Bankmed
your good health

2017 Benefit & Contribution Schedule

Information in this Benefit Brochure

PART A – Overview

PART B – Your Benefit Options

PART C – Specific Benefit Information

PART D – How to Claim and Manage your Membership

Contact us

Please use the following contact details when you need to get in touch.

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

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) for all Plans.
- Medical professionals may call 0800 132 345 directly for **Core Saver, Traditional, Comprehensive and Plus Plans**

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: enquiries@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.

- **Telephonic 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 or feature phone 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** 0800 BANKMED (0800 226 5633)

To register on the Baby-and-Me Maternity Programme:

- **Telephone (toll-free from a Telkom landline)** 0800 BANKMED (0800 226 5633)
- **E-mail** babyandme@bankmed.co.za
- **Fax** 011 529 6485

To register on the Oncology Treatment Programme:

- **Telephone (toll-free from a Telkom landline)** 0800 BANKMED (0800 226 5633)
- **E-mail** oncology@bankmed.co.za
- **Fax** 011 539 5417

To report fraud:

- **Call** 0800 004 500
- **E-mail** bankmed@tip-offs.com

Why Bankmed?

Bankmed Value

At Bankmed you are a member of an exclusive club. A club that is not for the average and is not open to just anyone.

Bankmed is a closed medical scheme that is tailored to the banking industry alone. This gives us invaluable experience and insights into your specific needs – and the ability to offer you a medical scheme that deals with what you need, when you need it.

Scheme Overview

Bankmed is registered in terms of the Medical Schemes Act 131 of 1998 and all benefits are approved by the Council for Medical Schemes. With more than 100 years of experience as a medical scheme, Bankmed exists solely for your benefit. Bankmed is not about pursuing profits or the accumulation of reserves. It is governed by the Board of Trustees, which prioritises the interests of the members and the sustainability of the Scheme.

Bankmed's 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 thereby on the health of the organisation.

Bankmed's initiatives contribute to the wellbeing and productivity of members

Bankmed participates in an annual survey commissioned by Health Quality Assessment (HQA), which measures the clinical quality of the benefit offering of medical schemes. Based on the HQA findings, Bankmed is ahead of the industry in many clinical quality indicators.

With benefits that are beyond the average and exceptional financial sustainability forming the foundation of Bankmed Medical Scheme, your needs are our sole consideration. Beyond profits, beyond the thin veneer of add-ons and incentives, is an exclusive commitment to you.

Because Bankmed is for you.

For your family.

For your good health.

Size of membership

1914

5 Members

2016

200 000+ Members

Bankmed is ranked among the top seven restricted medical schemes in the country – based on its sustainability.

– Alexander Forbes, 2016

What sets Bankmed apart

35%
better value in
2016

Compared to the average open scheme*

AA+

Global Credit Rating – 2016
(Highest in the industry)

43.3%
vs
33.3%

Bankmed Solvency Ratio
vs Industry Average

9%
vs industry average of
11%

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

6
Health Plans

A fair spread of Health Plans from which to choose, providing for low to high healthcare needs and affordability

Our value proposition includes:

Preventative Care and Wellness

Good health starts with knowing your health. Bankmed offers wellness initiatives and on-site (at your offices) Wellness Days and preventative care programmes that help us to identify your risks early, in order for us to manage your health optimally.

Prescribed Minimum Benefits (PMBs)

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

Good Governance

Bankmed is governed by a competent Board of Trustees who prioritise the interests of the members and the sustainability of the Scheme.

Sexual Health

Pap smears and birth control are available along with our circumcision benefit. In addition, members have access to HIV counselling and testing which forms part of your Insured Benefit, along with a full Treatment Programme.

Bankmed is always with you

With our Bankmed App and Electronic Health Record, you always have Bankmed by your side, wherever you or your family happen to be.

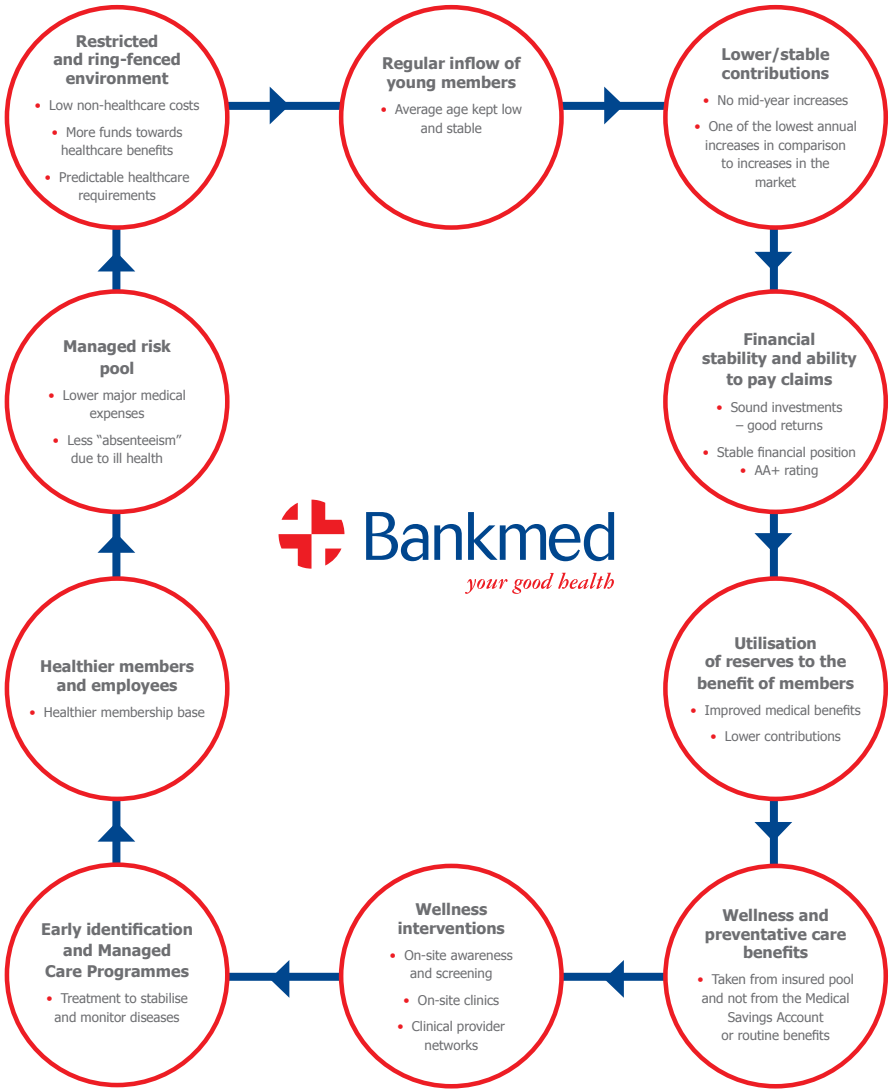
On-site Support

Bankmed offers on-site support to assist with any aspect of your medical scheme.

* based on an independent actuarial analysis

The Bankmed Value Cycle

The value of Bankmed is evident with over 100 years of history, which is made real through our commitment to you, to your family, to your good health.



A promise for a select few

Our commitment to you, each and every member, is reflected in the value we provide. We do this in the tailored Plans and benefits that are designed specifically for your 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 that reflect our understanding of your career, your challenges, your workplace and the risks that you face on a daily basis.

Bankmed offers incredible value for money

Apart from the six different Plans that speak to your financial means, Bankmed has consistently shown that we are – Rand for Rand – one of the most competitive medical schemes on the market, in terms of cost versus benefits offered.

Bankmed has spent over 100 years providing our members with value that can only be derived from bringing together the best in the business.
Your business is banking. Our business is keeping you healthy.

Bankmed exists solely for your medical needs

Bankmed is a not-for-profit organisation that reports to its members and not a group of shareholders and is effectively managed by a Board of Trustees. Every cent that goes into Bankmed Medical Scheme is used for the betterment of the members.

Bankmed has a very stable risk pool

The nature of the banking sector means that there are always younger members joining.This continual influx of younger, healthier members to the bank means a consistent refreshing of the member pool, along with members that remain with the Scheme for longer.

Bankmed offers integrated wellness initiatives

A huge part of the Bankmed value offering are our integrated wellness initiatives. Managing your health effectively is made easier with on-site wellness days and wellness clinics that identify areas of risk. These wellness initiatives are run by healthcare providers and all results are kept completely confidential.

Bankmed offers you the support you need

Early identification through the wellness initiatives is backed up by comprehensive treatment and Managed Care Programmes.

Getting the most out of your Plan

No matter which Plan you choose to look after your health, there are a few ways in which you can gain the maximum benefit and value for your money. Where possible, we have indicated the corresponding page in your 2017 Benefit & Contribution Schedule that will provide you with more information:

- Make use of day clinics rather than private hospitals for authorised planned admissions to avoid out-of-pocket payments (deductibles). See page 15 for a list of day clinic admissions that will not incur a deductible on admission.
- Undergo regular health screenings. They are paid from your Insured Benefits. See Wellness and Preventative Care benefits on pages 13 to 14.
- Save on medical expenses by utilising a network of Designated Service Providers (DSPs).
- Save on day-to-day benefits. Register on the Medicine Advisory Services Programme for chronic medication or the Baby-and-Me Maternity Programme.
- Manage your communication details, monitor your benefit usage, view your Electronic Health Record (EHR), request membership and tax certificates, find a specialist and more, via the website at www.bankmed.co.za.
- Keep your medical information with you by downloading the Bankmed App to your Smartphone or feature phone. Visit www.bankmed.co.za for details.

Remember

You have access to 24-hour medical transport and a medical advice hotline on 0860 999 911, as well as unlimited hospitalisation in the event of an emergency.

Hospital admission guidelines

Important information when being admitted to hospital

Being admitted to hospital is often stressful. We hope that by sharing this information with you, we will help you to better manage the circumstances surrounding the admission, to limit avoidable out-of-pocket expenses and to make the event as stress-free as possible.

Hospital pre-authorisation

Pre-authorisation must be obtained before any planned hospital admission or within 24-hours following an emergency admission.

Contact us for pre-authorisation as soon as you and your doctor have agreed on a time and date for admission. Relevant contact details are provided on page 2.

Have the following information on hand when calling for pre-authorisation:

- Your treating doctor's practice number
- Name of the hospital to which you or your dependant will be admitted (and when)
- The diagnosis code (ICD-10 code), and
- Any tariff and procedure codes that will be used.

Your treating doctor will be able to provide you with the above information.

An authorisation letter will be sent directly to the hospital as soon as the admission is approved and an SMS with pre-authorisation details will be sent to you, if we have your cellphone number on record. A copy of the hospital authorisation letter can be forwarded to you on request.

Deductibles payable on admission to hospital

You may be required to pay a deductible (co-payment) upon admission to hospital for certain admissions to private hospitals and day clinics (see page 16 for details). There are no deductibles for emergencies, re-admissions within six weeks of discharge, childbirth and PMB conditions.

Members will only be responsible for one deductible payment per admission. However, these are calculated using the highest deductible values that may apply to the admission. Below are two simple examples that illustrate this:

1. A Traditional Plan member accessing a non-network hospital to undergo dental treatment will pay the R4 500 non-network usage deductible, as this value is more that the dental deductible; or

2. A Comprehensive Plan member accessing a non-network hospital to undergo dental treatment will pay the R1 600 dental deductible, as this value is more that the non-network deductible.

Pre-authorisation is not a guarantee of payment

Pre-authorisation relates to the clinical appropriateness of the hospital admission. It is not a guarantee that all costs associated with the event will qualify for benefits or be covered in full.

Always refer to the benefit schedule for limits applicable to your Plan, and contact us on 0800 BANKMED (0800 226 5633) for benefit confirmation if you are unsure.

Reimbursement for treating doctors

The benefits (rate of cover and limits) to which you are entitled are set out in the benefit schedule from pages 12 to 36.

Always discuss costs with the treating doctor to determine whether he or she charges private rates (over and above what Bankmed covers on your Plan), as you will be liable for the difference. Ask whether other Healthcare Professionals (such as an anaesthetist or an assistant) will be involved in the treatment and whether they will be charging Scheme Rates.

There is significant value in negotiating tariffs upfront to limit the possibility of large out-of-pocket payments.

Reduced fees are payable when multiple procedures are performed under the same anaesthetic

Industry guidelines require that doctors charge lower tariffs (fees) for second and subsequent procedures performed under one anaesthetic, than they would charge when performing these procedures individually. Your treating doctor will be aware of these guidelines and should apply them to his or her accounts. Ask him or her to go through any planned charges with you, before you incur any costs. If more than one procedure is being performed under one anaesthetic, you will definitely benefit from making sure that you are not billed the full amount for the second and subsequent procedures being performed.

Prescribed Minimum Benefits (PMBs)

All emergency medical conditions and PMBs are covered, subject to PMB regulations. Please read more about PMBs on pages 41 to 43.

Discharge planning

Whilst you are in hospital, a case manager will stay in contact with the doctor and/or hospital to ensure that the authorisation is updated should there be any changes to the treatment plan.

The case manager will also assist with discharge planning should further rehabilitation be required in an alternative setting, such as a step-down facility or if home nursing is required.

Discharge planning will always take place in consultation with your doctor and benefits for step-down facilities and/or home nursing will be subject to the benefit limits applicable to your Plan.

Example

If pre-authorisation is granted for a hip replacement procedure, the hospital account could be covered in full (after the deductible), but the benefit for the prosthesis may be limited, depending on which Bankmed Plan you are on. Internal prosthesis limits are specified on pages 20 to 21.

Cover for emergencies

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

What to do in an emergency?

In an emergency, you may contact Discovery 911 on 0860 999 911 – this number is displayed on the front of your membership card for ease of reference.

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 all emergency calls. The line is managed by highly qualified emergency personnel, who will assess each case and provide immediate feedback and assistance.

Should 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. Should you be admitted to hospital, we cover your emergency hospital admission. There is no overall limit for hospital cover on your Plan.

Phoning from outside South Africa?

Should you be overseas you may contact us on +27 11 529 6616 for any queries or emergencies.

Note: This service is only available for international callers.

Glossary of terms

Term	Acronym	What
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 to specific Plans.
Annual Threshold	AT	A predetermined Rand value which is calculated based on the number 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.
Approved Baskets of Care (previously referred to as "Care Plans")	ABC	This is a predefined set of out-of-hospital consultations, procedures and diagnostic tests which are covered to manage Prescribed Minimum Benefit conditions.
Bankmed Rate (Scheme Rate)	BR	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.
Body Mass Index	BMI	Formula used to determine whether a person is within an acceptable weight range for his or her body. To calculate the BMI, divide weight in kilograms by height in centimetres squared. A healthy BMI is between 18 and 25.
Benefit Entry Criteria	BEC	Specific medical standards a member's doctor must have met in order for the member's condition to be covered by the Chronic Illness Benefit and to receive sustainable funding for cost-effective treatment.
Cost	C	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 for offering their benefits for Prescribed Minimum Benefit conditions.
Emergency Medical Condition	EMC	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.
External Medical Items	EMI	Medical items used on the exterior of the body such as prosthetic limbs, wheelchairs, crutches etc.
List of covered medicine (formulary)	F	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	IB	This is an out-of-hospital benefit that pays directly from a members risk spend, instead of from the member's Medical Savings Account.
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 to 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	PP	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 specific 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 listed and Chronic Disease List conditions in Annexure A of the Regulations or any emergency medical condition").
Rand Value	RV	This is the South African Rand amount a member would have paid if the specified service or treatment was obtained in South Africa.
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.

Overview of the Plan offerings

The table below provides an overview of the six Plans.

Plan	Wellness and preventative care benefits to assess risk factors, prevent illness and improve your health	Designated Service Providers (DSPs)	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	R22 900 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	R19 200 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 PMB and Basic plans In-hospital GP/specialist procedures covered at 125% of Scheme Rate	R17 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 (prescribed minimum benefits).

NB: Out-of-Hospital nurse-based services are covered on all Plans as follows: Three consultations and associated procedures covered from Insured Benefits. See page 31 for details.

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
Does this plan have a Medical Savings Account (MSA)? If "yes", please refer to the relevant contributions table on page 38. You can also read more about MSAs on page 45.		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)** **Visit www.bankmed.co.za and select "Registered Rules" and then "Exclusions (Annexure C)" for a comprehensive list of Scheme exclusions. 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 Associated benefits calculated as if the services were rendered in South Africa and limited to 100% of the Bankmed GP Entry Plan Network rate or Scheme Rate or other contracted rate (whichever would normally apply) for an equivalent non-PMB service in South Africa In the case of internal prosthesis and/or medical and surgical appliances (cover for PMBs only), funding will be limited to the amount or rate at which the Scheme would normally fund or procure such a 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 non-emergency surgery outside the borders of South Africa	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 a 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 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)	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 a 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	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 a 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	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 a 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	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 a 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
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 this schedule. Any relevant costs not provided for in this section, may be funded from available out-of-hospital benefits or Medical Savings Account (where applicable). The cost of associated consultations is not included in this section, unless indicated. See "GPs: Consultations in rooms" on pages 28 to 29 and "Specialists: Consultations in rooms" on page 30 of this schedule, for available consultation benefits on your Plan.						
3.1	**Glaucoma screening**	100% of Scheme Rate, limited to one screening pbpa age 55 years or older					
3.2	**Influenza vaccine**	100% of the Scheme's Medicine Reference Price, limited to one vaccination pbpa					
3.3	**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					
3.4	**Childhood vaccinations** (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 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
3.5	**Pneumococcal vaccine**	100% of the Scheme's Medicine Reference Price, limited as follows: • One vaccination per annum for adults 60 years and older • One vaccination per annum for beneficiaries younger than 60 years, who have been diagnosed with asthma, chronic obstructive pulmonary disease, diabetes, cardiovascular disease or HIV/AIDS					
3.6	**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)					
3.7	**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)					
3.8	**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)					
3.9	**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)					
3.10	**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 this schedule					
3.11	**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					
3.12	**Cholesterol screening, blood sugar screening and blood pressure measurements**	100% of cost, limited to R265 pbpa at clinics, pharmacies or Bankmed GP Entry Plan Network GPs' consulting rooms	100% of cost, limited to R265 pbpa at clinics, pharmacies or Bankmed GP Entry Plan Network GPs' consulting rooms	100% of cost, limited to R265 pbpa at clinics, pharmacies or doctors' consulting rooms	100% of cost, limited to R265 pbpa at clinics, pharmacies or doctors' consulting rooms	100% of cost, limited to R265 pbpa at clinics, pharmacies or doctors' consulting rooms	100% of cost, limited to R265 pbpa at clinics, pharmacies or doctors' consulting rooms
3.13	**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
3.14	**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 R420 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 R420 pbpa	100% of Scheme Rate, limited to one pbpa One associated nurse, GP or specialist consultation pb covered as an additional Insured Benefit, limited to R420 pbpa	100% of Scheme Rate, limited to one pbpa One associated nurse, GP or specialist consultation pb covered as an additional Insured Benefit, limited to R420 pbpa	100% of Scheme Rate, limited to one pbpa One associated nurse, GP or specialist consultation pb covered as an additional Insured Benefit, limited to R420 pbpa	100% of Scheme Rate, limited to one pbpa One associated nurse, GP or specialist consultation pb covered as an additional Insured Benefit, limited to R420 pbpa
3.15	**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; subject to completion and follow-up of assessment	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; subject to completion and follow-up of assessment	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; subject to completion and follow-up of assessment	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; subject to completion and follow-up of assessment	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; subject to completion and follow-up of assessment	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; subject to completion and follow-up of assessment
3.16	**Contraception: Oral contraceptives, devices and injectables**	No benefit	100% of cost, limited to R1 670 per female beneficiary per annum (oral contraceptives limited to one prescription or repeat prescription pb per month)	100% of cost, limited to R1 670 per female beneficiary per annum (oral contraceptives limited to one prescription or repeat prescription pb per month)	100% of cost, limited to R1 670 per female beneficiary per annum (oral contraceptives limited to one prescription or repeat prescription pb per month)	100% of cost, limited to R1 670 per female beneficiary per annum (oral contraceptives limited to one prescription or repeat prescription pb per month)	100% of cost, limited to R1 670 per female beneficiary per annum (oral contraceptives limited to one prescription or repeat prescription pb per month)

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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 this schedule, with continued funding for PMBs, subject to PMB regulations, after depletion of the relevant sub-limits.						
4.1	**Consultations and pathology**	Unlimited 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					
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					
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					
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 PRE-AUTHORISATION MAY LEAD TO BENEFITS BEING FORFEITED OR CO-PAYMENTS APPLIED **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 this schedule. The benefits under "hospitalisation" refer only to the hospital account • Any Healthcare Professionals attending to you during your hospital stay will submit their own accounts; these will be subject to the benefits, limits and/or any special conditions set out in this schedule under the relevant benefit categories • 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 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
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 ward rate
7.3	**Deductibles** Member to pay hospital or day clinic directly upon admission. Deductibles are payable for all hospital admissions, except under the following circumstances: 1. All Prescribed Minimum Benefit conditions including confinements and emergency medical conditions, as defined in the regulations governing the Prescribed Minimum Benefits. 2. Re-admissions to hospital within six weeks of discharge, following complications directly related to a prior admission for which a deductible was levied. 3. Admissions to a State Hospital. 4. Authorised day clinic admissions for specified procedures, as communicated to members from time to time. In addition to the above, the specified deductible shall not apply for day clinic admissions for the following procedures (subject to pre-authorisation having been obtained prior to admission): • Adenoidectomy (for children up to 12 years) • Circumcision (for children up to 12 years) • Myringotomy • Tonsillectomy • Tonsillectomy and adenoidectomy • Upper gastro-intestinal endoscopy, and • Vasectomy.						

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
7.3.1	**Hospital Network DSP deductible (specified list of conditions and procedures only)**						
	The following conditions/ procedures will always attract a deductible at a hospital/day clinic: • Colonoscopy • Gastroscopy • Oesophagoscopy • Proctoscopy • Sigmoidoscopy • Adenoidectomy • Myringotomy • Myringotomy with intubation (grommets) • Tonsillectomy • Cystourethroscopy • Circumcision • Simple abdominal hernia repair • Nasal plugging for nose bleeds • Nasal cautery • Vasectomy • Prostate biopsy • Arthrocentesis • Removal of pins and plates • Hysteroscopy • Diagnostic D and C • Vulva/cone biopsy • Cautery of vulva warts • Treatment of Bartholins cyst/gland	No deductible payable for PMBs	Deductible per admission: Day clinic: R215 Hospital: R540	Deductible per admission: Day clinic: R215 Hospital: R540	Deductible per admission: Day clinic: R215 Hospital: R540	Deductible per admission: Day clinic: R215 Hospital: R540	Deductible per admission: Day clinic: R215 Hospital: R540
7.3.2	**Other Hospitals (Non-DSPs)**						
	PMB admission: voluntary use of non-DSP (deductible applies to all admissions)	No deductible applies	Deductible per admission: Day clinic: R215 Hospital: R540	Deductible per admission: Day clinic: R215 Hospital: R540	Deductible per admission: Day clinic: R215 Hospital: R4 500	Deductible per admission: Day clinic: R215 Hospital: R540	Deductible per admission: Day clinic: R215 Hospital: R540
	Non-PMB admission	No benefit for non-PMB admissions	Deductible per admission: Day clinic: R215 Hospital: R540	Deductible per admission: Day clinic: R215 Hospital: R540	Deductible per admission: Day clinic: R215 Hospital: R4 500	Deductible per admission: Day clinic: R215 Hospital: R540	Deductible per admission: Day clinic: R215 Hospital: R540
7.3.3	**Dental Admission Deductibles**						
	DSPs and Non-DSPs:	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	Deductible per admission: Day clinic: R215 Hospital: R1 600	Deductible per admission: Day clinic: R215 Hospital: R1 600	Deductible per admission: Day clinic: R215 Hospital: R1 600
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.					

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
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", as described on page 30					
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 the 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 described on pages 28 to 29.					
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 this schedule, limited to PMBs	Benefits for hospitalisation as specified elsewhere in this schedule, limited to PMBs	Benefits for hospitalisation as specified elsewhere in this schedule, limited to PMBs	Benefits for hospitalisation as specified elsewhere in this schedule	Benefits for hospitalisation as specified elsewhere in this schedule	Benefits for hospitalisation as specified elsewhere in this schedule
11.2	**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)**	Limited to PMBs • 100% of cost, limited to PMBs • 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs • 100% of cost, limited to PMBs	Limited to PMBs • 100% of cost, limited to PMBs • 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs • 100% of cost, limited to PMBs	Limited to PMBs • 100% of cost, limited to PMBs • 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs • 100% of cost, limited to PMBs	Unlimited • 100% of cost • 80% of Scheme Medicine Reference Price plus contracted dispensing fee • 100% of cost	Unlimited • 100% of cost • 80% of Scheme Medicine Reference Price plus contracted dispensing fee • 100% of cost	Unlimited • 100% of cost • 80% of Scheme Medicine Reference Price plus contracted dispensing fee • 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
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
12.2	**Radiotherapy fees, chemotherapy facility and professional fees**	100% of Scheme Rate					
12.3	**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)**	Limited to PMBs • 100% of cost, limited to PMBs • 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs • 100% of cost, limited to PMBs	Limited to PMBs • 100% of cost, limited to PMBs • 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs • 100% of cost, limited to PMBs	Limited to PMBs • 100% of cost, limited to PMBs • 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs • 100% of cost, limited to PMBs	Unlimited • 100% of cost • 80% of Scheme Medicine Reference Price plus contracted dispensing fee • 100% of cost	Unlimited • 100% of cost • 80% of Scheme Medicine Reference Price plus contracted dispensing fee • 100% of cost	Unlimited • 100% of cost • 80% of Scheme Medicine Reference Price plus contracted dispensing fee • 100% of cost

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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):** • **Medication via designated pharmacy (DSP)** • **Medication via non-DSP (voluntary use of non-DSP)** • **Medication via non-DSP (involuntary use of non-DSP)**	Limited to PMBs • 100% of cost, limited to PMBs • 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs • 100% of cost, limited to PMBs	Limited to PMBs • 100% of cost, limited to PMBs • 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs • 100% of cost, limited to PMBs	Limited to PMBs • 100% of cost, limited to PMBs • 80% of Scheme Medicine Reference Price plus contracted dispensing fee, limited to PMBs • 100% of cost, limited to PMBs	Unlimited • 100% of cost • 80% of Scheme Medicine Reference Price plus contracted dispensing fee • 100% of cost	Unlimited • 100% of cost • 80% of Scheme Medicine Reference Price plus contracted dispensing fee • 100% of cost	Unlimited • 100% of cost • 80% of Scheme Medicine Reference Price plus contracted dispensing fee • 100% of cost
14	**PREGNANCY AND CHILDBIRTH**						
14.1	**Baby-and-Me Programme for expectant mothers**	No benefit	No benefit	Call 0800 226 5633 (0800 BANKMED) to register - see 14.8	Call 0800 226 5633 (0800 BANKMED) to register - see 14.8	Call 0800 226 5633 (0800 BANKMED) to register - see 14.8	Call 0800 226 5633 (0800 BANKMED) to register - see 14.8
14.2	**Hospitalisation and associated in-hospital services (subject to pre-authorisation)**	Benefits as specified elsewhere in this schedule Hospital network rules apply Limited to PMBs	Benefits as specified elsewhere in this schedule Hospital network rules apply	Benefits as specified elsewhere in this schedule Hospital network rules apply	Benefits as specified elsewhere in this schedule Hospital network rules apply	Benefits as specified elsewhere in this schedule Hospital network rules apply	Benefits as specified elsewhere in this schedule 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 R960 per case Limited to PMBs	100% of Scheme Rate, unlimited Cost of disposables limited to R960 per case	100% of Scheme Rate, unlimited Cost of disposables limited to R960 per case	100% of Scheme Rate, unlimited Cost of disposables limited to R960 per case	100% of Scheme Rate, unlimited Cost of disposables limited to R960 per case	100% of Scheme Rate, unlimited Cost of disposables limited to R960 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 this schedule Limited to PMBs	Benefits for GPs and specialists as specified elsewhere in this schedule	Benefits for GPs and specialists as specified elsewhere in this schedule Additional Insured Benefits - see 14.8	Benefits for GPs and specialists as specified elsewhere in this schedule Additional Insured Benefits - see 14.8	Benefits for GPs and specialists as specified elsewhere in this schedule Additional Insured Benefits - see 14.8	Benefits for GPs and specialists as specified elsewhere in this schedule
14.6	**Antenatal and postnatal care: Ultrasonic investigations (radiology)**	Benefits for radiology as specified elsewhere in this schedule 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 this schedule	Benefits for radiology as specified elsewhere in this schedule Additional Insured Benefits - see 14.8	Benefits for radiology as specified elsewhere in this schedule Additional Insured Benefits - see 14.8	Benefits for radiology as specified elsewhere in this schedule Additional Insured Benefits - see 14.8	Benefits for radiology as specified elsewhere in this schedule

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
14.7	**Antenatal and postnatal care: Pathology**	Benefits for pathology as specified elsewhere in this schedule Limited to PMBs	Benefits for pathology as specified elsewhere in this schedule	Benefits for pathology as specified elsewhere in this schedule Additional Insured Benefits - see 14.8	Benefits for pathology as specified elsewhere in this schedule Additional Insured Benefits - see 14.8	Benefits for pathology as specified elsewhere in this schedule Additional Insured Benefits - see 14.8	Benefits for pathology as specified elsewhere in this schedule
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 this schedule • two 2D ultrasounds at 100% of Scheme Rate • R1 180 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 this schedule • two 2D ultrasounds at 100% of Scheme Rate • R1 180 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 this schedule • two 2D ultrasounds at 100% of Scheme Rate • R1 180 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
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 on page 30, 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 020 pfpa	Radiology: 100% of Scheme Rate, limited to R3 370 pfpa (including a sub-limit of R1 120 pfpa for out-of-hospital pathology); thereafter subject to available Medical Savings Account Pathology: 100% of Scheme Rate, limited to R1 120 pfpa (included in the annual limit of R3 370 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 360 pfpa

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
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 R51 000 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 R51 000 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 R51 000 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 R51 000 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 R400 pb per day	50% of cost, limited to R400 pb per day	50% of cost, limited to R400 pb per day
16.6	**Home Nursing**	No benefit	No benefit	No benefit	100% of cost, limited to R305 pb per day	100% of cost, limited to R305 pb per day	100% of cost, limited to R305 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 R61 000 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 R61 000 pbpa for all internal prosthesis items	100% of cost as per Internal Prosthesis List, subject to a combined limit of R61 000 pbpa for all internal prosthesis items	100% of cost as per Internal Prosthesis List, subject to a combined limit of R61 000 pbpa for all internal prosthesis items	100% of cost as per Internal Prosthesis List, subject to a combined limit of R61 000 pbpa for all internal prosthesis items	100% of cost as per Internal Prosthesis List, subject to a combined limit of R61 000 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 R41 100 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R41 100 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R41 100 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R41 100 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R41 100 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 R60 750 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R60 750 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R60 750 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R60 750 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R60 750 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 R32 900 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R32 900 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R32 900 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R32 900 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R32 900 pbpa Subject to the combined Internal Prosthesis limit

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
17.5	**Cardiac valves**	Limited to PMBs 100% of cost for PMBs	100% of cost of device Limited to R34 600 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R34 600 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R34 600 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R34 600 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R34 600 pbpa Subject to the combined Internal Prosthesis limit
17.6	**Hip, knee and shoulder joints**	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate for device Limited to R40 600 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 R40 600 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 R40 600 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 R40 600 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 R40 600 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 R18 950 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R18 950 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R18 950 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R18 950 pbpa Subject to the combined Internal Prosthesis limit	100% of cost of device Limited to R18 950 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**	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
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 2017" 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	R14 430 pb per lifetime	R14 430 pb per lifetime	R14 430 pb per lifetime
20.3	**Cochlear implant device**	No benefit	No benefit	No benefit	R303 000 pb per lifetime	R303 000 pb per lifetime	R303 000 pb per lifetime
20.4	**Intra-operative audiology testing**	No benefit	No benefit	No benefit	R760 pb per lifetime	R760 pb per lifetime	R760 pb per lifetime
20.5	**Post-operative evaluation costs**	No benefit	No benefit	No benefit	R30 300 pb per lifetime	R30 300 pb per lifetime	R30 300 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 R113 150 pb over a five-year cycle	80% of cost, limited to R113 150 pb over a five-year cycle	80% of cost, limited to R113 150 pb over a five-year cycle

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
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 R24 300 per beneficiary every second year Benefit only available where beneficiary has not claimed for hearing aid/s in the previous calendar year	100% of cost, limited to R24 300 per beneficiary every second year Benefit only available where beneficiary has not claimed for hearing aid/s in the previous calendar year	100% of cost, limited to R28 400 per beneficiary every second year Benefit only available where beneficiary has not claimed for hearing aid/s in the previous calendar year
22.2	**Hearing aid repairs**	No benefit	No benefit	100% of cost, subject to available Medical Savings Account	100% of cost, limited to R1 260 pbpa	100% of cost, limited to R1 260 pbpa	100% of cost, limited to R1 260 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 R130 000 pfpa	90% of cost, limited to R130 000 pfpa	90% of cost, limited to R130 000 pfpa
23	**EXTERNAL PROSTHESIS, MEDICAL AND SURGICAL APPLIANCES, BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS** **Unless otherwise stated, benefits are subject to a doctor's prescription, clinical motivation and Scheme approval** **Bankmed reserves the right to request additional quotations prior to granting benefits** **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 680 pfpa Combined limit with medical and surgical appliances, blood pressure monitors, nebulisers and glucometers	100% of cost Limited to R2 680 pfpa Combined limit with medical and surgical appliances, blood pressure monitors, nebulisers, glucometers, arch supports and shoe insoles	100% of cost Limited to R20 800 pfpa	100% of cost Limited to R20 800 pfpa	100% of cost Limited to R20 800 pfpa
23.2	**Medical and Surgical Appliances**	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 680 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 680 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 120 pbpa Chronic appliances 100% of cost, limited to: • R19 220 pbpa for oxygen/ oxygen delivery systems • R19 220 pbpa for stoma products • *R6 120 pbpa for other chronic appliances, including wheelchairs • Sub-limits apply as follows: - R755 arch supports (per pair) - R1 135 shoe insoles (per pair) • Appliances for acute conditions: - 100% of cost, subject to other chronic appliances limit of R6 120 pbpa *Other chronic appliances limit extended to R8 950 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 120 pbpa Chronic appliances 100% of cost, limited to: • R19 220 pbpa for oxygen/ oxygen delivery systems • R19 220 pbpa for stoma products • *R6 120 pbpa for other chronic appliances, including wheelchairs • Sub-limits apply as follows: - R755 arch supports (per pair) - R1 135 shoe insoles (per pair) • Appliances for acute conditions: - 100% of cost, subject to available Medical Savings Account *Other chronic appliances limit extended to R8 950 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 120 pbpa Chronic appliances 100% of cost, limited to: • R19 220 pbpa for oxygen/ oxygen delivery systems • R19 220 pbpa for stoma products • *R6 120 pbpa for other chronic appliances, including wheelchairs • Sub-limits apply as follows: - R755 arch supports (per pair) - R1 135 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 R8 950 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 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
23.3	**Blood Pressure Monitors, Nebulisers and Glucometers**	Subject to pre-authorisation Limited to PMBs	Subject to pre-authorisation Combined limit of R2 680 pfpa with external prosthesis and medical/surgical appliances	Available on prescription without additional motivation or Scheme approval Subject to the combined limit of R2 680 pfpa with external prosthesis and medical/surgical appliances, and further limited as follows: • Blood pressure monitors: R1 030 pfpa • Nebulisers: R1 450 pfpa • Glucometers: R730 pfpa	Available on prescription without additional motivation or Scheme approval Subject to the combined limit of R6 120 pbpa for "other chronic appliances" under medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 030 pfpa • Nebulisers: R1 450 pfpa • Glucometers: R730 pfpa	Available on prescription without additional motivation or Scheme approval Subject to the combined limit of R6 120 pbpa for "other chronic appliances" under medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 030 pfpa • Nebulisers: R1 450 pfpa • Glucometers: R730 pfpa	Available on prescription without additional motivation or Scheme approval Subject to the combined limit of R6 120 pbpa for "other chronic appliances" under medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 030 pfpa • Nebulisers: R1 450 pfpa • Glucometers: R730 pfpa
23.4	**Arch Supports and Shoe Insoles**	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 680 pfpa • Sub-limits apply as follows: - R755 arch supports (per pair) - R1 135 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 120 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

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
24	**PSYCHIATRY, CLINICAL PSYCHOLOGY AND RELATED OCCUPATIONAL THERAPY**						
24.1	**Hospitalisation and in-hospital consultations/ sessions (subject to pre-authorisation)**	Limited to PMBs and subject to referral by 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 and subject to referral by 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	R57 000 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 in-hospital Continued benefits for PMBs subject to pre-authorisation and PMB regulations	R57 000 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 in-hospital Continued benefits for PMBs subject to pre-authorisation and PMB regulations	R57 000 pbpa covered as follows: • 100% of cost at contracted rate for Bankmed Network Specialists (DSP) • 100% of Scheme Rate for non-DSPs Combined limit with occupational therapy: psychiatric consultations/sessions in-hospital Continued benefits for PMBs subject to pre-authorisation and PMB regulations	R57 000 pbpa covered as follows: • 100% of cost at contracted rate for Bankmed Network Specialists (DSP) • 100% of Scheme Rate for non-DSPs Combined limit with occupational therapy: psychiatric consultations/sessions in-hospital Continued benefits for PMBs subject to pre-authorisation and PMB regulations
24.2	**Consultations/sessions out-of-hospital**	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 570 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 R8 900 pbpa for depression and/or bipolar mood disorder, subject to pre-authorisation and PMB regulations	R4 175 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 950 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 R12 600 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

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
25	**OCCUPATIONAL THERAPY**						
25.1	**Psychiatric consultations/ sessions in-hospital (subject to pre-authorisation)**	See "Psychiatry, clinical psychology and related occupational therapy: Hospitalisation and in-hospital consultations/sessions" on page 24					
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 750 pfpa	100% of Scheme Rate, limited to R1 840 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 340 pfpa Subject to PMB regulation
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 750 pfpa	100% of Scheme Rate, limited to R1 900 pfpa 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 R1 900 pfpa

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
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 530 pfpa	100% of Scheme Rate, limited to R2 100 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 on pages 28 to 29	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 530 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 (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
28.3	**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 680 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 680 pfpa

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
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, unlimited 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
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 • One topical fluoride treatment per child per year • Scale and polish limited to two pbpa	100% of Scheme Rate, unlimited; paid from Insured Benefits Limited to: • One oral examination pbpa • Amalgam and resin fillings only • Plastic dentures only • One topical fluoride treatment per child per year • 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 R15 200 for a single member and R23 000 for a family
31.2	**Advanced dentistry (caps, crowns, bridges and cost of endosteal and ossea-integrated 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: R5 860 pbpa M + 1 +: R9 100 pfpa Combined limit for advanced dentistry, orthodontics and all other dental services	100% of Scheme Rate, limited to: M: R4 570 pbpa M + 1 +: R7 650 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 R7 650 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 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
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 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

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
32.4	**GPs: Consultations in rooms**	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	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 850 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: R2 950 pbpa • M + 1: R5 360 pfpa • M + 2 +: R6 200 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 Rooms**	Limited to PMBs • 100% of 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) • 300% 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.

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
33	**SPECIALISTS** **NB: Psychiatrists, oncologists, radiologists, pathologists, maxillofacial and oral surgeons and other dental practitioners are dealt with elsewhere in this schedule**						
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 for Bankmed Network Specialists (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate for Bankmed Network Specialists (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate for Bankmed Network Specialists (DSPs), unlimited • 100% Scheme Rate for non-DSPs	• 100% of cost of contracted rate for Bankmed Network Specialists (DSPs), unlimited • 125% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate for Bankmed Network Specialists (DSPs), unlimited • 300% of Scheme Rate for non-DSPs
33.2	**Specialists: Consultations in rooms (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 670 pbpa M + 1 +: R2 625 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 account 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 pre-authorisation 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 • 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
33.3	**Specialists: Procedures in rooms**	Limited to PMBs • 100% of cost at contracted rate, unlimited for 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	Paid from Insured Benefits • 100% of cost at contracted rate, unlimited, for Bankmed Network Specialists (DSPs) • 125% of Scheme Rate for non-DSPs	Paid from Insured Benefits • 100% of cost at contracted rate, unlimited, for Bankmed Network Specialists (DSPs) • 300% of Scheme Rate for non-DSPs

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
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

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
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 R520 pb at any other optometrist Benefits limited to one eye test or one re-examination or one composite examination pb every two years	Insured Benefits available every two years • 100% of cost for PPN optometrists OR • 100% of cost, limited to R520 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 R3 840 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 R800 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 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
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: R170 per lens pb • Clear bifocal lenses: R372 per lens pb • Clear multifocal lenses: R680 per lens pb • Two pairs of readymade readers at R85 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: R170 per lens pb • Clear bifocal lenses: R372 per lens pb • Clear multifocal lenses: R680 per lens pb • Two pairs of readymade readers at R85 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 260 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 395 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" on page 32
35.5	**Fitting of contact lenses**	No benefit	No benefit	100% of cost, subject to available Medical Savings Account	100% of cost, limited to R240 pbpa	100% of cost, limited to R240 pbpa	See "Optometry: Consultations" on page 32
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 370 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" on page 32 Limit on accumulation to Annual Threshold and/or payment as an ATB includes the cost of hospitalisation, medication and all other associated services

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
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 page 13 for additional Insured Benefits for "Contraception: Oral contraceptives, devices and injectables")**	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 GP 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 850 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 850 pfpa	100% of cost, subject to available Medical Savings Account	Limited to: M: R3 350 pbpa M + 1: R6 170 pfpa M + 2 +: R6 700 pfpa The above limits include a maximum allowance of R1 330 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 R15 200 for a single member and R23 000 for a family

		ESSENTIAL PLAN 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017
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 (see page 36), 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 330 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)	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 R17 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 R19 200 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 R22 900 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 2017	BASIC PLAN 2017	CORE SAVER PLAN 2017	TRADITIONAL PLAN 2017	COMPREHENSIVE PLAN 2017	PLUS PLAN 2017

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 "2017 Plan Information" and then "Medicine Formularies 2017" 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
Abdominal pain/dyspepsia/heartburn/indigestion (includes reflux)	2
Helminthic (worms) infestation	2
Conjunctivitis, bacterial	2
Topical candidiasis (topical thrush)	2
Oral candidiasis (oral thrush)	2
Headache - analgesia	2

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

Calculate your monthly contribution

Take a look at the 2017 contribution tables provided on the following page and follow the steps from A to E to determine how much the Plan you are considering may cost. Remember to ask your Employer whether you are eligible for any subsidies, as this may influence your decision in terms of affordability:

STEP A Determine into which income category you belong.

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

STEP C Multiply the number of adult dependants* by the relevant amount under "Adult Dependant" in the "Total Monthly Contribution" column.

STEP D Multiply the number of child dependants** by the relevant amount under "Child Dependant" in the "Total Monthly Contribution" column. You only pay for a maximum of three children.

STEP E Add the values you wrote down in steps B, C and D to calculate your total contributions.***

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

** A child dependant is the member's natural 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 under the age of 23.

*** Late joiner penalties, where applicable, are not factored into this calculation and must still be added where relevant.

Contributions for 2017

ESSENTIAL PLAN No Medical Savings Account

Gross Income (Rands)	Total Monthly Contribution		
	Member	Adult Dependant	Child Dependant
0 – 5 000	R 619	R 556	R 155
5 001 – 6 000	R 677	R 609	R 177
6 001 – 7 000	R 747	R 673	R 192
7 001 – 8 000	R 821	R 739	R 210
8 001 – 9 000	R 938	R 846	R 232
9 001 – 10 000	R 1 043	R 938	R 262
10 001+	R 1 189	R 1 071	R 299

BASIC PLAN No Medical Savings Account

Gross Income (Rands)	Total Monthly Contribution		
	Member	Adult Dependant	Child Dependant
0 – 5 000	R 929	R 694	R 233
5 001 – 6 000	R 1 019	R 764	R 264
6 001 – 7 000	R 1 123	R 839	R 289
7 001 – 8 000	R 1 233	R 936	R 316
8 001 – 9 000	R 1 408	R 1 068	R 353
9 001 – 10 000	R 1 567	R 1 185	R 393
10 001+	R 1 784	R 1 338	R 448

Important:

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

Although every effort was made to ensure complete accuracy of these contribution tables, errors may occur. In the event of a dispute, the registered rules shall apply. You may view the registered rules at www.bankmed.co.za

CORE SAVER PLAN With Medical Savings Account

Gross Income (Rands)	Total Monthly Contribution (including Medical Savings Account)			Medical Savings Account (included in Total Contribution)		
	Member	Adult Dependant	Child Dependant	Member	Adult Dependant	Child Dependant
0 – 5 000	R 1 349	R 1 015	R 339	R 199	R 150	R 50
5 001 – 6 000	R 1 445	R 1 085	R 361	R 213	R 160	R 53
6 001 – 7 000	R 1 546	R 1 161	R 386	R 228	R 171	R 58
7 001 – 8 000	R 1 624	R 1 219	R 407	R 240	R 180	R 61
8 001 – 9 000	R 1 751	R 1 315	R 442	R 259	R 194	R 65
9 001 – 10 000	R 1 840	R 1 382	R 461	R 271	R 203	R 68
10 001+	R 2 029	R 1 517	R 510	R 298	R 224	R 75

TRADITIONAL PLAN No Medical Savings Account

Gross Income (Rands)	Total Monthly Contribution		
	Member	Adult Dependant	Child Dependant
0 – 5 000	R 2 232	R 1 671	R 557
5 001 – 10 000	R 2 602	R 1 949	R 654
10 001+	R 2 708	R 2 033	R 678

COMPREHENSIVE PLAN With Medical Savings Account

Gross Income (Rands)	Total Monthly Contribution (including Medical Savings Account)			Medical Savings Account (included in Total Contribution)		
	Member	Adult Dependant	Child Dependant	Member	Adult Dependant	Child Dependant
0 – 10 000	R 2 903	R 2 174	R 730	R 512	R 383	R 129
10 001+	R 3 023	R 2 267	R 757	R 534	R 400	R 134

PLUS PLAN With Medical Savings Account

Gross Income (Rands)	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	R 5 074	R 3 799	R 1 271	R 1 187	R 889	R 297

Maternity

Baby-and-Me

Baby-and-Me is Bankmed's Maternity Programme that informs and empowers expectant moms and dads during pregnancy. The Baby-and-Me Programme is only available to members on the Core Saver, Traditional, Comprehensive and Plus Plans. Plus Plan members do not qualify for the Additional Insured Benefits, however.

Benefits of joining

To access additional Insured Benefits during pregnancy, such as ultrasounds, additional consultations and more, it is imperative that expectant moms register on the Baby-and-Me Programme.

A Client Relationship Manager will assist you in registering on the Programme and provide you with ongoing advice throughout your pregnancy and after the birth of your baby.

How to register

1. Complete the Baby-and-Me application form:
   - Download the form online from www.bankmed.co.za
   - Request the form by e-mailing babyandme@bankmed.co.za
   - Contact us toll-free on 0800 BANKMED (0800 226 5633).
2. To complete the form, you will require:
   - Bankmed membership number
   - Details of mom-to-be
   - Details of mom-to-be's caregiver (Healthcare Professional)
   - Expected date of delivery
   - Details of medical history and previous pregnancies (where applicable).
3. When you register you will receive:
   - A "Practical Guide to Pregnancy"* handbook
   - Regular communication at different milestones throughout your pregnancy
   - Assistance with hospital pre-authorisation
   - A hospital checklist to prepare you for your hospital stay
   - A gift from Bankmed to you
   - Access to Discovery 911 medical advice and information.

Netcells – Stem Cell Banking

A special offering, we have been able to arrange a unique discount for Bankmed members with 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.

Netcells, Next Biosciences' umbilical cord stem cell banking service, provides expectant parents with the opportunity to collect their newly born baby's umbilical cord blood and tissue stem cells and cryogenically store them for potential future medical use.

Please note that the expenses related to stem cell banking will not be covered by Bankmed. The cash discount that is offered is passed directly on to you and is not paid from your Health Plan benefits.

Benefits for members

Bankmed members may receive 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
- 15% discount on payment on stem cells being successfully banked or
- 10% 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.

How to register

It is advisable to register with Netcells at about 30 weeks of pregnancy.

Once your registration and confirmation of initial payment is received, an arrangement will be made to deliver a Netcells collection kit to you. You should take the collection kit box to the birth of your baby so that the obstetrician or midwife can collect the stem cells after your baby has been delivered.

For more information regarding umbilical cord stem cell banking, kindly contact Netcells directly:

- Telephone: 011 697 2900
- E-mail: info@nextbio.co.za
- Website: www.nextbio.co.za/netcells.

*The "Practical Guide to Pregnancy" handbook may be substituted without notice as supply is dependent upon stock availability.

Chronic Illness, Oncology and HIV cover

Chronic Illness

Cover for chronic conditions

The Chronic Illness Benefit provides cover for medication for conditions where ongoing medication is required for a period of three months or longer. This includes the list of 25 conditions (including HIV and AIDS) referred to as the Chronic Disease List.

You may start claiming for chronic medications once we have approved your cover. You are required to complete a Chronic Illness Benefit application form with your doctor and send it to us in order to qualify for the benefit.

How to manage your chronic condition

As a Bankmed member you have access to the Medicine Advisory Services. Bankmed Medicine Advisory Services aims to provide you with a structured way to achieve the desired results with your medication usage, 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. Medicine Advisory Services may be contacted 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 an immediate chronic medication authorisation, your doctor or pharmacist may contact Bankmed's Chronic Managed Care Department on 0800 132 345 as a direct line or 0800 BANKMED (0800 226 5633). Clinical entry and verification criteria will be applied.

Alternatively, application forms may also be completed by your doctor and submitted in the following ways:

Core Saver, Traditional, Comprehensive and Plus Plans

E-mail: chronic@bankmed.co.za

Fax: 011 770 6247

Essential and Basic Plans

E-mail: chronicbasicessential@bankmed.co.za

Fax: 011 539 7000

Oncology

Cover for cancer

Should you be diagnosed with cancer, you have access to cover via 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 PMBs only, subject to pre-authorisation.

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

Inclusion of chemotherapy, radiotherapy and other healthcare services fundable from the Oncology Programme will be subject to consideration of evidence-based medicine, cost effectiveness and affordability.

Healthcare services that are deemed by the Scheme to be unaffordable and not cost effective or lacking clinical evidence to demonstrate efficacy, are excluded from cover. Bankmed's Oncology Programme follows the South African Oncology Consortium guidelines to ensure that you have access to the most appropriate level of treatment for the particular stage of your cancer.

How to register on the Oncology Programme

You may register for the Oncology Programme through any of the following channels:

- Call: 0800 BANKMED (0800 226 5633)
- E-mail: oncology@bankmed.co.za
- Fax: 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 the right to privacy and confidentiality of our members. When you register for 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 may be assured of confidentiality at all times.

Approved medications on our medicine list are covered in full. Medications not on our list are covered up to a set monthly amount.

You will need to obtain your medication from a designated service provider (DSP) to avoid any co-payments.

How to register on the HIV Programme

You may register for the HIV Programme through any of the following channels:

- Call: 0800 BANKMED (0800 226 5633)
- E-mail: hiv@bankmed.co.za
- Fax: 011 539 3151.

Prescribed Minimum Benefits (PMBs)

Statutory Prescribed Minimum Benefits (PMBs) – applicable to South African claims only

Important information regarding PMBs: (please read carefully)

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

- 100% of the diagnosis, treatment and care costs of the statutory PMBs, subject to PMB regulations, if those services are obtained from a DSP in South Africa; or
- The relevant Scheme Rate for the diagnosis, treatment and care costs of the statutory PMBs, if a beneficiary voluntarily accesses PMBs via a non-DSP in South Africa, when provision is made for a DSP; or
- 100% of cost for **involuntary use of a non-DSP in South Africa, subject to PMB regulations**.

Please refer to the "Visual Overview of Plans" on pages 10 and 11 for a list of DSP Networks applicable to you. Then visit www.bankmed.co.za and select "Network Providers" to find specific DSPs near you.

Kindly note:

- PMB regulations and their accompanying provisions do not apply to healthcare services obtained outside the borders of South Africa.
- PMB-related claims for services obtained outside the borders of South Africa shall be treated as "normal" (non-PMB) claims, subject to the relevant Scheme Rate and any other limitations applicable to normal (non-PMB) claims within the borders of South Africa.
- Pre-authorisation, medicine formularies (medicine lists) and Scheme protocols may apply. Please refer to the benefit schedule for details as to when pre-authorisation is needed.
- 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 used for the payment of relevant claims (including PMBs); thereafter continued funding will apply for PMB claims only, subject to PMB regulations.
- Claims for PMB conditions may not be funded from Medical Savings Accounts, in accordance with directives from the Council for Medical Schemes (CMS).
- Where a benefit is indicated as "payable from Medical Savings Account" or as "no benefit" in this schedule, Insured (Scheme) Benefits will nevertheless be provided for PMBs in South Africa, subject to PMB regulations.

Involuntary use of a non-DSP: In relation to PMB services obtained within the borders of South Africa, a beneficiary will be deemed to have involuntarily obtained a service from a healthcare provider other than the DSP, if:

- The service was not available from the DSP or would not be provided without reasonable delay; and/or
- Immediate medical or surgical treatment for a PMB condition was required under circumstances or locations which reasonably precluded the beneficiary from obtaining such treatment from a DSP, or there was no DSP within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

Except in the case of an **emergency medical condition**, pre-authorisation must be obtained by a member prior to "involuntary use of a non-DSP", in order to enable the Scheme to confirm that the circumstances outlined above, are applicable.

Consumer education: Prescribed Minimum Benefits

All Plans

The following extracts from the Council for Medical Schemes (CMS) website will assist you in understanding PMBs. For more consumer information on PMBs, please feel free to visit www.medicalschemes.com.

What are PMBs?

PMBs are a set of defined benefits that ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected. The aim is to provide people with continuous care to improve their health and well-being and to make healthcare more affordable.

PMBs are a feature of the Medical Schemes Act, in terms of which medical schemes are required to cover the costs related to the diagnosis, treatment and care of:

- Any 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).

When deciding whether a condition is a PMB, the doctor should only look at the symptoms and not at any other factors, such as how the injury or condition was contracted. This approach is called diagnosis-based. Once the diagnosis has been made, the appropriate treatment and care is decided upon as well as where the patient should receive the treatment (at a hospital, as an outpatient or in a doctor's rooms).

What are emergency conditions?

An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/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 diagnose the condition before admitting the patient for treatment. However, if doctors suspect that the patient suffers from a condition that is covered by PMBs, the medical scheme has to approve treatment. Schemes may request that the diagnosis be confirmed with supporting evidence within a reasonable period of time.

Which conditions are covered?

The Regulations of the Medical Schemes Act provide a long list of conditions identified as PMBs. The list is in the form of Diagnosis and Treatment Pairs (DTPs).

A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximately 270 PMB conditions should be treated. The treatment and care of PMB conditions should be based on healthcare that has proven to work best, taking affordability into consideration. Should there be a disagreement regarding the treatment of a specific case, the standards (also called practice and protocols) in force in the public sector will be applied.

The treatment and care of some of the conditions included in the DTP may include chronic medication, e.g. HIV-infection and menopausal management. In these cases, the public sector protocols will also apply to the chronic medication.

Which chronic conditions are covered?

The Chronic Disease List (CDL) specifies medication 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.

To manage risk and ensure appropriate standards of healthcare, so-called treatment algorithms were developed for the CDL conditions.

The algorithms, which have been published in the Government Gazette, can be regarded as benchmarks, or minimum standards, for treatment. This means that the treatment your medical scheme provides may not be inferior to the algorithms.

If you have one of the 25 listed chronic diseases, your medical scheme not only has to cover medication, but also doctors' consultations and tests related to your condition. The scheme may make use of protocols, formularies (lists of specified medication) and DSPs to manage this benefit.

What are your responsibilities as a medical scheme consumer of PMBs?

Obtain as much information as possible about your condition and the medication and treatments for it.

If there is a generic drug available, do your own research to find out whether there are any differences between the generic and the branded or original drug.

Don't bypass the system: if you must use a GP to refer you to a specialist, then do so. Make use of the Scheme's DSPs (contracted healthcare providers) as far as possible. Stick with the Scheme's listed drug for your medication, unless it is proven to be ineffective.

Make sure your doctor submits a complete account to the Scheme. It is especially important that the correct diagnosis code (ICD-10 code) is reflected.

Follow up and check that your account is submitted within four months and paid within 30 days after the claim was received (accounts older than four months are not paid by medical schemes).

At Bankmed, these benefits are subject to pre-authorisation, the application of clinical protocols and managed care programmes. This means that you MUST apply for these benefits or you may lose your entitlement to them. Certain benefits are only covered in full if you use DSPs. Refer to page 10 for an overview of the DSPs for your Plan. Where sub-limits are specified for chronic medication, these are first used to pay for all chronic medication, including PMBs and thereafter continued benefits are only provided for PMBs.

Annual Threshold (AT) and Above Threshold Benefits (ATB) – Applicable to Plus Plan members only

Plus Plan members only

The Above Threshold Benefit (ATB) acts as a safety net in the event 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 doctor charges fees that are higher 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 accumulate towards the Annual Threshold.As soon as you reach the Annual Threshold, the ATB will kick in and you will have limited Insured Benefits available for the payment of further out-of-hospital claims. You can make your Medical Savings Account last longer and avoid a Self-payment Gap by visiting a doctor that charges fees that are in line with the Scheme Rate.

Please note that there are limits to the amounts that can jointly accumulate towards the Annual Threshold and be paid from the ATB for certain categories, such as, but not limited to:

- Prescribed acute medication
- Dentistry claims (including preventative and basic dentistry, advanced dentistry and all other dental services), and
- Optometry consultations, prescription lenses and ready-made readers, contact lenses, fitting of contact lenses and other optometric services such as refractive surgery.

Please refer to the detailed benefit schedule for information on other categories where such limits apply.

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

EXAMPLE:

You are a single member who joins the Plus Plan on 1 January 2017, with an Annual Threshold of R15 200 and an ATB of R14 200. The maximum amount that can jointly accumulate towards the Annual Threshold and be paid as an ATB for dentistry is R15 200 (of which not more than R14 200 can be paid from the ATB).

Your first claim for the year is a dentistry account for R9 000, charged at 100% of Scheme Rate:

The claim is settled in full from your Medical Savings Account and R9 000 accumulates towards reaching the Annual Threshold.

You submit further non-dental claims, which are paid from your available Medical Savings Account until you reach the Annual Threshold of R15 200.

You are now entitled to the ATB of R14 200.

Your first day-to-day claim after reaching the Annual Threshold is a dentistry claim for R8 000, charged at 100% of Scheme Rate:

Remember that R9 000 (for dentistry claims) has already accumulated towards the Annual Threshold, and that the maximum amount for dentistry that can jointly accumulate towards the Annual Threshold and be covered from the ATB is R15 200.

We will therefore pay an Insured Benefit of R6 200 (R15 200 less the R9 000 that accumulated towards the Annual Threshold) from your available ATB of R14 200. You will have to settle the balance of R1 800 directly to the provider.

At this point, you will still have R8 000 available from the ATB, for the payment of non-dental claims (at 100% of Scheme Rate) for the rest of the year (calculated as R14 200 less the R6 200 paid from the ATB for your dental claim).

If, in the above example, none of the claims that accumulated towards the Annual Threshold of R15 200 were for dentistry and the first claim you submitted against your ATB of R14 200 was a dental claim for R15 200 (charged at 100% of Scheme Rate), the benefit payable for this claim from the ATB would have been R14 200, which is the maximum ATB amount available for a member without dependants.

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

The Annual Threshold and ATB is re-calculated when a dependant is added or removed during the year, or when a child dependant becomes an adult dependant (paying the rate for an adult dependant). The recalculation of the ATB will not result in a clawback (debt payable to the Scheme) should a member resign during the year, whilst having utilised benefits that are in excess of the recalculated ATB.

Medical Savings Account (MSA)

Core Saver, Comprehensive and Plus Plans

The Medical Savings Account works on a Rand-for-Rand basis. It is there for the payment of specific out-of-hospital (day-to-day) claims and what you put in, is what you can get out.

Similar to an interest-free loan, you have access to the full year's Medical Savings Account as an upfront benefit at the beginning of the year (pro-rated to the number of months remaining if you join after 1 January), and you pay this back in monthly instalments, as part of your monthly contribution payments to the Scheme. Interest accumulates monthly on positive balances (i.e. on unused funds in the Medical Savings Account for contributions that have already been paid to the Scheme).

You can calculate the amount you will have available in your Medical Savings Account for the payment of your claims by multiplying the Medical Savings Account portion of your total monthly contribution for you and your dependants, by 12 (or by the remaining number of months in the year, if you joined during the year).

As you only pay contributions for a maximum of three children (any additional children are free), the amount that will be allocated to your Medical Savings Account will also be limited to a maximum of three children.

What you don't spend in the form of claims against your Medical Savings Account, is carried over for your benefit to the following year (if you have opted for a Plan with a Medical Savings Account for that year) or will be paid out five months after you leave the Scheme or change to a Plan with no Medical Savings Account.

You may owe the Scheme money if you terminate your membership (or if a dependant resigns) during the course of year. This can happen if you have claimed more from your Medical Savings Account, than you have paid towards your Medical Savings Account contributions in the year.

Digital tools

When you're at the doctor – Electronic Health Record

Bankmed's Electronic Health Record (E.H.R.), allows your Healthcare Professional to have access to your health records. This will allow your Healthcare Professional to have your information in the palm of their hands, allowing for better and more efficient healthcare services. Once you provide consent, your doctor may use this tool to access your medical history, gain insight into the benefits of your Health Plan, make referrals to other Healthcare Professionals, study your blood test results and write electronic prescriptions and referrals.

Obtaining your consent

For doctors to view your confidential medical information, they are required to obtain your consent. Your personal information is protected and will only be viewed by the doctors to whom you grant access.

When you provide consent, you agree that you understand the Electronic Health Record contains details about any chronic conditions you may have, as well as pathology results, which include blood tests. Your consent also confirms that you understand how we protect this confidential information and how we comply with laws pertaining to confidential information of this kind.

In order for Bankmed Medical Scheme to have the correct information to cover you for your condition, your doctor may be required to release information about your treatment to Discovery Health, our administrator. You are therefore required to provide your consent to confirm you agree to this exchange of information and you understand the terms and conditions.

How to provide your consent

These are the ways in which you may provide consent:

Bankmed App

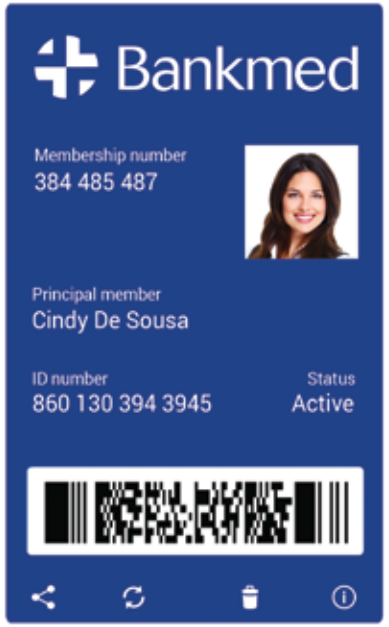
- On the "Health" tab in the Bankmed App, select "Doctor(s) Consent" to provide consent.

Bankmed website

- Log in to www.bankmed.co.za / YOUR DETAILS / Manage consent.

Bankmed App and your digital card

The Bankmed App allows you to have access to all your information and allows you access to your digital membership card. Your digital card may be used as proof of membership and presented to service providers on request.



Claims process

Details when submitting your claims

- Claims are required to be submitted within four months of the date of service. Claims older than this will be considered stale and will not be paid.
- Ensure that 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 require the details of the treatment or medication for which you are claiming in order for us to process your claim quickly and accurately.

How to claim

Using the Bankmed App

Download the Bankmed App which will allow you to:

- Use the camera on your Smartphone to take a photo of the claim and submit it via the App
- 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 and go to 'Claims' and click on 'Submit a claim'. Once there, go to 'UPLOAD' and click on 'Upload now'. Select the file you wish 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

- E-mail your scanned claims to claims@bankmed.co.za

The importance of selecting the right Plan

Whether you are an existing member considering your Plan choice or a new member joining us in 2017, choosing the right Plan is an important decision that can affect you for the entire year. We encourage you to take the time to understand your benefits before making your choice, as you may not change Plans during the year.

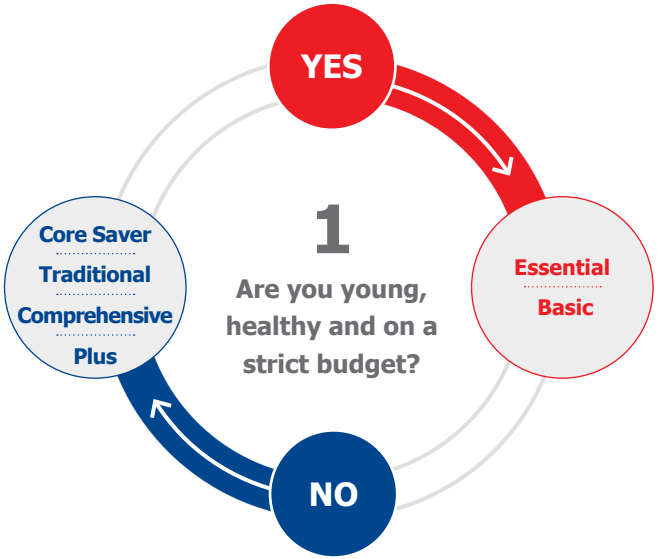
If you are an existing member: You will have received this schedule together with a Plan selection form for 2017. Plan selections for 2017 close on **9 December 2016**. This is your only opportunity to exercise a Plan change for 2017. If we do not receive an updated Plan selection by 9 December, you will automatically remain on the same Plan in 2017.

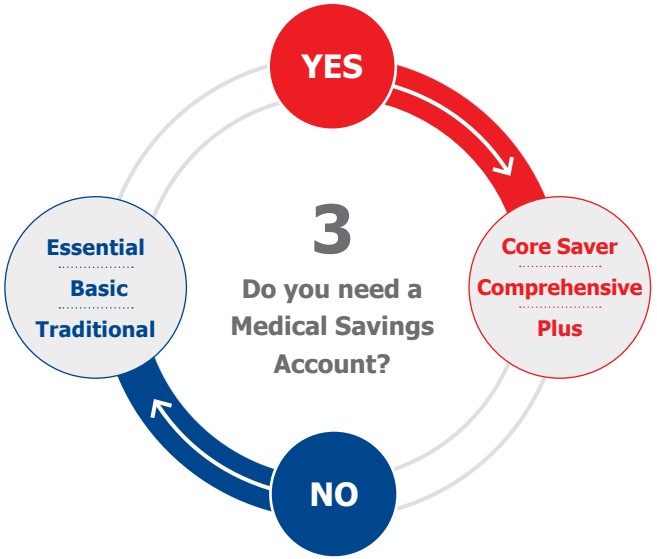
If you are a new member joining us in 2017: Welcome to Bankmed! You are receiving this schedule as part of your new member welcome pack. You would have been introduced to us via your Employer and would already have exercised your Plan choice with your application to join. You may already have seen the benefit schedule (via your Employer) or been directed to it on our website at www.bankmed.co.za.

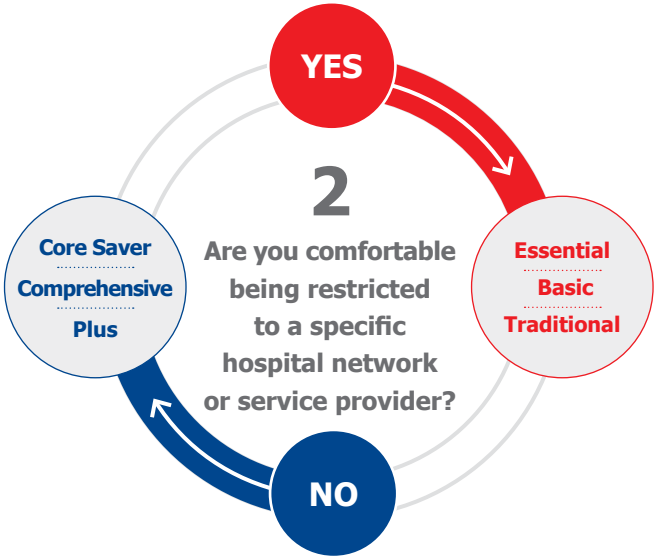
Should you decide that you have selected the incorrect Plan, please notify us within 60 days of joining and we will consider a once-off Plan change from your join date, as a special concession (adjusted contributions will apply). Late requests will, regrettably, not be considered. Depending on your conditions of employment and salary or subsidy arrangements, you may need to discuss your Plan choice with your Employer.

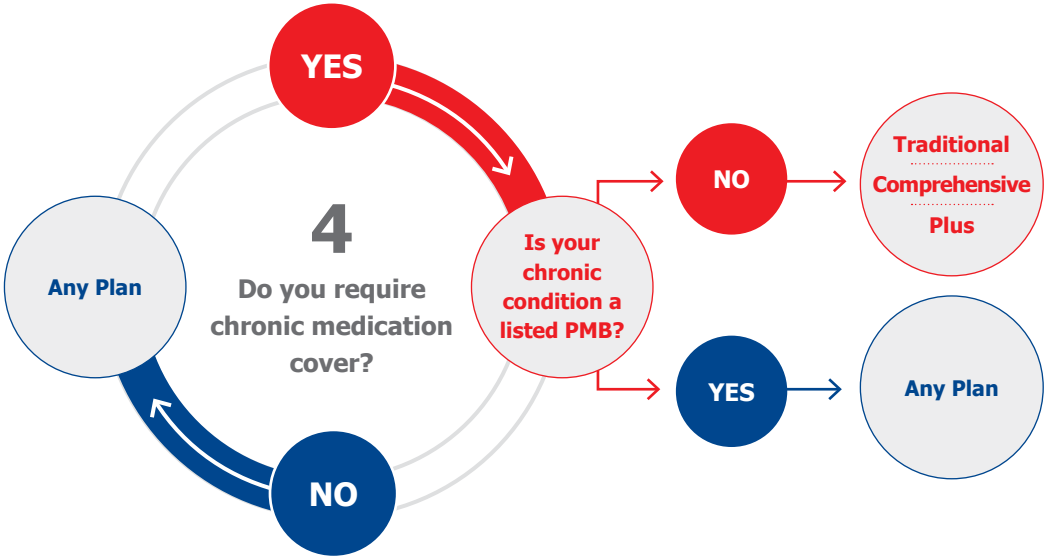
Choosing your Plan or looking to change Plans?

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









Reporting fraud or malpractice

Be part of the solution and not the problem. Take an active role in combating crime by reporting any fraudulent or unethical practice to us.

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

- Toll-free phone number: 0800 004 500
- SMS number: 43477
- Toll-free fax number: 0800 007 788
- E-mail: bankmed@tip-offs.com
- Post: Freepost DN298, Umhlanga Rocks 4320

General exclusions

What is not covered by Bankmed (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; and
- 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" and then "Registered Rules" followed by "Exclusions (Annexure C)"

Disclaimer

Although every effort has been made to ensure complete accuracy of this schedule, errors may occur. In the event of a dispute, the registered Rules shall apply. You may view the registered rules at www.bankmed.co.za.

Fair Collection Notice (FCN) and POPI

The Fair Collection Notice (FCN) 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 purpose not approved by Bankmed. The administrator and Managed Care service provider, in particular, may only use the information strictly in compliance with the agreement between Bankmed, the administrator and Managed Care service provider.

Bankmed believes that everyone has a right to privacy – our Constitution protects this right. And now, legislation contained within the Protection of Personal Information (POPI) Act (4 of 2013) further assists in the protection of this fundamental human right.

How does this affect you?

The POPI Act serves as a watchful protector over public and private organisations to which you have supplied, or may supply, your personal information. It protects your right to privacy under the following eight principles:

Accountability

An organisation is responsible for the personal information in its possession and needs to comply with conditions for processing information.

Processing limitation

We are required to process your personal information in a lawful and transparent manner. This means that processing may not be excessive, requires your consent and needs to be collected directly from you.

Clear purpose

Your personal information has to be collected for a specific and defined purpose. We are required to inform you of the purpose at the beginning of a business relationship. Also, we may not keep records longer than necessary for achieving the purpose.

Further processing limitation

Bankmed Medical Scheme and our administrator, Discovery Health (Pty) Ltd, may only use your personal information for those purposes that were specified at the time you provided consent to the processing of information. Should we need to use your personal information for any other purpose or wish to disclose it to any other recipients, you are required to provide further consent.

Information quality

Bankmed Medical Scheme and our administrator, Discovery Health (Pty) Ltd, have the responsibility to maintain the quality of the personal information that we process by ensuring that all personal information held by us is reliable and up-to-date.

Openness

In order for processing to be fair, you need to be aware of the personal information held about you by us – as well as the source of the information, if it was not collected from you. You are required to be made aware of the reason why your information is collected. We also need to maintain documents of all processing operations while meeting the legal requirements of the Promotion of Access to Information Act.

Security safeguards

Bankmed Medical Scheme and our administrator, Discovery Health (Pty) Ltd, may not keep your information longer than necessary and, when no longer required, it must be disposed of promptly and professionally. In addition, information security measures must be in place to keep your information safe. We are also required to report any breach of personal information to both the regulator and to you.

Your participation

You have the right to view your information. If you ask in writing and show proof of your identity, you are entitled to have your information corrected or destroyed.

Complaints and disputes

Complaints may be submitted in writing to:
Complaints,
Bankmed,
PO Box 1242
Cape Town, 8000

Although legislation provides that all complaints submitted in writing must be responded to within 30 days, we will always endeavour to respond to complaints within a much shorter time frame than prescribed.

If you have provided us with a reasonable opportunity 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) or 012 431 0500

012 430 7644

complaints@medicalschemes.com

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

Postal address:
Private Bag X34
Hatfield
0028

Notes

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

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