BANKMED

ANNEXURE B5: BANKMED COMPREHENSIVE PLAN (WITH SAVINGS)

Schedule of benefits with effect from 1 January 2020

STATUTORY PRESCRIBED MINIMUM BENEFITS

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

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

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

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

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

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

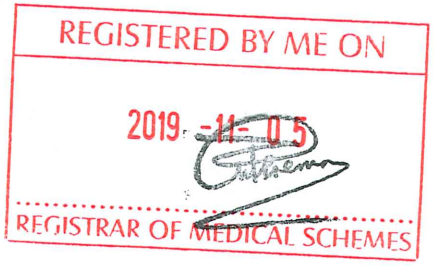
PMB claims shall not be funded from Savings

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

STATUTORY PRESCRIBED MINIMUM BENEFITS

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

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



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
OVERALL ANNUAL LIMIT		Unlimited	This plan has no overall annual limit.
HOSPITAL NETWORK/DSPs	Hospital Network DSPs are applicable on this plan. Reduced benefits apply for accommodation and associated fees charged by non-DSP hospitals, subject to PMB regulations. Hospital Network DSPs on this plan are: • Contracted private hospitals/facilities (restricted network) as communicated to members from time to time.		
HOSPITALISATION **Hospital Network DSPs** Deductibles apply to a specified list of conditions/procedures as set out in Appendix 3 All admissions at network DSP **Other hospitals (non-DSPS)** PMB admission: involuntary use of non-DSP (deductible does not apply) PMB admission: voluntary use of non-DSP (deductible applies to all admissions) Non-PMB admission (deductible applies to all admissions)	 100% of cost 100% of cost 100% of Scheme Rate 100% of Scheme Rate	 Unlimited (at general ward rates) Unlimited (at general ward rates) Unlimited (at general ward rates) Unlimited (at general ward rates)	Benefits subject to pre-authorisation and PMB regulations. Emergencies must be authorised within 24 hours of admission.
Deductibles payable on admission Healthcare services reflected in Appendix 3	Beneficiary responsible for a Deductible in respect of the hospital account for certain hospital events, unless the admission is related to a Prescribed Minimum Benefit diagnosis typically as a result of an emergency. The Deductible will apply regardless of the whether the procedure attracting the deductible was the primary reason for the admission or not.		

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

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
TO TAKE OUT DRUGS	100% of cost	Limited to PMBs and a maximum of 7 days' supply per admission	Benefit for medicine supplied by the hospital when a patient is discharged. If procedure took place in a day clinic, a maximum of a seven day supply will be funded from Insured Benefits if obtained from a retail pharmacy on the date of discharge only.
AMBULANCE SERVICES	100% of cost	Unlimited	Subject to pre-authorisation. Through Preferred Provider only. No benefit for services outside the borders of South Africa.
BLOOD TRANSFUSIONS **Blood products, materials, apparatus and operator's fees**	100% of cost	Unlimited	
ORGAN AND BONE MARROW TRANSPLANTS **Hospitalisation, and organ and patient preparation** **Medication (in and out of hospital)** • Medication via designated pharmacy (DSP) • Medication via non-DSP (voluntary use of non-DSP) • Medication via non-DSP (involuntary use of non-DSP) **Harvesting and transporting of organs, and other donor costs**	Benefits as for hospitalisation 100% of cost 80% of Scheme Medicine Reference Price plus dispensing fee 100% of cost 100% of cost	Benefits as for hospitalisation Unlimited Unlimited Unlimited Unlimited	Subject to pre-authorisation. The organ recipient must be a Bankmed beneficiary for benefits to apply. Benefits for Specialists will be as specified elsewhere this schedule. No benefit for travelling and non-hospital accommodation expenses.
ONCOLOGY (CHEMOTHERAPY AND RADIOTHERAPY) **In and out of hospital consultations, treatment and materials**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	Subject to pre-authorisation.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Associated Medicine/Drugs • Medication via designated courier pharmacy (DSP) • Medication via non-DSP (voluntary use of non-DSP) • Medication via non-DSP (involuntary use of non-DSP)	100% of cost 80% of Scheme Medicine Reference Price plus dispensing fee 100% of cost	Unlimited	
RENAL DIALYSIS **Procedures and Treatment** **Associated Medicine/Drugs** • Medication via designated courier pharmacy (DSP) • Medication via non-DSP (voluntary use of non-DSP) • Medication via non-DSP (involuntary use of non-DSP)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost 80% of Scheme Medicine Reference Price plus dispensing fee 100% of cost	Unlimited Unlimited	Subject to pre-authorisation.
PREGNANCY AND CHILDBIRTH **Hospitalisation and associated in hospital services (hospital network rules apply)** **Midwife care and delivery** **Birthing facilities**	As specified elsewhere in this schedule 100% of Scheme Rate 100% of Scheme Rate	As specified elsewhere in this schedule Unlimited Unlimited (Cost of disposables limited to R1 120 per case)	Subject to pre-authorisation. Benefits for hospitalisation and other in hospital services as specified elsewhere in this schedule. Subject to pre-authorisation. Subject to pre-authorisation. Only available where hospital services are not used (except for registered active birthing units).

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
GPs and Specialists	As specified elsewhere in this schedule	As specified elsewhere in this schedule	Benefits for General Practitioners and Specialists as specified elsewhere in this schedule.
Radiology and Pathology	As specified elsewhere in this schedule	As specified elsewhere in this schedule	Benefits for Radiology and Pathology specified elsewhere in this schedule.
Additional insured benefits at or subject to referral by a Bankmed Network GP and subject to registration on the Scheme's Maternity Programme (Baby and Me):			
• 5 ante-natal consultations per pregnancy	100% of cost for DSP 100% of Scheme Rate for non-DSP	As specified	Additional insured consultations covered at the applicable rate for General Practitioner/ Specialist consultations in rooms as specified elsewhere in this schedule.
• 2 x 2D ultrasounds per pregnancy	100% of Scheme Rate	As specified	
• R1 375 per pregnancy for ante-natal and post-natal classes	100% of Scheme Rate	As specified	
• Additional pathology benefits subject to Baby and Me Care Plan	100% of Scheme Rate	As specified	Additional insured pathology subject to Care Plan.
ALTERNATIVES TO HOSPITALISATION			
Frail Care Facilities	50% of cost	R470 per beneficiary per day	Frail care facilities: Subject to pre-authorisation. Available to permanently chronic sick or geriatric patients for accommodation in a registered nursing home or hospital. No Benefits for accommodation in old age homes. Available as alternative to home nursing not in addition hereto.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Step-down facilities	100% of Scheme Rate	Unlimited	Step-down facilities: Subject to pre-authorisation and available only as an alternative to hospitalisation. Such service follows pre-authorised hospitalisation or operation and is in lieu of further hospitalisation. The facility must be registered with the Department of Health.
Home nursing services	100% of cost	R355 per beneficiary per day	Home nursing services: Subject to pre-authorisation. Rendered at the patient's residence by a registered nurse or a person from a registered nursing institution. For such periods as the Scheme may determine as reasonable.
REGISTERED PRIVATE NURSE PRACTITIONERS (registered with the S. A. Nursing Council or its legal successor)			
Procedures	100% of Scheme Rate	Unlimited	For procedures not requiring admission to a day clinic or hospital; Includes the cost of vaccination and injection material administered by the Practitioner.
Consultations	100% of Scheme Rate	Three pbpa from the Insured Benefit Thereafter subject to available Savings	
HomeCare Services	100% of Scheme Rate	Unlimited	For procedures not requiring admission to a day clinic or hospital. Subject to Scheme Clinical Entry Criteria. Subject to preauthorisation.

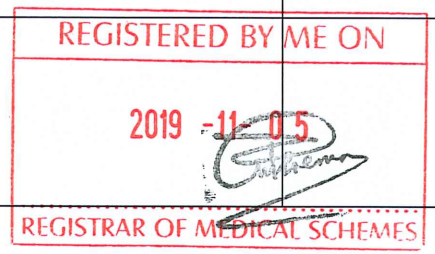
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
COMPASSIONATE CARE BENEFIT FOR NON-ONCOLOGY PATIENTS (IN-PATIENT CARE AND HOMECARE VISITS)	100% of Scheme Rate	Unlimited for PMB scope and level of treatment. R59 300 per person per lifetime for all claims, payment of PMB claims accumulate to this threshold.	Subject to authorisation and meeting the Scheme's guidelines.
ADVANCED ILLNESS BENEFIT FOR ONCOLOGY PATIENTS	100% of the Scheme Rate	Unlimited	Subject to authorisation and the treatment meeting the Scheme's guidelines and managed care criteria.
WELLNESS AND PREVENTATIVE CARE BENEFITS (VACCINATIONS AND SCREENING)			Benefits in this section do not contribute to the depletion of any insured limits specified elsewhere in this schedule. Associated consultation fees are not provided for in this section, unless indicated. See General Practitioners (GPs): out of hospital consultations and procedures in rooms for consultation benefits.
Contraception: oral contraceptives, devices and injectables	100% of Scheme Medicine Reference Price	R1 950 pbpa	For female beneficiaries only. Oral contraceptives limited to one prescription or repeat prescription per beneficiary per month.
Influenza vaccine	100% of Scheme Medicine Reference Price	One pbpa	
Human Papilloma Virus (HPV) vaccine	100% of Scheme Medicine Reference Price	Three doses pb	For male and female beneficiaries aged 9 to 16 years, and limited to a total course of three doses (depending on product and age).
Cholesterol screening, blood sugar screening and blood pressure measurements	100% of cost for DSPs	R310 pbpa	At clinics, pharmacies or Bankmed GP Network GPs' consulting rooms.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
HIV Counselling and Testing (HCT)	100% of cost for DSPs	Unlimited	HCT DSPs: Bankmed GP Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering onsite services at employer groups, subject to PMB regulations.
Mammogram	100% of Scheme Rate	One pbpa	For beneficiaries aged 40 years and older; Benefits for beneficiaries younger than 40 years, subject to motivation and prior approval.
Breast MRI (breast cancer risk only)	100% of Scheme Rate	One pbpa	For high risk beneficiaries only. Subject to clinical entry criteria and pre-authorisation.
Pap smear	100% of Scheme Rate	One pbpa	One associated nurse, Bankmed GP Network GP or Bankmed Prestige A&B Specialist Network consultation per beneficiary covered as an additional insured benefit, limited to R490 pbpa.
Bone densitometry **Prostate specific antigen** **Faecal occult blood test**	100% of Scheme Rate 100% of Scheme Rate 100% of Scheme Rate	One pbpa One pbpa One pbpa	For beneficiaries aged 50 years and older; Benefits for beneficiaries younger than 50 years, subject to motivation and prior approval. Should member not meet clinical entry criteria, and they are younger than age 50, the member may claim the bone densitometry test from their Radiology Benefit. Where the Radiology Benefit is exhausted, this test may be claimed from available Medical Savings Account.
Tuberculosis (TB) screening	100% of Scheme Rate	One chest x-ray pbpa	For TB screening requested by private nurse practitioners rendering onsite services at employer groups; All other TB screenings subject to available out of hospital radiology and/or pathology benefits, and PMB regulations.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Childhood vaccinations (BCG, Oral Polio, Rotavirus, Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio and Haemophilus influenza type B, Hepatitis B, Measles, Pneumococcal vaccine)	100% of Scheme Medicine Reference Price	Subject to EPI guidelines	For immunisations administered in accordance with the Department of Health's Expanded Programme on Immunisation (EPI) guidelines for children up to 12 years.
Pneumococcal vaccine	100% of Scheme Medicine Reference Price	Limited as follows:	• One vaccination every five years for adults 60 years and older. • One vaccination every five years for beneficiaries younger than 60 years, who have been diagnosed with Asthma, Chronic Obstructive Pulmonary Disease, Diabetes, Cardiovascular Disease, or HIV/Aids.
Herpes Zoster Virus vaccine (Reduces the rate of herpes zoster [shingles])	100% of Scheme Medicine Reference Price	Limited as follows:	One vaccination every five years for adults 60 years and older.
Personal Health Assessment (PHA)	100% of cost	Limited to one pbpa	One assessment pbpa. Benefit limited to Bankmed GP Network GPs, Bankmed Pharmacy Network and contracted providers rendering onsite services at employer groups; subject to completion and follow up of the assessment. Applies to members and beneficiaries aged 18 years and older only.
Personal Health Assessment (PHA) Additional Consultations for Dietician and Biokineticist	100% of Scheme Rate at a DSP only	Limited to two dietician visits per year plus two Biokineticist visits per year First visit to dietician and biokineticist to take place within 6 weeks of the PHA and second visit within 12 months of the	Limited to medium and high risk members only. Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA. Clinical Entry Criteria applies. Applies to members and beneficiaries aged 18 years and older only.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
		PHA, otherwise funded from day-to-day benefits	
Bankmed Stress Assessment			Free online assessment via www.bankmed.co.za; There is no limit on the number of assessments per beneficiary per annum.
New-born Screening Test	100% of Scheme Rate	Limited to one per beneficiary	Testing limited to services provided within the borders of South Africa. Test funded only if performed within 72 hours of birth.
New-born Hearing Test	100% of Scheme Rate	Limited to one per beneficiary	Testing limited to service provided by a registered Audiologist. Only the test is funded. Should the provider charge a consultation fee, the consultation fee will be funded from available consultation benefits. Test only funded if performed within eight weeks of birth. Thereafter funded from standard benefits.
Non-Invasive Prenatal Test (NIPT)	100% of Scheme Rate	Limited to one per pregnancy	Subject to the Scheme's protocols and clinical entry criteria. One assessment per beneficiary per pregnancy. Testing limited to services provided within the borders of South Africa. Applies to high risk beneficiaries aged 35 years and older at delivery. If member does not meet clinical entry criteria, the screening test is covered from the available balance in the member's Medical Savings Account on this Plan.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
DIABETES MANAGEMENT For members registered on the Scheme's Disease Management Programme	100% of cost for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP and member utilises the Scheme's DSP as their service provider. 100% of Scheme Rate if non-DSP used.	Unlimited	Basket of Care set by the Scheme, subject to PMB regulations.
RADIOLOGY **In Hospital** **Out of hospital**	 100% of Scheme Rate 100% of Scheme Rate	 Unlimited R3 920 pfpa (including a sub-limit of R1 305 pfpa for out of hospital pathology)	 Thereafter subject to available Savings
PATHOLOGY **In Hospital** **Out of hospital**	 100% of Scheme Rate 100% of Scheme Rate	 Unlimited R1 305 pfpa (and further subject to out of hospital radiology limit of R3 920 pfpa)	 Thereafter subject to available Savings
MRI / CT SCANS AND RADIONUCLIDE SCANS **In Hospital and out of hospital**	 100% of Scheme Rate	 Unlimited	 Subject to pre-authorisation (both in and out of hospital).
HIV/AIDS PROGRAMME Additional benefits subject to registration on HIV/Aids Programme. These additional benefits do not contribute to the depletion of other insured benefits provided by the Scheme.			Beneficiaries who do not register on the HIV/Aids Programme will be entitled to all other benefits as specified in this schedule, with continued funding for PMBs, subject to PMB regulations, after depletion of the relevant sub-limits.



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Consultations and pathology	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Subject to benefits available in Scheme's Basket of Care	
Associated Medicine/Drugs			
• Medication via designated courier pharmacy (DSP)	100% of cost	Unlimited	Designated courier pharmacy for HIV/Aids medication: as communicated to registered beneficiaries from time to time.
• Medication via non-DSP (voluntary use of non-DSP)	80% of Scheme Medicine Reference Price plus dispensing fee	Unlimited	A motivation is required for the use of a non-DSP for medication.
• Medication via non-DSP (involuntary use of non-DSP)	100% of cost	Unlimited	Subject to Scheme's approved formulary. Scheme's Medicine Reference Price applies to non-formulary medication.
INTERNAL PROSTHESIS			Benefits subject to clinical motivation, the application of clinical / funding protocols, Scheme approval and PMB regulations.
Combined limit for all internal prostheses items	100% of Scheme Rate	R70 950 pbpa	Defined as appliances placed in the body as an internal adjuvant, during an operation.
Internal prosthesis sub-limits:			Combined limit for all internal prosthesis items, excluding pacemakers and defibrillators; Sub-limits may apply depending on the prosthesis required.
Hip joint prostheses, knee joint prostheses and shoulder joint prostheses	100% of Scheme Rate	R47 220 per prosthesis per admission if prosthesis is not supplied by the Scheme's network provider. If supplied by the Schemes network provider, unlimited (not subject to combined limit for all internal prosthesis items)	All sub-limits as indicated are further subject to the combined limit for all internal prosthesis items, excluding pacemakers, defibrillators. The sub-limits are not "in addition to" the combined limit. Dental implants of any nature are not included in the definition of internal prosthesis.
Spinal fusions	100% of Scheme Rate	R47 800	The prostheses accumulate to the limit. The balance of the hospital and related accounts do not accumulate to the annual limit.
Cardiac stents	100% of Scheme Rate	R70 670	
Grafts	100% of Scheme Rate	R38 260	

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Cardiac Valves **Non-specified items**	100% of Scheme Rate 100% of Scheme Rate	R40 240 R22 050	
PACEMAKERS AND DEFIBRILLATORS	100% of cost of device if preferred provider used 100% of Scheme Rate if non-preferred provider used	Unlimited	Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval.
INTRAOCCULAR LENSES FOR CATARACT SURGERY (Permanent, implantable lenses, inclusive of basic and specialised lens varieties)	Up to a maximum of 100% of the Scheme Rate Scheme Rate is equal to the negotiated and agreed lens price plus 25% mark-up		Subject to pre-authorisation and the treatment meeting the Scheme's criteria. Covered in full when supplied by the Scheme's preferred suppliers, otherwise covered up to the Scheme Rate for the lens. Scheme Rate is equal to the negotiated and agreed lens price plus 25% mark-up Where the provider marks up the lens cost in excess of the agreed rate, the Scheme will not be responsible for the shortfall.
EXTERNAL PROSTHESIS Artificial limbs and eyes	100% of Scheme Rate	R24 200 pfpa	Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval. Benefit includes the repair of the prosthesis.
MEDICAL AND SURGICAL APPLIANCES **Post-surgery appliances** • Purchase or hire of: Braces, Splints, Slings, Corsets, Cervical collars, Post-op footwear (sandals and boots), Air-casts, Pressure garments, Compression hose, Cushions, Mastectomy brassiere/breast prosthesis. • Hire of: Wheelchairs, Walking frames, Crutches, Traction equipment, Toilet/bath riser, Bath swivel stool	100% of Scheme Rate	R7 115 pbpa	Benefits subject to a doctor's prescription, the application of clinical and funding protocols, and Scheme approval. Additional benefits may be provided for wheelchairs, subject to motivation, from occupational therapist and/or physiotherapist, a minimum of two cost quotations and Scheme approval. **Frequency limits apply:** Surgical/moonboot: one every 24 months Crutches: one set every 24 months

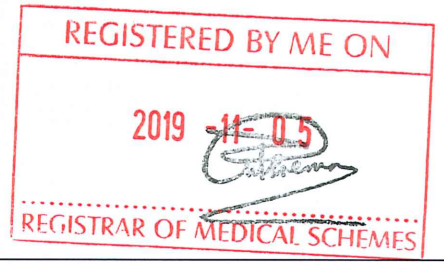
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Chronic appliances • Oxygen and oxygen delivery systems, i.e. items required for its delivery and administration (e.g. delivery tube, nasal cannulas and mask)	100% of Scheme Rate	R22 350 pbpa	Brace callipers: one set every 24 months Rigid back brace: one every 24 months Wig: one every 24 months Breast prosthesis bra: no limit on number of bras that may be purchased in 12 months; Rand limit applies for post-surgery appliances Breast prosthesis: one/two per 24 months (one/two is patient dependent)
Chronic appliances • Stoma products, including indwelling catheters and colostomy bags	100% of Scheme Rate	R22 350 pbpa	Commodes: one every 36 months Wheelchairs: one every 36 months Walking frames: one every 24 months
Other chronic appliances • Other chronic appliances includes Braces/Callipers/Surgical boots (in combination), Lumbar Sacral Corsets, Splints, Compression hose, "Be-sure" products, Heel pads/insoles/metatarsal bars, CPAP machines, Sleep apnoea monitor for infants (hire thereof), Suction machine and catheters, Nebulisers, Glucometers, Peak flow meters • Purchase of: Crutches, Wheelchairs, Walking frames, Toilet/bath risers, Commodes, Urinal bottles, Bed pans	100% of Scheme Rate	R7 115 pbpa Limit may be extended to R10 410 for beneficiaries requiring a CPAP machine Sub-limits apply as follows: R880 for arch supports (per pair) R1 320 for shoe insoles (per pair)	Surgical compression stockings: two pairs per 12 month period Sling/clavicle brace: one every 24 months Portable oxygen: one every 48 months Arch supports: one pair every 24 months Shoe insoles: one pair every 24 months CPAP machine: one every 36 months Humidifier: one every 36 months
Appliances for acute conditions	100% of Scheme Rate	Subject to available Savings	For conditions not covered under the post-surgery appliance benefit and the chronic appliances benefit. Repairs and maintenance of any appliances provided under any of these benefit categories.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS (Combined limit with medical and surgical appliances: other chronic appliances)	100% of Scheme Rate	R7 115 pbpa Sub-limits apply as follows: R1 200 pbpa for blood pressure monitors R1 690 pbpa for nebulisers R840 pbpa for glucometers	Benefits available on doctor's prescription without additional motivation or Scheme approval. **Frequency limits apply:** Blood pressure monitors: one every 36 months Nebulisers: one every 36 months Glucometers: one every 36 months
HEARING AIDS (SUPPLY AND FITMENT)	100% of Scheme Rate	R28 270 per beneficiary every 24 months	**Frequency limits apply:** Benefit only available where the beneficiary has not claimed for hearing aid/s in the previous calendar year. Rolling limit every 24 months. No benefit for replacement batteries.
HEARING AID REPAIRS	100% of Scheme Rate	R1 465 pbpa	
BONE ANCHORED HEARING AIDS	90% of Scheme Rate	R151 210 pfpa	
COCHLEAR IMPLANTS **Hospitalisation** **Pre-operative evaluation and associated preparation costs** **Cochlear implant device** **Intra-operative audiology testing** **Post-operative evaluation costs**	 Benefits for hospitalisation as specified elsewhere in this schedule 100% of Scheme Rate 100% of Scheme Rate 100% of Scheme Rate 100% of Scheme Rate	 As specified R16 810 pb per lifetime R352 450 pb per lifetime R880 pb per lifetime R35 300 pb per lifetime	Once in a lifetime benefit. Subject to pre-authorisation and Scheme protocols. Funding only available in recognised Centres of Excellence. Once in a lifetime benefit available to: • Children under 8 years of age • Persons over the age of 8 diagnosed as suffering from profound bilateral sensory neural hearing loss

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
UPGRADE OR REPLACEMENT OF SPEECH PROCESSORS	80% of Scheme Rate	R131 600 pb over a five year cycle	Subject to clinical motivation, the application of clinical / funding protocols and Scheme approval.
PSYCHIATRY, CLINICAL PSYCHOLOGY, & RELATED OCCUPATIONAL THERAPY **Hospitalisation:** **Hospital Network DSPs** All admissions at network DSP **Other hospitals (non-DSPS)** PMB admission: involuntary use of non-DSP PMB admission: voluntary use of non-DSP Non-PMB admission **In-hospital consultations / sessions** **Out of hospital consultations / sessions**	 100% of cost for Bankmed Network Psychiatric facilities (DSPs) 100% of cost 80% of Scheme Rate for non-DSPs 80% of Scheme Rate for non-DSPs 100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSPs 100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSPs	 R66 300 pbpa (Combined limit with occupational therapy: psychiatric consultations /sessions in hospital) R4 850 pbpa (Combined limit with occupational therapy: psychiatric consultations /sessions out of hospital) Combined limit may be may be extended to	 Subject to pre-authorisation. Continued benefits for PMBs subject to pre-authorisation and PMB regulations. PMBs limited to 80% of Scheme Rate for non-DSPs, subject to PMB regulations. Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the rand limit. PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations. When benefits are exceeded, all other non-PMB treatment will be subject to available Savings. Cover for 15 out-of-hospital psychotherapy sessions for PMBs, in line with PMB regulations with dual accumulation to the rand limit.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
		R11 575 for Depression and/or Bipolar Mood Disorder, subject to pre-authorisation and PMB regulations	
Post-hospital psychiatric consultation within 30 days of discharge from hospital (excluding day cases) for a psychiatric admission (Related to Major Depression, Schizophrenia and Bipolar Mood Disorder only)	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSP Psychiatrist	Limited to three consultations per beneficiary per annum	An additional consultation will be granted as an insured benefit, per beneficiary visiting a psychiatrist within 30 days of discharge, following an authorised psychiatric hospital admission (excluding day cases). PMBs limited to 100% of Scheme rate for non-DSPs, subject to PMB regulations. In the event that the member exceeds the three consultation limit (following three hospital admissions), the consultations will be subject to the standard psychiatry, clinical psychology and related occupational therapy benefit limits, thereafter, available funds in the Medical Savings Account.
OCCUPATIONAL THERAPY: PSYCHIATRIC CONSULTATIONS / SESSIONS			
Hospitalisation and in-hospital consultations / sessions	100% of Scheme Rate	R66 300 pbpa (Combined limit with occupational therapy: psychiatric consultations /sessions in hospital)	Subject to pre-authorisation. Continued benefits for PMBs subject to pre-authorisation and PMB regulations. PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.
Out of hospital	100% of Scheme Rate	R4 850 pbpa (Combined limit with occupational therapy: psychiatric consultations/sessions out of hospital)	PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations. When benefits are exceeded, all other non-PMB treatment will be subject to available Savings.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
		Combined limit may be may be extended to R11 575 for Depression and/or Bipolar Mood Disorder, subject to pre-authorisation and PMB regulations	
OCCUPATIONAL THERAPY: NON-PSYCHIATRIC CONSULTATIONS / SESSIONS			
In hospital	100% of Scheme Rate	Unlimited	Subject to pre-authorisation.
Out of hospital	100% of Scheme Rate	R2 150 pfpa	Thereafter subject to available Savings.
PHYSIOTHERAPY			
In hospital	100% of Scheme Rate	Unlimited	Subject to pre-authorisation.
Post-hospitalisation treatment (within 6 weeks of discharge from hospital)	100% of Scheme Rate	R2 445 pbpa	Following pre-authorised admission; Available Savings will be utilized where insured benefits have been exhausted.
Out of hospital	100% of cost	Subject to available Savings	
SPEECH THERAPY, AUDIO THERAPY AND AUDIOLOGY			
In and out of hospital	100% of Scheme Rate	R2 205 pfpa	Thereafter subject to available Savings.

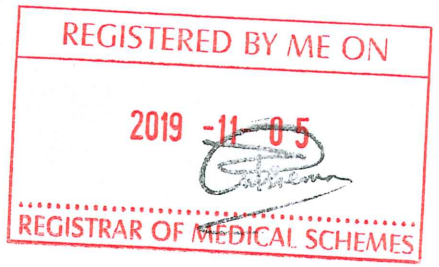


HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
ADDITIONAL BENEFITS FOR BENEFICIARIES WITH NEURODEVELOPMENTAL DISORDERS • Occupational therapy: psychiatric consultations/sessions (out of hospital) • Occupational therapy: non-psychiatric consultations/sessions (out of hospital) • Physiotherapy (out of hospital) • Speech therapy (out of hospital)	100% of Scheme Rate or contracted rate, whichever applies	As approved	Additional discretionary insured benefits may be granted for beneficiaries with neurodevelopmental disorders, subject to clinical motivation and Scheme approval. The quantum of additional benefits, if approved, shall be decided on a case-for-case basis, and granted at 100% of the Scheme Rate or contracted rate, whichever applies. These discretionary benefits are in addition to any other insured benefits normally applicable to these services, as specified elsewhere in this schedule.
OTHER AUXILIARY SERVICES **In and out of hospital** • Chiropody/Podiatry (consultations) • Dietetics/Nutritional Assessments • Orthotics (consultations) • Massage • Chiropractors • Herbalists • Naturopaths • Family planning clinics • Homeopaths • Biokineticists (fitness assessments)	100% of cost	Subject to available Savings	**Frequency limits apply:** Foot orthotics: one every 24 months If prescribed by a medical practitioner and provided that the supplier of service is registered as such in terms of any law. The fees must have been incurred for a definite complaint and treatment must be for curative purposes only.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
CHRONIC MEDICATION **Medication via DSP** (Bankmed Network GP and Bankmed Pharmacy Network) **Medication via non-DSP** (voluntary use of non-DSP) **Medication via non-DSP** (involuntary use of non-DSP)	Subject to Scheme approved Chronic Medicine List 100% of Scheme Medicine Reference Price 80% of Scheme Medicine Reference Price 100% of cost	R22 325 pbpa	Benefits for chronic medication, drugs and injection material subject to: • Prior application and approval of the Scheme • Each prescription or repeat prescription being limited to one month's supply per beneficiary • Such motivations and reports by appropriate Medical practitioners, as are required by the Scheme • PMB regulations • Scheme approved Chronic Medicine List Dispensing fee limited to the contracted dispensing fee applicable to Bankmed GP Network GPs and Bankmed Pharmacy Network (DSPs). Continued benefits for PMBs, subject to PMB Regulations.
PRESCRIBED ACUTE MEDICATION	100% of Scheme Medicine Reference Price	Subject to available Savings	
SELF-MEDICATION (OVER THE COUNTER MEDICINE) AND PHARMACY ADVISED THERAPY (PAT)	100% of Scheme Medicine Reference Price	Subject to available Savings	Covering medicines which a pharmacist is entitled to prescribe and dispense.
HOMEOPATHIC MEDICATION	Benefits as for prescribed acute/chronic medication	Benefits as for prescribed acute/chronic medication	On doctor's prescription only, and limited to items with NAPPI codes. No self-medication/PAT benefit for homeopathic medicines. 

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
SPECIALISTS			
In hospital consultations, operations and procedures	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	Subject to pre-authorisation. PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.
Out-of-hospital consultations in rooms	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSPs	Subject to available Savings	Benefit includes the cost of vaccination and injection material administered by the Specialist, except where indicated as a specified benefit under Vaccinations and Screening. PMBs limited to 100% of Scheme rate for non-DSPs, subject to PMB regulations.
Out-of-hospital procedures in rooms	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of scheme Rate for non-DSPs	Unlimited	
GENERAL PRACTITIONERS (GPs)			In-hospital benefits are subject to pre-authorisation.
In hospital consultations	100% of cost for Bankmed Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.
In hospital operations and procedures	100% of cost for Bankmed Network GPs: DSPs 125% of Scheme Rate for non-DSPs	Unlimited	
Out of hospital consultations in rooms	100% of cost for Bankmed Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Subject to available Savings	Includes the cost of vaccination and injection material administered by the GP, except where indicated as a specified benefit under Vaccinations and Screenings.
Out of hospital procedures in rooms	100% of cost for Bankmed Network GPs: DSPs 125% of Scheme Rate for non-DSPs	Unlimited	

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



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Elective Treatment Benefits cover: • Orthognatic surgery (surgical repositioning of jaws) • Surgical placement and exposure of implants excluding the cost of all components and transmucosal healing abutments • Surgical preparation of jaws for prosthetics • Functional corrections of malocclusions	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	Subject to pre-authorisation.
PREVENTATIVE AND BASIC DENTISTRY **Benefits for all members and beneficiaries:** • First dental examination per beneficiary per financial year • Scale and Polish • Limited x-rays to support diagnosis • Restorations (fillings) • Basic root canal therapy (including emergency root canal therapy) • Routine extractions • Full and partial dentures (restricted to plastic) and clasps • Repairing of dentures **Additional benefits for children below the age of 16 years:** • Topical fluoride treatment • Fissure sealant on first and second permanent molar teeth but subject to a maximum of 8 molar teeth per beneficiary per lifetime	100% of Scheme Rate	Unlimited Sub-limits apply as follows: One dental exam pbpa Two pbpa Fillings: Amalgam and resin only Plastic dentures only Two tropical fluoride treatments per child per year (age 15 years and younger). One topical fluoride treatment per year for all other beneficiaries. Limited to 8 molar teeth pb per lifetime	REGISTERED BY ME ON 2019 -11- 05 REGISTRAR OF MEDICAL SCHEMES

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
ADVANCED DENTISTRY Caps, crowns, bridges and cost of endosteal and ossea-integrated implants	100% of Scheme Rate	M = R5 315 pbpa M+ = R8 900 pfpa	Once exhausted, subject to available Savings
ORTHODONTICS	100% of Scheme Rate	R8 900 pfpa	Subject to orthodontic quotation and prior approval of the Scheme. Once exhausted, subject to available Savings. Benefits are not available for metal inlays in anterior teeth.
ALL OTHER DENTAL SERVICES • Second and subsequent examination in the same financial year • X-rays • Composite restorations/fillings • Metal/ceramic and/or resin restorations/inlays • Crowns and bridges • Bleaching of endodontically treated teeth • Periodontal treatment (includes both consultation, non-surgical and surgical procedures • Prosthodontics • Complete/partial dentures other than plastic including soft bases • Miscellaneous prosthetic procedures e.g. rebases, adjustment and relines • Restorative/Prosthodontic phase of implants • Oral surgery • Other surgical procedures i.e. Biopsy/soft tissue injuries • Bite plate for TMJ dysfunction • Other general services not classified but included in the Scheme Rate as relevant services	100% of Scheme Rate	Subject to available Savings	Placement of ossea-integrated implants is an insured benefit.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
OPTOMETRY **Subject to the Optometry Benefit Management program and clinical necessity**			
Consultations	100% of Scheme Rate	100% of Scheme Rate	Benefit only available every two years, and limited to one eye test or one re-examination or one composite examination per beneficiary every 24 months from previous date of service.
Frames and Extras	100% of Scheme Rate	Subject to available Savings	Extras subject to pre-authorisation and clinical necessity. One frame per beneficiary every 24 months from previous date of service.
Prescription Lenses Clear standard / generic - single vision, bifocal or multi-focal lenses	100% of Scheme Rate	100% of Scheme Rate	One pair of standard /generic lenses per beneficiary every 24 months from previous date of service.
Readymade Readers	100% of Scheme Rate	Two pairs at R100 a pair, pb every two years paid from available Savings	Readymade readers via optometrists and Pharmacies as an OTC benefit subject to benefit availability
Contact Lenses	100% of Scheme Rate	R1 635 pbpa	Clear contact lenses. A beneficiary may not claim for spectacles (lenses or frame) AND contact lenses in the same benefit year OR contact lenses within 24 months from previous date of service after receiving spectacles (lenses or frame).
Fitting of contact lenses	100% of Scheme Rate		
Other optometric services Refractive surgery/excimer laser treatment, hospitalisation and associated costs	100% of Scheme Rate	Subject to available Savings	One contact lens dispensing and/or assessment per beneficiary every 12 months Benefit via a network ophthalmologist. Includes the cost of hospitalisation, medication and all other associated services.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Sunglasses		No benefit	No benefit for sunglasses / prescription sunglasses / spectacles with a tint > 35%.
CLAIMS FOR SERVICES RENDERED OUTSIDE THE BORDERS OF SOUTH AFRICA	As per Annexure D	As per Annexure D	Foreign claims covered at the relevant Scheme Rate and/or Rand limit normally allowed for an equivalent non-PMB claim in South Africa. In the case of internal prosthesis and/or medical and surgical appliances, funding will be limited to the amount or rate at which the Scheme would normally fund or procure such device within the borders of South Africa. No benefits for emergency/ambulance transport outside the borders of South Africa. Medical motivation and prior approval required for elective/non-emergency surgery outside the borders of South Africa.
BENEFIT LIMITS EXHAUSTED/ ABOVE SCHEME RATE PORTIONS OF CLAIMS			All benefits are covered at the specified rate (percentage benefit) up to the annual limit, as per this schedule. Once specified limits are exceeded, continued benefits are paid at the specified rate (percentage benefit), from available Savings (except for PMB's, which are covered at 100% of cost, subject to PMB Regulations, after specified sub limits are depleted). Above Scheme Rate portions of claims are not automatically paid from Savings. Members may, however, apply in writing to have the above Scheme Rate portions of claims automatically paid from available Savings.

LEGEND:

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