all other dental services	100% of Scheme Rate, limited to: M: R4 820 pbpa M + 1 +: R8 070 pfpa Thereafter subject to available Medical Savings Account	
31.3	**Orthodontics** (subject to orthodontic quotation and prior approval from Scheme)	No benefit	No benefit	100% of cost, subject to available Medical Savings Account	100% of Scheme Rate, subject to advanced dentistry limit	100% of Scheme Rate, limited to R8 070 pfpa Thereafter subject to available Medical Savings Account	
31.4	**All other Dental Services**	No benefit	100% of cost via Bankmed Dental Network and subject to Scheme-approved formulary for: • Second and subsequent examinations in the same year • X-rays	100% of cost, subject to available Medical Savings Account	100% of Scheme Rate, subject to advanced dentistry limit	100% of Scheme Rate, subject to available Medical Savings Account	

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
32	GENERAL PRACTITIONERS (GPs)						
32.1	**GP Consultations** (in-hospital)	Limited to PMBs • 100% of cost at contracted rate, unlimited for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs
32.2	**GP Procedures** (in-hospital)	Limited to PMBs • 100% of cost at contracted rate for PMBs via Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs (including PMBs) No benefit for dental surgery, except for PMBs	Benefit unlimited • 100% of cost at contracted rate via Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs (including PMBs) No benefit for dental surgery, except for PMBs	Benefit unlimited • 100% of cost at contracted rate via Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs (including PMBs) No benefit for dental surgery, except for PMBs	Benefit unlimited • 100% of cost at contracted rate, unlimited for Bankmed Network GPs (DSPs) • 125% of Scheme Rate for non-DSPs	Benefit unlimited • 100% of cost at contracted rate via Bankmed Network GPs (DSPs) • 125% of Scheme Rate for non-DSPs	Benefit unlimited • 100% of cost at contracted rate via Bankmed Network GPs (DSPs) • 300% of Scheme Rate for non-DSPs
32.3	**Post-hospital GP Consultation within 30 days of discharge from hospital (excluding day cases)**	Limited to PMBs • 100% of cost at contracted rate for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at the contracted rate via Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs Subject to out-of-network limit for non-Bankmed GP Entry Plan Network GPs. See “GPs: Consultations in rooms” for details	One additional post-hospitalisation GP consultation covered as an Insured Benefit (not payable from Medical Savings Account or other insured limits), per beneficiary 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 (DSPs) • 100% of Scheme Rate for non-DSPs	One additional post-hospitalisation GP consultation covered as an Insured Benefit (not payable from Medical Savings Account or other insured limits), per beneficiary 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 (DSPs) • 100% of Scheme Rate for non-DSPs	One additional post-hospitalisation GP consultation covered as an Insured Benefit (not payable from Medical Savings Account or other insured limits), per beneficiary 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 (DSPs) • 100% of Scheme Rate for non-DSPs	One additional post-hospitalisation GP consultation covered as an Insured Benefit (not payable from Medical Savings Account or other insured limits), per beneficiary 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 (DSPs) • 100% of Scheme Rate for non-DSPs

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32.4	**GPs: Consultations in room**	Limited to PMBs 100% of cost at contracted rate, unlimited for Bankmed GP Entry Plan Network GPs (DSPs) 100% of Scheme Rate for non-DSPs **IMPORTANT INFORMATION** Pre-authorisation is required for PMB funding of treatment and care of the PMB Chronic Disease List (CDL) conditions. Have your doctor 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.	Members must make use of Bankmed GP Entry Plan Network GPs (DSPs) on this Plan • 100% of cost at contracted rate, unlimited for selected Bankmed GP Entry Plan Network GPs (DSP) in accordance with preferred provider contract • Limited to three visits, to a maximum of R1 955 pfpa (at Bankmed GP Entry Plan Network rate) for consultations, procedures and medicine at non-Bankmed GP Entry Plan Network GPs, when the selected Bankmed GP Entry Plan Network GP is not available or the beneficiary is out of town; Out-of-network limit includes all costs arising from the out-of- network consultation	Benefits for a Bankmed Network GP (DSP): • 100% of cost at contracted rate, unlimited for PMBs • Two consultations at contracted rate from Insured Benefits, for non-PMBs (thereafter payable from available Medical Savings Account) Benefits for any other GP (non-DSP): • 100% of Scheme Rate from Insured Benefits for PMBs • 100% of Scheme Rate from the Medical Savings Account for non-PMBs	Combined limit for GP and specialist consultations in rooms: • M: R3 113 pbpa • M + 1: R5 650 pfpa • M + 2 +: R6 550 pfpa GPs paid as follows: • 100% of cost at contracted rate for Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs • Unlimited if DSP used Continued benefits for beneficiaries with PMB conditions, subject to PMB regulations	Benefits subject to available Medical Savings Account: • 100% of cost at contracted rate for Bankmed Network GPs (DSPs); • 100% of Scheme Rate for non-DSPs PMB treatment: • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Network GPs (DSPs); • 100% of Scheme Rate for non-DSPs	300% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached PMB treatment: • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Network GPs (DSPs); • 100% of Scheme Rate for non-DSPs
32.5	**GPs: Procedures in room**	Limited to PMBs • 100% of cost at contracted rate, unlimited for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	See "GPs: Consultations in rooms" in section 32.4	• 100% of cost of contracted rate for Bankmed Network GPs (DSPs), unlimited • 100% of Scheme Rate, subject to available Medical Savings Account for non-DSPs	• 100% of cost of contracted rate for Bankmed Network GPs (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	Paid from Insured Benefits: • 100% of cost of contracted rate for Bankmed Network GPs (DSPs) • 125% of Scheme Rate for non-DSPs	Paid from Insured Benefits: • 100% of cost of contracted rate for Bankmed Network GPs (DSPs) • 125% of Scheme Rate for non-DSPs

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33	SPECIALISTS NB: Psychiatrists, oncologists, radiologists, pathologists, maxillofacial and oral surgeons and other dental practitioners are dealt with elsewhere in these Benefit Tables						
33.1	**Specialist consultations and procedures** (in-hospital)	Limited to PMBs • 100% of cost of contracted rate at Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Network Specialists (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Network Specialists (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Network Specialists (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Network Specialists (DSPs), unlimited • 125% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Network Specialists (DSPs), unlimited • 300% of Scheme Rate for non-DSPs
33.2	**Specialists: Consultations in room** (pre-authorisation required for all Plans, excluding Comprehensive and Plus) Be sure to obtain a referral from your GP and an authorisation number before seeing a specialist – for all plans, excluding Comprehensive and Plus Make use of our DSPs to limit or avoid co-payments	Limited to PMBs Benefits subject to referral by a Bankmed GP Entry Plan Network GP and approved basket of care registration for PMB conditions: • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 80% of cost if no pre-authorisation and no referral from a Bankmed GP Entry Plan Network GP (DSP) • 100% of Scheme Rate for non-DSPs • 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed GP Entry Plan Network GP (DSP)	Benefits subject to referral by a Bankmed GP Entry Plan Network GP, and limited to: M: R1 765 pbpa M + 1 +: R2 770 pfpa (combined limit with specialist procedures in rooms) Covered as follows: • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 80% of cost if no pre-authorisation and no referral from a Bankmed GP Entry Plan Network GP (DSP) • 100% of Scheme Rate for non-DSPs • 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed GP Entry Plan Network GP (DSP) Annual limit includes basic radiology, scans, pathology and acute medication prescribed by specialist/ appearing on specialist's claim Continued benefits for PMBs, subject to PMB regulations and approval	Specialist consultations approved for beneficiaries registered for PMB Chronic Disease List (CDL) conditions, subject to approved basket of care and referral by a Bankmed Network GP: • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 80% of cost if no pre-authorisation and no referral from a Bankmed Network GP (DSP) • 100% of Scheme Rate for non-DSPs • 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed Network GP (DSP) Non-basket of care benefits covered at 100% of Scheme Rate, subject to available Medical Savings Account Continued benefits for PMBs, subject to PMB regulations and approval	Combined limit with GP consultations in rooms, and paid as follows: • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 80% of cost if no preauthorisation and no referral from a Bankmed Network GP (DSP) • 100% of Scheme Rate for non-DSPs (including PMBs) • 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed GP Network GP (DSP) Continued benefits for PMBs, subject to PMB regulations and approval	125% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs	300% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached • 100% of cost at contracted rate for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs

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33.3	**Specialists: Procedures in rooms**	Limited to PMBs • 100% of cost of contracted rate at Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs	See "Specialists: Consultations in rooms" in section 33.2	Limited to PMBs • 100% of cost at contracted rate, unlimited for Bankmed Network Specialists (DSPs) • 100% of Scheme Rate for non-DSPs • 80% of cost if no pre-authorisation or no referral from Bankmed GP Network GP (DSP)	• 100% of cost at contracted rate, unlimited for Bankmed Network Specialists (DSPs) • 125% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed Network Specialists (DSPs) • 125% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed Network Specialists (DSPs) • 300% of Scheme Rate for non-DSPs
34	**REGISTERED PRIVATE NURSE PRACTITIONERS**						
34.1	**Consultations and Procedures**	Limited to PMBs Procedures: • 100% of cost, unlimited for PMBs Consultations: • Three consultations pbpa at 100% of cost for PMBs	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 100% of Scheme Rate	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 100% of Scheme Rate from Insured Benefits Thereafter subject to available Medical Savings Account	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 125% of Scheme Rate Thereafter, 125% of Scheme Rate, subject to out-of-hospital GP/Specialist limit	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 125% of Scheme Rate from Insured Benefits Thereafter subject to available Medical Savings Account	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 300% of Scheme Rate from Insured Benefits Thereafter subject to available Medical Savings Account ATB applies once the Annual Threshold is reached

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35	OPTOMETRY CONSULTATIONS, SPECTACLES, FRAMES, LENSES AND CONTACT LENSES						
35.1	**Optometry: Consultations**	No benefit	100% of cost, limited to one consultation pb every two years, via Iso Leso Optometry Network Out of network: No benefit	100% of cost, subject to available Medical Savings Account	Benefits available every two years • 100% of cost for PPN optometrists OR • 100% of cost, limited to R545 pb at any other optometrist Benefits limited to one eye test or one re-examination or one composite examination pb every two years	Benefits available every two years • 100% of cost for PPN optometrists OR • 100% of cost, limited to R545 pb at any other optometrist Benefits limited to one eye test or one re-examination or one composite examination pb every two years	100% of cost, subject to available Medical Savings Account, however 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 R4 050 pbpa for optometric consultations, prescription lenses, readymade readers, contact lenses, fitting of contact lenses and other optometric services
35.2	**Frames and Extras**	No benefit	100% of cost • Limited to one consultation pb every two years, via Iso Leso Optometry Network Out of network: No benefit	100% of cost, subject to available Medical Savings Account	Benefits available every two years • Limited to R850 pb for a PPN optometrist or any other optometrist	100% of cost, subject to available Medical Savings Account for a PPN optometrist or any other optometrist	100% of cost, subject to available Medical Savings Account Frames and extras do not accumulate towards reaching the Annual Threshold and are not covered as an ATB benefit

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
35.3	**Prescription Lenses and Readymade Readers**	No benefit	100% of cost • Limited to one pair of prescription lenses pb every two years, via Iso Leso Optometry Network • Out of network: No benefit • No benefit for readymade readers	100% of cost, subject to available Medical Savings Account Readymade readers from optometrists (only), subject to available Medical Savings Account	Benefits for prescription lenses limited to one pair of lenses pb every two years, and covered as follows: • 100% of cost for clear single vision, clear acuity bifocal or clear acuity multifocal lenses from a PPN optometrist OR The following limits for any other optometrists: • Clear single vision lenses: R175 per lens pb • Clear bifocal lenses: R380 per lens pb • Clear multifocal lenses: R695 per lens pb • Two pairs of readymade readers at R90 a pair, may be claimed from the above limits, pb every two years, from PPN accredited outlets or from the online ordering facility at www.ppn.co.za The cost of the readers will be deducted from the available clear lens benefit	Benefits for prescription lenses limited to one pair of lenses pb every two years, and covered as follows: • 100% of cost for clear single vision, clear acuity bifocal or clear acuity multifocal lenses from a PPN optometrist OR The following limits for any other optometrists: • Clear single vision lenses: R175 per lens pb • Clear bifocal lenses: R380 per lens pb • Clear multifocal lenses: R695 per lens pb • Two pairs of readymade readers at R90 a pair, may be claimed from the above limits, pb every two years, from PPN accredited outlets or from the online ordering facility at www.ppn.co.za The cost of the readers will be deducted from the available clear lens benefit	100% of cost, subject to available Medical Savings Account Frames and extras do not accumulate towards reaching the Annual Threshold, and are not covered as an ATB benefit
35.4	**Contact Lenses**	No benefit	No benefit	100% of cost, subject to available Medical Savings Account	100% of cost, limited to R1 335 pbpa for a PPN optometrist or any other optometrist Beneficiary may not claim for contact lenses and prescription lenses/readymade readers in the same calendar year	100% of cost, limited to R1 480 pbpa for a PPN optometrist or any other optometrist Paid from Insured Benefits Beneficiary may not claim for contact lenses and prescription lenses/readymade readers in the same calendar year	See “Optometry: Consultations” in the Benefit Table
35.5	**Fitting of Contact Lenses**	No benefit	No benefit	100% of cost, subject to available Medical Savings Account	100% of cost, limited to R255 pbpa	100% of cost, limited to R255 pbpa	See “Optometry: Consultations”

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
36	**REFRACTIVE SURGERY AND ASSOCIATED COSTS (INCLUDING HOSPITALISATION)**						
36.1	**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	No benefit, including the cost of hospitalisation, medication and all other associated services	100% of cost, subject to available Medical Savings Account, including the cost of hospitalisation, medication and all other associated services	100% of Scheme Rate, limited to R3 555 pfpa, including the cost of hospitalisation, medication and all other associated services	100% of cost, subject to available Medical Savings Account, including the cost of hospitalisation, medication and all other associated services	See "Optometry: Consultations" Limit on accumulation to Annual Threshold and/or payment as an ATB includes the cost of hospitalisation, medication and all other associated services
37	**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 per beneficiary per month**						
37.1	**Prescribed Acute Medication** (See "Contraception: Oral contraceptives, devices and injectables" for additional Insured Benefits)	Limited to PMBs 100% of cost for PMBs at contracted rate, unlimited via Bankmed GP Entry Plan Network GP (DSP) and subject to OH-DTPMB approval	Medication via DSP (Bankmed Entry Plan Network GP and Bankmed Pharmacy Network): • 100% of cost plus contracted dispensing fee, unlimited Medication via non-DSP (voluntary): • 100% of cost plus contracted dispensing fee • Subject to out-of-network GP consultations and procedures limit of R1 995 pfpa Medication via non-DSP (involuntary): • 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 consultations and procedures limit of R1 955 pfpa	100% of cost, subject to available Medical Savings Account	Limited to: • M: R3 540 pbpa • M + 1: R6 510 pfpa • M + 2 +: R7 070 pfpa The above limits include a maximum allowance of R1 400 pfpa towards self-medication/ PAT Paid as follows: Bankmed Network GPs/ Bankmed Pharmacy Network (DSPs): • 100% of the Scheme's Medicine Reference Price plus contracted dispensing fee for generic medication • 80% of Scheme's Medicine Reference Price plus contracted dispensing fee for original medication (medication where a generic alternative is available) Non-DSPs: • 80% of Scheme's Medicine Reference Price for generic medication and original medicines (medication where a generic alternative is available)	100% of cost, subject to available Medical Savings Account	100% of the Scheme's Medicine Reference Price plus contracted dispensing fee as applicable to Bankmed Network GPs or Bankmed Pharmacy Network (DSPs), subject to available Medical Savings Account 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 R16 050 for a single member and R24 300 for a family

		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
37.2	**Self-medication: Over-the-counter Medication/Pharmacy Advised Therapy (PAT)**	No benefit	No benefit	100% of cost 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 medicine list (formulary) for PAT All other acute and over-the-counter medication subject to available Medical Savings Account	100% of the Scheme's Medicine Reference Price for Bankmed Pharmacy Network (DSP) 80% of the Scheme's Medicine Reference Price for non-DSPs Limited to R1 400 pfpa, and further subject to the annual limit for prescribed acute medication	100% of cost, subject to available Medical Savings Account	100% of cost, subject to available Medical Savings Account Self-medication/PAT does not accumulate towards the Annual Threshold and is not covered as an ATB benefit
37.3	**Homeopathic Medication** (on prescription only, and limited to items with NAPPI codes)	No benefit	No benefit	Benefits as for prescribed acute/ chronic medication No self-medication benefit for homeopathic medication	Benefits as for prescribed acute/ chronic medication No self-medication benefit for homeopathic medication	Benefits as for prescribed acute/ chronic medication No self-medication benefit for homeopathic medication	Benefits as for prescribed acute/ chronic medication No self-medication benefit for homeopathic medication
37.4	**Chronic Medication** (subject to prior application and approval)	Limited to PMBs 100% of cost for PMBs at contracted rate, unlimited via Bankmed GP Entry Plan Network (DSP) and subject to Scheme-approved medicine list (formulary)	• 100% of cost at contracted rate, unlimited via Bankmed GP Entry Plan Network (DSP) and subject to Scheme-approved medicine list (formulary) Medication via non-DSP (voluntary use of non-DSP): • 80% of Scheme Medicine Reference Price • Subject to out of network GP consultations and procedures limit of R1 955 pfpa Medication via non-DSP (involuntary use of non-DSP): • 100% of cost plus contracted dispensing fee	Limited to Core Saver medicine list (formulary) for PMB conditions and paid as follows: • 100% of the Scheme's Maximum Medical Aid Price (MMAP) for Bankmed Network GPs (DSPs) or Bankmed Pharmacy Network (DSP) • 80% of Scheme's Maximum Medical Aid Price (MMAP) for non-DSPs • 100% of cost for medication via non-DSP (involuntary use of a non-DSP)	Limited to R18 700 pbpa and paid as follows: • 100% of the Scheme's Maximum Medical Aid Price (MMAP) for Bankmed Network GPs (DSPs) or Bankmed Pharmacy Network (DSP) • 80% of Scheme's Maximum Medical Aid Price (MMAP) for non-DSPs • 100% of cost for medication via non-DSP (involuntary use of a non-DSP) Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations	Limited to R20 250 pbpa (Insured Benefits) and paid as follows: • 100% of the Scheme's Maximum Medical Aid Price (MMAP) for Bankmed Network GPs (DSPs) or Bankmed Pharmacy Network (DSP) • 80% of Scheme's Maximum Medical Aid Price (MMAP) for non-DSPs • 100% of cost for medication via non-DSP (involuntary use of a non-DSP) Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations	Limited to R24 150 pbpa (Insured Benefits) and paid as follows: • 100% of the Scheme's Maximum Medical Aid Price (MMAP) for Bankmed Network GPs (DSPs) or Bankmed Pharmacy Network (DSP) • 80% of Scheme's Maximum Medical Aid Price (MMAP) for non-DSPs • 100% of cost for medication via non-DSP (involuntary use of a non-DSP) Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations

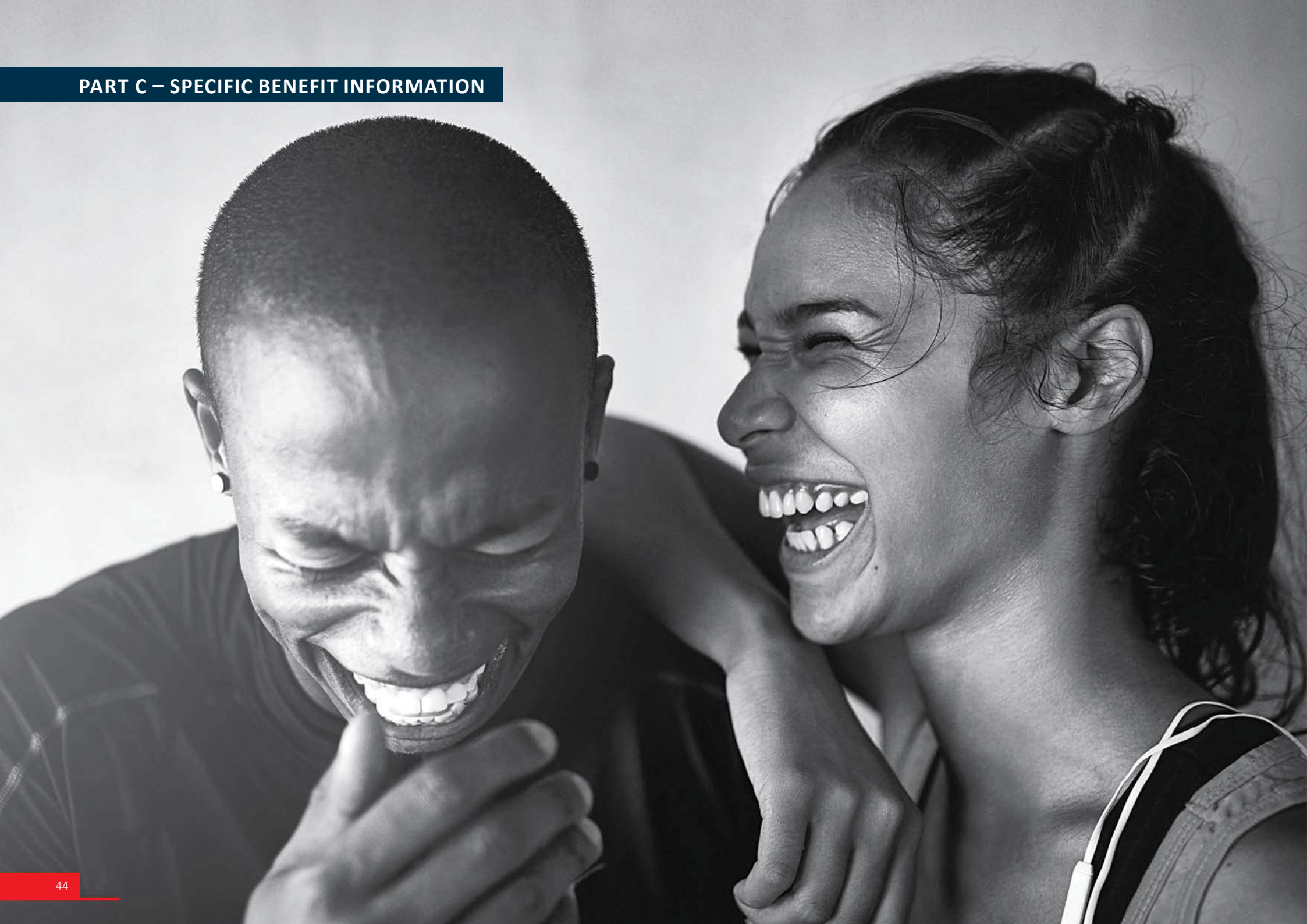
		ESSENTIAL PLAN 2018	BASIC PLAN 2018	CORE SAVER PLAN 2018	TRADITIONAL PLAN 2018	COMPREHENSIVE PLAN 2018	PLUS PLAN 2018
37.5	**Biologics and High-cost Specialised Medication** (utilised in the management of PMB CDL and Non-PMB chronic conditions) Includes all off-label drugs (request for a drug not registered for the condition by the Medicines Control Council (MCC) and all Section 21 drugs (drugs not registered by MCC for use in SA).	PMB only	PMB only				
	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	No benefit	70% of Scheme Rate	100% of Scheme Rate	100% of Scheme Rate
		Subject to PMB regulations	Subject to PMB regulations	Subject to PMB regulations	Subject to PMB regulations	Subject to PMB regulations	Subject to PMB regulations
38	PLAN SPECIFIC INFORMATION						
38.1	**CORE SAVER MEDICINE LIST (FORMULARY) FOR PHARMACY ADVISED THERAPY (PAT)**						

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 medicine list (formulary) for PAT) for the following conditions and up to the specified number of incidents per beneficiary per annum, on pharmacist's recommendation (PAT) only. Visit www.bankmed.co.za, select "2018 Plan Information" and then "Medicine Formularies 2018" to view the Core Saver medicine list (formulary) for PAT - non-formulary drugs and other acute medication subject to available Medical Savings Account.

CONDITION	INCIDENTS COVERED	CONDITION	INCIDENTS COVERED
Abdominal pain/dyspepsia/heartburn/indigestion (includes reflux)	2	Upper respiratory and lower respiratory tract infections	2
Helminthic (worms) infestation	2	Gastroenteritis	2
Conjunctivitis, bacterial	2	Urticaria, insect bites and stings	2
Topical candidiasis (topical thrush)	2	Urinary tract infection	2
Oral candidiasis (oral thrush)	2	Treatment of wounds and/or infection of the skin/subcutaneous tissues (excluding post-operative wound care)	2
Headache - analgesia	2		

PART C – SPECIFIC BENEFIT INFORMATION



HOSPITAL ADMISSION GUIDELINES

Important information to note when being admitted to hospital

Being admitted to hospital can be stressful. We hope that by sharing this information with you, we can help you plan your admission.

Hospital pre-authorisation

You must get authorisation before you are admitted to hospital for a planned procedure. Contact us for pre-authorisation as soon as you and your Healthcare Professional have agreed on a date for admission by:


calling 0800 BANKMED (0800 226 5633)


sending an e-mail to treatment@bankmed.co.za or


sending a fax to 021 527 1928

If your Healthcare Professional obtains authorisation on your behalf, it is essential that you ensure that you obtain all the information about the authorisation from the Healthcare Professional. This will include information about what will and will not be covered, any co-payments or deductibles and possible shortfalls. Bankmed cannot be held liable for information not shared with members by their Healthcare Professionals.

If you are admitted to hospital in case of an emergency, please contact us for authorisation within 48 hours.

Ask your treating Healthcare Professional for the following information and have it at hand when calling 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 that will be used

We send an authorisation letter directly to the hospital and to the member as soon as the admission is approved and we will send you an SMS with pre-authorisation details if we have your cellphone number.

Pre-authorisation is not a guarantee of payment

When we give you pre-authorisation, we confirm that your hospital admission meets our clinical protocols for funding. It does not guarantee we will cover all the costs related to the hospitalisation as this depends on your Plan's limits. Always check your Plan limits in the benefit schedule and call us on 0800 BANKMED (0800 226 5633) for benefit confirmation if you are unsure.

Upfront payment (deductible) when you are admitted to hospital

You may have to pay an amount upfront when you are admitted to a hospital or a day clinic for certain procedures. You don't have any upfront payments for emergency admissions, re-admissions within six weeks of discharge or childbirth.

If you have an upfront payment, you will only have to pay one deductible for each admission. However, we calculate the upfront payment according to the highest deductible for the admission.

Refer to the section on Deductibles in this Benefit and Contribution Schedule for more information.

How we pay your treating Healthcare Professional?

The benefits (rate of cover and limits) to which you are entitled are set out in the Benefit and Contribution Schedule.

Always discuss costs with the treating Healthcare Professional and ask if they charge the Scheme Rate. If they charge more than the Scheme Rate, you have to pay the difference.

Ask whether other Healthcare Professionals (such as an anaesthetist or an assistant) will be involved in your treatment and if they charge the Scheme Rate.

If you negotiate tariffs upfront, you can avoid unexpectedly having to pay a large amount yourself.

We pay a lower fee if more than one procedure is done while under one anaesthetic.

Industry guidelines require that Healthcare Professionals charge lower fees for second and subsequent procedures performed under one anaesthetic, than they would charge when performing these procedures individually. Your treating Healthcare Professional is aware of these guidelines and should follow them. Ask them to go through any planned charges with you before the procedure and discuss the cost. Make sure that you are not billed the full amount if you are having more than one procedure under one anaesthetic.

Ensure your contact details are updated at all times

We send pre-authorisation letters to the provider and to the member directly when pre-authorisation is granted. We send the pre-authorisation letters directly to your dependant if the dependant is aged 18 years or older.

Please ensure that your e-mail address is updated with us at all times. Please also ensure that we have been provided with your dependant's e-mail address if they are aged 18 years and older. These letters contain important information about what will and will not be covered by Bankmed.

Bankmed cannot be held liable for any consequence resulting from lack of receipt of letters by members and/or their dependants when contact details were not updated for correspondence and confirmation purposes.

Discharge planning

While you are in hospital, your Healthcare Professional and the hospital stays in contact with us to ensure we have updates to your authorisation if your treatment plan changes. A case manager also helps you with leaving hospital if you need rehabilitation in another setting, such as a step-down facility, or if you need home nursing. Cover for step-down facilities and/or home nursing depends on the available benefits on your Plan.

COVER FOR EMERGENCIES

Your benefits also include cover for medical emergencies in South Africa.

What to do in an emergency?

In an emergency, call Discovery 911 on **0860 999 911**. This number is on your membership card so you always have it on hand. We suggest you save it on your cellphone under "medical aid emergency" too.

Emergency services

Discovery 911 offers real-time emergency care for all Bankmed members. This number is available 24 hours a day, seven days a week for any emergency calls. The line is managed by highly qualified emergency personnel who assess each case and provide immediate feedback and assistance. If you require medically equipped transport in South Africa, Discovery 911 will send emergency transport, such as an ambulance or helicopter, to take you to hospital. We will cover the costs from your Hospital Benefit, whether you are admitted to hospital or not. You may go to any private hospital in an emergency. If you are admitted to hospital we cover your emergency hospital admission. There is no overall limit for hospital cover on your Plan.

Calling from outside South Africa

If you are outside the borders of South Africa call **+27 11 529 6616** in an emergency or if you have any questions. Note: This line is only for international callers. We advise that you save this number on your mobile device to have immediate access in case of an emergency.

MATERNITY

Baby-and-Me Programme

Baby-and-Me is Bankmed's maternity programme that provides expecting moms and their partners with information. The Baby-and-Me Programme is only available to members on the Core Saver, Traditional and Comprehensive Plans. Members on the Plus Plan don't qualify for the additional Insured Benefits.

Benefits of joining

Expecting moms have to register on the Baby-and-Me Programme for additional cover from Insured Benefits during pregnancy for services such as ultrasounds and additional consultations. A Client Relationship Manager will help you to register for the programme and give you advice throughout your pregnancy and after the birth of your baby.

When you register, you will receive:

- A Bankmed baby hamper*
- Regular communication at different milestones throughout your pregnancy
- Assistance with hospital pre-authorisation
- A hospital checklist to prepare you for your hospital stay

How to join?

You have to complete the ***Baby-and-Me*** application form to register with the programme:

0800 BANKMED (0800 226 5633)

babyandme@bankmed.co.za

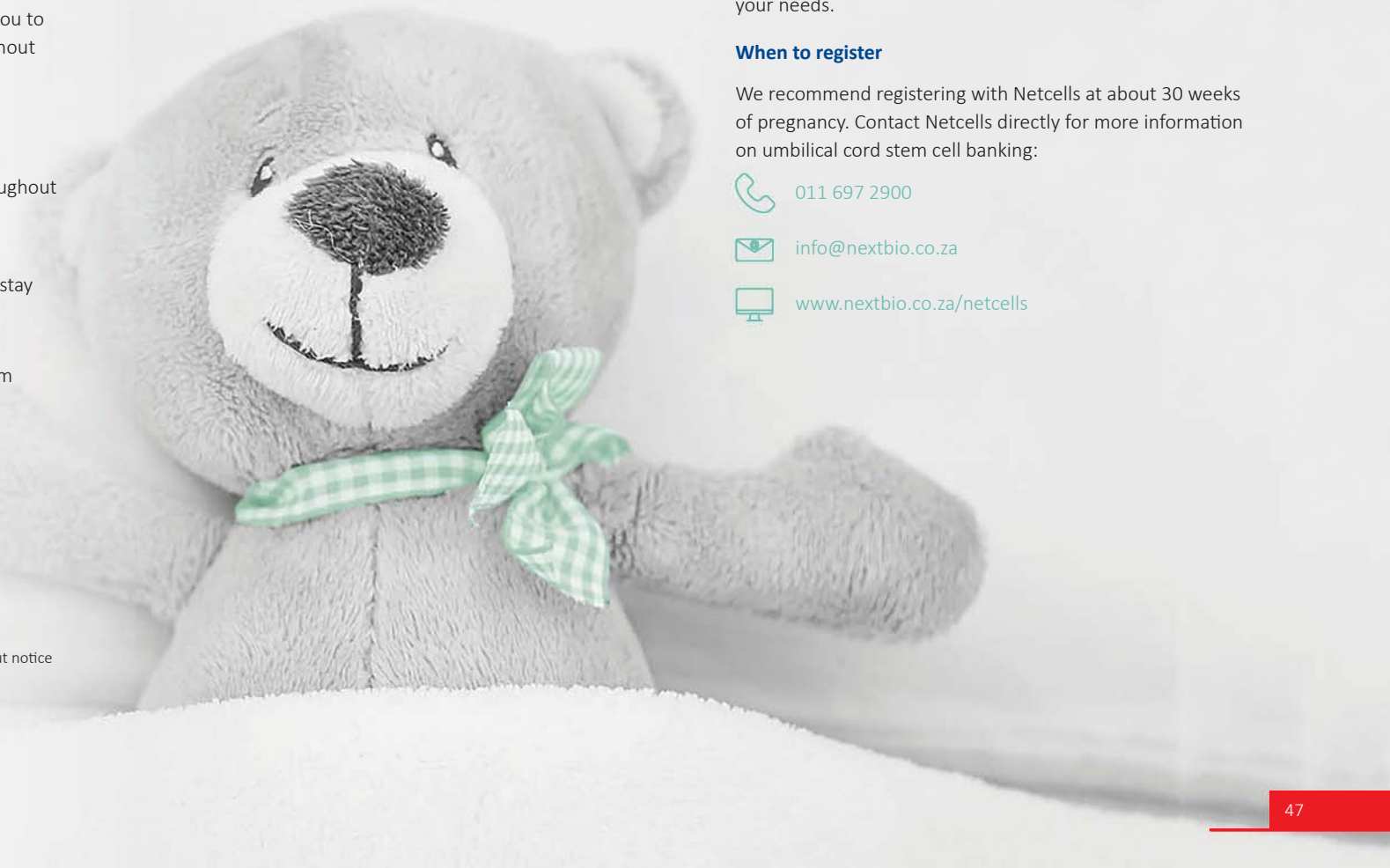
www.bankmed.co.za

*The contents of the Bankmed baby hamper may be substituted without notice as supply is dependent on stock availability.

Discount on stem cell banking with Netcells

Bankmed members have access to a discount at Next Biosciences, Africa's leading Biotech Company that combines medication, science and technology to create innovative products and services, enabling you to invest in your future health. Expecting parents can have their newborn's umbilical cord blood and tissue stem cells collected and cryogenically stored for potential future medical use.

Please note that we don't pay for this service. Bankmed passes the cash discount directly on to you.



You can get up to 25% off the stem cell banking fee when you register to store your baby's stem cells with Netcells. The discount applies to the Netcells banking fee and the amount depends on the payment plan you choose:

- **25%** discount on payment upon registration
- **20%** discount on payment on stem cells being successfully banked or
- **15%** discount on a payment plan

Netcells offers flexible storage options and flexible interest free payment plans, allowing you to tailor-make a plan to suit your needs.

When to register

We recommend registering with Netcells at about 30 weeks of pregnancy. Contact Netcells directly for more information on umbilical cord stem cell banking:

011 697 2900

info@nextbio.co.za

www.nextbio.co.za/netcells

CHRONIC ILLNESS BENEFIT

Cover for chronic conditions

The Chronic Illness Benefit gives cover for medication if you have a listed condition for which you have to take medication for three months or longer. You have cover for 25 conditions (including HIV and AIDS) on the Chronic Disease List.

You have to register on the Chronic Illness Benefit and meet our clinical criteria before you can start claiming for chronic medication. To apply, your Healthcare Professional must complete a ***Chronic Illness Benefit*** application form and send it to us.

How to manage your chronic condition?

As a member on the Core Saver, Traditional, Comprehensive or Plus Plan, you have access to Medicine Advisory Services. Bankmed Medicine Advisory Services aims to provide you with a structured way to achieve the desired results from medication use, especially with chronic medication.

Bankmed Medicine Advisory Services provides an efficient pre-authorisation process for chronic medication users, which combines advanced technology with pharmacological and medical expertise. Contact Medicine Advisory Services to register for, change, or update your chronic medication. Applications for medication are assessed in accordance with clinical guidelines and evidence-based medicine.

How to apply for chronic medication?

To obtain authorisation for your chronic medicine ask your Healthcare Professional or pharmacist to call Bankmed's Chronic Managed Care Department on 0800 132 345 or 0800 BANKMED (0800 226 5633). Your condition has to meet the clinical entry criteria and we may ask for proof that you meet the criteria.

Your Healthcare Professional can complete the ***Chronic Illness Benefit*** application form and send it to us by:

Essential and Basic Plans

chronicbasicessential@bankmed.co.za

011 539 7000

ONCOLOGY

Cover for cancer

If you are diagnosed with cancer, you have access to cover through the Oncology Programme once we approve your cancer treatment.

On the Essential, Basic and Core Saver Plans, cover for approved cancer treatment is limited to Prescribed Minimum Benefits (PMBs) only, subject to pre-authorisation.

On the Traditional, Comprehensive and Plus Plans, cover for approved cancer treatment is unlimited, subject to pre-authorisation.

Chemotherapy, radiotherapy and other healthcare services payable from the Oncology Programme are subject to evidence-based medication, cost effectiveness and affordability.

If the healthcare service does not meet the Scheme's criteria, it will not be funded by the Scheme. Bankmed's Oncology Programme follows the South African Oncology Consortium's guidelines to make sure you have access to the most appropriate level of treatment for the particular stage of your cancer.

How to register on the Oncology Programme?

Register for the Oncology Programme by:

0800 BANKMED (0800 226 5633)

oncology@bankmed.co.za

011 539 5417

HIV and AIDS

Cover for HIV and AIDS

For members living with HIV and AIDS, Bankmed's HIV Programme provides comprehensive disease management.

We take the utmost care to protect your right to privacy and confidentiality. When you register on our HIV Programme you are covered for the all-inclusive care that you require. You will have access to clinically-sound and cost-effective treatment and you are assured of confidentiality at all times.

We cover approved medication on our medicine list (formulary) in full. We cover medication not on our list up to a set monthly amount.

You need to obtain your medication from a Designated Service Provider to avoid having to pay part of the cost yourself.

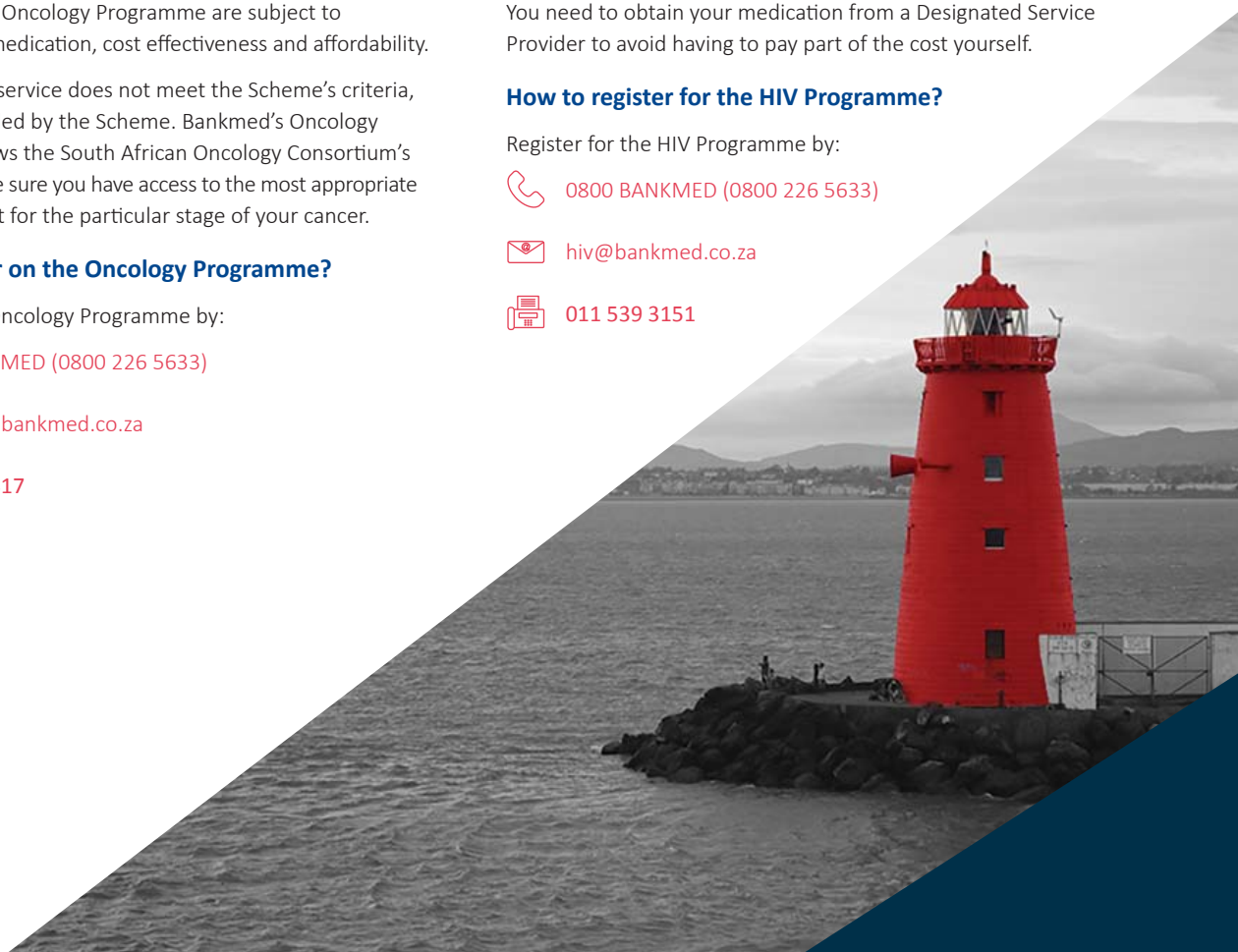
How to register for the HIV Programme?

Register for the HIV Programme by:

0800 BANKMED (0800 226 5633)

hiv@bankmed.co.za

011 539 3151



PRESCRIBED MINIMUM BENEFITS (PMBs)

What you need to know about Prescribed Minimum Benefits (PMBs)?

According to the Medical Schemes Act 131 of 1998, all medical schemes must cover the costs of Prescribed Minimum Benefits (PMBs) as long as the member meets the clinical entry criteria, follows the prescribed treatment and uses a Network Provider, sometimes called a Designated Service Provider (DSP). **PMBs only apply within the borders of South Africa.**

What are Prescribed Minimum Benefits (PMBs)?

PMBs are a set of defined benefits that make sure that all medical scheme members have access to certain minimum health services, regardless of their Plan. Medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- Any life-threatening emergency medical condition
- A limited set of 270 medical conditions (defined in the Diagnosis Treatment Pairs)
- 25 chronic conditions (defined in the ***Chronic Disease List***)

Criteria for full Prescribed Minimum Benefit cover

There are three criteria for full cover:

1. *Your condition must be on the PMB lists*
2. *You must use Formularies and the treatment provided for in the Basket of Care*

   There are limits and conditions to cover. You must use medication from our medicine list to avoid any out of pocket expenses.

3. *You must use our Designated Service Providers for full cover*

   A Designated Service Provider is a Healthcare Professional we have a payment agreement with. You may use a non-Designated Service Provider, but this may mean you have to pay part of the claim yourself.

   If you are in hospital, we fund claims if you obtained the necessary pre-authorisation.

Is my condition covered?

A ***life-threatening emergency medical condition*** is the sudden and unexpected start of a health condition that needs immediate treatment or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death. In an emergency, it is not always possible to know if the medical condition is life-threatening. Bankmed may request that the diagnosis be confirmed with supporting evidence within a reasonable period of time.

A Healthcare Professional must diagnose you with a condition on ***the list of 270 PMB diagnoses***. For us to cover you, your Healthcare Professional must use the correct ICD 10 code for the condition.

We cover ***chronic conditions*** through our Chronic Illness Benefit. If you are diagnosed with a chronic PMB condition, you have to register before you have access to its cover. If you don't register, we will cover your treatment from your day-to-day benefits.

The **Chronic Disease List (CDL)** specifies medicine and treatment for the 25 chronic conditions that are covered in this section of the PMBs:

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disease
- Chronic renal disease
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus types 1 & 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

For more info on PMBs, visit www.medicalschemes.com and click on Prescribed Minimum Benefits under Quick Links.

How Bankmed pays for Prescribed Minimum Benefits (PMBs)?

We pay for the cost of the diagnosis, treatment and care of PMBs in South Africa. We pay for PMBs in full from your Insured Benefit if you follow the three criteria for full cover. We always pay for emergency medical treatment, even if you use a non-Network Provider.

If it is not a medical emergency, a Network Provider is available and you use a non-Network Provider, we cover the diagnosis, treatment and care of PMBs at the Scheme Rate.

At Bankmed, these PMBs are subject to pre-authorisation, clinical protocols and registering for Managed Care Programmes. This means you ***must apply for these benefits*** or we pay for treatment from your day-to-day benefits. After you reach your sub-limit for chronic medication, we only provide funding for medicine as a PMB.

Please refer to the Visual Overview of each Plan for a list of Network Providers. Visit www.bankmed.co.za and select ***Network Providers*** to find a DSP near you.

Kindly note:

- Claims for services that would have qualified as PMBs in South Africa but are obtained outside the borders of South Africa, are treated as ordinary claims and payment depends on your Plan's benefits
- Pre-authorisation, medicine lists (formularies) and Scheme protocols apply for PMB cover
- We only pay diagnosis costs as a PMB if the diagnostic investigation confirms a PMB diagnosis
- When this schedule sets out insured limits, we pay relevant claims (including PMBs) up to the limit. When you reach the limit, we only fund PMBs if they meet the criteria for PMB cover
- As per the Council for Medical Schemes directive, Medical Schemes are not allowed to pay any PMB claims from members' Medical Savings Account
- Even if we usually fund a benefit as "payable from Medical Savings Account" or as "no benefit" in this schedule, we still pay for PMBs as long as members meet the criteria for PMB cover

What if I cannot use a Network Provider?

In a medical emergency, you may go straight to the nearest hospital. Otherwise, you should find a Healthcare Professional in our Network or find out if your Healthcare Professional is in our Network before you visit them.

There are two other situations in which you may be forced to (involuntarily) use the services of a non-network Healthcare Professional. For us to pay as a PMB, you must first get pre-authorisation so we can confirm if an exception applies to you:

- The service is not available from a Network Provider or cannot be provided without reasonable delay and/or
- You need immediate medical or surgical treatment for a PMB condition and the circumstances or location reasonably prevent you from using a Network Provider, or no Network Provider is within reasonable proximity to your home or work address

SAVE YOUR MEDICINE BENEFITS AND MAKE YOUR RAND GO FURTHER

What we do to help you save costs

As chronic and acute medication can be very expensive, it is important to ensure that your benefits are used wisely. We have a few tips to help you save your benefits.

What is chronic medication?

Chronic medication refers to medication you have to use on a continuous basis over an extended period of time to control life-threatening conditions, such as high blood pressure or asthma. This differs from acute medication, which is medication prescribed to treat a single incidence of an illness, such as colds and flu.

What is generic medication?

Generic medication is merely a 'copy' of the original brand-name medication. They are chemically identical to their brand-name equivalents in dosage, strength, quality, performance characteristics and intended use.

The only differences are that generics may look different and are more cost-effective than branded medication. Remember that generics are not equally priced. Some generics are more cost-effective than others. Ask your pharmacist or Healthcare Professional for the more cost-effective generic when claiming, to avoid any out of pocket expenses.

Tips for extending your benefits

When applications for chronic medication are reviewed, Bankmed may recommend substitution of the prescribed medication with a cost-effective generic alternative to ensure you have the best cover. In this case, it is important to note that no changes to your medication will be implemented if your Healthcare Professional has not agreed to a generic substitution.

For members on the **Essential and Basic Plans,** generic medication is subject to a prescribed formulary. Please check with your Healthcare Professional that it is on the formulary.

Members on the **Core Saver, Traditional, Comprehensive or Plus Plans** may also have a co-payment for generic medication. Please consult your Healthcare Professional.

MEDICAL SAVINGS ACCOUNT (MSA)

Which Plan has a MSA?

Members on the Core Saver, Comprehensive and Plus Plans have access to an MSA.

What is a Medical Savings Account (MSA)?

The MSA is an upfront benefit we provide you with at the beginning of the year. This amount is pro-rated by the number of months remaining if you join after 1 January. You may use your MSA to pay for day-to-day medical costs like Healthcare Professional visits, x-rays and dentist visits. Legislation prevents Bankmed from funding PMBs from your Medical Savings Account even when requested by you. This advanced amount will be paid back by you as part of your monthly contribution to the Scheme. The money in your MSA that you haven't used by the end of the year is carried over to the following year.

How can you manage your MSA so you and your family can enjoy the benefits for the whole year?

Pace yourself

Work out a budget just as you would with a savings account at the bank. Know how much you have available for the year, and plan important check-ups over the course of the year. Use pharmacies or clinic services that offer free blood pressure tests or administration of flu shots (covered from your Insured Benefit so you don't use the funds in your Medical Savings Account).

Choose medication wisely

According to the International Generic Pharmaceutical Alliance, generics can be between 20 and 90 percent cheaper than non-generic brands. When you fill your prescription, ask the pharmacist if a generic is available. Remember to ask for cost-effective generics as they vary in cost.

You can also save by only using one medication to treat a condition. For example, if you have a runny nose, congestion and headache, ask your pharmacist if there is a single medication to relieve all your symptoms.

Stay healthy

A healthy lifestyle and diet, and regular exercise go a long way to ensuring wellbeing. Cut back on bad habits like smoking to improve your overall health. The first step to improving your health is to have a Personal Health Assessment to identify health risks.

Visit www.bankmed.co.za for more information.

We offer preventative and screening benefits that include health tests, screenings and vaccinations to prevent and manage diseases. This is paid from your Insured Benefits so they don't affect your MSA balance.

Contact us

If you have any questions about your MSA or Plan benefits, visit www.bankmed.co.za where you have access to your MSA balance and your claims.

ANNUAL THRESHOLD (AT) AND THE ABOVE THRESHOLD BENEFIT (ATB)

Plus Plan members only

The Above Threshold Benefit (ATB) acts as a safety net if you run out of funds in your Medical Savings Account during the year. It is an Insured Benefit, which can only be accessed when claims paid from the Medical Savings Account reach a specific level, known as the Annual Threshold.

Claims paid from the Medical Savings Account accumulate to the Annual Threshold at 100% of the Scheme Rate. If your Healthcare Professional charges more than the Scheme Rate, you run the risk of running out of funds in your Medical Savings Account before reaching the Annual Threshold and you may end up with a Self-payment Gap.

If this happens, you must continue to submit your claims to Bankmed even if no benefits are available. The claims will continue to add up to the Annual Threshold. As soon as you reach the Annual Threshold, the Above Threshold Benefit will kick in and you will have limited Insured Benefits available to pay further out-of-hospital claims. You can make your Medical Savings Account last longer and avoid a Self-payment Gap by visiting a Healthcare Professional that charges fees that are in line with the Scheme Rate.

Please note that there are limits to the amounts that can accumulate towards the Annual Threshold and be paid from the Above Threshold Benefit for certain categories, including, but not limited to:

- Prescribed acute medicine (medicine you have to take for a limited time)
- Dentistry claims (including preventative and basic dentistry, advanced dentistry and all other dental services), and
- Optometry consultations, prescription lenses and readymade readers, contact lenses, fitting of contact lenses and other optometric services such as refractive surgery

Although the maximum amount that can accumulate towards the Annual Threshold and be covered from the Above Threshold Benefit for these claims may be higher than your Above Threshold Benefit, the amount funded from the Above Threshold Benefit for these claims can never be more than the total Above Threshold Benefit available for your family.

DEDUCTIBLES THAT APPLY WHEN YOU ARE ADMITTED TO HOSPITAL OR A DAY CLINIC

A deductible is an upfront payment that you need to make if you are admitted to a hospital or day clinic for certain procedures. The Benefit Tables briefly outline the deductibles applicable per Plan type. This section of the Benefit and Contribution Schedule sets out the detail in respect of deductibles that may be applicable to you.

A beneficiary will be 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 whether the procedure attracting the deductible is the primary reason for the admission or not. There are other instances where the deductible does not apply and we have set this out later in this section. Except where provided for in the Prescribed Minimum Benefits, a Deductible will apply under the following circumstances:

1. DEDUCTIBLE APPLICABLE TO USE OF A NON-DSP FACILITY

A deductible will apply to all beneficiaries on the below Plans when the beneficiary chooses to utilise a Non-DSP facility (both hospital and day clinics). The deductible applies upfront and will need to be settled at the facility prior to admission.

Applicable to Basic, Core Saver, Comprehensive and Plus Plans	Applicable to Traditional Plan
Member to fund the specified deductible upfront upon admission:	Member to fund the specified deductible upfront upon admission:
PMB admission: involuntary use of non-DSP No deductible	**PMB admission: involuntary use of non-DSP** No deductible
PMB admission: voluntary use of non-DSP (deductible applies to all admissions) Day clinic: R227 per admission Hospital: R570 per admission	**PMB admission: voluntary use of non-DSP (deductible applies to all admissions)** Day clinic: R227 per admission Hospital: R4 750 per admission
Non-PMB admission Day clinic: R227 per admission Hospital: R570 per admission	**Non-PMB admission** Day clinic: R227 per admission Hospital: R4 750 per admission

2. DEDUCTIBLE APPLICABLE TO A SPECIFIC LIST OF TREATMENT/PROCEDURES CARRIED OUT IN A DAY SURGERY NETWORK

Applicable to Basic, Core Saver, Traditional, Comprehensive and Plus Plans. Deductible applicable to the Essential Plan in so far as PMB admissions are concerned.

The following conditions/procedures will NOT attract a deductible at a Day Surgery Network (list of conditions/procedures applies to DSP only):

1. Adenoidectomy
2. Arthrocentesis
3. Cataract Surgery
4. Cautery of vulva warts
5. Circumcision
6. Colonoscopy
7. Cystourethroscopy
8. Diagnostic D and C
9. Gastroscopy
10. Hysteroscopy
11. Myringotomy
12. Myringotomy with intubation (grommets)
13. Nasal cautery
14. Nasal plugging for nose bleeds
15. Proctoscopy
16. Prostate biopsy
17. Removal of pins and plates
18. Sigmoidoscopy
19. Tonsillectomy
20. Treatment of Bartholins cyst/gland
21. Vasectomy
22. Vulva/cone biopsy

If the member chooses to have the abovementioned procedures/treatments performed in a non-network Day Surgery facility or in a hospital, the member will be liable for a R1 500 deductible per admission.

Essential Plan members do not have access to the full list of treatments/procedures listed above as cover is limited to PMB cover. In the event that an Essential Plan member elects to have the procedure performed, and the underlying diagnosis is a PMB diagnosis, then the member qualifies for the treatment. However if the listed procedure is performed in a non-network Day Surgery facility, or in a hospital, the member will be liable for a R1 500 deductible per admission.

Other hospitals (non-DSPS)

If the member has the listed procedure/treatment performed in a hospital or non-DSP day surgery facility, the deductible applies as follows:

PMB admission: involuntary use of a non-DSP:	No deductible
PMB admission: voluntary use of non-DSP:	R1 500 deductible per admission
Non-PMB admission:	R1 500 deductible per admission

Deductible payable on admission.

3. DEDUCTIBLE APPLICABLE TO DENTAL ADMISSIONS TO PRIVATE HOSPITALS AND DAY CLINICS

A deductible will apply to all beneficiaries on the below Plans when the beneficiary is admitted to hospital or a day clinic for dental treatment. The deductible applies upfront and will need to be settled at the facility prior to admission.

Applicable to Traditional, Comprehensive and Plus Plans	
Member to fund the specified deductible upfront upon admission:	
Day clinic:	R227 per admission
Hospital:	R1 690 per admission

4. DEDUCTIBLE APPLICABLE TO A SPECIFIC LIST OF TREATMENT/PROCEDURES PERFORMED IN HOSPITAL NETWORK DSPS

A deductible will apply to all beneficiaries on the below Plans when the beneficiary obtains treatment for the specified treatment/procedures set out below. The deductible applies when the beneficiary is admitted to hospital or a day clinic that falls within the list of DSP/network providers. The deductible applies upfront and will need to be settled at the facility prior to admission.

The following conditions/procedures will always attract a deductible at a hospital/day clinic (list of conditions/procedures applies to DSP only):

1. Oesophagoscopy
2. Simple abdominal hernia repair

Applicable to Basic, Core Saver, Traditional, Comprehensive and Plus Plans Hospital Network DSPs	
Member to fund the specified deductible upfront upon admission:	
Day clinic:	R227 per admission
Hospital:	R570 per admission

5. GENERAL INFORMATION ABOUT DEDUCTIBLES

Deductibles are payable in respect of all hospital admissions except under the following circumstances:

a. Prescribed Minimum Benefit conditions where admission to a non-DSP is on an involuntary basis. In the case of other PMB conditions, where a non-DSP has been used on a voluntary basis, the deductible will be applied.

b. Confinements are excluded from deductibles.

c. Re-admissions to hospital within 6 weeks of discharge following complications directly related to a prior admission in respect of which a deductible was levied.

d. Admissions to a State Hospital.

e. Authorised day clinic admissions for specified procedures, as communicated to members from time to time.

If you have an upfront payment, you will only have to pay one deductible for each admission. However, we calculate the upfront payment according to the highest deductible for the admission.

For example:

a. A Traditional Plan member going to a non-network hospital for dental treatment will pay R4 750 upfront for not using a network hospital as this is more than the dental upfront payment.

b. A Comprehensive Plan member going a non-network hospital for dental treatment will pay R1 690 upfront for the dental procedure as this is more that the non-network upfront payment.

PART D – CLAIMING PROCESSES AND FINDING A HEALTHCARE PROFESSIONAL

CLAIMS PROCESS

Details when submitting your claims

- You must submit your claim within four months from the date of service. We consider claims older than this stale and as a result the claim will not be settled
- Make sure your membership number and the 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, to process your claim quickly and accurately

How to claim

Using the Bankmed App

Download the Bankmed App and:

- Use the camera on your smartphone to take a photo of the claim and submit it via the App or
- Use your smartphone to scan the QR code on the claim provided by your Healthcare Professional (for those claims that contain QR codes)

Visiting the Bankmed website

Log on 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

By sending us an e-mail

your scanned claims to claims@bankmed.co.za

DIGITAL TOOLS

When you're at the Healthcare Professional – Electronic Health Record (EHR)

Bankmed's Electronic Health Record (EHR) allows your Healthcare Professional to access your health records. This gives your Healthcare Professional your medical information at their fingertips so they have all the information to make better decisions about your healthcare. 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

You must give consent to Healthcare Professionals to view your confidential medical information. Your personal information is protected and will only be viewed by Healthcare Professionals who have been given consent by you.

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. Your consent also confirms that you understand how we protect your confidential information and how we comply with laws governing confidential information.

For Bankmed to have the correct information to cover treatment for your condition, your Healthcare Professional may have to share information about your treatment with Discovery Health, our administrator. Therefore, your consent confirms you agree to this exchange of information and you understand the terms and conditions.

How to give consent

Bankmed App

On the **Health** tab in the Bankmed App, select **Doctor(s) Consent** to provide consent.

Bankmed website

Log in to *www.bankmed.co.za* / **YOUR DETAILS** /

Bankmed App and your digital card

The Bankmed App gives you access to all your medical scheme information and your digital membership card. You can use your digital membership card as proof of membership for service providers.

FIND A HEALTHCARE PROFESSIONAL

To find a Healthcare Professional we have a “Maps advisor tool” available to help you locate a HealthCare Professional or hospital closest to you and the area you prefer. It also gives you the option to select a specific treating Healthcare Professional e.g. Orthodontist.

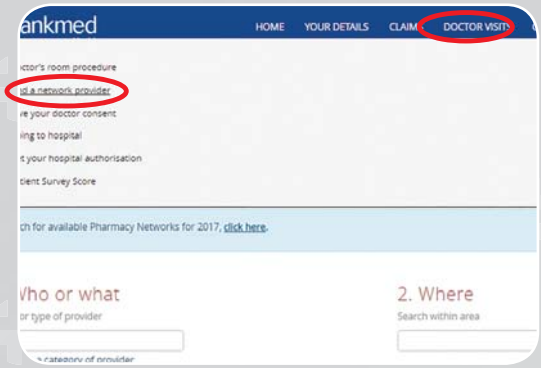
STEP 1: Drop down the Doctor visits navigation item and click find a Network Provider

STEP 2: You will need to add information on **Who/What** and **Where** you would like to be treated

STEP 3: Once you have selected your provider, you will have to indicate whether your consultation will be out-of-hospital or in-hospital and whether you would prefer to generate providers with maximum/full cover

STEP 4: A list of providers will appear on your screen and you will be able to see how you are covered for each provider

STEP 5: Select your preferred Network Provider



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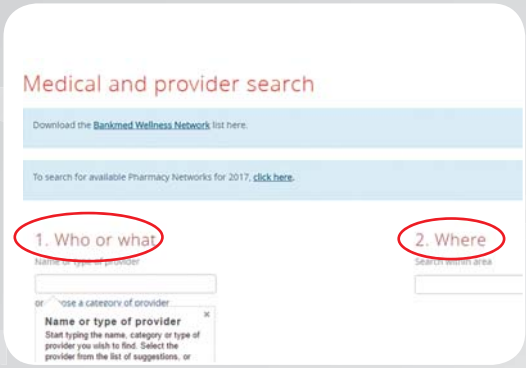
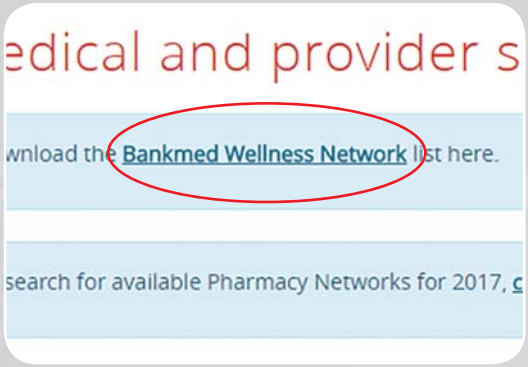
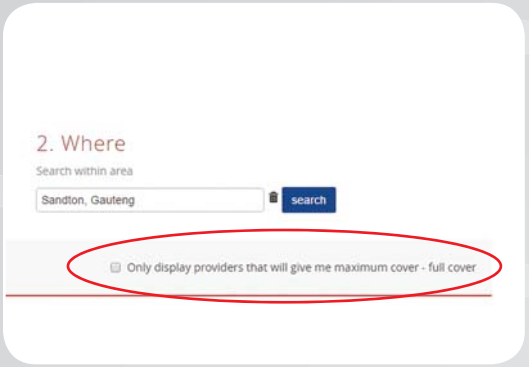
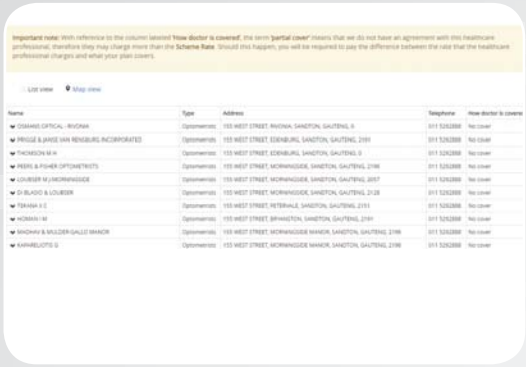


STEP 2: You will need to add information on Who/What and Where you would like to be treated







STEP 3: Once you have selected your provider, you will have to indicate whether your consultation will be out-of-hospital or in-hospital and whether you would prefer to generate providers with maximum/full cover

STEP 4: A list of providers will appear on your screen and you will be able to see how you are covered for each provider

STEP 5: Select your preferred Network Provider

PART E - MANAGE YOUR MEMBERSHIP

CONTACT US

For emergency ambulance services, contact Discovery 911

Telephone: 0860 999 911

To obtain pre-authorisation for a hospital admission, MRI, CT scan or radionuclide scan

Telephone: (toll-free from a Telkom landline)
0800 BANKMED
(0800 226 5633)

Fax: 021 527 1928

E-mail: treatment@bankmed.co.za

To obtain authorisation for chronic medication (Medicine Advisory Services Programme)

Telephone: (toll-free from a Telkom landline)
0800 BANKMED (0800 226 5633)

Core Saver, Traditional, Comprehensive and Plus Plans
E-mail: chronic@bankmed.co.za
Fax: 011 770 6247
Your pharmacist may contact our Call Centre 0800 BANKMED (0800 226 5633)
Medical Professionals may call 0800 132 345 directly for Core Saver, Traditonal, Comprehensive and Plus Plans

Essential and Basic Plans
E-mail: chronicbasicessential@bankmed.co.za
Fax: 011 539 7000
Your pharmacist may contact our Call Centre 0800 BANKMED (0800 226 5633)

To submit a claim (remember to include your membership number and to ensure that all claims are legible)

E-mail: claims@bankmed.co.za

Fax: 021 527 1940

Post: Bankmed Claims, PO Box 1242, Cape Town, 8000

To find information on our Designated Service Providers (DSPs)

Website: www.bankmed.co.za (Select "Network Providers")

Bankmed App: (Select "Find a Healthcare Provider")

For customer service enquiries, requests or complaints

Telephone: (toll-free from a Telkom landline) 0800 BANKMED (0800 226 5633)

E-mail active employees: enquries@bankmed.co.za

Pensioners: pensioners@bankmed.co.za

Fax: 021 527 1926

Post: Bankmed Customer Services, PO Box 1242, Cape Town, 8000

For self-help enquiries

Try our easy-to-use App, telephonic or web-based facilities to obtain or request information and to update personal details without having to speak to an agent.
Telephone self-help facility 0800 BANKMED (0800 226 5633) - log in with your membership number and ID number**.**

Web based self-help facility www.bankmed.co.za - sign in with your username and password; if you haven't registered before you will be prompted to register the first time you sign in.
Bankmed mobi site m.bankmed.co.za
Bankmed Mobile App Download the Bankmed Mobile App to your Smartphone and follow the prompts. You may download the App from the different App stores, or visit the Bankmed website www.bankmed.co.za for instructions.

NB: If you have registered via the website you will need to use the same log in details for the Bankmed App

To register on our HIV/AIDS Programme (confidentiality guaranteed)

Telephone: (toll-free from a Telkom landline)
0800 BANKMED
(0800 226 5633)

To register on the Baby-and-me Programme

Telephone: (toll-free from a Telkom landline)
0800 BANKMED
(0800 226 5633)

Fax: 021 529 6485

E-mail: babyandme@bankmed.co.za

To register on the Oncology Treatment Programme

Telephone: (toll-free from a Telkom landline)
0800 BANKMED
(0800 226 5633)

Fax: 021 539 5417

E-mail: oncology@bankmed.co.za

To report fraud

Telephone: 0800 004 500
E-mail: bankmed@tip-offs.com

REPORTING FRAUD

Reporting fraud or malpractice

Be part of the solution. Take an active role in combating crime by reporting any fraudulent or unethical practice.

If you suspect any fraudulent behaviour relating to your healthcare cover, you may anonymously report this by using the following details:


0800 004 500


sms 43477


0800 007 788


bankmed@tip-offs.com


Freepost DN298, Umhlanga Rocks 4320

GENERAL EXCLUSIONS

What does Bankmed not cover (Scheme exclusions)?

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

- Operations, treatment and procedures for cosmetic purposes
- Sunscreens and tanning agents
- Travel expenses
- Accommodation in assisted living homes or similar institutions
- Sunglasses
- Accommodation and/or treatment in headache and stress-relief clinics
- The cost of holidays for recuperative purposes (for example spas and health resorts)
- Telephone consultations with medical practitioners
- 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

For a complete set of Scheme exclusions, please log into www.bankmed.co.za and select ABOUT US, Registered Rules and Exclusions (Annexure C).

COMPLAINTS AND DISPUTES

Although legislation provides that all complaints submitted in writing must be responded to within 30 days, we always to try to respond much sooner.

If you have given us a reasonable chance to address any concerns raised and feel that you have been treated unfairly by us in any way, you may lodge a formal complaint with the Council for Medical Schemes, as follows:


0861 123 267 (sharecall from a Telkom landline)


012 431 0500


012 430 7644


complaints@medicalschemes.com

Council for Medical Schemes
Block A
Eco Glades 2 Office Park
420 Witch-Hazel Avenue
Eco Park, Centurion
0157

Council for Medical Schemes
Private Bag X34
Hatfield
0028

Complaints can be submitted in writing to:

Complaints
Bankmed
PO Box 1242
Cape Town
8000

PRIVACY STATEMENT

The Privacy Statement (PS) explains how Bankmed and its administrator and Managed Care service provider (Discovery Health (Pty) Ltd) obtain, use, disclose and otherwise process personal information, which may include health and financial information (personal information), as required by the Protection of Personal Information Act (POPIA).

Application of requirements of the Protection of Personal Information Act ("POPI")

1.1 This Privacy Statement explains how Bankmed and its administrator and managed care service provider (currently Discovery Health (Pty) Ltd) (we/us) obtain, use, disclose and otherwise process personal information, which may include health and financial information ("Personal Information"), as required by the Protection of Personal Information Act ("POPIA"). Any other party, including the administrator and managed care service provider, that may have access to your Personal Information via Bankmed, is prohibited from using such information for any other purpose not approved by Bankmed. The administrator and managed care service provider, in particular, can only use the information strictly in compliance with the agreement between Bankmed and the administrator and managed care service provider.

1.2 Please note:

- We may amend this Notice from time to time. Please check our website periodically to remain informed of any changes;
- You have the right to object to the processing of your Personal Information;
- Should you believe that we have utilised your Personal Information contrary to applicable law, you shall first resolve any concerns with us. Should you not be satisfied with the process, you have the right to lodge a complaint with the Information Regulator, under POPIA.

1.3 Any information, including Personal Information relating to yourself and your dependants and/or beneficiaries, supplied to us or collected from other sources ("Your Personal Information") will be kept confidential.

- You confirm that when you provide us with your Personal Information, your dependant/s and/or beneficiaries have provided you with the appropriate permission to disclose their Personal Information to us for the purposes set out below and any other related purposes. In the event that you are providing information and signing consent on behalf of a minor (person younger than 18 years old) you confirm that you are a competent person and authorised do so on their behalf.

1.4 You agree to our processing and disclosing Your Personal Information in the following manner:

We may collect, collate, process, store and disclose your Personal Information:

- For the administration of your health plan;
- For the provision of managed care services to you or any dependant/s on your health plan;
- For the provision of relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s on your health plan;
- In the event of any member ceasing to be a member, any amount still owing by such member in respect of himself or his dependants shall be a debt due to the Scheme and recoverable by it. Therefore, for the provision of information to a contracted third party who performs a debt collection service to the Scheme, where you owe the Scheme an outstanding debt;
- To profile and analyse risk;
- For academic research only where this is specifically approved by Bankmed.

Examples of how this will happen includes:

a) Obtaining Your Personal Information from other relevant sources, including any entity that is related to the administrator, medical practitioners, contracted service providers, employers, credit bureaus or industry regulatory bodies ("Sources"), and further processing of such Information to consider your membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses. We may (at any time and on an ongoing basis) verify with the Sources that your Personal information is true, correct and complete. This, amongst other things, will allow the Scheme and the administrator (although to a limited extent) to ensure that a member is not a member of more than one medical scheme as this is prohibited by the Medical Schemes Act;

b) Communicating with you regarding any changes in your health plan, including your contributions or changes and enhancements to the benefits you are entitled to on the health plan you have selected;

c) Transferring your Personal Information outside the borders of the Republic of South Africa where appropriate, if you provide an e-mail address which is hosted outside the borders of South Africa, or for processing, storage or academic research (where such research is specifically approved by Bankmed). We will ensure that anyone to whom we pass your Personal Information agrees to treat your information with the same level of protection as we are obliged to;

d) Utilising external health specialists to assess or evaluate certain clinical information. Your Personal Information will be shared with such specialist/s in the event that you or your dependant/s are subject to such a clinical assessment.

1.5 If asked to do so, we will share your Personal Information with a third party if you have already given your consent for the disclosure of this information to such third party or if a contractual relationship exists in terms of which we are obliged to provide the information to such third party.

1.6 Should you wish to share your information for any other reason, we will do so only with your permission.

1.7 You have the right to request a copy of the Personal Information we hold about you. To do this, simply complete the 'Access Request Form' on www.bankmed.co.za/legal and specify what information you would like. We will take all reasonable steps to confirm your identity before providing details of your Personal Information. Please note that any such Data Subject Request may be subject to a payment of a legally allowable fee.

1.8 You have the right to contact and ask us to update, correct or delete your Personal Information. Bankmed and its administrator have the right to communicate with you electronically about any changes on your health plan, including your contributions or changes to the benefits you are entitled to on the health plan you have chosen.

1.9 You agree that we may retain your Personal Information until such time as you request us to destroy it (unless we are obliged by law to retain it, regardless of such request). Where we cannot delete your personal information, we will take all practical steps to depersonalise it.

1.10 Bankmed and its administrator and managed care service provider are required to collect and retain information in terms of the following legislation (amongst others):

- The Medical Schemes Act, 1998
- The Consumer Protection Act, 2008
- The Protection of Personal Information Act, 2013
- Electronic Communications and Transactions Act, 2002
- Promotion of Access to Information Act, 2000

Legislation specific to the administrator and managed care service provider only:

- Financial Advisory and Intermediary Services Act, 2002
- Companies Act, 2008

1.11 You agree that Bankmed and its administrator may transfer your personal information outside South Africa:

- if you give us an email address that is hosted outside South Africa; or
- for processing, storage or academic research, only where this is specifically approved by Bankmed; or
- to administer certain services, for example, cloud services.

When we share your information to administer certain services, we will ensure that any country, company or person that we pass your personal information to agrees to treat your information with the same level of protection as we are obliged to do in South Africa. Unless you specifically give us consent to share your personal information with such person (or company).

1.12 Bankmed may change this Privacy Statement at any time. The current version is available on the Bankmed website (www.bankmed.co.za). Scroll to the bottom of the webpage once you have logged in and select the "Legal" tab. Alternatively, you may click on this link to access the document: https://www.bankmed.co.za/assets/medical-schemes/bankmed/bankmed-fair-collections-notice-final.pdf

1.13 If you believe that Bankmed or its administrator have used your personal information contrary to this Privacy Statement, you have the right to lodge a complaint with the Information Regulatory, under POPIA, but we encourage you to first follow our internal complaints process to resolve the complaint. We explain the complaints and disputes process on the Bankmed website. You may click on this link to access the complaints and escalations process: https://www.bankmed.co.za/medicalschemes_za/bankmed/web/health/linked_content/documents/latest_info/complaints_and_escalations.pdf

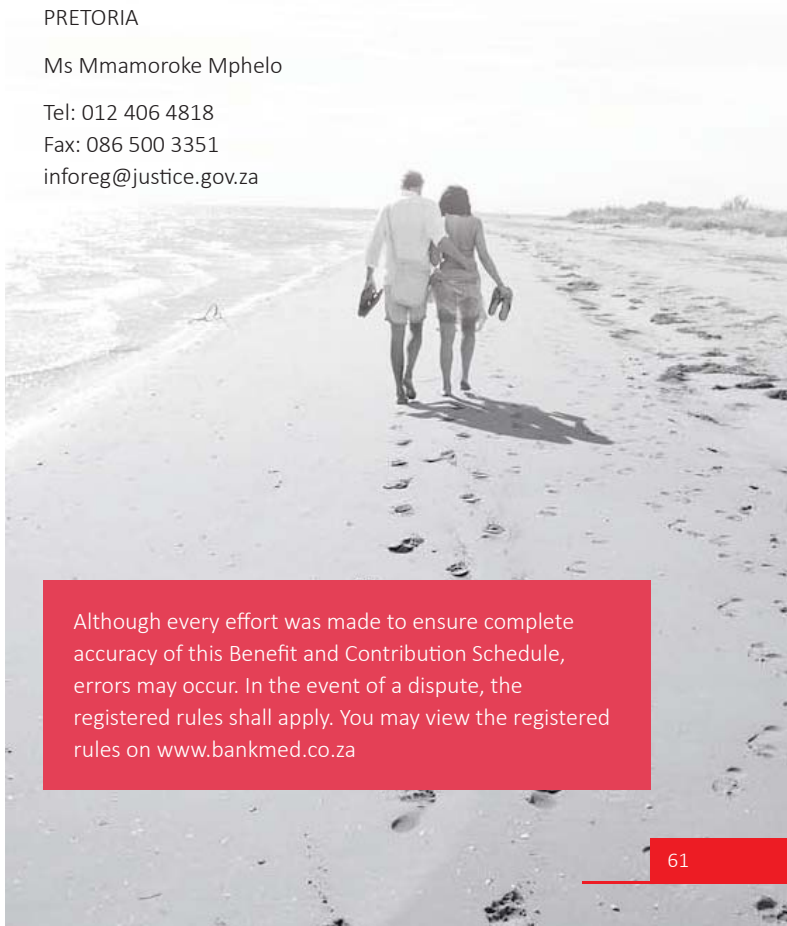
If you are not satisfied after this process, you have the right to lodge a complaint with the Information Regulator, under POPIA.

Contact details for the Information Regulator are:

The Information Regulator (South Africa)
SALU Building
316 Thabo Sehume Street
PRETORIA

Ms Mmamoroke Mphelo

Tel: 012 406 4818
Fax: 086 500 3351
inforeg@justice.gov.za



Although every effort was made to ensure complete accuracy of this Benefit and Contribution Schedule, errors may occur. In the event of a dispute, the registered rules shall apply. You may view the registered rules on www.bankmed.co.za

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Bankmed
your good health

0800 BANKMED (0800 226 5633)

enquiries@bankmed.co.za

www.bankmed.co.za

Bankmed App

CMS
Council for Medical Schemes

Accredited by the Council for Medical Schemes
Customer Care Centre: 086 112 3267

Bankmed Medical Scheme. Registration number: 1279.

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