Bankmed
Yours in good health



BENEFITS & CONTRIBUTIONS

SCHEDULE 2027

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

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



Terminology Explained

01

Terminology Explained

A

ABOVE THRESHOLD BENEFIT (ATB)

Plus Plan members have access to the Above Threshold Benefit (ATB). Once the combined Annual Threshold has been reached, specified day-to-day claims are funded from the ATB at 100% of the Scheme Rate until the ATB is depleted.

ADDITIONAL DISEASE LIST (ADL)

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

ANNUAL THRESHOLD

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

B

BASKET-OF-CARE

A defined set of healthcare services, treatments, medicines and other care that the Scheme covers for a specific condition. Funding is subject to the applicable clinical criteria, treatment protocols, Scheme Rules and the benefits available on the member's Plan. A Basket-of-Care can specify approved provider types and the number or frequency of services.

BENEFICIARY

A member or a dependant registered on the medical scheme and entitled to benefits in terms of the Scheme's registered rules.

BOARD OF HEALTHCARE FUNDERS (BHF)

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

C

CARE COORDINATION NETWORK

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

CARE NAVIGATORS

A dedicated team who will help you to:

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

CHRONIC DISEASE LIST (CDL)

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

CHRONIC ILLNESS BENEFIT (CIB)

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

CLINICAL ENTRY CRITERIA

The medical requirements you must meet to qualify for a particular benefit or care programme. Bankmed may require diagnostic results or other clinical information to confirm eligibility.

CO-PAYMENT

This is an amount that you may have to pay towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service or if the amount the Healthcare Professional charges is higher than the rate we cover. If the co-payment amount is higher than the amount charged for the healthcare service, you will have to pay this amount yourself. A co-payment is not a deductible. See deductible definition.

COUNCIL FOR MEDICAL SCHEMES (CMS)

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

COVER

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

CONTRIBUTIONS (RISK CONTRIBUTION / MSA CONTRIBUTION)

Your risk contribution funds pooled Insured Benefits. Your MSA contribution funds your personal Medical Savings Account, where applicable. Together these form the total contribution shown for Plans with an MSA.

Terminology Explained

D

DAY-TO-DAY BENEFITS

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

DEDUCTIBLE

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

DEPENDANT

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

DESIGNATED SERVICE PROVIDER (DSP) OR NETWORK

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

E

EMERGENCY MEDICAL CONDITION

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

F

FIND A BENEFIT PLAN TOOL

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

FIND A HEALTHCARE PROFESSIONAL TOOL

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

H

HEALTHID

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

COUNCIL FOR MEDICAL SCHEMES (CMS)

HOME CARE
Bankmed offers you access to care at home through HomeCare. HomeCare is an additional service offering which provides you with quality home-based care in the comfort of your home for healthcare services like IV infusions, wound care, post-natal care, and advanced illness care.

I

ICD-10 CODE

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

INSURED BENEFIT

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

Terminology Explained

M

MEDICAL SAVINGS ACCOUNT (MSA)

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

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

MEDICAL SAVINGS ACCOUNT CLAWBACK

The amount you must repay if you leave the Scheme after spending more of your allocated Medical Savings Account than you have contributed.

MEDICATION LIST (FORMULARY)

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

MEDICAL SCHEMES ACT AND REGULATIONS

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

MEDICATION REFERENCE PRICE

The maximum amount Bankmed funds for a medication under the applicable reference-pricing arrangement. Choosing a medication above this price may result in a shortfall, subject to applicable PMB protections.

MEMBERSHIP OR MEMBER

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

N

NETWORKS

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

O

ONCOLOGY BENEFIT THRESHOLD

The amount of approved oncology claims accumulated before a different funding percentage applies to specified non-PMB treatment. It applies to certain Plans over a rolling 12-month cycle. Separate rules apply to the Oncology Innovation Benefit.

ONCOLOGY INNOVATION BENEFIT (OIB)

Cover for a defined list of approved novel and ultra-high-cost non-PMB cancer treatments. Eligibility, authorisation and treatment-response requirements apply. Members contribute towards treatment from the first rand, according to their Plan's funding percentage.

OUT-OF-HOSPITAL DIAGNOSIS AND TREATMENT PAIR (OHDTP)

A qualifying PMB diagnosis and its associated treatment out-of-hospital. Funding follows an approved Basket-of-Care, including specified services, provider requirements and service frequencies. Registration and approval requirements apply.

P

PARTICIPATING EMPLOYER

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

Terminology Explained

PAYMENT ARRANGEMENTS

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

PERSONAL HEALTH ASSESSMENT (PHA)

The PHA measures health indicators like blood pressure, cholesterol, blood sugar, waist circumference, and BMI. The PHA is paid by Bankmed and the results used to unlock additional benefits, where appropriate.

PREMIER PLUS GP

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

PRESCRIBED MINIMUM BENEFITS (PMBS)

Prescribed Minimum Benefits (PMBs) are a set of healthcare benefits that all registered medical schemes are required by law to cover. They provide access to the diagnosis, treatment and care of defined medical conditions, including emergency medical conditions, specified diagnoses and the Chronic Disease List conditions.

PMB LEVEL OF CARE

PMB level of care is the treatment and healthcare services that must be provided for a PMB condition, as defined by the applicable PMB requirements. This may include specific consultations, investigations, procedures and medicines required for the diagnosis, treatment and ongoing management of the condition.

PRE-AUTHORISATION

Approval from Bankmed before a planned admission, treatment or specified service. Approval confirms that clinical requirements have been met. Payment still depends on your Plan benefits, applicable rates, limits and provider arrangements.

PREFERRED PROVIDER

A provider Bankmed encourages members to use for a particular service. Cover remains subject to the applicable Plan benefits and PMB requirements. The emergency ambulance section uses this term specifically.

PRIMARY CARE PROVIDER (PCP)

The Bankmed Network GP you nominate to coordinate your chronic care where your Plan requires this. Using another provider without meeting the applicable exceptions may result in a co-payment.

PRO RATA / PRO-RATED

An adjustment to an annual amount for the applicable part of the year. For example, the Annual Threshold and ATB reduce when membership starts after January and may change when dependants join or leave the Scheme.

R

RELATED ACCOUNTS

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

RESIGNEE

A member who resigns from a participating employer and is eligible to continue their Bankmed membership in terms of the Scheme Rules.

S

SCHEME LIABILITY

The amount the Scheme will pay towards a benefit. Where a benefit is shown as a percentage, the percentage is calculated on the lower of the actual amount charged and the applicable Scheme Rate, tariff, reference price, Scheme Medication Rate or other benefit amount. The Scheme will not pay more than the actual cost of the service, medication or treatment.

SCHEME MEDICATION RATE

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

SCHEME RATE

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

Terminology Explained

SELF-PAYMENT GAP (SPG)

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

SINGLE EXIT PRICE (SEP)

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

V

VOLUNTARY / INVOLUNTARY USE OF A NON-DSP

Voluntary use means choosing a non-DSP when an appropriate DSP is available. Involuntary use includes circumstances such as an emergency, unavailable services, unreasonable delays or no DSP within reasonable proximity. Different funding rules apply.

W

WHO GLOBAL OUTBREAK BENEFIT

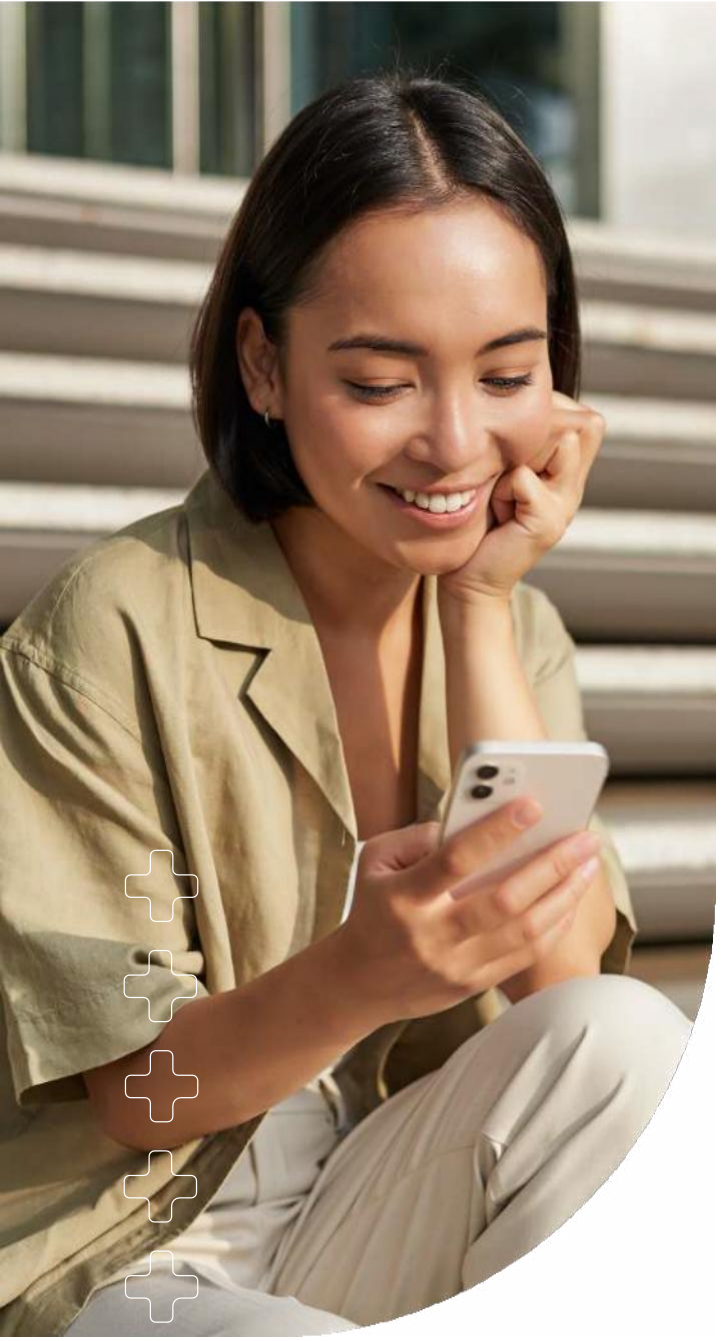
The WHO Global Outbreak Benefit provides cover for approved global disease outbreaks recognised by the World Health Organization (WHO) such as COVID-19 and Mpox. This benefit provides access to a defined Basket-of-Care per disease outbreak, which includes cover for the administration of vaccines, where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





About Bankmed
What Makes Bankmed Special

02



Who **We Are**

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

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

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

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

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

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

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

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

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

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

What Makes Bankmed Special

Bankmed: your partner in health and wellness

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

ACCESS TO QUALITY CARE

Bankmed participates in the Health Quality Assessment (HQA), a national not-for-profit initiative that independently measures the quality, accessibility, and value of healthcare in South Africa. Participation enables Bankmed to benchmark its performance, enhance care quality, and ensure members receive excellent healthcare value. The 2025 HQA findings confirmed that Bankmed members enjoy superior healthcare quality across multiple clinical indicators.

MORE VALUE, BECAUSE YOU DESERVE MORE

Not all medical schemes are the same. At Bankmed, members enjoy more value through lower contributions and enhanced benefits, delivering a better healthcare experience with stable increases and richer cover.

Our ongoing digital transformation, through the Bankmed Health App and member-centric digital tools, makes managing your health simpler and smarter.

Combined with our innovative wellness and preventative care benefits and programmes, such as Childhood Preventative Dental Check-ups and Diabetes and Wellness Management (including access to insulin pumps and continuous glucose monitoring devices), Bankmed ensures you and your family receive high-quality, personalised care when it matters most.

FINANCIAL STRENGTH AND SUSTAINABILITY: WE'VE GOT YOU COVERED

The healthcare industry is facing rising cost pressures as medical inflation continues to outpace general inflation, driving up hospital, medicine and specialist costs. Members across South Africa are claiming more than contributions cover, creating an imbalance that threatens long-term sustainability. Without decisive action, these trends could impact affordability and access to quality care.

Bankmed remains financially strong and well-positioned to navigate these challenges. Through disciplined financial management, sound risk controls, and maintaining required solvency reserves, the Scheme continues to meet its obligations and fund members' claims — even during periods of high demand. Our focus remains on balancing affordability, sustainability, and innovation to protect members' access to quality healthcare now and into the future.

AA+ GLOBAL CREDIT RATING: A SOLID FOUNDATION FOR YOUR HEALTH

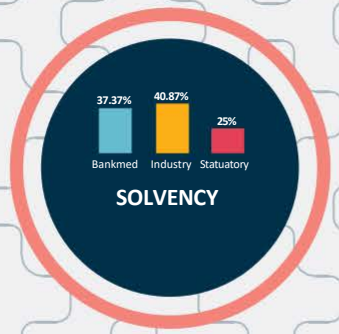
In 2026, Bankmed once again achieved the prestigious AA+ Global Credit Rating, marking 16 consecutive years of financial excellence. This rating reflects Bankmed's strong financial management, prudent reserves, and ability to meet member claims – even during times of industry pressure. As one of the few closed medical schemes in South Africa with this rating, Bankmed's financial strength enables it to deliver enhanced benefits and more affordable contributions, ensuring your financial wellbeing is protected alongside your health.

YOUR INVESTMENT IN MEMBERSHIP TAKES CARE OF YOU

Bankmed operates as a non-profit medical scheme, funded entirely by member contributions and investment income. In a year marked by rising healthcare costs and economic uncertainty, your contributions continue to work collectively; pooled to cover members' claims and ensure the Scheme remains financially stable.

While the industry faces pressure from medical inflation and higher utilisation, Bankmed continues to apply disciplined financial management to safeguard reserves and maintain solvency above regulatory requirements. Every rand is reinvested into protecting your benefits, ensuring long-term affordability, sustainability, and access to quality healthcare for all members.

Bankmed gives you **Better Benefits**



Bankmed's solvency ratio 37.37% (as at 31 December 2025) compared to the industry average of 40.87% (CMS Annual Report 2024*); 25% statutory requirement

6
PLANS

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

HEALTHCARE EXPENDITURE
103.27%
VS. 96.18%

Relevant healthcare expenditure, expressed as a percentage of risk contribution income, was 103.27% for 2025 (as at 31 December 2025) compared to the industry average of 96.18% (CMS Annual Report 2024*)

DAE
6.74%
VS. 6.89%

Bankmed's Directly Attributable Insurance Service Expenditure (DAE) as a % of Insurance Revenue (as at 31 December 2025) compared to the industry average of 6.89% (CMS Annual Report 2024*)

AA+
CREDIT RATING

For 16 consecutive years, Bankmed has been awarded the prestigious AA+ Global Credit Rating

* CMS Annual Report 2024 referenced as 2025 annexures have not yet been published.



2027 Benefit Enhancements & Plan Highlights 03

What's New in 2027

Better access. Better care. Better outcomes. Sustainable healthcare.

At Bankmed, we understand the importance of protecting your health and your family's wellbeing. For 2027, we've reviewed benefits and contributions to keep your cover relevant and valuable while responding responsibly to rising healthcare costs and service use.

The Board of Trustees considered affordability, member value, access to quality healthcare, clinical best practice and Bankmed's long-term sustainability.

For 2027, the Board has approved Plan-specific contribution increases averaging 9.4%, alongside benefit changes to strengthen member value. Although above inflation, the increases apply to a lower contribution base than many open medical scheme options, helping Bankmed maintain competitive value in a challenging healthcare environment. The changes remain subject to the Council for Medical Schemes (CMS) approval.

The 2027 changes focus on access to appropriate care, stronger care coordination and protecting the long-term value of your benefits.



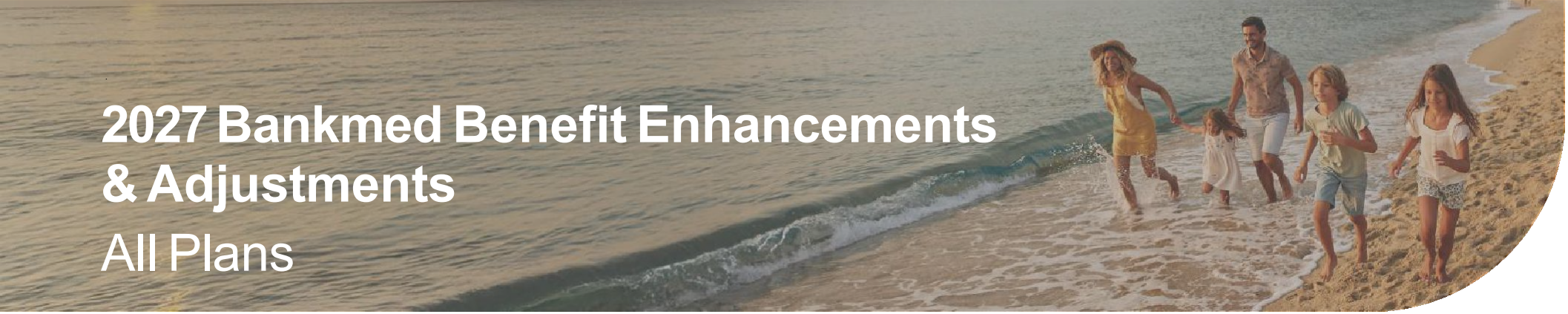
AT A GLANCE

What members can expect in 2027

In practical terms, the 2027 review focusses on four outcomes:

- **Better Access**
  Supporting access to appropriate care through selected new benefits and innovations.
- **Better Care**
  Helping members navigate their care through clearer clinical pathways, enhanced chronic and Prescribed Minimum Benefit care, and appropriate provider arrangements.
- **Better Outcomes**
  Supporting clinically appropriate care through stronger treatment pathways, clinical oversight and coordinated care.
- **A Sustainable Future**
  Balancing affordability, access to care and benefit value so that Bankmed can continue supporting our members long into the future.

2027 changes remain subject to CMS approval and the registered Scheme Rules. Plan benefits and clinical requirements apply.



2027 Bankmed Benefit Enhancements & Adjustments

All Plans

Summarised benefit enhancements and adjustments affecting all Plans in 2027

BENEFIT LIMITS

Annual Benefit Limits

Benefit limits across our Plans will see an average increase of 4.5%, ensuring you have the coverage you need, when you need it.

HEALTHCARE AND FACILITY NETWORKS

Drug and Alcohol Rehabilitation DSP

A Designated Service Provider (DSP) network will be introduced for drug and alcohol rehabilitation services, providing access to accredited facilities offering coordinated detoxification and rehabilitation programmes. A 20% co-payment applies only when a member voluntarily uses a non-DSP facility.

Elective Hip and Knee Replacements

The Arthroplasty Network has been designed around exceptional quality outcomes and becomes a DSP for elective unilateral hip and knee replacements. Voluntary non-network use attracts a 20% co-payment on the hospital claim and prosthesis, or the relevant non-preferred prosthesis limit. Radiology and pathology remain outside the global fee. This change excludes emergency or trauma surgery and is subject to Plan benefits.

Hospital Care after an Emergency

All Plans, where a hospital DSP applies

Emergency treatment remains subject to PMB protections. Once a member is clinically stable and safe to transfer, Bankmed may arrange transfer from a non-DSP hospital to an appropriate DSP facility. This hospital-transfer pathway is separate from the ambulance preferred provider network. Confirm ongoing authorisation and funding arrangements with Bankmed.

EMERGENCY CARE

Emergency Ambulance Services Network

From 2027, Bankmed has appointed a preferred provider for emergency ambulance services. A preferred provider is the provider that members are encouraged to use when emergency ambulance services are required. Cover remains subject to the benefits available on the member's Plan and applicable Prescribed Minimum Benefit (PMB) requirements.

MANAGED ONCOLOGY BENEFIT

Basket-of-Care Applicable from 2027

From 2027, registered Managed Oncology Benefit members will be allocated Baskets-of-Care associated with their cancer benefits. Treatment is funded in line with the applicable oncology Basket-of-Care, clinical criteria, protocols and Scheme funding rules. There is no overall rand limit on approved PMB and non-PMB oncology treatment (Traditional, Comprehensive and Plus Plans), but this does not mean that all oncology services are unlimited. Cover is restricted to the services and frequency limits set out in your Basket-of-Care, which Bankmed will confirm to registered members in their Basket-of-Care letter. Please refer to plan-specific oncology benefit changes later in this Benefits & Contribution Schedule.

COORDINATED CARE PROGRAMMES

Integrated Care Programme

Selected eligible adult beneficiaries across Plans

The programme identifies adults with complex emerging healthcare needs who may benefit from proactive care coordination. A nurse care coordinator and the treating team develop a personalised care plan. Support may include medicine review, home or virtual care and pre-admission or post-discharge support. Services remain subject to clinical criteria, Plan benefits, limits and approved discretionary funding.

Coordinated Renal Care

Allocated Life Healthcare dialysis members

From 2027, a care coordinator supports multidisciplinary renal care and treatment adherence through the Life Healthcare holistic care programme.

*Refer to specific Plan limits and increases in your chosen Plan's benefit table.
2027 changes remain subject to CMS approval and the registered Scheme Rules. Plan benefits and clinical requirements apply.



2027 Bankmed Benefit Enhancements & Adjustments

Plan-specific

SPECIALISED RADIOLOGY (MRI, CT & RADIONUCLIDE SCANS)

Core Saver, Traditional and Comprehensive Plans

Specialised diagnostic benefits are being managed to support appropriate utilisation while preserving access to advanced imaging when clinically required.

Annual benefit limits will apply to specialised radiology scans performed in-hospital or out-of-hospital in 2027:

- Core Saver Plan: R25 000
- Traditional Plan: R30 000
- Comprehensive Plan: R35 000

Members will also be responsible for the upfront payment of a deductible as follows:

- Out-of-hospital: R1 000 per scan
- In-hospital: R2 000 per admission

The annual limit and the deductible both apply to each claim. Qualifying PMB claims are still paid through the limit, in line with PMB requirements.

ASSISTED REPRODUCTIVE THERAPY (ART)

Plus Plan

A new benefit provides selected fertility interventions through a DSP network of SASREG-accredited centres. The annual limit is R140 000 per person. Bankmed funds 75% of approved costs and the member pays 25%.

Selected services include IVF-related treatment, egg and sperm storage, embryo freezing and egg donation, subject to approved eligibility, covered-service rules and authorisation.

DENTAL ADMISSION DEDUCTIBLES

Traditional, Comprehensive and Plus Plans

Members admitted for in-hospital dental treatment will be responsible for the upfront payment of a deductible, which depends on the type of facility used and the beneficiary's age:

- **Younger than 14 years:** R1 000 at a day clinic and R3 000 at an acute hospital
- **Age 14 and older:** R3 000 at a day clinic and R5 000 at an acute hospital

Confirm the treatment setting and deductible before admission.

*Refer to specific Plan limits and increases in your chosen Plan's benefit table.
2027 changes remain subject to CMS approval and the registered Scheme Rules. Plan benefits and clinical requirements apply.



2027 Bankmed Benefit Enhancements & Adjustments

Plan-specific

PRIMARY CARE PROVIDER NOMINATION

Members with Registered Chronic Illnesses on Core Saver and Traditional Plans

Research shows that members using a primary care GP to coordinate chronic care are better controlled and more compliant with prescribed care.

Bankmed requires that members on the Core Saver and Traditional Plans nominate and use a Bankmed Network GP to coordinate chronic care. Members with nominated primary care providers (PCP) are reimbursed at the contracted rate. A 20% co-payment applies to GP visits and related services where PCP rules are not followed.

One out-of-area visit is allowed. Members may change their nominated GP twice a year. Approved specialist consultations within the Basket-of-Care do not attract the PCP penalty.

ANNUAL THRESHOLD AND ABOVE THRESHOLD BENEFIT

Plus Plan

The Annual Threshold and Above Threshold Benefit (ATB) increase in 2027.

	Principal Member	Adult Dependant	Child*
Annual Threshold	R28 200	R21 000	R6 900
ATB limit	R25 300	R19 000	R6 300

*Limited to three children. Family amounts combine the applicable amount for each beneficiary. Annual Threshold and ATB amounts are pro-rated for membership changes during the year.

OUT-OF-HOSPITAL DIAGNOSIS AND TREATMENT PAIR (OHDTP) PRESCRIBED MINIMUM BENEFITS

Core Saver, Traditional, Comprehensive and Plus Plans

An Out-of-hospital Diagnosis and Treatment Pair (OHDTP) refers to the diagnosis and treatment of certain Prescribed Minimum Benefit (PMB) conditions where care is provided outside of hospital. For each qualifying condition, PMB funding follows a defined Basket-of-Care, which sets out the services, provider types and number or frequency of services covered.

From 1 January 2027, members on the Core Saver, Traditional, Comprehensive and Plus Plans must apply to Bankmed to have their OHDTP condition registered before the applicable Basket-of-Care can be funded from the PMB benefit.

The application confirms that the diagnosis meets the relevant PMB requirements and may require clinical or diagnostic information to show that the clinical entry criteria have been met.

Unlike the previous automatic claims-payment approach, OHDTP claims will not automatically be funded from the PMB benefit simply because a PMB diagnosis code appears on the claim. Members must apply for and obtain approval for the relevant OHDTP. Once approved, claims will be assessed against the applicable Basket-of-Care, including approved services, provider requirements and service frequencies, in line with the Scheme's clinical protocols and funding rules.

All members on these plans who require OHDTP funding from the PMB benefit must complete the PMB registration process, including members whose qualifying claims were previously paid automatically. Members who meet the clinical entry criteria will be registered and allocated a Basket-of-Care for claims during the year. Benefits are limited to the allocated Basket-of-Care and its frequency limits. Approvals will be communicated to registered members, together with the confirmed Basket-of-Care and frequency limits.

*Refer to specific Plan limits and increases in your chosen Plan's benefit table.
2027 changes remain subject to CMS approval and the registered Scheme Rules. Plan benefits and clinical requirements apply.



2027 Bankmed Benefit Enhancements & Adjustments

Managed Oncology Benefit

CHANGES TO ONCOLOGY COVER IN 2027

Bankmed continues to provide comprehensive oncology cover, with treatment managed through approved oncology Baskets of Care and the Scheme's clinical protocols. From 2027, a funding threshold will apply to approved non-PMB oncology treatment on the Traditional and Comprehensive Plans. Once the threshold is reached, Bankmed will continue to fund approved non-PMB treatment at 80% of the applicable rate.

MANAGED ONCOLOGY BENEFIT THRESHOLD

Traditional and Comprehensive Plans

From 2027, the Traditional and Comprehensive Plans will have an Oncology Benefit Threshold for approved non-PMB cancer treatment. The threshold is R350 000 per beneficiary per rolling 12-month cycle on the Traditional Plan and R500 000 on the Comprehensive Plan. Approved treatment is provided in accordance with the applicable oncology Basket-of-Care, clinical criteria, protocols and Scheme funding rules.

Once the applicable threshold is reached, approved non-PMB oncology treatment will continue to be funded at 80% of the applicable Scheme Rate, Scheme Medication Rate or approved reference price, with the member responsible for the remaining 20%. Qualifying PMB oncology treatment remains funded without an overall limit, subject to the applicable PMB requirements.

Important note for Plus Plan members

The Plus Plan does not apply an Oncology Benefit Threshold and there is no overall rand limit to approved PMB and non-PMB oncology treatment. This does not mean that all oncology services are unlimited. Cover is restricted to the services and frequency limits set out in your Basket-of-Care. Bankmed will confirm these to registered members in their Basket-of-Care letter.

ONCOLOGY INNOVATION BENEFIT

Traditional, Comprehensive and Plus Plans

The Oncology Innovation Benefit gives eligible members access to a defined list of approved novel and ultra-high-cost non-PMB oncology treatments for specific cancers. Cover is subject to your Plan, the approved medicine list, clinical entry criteria and prior authorisation. Treatment may be approved for a defined number of cycles, and continued funding depends on evidence of treatment response and the Scheme's continuation criteria.

A co-payment applies from the first rand of treatment funded through the Oncology Innovation Benefit. For example, where the Comprehensive Plan funds this treatment at 50%, the remaining 50% is for the member's account.

Members may apply for co-payment assistance through pharmaceutical company support programmes, where available. Assistance varies by medicine and programme. Members must apply through their healthcare professional, as Bankmed is not involved in these programmes.

Oncology Innovation Benefit claims accumulate to the Oncology Benefit Threshold, where applicable.

It is important to note that once the threshold is reached, the OIB funding percentage remains unchanged and does not increase to the 80% funding level applicable to other approved non-PMB oncology treatment after the threshold.

*Refer to specific Plan limits and increases in your chosen Plan's benefit table.
2027 changes remain subject to CMS approval and the registered Scheme Rules. Plan benefits and clinical requirements apply.



2027 Bankmed Benefit Enhancements & Adjustments

Managed Oncology Benefit

ONCOLOGY MEDICINE REFERENCE PRICING

Essential and Basic Plans

From 2027, selected oncology medicines on the Essential and Basic Plans will be funded up to an approved reference price. The reference price is the maximum amount Bankmed will fund for a medicine where clinically appropriate, cost-effective treatment alternatives are available. If a member chooses a medicine that costs more than the applicable reference price, they may be required to pay the difference. PMB protections continue to apply to qualifying PMB oncology treatment.

ONCOLOGY SPECIALIST REIMBURSEMENT RATES

Traditional Plan

From 2027, specialist oncology consultations and treatment on the Traditional Plan will be funded at 100% of the Scheme Rate, whether members use a network or non-network specialist oncologist. This is an enhancement from the previous 80% of the Scheme Rate funding that applied when using a non-network specialist.

IMPORTANT INFORMATION

Before accessing benefits

- Confirm whether registration, pre-authorisation or a clinical motivation is required.
- Use the applicable network or DSP where required to avoid co-payments.
- Confirm the approved provider, medicine formulary, benefit limit and member contribution before treatment.
- Refer to the registered Scheme Rules and your Plan-specific Benefit Guide for full benefit terms and conditions.

Bankmed remains committed to delivering value, supporting member wellbeing and helping members access quality healthcare with confidence.

The 2027 benefits are designed to balance meaningful benefit improvements with responsible funding so that members can continue to rely on Bankmed now and into the future.

*Refer to specific Plan limits and increases in your chosen Plan's benefit table.
2027 changes remain subject to CMS approval and the registered Scheme Rules. Plan benefits and clinical requirements apply.

Key Features & Plan Overviews

Plan	**Wellness and Preventative Care Benefits** Determine your risk, detect conditions early, and improve your health	**Networks** For full cover, PMBs, and other treatment	**Major medical expenses and hospital cover**	**Chronic medication**	**PMBs**
PLUS PLAN	• PHA for members aged 16+ • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Female contraception • Colorectal Cancer Self-screening Kit • Cervical Cancer Self-screening Kit • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Childhood Preventative Dental Benefit • Post-engagement Wellness Management Programme • Weight screening for children aged nine to 15 years • Dementia screening for members aged 65+	• Wide network of contracted private hospitals and facilities • Bankmed GP Network • Bankmed Prestige A and B Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network • Bankmed Arthroplasty Network • Bankmed Drug and Alcohol Rehabilitation Network	• Comprehensive cover for hospitalisation and most hospital care • Any contracted private hospital • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 300% of the Scheme Rate • We pay 80% of the Scheme Rate for use of a non-network facility for elective procedures	• R37 275 a year per member • We pay less for the medication you obtain from pharmacies that are not in our network • You might have to pay part of the cost yourself • You need to apply for chronic benefit cover	• We pay the full cost of PMBs for network Healthcare Professionals • Reduced benefits if you use Healthcare Professionals who are not in our network • You may have to pay part of the treatment cost yourself • You need to apply for Out-of-hospital PMB cover
COMPREHENSIVE PLAN	• PHA for members aged 16+ • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Female contraception • Colorectal Cancer Self-screening Kit • Cervical Cancer Self-screening Kit • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Childhood Preventative Dental Benefit • Post-engagement Wellness Management Programme • Weight screening for children aged nine to 15 years • Dementia screening for members aged 65+	• Wide network of contracted private hospitals and facilities • Bankmed GP Network • Bankmed Prestige A and B Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network • Bankmed Arthroplasty Network • Bankmed Drug and Alcohol Rehabilitation Network	• Comprehensive cover for hospitalisation and most hospital care • Any contracted private hospital • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 100% of the Scheme Rate • We pay 80% of the Scheme Rate for use of a non-network facility for elective procedures	• R31 260 a year per member • We pay less for the medication you obtain from pharmacies that are not in our network • You might have to pay part of the cost yourself • You need to apply for chronic benefit cover	• We pay the full cost of PMBs for network Healthcare Professionals • Reduced benefits if you use Healthcare Professionals who are not in our network • You may have to pay part of the treatment cost yourself • You need to apply for Out-of-hospital PMB cover
TRADITIONAL PLAN	• PHA for members aged 16+ • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Female contraception • Colorectal Cancer Self-screening Kit • Cervical Cancer Self-screening Kit • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Childhood Preventative Dental Benefit • Post-engagement Wellness Management Programme • Weight screening for children aged nine to 15 years • Dementia screening for members aged 65+	• Traditional Plan Hospital Network • Bankmed GP Network • Bankmed Prestige A and B Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network • Bankmed Arthroplasty Network • Bankmed Drug and Alcohol Rehabilitation Network	• Comprehensive cover for hospitalisation and most hospital care • Restricted hospital network • More extensive hospital network than the Essential and Basic Plans • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 100% of the Scheme Rate where a DSP is used. Where a non-DSP GP or Specialist is used, claims are reimbursed at 80% of the Scheme Rate • We pay 80% of the Scheme Rate for use of a non-network facility for elective procedures	• R27 695 a year per member • We pay less for the medication you obtain from pharmacies that are not in our network • You might have to pay part of the cost yourself • You need to apply for chronic benefit cover • You need to nominate a Primary Care Practitioner (PCP) in the GP Network if you are registered with a chronic illness	• We pay the full cost of PMBs for network Healthcare Professionals • Reduced benefits if you use Healthcare Professionals who are not in our network • You may have to pay part of the treatment cost yourself • You need to apply for Out-of-hospital PMB cover

Plan	Wellness and Preventative Care Benefits Determine your risk, detect conditions early, and improve your health	Networks For full cover, PMBs, and other treatment	Major medical expenses and hospital cover	Chronic medication	PMBs
CORE SAVER	• PHA for members aged 16+ • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Female contraception • Colorectal Cancer Self-screening Kit • Cervical Cancer Self-screening Kit • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Childhood Preventative Dental Benefit • Post-engagement Wellness Management Programme • Weight screening for children aged nine to 15 years • Dementia screening for members aged 65+	• Wide network of contracted private hospitals and facilities • Bankmed GP Network • Bankmed Prestige A and B Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network • Bankmed Arthroplasty Network • Bankmed Drug and Alcohol Rehabilitation Network	• Comprehensive cover for hospitalisation and most hospital care • Any contracted private hospital • Organ transplants and oncology treatment are limited to PMBs • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 100% of the Scheme Rate • We pay 80% of the Scheme Rate for use of a non-network facility for elective procedures	• No overall limit, but benefits subject to Core Saver medication list (formulary) for PMB conditions only • We pay less for the medication you obtain from pharmacies that are not in our network • You might have to pay part of the cost yourself • You need to apply for chronic benefit cover • You need to nominate a Primary Care Practitioner (PCP) in the GP Network if you are registered with a chronic illness	• We pay the full cost of PMBs for network Healthcare Professionals • Reduced benefits if you use Healthcare Professionals who are not in our network • You may have to pay part of the treatment cost yourself • You need to apply for Out-of-hospital PMB cover
BASIC	• PHA for members aged 16+ • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Female contraception • Colorectal Cancer Self-screening Kit • Cervical Cancer Self-screening Kit • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Childhood Preventative Dental Benefit • Post-engagement Wellness Management Programme • Weight screening for children aged nine to 15 years • Dementia screening for members aged 65+	• Basic Plan Hospital Network • Bankmed Entry Plan GP Network • Bankmed Entry Plan Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network • Bankmed Arthroplasty Network • Bankmed Drug and Alcohol Rehabilitation Network • Bankmed Dental Network (applies to Childhood Preventative Dental benefit)	• Comprehensive cover for hospitalisation and most hospital care from a restricted hospital network • Hospital network more limited than the Traditional Plan • Organ transplants, oncology treatment and renal dialysis, are limited to PMBs • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 100% of the Scheme Rate • We pay 80% of the Scheme Rate for use of a non-network facility for elective procedures	• No overall limit, but benefits subject to CIB medication list (formulary) • Network Healthcare Professionals only • We pay less for the medication you obtain from pharmacies that are not in our network • You might have to pay part of the cost yourself • You need to apply for chronic benefit cover	• We pay the full cost of PMBs for network Healthcare Professionals • Reduced benefits if you use Healthcare Professionals who are not in our network • You may have to pay part of the treatment cost yourself • You need to apply for Out-of-hospital PMB cover
ESSENTIAL	• PHA for members aged 16+ • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Female contraception • Colorectal Cancer Self-screening Kit • Cervical Cancer Self-screening Kit • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Childhood Preventative Dental Benefit • Post-engagement Wellness Management Programme • Weight screening for children aged nine to 15 years • Dementia screening for members aged 65+	• Essential Plan Hospital Network • Bankmed Entry Plan GP Network • Bankmed Entry Plan Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network • Bankmed Arthroplasty Network • Bankmed Drug and Alcohol Rehabilitation Network • Bankmed Dental Network for Childhood Preventative Dental benefit	• Limited to PMBs from a restricted hospital network • Hospital network more limited than the Basic and Traditional Plans • Organ transplants, oncology treatment and renal dialysis, are limited to PMBs • Specific categories subject to rand limits • In-hospital procedures limited to PMBs • We pay 80% of the Scheme Rate for use of a non-network facility for elective procedures	• No overall limit, but limited to PMBs • Covered at 100% of cost at Bankmed Entry Plan GP network • Subject to CIB medication list (formulary) • You need to apply for chronic benefit cover	• We pay the full cost of PMBs for network Healthcare Professionals • Reduced benefits if you use Healthcare Professionals who are not in our network • You may have to pay part of the treatment cost yourself • You need to apply for Out-of-hospital PMB cover

Maximising Your **Plan's Benefits**

STRATEGIES FOR EXTRACTING THE BEST VALUE FROM YOUR PLAN AND REDUCING OUT-OF-POCKET EXPENDITURE

USE BANKMED'S EXTENSIVE NETWORKS

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

USE BANKMED'S 'FIND A HEALTHCARE PROFESSIONAL' TOOL

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

SAVE YOUR MEDICAL SAVINGS ACCOUNT (MSA)

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

REGISTER ON THE CIB PROGRAMME

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

BABY-AND-ME PROGRAMME

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

USE THE BANKMED DAY SURGERY NETWORK

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

UPDATE CONTACT DETAILS FOR YOU AND YOUR DEPENDANTS

- Ensure your contact details, including a current e-mail and mobile number, are up-to-date.
- Dependants aged 18+ must also have valid contact information on file. Without these, we can't confirm hospital authorisations, and the Scheme won't cover claim shortfalls for non-DSP use.
- Your pre-authorisation letter confirms the DSP status of your provider and facility.

OBTAIN PRE-AUTHORISATION BEFORE HAVING A PROCEDURE

- Confirm your benefits beforehand to avoid possible non-payment for a procedure or treatment.
- Check the authorisation letter sent to you to confirm whether your chosen Healthcare Professional and/or facility, are part of the Bankmed network.
- Remember that we e-mail the patient's pre-authorisation letter and SMS the pre-authorisation number. It is critical that we have your or the patient's contact details.

AVOID DEDUCTIBLES

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

JOIN OUR CARE PROGRAMMES

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

APPLY FOR OUT-OF-HOSPITAL PMB COVER

- Register for out-of-hospital PMB cover so eligible care does not use your day-to-day benefits.
- Use DSPs to avoid co-payments.
- Baskets of Care provide defined benefits and support for registered PMB conditions.

How to Choose a Plan

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

DIGITAL TOOLS

PLAN COMPARISON TOOL

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

FIND A BENEFIT PLAN TOOL

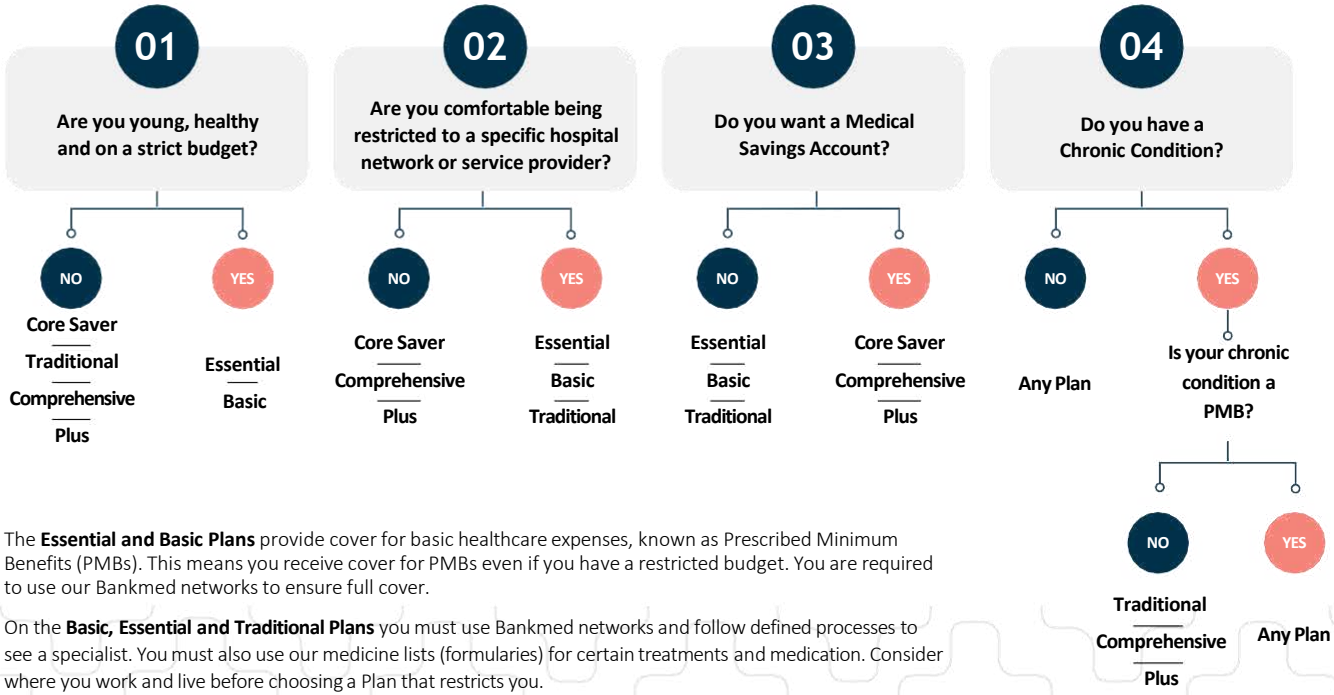
- This tool was developed to assist members to better understand their benefits and how to select a Plan that best meets their needs.
- Plan selection and quote based on individual needs. This is not a comparison tool.

LOOK-UP PLAN BENEFITS TOOL

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

WHAT TO CONSIDER WHEN CHOOSING A PLAN

Make sure your healthcare cover suits your needs and budget. This infographic gives a broad overview of things you need to keep in mind when choosing your Plan. Should you wish to explore more information about changing your Plan, please access our *'Choose a Plan'* reference guide on the Bankmed website.



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

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



Understanding your Emergency Cover, PMBs & DSPs

04

Emergency Cover

What is a medical emergency?

The Medical Schemes Act provides the criteria for what qualifies as a medical emergency. To ensure your claims are funded from appropriate benefits, a medical condition must meet the following criteria:

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

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

ASSISTANCE DURING OR AFTER TRAUMA EVENTS

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

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

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

WHAT WE COVER

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

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

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





Prescribed Minimum Benefits (PMBs)

What are PMBs?

PMBs are essential medical services that medical schemes in South Africa are obliged to provide to all their members under the Medical Schemes Act number 131 of 1998.

These benefits include the diagnosis, treatment, and ongoing care costs for life-threatening emergency medical conditions, a specified set of 270 medical conditions (defined in the Diagnosis Treatment Pairs), and 27 chronic conditions (defined in the CDL).

HOW BANKMED FUNDS PMBs AND NON-PMBs

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

IMPORTANT POINTS TO REMEMBER

- **Emergency admissions at non-DSP hospitals**
- In an emergency, members should obtain the care they need without delay. If a member is admitted to a hospital that is not a Designated Service Provider (DSP), the Scheme may, once the member's condition has stabilised and where it is clinically appropriate and reasonably possible, arrange for the member to be transferred to a DSP for continued care. Any transfer will take the member's clinical condition and care requirements into account.

IMPORTANT POINTS TO REMEMBER

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

Prescribed Minimum Benefits (PMBs)

REQUIREMENTS FOR PMB COVERAGE

To benefit from PMBs, certain criteria must be met:

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

REGISTERING CHRONIC AND PMB CONDITIONS

- Members on all Plans need to register for out-of-hospital PMB or chronic conditions, by obtaining and submitting the prescribed forms.
- Only correctly coded claims will be funded from PMB benefits, while claims that do not meet PMB criteria will be paid from available day-to-day benefits.

WHAT CONDITIONS ARE COVERED AS PRESCRIBED MINIMUM BENEFITS?

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

PRIMARY CARE PROVIDER (PCP)

Members on the Core Saver and Traditional Plans must nominate a GP as your PCP. Your choice of PCP affects both how much the Scheme pays for your chronic care and whether you qualify for a Care Programme. Nominate a Bankmed Network GP and your chronic care benefits are funded at 100% of the Scheme Rate. Nominate a non-network GP and funding reduces to 80% of the Scheme Rate. If you do not nominate a PCP at all, funding is also limited to 80% of the Scheme Rate and you will not qualify for a Bankmed Care Programme. If you are enrolled on a Care Programme, you must specifically nominate a Premier Plus GP as your PCP to remain eligible for the programme.

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

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

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

Designated Service Providers (DSPs)

A DSP is a Healthcare Professional with whom we have an agreement, otherwise referred to as a network or network Healthcare Professional.

While you are allowed to use a non-DSP, please keep in mind that you may have to pay part of the claim yourself. By using DSPs, your PMB treatment is paid in full.

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

WHAT IF I CANNOT USE A DSP?

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

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

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

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

Authorisation and Funding Guidelines for your Health Conditions

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

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

Ongoing management of your condition, involving Healthcare Professionals such as radiologists, dietitians, and podiatrists, is fully covered from the treatment baskets.

Claims from pathologists are paid in full, up to the agreed rate or up to the Scheme Rate, if there is no payment arrangement.

Claims from Diabetes Educators are covered up to the agreed rate, subject to the limit and network Healthcare Professional criteria.

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

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





Balance, Wellness & Preventative Care Benefits

05

Balance
Exclusive to Bankmed members

Your Wellness Programme

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

1 KNOW YOUR HEALTH

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

2 IMPROVE YOUR HEALTH

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

3 GET REWARDED

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

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

BALANCE TERMS AND CONDITIONS

Earn points by getting healthier

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

	Blue Status	Bronze status	Silver status	Gold status	Diamond status
Single member	You start at Blue Balance status	7 500	25 000	40 000	50 000
Main member +1 member 18 years or older		15 000	50 000	80 000	100 000
Main member +2 members 18 years or older		18 750	62 000	100 000	125 000
For each additional member 18 years or older		+ 3 750	+ 12 500	+ 20 000	+ 25 000

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

Your rewards in a snapshot

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



Up to 15%

back on HealthyFood at Checkers or Woolworths

Checkers Checkers Sixty60 | WOOLWORTHS ONLINE APP DASH

Up to 15%

back on thousands of HealthyCare items at Clicks or Dis-Chem stores.

CLICKS | Dis-Chem PHARMACIES

Active Rewards

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

Up to 15%

upfront discount on qualifying sports gear and equipment from Sportsmans Warehouse and Totalsports.

Sportsmans Warehouse | TOTALSPORTS

30% off

your monthly gym fees from Virgin Active or Planet Fitness.

Virgin active | planet fitness

Up to 80% off

Smoking cessation support through Allen Carr's Easyway to Stop Smoking and GoSmokeFree.

go smoke FREE | Allen Carr's Easyway To Stop Smoking

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

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

Terms and conditions apply

IMPORTANT INFORMATION ABOUT BALANCE:

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



ACTIVE REWARDS

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

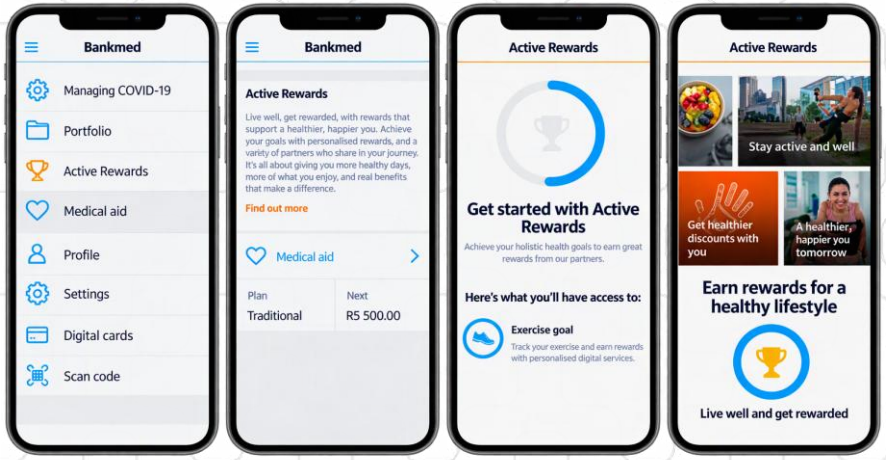
How Active Rewards works

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

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

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

FOLLOW THESE STEPS TO ACTIVATE ACTIVE REWARDS



Step 01
Log into the Balance app

Step 02
Select 'Active Rewards'

Step 03
Click 'Get Started'

Step 04
Get active and start earning points

Step 05
Reach your personalised exercise goals to earn rewards

Balance Travel

Enjoy rewards with Balance Travel

Save 5% on domestic flights with Balance Travel across partner airlines: Airlink, Lift, CemAir and South African Airways. Plus, pay zero booking fees.



How to use the Balance Travel benefit

5% Save 5% on domestic flights with Balance Travel across partner airlines: Airlink, Lift, CemAir and South African Airways.

Who can join:
All adult Balance beneficiaries aged 18 years and older.

6 bookings per year.

No booking fees when booking online via Balance Travel.

AIRLINK

CemAir

lift

South African Airways
A STAR ALLIANCE MEMBER

Wellness & Preventative Care Benefits

We believe that good health is a true form of wealth, and understanding your health status is its foundation. Regular health screenings are essential for the early detection of medical conditions, allowing for timely and effective intervention that leads to better outcomes.

Optimal health extends beyond the absence of symptoms, as early signs of medical issues can be easily missed. If left untreated, conditions can worsen and eventually require costly surgeries or intensive medical care. Our Wellness and Preventative Care Benefits offer essential screenings for early detection and preventative care.

IMPORTANT

Wellness and Preventative Care benefits support early detection of potential health risks. Screening does not replace medical advice, diagnosis or treatment.

Members are encouraged to discuss their results with a healthcare professional and follow any recommended care.

Participation is voluntary, and Bankmed Medical Scheme and Discovery Health cannot be held responsible for outcomes resulting from a member not seeking or following appropriate medical care.

Key Points about Wellness and Preventative Care Benefits:

COVERAGE UNDER INSURED BENEFIT

- These benefits are covered by your Insured Benefits, and do not deplete your out-of-hospital insured sub-limits or your MSA, where applicable.
- Using a DSP ensures that you do not incur any co-payments.
- Healthcare Professional consultation costs are excluded and will be paid from your available day-to-day benefits.

ESSENTIAL SCREENING AND PREVENTATIVE CARE BENEFITS

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

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

We have summarised our screening benefits on the next page.

Wellness Toolkit

POSITIVE IMPACT OF WELLNESS INITIATIVES

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

SELF-SAMPLING KITS FOR CERVICAL AND COLORECTAL CANCER SCREENING

Bankmed members can now complete cervical and colorectal cancer screenings at home, without a Healthcare Professional's referral. This convenient option makes early detection simpler and more accessible.

Key benefits:

- This benefit allows members to complete HPV (cervical) and colorectal cancer screening in the comfort and privacy of their own home, with no Healthcare Professional's referral required.
- Self-sampling kits are available from participating Ampath and Lancet laboratories, Clicks and Medirite pharmacies, selected local pharmacies, and participating GP rooms. Members should confirm stock availability before visiting.
- Members collect samples at home and return them to the pharmacy, pathology lab, or GP's room where the kit was obtained.
- Pathology labs handle analysis, with results shared via the lab app or through your Healthcare Professional.
- Follow-up guidance: Negative results require no further action; positive results will be managed in consultation with your Healthcare Professional, funded from Day-to-Day benefits.
- The self-screening kit is covered at 100% of the Scheme Rate.

From 1 January 2027, view participating providers using the Find a Healthcare Professional tool and search for "cancer screening". Only providers stocking the kits will appear.

Wellness & Preventative Care Benefits Screening Summary

PREVENTATIVE & CARE BENEFITS

PRIMARY HEALTHCARE
- Three nurse consultations
- Contraceptive Benefit (family planning)
- Intra-muscular injection

VACCINATIONS
- Childhood vaccines
- Flu vaccination
- HPV vaccination
- Pneumococcal vaccine

POST WELLNESS SCREENING PROGRAMME
- Post-PHA Screening Basket:
  - Medium- to high-risk: biokineticist and dietitian consult
  - High-risk: GP consult post-assessment
- Diabetes management

MENTAL HEALTH
- Mental Health 'At-Risk' Benefit
- Mental Health Care Programme

CHILD HEALTH
- Post-Child Health Assessment Basket:
  - Medium – to high-risk: biokineticist and dietitian consult
  - High-risk: GP consult post-assessment
- Childhood Vaccines
- Childhood Preventative Dental Benefit

CARE PROGRAMMES
- Disease Prevention Programme
- Mental Health Readmission Programme
- Oncology Programme
- Renal Care Programme
- Diabetes Care Programme
- Continuous Glucose Monitoring Benefit
- HIV Care Programme
- Cardio Care Programme
- Mental Health Care Programme

POST-HOSPITALISATION CARE BENEFITS
- 30-Day Post-hospital GP Consultation Benefit
- 30-Day Post-hospital Psychiatric Consultation Benefit
- Post-hospitalisation Physiotherapy Benefit

WELLNESS TOOLKIT

SCREENING BENEFITS

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

CHILD HEALTH SCREENING
- Child Health Assessment – measures specific child health indicators like blood pressure, waist circumference, and BMI

CANCER SCREENING
- Mammogram
- Breast MRI
- Prostate-Specific Antigen (PSA)
- Faecal Occult Blood Test
- Pap Smear Pathology or HPV Testing
- Pap Smear Consultation
- Colorectal Cancer Self-screening Kit
- Cervical Cancer Self-screening Kit

MENTAL HEALTH SCREENING
- Mental Wellbeing Online Assessment
- Dementia Screening

OCCUPATIONAL HEALTH SCREENING
- Tuberculosis (TB)

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



Day-to-Day Benefits & Cover

06

Day-to-Day
Benefits & Cover

Your day-to-day healthcare expenditure is covered through your Day-to-Day Insured Benefits, Medical Savings Account (MSA), and Above Threshold Benefit (ATB), depending on your Plan type.

WHAT ARE DAY-TO-DAY BENEFITS?

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

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

WHAT ARE INSURED BENEFITS?

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

Choose your MSA reimbursement rate

You can choose between Cost or Scheme Rate. Cost fully covers eligible claims, including out-of-network ones. Scheme Rate limits coverage to the Scheme Rate and within benefit limits.

New members default to the Scheme Rate if no choice is made, but they can switch between options anytime.

MEDICAL SAVINGS ACCOUNT (MSA)

Available on Core Saver, Comprehensive and Plus Plans

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

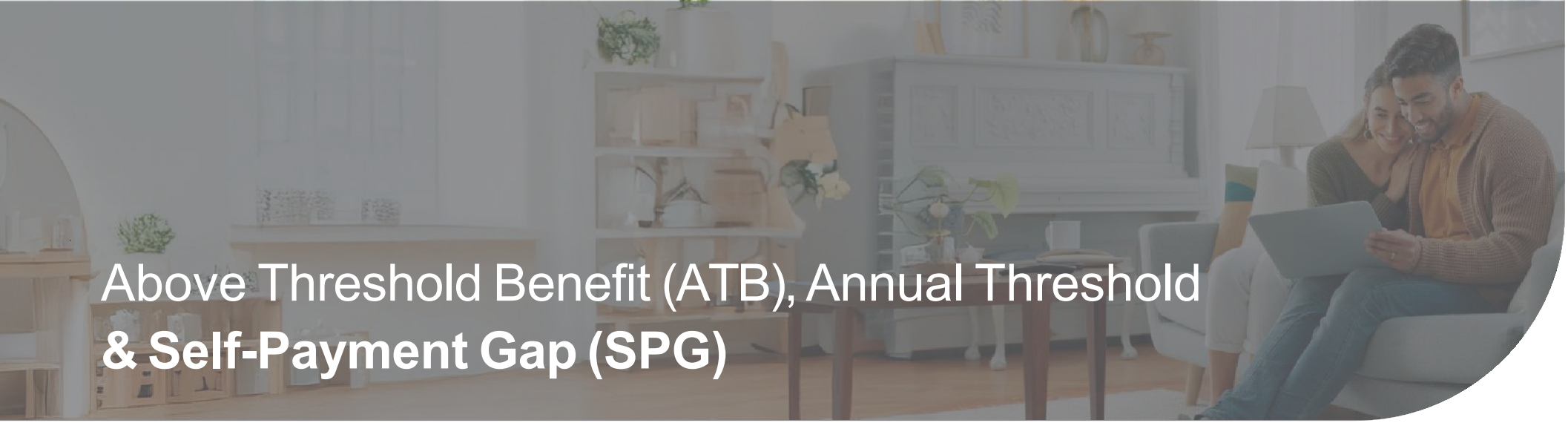
At the start of each year, we give you full access to a yearly amount.

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

If you join Bankmed after 1 January 2027, we calculate your MSA amount for the rest of the year by multiplying the monthly amount you contribute towards your MSA, by the number of months left in the year.

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





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

Plus Plan exclusive features

ATB

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

ANNUAL THRESHOLD

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

SPG

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

LIMITS TO AMOUNTS ADDING UP AND BENEFIT CATEGORIES

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

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

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

IMPORTANT

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

2027 ATB AND ANNUAL THRESHOLD

Annual Threshold			
	M	A	C
Threshold Level	R28 200	R21 000	R6 900
Threshold Amount	R25 300	R19 000	R6 300

*Limited to three children. Family amounts combine the applicable amount for each beneficiary. Annual Threshold and ATB amounts are pro-rated for membership changes during the year.

How to calculate the Annual Threshold

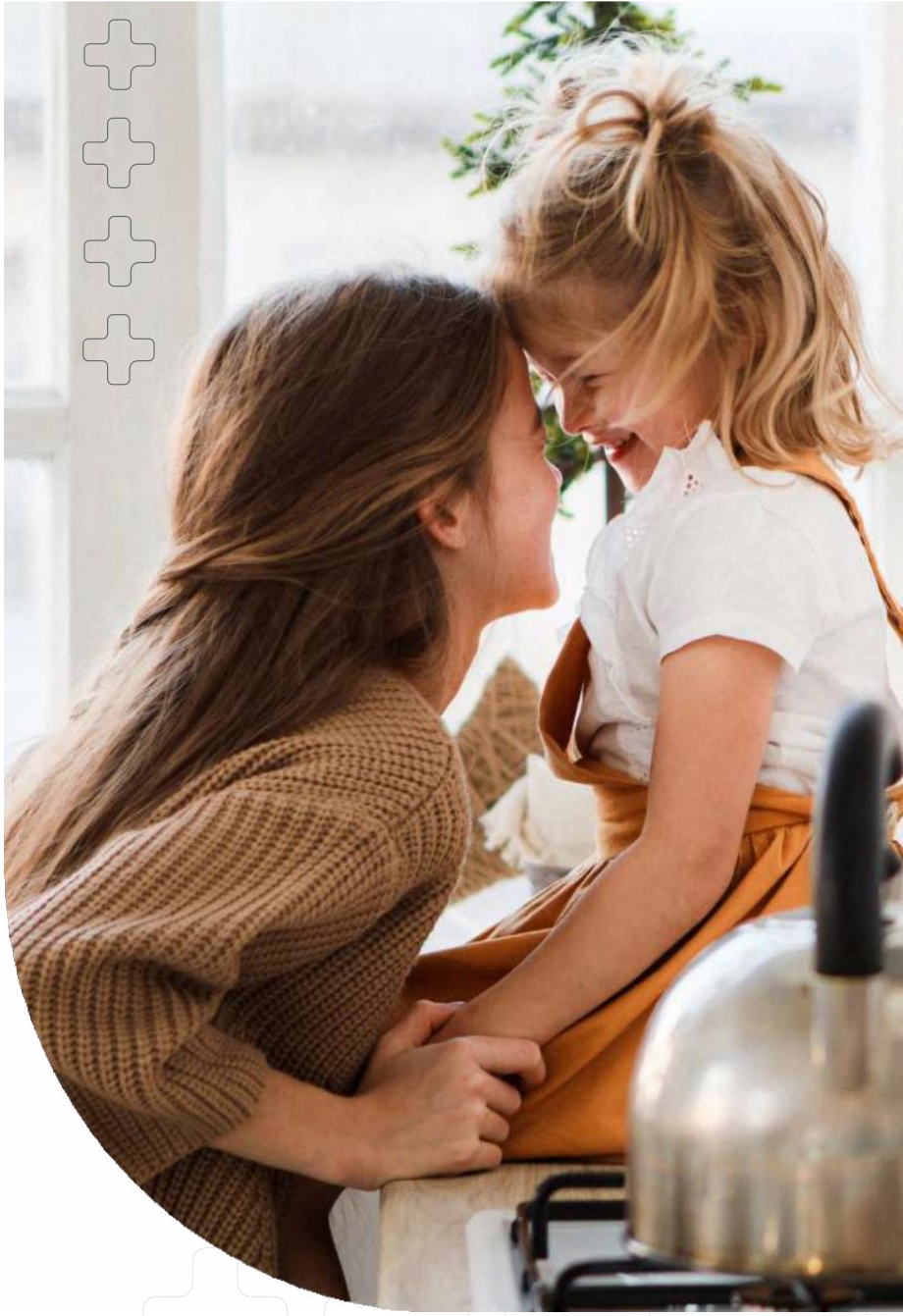
The Annual Threshold is a combined family threshold and is calculated by adding the threshold level amount for each family member together. See example below:

Principal Member		Adult Dependant		Child		Family
R28 200	+	R21 000	+	R6 900	=	R56 100

How to calculate the ATB

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

Principal Member		Adult Dependant		Child		Family
R25 300	+	R19 000	+	R6 300	=	R50 600



Day-to-Day **Benefits**

	Medical Savings Account (MSA)	Day-to-Day Benefit Funding	How the Funding Works
PLUS PLAN	Yes	MSA ATB	• All day-to-day claims are paid from your MSA until the Annual Threshold is reached. After reaching the Annual Threshold, access to the ATB provides additional cover for high out-of-hospital expenses. • ATB covers GP and specialist consultations, in-room procedures, acute medication, blood tests, X-rays, basic and advanced dentistry, orthodontics, hearing aids, and other specified services. • Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
COMPREHENSIVE PLAN	Yes	MSA	• Day-to-day claims, including GP and specialist consultations, acute medication, blood tests, and X-rays, are paid from your MSA. • In-room procedures by GPs or specialists, and basic dentistry, are funded from Insured Benefits with no set limits. • Advanced dentistry, orthodontics, hearing aids, and specific categories have limited coverage under Insured Benefits. Once limits are reached, expenses are covered from available MSA funds. • Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
TRADITIONAL PLAN	No	Insured Benefits	• Day-to-day benefits, including GP and specialist consultations, acute medication, X-rays, blood tests, basic and advanced dentistry, orthodontics, hearing aids, and other categories, are covered by the Insured Benefit up to Plan limits. Unlimited coverage is provided for procedures performed by GPs and specialists in their rooms. • Limited cover is available for eye tests, glasses, or contact lenses every two years. • Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
CORE SAVER PLAN	Yes	MSA	• Unlimited PMB cover when using network GPs or specialists and following the recommended care. Chronic Illness Benefit registration is required for chronic conditions. • Two non-PMB consultations covered by Insured Benefit, then day-to-day expenses use MSA funds. • MSA covers non-PMB expenses like dentistry, eye care, and acute medication. Limited cover for acute medication from pharmacists. • Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
BASIC PLAN	No	Insured Benefits	• Unlimited cover for GP consultations, acute medication from the formulary, and basic dentistry via the Bankmed Dental Network. No reimbursement for basic dentistry from non-preferred providers or treatments not on the formulary; advanced dentistry and orthodontics not covered. • Limited eye care benefits available every two years through the Bankmed Optometry Network. • Additional benefits up to a specified limit when using a Bankmed Entry Plan Network GP or with a referral to another network Healthcare Professional. • Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
ESSENTIAL PLAN	No	Insured Benefits	• Cover limited to PMBs

Benefit Terminology:

- Acute medication (short-term prescriptions)
- Blood tests (pathology)
- X-rays (radiology)
- Basic dentistry (dentist consultations, teeth cleaning, and fillings)



Maternity Benefits & Bankmed's Baby-and-Me Programme

07



Cover for Pregnancy & Childbirth

IN-HOSPITAL COVER GUIDELINES

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

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

MATERNITY BENEFITS COVERED BY BANKMED

- Midwife care and delivery.
- Birthing facilities as an alternative to hospitalisation.
- Cost of disposables are limited to R1 500 for each case.
- Out-of-hospital cover includes certain pregnancy-related expenses based on your Plan benefits.
- Antenatal and post-natal care includes services of GPs, specialist consultations, and procedures performed in the Healthcare Professional's rooms.
- Ultrasonic investigations are limited per Plan type.
- Pathology tests.
- Newborn screening test:
  - Available to all newborns to detect certain metabolic and endocrine disorders.
  - Clinical entry criteria and Plan limitations apply.
- Newborn hearing test:
  - Funding only covers the test, provided by a registered Audiologist.
- Plan limitations apply.
- T21 chromosome test or non-invasive prenatal test (NIPT):
  - Clinical entry criteria and Plan limitations apply; applicable to high-risk beneficiaries aged 35 years and older at delivery.
  - If a T21 test is positive, the Healthcare Professional may refer for NIPT, and Bankmed will fund both tests, subject to pre-authorisation.
- Amniocentesis:
  - Clinical entry criteria and Plan limitations apply.
  - Any registered pathologist may perform the test, subject to gynaecologist referral.

ITEMS NOT COVERED

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

ADDITIONAL INSURED BENEFITS

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

IMPORTANT

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

Bankmed's **Baby-and-Me Programme**

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

KEY BENEFITS AND REASONS TO JOIN

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

UPON REGISTRATION, YOU RECEIVE

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

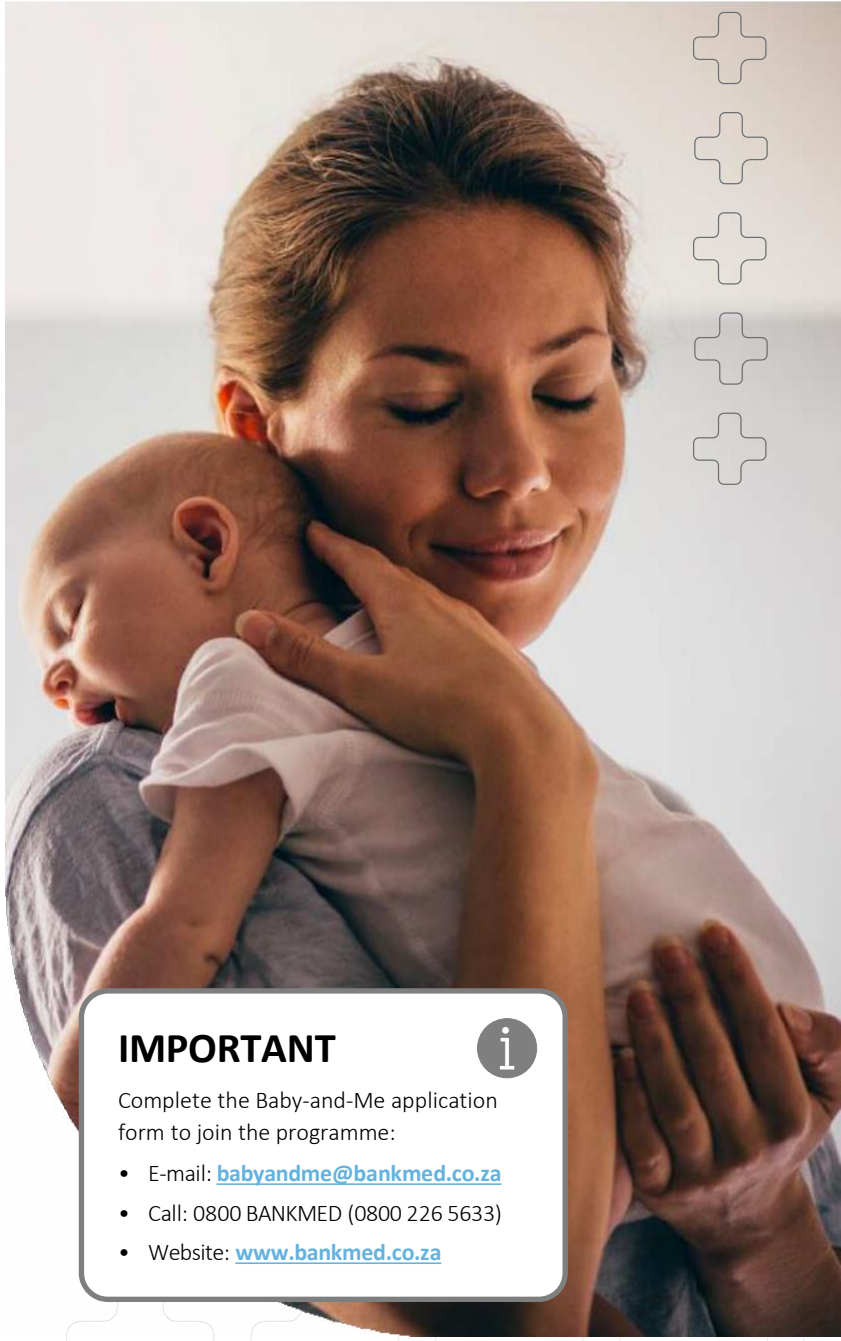
** Note: The contents of the Bankmed baby hamper are subject to change without notice based on stock availability.*

ADDITIONAL INSURED BENEFITS

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

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

- Six antenatal consultations per pregnancy at applicable rates for both GP and specialist in-room consultations.
- Three 2D ultrasounds covered at 100% of the Scheme Rate.
- A reimbursement of R1 930 (per pregnancy) for antenatal and postnatal classes.
- Additional pathology tests covered at 100% of the Scheme Rate, subject to the Baby-and-Me Programme Basket-of-Care.



IMPORTANT

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

- E-mail: babyandme@bankmed.co.za
- Call: 0800 BANKMED (0800 226 5633)
- Website: www.bankmed.co.za



Chronic Illness Benefit & Bankmed Care Programmes

08

Chronic Illness Benefit

You are covered for 27 chronic conditions (including HIV and AIDS). You must register on the CIB. Once approved we will start paying for your chronic medication. If you do not register, we pay for your chronic medication from your day-to-day benefits.

MEDICATION ADVISORY SERVICES

Core Saver, Traditional, Comprehensive and Plus Plans

We aim to provide structure and ensure your chronic medication is effective. Our efficient pre-authorisation process combines advanced technology with medical expertise to assess applications according to clinical guidelines.

HOW TO REGISTER

We ask your treating Healthcare Professional about your condition and may request test results or additional proof to confirm eligibility for coverage.

Core Saver, Traditional, Comprehensive and Plus Plans

To get authorisation for immediate chronic medication, your Healthcare Professional or pharmacist can contact Bankmed on **0800 13 23 45**.

Alternatively, ask your treating Healthcare Professional to fill in a registration form.

E-mail the completed form to chronic@bankmed.co.za.

Essential and Basic Plans

Ask your treating Healthcare Professional to fill in a registration form. E-mail the completed form to chronicbasicessential@bankmed.co.za.

TIPS FOR EXTENDING YOUR BENEFITS

When applying to join the CIB, we recommend that your Healthcare Professional prescribes a generic version of your medication. Generics help lower your claim costs, extend your benefits, and reduce the chance of a co-payment at the pharmacy.

By law, only you and your Healthcare Professional can decide on your treatment. We will not change your medication without your Healthcare Professional's approval.

Essential and Basic Plans

To ensure coverage, you must use medication from our approved list (formulary). Please consult your Healthcare Professional and check the Bankmed website or App to confirm if the medication is on the formulary.

Core Saver, Traditional, Comprehensive and Plus Plans

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

CHOOSE MEDICATION WISELY

As per the International Generic Pharmaceutical Alliance, generics are 20 to 90 percent more cost-effective than original medications. Ask your pharmacist about generics and their costs.

You can also save by choosing one medication that treats multiple symptoms.

What is generic medication?

A generic medication has the same active ingredients, dosage, strength, and intended use as the original but comes in different packaging and is usually more affordable. The original medication's higher cost is due to exclusive selling rights, which expire when the patent does, allowing generics to be produced.

For PMB conditions, medication is covered at 100% of the Scheme's Medication Reference Price if obtained from a DSP, such as a Bankmed Network GP or Bankmed Pharmacy Network.

If voluntarily obtained from a non-DSP, it's covered at 80%. Involuntary non-DSP purchases are covered at cost, pending the Scheme's review. All medication must be on the Scheme's approved Condition Medication List (CML).

IMPORTANT: CORE SAVER & TRADITIONAL PLAN MEMBERS WITH CHRONIC CONDITIONS

Nominate your Primary Care Provider (PCP)

Research shows that members using a primary care GP to coordinate chronic care are better controlled and more compliant with prescribed care. Bankmed requires that members on the Core Saver and Traditional Plans nominate and use a Bankmed Network GP to coordinate chronic care. Members with nominated primary care providers (PCP) are reimbursed at the contracted rate. A 20% co-payment applies to GP visits and related services where PCP rules are not followed.

One out-of-area visit is allowed. Members may change their nominated GP twice a year. Approved specialist consultations within the Basket-of-Care do not attract the PCP penalty.

THE CDL COVERS SPECIFIC CONDITIONS

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

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

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

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

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

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

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

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

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

Additional Disease List (covered on the Basic Plan only)

- Major Depression.

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

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

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

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

Bankmed's **Care Programmes**

Spinal Conservative Care Programme

OVERVIEW

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

SUBJECT TO CLINICAL ENTRY CRITERIA

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

To allow your chosen Healthcare Professional to access your medical records on HealthID, you need to provide consent under 'Digital Tools' by selecting 'Provide Your Doctor Consent'. This enables you and your doctor to set key goals and monitor your progress together through the programme.

MANAGING YOUR CONDITION WITH YOUR HEALTHCARE PROFESSIONAL

The Spinal Conservative Care Programme offers a defined Basket-of-Care for consultations with network physiotherapists or chiropractors over six to 12 weeks, either in person or via the Bankmed Connected Care platform. Your Healthcare Professional will determine the best treatment for you. Once enrolled, consultations are fully covered without affecting your day-to-day benefits. Additional conservative care services outside the approved Basket-of- Care will be covered according to your chosen Plan's benefits.

FIND A NETWORK PHYSIOTHERAPIST OR CHIROPRACTOR

1. Bankmed Website

On the Bankmed website, go to 'Digital Tools' and select 'Find a Healthcare Professional'. Enter the category (e.g. Physiotherapist) and your address, then click 'Search'. To filter for the Spinal Conservative Care Programme, tick the 'Care Programmes' filter and select 'Spinal Conservative Care'.

2. Log in to your Bankmed Health App

On the Bankmed Health App, go to 'Digital Tools' and select 'Find a Healthcare Professional'. Enter the name or category (e.g.
Chiropractor), then choose 'Filters'. Under 'Care Programmes', select 'Spinal Conservative Care', return to the search page, and click 'Apply'.

YOUR COVER ON THE PROGRAMME

If you are enrolled on the Spinal Conservative Care Programme:

- Any additional conservative healthcare services, outside of the sessions approved as part of the defined Basket-of-Care, will be covered in accordance with your chosen Plan benefits.
- If you change conservative care network Healthcare Professionals, we continue counting the sessions from where you left off with your first Healthcare Professional. Your cover does not reset with the new Healthcare Professional.
- If you stop the programme, we do not pay further costs.
- Where clinically appropriate, your conservative care network Healthcare Professional can refer you for further assessment with a network spinal surgeon. If you need to have surgery, the Spinal Conservative Care Programme will end.
- You are eligible for the Spinal Conservative Care Programme only once per year, even if your condition recurs or a new area of concern arises.
- If you have had spinal surgery in the past 12 months, you do not qualify for the programme.

Advanced Illness Benefit (AIB)

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

ENROLLING IN THE AIB

Your Healthcare Professional will initiate your AIB enrolment by completing the application form available at www.bankmed.co.za and e-mailing it to AIB@bankmed.co.za. Access is voluntary and subject to clinical entry criteria.

KEY FEATURES OF THE AIB

The AIB provides funding for palliative care for members in advanced stages of illness, where curative treatment has ended. It includes a comprehensive care plan focused on symptom management. Once approved, you will have access to the AIB benefits.

BENEFITS OVERVIEW

Support from a dedicated care coordinator:

Upon registration, a dedicated care coordinator, who is a registered nurse, will work with you or your family. They will provide support, collaborate with your GP and/or specialist, and ensure you receive optimal care.

Personalised support and counselling:

Members and their families enrolled in the AIB have access to counselling services for essential support during difficult times.

Comprehensive home-based care:

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

Specialised telephonic support:

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

COVER DETAILS

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

NOMINATION AND ASSISTANCE

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

ADVANCED ILLNESS MEMBER SUPPORT PROGRAMME (AIMSP)

The AIB provides members with advanced cancer access to a comprehensive range of out-of-hospital palliative care benefits. Through AIMSP, members engage with a dedicated team, including a social worker, counsellor, and palliative care GP, to understand their illness, explore care options, and create a personalised care plan. Research shows that early discussions about care plans increase the likelihood of members receiving appropriate end-of-life care when needed.

Disease Prevention Programme

The Disease Prevention Programme aims to enhance access to care and improve health outcomes. All adult dependants across all Plans are eligible and identified through a PHA. High-risk members for diabetes may qualify for enrolment.

ENROLMENT PROCESS

Our predictive model assesses your PHA results, health claim patterns, family history, and other data to determine your diabetes risk. Eligible members are contacted by a Health Coach and referred to a Premier Plus GP for confirmation. Your GP will register you on HealthID and connect you with a dietitian.

Together, your GP, dietitian, and Health Coach will support you in preventing diabetes progression.

The Health Coach will assist with behavioural changes, and you'll have access to a Basket-of-Care for consultations and pathology tests. Coverage depends on clinical criteria, guidelines, protocols, and preferred providers, paid up to the Scheme Rate.

Kidney Care Programme

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

HOW TO REGISTER

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

COVER FOR RENAL DIALYSIS SERVICES

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

KIDNEY CARE PROGRAMME

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

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

Cardio Care Programme

WHAT IS CARDIOVASCULAR DISEASE

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

NOTE TO BASIC PLAN MEMBERS

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

THE CARDIO CARE PROGRAMME

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

- Hypertension
- Ischaemic heart disease
- Hyperlipidaemia



Cover for Cancer

Bankmed's Managed Oncology Benefit Programme

A practical guide to accessing authorised cancer care through the Managed Oncology Benefit Programme

YOUR ONCOLOGY BENEFIT

Support for authorised cancer care, from diagnosis through treatment and follow-up

- The Programme supports approved chemotherapy, radiotherapy, oncology medicines, consultations and related healthcare services. What is funded depends on your Plan, diagnosis, approved treatment plan, clinical criteria, Basket-of-Care, provider network and the applicable Scheme funding rate.
- Please register as soon as the diagnosis is confirmed. The benefit starts from the date of registration, subject to approval of the treatment plan.
- Before registration, services are considered under your ordinary Plan benefits, except where the PMB Regulations require otherwise.
- Only services directly related to the active oncology episode and authorised Basket-of-Care or treatment plan are considered under this benefit.

IMPORTANT

A cancer diagnosis can bring many questions. The Managed Oncology Benefit Programme helps you and your treating team navigate approved care, understand what must be authorised and know where member costs may arise.

ACTIVATING YOUR BENEFITS

1. Register

Contact Bankmed as soon as the diagnosis is confirmed. Registration links the active oncology episode to the Programme.

2. Submit the treatment plan

Your oncologist submits the diagnosis, medicine, dose, treatment cycles and supporting clinical information for review.

3. Obtain authorisation

Obtain authorisation at least 48 hours before planned treatment or investigations. Approval confirms the treatment and benefit position.

4. Use approved providers

Use the applicable DSP, oncology network, facility and dispensing provider. Confirm the network position before receiving care.

5. Keep approval current

Changes to medicine, dose, provider, treatment cycles or the clinical plan may require updated authorisation.

What the Programme may cover

YOUR 2027 COVER BY PLAN

	Main Oncology Cover	Oncology Benefit Threshold and Funding Position
PLUS PLAN	Approved Tier 1, 2 and 3 oncology treatment is funded subject to clinical entry criteria, Scheme protocols and formularies, preferred products, Basket-of-Care and Scheme rates. DSP use and clinical approval are required. Treatment outside these requirements may not be funded. Novel treatments require approval under the Oncology Innovation Benefit.	• No Oncology Benefit Threshold applicable. Approved treatment is funded at the applicable Scheme Medication Rate or Scheme Rate, whichever is applicable. • Approved treatment under the Oncology Innovation Benefit is funded by Bankmed at 70% of the Scheme Rate.
COMPREHENSIVE PLAN	Approved Tier 1, 2 and 3 oncology treatment is funded subject to clinical entry criteria, Scheme protocols and formularies, preferred products, Basket-of-Care and Scheme rates. DSP use and clinical approval are required. Treatment outside these requirements may not be funded. Novel treatments require approval under the Oncology Innovation Benefit.	• Oncology Benefit Threshold equal to R500 000 per beneficiary over a rolling 12-month period. Approved treatment is funded at the applicable Scheme Medication Rate or Scheme Rate, whichever is applicable, within the threshold. After the threshold, qualifying PMB treatment continues at the applicable Scheme Rate; qualifying non-PMB treatment is funded at 80% of the applicable Scheme Rate. • Approved treatment under the Oncology Innovation Benefit is funded by Bankmed at 50% of the Scheme Rate.
TRADITIONAL PLAN	Approved Tier 1, 2 and 3 oncology treatment is funded subject to clinical entry criteria, Scheme protocols and formularies, preferred products, Basket-of-Care and Scheme rates. DSP use and clinical approval are required. Treatment outside these requirements may not be funded. Novel treatments require approval under the Oncology Innovation Benefit.	• Oncology Benefit Threshold equal to R350 000 per beneficiary over a rolling 12-month period. Approved treatment is funded at the applicable Scheme Medication Rate or Scheme Rate, whichever is applicable, within the threshold. After the threshold, qualifying PMB treatment continues at the applicable Scheme Rate; qualifying non-PMB treatment is funded at 80% of the applicable Scheme Rate. • Approved treatment under the Oncology Innovation Benefit is funded by Bankmed at 50% of the Scheme Rate.
CORE SAVER PLAN	Qualifying PMB oncology treatment at Tier 1 level of care.	• No Oncology Benefit Threshold. Non-PMB Tier 2 and Tier 3 treatment and the Oncology Innovation Benefit are not included.
BASIC PLAN	Qualifying PMB oncology treatment at Tier 1 level of care.	• No Oncology Benefit Threshold. Non-PMB Tier 2 and Tier 3 treatment and the Oncology Innovation Benefit are not included.
ESSENTIAL PLAN	Qualifying PMB oncology treatment at Tier 1 level of care.	• No Oncology Benefit Threshold. Non-PMB Tier 2 and Tier 3 treatment and the Oncology Innovation Benefit are not included.

THE MANAGED ONCOLOGY BENEFIT PROGRAMME MAY INCLUDE:

- Approved Tier 1 treatment for qualifying Prescribed Minimum Benefit (PMB) oncology conditions.
- Tier 2 treatment and, where included in your Plan, Tier 3 treatment that meets the Scheme's clinical entry criteria and protocols.
- Authorised chemotherapy and radiotherapy, including approved facility, planning, technical and professional services.
- Oncology and oncology-related medicine, including approved supportive medicine.
- Oncology consultations and authorised stomatherapy, lymphoedema care, pathology, radiology, scopes and specified scans that relate directly to the active oncology episode.
- Approved novel and ultra-high-cost non-PMB treatment through the Oncology Innovation Benefit, where available on your Plan.

Important: Benefits start from the date of registration, subject to approval of the treatment plan. Before registration, services are considered under your ordinary Plan benefits, except where the PMB Regulations require otherwise.

About the Oncology Benefit Threshold

Only services specifically identified in the Scheme Rules accumulate to the threshold, from the date of benefit registration. Hospital surgery for removal of a cancerous tumour, wigs and acute medicine outside the supportive formulary are funded under the relevant Plan benefit and do not accumulate to the threshold.

Care considered through the Programme

Funding is based on your authorised treatment plan and the benefits available on your Plan

Treatment for Cancer

- Approved chemotherapy and radiotherapy
- Approved oncology medicines
- Facility, planning, technical and professional services linked to treatment
- Tier 1 PMB treatment and Tier 2 or included Tier 3 care where your Plan provides for it

Related Healthcare Services

- Oncology consultations
- Authorised pathology and radiology
- Specified scans and scopes
- Approved supportive medicine
- Stomatherapy and lymphoedema care linked to the active oncology episode

Care Funded Elsewhere

- Hospital surgery to remove a cancerous tumour, wigs and certain acute medicines may be funded from the relevant hospital, day-to-day or acute medicine benefit, and may not accumulate to the Oncology Benefit Threshold
- Please refer to the benefit tables at the back of the Benefit & Contribution Schedule

UNDERSTANDING THE TREATMENT TIERS

Tier 1

Qualifying PMB oncology treatment at the statutory level of care, subject to the PMB Regulations and Scheme Rules.

Means 'Primary Level of Care' in the SAOC treatment guidelines, or the corresponding treatment guideline or protocol approved or adopted by the Scheme.

Tier 2

Approved treatment that meets clinical entry criteria, protocols and preferred-product arrangements.

Means 'Standard Level of Care' in the SAOC treatment guidelines, or the corresponding treatment guideline or protocol approved or adopted by the Scheme.

Tier 3

Specified higher-cost treatment available only where included by the Plan and where clinical criteria are met.

Means 'Novel Treatment' in the SAOC treatment guidelines, or the corresponding treatment guideline or protocol approved or adopted by the Scheme.

Oncology Innovation Benefit

Approved novel or ultra-high-cost non-PMB treatment considered on qualifying Plans.

Approval may be limited to specified cycles. Continued funding may require clinical, radiology, pathology or other evidence showing an appropriate response.

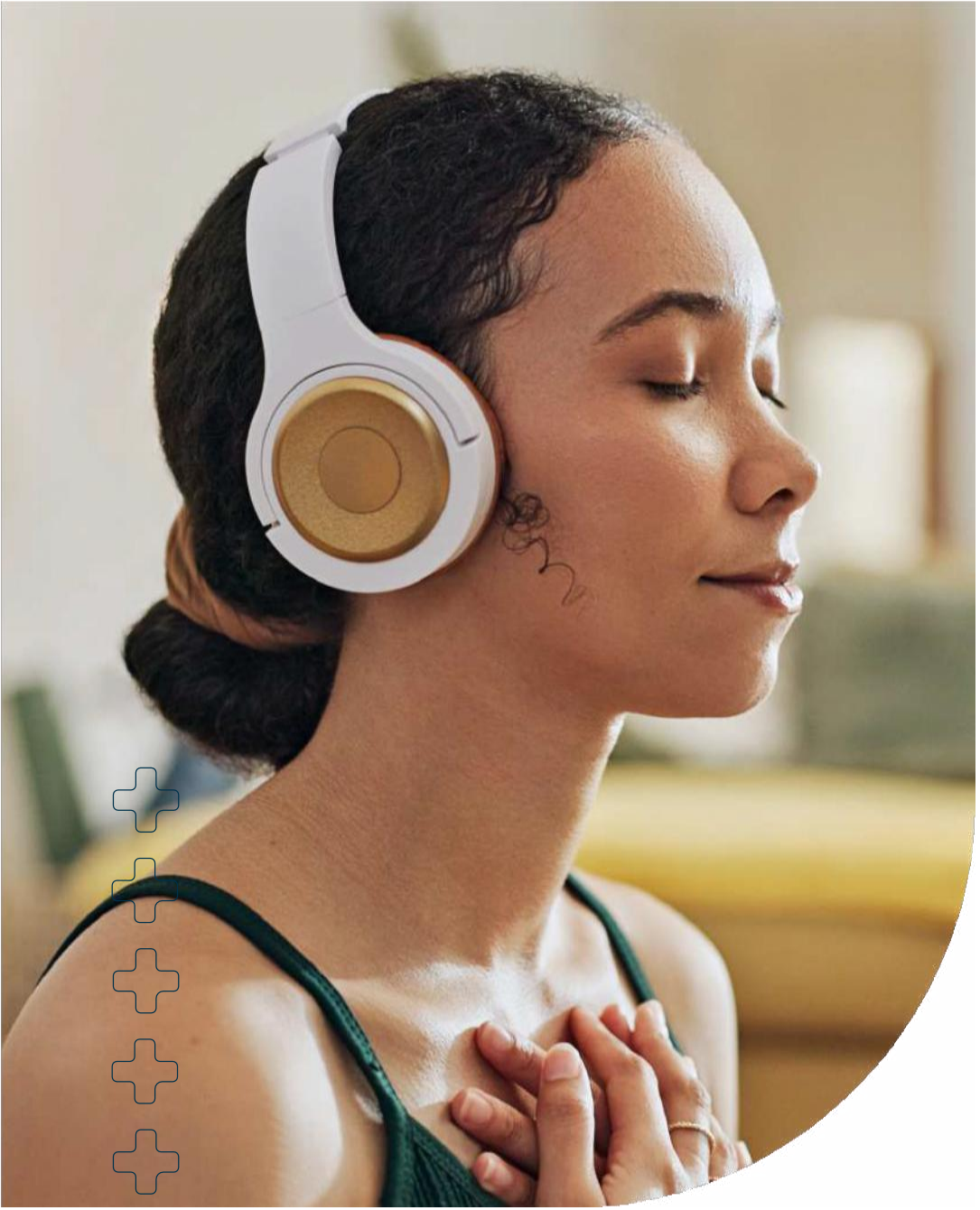
IMPORTANT RULES AND COSTS TO CONSIDER

- **Use the network/DSP:** Voluntary non-network use may be funded at 80%, with the balance payable by you. PMB exceptions may apply.
- **Medication:** Formularies, preferred medicines and reference pricing apply. Non-preferred medicines may attract a 20% member portion and/or price difference.
- **Funding adjustments:** Where multiple 20% adjustments apply, only one is applied, unless the Scheme Rules state otherwise.
- **PMBs:** Qualifying PMB oncology care is funded at Tier 1, subject to applicable PMB requirements.
- **Clinical approval:** Tier 2 and 3 treatment must meet Scheme clinical criteria and protocols. Novel treatment requires Oncology Innovation Benefit approval.

REGISTER OR LEARN MORE

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

- E-mail: oncology@bankmed.co.za
- Call: 0800 BANKMED (0800 226 5633)



Bankmed's Mental Health Care Programme

Make mental wellbeing part of your holistic approach to health

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

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

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

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

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

Bankmed's Mental Health Care Programme

COMPLETE THE ONLINE MENTAL WELLBEING ASSESSMENT

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

THE BANKMED MENTAL HEALTH CARE PROGRAMME OFFERING

On the Mental Health Care Programme, you and your Healthcare Professional have access to tools and benefits to monitor and manage your condition and to ensure you have access to coordinated care.

Your Healthcare Professional can track your progress on a personalised dashboard on HealthID. This will help to identify which areas may need attention so that your Healthcare Professional can improve the management of your condition.

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

Bankmed members can access confidential mental health support 24 hours a day through a dedicated helpline. The service offers immediate assistance, emotional support and guidance to appropriate care and support services when needed.

HOW TO JOIN THE MENTAL HEALTH CARE PROGRAMME

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

BENEFITS AVAILABLE ON THE MENTAL HEALTH CARE PROGRAMME

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

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

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

To improve access and quality of care, Bankmed introduced iCBT for all members diagnosed with depression and Generalised Anxiety Disorder.

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

The service is only available to members with diagnosed depression and/or Generalised Anxiety Disorder, and on the recommendation of a Healthcare Professional, where the diagnosis and treatment of depression and/or Generalised Anxiety Disorder are within their scope of practice (psychiatrist, psychologist, GP, and clinical social worker).

Benefits are subject to your mental health benefits. You must be registered on the Mental Health Care Programme to access this benefit. Please refer to the Benefit Tables in this guide for details about limits.

Bankmed's HIV Care Programme

ACCESS TO CLINICALLY SOUND AND COST-EFFECTIVE TREATMENT

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

PREFERRED PHARMACY PROVIDER NETWORK FOR HIV MEDICATION

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

CONFIDENTIALITY AND HOSPITALISATION

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

PREVENTATIVE TREATMENT WITHOUT WAITING PERIODS

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

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

GP and specialist consultations

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

HIV monitoring blood tests

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

ANTIRETROVIRAL MEDICATION AND SUPPORTIVE TREATMENT

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



NUTRITIONAL FEEDS FOR MOTHER-TO-CHILD PREVENTION

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

PREMIER PLUS HIV GP NETWORK AND FULL COVER FOR HEALTHCARE PROFESSIONALS

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

APPROVED MEDICATION AND PRESCRIPTION REQUIREMENTS

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

PRESCRIBED MINIMUM BENEFITS

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

OUT-OF-HOSPITAL TREATMENTS AND APPEALS

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

TO REGISTER OR LEARN MORE

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

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

HIV self-testing

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

WHAT IS AN HIV SELF-TEST?

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

Order kit now

DISCLAIMER

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



Diabetes Care Programme

Comprehensive Diabetes Care Programme

Living with diabetes requires continuous management and presents daily challenges. Our Diabetes Care Programme supports you with a dedicated team of Healthcare Professionals, offering high-quality, coordinated care to help improve your health outcomes.

Key Features:

Dedicated healthcare team:
A specialised team of Healthcare Professionals collaborates to deliver comprehensive care, tailored to your diabetes management needs.

Tools and additional benefits:
A range of tools and supplementary benefits aimed at monitoring and effectively managing your condition.

Dedicated care navigators:
Our programme includes dedicated care navigators, ready to assist with all your diabetes-related enquiries and needs.

PROGRAMME ENROLLMENT

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

Find a Healthcare Professional

HEALTHCARE PROFESSIONAL PARTNERSHIP IN MANAGING YOUR CONDITION

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

By collaborating with your network Healthcare Professional, you can:

- Set key health goals.
- Track progress via a personalised HealthID dashboard.
- View your Diabetes Management Score to identify areas needing attention.

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

DIABETES CARE NAVIGATORS

Our Care Navigators guide you through your diabetes benefits

Managing diabetes is complex, but Bankmed's Diabetes Care Programme offers extra benefits and tools beyond the Chronic Illness Benefit. Research shows that coordinated care led by one Healthcare Professional, along with specialists like dietitians and podiatrists, delivers the best health outcomes. Our dedicated call centre is here to assist you.

How can your Care Navigator help you?

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

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

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

- E-mail: Members_DCP@bankmed.co.za
- Call: 0860 444 439

Please save these contact details if you are already registered for the Diabetes Care Programme. The care navigator call centre agents can answer any questions about your cover for diabetes.

COVER FOR CONTINUOUS GLUCOSE MONITORING (CGM) SENSORS

Continuous Glucose Monitoring (CGM) automatically tracks your blood glucose levels, allowing you to monitor them anytime for better management. Members with type-1 and type-2 diabetes are covered for CGM sensors when prescribed by a network Healthcare Professional, depending on your chosen Plan. Note that clinical entry criteria apply.



Hospital Benefits & Going to Hospital

09

Hospital Care & Procedures

HOSPITAL BUILDING VERSUS BEING IN HOSPITAL

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

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

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

HOSPITAL PRE-AUTHORISATION

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

- Call: 0800 BANKMED (0800 226 5633)
- E-mail: treatment@bankmed.co.za

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

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

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

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

While pre-authorisation confirms that your hospital admission meets our clinical guidelines for funding, actual coverage depends on your Plan's limits and whether you use a Healthcare Professional within our network.

It's essential that you review your Plan's limits in this Benefit and Contribution Schedule and refer to the Scheme Rules on the website where required. If uncertain, please contact us at 0800 BANKMED (0800 226 5633) for benefit confirmation.

IT IS YOUR RESPONSIBILITY TO OBTAIN PRE-AUTHORISATION

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

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

PROVIDING ACCURATE AND COMPLETE CONTACT DETAILS

To ensure smooth and timely communication, please make sure your e-mail address and cellphone number are always up to date. Without accurate contact details, we cannot share important information such as pre-authorisation confirmations, whether your chosen Healthcare Professional is a Designated Service Provider (DSP), or if upfront deductibles apply. If you have not yet provided an e-mail address or cellphone number, please do so as soon as possible.

Remember that dependants aged 18 and older must maintain their own contact details, as we can only communicate directly with them if they have given explicit consent for you to receive their information. Bankmed and its Administrator cannot be held liable for any losses or costs incurred as a result of outdated or incorrect contact information.



HOW WE PAY YOUR TREATING HEALTHCARE PROFESSIONAL

The specifics of your benefits, including the rate of cover and limits, are outlined in this Benefit and Contribution Schedule. You must discuss the costs of the treatment with your treating Healthcare Professional and enquire if they charge the Scheme Rate.

In instances where they charge more than the Scheme Rate, you are responsible for covering the difference, known as a co-payment. Also, clarify whether other Healthcare Professionals, such as an anaesthetist or assistant, will be involved in your treatment and if they also charge the Scheme Rate.

PRE-ASSESSMENTS AHEAD OF PROCEDURES

Bankmed offers claim pre-assessments if you provide detailed quotes from your treating Healthcare Professional well in advance of your procedure.

Although a pre-assessment isn't a guarantee of cover, it helps identify potential cost differences between the professional's charges and the Bankmed Scheme Rate, highlighting possible shortfalls and co-payments.

To avoid unexpected costs, we recommend negotiating tariffs upfront. When multiple procedures are done under one anaesthetic, Healthcare Professionals should apply reduced fees for subsequent procedures, according to industry guidelines. Ensure your Healthcare Professional follows these guidelines and discusses the charges with you beforehand.

UPDATE CONTACT DETAILS FOR YOU AND YOUR DEPENDANTS

- We send pre-authorisation letters to both you and your Healthcare Professional once approval is granted.
- The pre-authorisation letter we e-mail confirms the DSP status of your provider and facility.
- If your dependant is 18 or older, they will receive their own communication.
- These letters detail what Bankmed will and will not cover, so it's essential to ensure we have the correct e-mail addresses on file for both you and your dependants.
- Bankmed is not responsible for any issues arising from incorrect contact details.

DISCHARGE PLANNING

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

Deductibles

UPFRONT PAYMENT (DEDUCTIBLE)

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

THE DAY SURGERY NETWORK DEDUCTIBLE

How the Day Surgery Procedure List and Day Surgery Network operate

- **Procedure performed is listed on the Bankmed Day Surgery Procedure List and is performed at a Bankmed Day Surgery Network Facility**
  - If you have one of the procedures listed on Bankmed's Day Surgery Procedure list performed in the Bankmed Day Surgery Network, you do not pay a deductible.
- **Procedure performed is listed on the Bankmed Day Surgery Procedure List and is NOT performed at a Bankmed Day Surgery Network Facility**
  - If you have one of the procedures listed on the Bankmed's Day Surgery Procedure list performed at a facility that is not in the Bankmed Day Surgery Network, you will pay a deductible of R6 865 per admission.

IMPORTANT NOTE FOR ESSENTIAL PLAN MEMBERS

If you are an Essential Plan member, you do not have access to the full list of treatments/ procedures, as your cover is limited to PMB cover. As an Essential Plan member, if you have the PMB procedure/treatment performed at a facility not in the Bankmed Day Surgery Network (day surgery facility or hospital), you will be liable for a R6 865 deductible per admission.

Other hospitals (non-DSPS)

- PMB admission: involuntary use of a non-DSP: No deductible.
- PMB admission: voluntary use of a non-DSP: R6 865 per admission.
- Non-PMB admission: R6 865 per admission.
- The deductible is payable on admission.

Day surgery pre-authorisation

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

- Call: 0800 BANKMED (0800 226 5633)
- E-mail: treatment@bankmed.co.za

UPFRONT PAYMENT (DEDUCTIBLE) FOR NOT USING A NETWORK FACILITY

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

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

Traditional Plan

- Hospital: R7 330 for each admission.

UPFRONT PAYMENTS (DEDUCTIBLES) FOR DENTAL ADMISSIONS

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

Applicable to Traditional, Comprehensive and Plus Plans

Member to fund the specified deductible upfront upon admission:

FOR CHILDREN AGED 13 YEARS AND YOUNGER:	
Day surgery:	R1 000 per admission
Hospital:	R3 000 per admission
FOR BENEFICIARIES AGED 14 YEARS AND OLDER:	
Day surgery:	R3 000 per admission
Hospital:	R5 000 per admission

ONLY ONE UPFRONT PAYMENT (DEDUCTIBLE) PER ADMISSION

EXAMPLE:

- A Traditional Plan member going to a non-network hospital (R7 330 upfront) for dental treatment (R5 000 upfront) pays R7 330 upfront for not using a network hospital, as this is more than the dental upfront payment.

Basic, Essential and Core Saver Plans

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

You do not have to pay an amount upfront if:

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

Deductible applicable to Extraction of Impacted Wisdom Tooth/Teeth

In-rooms (Applicable to All Plans)

Member to fund the specified deductible: In-rooms: R1 830 per event.



Day Surgery

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

BANKMED HAS CREATED AN ENHANCED DAY SURGERY NETWORK

Bankmed's Day Surgery Network has been enhanced to include a defined list of contracted day surgery facilities as well as contracted acute hospitals providing day surgery facilities at day surgery rates.

You now have more choice when choosing a healthcare facility in our network.

Within the network, you have access to a defined list of medical and surgical procedures that can be performed on a same-day basis. A clinical exceptions process applies to all complex cases and those procedures that may need an extended length of stay.

BANKMED'S DAY SURGERY PROCEDURE LIST

Over the years, our Day Surgery Procedure List has been expanded to include a host of additional procedures and treatments available at Bankmed's Day Surgery Network.

Our list has been published on the next page.

DAY SURGERY DEDUCTIBLE

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

However, if you have one of the procedures listed on the Bankmed's Day Surgery Procedure list performed at a facility that is not in the Bankmed Day Surgery Network, you will pay a deductible of R6 865 per admission.

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

DAY SURGERY PRE-AUTHORISATION

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

- Call: 0800 BANKMED (0800 226 5633)
- E-mail: treatment@bankmed.co.za

Bankmed's Day Surgery Procedure List – 2027

1. Anorectal procedures
   1.1. Treatment of haemorrhoids, fissure, fistula

2. Biopsies
   2.1. Skin, subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes

3. Colonoscopy

4. Cystourethroscopy

5. Ear, Nose and Throat Procedures
   5.1. Tonsillectomy and/or adenoidectomy
   5.2. Simple procedures for nose bleed (extensive cautery, nasal plugging)
   5.3. Scopes (nasal endoscopy, laryngoscopy)
   5.4. Repair nasal turbinates, nasal septum
   5.5. Sinus lavage
   5.6. Middle ear procedures (mastoidectomy, myringoplasty, myringotomy and/or grommets)

6. Eye procedures
   6.1. Cataract surgery
   6.2. Treatment of glaucoma
   6.3. Other eye procedures: removal of foreign body, vitrectomy, conjunctivital surgery (repair laceration, pterygium), glaucoma surgery, probing and repair of tear ducts, retinal surgery, eyelid surgery, strabismus repair

7. Ganglionectomy

8. Gastroscopy

9. Gynaecological procedures
   9.1. Diagnostic laparoscopy
   9.2. Cautery of vulva warts
   9.3. Colposcopy with LLETZ
   9.4. Diagnostic Dilation and Curettage (D&C)
   9.5. Endometrial ablation
   9.6. Diagnostic Hysteroscopy
   9.7. Examination under anaesthesia
   9.8. Simple vulva and introitus procedures: Simple hymenotomy, partial hymenectomy, simple vulvectomy, excision/treatment Bartholin's gland cyst
   9.9. Vaginal, cervix and oviduct procedures: excision vaginal septum, cyst or tumour, tubal ligation or occlusion, uterine cervix cerclage, removal cerclage suture
   9.10. Suction curettage
   9.11. Uterine evacuation and curettage

10. Incision and drainage of abscess and/or cyst
    10.1. Subcutaneous tissue, soft tissue, bone, bursa, mouth, tonsil, pilonidal, ovary, Bartholin's gland, vagina

11. Nerve Procedures
    11.1. Neuroplasty median nerve, ulnar nerve, digital, nerve of hand or foot

12. Orthopaedic procedures
    12.1. Arthrocentesis
    12.2. Arthroscopy, arthrotomy (knee, shoulder, elbow, hand, wrist, ankle, foot, temporomandibular joint), arthrodesis (hand, wrist, foot)
    12.3. Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty)
    12.4. Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy)
    12.5. Repair bunion or toe deformity
    12.6. Treatment of simple closed fractures and/or dislocations, removal of pins and plates.
    12.7. Incision and drainage/excision of abscess and/or cyst/tumour: subcutaneous tissue, soft tissue, bone, bursa
    12.8. Biopsies: subcutaneous tissue, soft tissue, muscle, bone
    12.9. Treatment of closed fractures and/or dislocations, removal of pins and plates

13. Oesophagoscopy

14. Proctoscopy

15. Removal of foreign body
    15.1. Subcutaneous tissue, muscle, external auditory canal under general anaesthesia

16. Sigmoidoscopy

17. Simple Hernia Procedures
    17.1. Simple abdominal hernia repair
    17.2. Umbilical hernia repair
    17.3. Inguinal hernia repair

18. Simple superficial lymphadenectomy

19. Skin Procedures
    19.1. Debridement
    19.2. Removal of lesions (dependent on site and diameter)
    19.3. Simple repair of superficial wounds

20. Urological Procedures
    20.1. Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocele vasectomy)

21. Lumpectomy (fibroadenoma)



Digital Healthcare & Bankmed's Digital Tools

10

Digital Healthcare

We've gone digital!

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

BANKMED HEALTH APP

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

GET IT ON Google Play Download on the App Store

BANKMED WEBSITE

Log in to www.bankmed.co.za

FIND A BENEFIT PLAN TOOL

The Benefit Plan Tool helps you explore your options and identifies the plans that best suit your individual needs, using your claims profile to create a personalised shortlist. Please note that these recommendations are based on the information provided, and actual claims may differ.

Use the 'Find a Benefit Plan' tool to gain a clearer understanding of your benefits and select the Plan that aligns most closely with your requirements. Plan selections and quotes are tailored to each member's unique circumstances. This is a guidance tool, not a comparison tool.

Bankmed Navigator



Bankmed's Digital Tools

ASK FOR HELP

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

GET INSTANT HELP FROM OUR VIRTUAL ASSISTANT, 'ASK BANKMED'

'Ask Bankmed' now available on the Bankmed website, Bankmed Health App, and WhatsApp

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

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

BANKMED NEWS

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

Bankmed news

INTERACTIVE PLAN GUIDE

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

Interactive Plan guide

PLAN COMPARISON TOOL

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

Compare medical aid plans

LOOK-UP PLAN BENEFITS TOOL

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

Bankmed Navigator

CONTRIBUTION CALCULATOR

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

Contribution calculator

DIGITAL MEMBERSHIP CARD

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



DIGITAL CLAIMING

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

Submitting claims

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

Bankmed's Digital Tools

How to claim

1. Bankmed Health App

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

2. Bankmed website

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

3. E-mail

Scan your claim and e-mail it to claims@bankmed.co.za

FIND A HEALTHCARE PROFESSIONAL TOOL

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

Bankmed website

Check whether a Healthcare Professional is on the Bankmed network:

1. Log in to www.bankmed.co.za
2. Under 'Digital Tools' click on 'Find a Healthcare Professional'.

- Type their name under '1. Who or what'.
- Select their name from the drop-down list.
- If the system shows 'Partial cover' or the search does not find them, they are not part of our network.

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

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

SOCIAL MEDIA

ELECTRONIC HEALTH RECORD

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

Consent

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

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

Bankmed's Digital Tools

Electronic Health Record (EHR)

With Connected Care you can access and share your Electronic Health Record with Healthcare Professionals.

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

E-scripting

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

SMART DEVICES: SMART HEALTH

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

Different devices offer different features, but a basic step tracker counts how many steps you take a day. These devices synchronise with an application on your smartphone.

More advanced devices can monitor your heart rate and detect what kind of activity you are doing.

You do not need to buy an additional device to track your health. Any smartphone can be converted into a fitness-tracking and health-monitoring device.

Some smart devices come with a pre-installed health and fitness application, but there are many free applications you can download to help you track your health. Fitness devices and applications make sure that you have an accurate record of your physical activity.

Smartphones can help support good health

Applications have changed how people view and engage with their health and fitness. Applications are available to improve diet (for example the MyFitnessPal App) and track moods.

Some applications also give exercise advice. Productivity applications are becoming popular because they allow users to set realistic goals about eating, exercise, remembering to take medication, and sleep.

Get Balance and Active Rewards on your smartphone

Balance focuses on incentivising your efforts to lead a healthier life through these three straightforward steps.

Use the Balance App to get personalised, weekly physical activity targets through the Active Rewards feature.

Track your physical activity with a compatible fitness device, monitoring your progress towards the set weekly goals.

Get rewarded

As a valued Balance member, you qualify for a variety of rewards that recognise and celebrate your commitment to a healthy lifestyle.

Rewards range from weekly incentives to exclusive discounts and savings, making your journey towards wellness both fulfilling and rewarding.

Balance

In-App booking

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

Online consultations

Book an online Healthcare Professional consultation from the comfort of your home. Online consultations with a Healthcare Professional in the Bankmed Health App with a network GP are covered by the available day-to-day benefits or Insured Benefits depending on your Plan choice.

Connected Care users can also access Healthcare Professionals who are online immediately, without having to make a booking.

BANKMED'S E-PHARM

Bankmed has partnered with Dis-Chem to bring you an easy and convenient way to order your medication online. Our e-Pharm offering is an innovative way for you to receive your medication effortlessly; delivered to your doorstep with no delivery charge, if you stay within a 15-kilometre radius of the nearest Dis-Chem. Alternatively, you can order your medication online and collect it at a Dis-Chem pharmacy, without having to wait in a queue.

Important: Please be aware that Bankmed is unable to assist with any queries pertaining to medication orders or deliveries. These may only be directed to the Dis-Chem Careline. E-mail careline@dischem.co.za or call 0869 347 243.

e-Pharm orders



Contributions 2027

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Contributions 2027

Schedule of monthly contributions with effect from 1 January 2027.

ESSENTIAL PLAN (No MSA)

	2027 Total Contribution		
Income	M	A	C
> R5 000	R942	R845	R236
R5 001 – R6 000	R1 029	R927	R269
R6 001 – R7 000	R1 137	R1 023	R292
R7 001 – R8 000	R1 249	R1 124	R322
R8 001 – R9 000	R1 426	R1 287	R353
R9 001 – R10 000	R1 588	R1 426	R400
R10 001 +	R1 808	R1 630	R457

BASIC PLAN (No MSA)

	2027 Total Contribution		
Income	M	A	C
> R5 000	R1 624	R1 214	R409
R5 001 – R6 000	R1 785	R1 338	R460
R6 001 – R7 000	R1 967	R1 469	R508
R7 001 – R8 000	R2 157	R1 641	R557
R8 001 – R9 000	R2 465	R1 868	R617
R9 001 – R10 000	R2 743	R2 076	R690
R10 001 +	R3 123	R2 340	R782

TRADITIONAL PLAN (No MSA)

	2027 Total Contribution		
Income	M	A	C
> R5 000	R4 497	R3 368	R1 123
R5 001 – R10 000	R5 241	R3 928	R1 317
R10 000 +	R5 455	R4 097	R1 366

Important

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

CORE SAVER PLAN (With MSA)

	2027 Total Contribution			2027 Risk Contribution			2027 MSA Contribution		
Income	M	A	C	M	A	C	M	A	C
> R5 000	R2 687	R2 024	R674	R2 416	R1 820	R606	R271	R204	R68
R5 001 – R6 000	R2 879	R2 162	R720	R2 590	R1 943	R650	R289	R219	R70
R6 001 – R7 000	R3 082	R2 312	R770	R2 772	R2 079	R690	R310	R233	R80
R7 001 – R8 000	R3 238	R2 428	R814	R2 912	R2 182	R731	R326	R246	R83
R8 001 – R9 000	R3 488	R2 623	R881	R3 136	R2 359	R792	R352	R264	R89
R9 001 – R10 000	R3 667	R2 757	R919	R3 298	R2 481	R828	R369	R276	R91
R10 001 +	R4 044	R3 026	R1 017	R3 639	R2 721	R916	R405	R305	R101

Contributions 2027

Schedule of monthly contributions with effect from 1 January 2027.

COMPREHENSIVE PLAN (with MSA)

	2027 Total Contribution			2027 Risk Contribution			2027 MSA Contribution		
Income	M	A	C	M	A	C	M	A	C
R0 – R10 000	R5 969	R4 470	R1 501	R5 072	R3 799	R1 275	R897	R671	R226
R10 001 +	R6 216	R4 659	R1 556	R5 282	R3 958	R1 322	R934	R701	R234

PLUS PLAN (with MSA)

	2027 Total Contribution			2027 Risk Contribution			2027 MSA Contribution		
Income	M	A	C	M	A	C	M	A	C
All Incomes	R10 599	R7 936	R2 653	R8 477	R6 348	R2 122	R2 122	R1 588	R531

Important

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

LATE-JOINER PENALTY

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

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

LATE JOINER PENTALTY BANDS

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



Exclusions, Privacy Statements, Complaints Process & Contacts

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Exclusions

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

- Operations, treatment, and procedures for cosmetic purposes.
- Sunscreens and tanning agents.
- Travel expenses.
- Accommodation in retirement homes or similar institutions.
- Sunglasses.
- Accommodation and/or treatment in headache or stress-relief clinics.
- The cost of holidays for recuperative purposes (for example spas and health resorts).
- 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.
- Tonics and stimulants, including weight loss remedies.

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

Bankmed Privacy Statement

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

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

Access the **full Statement.**

Complaints Process

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

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

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

LODGE A FORMAL COMPLAINT

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

- Customer Care Line: 0861 123 267
- ShareCall from a Telkom landline
- Reception: 012 431 0500
- E-mail: **complaints@medicalschemes.co.za**
- Post: Council for Medical Schemes, Block A, Eco Glades 2 Office Park, 420 Witch Hazel Avenue, Eco Park, Centurion, 0157 or Council for Medical Schemes, Private Bag X34, Hatfield, 0028

Contacts

Medical Emergencies: 0860 999 911

GENERAL INFORMATION

- Website: www.bankmed.co.za
- Call: 0800 BANKMED (0800 226 5633)
- Toll-free on a Telkom landline
- E-mail for members: enquiries@bankmed.co.za
- E-mail for pensioners: pensioners@bankmed.co.za
- Post: Bankmed Customer Services, Private Bag X2, Rivonia 2128

DIGITAL TOOLS

- View information about your membership and update your contact details
- Website: Log in to the member portal at www.bankmed.co.za
- Bankmed Health App: Download from your App store and log in
- Your username and password are the same for the website, mobile site, and App

CLAIMS

- Include your membership number and make sure the claim is easy to read
- Bankmed Health App: Download from the App Store or Google Play Store
- E-mail: claims@bankmed.co.za
- Post: Bankmed Claims, Private Bag X2, Rivonia 2128

PRE-AUTHORISATION

- For Hospital or Day Surgery facility admissions, MRI, CT scan or radionuclide scan
- Call: 0800 BANKMED (0800 226 5633)
- Toll-free on a Telkom landline
- E-mail: treatment@bankmed.co.za

REPORT FRAUD

- Call: 0800 004 500 / 0800 007 788
- SMS: 43477
- E-mail: bankmed@tip-offs.com
- Post: Freepost DN298, Umhlanga Rocks 4320

CHRONIC MEDICATION AUTHORISATION

- Register to gain access to these benefits
- Call: 0800 BANKMED (0800 226 5633)
- *Toll-free on a Telkom landline*

Core Saver, Traditional, Comprehensive and Plus Plans

- E-mail: chronic@bankmed.co.za
- Your pharmacist can call 0800 BANKMED (0800 226 5633)
- Healthcare Professionals can call 0800 132 345

Essential and Basic Plans

- E-mail: chronicbasicessential@bankmed.co.za
- Your pharmacist can call 0800 BANKMED (0800 226 5633)

HIV Programme

Baby-and-Me Programme

Managed Oncology Benefit Programme

Chronic Illness Benefit



Benefit Tables

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BENEFIT TABLES **2027**

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
Does this Plan have an MSA?		No	No	No	Yes	Yes	Yes
Percentage of gross contribution allocated to MSA		N/A	N/A	N/A	~10%*	15%*	20%*
					*The percentage of Gross Contribution allocated to the MSA varies based on dependant type, income band, rounding, and contribution increases. The published percentage is an aggregate value.		
MSA reimbursement		N/A	N/A	N/A	Cost or Scheme Rate	Cost or Scheme Rate	Cost or Scheme Rate
					Members can choose between Cost or Scheme Rate. Cost covers eligible claims fully, including out-of-network claims. Scheme Rate limits coverage to the Scheme Rate and within benefit limits. If no choice is made, new members default to the Scheme Rate, but they can switch between options anytime.		
1.	**PRESCRIBED MINIMUM BENEFITS**						
1.1.	**General Provisions:** Notwithstanding any provisions to the contrary in this schedule, the Scheme will fund: • 100% of the diagnosis, treatment and care costs of the Statutory Prescribed Minimum Benefits (PMBs), subject to PMB regulations, if those services are obtained from a Designated Service Provider (DSP) in South Africa; or • the relevant Scheme Rate for the diagnosis, treatment and care costs of the Statutory Prescribed Minimum Benefits if a beneficiary voluntarily accesses PMBs via a non-DSP in South Africa, when provision is made for a DSP according to this schedule; or • 100% of cost for involuntary use of a non-DSP in South Africa, subject to PMB regulations. • Benefits in respect of an out-of-hospital Diagnosis and Treatment Pair forming part of the Prescribed Minimum Benefits shall be subject to confirmation of the applicable Prescribed Minimum Benefit diagnosis and shall be limited to the healthcare services, provider types and number of services specified in the applicable Basket-of-Care . Claims shall qualify for payment as Prescribed Minimum Benefits only where the diagnosis and treatment meet the requirements of the applicable Diagnosis and Treatment Pair and Basket-of-Care . Once the services specified in the Basket-of-Care have been exhausted, further services shall be funded from the beneficiary's available out-of-hospital benefits, where applicable, subject to this Benefit Schedule. • Pre-authorisation, medicine formularies and Scheme protocols (also known as "Care Plans", "Basket-of-Care", or "Treatment Baskets") may apply. • Diagnosis costs are only regarded as a PMB if the result of diagnostic investigations confirms a PMB diagnosis. • When insured limits are specified in this schedule, the limit will first be utilised for the payment of the relevant claims, and thereafter continued funding will apply for PMB claims only, subject to PMB regulations. • Where a benefit is indicated as "payable from Savings" or as "no benefit" in this schedule, insured benefits shall nevertheless be provided for PMBs in South Africa, subject to PMB regulations. • PMB claims shall not be funded from Savings. • Additional arrangements pertaining to PMBs (subject to PMB regulations) are set out in the Preamble to Annexure B and in Annexure D (Claims Procedure and General Provisions Regarding Benefits).						
2.	**OVERALL ANNUAL LIMIT**						
2.1.		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
3.	**CLAIMS FOR SERVICES RENDERED OUTSIDE THE BORDERS OF SOUTH AFRICA (FOREIGN CLAIMS)** Consider purchasing comprehensive travel insurance before travelling abroad as not all foreign claims may receive full coverage						
3.1.		• PMB conditions and life-threatening emergencies only • No benefits for emergency/ ambulance transport outside borders of South Africa • No benefits for services not normally covered at the	• Foreign claims covered at Scheme Rate and/or Rand limit subject to benefits available • No benefits for emergency/ ambulance transport outside borders of South Africa • No benefits for services not normally covered at the	• Foreign claims covered at the Scheme Rate and/or Rand limit subject to benefits available • No benefits for emergency/ambulance transport outside borders of South Africa • Medical motivation and prior approval required for non-emergency surgery outside borders of South Africa			

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
		Scheme's preferred provider network (Bankmed Entry Plan GP Network) for out-of-hospital consultations, medication, and treatment (except via Bankmed Entry Plan GP Network providers in Lesotho) • Medical motivation and prior approval required for non-emergency surgery outside borders of South Africa	Scheme's preferred provider network (Bankmed Entry Plan GP Network) for out-of-hospital consultations, medication, and treatment (except via Bankmed Entry Plan GP Network providers in Lesotho) • Medical motivation and prior approval required for non-emergency surgery outside borders of South Africa				
4.	**WELLNESS AND PREVENTATIVE CARE BENEFITS (INSURED BENEFITS)** Wellness and Preventative Care Benefits are additional Insured Benefits and do not deplete other Insured Benefits or MSA. Consultation costs related to these benefits are not covered						
4.1.	**Flu vaccine**	• 100% of Scheme Medicine Reference Price • Limited to one vaccine pbpa					
4.2.	**Human Papilloma Virus (HPV) vaccine**	• 100% of Scheme Medicine Reference Price • Limited to three course doses (product and age dependent) per male or female beneficiary, aged nine to 25 years					
4.3.	**Childhood vaccines** • BCG, oral polio, rotavirus, diphtheria, tetanus, acellular pertussis, inactivated polio and haemophilus influenza type B, hepatitis B, measles, pneumococcal vaccine	• 100% of Scheme Medicine Reference Price • For children up to age 12 • Limited to immunisations per the Department of Health's Expanded Programme on Immunisation (EPI) guidelines					
4.4.	**Pneumococcal vaccine**	• 100% of Scheme Medicine Reference Price, limited as follows: • One vaccine every five years for adults 60 years and older • One vaccine every five years for beneficiaries younger than 60 years, diagnosed with asthma, chronic obstructive pulmonary disease, diabetes, cardiovascular disease, or HIV/AIDS					
4.5.	**Tuberculosis (TB) screening**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one x-ray pbpa • For TB screening requested by onsite registered private nurse at Employer Groups • All other TB screenings subject to available out-of-hospital radiology and/or pathology benefits					
4.6.	**Mammogram**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa age 40 years and older • Benefits for beneficiaries younger than 40 years subject to motivation and prior approval					
4.7.	**Breast MRI** • Limited to high-risk breast cancer beneficiaries • Subject to clinical entry criteria and preauthorisation	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa • Breast Cancer Risk Calculator available on website					

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
4.8.	**Bone densitometry**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa aged 50 years and older • Benefits for beneficiaries younger than 50 years subject to motivation and prior approval • Where clinical entry criteria not met and member under age 50, test can be claimed from available radiology benefit or MSA, where applicable					
4.9.	**Prostate-specific antigen**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa aged 50 years and older • Benefits for beneficiaries younger than 50 years subject to motivation and prior approval					
4.10.	**Colorectal cancer screening** • **Faecal occult blood test, or** • **Colorectal cancer self-sampling kit**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa aged 50 years and older • Benefits for beneficiaries younger than 50 years subject to motivation and prior approval • 100% of Scheme Rate for test code • Limited to one pbpa aged 50 years and older • Benefits for beneficiaries younger than 50 years subject to motivation and prior approval • Beneficiaries may select one of either a faecal occult or colorectal cancer self-sampling screening kit only, not both					
4.11.	**Cholesterol screening, blood sugar screening and blood pressure measurements**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R435 pbpa at DSP • DSP: clinics, pharmacies, or Bankmed Entry Plan GP Network consulting rooms		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R435 pbpa at DSP • DSP: clinics, pharmacies, or Bankmed GP Network consulting rooms			
4.12.	**HIV counselling and testing (HCT)**	• Unlimited • 100% of cost for HCT DSP • DSP: Bankmed Entry Plan GP Network, Bankmed Pharmacy Network, contracted onsite HCT providers at Employer Groups • 100% of Scheme Rate at non-DSP • Subject to PMB regulations		• Unlimited • 100% of cost for HCT DSP • DSP: Bankmed GP Network, Bankmed Pharmacy Network, contracted onsite HCT providers at Employer Groups • 100% of Scheme Rate at non-DSP • Subject to PMB regulations			
4.13.	**Bankmed mental wellbeing assessment**	• Unlimited online Mental Wellbeing Assessments					

4.14.	**Mental Health "At Risk" Benefit: post-online mental wellbeing assessment (Consultation with Premier Plus Network GP/network psychologist)**
	• Additional consultation for Network GP or network psychologist subject to clinical entry criteria
		• 100% of cost at DSP only
		  • DSP: Premier Plus GP Network or network psychologist
		  • Not covered at non-DSP
		  • Limited to one consultation per qualifying beneficiary
		• **Limited to:**
		  • High-risk members aged 18 years and older
		  • High-risk members identified and risk-rated using results
			• 100% of cost at DSP only
			  • DSP: Premier Plus GP Network or network psychologist
			  • Not covered at non-DSP
			  • Limited to one consultation per qualifying beneficiary
			• **Limited to:**
			  • High-risk members aged 18 years and older
			  • High-risk members identified and risk-rated using results
				• 100% of cost at DSP only
				  • DSP: Premier Plus GP Network or network psychologist
				  • Not covered at non-DSP
				  • Limited to one consultation per qualifying beneficiary
				• **Limited to:**
				  • High-risk members aged 18 years and older
				  • High-risk members identified and risk-rated using results from the Online Mental Wellbeing Assessment, therefore subject to completion of the Online Mental Wellbeing Assessment			

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		

		from the Online Mental Wellbeing Assessment, therefore subject to completion of the Online Mental Wellbeing Assessment
		• **Benefit use requirements:**
		  • Within three months of Online Mental Wellbeing Assessment
		  • Otherwise not funded
		  • Subject to PMB regulations
			from the Online Mental Wellbeing Assessment, therefore subject to completion of the Online Mental Wellbeing Assessment
			• **Benefit use requirements:**
			  • Within three months of Online Mental Wellbeing Assessment
			  • Otherwise funded from day-to-day benefits
				• **Benefit use requirements:**
				  • Within three months of Online Mental Wellbeing Assessment
				  • Otherwise funded from day-to-day benefits			

4.15.	**Cervical cancer screening** • **Pap smear; or** • **Cervical cancer self-sampling kit**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa • One associated nurse, Bankmed Entry Plan GP Network GP, or Bankmed Entry Plan Specialist Network consultation pb covered as an additional Insured Benefit limited to R685 pbpa • 100% of Scheme Rate for test code • Limited to one pbpa • One per beneficiary per annum. • Beneficiaries may select one of either a pap smear or cervical cancer self-sampling screening kit only, not both.		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa • One associated nurse, Bankmed GP Network, or Bankmed Prestige A and B Specialist Network consultation pb covered as an additional Insured Benefit limited to R685 pbpa • 100% of Scheme Rate for test code • Limited to one pbpa • One per beneficiary per annum. • Beneficiaries may select one of either a pap smear or cervical cancer self-sampling screening kit only, not both.		

4.16.	**Personal Health Assessment (PHA)**
	• Limited to members and beneficiaries aged 16 years and older
		• 100% of cost at DSP only
		  • DSP: Bankmed Entry Plan GP Network, Bankmed Pharmacy Network and contracted onsite providers at Employer Groups
		  • Not covered at non-DSP
		  • Limited to one assessment pbpa
				• 100% of cost at DSP only
				  • DSP: Bankmed GP Network, Bankmed Pharmacy Network and contracted onsite providers at Employer Groups
				  • Not covered at non-DSP
				  • Limited to one assessment pbpa			

4.17.	**Post-Personal Health Assessment (PHA): additional consultations for biokineticist and dietitian**
	• Limited to members and beneficiaries aged 16 years and older
	• Additional consultations for dietitian and biokineticist subject to clinical entry criteria
	• Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA
		• 100% of cost at DSP
		• 100% of Scheme Rate at a non-DSP
		• Benefit includes two 30-minute dietitian consultations pbpa and two biokineticist consultations pbpa
		• **Limited to:**
		  • Medium- and high-risk members identified via the PHA
		  • Members with a BMI ≥ 30
		• **Benefit use requirements:**
		  • Within 6 weeks of PHA: first visit to dietitian and biokineticist
		  • Within 12 months of PHA: second visit to dietitian and biokineticist
		  • Otherwise funded from day-to-day benefits, where available					

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		

4.18.	**Post-Personal Health Assessment (PHA): Additional Consultation with Bankmed Network GP**
	• Limited to members and beneficiaries aged 16 years and older
	• Additional consultations for Bankmed Network GP subject to clinical entry criteria
		• 100% of cost at DSP only
		  • DSP: Bankmed Entry Plan Network GP
		  • Not covered at non-DSP
		  • Limited to one consultation per qualifying beneficiary
		• **Limited to:**
		  • High-risk members aged 16 years and older
		  • High-risk members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA
		• **Benefit use requirements:**
		  • Within 6 weeks of PHA
		  • Otherwise not funded
		  • Subject to PMB regulations
			• 100% of cost at DSP only
			  • DSP: Bankmed Entry Plan Network GP
			  • Not covered at non-DSP
			  • Limited to one consultation per qualifying beneficiary
			• **Limited to:**
			  • High-risk members aged 16 years and older
			  • High-risk members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA
			• **Benefit use requirements:**
			  • Within 6 weeks of PHA
			  • Otherwise funded from day-to-day benefits
				• 100% of cost at DSP only
				  • DSP: Bankmed Network GP
				  • Not covered at non-DSP
				  • Limited to one consultation per qualifying beneficiary
				• **Limited to:**
				  • High-risk members aged 16 years and older
				  • High-risk members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA
				• **Benefit use requirements:**
				  • Within 6 weeks of PHA
				  • Otherwise funded from day-to-day benefits		

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

4.20.	• **Amniocentesis**
	(South African testing only)
		• 100% of cost at DSP
		• 100% of Scheme Rate at non-DSP
		  • Limited to one test pb per pregnancy
		  • Subject to gynaecologist referral and pre-authorisation					

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

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

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		

4.23.	**Contraception**
	• Oral Contraceptives, Devices and Injectables
		• No benefit	• 100% of Scheme Medicine Reference Price
			  • Limited to R2 735 per female beneficiary per annum
			  • Oral contraceptives limited to one prescription/repeat prescription pbpm				

4.24.	**Diabetes management** • For members registered on the Scheme's Disease Management Programme • BOC set by the Scheme • Subject to PMB regulations	• Unlimited • 100% of cost for services covered in the Scheme's BOC • Subject to referral from DSP • Subject to member using a DSP • 100% of Scheme Rate at non-DSP	• Unlimited • 100% of cost for services covered in Scheme's BOC • Subject to referral from DSP • Subject to member using a DSP • 100% of Scheme Rate at non-DSP • The 'Out-of-network GP Benefit' limit applies to non-DSP	• Unlimited • 100% of cost for services covered in Scheme's BOC • Subject to referral from DSP • Subject to member using a DSP • 80% of Scheme Rate at non-DSP	• Unlimited • 100% of cost for services covered in Scheme's BOC • Subject to referral from DSP • Subject to member using a DSP • 100% of Scheme Rate at non-DSP		
4.25.	**Continuous Glucose Monitoring Device (CGM)** • Available to Type 1 and Type 2 diabetics meeting the Scheme's clinical entry criteria • Subject to PMB regulations	• Unlimited • Subject to authorisation and/or approval • Subject to the Scheme's protocols, treatment guidelines and clinical entry criteria • Members with a CGM device have limited glucose strip benefits, where approved					
4.26.	**Disease Prevention Programme** Programme designed to support members identified as being at risk of developing diabetes • Clinical entry criteria apply • BOC as specified by the Scheme • Subject to PMB regulations	• Limited to BOC determined by Scheme • 100% of Scheme Rate • Subject to authorisation and/or approval • Limited to PMBs		• Limited to BOC determined by Scheme • 100% of Scheme Rate • Subject to authorisation and/or approval			

4.27.	**Child Weight Assessment**
	• Applies to children aged 9 years to 15 years only
		• 100% of cost at DSP
		  • Not covered at a non-DSP
		  • Limited to one assessment per qualifying beneficiary					

4.28.	**Post-Child Weight Assessment: additional consultations for biokineticist and dietitian**
	• Applies to children aged 9 years to 15 years only
	• Additional consultations for dietitian and biokineticist subject to clinical entry criteria
		• 100% of cost at DSP
		• 100% of Scheme Rate at a non-DSP
		• Benefit includes two 30-minute dietitian consultations pbpa and two biokineticist consultations pbpa
		• **Limited to:**
		  • Medium and high-risk beneficiaries and/or
			• 100% of cost at DSP
			• 100% of Scheme Rate at a non-DSP
			• Benefit includes two 30-minute dietitian consultations pbpa and two biokineticist consultations pbpa
			• **Limited to:**
			  • Medium and high-risk beneficiaries and/or beneficiaries based on Body Mass Index (BMI)
			  • Beneficiaries identified and risk-rated using results from the Child Weight Assessment, therefore subject to completion of the Child Weight Assessment				

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
		beneficiaries based on Body Mass Index (BMI) • Beneficiaries identified and risk-rated using results from the Child Weight Assessment, therefore subject to completion of the Child Weight Assessment • **Benefit use requirements:** • Within 6 weeks of Child Weight Assessment: first visit to dietitian and biokineticist • Within 12 months of Child Weight Assessment: second visit to dietitian and biokineticist • Otherwise not funded	• **Benefit use requirements:** • Within 6 weeks of Child Weight Assessment: first visit to dietitian and biokineticist • Within 12 months of Child Weight Assessment: second visit to dietitian and biokineticist • Otherwise funded from day-to-day benefits, where available				
4.29.	**Post- Child Weight Assessment: Additional Consultations for Network GP** • Applies to children aged 9 years to 15 years only • Additional consultation for Bankmed Network GP subject to clinical entry criteria	• 100% of cost at DSP only • DSP: Bankmed Entry Plan Network GP • Not covered at non-DSP • Limited to one consultation per qualifying beneficiary • **Limited to:** • Limited to high-risk beneficiaries and/or beneficiaries based on Body Mass Index (BMI) • Beneficiaries identified and risk-rated using results from the Child Weight Assessment, therefore subject to completion of the Child Weight Assessment • **Benefit use requirements:** • Within 6 weeks of Child Weight Assessment: visit to Bankmed Entry Plan Network GP • Otherwise not covered	• 100% of cost at DSP only • DSP: Bankmed Entry Plan Network GP • Not covered at non-DSP • Limited to one consultation per qualifying beneficiary • **Limited to:** • Limited to high-risk beneficiaries and/or beneficiaries based on Body Mass Index (BMI) • Beneficiaries identified and risk-rated using results from the Child Weight Assessment, therefore subject to completion of the Child Weight Assessment • **Benefit use requirements:** • Within 6 weeks of Child Weight Assessment: visit to Bankmed Entry Plan Network GP • Otherwise funded from day-to-day benefits	• 100% of cost at DSP only • DSP: Bankmed Network GP • Not covered at non-DSP • Limited to one consultation per qualifying beneficiary • **Limited to:** • Limited to high-risk beneficiaries and/or beneficiaries based on Body Mass Index (BMI) • Beneficiaries identified and risk-rated using results from the Child Weight Assessment, therefore subject to completion of the Child Weight Assessment • **Benefit use requirements:** • Within 6 weeks of Child Weight Assessment: visit to Bankmed Network GP • Otherwise funded from day-to-day benefits		

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		

4.30.	**Preventative Childhood Dental Check**
	• Applies to children and adolescents aged 3 years up to 17 years of age only
		• 100% of cost at DSP
		  • DSP: Bankmed Dental Network
		  • Not covered outside of the Bankmed Dental Network
		• **Limited to:**
		  • Limited to two dental check-ups per qualifying beneficiary per annum
		  • Benefits as set out in the Scheme approved formulary
		  • Should the provider charge for additional services, these services will be funded from standard available benefits, where applicable
				• 100% of Scheme Rate
				• **Limited to:**
				  • Limited to two dental check-ups per qualifying beneficiary per annum
				  • Benefits as set out in the Scheme approved formulary
				  • Should the provider charge for additional services, these services will be funded from standard available benefits, where applicable			

4.31.	**Dementia Screening and Assessment Benefit**	• 100% of cost at DSP
		  • DSP: registered Network occupational therapist
		  • Where an occupational therapist is not available, the member may consult a Bankmed network psychologist for the assessment
		  • 100% of Scheme Rate at a non-DSP
		• **Limited to:**
		  • Applies to members and beneficiaries aged 65 years and older only
		  • Limited to one consultation and one comprehensive cognitive assessment per qualifying beneficiary per annum
		  • Only the consultation and assessment are funded
		  • Should the provider charge for additional services, these services will be funded from standard available benefits, where relevant					

5.	**HIV/AIDS CARE PROGRAMME** Enrolment in the Scheme's HIV/AIDS Care Programme grants extra benefits that do not diminish any other Insured Benefits. Unregistered beneficiaries retain access to all standard benefits outlined in the Benefit Tables, including PMB coverage in accordance with regulations, even after respective sub-limits have been reached						
5.1.	**Consultations and pathology**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to benefits available in Scheme's BOC					
5.2.	**Medication via DSP** • Bankmed Pharmacy Network	• Unlimited • 100% of cost at DSP • 100% of Scheme Medicine Reference Price for non-formulary medication • Subject to Scheme Medication Formulary (medicine list) • Motivation is required for the use of a non-DSP					
5.3.	**Medication via non-DSP** • Voluntary use of a non-DSP	• Unlimited • 80% of Scheme Medicine Reference Price • Subject to Scheme Medication Formulary (medicine list) • 100% of Scheme Medicine Reference Price for non-formulary medication • Motivation is required for the use of a non-DSP					
5.4.	**Medication via non-DSP** • Involuntary use of a non-DSP	• Unlimited • 100% of cost • 100% of Scheme Medicine Reference Price for non-formulary medication • Subject to Scheme Medication Formulary (medicine list) • Motivation is required for the use of a non-DSP					
6.	**24-HOUR MEDICAL ADVICE LINE (CALL 0860 999 911)** Free service to Bankmed members						
6.1.	Call 0860 999 911 for 24-hour medical advice from a registered nurse						

Terminology Reminders:

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

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		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
7.	**AMBULANCE SERVICES (CALL 0860 999 911 FOR PRE-AUTHORISATION)** Subject to pre-authorisation and PMB regulations						
7.1.	**BENEFITS FOR EMERGENCY SERVICES ARE SUBJECT TO USE OF THE SCHEME'S DSP. FAILURE TO USE THE DSP MAY LEAD TO CO-PAYMENTS BEING APPLIED** **CALL 0860 999 911 – 24 HOURS A DAY, SEVEN DAYS A WEEK AND YOU WILL BE CONNECTED WITH HIGHLY QUALIFIED INDIVIDUALS WHO WILL ASSIST WITH YOUR EMERGENCY** • Unlimited • 100% of cost via the Scheme's DSP • 100% of Scheme Rate via non-DSP • No benefit outside the borders of South Africa						
8.	**HOSPITALISATION** Subject to pre-authorisation and PMB regulations. Bankmed reserves the right to obtain a second opinion prior to granting authorisation for spinal surgery						
	HOSPITALISATION AND ASSOCIATED IN-HOSPITAL BENEFITS ARE SUBJECT TO PRE-AUTHORISATION AND PMB REGULATIONS **FAILURE TO OBTAIN PRE-AUTHORISATION MAY LEAD TO CO-PAYMENTS BEING APPLIED OR BENEFITS BEING DECLINED UPON REVIEW** **CONTACT US ON 0800 226 5633 FOR AUTHORISATION PRIOR TO ANY PLANNED HOSPITAL ADMISSION, DAY SURGERY PROCEDURE, MRI SCAN, CT SCAN OR RADIONUCLIDE SCAN, OR WITHIN 24 HOURS OF AN EMERGENCY ADMISSION** • Pre-authorisation for a hospital admission **does not guarantee** that all claims related to the hospital event will be **covered in full** • **The onus is on you, as the member, to ensure that the hospital, treatment facility or day surgery facility, as well as treating Healthcare Professionals are DSPs or in the Bankmed network to avoid co-payments** • **Pre-assessment of costs:** Members may request a pre-assessment of expected procedure costs against the applicable Scheme Rate to identify potential shortfalls or co-payments before undergoing a procedure. Refer to the detailed 'Pre-authorisation' section of this schedule for further information • Benefits and limitations applicable to your Plan are set out in these Benefit Tables as well as in the Scheme Rules available on the Bankmed website. The benefits under the 'Hospitalisation' benefit section refer only to the hospital account • Any Healthcare Professionals attending to you during your hospital stay must submit a valid account for payment • The payment will be subject to the benefits, limits and/or any special conditions set out in these Benefit Tables and Scheme Rules under the relevant benefit categories • **You are responsible for ensuring the claims are submitted for payment by the Healthcare Professional** • Please take care to determine the limits for your Plan (if any) and the rate at which the Scheme will reimburse your claims • Always understand the fees to be charged by your Healthcare Professional, and where necessary, negotiate fees with your attending Healthcare Professionals before incurring costs to avoid out-of-pocket payments • Please log in to the website for a list of procedures that can be safely performed in the doctor's rooms as an alternative to hospitalisation					
8.1.	**Hospitalisation overall annual limit**	• No overall annual limit • Limited to PMBs	• No overall annual limit				
8.2.	**Hospital network (DSP) applicable**	• Bankmed Hospital Network DSP for the Essential Plan	• Bankmed Hospital Network DSP for the Basic Plan	• Bankmed Hospital Network DSP for the Traditional Plan	• All contracted Netcare, National Hospital Network (NHN), Life Healthcare, Mediclinic and Clinix hospitals, and any other independent private hospitals contracted to the Scheme		
8.3.	**Hospitalisation at a DSP** • All admissions	• 100% of cost					
8.4.	**Hospitalisation at non-DSP for PMB admission** • Involuntary use of non-DSP	• 100% of cost					
8.5.	**Hospitalisation at non-DSP for PMB admission** • Voluntary use of non-DSP	• 80% of Scheme Rate		• 100% of Scheme Rate • Deductible applies	• 100% of Scheme Rate		
8.6.	**Hospitalisation at non-DSP for non-PMB admission**	• No benefit	• 80% of Scheme Rate	• 100% of Scheme Rate • Deductible applies	• 100% of Scheme Rate		
8.7.	**Ward rate**	• General ward					• General and private wards
8.8.	**Referral requirement**	• Benefits only available on referral from GP in Bankmed Entry Plan GP Network, or referred specialist subject to PMB regulations		• Not applicable			

Terminology Reminders:

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

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		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
8.9.	**Other**	• No benefit for dental surgery and auxiliary services, except for PMBs		• Not applicable			

8.10.	**To-take-out (TTO) medication**
	• Supplied by the hospital when a patient is discharged
		• 100% of cost
		  • Limited to PMBs and a maximum of a seven-day supply per admission
		  • Must be charged on the hospital account where a hospital event has taken place
		  • Not payable if obtained via a pharmacy after discharge
		  • If procedure takes place in a day surgery facility, a maximum of a seven-day supply will be funded from Insured Benefits if obtained from a retail pharmacy on the date of discharge only					

9.	**DEDUCTIBLES (UPFRONT PAYMENT)** A beneficiary will be responsible for a deductible for certain hospital and day surgery events, unless the admission is related to a PMB diagnosis, typically as a result of an emergency. This applies even if the procedure is not the main reason for admission. Payment is due directly to the facility at the time of admission						
9.1.	**Deductibles** Deductible waiver conditions: • PMB conditions where admission to a non-DSP is on an involuntary basis. In the case of other PMB conditions, where a DSP has been used on a voluntary basis, the deductible will be applied • Confinements are excluded from deductibles • Re-admissions to hospital within six weeks of discharge following complications directly related to a prior admission in respect of which a deductible was levied • Admissions to a State hospital or facility • Authorised day surgery admissions for specified procedures. Refer to 'Bankmed Day Surgery Procedure List'						
9.2.	**Day Surgery Network deductible** Bankmed's Day Surgery Network comprises a defined list of contracted day surgery facilities as well as contracted acute hospitals providing day surgery facilities at day surgery rates						
	Day surgery deductible waiver conditions • Applicable to Day Surgery Procedure List • Treatment/procedure performed at Bankmed Day Surgery Network facility	• Refer to 'Bankmed Day Surgery Procedure List' in 9.3 below • No deductible • Limited to PMBs		• Refer to 'Bankmed Day Surgery Procedure List' in 9.3 below • No deductible			
	PMB admission • Treatment/procedure NOT performed at Bankmed Day Surgery Network facility • Involuntary use of non-DSP	• Refer to 'Bankmed Day Surgery Procedure List' in 9.3 below • No deductible • Limited to PMBs		• Refer to 'Bankmed Day Surgery Procedure List' in 9.3 below • No deductible			
	PMB admission • Treatment/procedure NOT performed at Bankmed Day Surgery Network facility • Voluntary use of non-DSP	• Refer to 'Bankmed Day Surgery Procedure List' in 9.3 below • R6 865 per admission • Limited to PMBs		• Refer to 'Bankmed Day Surgery Procedure List' in 9.3 below • R6 865 per admission			
	Non-PMB admission • Treatment/procedure NOT performed at Bankmed Day Surgery Network facility	• No benefit		• Refer to 'Bankmed Day Surgery Procedure List' in 9.3 below • R6 865 per admission			
9.3.	**Bankmed Day Surgery Procedure List** Bankmed's Day Surgery Procedure List comprises a defined list of procedures/treatments that can be safely performed at a contracted facility in the Bankmed Day Surgery Network without incurring a deductible						

Terminology Reminders:

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

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		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
	1. Anorectal procedures 1.1. Treatment of haemorrhoids, fissures, fistula 2. Biopsies 2.1. Skin, subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes 3. Colonoscopy 4. Cystourethroscopy 5. Ear, Nose and Throat Procedures 5.1. Tonsillectomy and/or adenoidectomy 5.2. Simple procedures for nosebleed (extensive cautery, nasal plugging) 5.3. Scopes (nasal endoscopy, laryngoscopy) 5.4. Repair nasal turbinates, nasal septum 5.5 Sinus lavage 5.6 Middle ear procedures (mastoidectomy, myringoplasty, myringotomy and/or grommets) 6. Eye procedures 6.1. Cataract surgery 6.2. Treatment of glaucoma 6.3. Other eye procedures: removal of foreign body, vitrectomy, conjunctivital surgery (repair laceration, pterygium), glaucoma surgery, probing and repair of tear ducts, retinal surgery, eyelid surgery, strabismus repair		7. Ganglionectomy 8. Gastroscopy 9. Gynaecological procedures 9.1. Diagnostic laparoscopy 9.2. Cautery of vulva warts 9.3. Colposcopy with LLETZ 9.4. Diagnostic Dilation and Curettage (D&C) 9.5. Endometrial ablation 9.6. Diagnostic Hysteroscopy 9.7. Examination under anaesthesia 9.8. Simple vulva and introitus procedures: Simple hymenotomy, partial hymenectomy, simple vulvectomy, excision/treatment Bartholin's gland cyst 9.9. Vaginal, cervix and oviduct procedures: excision vaginal septum, cyst or tumour, tubal ligation or occlusion, uterine cervix cerclage, removal cerclage suture 9.10. Suction curettage 9.11. Uterine evacuation and curettage 10. Incision and drainage of abscess and/or cyst 10.1. Subcutaneous tissue, soft tissue, bone, bursa, mouth, tonsil, pilonidal, ovary, Bartholin's gland, vagina		11. Nerve Procedures 11.1. Neuroplasty median nerve, ulnar nerve, digital, nerve of hand or foot 12. Orthopaedic procedures 12.1. Arthrocentesis 12.2. Arthroscopy, arthrotomy (knee, shoulder, ankle, foot, temporomandibular joint, elbow, hand, wrist), arthrodesis (hand, wrist, foot) 12.3. Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty) 12.4. Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy) 12.5. Repair bunion or toe deformity 12.6. Treatment of simple closed fractures and/or dislocations, removal of pins and plates 12.7. Incision and drainage/excision of abscess and/or cyst/tumour: subcutaneous tissue, soft tissue, bone, bursa 12.8. Biopsies: subcutaneous tissue, soft tissue, muscle, bone		12.9. Treatment of closed fractures and/or dislocations, removal of pins and plates 13. Oesophagoscopy 14. Proctoscopy 15. Removal of foreign body 15.1. Subcutaneous tissue, muscle, external auditory canal under general anaesthesia 16. Sigmoidoscopy 17. Simple Hernia Procedures 17.1. Simple abdominal hernia repair 17.2. Umbilical hernia repair 17.3. Inguinal hernia repair 18. Simple superficial lymphadenectomy 19. Skin Procedures 19.1. Debridement 19.2. Removal of lesions (dependent on site and diameter) 19.3. Simple repair of superficial wounds 20. Urological Procedures 20.1. Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocele vasectomy) 21. Lumpectomy (fibroadenoma)
9.4.	**Dental admission deductible** Deductible applies to dental admissions at private hospitals and day surgery facilities (both DSPs and non-DSPs)						
	Dental admission deductible • **Beneficiaries under 14 years of age:** • **Beneficiaries aged 14 years and older:**	• No benefit for in-hospital dental treatment, except PMBs	Upfront deductible applied: • **In-hospital:** R3 000 per admission • **Day-surgery:** R1 000 per admission • **In-hospital:** R5 000 per admission • **Day-surgery:** R3 000 per admission		• No benefit for in-hospital dental treatment, except PMBs	Upfront deductible applied: • **In-hospital:** R3 000 per admission • **Day-surgery:** R1 000 per admission • **In-hospital:** R5 000 per admission • **Day-surgery:** R3 000 per admission	
9.5.	**Deductible applicable to Extraction of Impacted Wisdom Tooth/Teeth In-rooms** Deductible applies to events in-rooms (both DSPs and non-DSPs)						
	PMB: In-rooms: • Designated Service Provider (DSP)	Limited to PMBs • Deductible in-rooms: None	• Deductible in-rooms: None		Limited to PMBs • Deductible in-rooms: None	• Deductible in-rooms: None	

Terminology Reminders:

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

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		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
	PMB: In-rooms: • Non-DSP (voluntary use of non-DSP)	• Deductible in-rooms: R1 830		• Deductible in-rooms: R1 830	• Deductible in-rooms: R1 830	• Deductible in-rooms: R1 830	
	PMB: In-rooms: • Non-DSP (involuntary use of non-DSP)	• Deductible in-rooms: None		• Deductible in-rooms: None	• Deductible in-rooms: None	• Deductible in-rooms: None	
	Non-PMB: In-rooms: • Bankmed Network Provider Not Used	• No benefit		• Deductible in-rooms: R1 830	• No benefit	• Deductible in-rooms: R1 830	
8.6	**Non-DSP facility deductible** Deductible applicable to a use of a non-DSP facility Applies to all procedures NOT listed in the Bankmed Day Surgery Procedure List in 8.3						
	PMB admission: Non-DSP • Involuntary use of non-DSP	• Not applicable		• No deductible payable for PMBs	• Not applicable		
	PMB admission: Non-DSP • Voluntary use of non-DSP			• Applies to all admissions • Hospital deductible: R7 330			
	Non-PMB admission: Non-DSP			• Applies to all admissions • Hospital deductible: R7 330			
10.	**OUTPATIENT CONSULTATIONS AND FACILITY FEES FOR OUTPATIENT VISITS**						
10.1.	**Casualty and outpatient consultations** • GP or specialist consultation at hospital emergency unit, casualty or outpatient unit	• Regarded as an out-of-hospital GP/specialist consultation in rooms, unless resulting in an authorised hospital admission • Refer to 'GP Consultations In-room or Out-of-hospital', and 'Specialist Consultations In-room or Out-of-hospital' benefit sections					
10.2.	**Facility fees** • For casualty and outpatient consultations at a hospital emergency unit, casualty unit, or outpatient unit	• Facility fees not covered, unless resulting in an authorised hospital admission	• Facility fees subject to 'Specialist Consultations In-room or Out-of-hospital' benefit, unless resulting in an authorised hospital admission				
11.	**GP CONSULTATION WITHIN 30 DAYS OF DISCHARGE FROM HOSPITAL**						
11.1.	**Post-hospital GP consultation within 30 days of discharge from hospital**	• Additional Insured Benefit • Refer to '30-Day Post-hospital GP Consultation Benefit' section					
12.	**BLOOD TRANSFUSIONS** Subject to pre-authorisation and PMB regulations						
12.1.	**Blood transfusions**	• 100% of cost • Limited to PMBs	• 100% of cost • Unlimited				

Terminology Reminders:

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		NON-MSA PLANS			MSA PLANS		
13.	**ORGAN AND BONE MARROW TRANSPLANTS** Subject to pre-authorisation and PMB regulations. Organ recipient must be a Bankmed beneficiary for benefits to apply. No benefits for travelling and non-hospital accommodation expenses						
13.1.	**Hospitalisation/organ and patient preparation**	• Refer to 'Hospitalisation' benefit section • Limited to PMBs		• Refer to 'Hospitalisation' benefit section	• Refer to 'Hospitalisation' benefit section • Limited to PMBs	• Refer to 'Hospitalisation' benefit section	
13.2.	**Medication** • In- and out-of-hospital	• Limited to PMBs		• Unlimited	• Limited to PMBs	• Unlimited	
	Medication via DSP • Designated pharmacy	• 100% of cost		• 100% of cost	• 100% of cost	• 100% of cost	
	Medication via non-DSP • Voluntary use of non-DSP	• 80% of Scheme Medicine Reference Price plus dispensing fee		• 80% of Scheme Medicine Reference Price plus dispensing fee	• 80% of Scheme Medicine Reference Price plus dispensing fee	• 80% of Scheme Medicine Reference Price plus dispensing fee	
	Medication via non-DSP • Involuntary use of non- DSP	• 100% of cost		• 100% of cost	• 100% of cost	• 100% of cost	
13.3.	**Harvesting and transporting organs and other donor costs**	• 100% of cost, limited to PMBs		• 100% of cost, unlimited	• 100% of cost, limited to PMBs	• 100% of cost, unlimited	
14.	**ONCOLOGY: MANAGED ONCOLOGY BENEFIT PROGRAMME** Chemotherapy, radiotherapy, oncology-related consultations, treatment, materials, medicines and other healthcare services specified in Appendices 4A and 4B of the Bankmed Scheme Rules						
14.1.	**General provisions:** • **Governing documents:** All benefits are subject to the Bankmed Scheme Rules, Appendices 4A and 4B, Annexure B, the applicable Plan benefit table, the authorised treatment plan and the Prescribed Minimum Benefit Regulations. • **How claims are funded:** Healthcare services that qualify under the Managed Oncology Benefit Programme are funded under the Programme first. The ordinary specialist network provisions, and any associated non-network co-payment, apply only to an oncology-related claim that does not qualify under the Programme. • **Using the network:** Where the Scheme has appointed a Designated Service Provider (DSP) or oncology network for a healthcare service, treatment must be obtained from that DSP or network. If a beneficiary voluntarily obtains the service from a provider outside the applicable network, funding may be limited to 80% of the applicable Scheme Rate, Scheme Medication Rate or approved Oncology Reference Price, subject to the Prescribed Minimum Benefit Regulations and any involuntary-use provisions. • **More than one funding adjustment:** Where more than one funding adjustment applies to the same claim, for example, non-DSP used, and non-formulary medication claimed, both of which attract a 20% member co-payment, the adjustments are not applied cumulatively unless the Rules expressly provide otherwise. The claim is funded under the single adjustment that results in the lowest amount payable by the Scheme, subject to the Prescribed Minimum Benefit Regulations. In this example, the 20% co-payment applies only once and not twice. • **Oncology Benefit Threshold:** Applicable to Traditional and Comprehensive Plans only. Only healthcare services expressly stated in Appendices 4A and 4B accumulate to the Oncology Benefit Threshold, where applicable. Claims accumulate to the Threshold from the date of benefit registration. Services expressly excluded from the Threshold are funded from the applicable benefit as may be described elsewhere in the benefit tables, subject to the limits and conditions in Annexure B, Appendix 4A or the applicable Plan benefit schedule. • **Prescribed Minimum Benefits (PMBs):** Nothing in this schedule limits a beneficiary's entitlement to the diagnosis, treatment and care of a qualifying PMB condition. Statutory PMB oncology treatment covers the diagnosis, treatment and care of a qualifying PMB oncology condition, including chemotherapy, radiotherapy and other healthcare services that form part of the applicable oncology Basket-of-Care. Any DSP requirement, co-payment, reference price shortfall, formulary requirement, treatment protocol or reduction in funding applies subject to the Prescribed Minimum Benefit Regulations and Annexure B. • **Tier 1 treatment:** PMB treatment is limited to PMB level-of-care as set out in the Regulations. PMB treatment is not subject to an overall limit. PMB treatment is limited to Tier 1 treatment. • **Tier 2 and Tier 3 treatment:** Tier 2 treatment, and Tier 3 treatment where it is included in the beneficiary's Plan benefit schedule, is covered, subject to authorisation, Clinical Entry Criteria, the Scheme's protocols and the Oncology Preferred Product List. An individual item within Tier 2 or Tier 3 treatment that the Scheme determines to be unaffordable, not cost-effective or unsupported by sufficient clinical evidence of safety and efficacy is not covered. • **What is not covered:** Non-PMB healthcare services that the Scheme determines to be unaffordable, not cost-effective, or unsupported by sufficient clinical evidence of safety and efficacy, are excluded from cover. This includes out-of-protocol treatment, treatment where Scheme's Clinical Entry Criteria has not been met, and treatment that is not approved under the Oncology Innovation Benefit.						

Terminology Reminders:

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

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		NON-MSA PLANS			MSA PLANS		
14.2.	**Subject to the following conditions before treatment commences:** • Registration on the Managed Oncology Benefit Programme • Pre-authorisation • Meeting the Scheme's Clinical Entry Criteria • Peer-review by an internal or external panel of specialists appointed by the Scheme • Planned treatment or investigation must be authorised at least 48 hours before it happens • Benefits commence on the date of registration, subject to approval of the treatment plan • If a member is not registered, services fall under their ordinary Plan benefits and don't qualify under the Programme, except as the PMB Regulations require • The oncology Baskets-of-Care apply only during an active oncology episode			**Treatment funding principles subject to:** • Evidence-based medication, cost-effectiveness and affordability • Designated Service Provider arrangements • The Scheme's oncology Basket-of-Care, formularies, oncology preferred product list and/or protocols • Oncology Scheme Medication Rate, Scheme Rate or Oncology Reference Pricing, whichever is applicable, as specified in Appendix 4B • Generic substitution and/or switching to cost-effective therapeutic equivalents (drug utilisation review) • Medication must be dispensed through the DSP. Where a non-network provider is used voluntarily, funding will be approved up to a maximum of 80% of the Scheme Medication Rate or Oncology Reference Price, whichever is applicable, and the balance will be for the member's own pocket		
14.3.	**Oncology Benefit Threshold** The amount of approved oncology claims accumulated before a different funding percentage applies to specified non-PMB treatment. It applies to certain Plans over a rolling 12-month cycle	• No Oncology Benefit Threshold • Limited to PMBs		• **Subject to Oncology Benefit Threshold:** R350 000 pb per rolling 12-month cycle • **Within Oncology Benefit Threshold:** 100% of Scheme Rate or Scheme Medication Rate, whichever is applicable • Approved Oncology Innovation Benefit treatment funded at 50% of the Scheme Medication Rate • **After Oncology Benefit Threshold is reached (PMB):** 100% of the Scheme Rate or Scheme Medication Rate whichever is applicable • **After Oncology Benefit Threshold is reached (Non-PMB):** 80% of the Scheme Rate or Scheme Medication Rate whichever is applicable • Approved Oncology Innovation Benefit treatment funded at 50% of the Scheme Medication Rate • No overall limit for qualifying treatment	• No Oncology Benefit Threshold • Limited to PMBs	• **Subject to Oncology Benefit Threshold:** R500 000 pb per rolling 12-month cycle • **Within Oncology Benefit Threshold:** 100% of Scheme Rate or Scheme Medication Rate, whichever is applicable • Approved Oncology Innovation Benefit treatment funded at 50% of the Scheme Medication Rate • **After Oncology Benefit Threshold is reached (PMB):** 100% of the Scheme Rate or Scheme Medication Rate whichever is applicable • **After Oncology Benefit Threshold is reached (Non-PMB):** 80% of the Scheme Rate or Scheme Medication Rate whichever is applicable • Approved Oncology Innovation Benefit treatment funded at 50% of the Scheme Medication Rate • No overall limit for qualifying treatment	• No Oncology Benefit Threshold • 100% of Scheme Rate or Scheme Medication Rate, whichever is applicable • Approved Oncology Innovation Benefit treatment funded at 70% of the Scheme Medication Rate • No overall limit for qualifying treatment

Terminology Reminders:

DSP	Designated Service Provider	**PMB**	Prescribed Minimum Benefit	**MSA**	Medical Savings Account	**BOC**	Basket-of-Care
ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
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		NON-MSA PLANS			MSA PLANS		
14.4.	**Approved treatment Tier 1 Statutory Prescribed Minimum Benefit oncology treatment** Diagnosis, treatment and care for a qualifying Prescribed Minimum Benefit oncology condition, including chemotherapy, radiotherapy and other healthcare services forming part of the applicable oncology Basket-of-Care	• No overall limit for qualifying PMBs • Approved Tier 1 treatment • Subject to Regulation 8, Annexure B and the PMB Regulations		• Accumulates to Oncology Benefit Threshold • No overall limit for qualifying treatment • Approved Tier 1 treatment • Subject to Regulation 8, Annexure B and the PMB Regulations	• No overall limit for qualifying PMBs • Approved Tier 1 treatment • Subject to Regulation 8, Annexure B and the PMB Regulations	• Accumulates to Oncology Benefit Threshold • No overall limit for qualifying treatment • Approved Tier 1 treatment • Subject to Regulation 8, Annexure B and the PMB Regulations	• No overall limit for qualifying treatment • Approved Tier 1 treatment • Subject to Regulation 8, Annexure B and the PMB Regulations
14.5.	**Approved treatment Tier 2 and Tier 3 (Non-PMB)** Access to Tier 2 treatment and, where included in the beneficiary's Plan benefit schedule, Tier 3 treatment, or the corresponding treatment guideline or protocol approved or adopted by the Scheme from time to time, including chemotherapy, radiotherapy and other healthcare services forming part of the applicable oncology Basket-of-Care	• No benefit		• Subject to Oncology Benefit Threshold • No overall limit for qualifying treatment	• No benefit	• Subject to Oncology Benefit Threshold • No overall limit for qualifying treatment	• No overall limit for qualifying treatment
14.6.	**Scheme's oncology formulary and preferred product list/ medication**	• Limited to PMBs • **On formulary/preferred product/medication:** 100% of Scheme's Oncology Reference Price or Scheme Rate, whichever is applicable • **Off- formulary/non-preferred product/ medication:** 80% of Scheme's Oncology Reference Price or Scheme Rate, whichever is applicable • DSP rules apply		• **On formulary/preferred product/medication:** 100% of Scheme's Oncology Reference Price or Scheme Rate, whichever is applicable • **Off- formulary/non-preferred product/ medication:** 80% of Scheme's Oncology Reference Price or Scheme Rate, whichever is applicable • DSP rules apply	• Limited to PMBs • **On formulary/preferred product/medication:** 100% of Scheme's Oncology Reference Price or Scheme Rate, whichever is applicable • **Off- formulary/non-preferred product/ medication:** 80% of Scheme's Oncology Reference Price or Scheme Rate, whichever is applicable • DSP rules apply	• **On formulary/preferred product/medication:** 100% of Scheme's Oncology Reference Price or Scheme Rate, whichever is applicable • **Off- formulary/non-preferred product/ medication:** 80% of Scheme's Oncology Reference Price or Scheme Rate, whichever is applicable • DSP rules apply	• **On formulary/preferred product/medication:** 100% of Scheme's Oncology Reference Price or Scheme Rate, whichever is applicable • **Off- formulary/non-preferred product/ medication:** 80% of Scheme's Oncology Reference Price or Scheme Rate, whichever is applicable • DSP rules apply

Terminology Reminders:

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

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		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
14.7.	**Chemotherapy, radiotherapy and associated oncology treatment** Chemotherapy, including facility fees, and radiotherapy, including technical and professional fees, technical planning scans, internal radiotherapy, stereotactic radiation, embolisation and chemo-embolisation, and any other treatment approved under the Programme	• Limited to PMBs • No overall limit for qualifying PMB treatment • Subject to Scheme's oncology formulary and/or preferred product list		• Subject to Oncology Benefit Threshold • No overall limit for qualifying treatment • Subject to Scheme's oncology formulary and/or preferred product list	• Limited to PMBs • No overall limit for qualifying PMB treatment • Subject to Scheme's oncology formulary and/or preferred product list	• Subject to Oncology Benefit Threshold • No overall limit for qualifying treatment • Subject to Scheme's oncology formulary and/or preferred product list	• No overall limit for qualifying treatment • Subject to Scheme's oncology formulary and/or preferred product list
		• **DSP:** 100% of Scheme Rate or Oncology Reference Price, whichever is applicable • **Non-DSP (involuntary use):** 100% of Scheme Rate or Oncology Reference Price, whichever is applicable • **Non-DSP (voluntary use):** 80% of Scheme Rate or Oncology Reference Price, whichever is applicable		• **DSP:** 100% of Scheme Rate or Scheme Medication Rate, whichever is applicable • **Non-DSP (involuntary use):** 100% of Scheme Rate or Scheme Medication Rate, whichever is applicable • **Non-DSP (voluntary use):** 80% of Scheme Rate or Scheme Medication Rate, whichever is applicable	• **DSP:** 100% of Scheme Rate or Scheme Medication Rate, whichever is applicable • **Non-DSP (involuntary use):** 100% of Scheme Rate or Scheme Medication Rate, whichever is applicable • **Non-DSP (voluntary use):** 80% of Scheme Rate or Scheme Medication Rate, whichever is applicable	• **DSP:** 100% of Scheme Rate or Scheme Medication Rate, whichever is applicable • **Non-DSP (involuntary use):** 100% of Scheme Rate or Scheme Medication Rate, whichever is applicable • **Non-DSP (voluntary use):** 80% of Scheme Rate or Scheme Medication Rate, whichever is applicable	• **DSP:** 100% of Scheme Rate or Scheme Medication Rate, whichever is applicable • **Non-DSP (involuntary use):** 100% of Scheme Rate or Scheme Medication Rate, whichever is applicable • **Non-DSP (voluntary use):** 80% of Scheme Rate or Scheme Medication Rate, whichever is applicable
14.8.	**Oncology and oncology-related medication** Medication administered in a healthcare professional's rooms or obtained from a pharmacy or courier pharmacy	• Limited to PMBs • No overall limit for qualifying PMB treatment • Subject to Scheme's oncology formulary, oncology supportive formulary and/or preferred product list		• Subject to Oncology Benefit Threshold • No overall limit for qualifying treatment • Subject to Scheme's oncology formulary, oncology supportive formulary and/or preferred product list	• Limited to PMBs • No overall limit for qualifying PMB treatment • Subject to Scheme's oncology formulary, oncology supportive formulary and/or preferred product list	• Subject to Oncology Benefit Threshold • No overall limit for qualifying treatment • Subject to Scheme's oncology formulary, oncology supportive formulary and/or preferred product list	• No overall limit for qualifying treatment • Subject to Scheme's oncology formulary, oncology supportive formulary and/or preferred product list
		• **DSP:** 100% of Oncology Reference Price • **Non-DSP (involuntary use):** 100% of Oncology Reference Price • **Non-DSP (voluntary use):** 80% of Oncology Reference Price • **Medication above the Oncology Reference Price:** member pays the difference where an appropriate formulary alternative is available • **Preferred medication:** 100% of Scheme's Oncology Reference Price • **Non-preferred medication:** 80% of Scheme's Oncology Reference Price, where an appropriate formulary alternative is available • **Medication that is both non-preferred and above the Oncology Reference Price:** adjustments are not cumulative – Scheme pays 80% of the lower of the applicable Oncology Reference Price or claimed		• **DSP:** 100% of Scheme Medication Rate • **Non-DSP (involuntary use):** 100% of Scheme Medication Rate • **Non-DSP (voluntary use):** 80% of Scheme Medication Rate • **Medication above the Scheme Medication Rate:** member pays the difference where an appropriate formulary alternative is available • **Preferred medication:** 100% of Scheme Medication Rate • **Non-preferred medication:**	• **DSP:** 100% of Scheme Medication Rate • **Non-DSP (involuntary use):** 100% of Scheme Medication Rate • **Non-DSP (voluntary use):** 80% of Scheme Medication Rate • **Medication above the Scheme Medication Rate:** member pays the difference where an appropriate formulary alternative is available • **Preferred medication:** 100% of Scheme Medication Rate • **Non-preferred medication:**	• **DSP:** 100% of Scheme Medication Rate • **Non-DSP (involuntary use):** 100% of Scheme Medication Rate • **Non-DSP (voluntary use):** 80% of Scheme Medication Rate • **Medication above the Scheme Medication Rate:** member pays the difference where an appropriate formulary alternative is available • **Preferred medication:** 100% of Scheme Medication Rate • **Non-preferred medication:**	• **DSP:** 100% of Scheme Medication Rate • **Non-DSP (involuntary use):** 100% of Scheme Medication Rate • **Non-DSP (voluntary use):** 80% of Scheme Medication Rate • **Medication above the Scheme Medication Rate:** member pays the difference where an appropriate formulary alternative is available • **Preferred medication:** 100% of Scheme Medication Rate • **Non-preferred medication:**

Terminology Reminders:

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

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		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
				80% of Scheme Medication Rate, where an appropriate formulary alternative is available • **Medication that is both non-preferred and above the Scheme Medication Rate:** adjustments are not cumulative – Scheme pays 80% of the lower of the applicable Scheme Medication Rate or claimed	80% of Scheme Medication Rate, where an appropriate formulary alternative is available • **Medication that is both non-preferred and above the Scheme Medication Rate:** adjustments are not cumulative – Scheme pays 80% of the lower of the applicable Scheme Medication Rate or claimed	80% of Scheme Medication Rate, where an appropriate formulary alternative is available • **Medication that is both non-preferred and above the Scheme Medication Rate:** adjustments are not cumulative – Scheme pays 80% of the lower of the applicable Scheme Medication Rate or claimed	80% of Scheme Medication Rate, where an appropriate formulary alternative is available • **Medication that is both non-preferred and above the Scheme Medication Rate:** adjustments are not cumulative – Scheme pays 80% of the lower of the applicable Scheme Medication Rate or claimed
14.9.	**Prescribed medication outside the Scheme's supportive formulary** Acute medication related to the cancer or oncology treatment, including acute antibiotics, which is not included in the Scheme's supportive formulary	• Refer to 'Prescribed acute medication' section		• Refer to 'Prescribed acute medication' section • Does not accumulate to Oncology Benefit Threshold	• Refer to 'Prescribed acute medication' section	• Refer to 'Prescribed acute medication' section • Does not accumulate to Oncology Benefit Threshold	• Refer to 'Prescribed acute medication' section
14.10.	**Chronic medication for supportive care** Medication for pain, nausea, vomiting, mild depression, osteopaenia or convulsions arising from the cancer or oncology treatment	• Refer to 'Oncology and oncology-related medication' section		• Refer to 'Oncology and oncology-related medication' section	• Refer to 'Oncology and oncology-related medication' section	• Refer to 'Oncology and oncology-related medication' section	• Refer to 'Oncology and oncology-related medication' section
14.11.	**Specified consultations and associated healthcare services** Oncology consultations and authorised stomatherapy, lymphoedema care, scopes, pathology and radiology, including basic X-rays, CT and MRI scans, isotope and bone scans, mammography and other specialised scans. Services must relate directly to the active oncology episode and form part of the authorised oncology Basket-of-Care or treatment plan. Where	• Funded in accordance with applicable Plan benefits • Limited to PMBs • No overall limit for qualifying PMB treatment		• Funded in accordance with applicable Plan benefits • Subject to Oncology Benefit Threshold, unless expressly excluded in Appendix 4A • See 'Oncology Benefit Threshold' above for rules • No overall limit for qualifying treatment	• Funded in accordance with applicable Plan benefits • Limited to PMBs • No overall limit for qualifying PMB treatment	• Funded in accordance with applicable Plan benefits • Subject to Oncology Benefit Threshold, unless expressly excluded in Appendix 4A • See 'Oncology Benefit Threshold' above for rules • No overall limit for qualifying treatment	• Funded in accordance with applicable Plan benefits • No overall limit for qualifying treatment

Terminology Reminders:

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

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		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
	required, services must be provided by an appropriately qualified and accredited provider, or at a facility meeting the Scheme's applicable oncology network, accreditation or credentialling requirements.						
14.12.	**Specified surgery for the removal of cancerous tumours** Authorised surgery directly related to the treatment of the confirmed cancer diagnosis	• Refer to 'Hospitalisation' section		• Refer to 'Hospitalisation' section • Does not accumulate to Oncology Benefit Threshold	• Refer to 'Hospitalisation' section	• Refer to 'Hospitalisation' section • Does not accumulate to Oncology Benefit Threshold	• Refer to 'Hospitalisation' section
14.13.	**Wigs** As specified in the applicable Plan benefit schedule	• Refer to 'Medical and surgical appliances' section		• Refer to 'Medical and surgical appliances' section • Does not accumulate to Oncology Benefit Threshold	• Refer to 'Medical and surgical appliances' section	• Refer to 'Medical and surgical appliances' section • Does not accumulate to Oncology Benefit Threshold	• Refer to 'Medical and surgical appliances' section
14.14.	**Oncology Innovation Benefit Approved novel and ultra-high-cost non-Prescribed Minimum Benefit oncology treatment** Provides access to an approved defined treatment list, is subject to Clinical Entry Criteria, protocols, referral to internal or external clinical panel and may authorise a specified number of treatment cycles **Beneficiary co-payment** The beneficiary is liable for the portion of the approved treatment cost not funded by the Scheme	• No benefit		• Subject to Oncology Benefit Threshold • Limited to 50% of the Scheme Medication Rate • Continue to fund at 50% of the Scheme Medication Rate after the threshold is reached • **Beneficiary copayment:** 50% copayment applies from commencement of the approved treatment • Any pharmaceutical co-payment support arrangement is an arrangement between the pharmaceutical company, the treating healthcare provider, the dispensing provider and the beneficiary • It is not administered or guaranteed by the Scheme • Continued funding may require clinical, radiology, pathology or other information demonstrating an appropriate response to treatment.	• No benefit	• Subject to Oncology Benefit Threshold • Limited to 50% of the Scheme Medication Rate • Continue to fund at 50% of the Scheme Medication Rate after the threshold is reached • **Beneficiary copayment:** 50% copayment applies from commencement of the approved treatment • Any pharmaceutical co-payment support arrangement is an arrangement between the pharmaceutical company, the treating healthcare provider, the dispensing provider and the beneficiary • It is not administered or guaranteed by the Scheme • Continued funding may require clinical, radiology, pathology or other information demonstrating an appropriate response to treatment.	• Limited to 70% of the Scheme Medication Rate • **Beneficiary copayment:** 30% copayment applies from commencement of the approved treatment • Any pharmaceutical co-payment support arrangement is an arrangement between the pharmaceutical company, the treating healthcare provider, the dispensing provider and the beneficiary • It is not administered or guaranteed by the Scheme • Continued funding may require clinical, radiology, pathology or other information demonstrating an appropriate response to treatment.

Terminology Reminders:

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

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		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
15.	**RENAL DIALYSIS** Subject to pre-authorisation and PMB regulations						
15.1.	**Procedures and treatment**	• Limited to PMBs • 100% of cost at DSP • 100% of Scheme Rate at non-DSP		• Unlimited • 100% of cost at DSP • 80% of Scheme Rate at non-DSP	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate at non-DSP		
15.2.	**Medication** • In- and out-of-hospital	• Limited to PMBs		• Unlimited			
	Medication via DSP • Bankmed Pharmacy Network	• 100% of cost, limited to PMBs		• 100% of cost			
	Medication via a non-DSP • Voluntary use of non-DSP	• 80% of Scheme Medicine Reference Price plus dispensing fee, limited to PMBs		• 80% of Scheme Medicine Reference Price plus dispensing fee			
	Medication via non-DSP • Involuntary use of non-DSP	• 100% of cost, limited to PMBs		• 100% of cost			
16.	**PREGNANCY AND CHILDBIRTH** Subject to pre-authorisation and PMB regulations						
16.1.	**Baby-and-Me Programme for expectant mothers**	• No benefit	• Call 0800 BANKMED (0800 226 5633) to register				• No benefit
16.2.	**Hospitalisation and associated in-hospital services** • Subject to pre-authorisation	• Refer to 'Hospitalisation' benefit section • Hospital network rules apply • Limited to PMBs	• Refer to 'Hospitalisation' benefit section • Hospital network rules apply				
16.3.	**Midwife care and delivery** • Subject to pre-authorisation	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited			
16.4.	**Birthing facilities as an alternative to hospitalisation** Subject to pre-authorisation • Only available where hospital services are not used, except registered active birthing units	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs • Cost of disposables limited to R1 570 per case		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited • Cost of disposables limited to R1 570 per case			
16.5.	**Antenatal and postnatal care** • GP and specialist consultations and procedures in-rooms	• Refer to 'GP Consultations In-room or Out-of-hospital', and 'Specialist Consultations In-room or Out-of-hospital' benefit sections • Limited to PMBs	• Refer to 'GP Consultations In-room or Out-of-hospital', and 'Specialist Consultations In-room or Out-of-hospital' benefit sections • Refer to additional Insured Benefits under Baby-and-Me Programme				• Refer to 'GP Consultations In-room or Out-of-hospital', and 'Specialist Consultations In-room or Out-of-hospital' benefit sections

Terminology Reminders:

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

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		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
16.6.	**Antenatal and postnatal care** • Ultrasonic investigations Radiology	• Refer to 'Radiology and pathology' benefit section • Limited to PMBs	• Refer to 'Radiology and pathology' benefit section • Refer to additional Insured Benefits under Baby-and-Me Programme				• Refer to 'Radiology and pathology' benefit section
16.7.	**Antenatal and postnatal care** • Pathology	• Refer to 'Radiology and pathology' benefit section • Limited to PMBs	• Refer to 'Radiology and pathology' benefit section • Refer to additional Insured Benefits under Baby-and-Me Programme				• Refer to 'Radiology and pathology' benefit section

16.8.	**Additional Insured Benefits**
	• Subject to registration on the Baby-and-Me Programme
		• No benefit	• Additional Insured Benefits subject to referral by GP in Bankmed Entry Plan GP Network (Basic Plan member) or GP in Bankmed GP Network (Core Saver, Traditional and Comprehensive Plan members)
			  • Six antenatal consultations per pregnancy at the contracted rate for Bankmed's GP Network and Prestige A and B Specialist Network
			  • Refer to 'GP Consultations In-room or Out-of-hospital', and 'Specialist Consultations In-room or Out-of-hospital' benefit sections
			  • Three 2D ultrasounds at 100% of Scheme Rate
			  • R1 930 per pregnancy for antenatal and postnatal classes at 100% of Scheme Rate
			  • Additional pathology at 100% of Scheme Rate, subject to Baby-and-Me approved BOC
							• Additional Insured Benefits not applicable on this Plan
							  • Members may register on the programme to obtain information, guidance and support throughout the pregnancy

17.	**ASSISTED REPRODUCTIVE THERAPY (ART)**						
17.1.	**Assisted Reproductive Therapy (ART)** healthcare services which include: • consultations • radiology, including ultrasound scans, and pathology • oocyte retrieval • embryo freezing, storage and transfer • related admission costs • related laboratory fees • supportive medication • oocyte and sperm cryopreservation • egg donor matching fee	• No benefit save for what is provided for under PMB regulations					• Subject to pre-authorisation • Limited to R140 000 pbpa • 75% of the Scheme Rate • Basket-of-Care as set by the Scheme • Cryopreservation for up to maximum of 5 years Subject to: • Clinical Entry Criteria • Treatment at a Designated Service Provider within the Scheme's SASREG-accredited fertility network • The Scheme's approved Assisted Reproductive Therapy Basket-of-Care, protocols and funding rules • Applicable annual, lifetime or cycle limits where approved • A beneficiary co-payment of 25% of the approved treatment cost • Any exclusions or restrictions specified elsewhere in this Benefit Schedule • PMB regulations apply.

Terminology Reminders:

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

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		NON-MSA PLANS			MSA PLANS		
18.	**RADIOLOGY AND PATHOLOGY**						
18.1.	**Radiology** • In-hospital	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited				
18.2.	**Pathology** • In-hospital	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited				
18.3.	**MRI/CT scans, radionuclide scans** In- and out-of-hospital Subject to pre-authorisation and PMB regulations Differentiated deductible applies to scans performed in-hospital and out-of-hospital as per Appendix 3	• Subject to pre-authorisation • Limited to PMBs		• Subject to pre-authorisation • Limited to R30 000 pfpa • All MRI/CT Scans and Radionuclide Scans accumulate to the limit • PMBs fund through the limit as per PMB regulations Upfront deductible applied: • **In-hospital non-PMB:** R2 000 per admission • **Day-surgery non-PMB:** R2 000 per admission • **Out-of-hospital non-PMB:** R1 000 per scan • **PMB:** deductible does not apply	• Subject to pre-authorisation • Limited to R25 000 pfpa • All MRI/CT Scans and Radionuclide Scans accumulate to the limit • PMBs fund through the limit as per PMB regulations Upfront deductible applied: • **In-hospital non-PMB:** R2 000 per admission • **Day-surgery non-PMB:** R2 000 per admission • **Out-of-hospital non-PMB:** R1 000 per scan • **PMB:** deductible does not apply	• Subject to pre-authorisation • Limited to R35 000 pfpa • All MRI/CT Scans and Radionuclide Scans accumulate to the limit • PMBs fund through the limit as per PMB regulations Upfront deductible applied: • **In-hospital non-PMB:** R2 000 per admission • **Day-surgery non-PMB:** R2 000 per admission • **Out-of-hospital non-PMB:** R1 000 per scan • **PMB:** deductible does not apply	• Subject to pre-authorisation • Unlimited • Deductible does not apply
	In-hospital Subject to pre-authorisation and PMB regulations	• 100% of cost at radiology facilities at Hospital Network DSP • 100% of Scheme Rate at non-DSP • Unlimited • **PMB**: deductible does not apply		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to 'MRI/CT Scans and Radionuclide Scans limit'	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to 'MRI/CT Scans and Radionuclide Scans limit'	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to 'MRI/CT Scans and Radionuclide Scans limit'	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP
	Out-of-hospital Subject to pre-authorisation and PMB regulations	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited • **PMB:** deductible does not apply		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP
18.4.	**Radiology and pathology** • Out-of-hospital	• Limited to PMBs • 100% of cost for PMBs • Benefits subject to a CDL (BOC) registration for PMB conditions	• Unlimited via DSP • 100% of cost at DSP • DSP: Bankmed Entry Plan GP Network • Subject to Scheme Radiology and Pathology Formulary • Specialist requested/performed radiology/pathology subject to	• 100% of cost at DSP for PMB • 100% of Scheme Rate, limited to R7 860 pfpa for non-DSP or non-PMB • Combined limit for 'Radiology and pathology out-of-hospital'	• 100% of cost at DSP for PMB • Subject to referral by GP in Bankmed GP Network (DSP) • 100% of Scheme Rate, subject to a CDL (BOC) and referral by GP in Bankmed GP Network (DSP)	**Radiology:** • 100% of cost at DSP for PMB • 100% of Scheme Rate, limited to R5 490 pfpa (including a sub-limit of R3 480 pfpa for out-of-hospital pathology) • Thereafter subject to available MSA	• 100% of cost at DSP for PMB • 300% of Scheme Rate, subject to available MSA • ATB applies once Annual Threshold is reached • The maximum amount that can jointly accumulate towards

Terminology Reminders:

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

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		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
			available 'Specialist Consultations In-room or Out-of-hospital' benefit		• Benefits approved for beneficiaries registered for PMB CDL conditions • Non-CDL benefits subject to available MSA	**Pathology:** • 100% of cost at DSP for PMB • 100% of Scheme Rate, limited to R3 480 pfpa (included in the annual limit of R5 490 pfpa for out-of-hospital radiology) • Thereafter subject to available MSA	reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an ATB (always subject to available ATB) is R8 725 pfpa
19.	**ALTERNATIVES TO HOSPITALISATION** Subject to pre-authorisation and PMB regulations						
19.1.	**Step-down facilities**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited				
19.2.	**Advanced Illness Benefit** • End-of-life treatment • Subject to pre-authorisation and PMB regulations and the treatment meeting the Scheme's guidelines and managed care criteria	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited			
19.3.	**Frail care facilities**	• No benefit		• 100% of cost, limited to R600 pb per day	• No benefit	• 100% of cost, limited to R625 pb per day	
19.4.	**Home nursing**	• No benefit		• 100% of cost, limited to R475 pb per day	• No benefit	• 100% of cost, limited to R495 pb per day	
19.5.	**HomeCare services** • For procedures not requiring admission to a day surgery or hospital. Subject to clinical entry criteria, pre-authorisation, and PMB regulations	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited				
19.6.	**Spinal Conservative Care Programme** • In- and out-of-hospital management for spinal care and surgery • Limited to a defined list of clinically appropriate procedures, including Lumbar Fusion, Cervical Fusion, Laminectomy, Laminotomy	• 100% of cost for the hospital account at a network facility • Network does not apply to any admissions related to trauma • 100% of the Scheme Rate for the hospital account if performed at a non-network facility • 100% of cost for related accounts at a DSP		• 100% of cost for the hospital account at a network facility • Network does not apply to any admissions related to trauma • 100% of the Scheme Rate for the hospital account if performed at a non-network facility • 100% of cost for related accounts at a DSP	• 100% of cost for the hospital account at a network facility • Network does not apply to any admissions related to trauma • 100% of the Scheme Rate for the hospital account if performed at a non-network facility • 100% of cost for related accounts at a DSP		

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
		• 100% of Scheme Rate for related accounts at a non-DSP • Limited to PMBs • Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria • Subject to PMB regulations • BOC as set by the Scheme for out-of-hospital conservative treatment		• 80% of Scheme Rate for related accounts at a non-DSP • Unlimited • Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria • Subject to PMB regulations • BOC as set by the Scheme for out-of-hospital conservative treatment	• 100% of Scheme Rate for related accounts at a non-DSP • Unlimited • Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria • Subject to PMB regulations • BOC as set by the Scheme for out-of-hospital conservative treatment		
20.	**HIP AND KNEE JOINT REPLACEMENTS** Subject to pre-authorisation, clinical motivation, the application of clinical and funding protocols, Scheme approval, and PMB regulations. The prostheses accumulate to the limit and not the hospital and related account						
20.1.	**Hospitalisation**	• Refer to 'Hospitalisation' benefit section	• Refer to 'Hospitalisation' benefit section	• Refer to 'Hospitalisation' benefit section	• Refer to 'Hospitalisation' benefit section		
	• **Related Healthcare Professional and Facility Services: DSP**	• 100% of cost at DSP	• 100% of cost at DSP	• 100% of cost at DSP	• 100% of cost at DSP		
	• **Related Healthcare Professional and Facility Services: Non-DSP**	• 80% of Scheme Rate at non-DSP	• 80% of Scheme Rate at non-DSP	• 80% of Scheme Rate at non-DSP	• 80% of Scheme Rate at non-DSP		
	• **Prosthesis/Prostheses Medical and surgical appliances**	• Limited as set out under the 'Internal Prosthesis' Benefit/Limit section, specifically as stated under 'hips and knees' • Limited to PMBs • Subject to referral from a Bankmed GP Entry Plan Network GP (DSP)	• Limited as set out under the 'Internal Prosthesis' Benefit/Limit section, specifically as stated under 'hips and knees' • Subject to referral from a Bankmed GP Entry Plan Network GP (DSP)	• Limited as set out under the 'Internal Prosthesis' Benefit/Limit section, specifically as stated under 'hips and knees' • Subject to referral from a Bankmed Network GP (DSP)	• Limited as set out under the 'Internal Prosthesis' Benefit/Limit section, specifically as stated under 'hips and knees'		
21.	**INTERNAL PROSTHESIS** Subject to clinical motivation, the application of clinical and funding protocols and Scheme approval. Bankmed reserves the right to obtain further quotations prior to granting approval. The prostheses accumulate to the limit and not the hospital and related accounts. All sub-limits are subject to the combined Internal Prosthesis limit of R99 345 pbpa (excluding pacemakers and defibrillators)						
21.1.	**Internal prosthesis**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to the combined 'Internal prosthesis' limit of R99 345 pbpa for all internal prosthesis items				

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
21.2.	**Spinal fusions**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of Scheme Rate for device • Limited to R66 930 pbpa • Subject to the combined 'Internal prosthesis' limit				
21.3.	**Cardiac stents**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of Scheme Rate for device • Limited to R98 950 pbpa • Subject to the combined 'Internal prosthesis' limit				
21.4.	**Grafts**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of Scheme Rate for device • Limited to R53 565 pbpa • Subject to the combined 'Internal prosthesis' limit				
21.5.	**Cardiac valves**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of Scheme Rate for device • Limited to R56 340 pbpa • Subject to the combined 'Internal prosthesis' limit				
21.6.	**Hip, knee and shoulder joints**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of Scheme Rate for device • If prosthesis is not supplied by Scheme's network provider (DSP): Limited to R66 110 per prosthesis per admission • If prosthesis is supplied by the Scheme's network provider (DSP): Unlimited and not subject to the combined 'Internal prosthesis' limit				
21.7.	**Non-specified Items**	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of Scheme Rate for device • Limited to R30 870 pbpa • Subject to the combined 'Internal prosthesis' limit				
22.	**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						
22.1.	**Pacemakers and defibrillators**	• Limited to PMBs • 100% of cost at hospital network DSP • 80% of cost at non-DSP	• 100% of cost, unlimited, if preferred provider used • 100% of Scheme Rate if non-preferred provider used to purchase device				
23.	**INTRAOCULAR LENSES FOR CATARACT SURGERY** Subject to pre-authorisation and PMB regulations and the treatment meeting the Scheme's criteria. Covered in full when supplied by the Scheme's preferred suppliers, otherwise covered up to 100% of the Scheme Rate for the lens						
23.1.	**Intraocular lenses for cataract surgery** • Permanent, implantable lenses, inclusive of basic and specialised lens varieties	• 100% of cost, unlimited, if preferred supplier's lens is used • 100% of Scheme Rate if lens used is not a preferred supplier lens • Scheme Rate is equal to the lens base price/lens reference price, plus 25% mark-up • Where the provider marks up the lens cost in excess of the agreed rate, the Scheme will not be responsible for the shortfall • Limited to PMBs	• 100% of cost, unlimited, if preferred supplier's lens is used • 100% of Scheme Rate if lens used is not a preferred supplier lens • Scheme Rate is equal to the lens base price/lens reference price, plus 25% mark-up • Where the provider marks up the lens cost in excess of the agreed rate, the Scheme will not be responsible for the shortfall				

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
24.	**COCHLEAR IMPLANT** Subject to pre-authorisation and PMB regulations and Scheme protocols. Once in a lifetime benefit. Funding only available in recognised Centres of Excellence. Bilateral cochlear implant benefits may be awarded to children under the age of 5 years, where clinical entry criteria are met. Subject to special motivation, clinical review and authorisation						
24.1.	**Hospitalisation**	• No benefit		• Refer to 'Hospitalisation' benefit section	• No benefit	• Refer to 'Hospitalisation' benefit section	
24.2.	**Pre-operative evaluation and associated preparation costs**	• No benefit		• R23 540 pb per lifetime • 100% of Scheme Rate	• No benefit	• R23 540 pb per lifetime • 100% of Scheme Rate	
24.3.	**Cochlear implant device**	• No benefit		• R493 490 pb per lifetime • 100% of Scheme Rate	• No benefit	• R493 490 pb per lifetime • 100% of Scheme Rate	
24.4.	**Intra-operative audiology testing**	• No benefit		• R1 230 pb per lifetime • 100% of Scheme Rate	• No benefit	• R1 230 pb per lifetime • 100% of Scheme Rate	
24.5.	**Post-operative evaluation costs**	• No benefit		• R49 430 pb per lifetime • 100% of Scheme Rate	• No benefit	• R49 430 pb per lifetime • 100% of Scheme Rate	
25.	**SPEECH PROCESSORS** Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval						
25.1.	**Upgrade or replacement of speech processors**	• No benefit		• 100% of Scheme Rate • Limited to R254 980 pb over a three-year cycle	• No benefit	• 100% of Scheme Rate • Limited to R254 980 pb over a three-year cycle	
26.	**HEARING AIDS**						
26.1.	**Hearing aids** • Supply and fitment	• No benefit, except for PMBs		• 100% of Scheme Rate, limited to R37 970 pb every second year (rolling 24 months)	• 100% of Scheme Rate, subject to available MSA	• 100% of Scheme Rate, limited to R39 585 pb every second year (rolling 24 months)	• 100% of Scheme Rate, limited to R46 345 pb every second year (rolling 24 months)
26.2.	**Hearing aid repairs**	• No benefit		• 100% of Scheme Rate • Limited to R1 970 pbpa	• 100% of Scheme Rate • Subject to available MSA	• 100% of Scheme Rate • Limited to R2 055 pbpa	
26.3.	**Bone anchored hearing aids**	• No benefit		• 90% of Scheme Rate • Limited to R211 720 pfpa	• 100% of Scheme Rate • Subject to available MSA	• 90% of Scheme Rate • Limited to R211 720 pfpa	
27.	**EXTERNAL PROSTHESIS, MEDICAL AND SURGICAL APPLIANCES, BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS** Benefit includes the repair of the prosthesis						
27.1.	**External prosthesis** • Benefit for limbs and eyes	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R4 365 pfpa • Combined limit with 'Blood pressure monitors, nebulisers and glucometers' benefits	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R32 510 pfpa	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R4 365 pfpa • Combined limit with 'Medical and surgical appliances', 'Blood pressure monitors, nebulisers and glucometers', and 'Arch supports and shoe insoles' benefits	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R33 890 pfpa	

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		

27.2.	**Medical and surgical appliances**
	• Refer to claim 'Frequency limits' in 27.6 below
		• 100% of cost at DSP
		• 100% of Scheme Rate at non-DSP
		• Limited to PMBs
		
		• No benefit for wheelchairs and large orthopaedic appliances on this Plan, except for PMBs
		
		• Only payable if claimed from a service provider with a valid BHF practice number
			• 100% of cost at DSP
			• 100% of Scheme Rate at non-DSP
			• Limited to PMBs
			• Combined limit of R4 365 pfpa with 'External prosthesis', 'Blood pressure monitors', 'Nebulisers and glucometers' benefits
			
			• Subject to pre- authorisation and PMB regulations
			
			• No benefit for wheelchairs and large orthopaedic appliances on this Plan, except for PMBs
			
			• Only payable if claimed from a service provider with a valid BHF practice number
				Post-surgery appliances:
				• 100% of Scheme Rate
				• Limited to R9 555 pbpa
				
				Chronic appliances:
				• 100% of cost
				• Limited to:
				  • R30 010 pbpa for oxygen/ oxygen delivery systems
				  • R30 010 pbpa for stoma products
				  • R9 555 pbpa for 'Other chronic appliances', including wheelchairs
				
				• Sub-limits as follows:
				  • R1 175 arch supports (Per pair)
				  • R1 770 shoe insoles (Per pair)
				• 'Other chronic appliances' limit extended to R13 980 for beneficiaries requiring a CPAP machine
				
				Appliances for acute conditions:
				• 100% of Scheme Rate
				• Limited to R9 555 pbpa
				• Combined limit with 'Other chronic appliances' benefits
				
				• Additional discretionary benefits may be granted for wheelchairs, subject to occupational therapist or physiotherapist motivation, at least two cost quotations and Scheme approval
				
				• Only payable if claimed from a service provider with a valid BHF practice number
					• Limit of R4 365 pfpa
					• Combined limit with 'External prosthesis', 'Blood pressure monitors, nebulisers and glucometers', and 'Arch supports and shoe insoles' benefits
					
					• Benefits for wheelchairs and large orthopaedic appliances at 100% of Scheme Rate, subject to available MSA
					• Sub-limits as follows:
					  • R1 230 arch supports (Per pair)
					  • R1 845 shoe insoles (Per pair)
					
					• Only payable if claimed from a service provider with a valid BHF practice number
						Post-surgery appliances:
						• 100% of Scheme Rate
						• Limited to R9 965 pbpa
						
						Chronic appliances:
						• 100% of cost
						• Limited to:
						  • R31 285 pbpa for oxygen/ oxygen delivery systems
						  • R31 285 pbpa for stoma products
						  • R9 965 pbpa for 'Other chronic appliances', including wheelchairs
						
						• Sub-limits as follows:
						  • R1 230 arch supports (Per pair)
						  • R1 845 shoe insoles (Per pair)
						• 'Other chronic appliances' limit extended to R14 580 for beneficiaries requiring a CPAP machine
						
						Appliances for acute conditions:
						• 100% of Scheme Rate
						• Subject to available MSA
						
						• Additional discretionary benefits may be granted for wheelchairs, subject to occupational therapist or physiotherapist motivation, at least two cost quotations and Scheme approval
						
						• Only payable if claimed from a service provider with a valid BHF practice number
							Post-surgery appliances:
							• 100% of Scheme Rate
							• Limited to R9 965 pbpa
							
							Chronic appliances:
							• 100% of cost
							• Limited to:
							  • R31 285 pbpa for oxygen/ oxygen delivery systems
							  • R31 285 pbpa for stoma products
							  • R9 965 pbpa for 'Other chronic appliances', including wheelchairs
							
							• Sub-limits as follows:
							  • R1 230 arch supports (Per pair)
							  • R1 845 shoe insoles (Per pair)
							• 'Other chronic appliances' limit extended to R14 580 for beneficiaries requiring a CPAP machine
							
							Appliances for acute conditions:
							• 100% of Scheme Rate
							• Subject to available MSA
							• ATB applies once the Annual Threshold is reached
							• 100% of Scheme Rate in ATB
							• Additional discretionary benefits may be granted for wheelchairs, subject to occupational therapist or physiotherapist motivation, at least two cost quotations and Scheme approval
							
							• Only payable if claimed from a service provider with a valid BHF practice number

IMPORTANT INFORMATION

- Claims for medical and surgical appliances are payable only if purchased from a Healthcare Professional with a valid BHF practice number.
- Bankmed cannot refund claims for items bought from non-BHF-registered companies or individuals.
- This includes purchases from Takealot, Gumtree, old age homes, battery suppliers, or other general retailers (e.g. wheelchairs, breast pumps, crutches, blood pressure monitors, nebulisers, etc.).
- Members must confirm the provider's BHF registration before ordering or making payment.

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		

27.3.	**Blood pressure monitors (BPM), nebulisers and glucometers**
	• Refer to claim 'Frequency limits' in 27.6 below
		• Subject to pre-authorisation and PMB regulations
		• 100% of cost at DSP
		• 100% of Scheme Rate at non-DSP
		• Limited to PMBs
			• Subject to pre-authorisation and PMB regulations
			• 100% of Scheme Rate
			• Limit of R4 365 pfpa
			• Combined limit with 'External prosthesis' and 'Medical and surgical appliances' benefits
			• Sub-limits as follows:
			  • BPM: R1 675 pbpa
			  • Nebulisers: R2 365 pbpa
			  • Glucometers: R1 180 pbpa
			• Only payable if claimed from a service provider with a valid BHF practice number
				• Available on prescription without additional motivation or Scheme approval
				• 100% of Scheme Rate
				• Limit of R9 555 pbpa
				• Combined limit with 'Other chronic appliances' under 'Medical and surgical appliances' benefits
				• Sub-limits as follows:
				  • BPM: R1 675 pbpa
				  • Nebulisers: R2 365 pbpa
				  • Glucometers: R1 180 pbpa
				• Only payable if claimed from a service provider with a valid BHF practice number
					• Available on prescription without additional motivation or Scheme approval
					• 100% of Scheme Rate
					• Limit of R4 365 pfpa
					• Combined limit with 'External prosthesis', 'Medical and surgical appliances', and 'Arch supports and shoe insoles' benefits
					• Sub-limits as follows:
					  • BPM: R1 675 pbpa
					  • Nebulisers: R2 365 pbpa
					  • Glucometers: R1 180 pbpa
					• Only payable if claimed from a service provider with a valid BHF practice number
						• Available on prescription without additional motivation or Scheme approval
						• 100% of Scheme Rate
						• Limit of R9 965 pbpa
						• Combined limit with 'External prosthesis' and 'Medical and surgical appliances' benefits
						• Sub-limits as follows:
						  • BPM: R1 675 pbpa
						  • Nebulisers: R2 365 pbpa
						  • Glucometers: R1 180 pbpa
						• Only payable if claimed from a service provider with a valid BHF practice number

27.4.	**Arch supports and shoe insoles** • Refer to claim 'Frequency limits' in 27.6 below	• No benefit		• Refer to 27.2	• Refer to 27.2	• Refer to 27.2	
27.5.	**Breast pumps and baby monitors**	• No benefit		• Limit of R9 555 pbpa • Combined limit with 'Other chronic appliances' under 'Medical and surgical appliances' benefits • Only payable if claimed from a service provider with a valid BHF practice number	• Funded from available MSA • Only payable if claimed from a service provider with a valid BHF practice number		
27.6.	**Frequency limits pertaining to medical and surgical appliances, blood pressure monitors, nebulisers, glucometers, etc.**	• Appliances may be claimed once over a specified period • The following appliances may be claimed once per the specified period below:					

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

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

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

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

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

Terminology Reminders:

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ASA	Accumulated Savings Account	**CIB**	Chronic Illness Benefit	**CDL**	Chronic Disease List	**ATB**	Above Threshold Benefit
pfpa	per family per annum	**pb**	per beneficiary	**pbpa**	per beneficiary per annum	**pbpm**	per beneficiary per month

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		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
27.7.	**Insulin Pump** • Must be prescribed by Physician/Endocrinologist	No benefit		• Limit of R41 800 pfpa • Only payable if claimed from a service provider with a valid BHF practice number • Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols. **Frequency Limit:** • One pump pfpa every 36-month cycle			
28.	**PSYCHIATRY, CLINICAL PSYCHOLOGY AND RELATED OCCUPATIONAL THERAPY**						
28.1.	**Hospitalisation** • Subject to pre-authorisation and PMB regulations	• Limited to PMBs • Subject to referral from a Bankmed Entry Plan GP Network GP (DSP)		• Limited to R92 835 pbpa	• Limited to R92 835 pbpa		
	Hospital Network DSP • All admissions at network DSP	• 100% of cost for Bankmed Network Psychiatric facilities (DSP)		• 100% of cost for Bankmed Network Psychiatric facilities (DSP)	• 100% of cost for Bankmed Network Psychiatric facilities (DSP)		
	Other hospitals (non-DSP) • **PMB admission** Involuntary use of non-DSP	• 100% of cost		• 100% of cost	• 100% of cost		
	• **PMB admission** Voluntary use of non-DSP	• 80% of Scheme Rate		• 80% of Scheme Rate	• 80% of Scheme Rate		
	• **Non-PMB admission**	• No benefit		• 80% of Scheme Rate	• 80% of Scheme Rate		

	In-hospital consultations/ Sessions	• 100% of cost for Bankmed Entry Plan Specialist Network (DSP)
		• 100% of Scheme Rate for non-DSP
		  • Cover for 21 days in hospital in line with PMB regulations
				• 100% of cost for Bankmed Prestige A and B Specialist Network (DSP)
				• 80% of Scheme Rate for non-DSP
				  • Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the Rand limit
				  • Continued benefits for PMBs subject to pre-authorisation and PMB regulations
				  • Combined limit with 'Occupational therapy: psychiatric consultations/sessions in hospital' benefit
					• 100% of cost for Bankmed Prestige A and B Specialist Network (DSP)
					• 100% of Scheme Rate for non-DSP
					  • Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the Rand limit
					  • Continued benefits for PMBs subject to pre-authorisation and PMB regulations
					  • Combined limit with 'Occupational therapy: psychiatric consultations/sessions in hospital' benefit		

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
28.2.	**30-Day Post-hospital Psychiatric Consultation Benefit** • Access to psychiatric consultation within 30 days of hospital discharge following a psychiatric admission • Applies for psychiatric admissions for Major depression, Schizophrenia and Bipolar mood disorder only (excluding day cases)	• One additional post-hospitalisation psychiatrist consultation covered pb within 30 days of being discharged from hospital following an authorised psychiatric admission • Covered as an Insured Benefit • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Entry Plan Specialist Network for psychiatrist only • Limited to three consultations pbpa, following an authorised admission, thereafter, funded from 'Specialist Consultations In-room or Out-of-hospital' benefits		• One additional post-hospitalisation psychiatrist consultation covered pb within 30 days of being discharged from hospital following an authorised psychiatric admission • Covered as an Insured Benefit • 100% of cost at DSP • 80% of Scheme Rate for non-DSP • DSP: Bankmed Prestige A and B Specialist Network for psychiatrist only • Limited to three consultations pbpa, following an authorised admission, thereafter, funded from 'Specialist Consultations In-room or Out-of-hospital' benefits	• One additional post-hospitalisation psychiatrist consultation covered pb within 30 days of being discharged from hospital following an authorised psychiatric admission • Covered as an Insured Benefit • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Prestige A and B Specialist Network for psychiatrist only • Limited to three consultations pbpa, following an authorised admission, thereafter, funded from 'Specialist Consultations In-room or Out-of-hospital' benefits or available MSA, as applicable per Plan		
28.3.	**Consultations/sessions** • Out-of-hospital **Important note:** • Cover for 15 out-of-hospital psychotherapy sessions for PMBs	• Limited to PMBs • Benefits subject to pre-authorisation and PMB regulations and referral from a Bankmed Entry Plan GP Network GP (DSP) • 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSP) • 100% of Scheme Rate for non-DSP		• Limited to R5 580 pbpa • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) • 80% of Scheme Rate for non-DSP • Combined limit with 'Occupational therapy: Psychiatric consultations/ sessions out-of-hospital' benefit • Combined limit may be extended to R13 900 pbpa for Depression and/or Bipolar mood disorder, subject to pre-authorisation and PMB regulations	• Subject to available MSA • Benefits subject to pre-authorisation and PMB regulations and referral from a Bankmed Network GP (DSP) • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP, subject to available MSA	• Limited to R6 800 pbpa • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP • Combined limit with 'Occupational therapy: Psychiatric consultations/ sessions out-of-hospital' benefit • Combined limit may be extended to R16 205 pbpa for Depression and/or Bipolar mood disorder, subject to pre-authorisation and PMB regulations	• Subject to available MSA • Benefits subject to PMB regulations and Bankmed Prestige A and B Specialist Network (DSP) • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Prestige A and B Specialist Network (DSP) • 300% of Scheme Rate for non-DSP, subject to available MSA • ATB applies once Annual Threshold is reached • The maximum amount that can accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an ATB (always subject to available ATB) is R20 535 pfpa

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
28.4.	**Mental Health Integrated Disease Management Programme** • Management of specified mental health conditions for members registered on the Scheme's Programme	• In addition to the cover provided under the PMB regulations • 100% of the Scheme Rate for services covered in the Scheme's BOC if referred by the Scheme's DSP • 100% of Scheme Rate for services performed by the Scheme's DSP • Limited to the BOC set by the Scheme • Subject to the treatment meeting the Scheme's treatment guidelines and managed care criteria • Subject to PMB regulations					
28.5.	**Alcohol and Drug Rehabilitation**	• Limited to PMBs • Subject to pre-authorisation • Cover for 21 days in hospital in line with PMB regulations (combined 21-day limit with psychiatry, clinical psychology & related occupational therapy limit in hospital).	• Limited to PMBs • Subject to pre-authorisation • Cover for 21 days in hospital in line with PMB regulations (combined 21-day limit with psychiatry, clinical psychology & related occupational therapy limit in hospital).	• Limited to PMBs • Subject to pre-authorisation • Cover for 21 days in hospital in line with PMB regulations • Combined 21-day limit with 'combined limit with occupational therapy: psychiatric consultations/ sessions in hospital' as specified elsewhere in this schedule	• Limited to PMBs • Subject to pre-authorisation • Cover for 21 days in hospital in line with PMB regulations • Combined 21-day limit with 'combined limit with occupational therapy: psychiatric consultations/ sessions in hospital' as specified elsewhere in this schedule		
	Bankmed Drug and Alcohol Facility/Provider Network DSPs • All admissions at network DSP	• 100% of cost for Bankmed Drug and Alcohol Facility/Provider Network (DSPs)	• 100% of cost for Bankmed Drug and Alcohol Facility/Provider Network (DSPs)	• 100% of cost for Bankmed Drug and Alcohol Facility/Provider Network (DSPs)	• 100% of cost for Bankmed Drug and Alcohol Facility/Provider Network (DSPs)		
	Other Drug and Alcohol Facility (non-DSPS) • **PMB admission:** involuntary use of non-DSP • **PMB admission:** voluntary use of non-DSP • **Non-PMB admission**	• 100% of cost • 80% of Scheme Rate for non-DSPs • No benefit	• 100% of cost • 80% of Scheme Rate for non-DSPs • No benefit • Required referral from a Bankmed GP Entry Plan Network GP (DSP).	• 100% of cost • 80% of Scheme Rate for non-DSPs • Subject to the 'Psychiatry, Clinical Psychology & Related Occupational Therapy Benefits' and limits as mentioned elsewhere in this schedule • Required referral from a Bankmed Network GP (DSP).	• 100% of cost • 80% of Scheme Rate for non-DSPs • Subject to the 'Psychiatry, Clinical Psychology & Related Occupational Therapy Benefits' and limits as mentioned elsewhere in this schedule		
29.	**OCCUPATIONAL THERAPY**						
29.1.	**Psychiatric consultations/ sessions** • In-hospital • Subject to pre-authorisation and PMB regulations	• Refer to 'Psychiatry, clinical psychology and related occupational therapy: Hospitalisation and in-hospital consultations/sessions' benefit section					
29.2.	**Psychiatric consultations/ sessions** • Out-of-hospital	• Refer to 'Psychiatry, clinical psychology and related occupational therapy: Consultations/sessions out-of-hospital' benefit section					

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
29.3.	**Non-psychiatric consultations/sessions** • In-hospital • Subject to pre-authorisation and PMB regulations	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	
29.4.	**Non-psychiatric consultations/sessions** • Out-of-hospital • Subject to PMB regulations	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs • Subject to pre-authorisation and PMB regulations, and referral from a Bankmed Entry Plan GP Network (DSP)		• 100% of cost for PMB at DSP • 100% of Scheme Rate at non-DSP • Limited to R2 740 pfpa	• 100% of cost for PMB at DSP • 100% of Scheme Rate at non-DSP • 100% of Scheme Rate, subject to available MSA for non-PMBs	• 100% of cost for PMB at DSP • 100% of Scheme Rate at non-DSP • Limited to R3 000 pfpa, from Insured Benefits • Thereafter subject to available MSA	• 100% of cost at DSP from Insured Benefits for PMBs • 300% of Scheme Rate, subject to available MSA for non-PMBs • ATB applies once Annual Threshold is reached • The maximum amount that can accumulate towards reaching the Annual Threshold at 100% of Scheme Rate and/or be paid as an ATB (always subject to available ATB) is R10 355 pfpa.
30.	**SPEECH THERAPY, AUDIO THERAPY AND AUDIOLOGY**						
30.1.	**Speech therapy, audio therapy and audiology** • In- and out-of-hospital	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs • Subject to pre-authorisation and PMB regulations, and referral from a Bankmed Entry Plan GP Network (DSP) • Out-of-hospital cover is subject to PMB application	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs • Subject to pre-authorisation and PMB regulations, and referral from a Bankmed Entry Plan GP Network (DSP)	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R2 740 pfpa	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to available MSA • 100% of cost paid from Insured Benefits for PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R3 090 pfpa • 100% of cost paid from Insured Benefits for PMBs • Thereafter subject to available MSA	• 100% of cost at DSP • 300% of Scheme Rate at non-DSP • Subject to available MSA • 100% of cost paid from Insured Benefits for PMBs • ATB applies once Annual Threshold is reached • The maximum amount that can jointly accumulate towards reaching the Annual Threshold at 100% of Scheme Rate and/or be paid as an ATB (always subject to available ATB) is R3 090 pfpa
31.	**PHYSIOTHERAPY**						
31.1.	**Physiotherapy** • In-hospital • Subject to pre-authorisation	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	
31.2.	**Post-hospitalisation Physiotherapy Benefit** • Applies within six weeks of discharge from hospital or approved day surgery	• Refer to 'Physiotherapy out-of-hospital' benefit section		• 100% of Scheme Rate • Limited to R3 965 pfpa	• Refer to 'Physiotherapy out-of-hospital' benefit section	• 100% of Scheme Rate • Limited to R3 430 pbpa from Insured Benefits • Thereafter subject to available MSA	• Refer to 'Physiotherapy out-of-hospital' benefit section

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
	facility, following an authorised hospital or approved day surgery facility admission			• 100% of cost at DSP • 100% of Scheme Rate at non-DSP		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP	
31.3.	**Physiotherapy** • Out-of-hospital	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to pre-authorisation and PMB regulations, and referral from a Bankmed Entry Plan GP Network GP (DSP) • Limited to PMBs		• 100% of Scheme Rate • Subject to 'GP Consultations In-room or Out-of-hospital', and 'Specialist Consultations In-room or Out-of-hospital' benefits • 100% of cost at DSP • 100% of Scheme Rate at non-DSP	• 100% of Scheme Rate • Subject to available MSA for non-PMBs • 100% of cost for PMBs • 100% of cost at DSP • 100% of Scheme Rate at non-DSP		• 300% of Scheme Rate, subject to available MSA for non-PMBs • 100% of cost for PMBs • 100% of cost at DSP • 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 (subject to available ATB) is R4 135 pbpa
32.	**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						
32.1.	**Occupational therapy: psychiatric consultations/ sessions** • Out-of-hospital	• No benefit	• 100% of Scheme Rate or contracted rate, whichever applies				
32.2.	**Occupational therapy: non-psychiatric consultations/ sessions** • Out-of-hospital	• No benefit	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP				
32.3.	**Physiotherapy** • Out-of-hospital	• No benefit	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP				
32.4.	**Speech therapy** • Out-of-hospital	• No benefit	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP				
33.	**OTHER AUXILIARY SERVICES** In- and out-of-hospital						
33.1.	**Auxiliary allied services** • Chiropody, Podiatry, Dietetics (nutritional assessments), Orthotics, Massage, Chiropractors, Herbalists, Naturopaths, Family Planning Clinics, Homeopaths and Biokineticists (fitness assessments)	• Limited to PMBs and subject to PMB regulations • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Out-of-hospital cover is subject to PMB application, referral by GP in the Bankmed Entry Plan GP Network (DSP), and pre-authorisation • Frequency limits apply		• Limited to R4 185 pfpa • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Frequency limits apply	• Limited to available MSA for non-PMBs • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Frequency limits apply		• Limited to available MSA for non-PMBs • 100% of cost at DSP • Frequency limits apply • ATB applies once Annual Threshold is reached • The maximum amount that can jointly accumulate towards reaching the Annual Threshold

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
							(at 100% of Scheme Rate) and/ or be paid as an ATB (always subject to available ATB) is R4 365 pfpa
34.	**MAXILLOFACIAL AND ORAL SURGERY** Benefits for caps, crowns, bridges, endosteal and ossea-integrated implants are detailed under 'Advanced dentistry' whilst orthodontic benefits are detailed under 'Orthodontics'						
34.1.	**Maxillofacial and oral surgery** • Procedures and treatment in- and out-of-hospital • Subject to pre-authorisation and PMB regulation	• Limited to PMBs • 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSP) • 100% of Scheme Rate for non-DSP		• Unlimited • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) • 80% of Scheme Rate for non-DSP • Benefit inclusive of elective treatment	• Limited to PMBs • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP	• Unlimited • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP • Benefit inclusive of elective treatment	
35.	**DENTISTRY** Subject to pre-authorisation and PMB regulations.						

35.1.	**Preventative and basic dentistry**
	• Preventative and Basic Dentistry not covered in-hospital. Subject to PMB regulations
		• No benefit	• Unlimited
			• 100% of cost at Bankmed Dental Network (DSP)
			• Bankmed Dental Formulary applies
			• No benefits for non-DSP or non-Formulary treatment
				• Unlimited
				• 100% of cost at DSP
				• 80% of Scheme Rate at non-DSP
				• Sub-limits apply:
				  • One oral examination pbpa
				  • Amalgam/resin fillings only
				  • Plastic dentures only
				  • Two topical fluoride treatments pbpa (age 15 years and younger)
				  • One topical fluoride treatment pfpa
				  • Limited to eight molar teeth pb per lifetime
				  • Scale/polish limited to two pbpa
					• Limited to available MSA
					• 100% of cost at DSP
					• 100% of Scheme Rate at non-DSP
						• Unlimited from Insured Ben
						• 100% of cost at DSP
						• 100% of Scheme Rate at non-DSP
						• Sub-limits apply:
						  • One oral examination pbpa
						  • Amalgam/resin fillings only
						  • Plastic dentures only
						  • Two topical fluoride treatments pbpa (age 15 years and younger)
						  • One topical fluoride treatment pfpa
						  • Limited to eight molar teeth pb per lifetime
						  • Scale/polish limited to two pbpa
							• 100% of cost at DSP
							• 300% of Scheme Rate, subject to available MSA
							• ATB applies once Annual Threshold is reached
							• The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/ or be paid as an ATB (always subject to available ATB), is R24 760 for a single member and R37 510 for a family

35.2.	**Advanced dentistry**
	• Caps, crowns, bridges and cost of endosteal and ossea-integrated implants
		• No benefit		• 100% of cost at DSP
				• 80% of Scheme Rate at non-DSP
				• Limited to:
				  • M: R9 165 pbpa
				  • M + 1 +: R14 210 pfpa
				• Combined limit for 'Advanced dentistry', 'Orthodontics' and 'All other dental services'
					• 100% of cost at DSP
					• 100% of Scheme Rate at non-DSP
					• 100% of cost for PMBs
					• Subject to available MSA for non-PMBs
						• 100% of cost at DSP
						• 100% of Scheme Rate at non-DSP
						• Limited to:
						  • M: R7 440 pbpa
						  • M + 1 +: R12 460 pfpa
						  • Thereafter subject to available MSA	

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
35.3.	**Orthodontics** • Subject to orthodontic quotation and prior approval from Scheme	• No benefit		• 100% of cost at DSP • 80% of Scheme Rate at non-DSP • Subject to 'Advanced dentistry' limit	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to available MSA	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R12 460 pfpa, thereafter subject to MSA	
35.4.	**All other dental services**	• No benefit	• 100% of cost at Bankmed Dental Network (DSP), and • Bankmed Dental Formulary applies to: • Second and subsequent exams in same year, and X-rays	• 100% of cost at DSP • 80% of Scheme Rate at non-DSP • Subject to 'Advanced dentistry' limit	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to available MSA		
35.5. 2.4	**Extraction of impacted wisdom tooth/teeth in-rooms** • Subject to pre-authorisation and PMB regulations	Limited to PMBs			Limited to PMBs		
	PMB: In-rooms: • Designated Service Provider (DSP)	• 100% of cost for Bankmed Specialist Network: DSPs • 100% of cost for Bankmed Dental Network: DSPs • Deductible does not apply		• 100% of cost for Bankmed Prestige A&B Specialist Network: DSPs • 100% of cost for Bankmed Dental Network: DSPs • Deductible does not apply	• 100% of cost for Bankmed Prestige A&B Specialist Network: DSPs • 100% of cost for Bankmed Dental Network: DSPs • Deductible does not apply	• 100% of cost for Bankmed Prestige A&B Specialist Network: DSPs • 100% of cost for Bankmed Dental Network: DSPs • Deductible does not apply	
	PMB: In-rooms: • Non-DSP (voluntary use of non-DSP)	• 80% of Scheme Rate • Deductible applies		• 80% of Scheme Rate • Deductible applies	• 80% of Scheme Rate • Deductible applies	• 80% of Scheme Rate • Deductible applies	
	PMB: In-rooms: • Non-DSP (involuntary use of non-DSP)	• 100% of cost • Deductible does not apply		• 100% of cost • Deductible does not apply	• 100% of cost • Deductible does not apply	• 100% of cost • Deductible does not apply	
	Non-PMB: In-rooms: • Bankmed Network Provider Not Used	• No benefit		• 80% of Scheme Rate • Deductible applies	• No benefit	• 80% of Scheme Rate • Deductible applies	
36.	**GENERAL PRACTITIONERS (GPs)**						
36.1.	**GP consultations** • In-hospital	• Limited to PMBs • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Entry Plan GP Network	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Entry Plan GP Network	• Unlimited • 100% of cost at DSP • 80% of Scheme Rate for non-DSP • DSP: Bankmed GP Network	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed GP Network		
36.2.	**GP procedures** • In-hospital	• Limited to PMBs • 100% of cost at DSP • 100% of Scheme Rate for non-DSP (including PMBs)	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP (including PMBs)	• Unlimited • 100% of cost at DSP • 80% of Scheme Rate for non-DSP (including PMBs)	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP (including PMBs)	• Unlimited • 100% of cost at DSP • 125% of Scheme Rate for non-DSP (including PMBs)	• Unlimited • 100% of cost at DSP • 300% of Scheme Rate for non-DSP (including PMBs)

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
		• DSP: Bankmed Entry Plan GP Network • No benefit for dental surgery, except for PMBs	• DSP: Bankmed Entry Plan GP Network • No benefit for dental surgery, except for PMBs	• DSP: Bankmed GP Network	• DSP: Bankmed GP Network • No benefit for dental surgery, except for PMBs	• DSP: Bankmed GP Network	• DSP: Bankmed GP Network
36.3.	**30-Day Post-hospital GP Consultation Benefit** • Consultation within 30 days of discharge from hospital (excluding day cases)	• Limited to PMBs • One additional post-hospitalisation GP consultation covered as an Insured Benefit pb visiting a GP within 30 days of discharge, following an authorised hospital admission • 100% of cost at the contracted rate for Bankmed Entry Plan GP Network (DSP) • 100% of Scheme Rate for non-DSP	• One additional post-hospitalisation GP consultation covered as an Insured Benefit pb visiting a GP within 30 days of discharge, following an authorised hospital admission • 100% of cost at the contracted rate via Bankmed Entry Plan GP Network (DSP) • 100% of Scheme Rate for non-DSP • Subject to the 'Out-of-network GP Benefit' limit	• One additional post-hospitalisation GP consultation covered as an Insured Benefit pb visiting a GP within 30 days of discharge, following an authorised hospital admission (excluding day cases): • 100% of cost at contracted rate for Bankmed Network GPs (DSP) • 80% of Scheme Rate for non-DSP	• One additional post-hospitalisation GP consultation covered as an Insured Benefit pb visiting a GP within 30 days of discharge, following an authorised hospital admission (excluding day cases): • 100% of cost at contracted rate for Bankmed Network GPs (DSP) • 100% of Scheme Rate for non-DSP		
36.4.	**Primary Care Provider for members registered with a chronic condition** Upon registration for Chronic Illness Benefits, the member must nominate a primary care GP participating in the Bankmed GP Network. GP consultations and procedures associated with an approved chronic condition must be obtained from the member's nominated primary care GP. Where the member has not nominated a primary care GP, or uses a GP who does not participate in the Bankmed GP Network, the member is liable for a co-payment equal to 20% of the Scheme Rate and any amount charged by the provider above the Scheme Rate. Subject to PMB Regulations.	• Not applicable		• Applies to beneficiaries with an approved chronic condition • Members must nominate a primary care GP in the Bankmed GP Network **Funding:** • GP consultations and procedures associated with an approved chronic condition • **Obtained from nominated primary care GP:** 100% of cost • **Obtained from non-network GP:** 80% of the Scheme Rate • **Beneficiary has not nominated a primary care GP:** 80% of the Scheme Rate • Subject to the authorised Chronic Illness Benefit Care Plan and applicable Basket-of-Care	• Applies to beneficiaries with an approved chronic condition • Members must nominate a primary care GP in the Bankmed GP Network **Funding:** • GP consultations and procedures associated with an approved chronic condition • **Obtained from nominated primary care GP:** 100% of cost • **Obtained from non-network GP:** 80% of the Scheme Rate • **Beneficiary has not nominated a primary care GP:** 80% of the Scheme Rate • Subject to the authorised Chronic Illness Benefit Care Plan and applicable Basket-of-Care	• Not applicable

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
				• One consultation per beneficiary per benefit year with a GP other than the beneficiary's nominated primary care GP, funded up to 100% of the Scheme Rate • The beneficiary may change their nominated primary care GP no more than twice during a benefit year	• One consultation per beneficiary per benefit year with a GP other than the beneficiary's nominated primary care GP, funded up to 100% of the Scheme Rate • The beneficiary may change their nominated primary care GP no more than twice during a benefit year		

36.5.	**GP consultations**
	• In-room or out-of-hospital
		• Limited to PMBs
		• 100% of cost at DSP
		• 100% of Scheme Rate for non-DSP
		• DSP: Bankmed Entry Plan GP Network
			• Unlimited
			• 100% of cost at DSP
			• 100% of Scheme Rate for non-DSP
			• DSP: Bankmed Entry Plan GP Network
			• Member to nominate primary GP within network
			• **Out-of-network GP Benefit**
			  • Limited to three visits, up to R3 000 pfpa (at DSP rate) for consultations, procedures and medication at non-network GP
			  • When nominated DSP GP is unavailable or beneficiary is out of town, 'Out-of-network GP Benefit' includes all related consultation costs
				• Combined limit for 'GP Consultations In-room or Out-of-hospital', and 'Specialist Consultations In-room or Out-of-hospital' benefits:
				  • M: R4 620 pbpa
				  • M + 1: R8 365 pfpa
				  • M + 2 +: R9 700 pfpa
				• 100% of cost at DSP
				• 80% of Scheme Rate for non-DSP
				• DSP: Bankmed GP Network
				• Unlimited if DSP used
				• Continued benefits for beneficiaries with PMB conditions, subject to PMB regulations
				• **Beneficiaries with an approved chronic condition are required to nominate a primary care GP in the Bankmed GP Network**
				• Refer to 'Primary Care Provider for members registered with a chronic condition' section above to avoid co-payments
					• **Bankmed GP Network benefits (DSP):**
					  • Unlimited for PMBs
					  • 100% of cost
					  • Limited to two consultations from Insured Benefits for non-PMBs, thereafter subject to available MSA
					• **Non-network GP benefits (non-DSP):**
					  • 100% of Scheme Rate from Insured Benefits for PMBs
					  • 100% of Scheme Rate, subject to available MSA for non-PMBs
					• Continued benefits for beneficiaries with PMB conditions, subject to PMB regulations
					• **Beneficiaries with an approved chronic condition are required to nominate a primary care GP in the Bankmed GP Network**
					• Refer to 'Primary Care Provider for members registered with a chronic condition' section above to avoid co-payments
						• **Bankmed GP Network benefits (DSP):**
						  • Unlimited for PMBs
						  • 100% of cost
						  • Non-PMBs subject to available MSA
						• **Non-network GP benefits (non-DSP):**
						  • 100% of Scheme Rate from Insured Benefits for PMBs
						  • 100% of Scheme Rate, subject to available MSA for non-PMBs
							• **Bankmed GP Network benefits (DSP):**
							  • Unlimited for PMBs
							  • 100% of cost
							  • Non-PMBs subject to available MSA/ATB
							• **Non-network GP benefits (non-DSP):**
							  • 100% of Scheme Rate from Insured Benefits for PMBs
							  • 300% of Scheme Rate, subject to available MSA/ATB for non-PMBs
							  • ATB applies once Annual Threshold is reached

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		

36.6.	**GP procedures**
	• In-room or out-of-hospital
		• Limited to PMBs
		• 100% of cost at DSP
		• 100% of Scheme Rate for non-DSP
		• DSP: Bankmed Entry Plan GP Network
			• Refer to 'GP Consultations In-room or Out-of-hospital' benefit section	• Unlimited
				• 100% of cost at DSP
				• 80% of Scheme Rate for non-DSP
				• DSP: Bankmed GP Network
				• Continued benefits for beneficiaries with PMB conditions, subject to PMB regulations
				• **Beneficiaries with an approved chronic condition are required to nominate a primary care GP in the Bankmed GP Network**
				• Refer to 'Primary Care Provider for members registered with a chronic condition' section above to avoid co-payments
					• **Bankmed GP Network benefits (DSP):**
					  • Unlimited for PMBs
					  • 100% of cost
					  • Non-PMBs subject to available MSA
					• **Non-network GP benefits (non-DSP):**
					  • 100% of Scheme Rate from Insured Benefits for PMBs
					  • 100% of Scheme Rate, subject to available MSA for non-PMBs
					• Continued benefits for beneficiaries with PMB conditions, subject to PMB regulations
					• **Beneficiaries with an approved chronic condition are required to nominate a primary care GP in the Bankmed GP Network**
					• Refer to 'Primary Care Provider for members registered with a chronic condition' section above to avoid co-payments
						• **Bankmed GP Network benefits (DSP):**
						  • Unlimited for PMBs
						  • 100% of cost
						• **Non-network GP benefits (non-DSP):**
						  • 100% of Scheme Rate from Insured Benefits for PMBs
						  • 125% of Scheme Rate from Insured Benefits for non-PMBs
							• **Bankmed GP Network benefits (DSP):**
							  • Unlimited for PMBs
							  • 100% of cost
							• **Non-network GP benefits (non-DSP):**
							  • 100% of Scheme Rate from Insured Benefits for PMBs
							  • 300% of Scheme Rate from Insured Benefits for non-PMBs

36.7.	**GP consultations** • Virtual or online • Subject to verification notes submitted by claiming GP Subject to Out-of-hospital GP Benefits and Limits	• 100% of cost for Bankmed Entry Plan GP Network GPs (DSP) • 100% of Scheme Rate for non-DSP • Limited to three consultations pbpa • Limited to PMBs	• 100% of cost for Bankmed Entry Plan GP Network GPs (DSP) • 100% of Scheme Rate for non-DSP • Limited to three consultations pbpa • Subject to the 'Out-of-network GP Benefit' limit if non-DSP used	• 100% of cost for Bankmed Network GPs (DSP) • 80% of Scheme Rate for non-DSP • Limited to three consultations pbpa • **Beneficiaries with an approved chronic condition are required to nominate a primary care GP in the Bankmed GP Network** • Refer to 'Primary Care Provider for members registered with a chronic condition' section above to avoid co-payments	• 100% of cost for Bankmed Network GPs (DSP) • 100% of Scheme Rate for non-DSP • Limited to three consultations pbpa • Subject to available MSA for non-PMBs • **Beneficiaries with an approved chronic condition are required to nominate a primary care GP in the Bankmed GP Network** • Refer to 'Primary Care Provider for members registered with a chronic condition' section above to avoid co-payments	• 100% of cost for Bankmed Network GPs (DSP) • 100% of Scheme Rate for non-DSP • Limited to three consultations pbpa • Subject to available MSA for non-PMBs	• 100% of cost for Bankmed Network GPs (DSP) • 100% of Scheme Rate for non-DSP • Limited to three consultations pbpa • Subject to available MSA/ATB for non-PMBs

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
37.	**SPECIALISTS** NB: Psychiatrists, oncologists, radiologists, pathologists, and other dental practitioners are covered elsewhere in these Benefit Tables						
37.1.	**Specialist consultations and procedures** • In-hospital	• Limited to PMBs • 100% of cost for Bankmed Entry Plan Specialist Network (DSP) • 100% of Scheme Rate for non-DSP	• Unlimited • 100% of cost for Bankmed Entry Plan Specialist Network (DSP) • 100% of Scheme Rate for non-DSP	• Unlimited • 100% of cost for Bankmed Prestige A and B Specialist Network (DSP) • 80% of Scheme Rate for non-DSP	• Unlimited • 100% of cost for Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP		• Unlimited • 100% of cost for Bankmed Prestige A and B Specialist Network (DSP) • 300% of Scheme Rate for non-DSP

37.2.	**Specialist consultations**
	• In-room or out-of-hospital
	• Pre-authorisation required for all Plans, excluding Comprehensive and Plus
	• Make use of our DSP to limit or avoid co-payments
		• Limited to PMBs
		• Benefits subject to referral by GP in Bankmed Entry Plan GP Network and approved BOC registration for PMB conditions
		• 100% of cost for Bankmed Entry Plan Specialist Network (DSP)
		• 80% of cost if no pre-authorisation and no referral from a Bankmed Entry Plan GP Network GP (DSP)
		• 100% of Scheme Rate for non-DSP
		• 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed Entry Plan GP Network GP (DSP)
			• Limited to:
			  • M: 4 860 pbpa
			  • M + 1 +: R7 610 pfpa
			  Combined limit with 'Specialist procedures: In-room or Out-of-hospital' benefit
			• Benefits subject to referral by a Bankmed Entry Plan GP Network GP
			• 100% of cost for Bankmed Entry Plan Specialist Network (DSP)
			• 80% of cost if no pre-authorisation and no referral from a Bankmed Entry Plan GP Network GP (DSP)
			• 100% of Scheme Rate for non-DSP
			• 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed Entry Plan GP Network GP (DSP)
			• Annual limit includes basic radiology, scans, and pathology prescribed by specialist/ appearing on specialist's claim
			• Continued benefits for PMBs, subject to PMB regulations and approval
				• Combined limit for GP and specialist consultations in rooms:
				  • M: R4 620 pbpa
				  • M + 1: R8 365 pfpa
				  • M + 2 +: R9 700 pfpa
				• Benefits subject to referral by a Bankmed GP Network GP
				• 100% of cost at Bankmed Prestige A and B Specialist Network (DSP)
				• 80% of cost if no pre-authorisation and no referral from Bankmed GP Network GP (DSP)
				• 80% of Scheme Rate for non-DSP (including PMBs)
				• 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed Network GP (DSP)
				• Continued benefits for PMBs, subject to PMB regulations and approval
					• Specialist consultations approved for beneficiaries registered for PMB Chronic Disease List (CDL) conditions
					• Benefits subject to approved BOC and referral by a Bankmed Network GP
					• 100% of cost for Bankmed Prestige A and B Specialist Network (DSP)
					• 80% of cost if no pre-authorisation and no referral from a Bankmed Network GP (DSP)
					• 100% of Scheme Rate for non-DSP
					• 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed Network GP (DSP)
					• Non-BOC benefits covered at 100% of Scheme Rate, subject to available MSA
					• Continued benefits for PMBs, subject to PMB regulations and approval
						• 100% of Scheme Rate, subject to available MSA
						• 100% of cost for Bankmed Prestige A and B Specialist Network (DSP)
						• 100% of Scheme Rate for non-DSP
							• 300% of Scheme Rate, subject to available MSA
							• ATB applies once Annual Threshold is reached
							• 100% of cost for Bankmed Prestige A and B Specialist Network (DSP)
							• 300% of Scheme Rate for non-DSP

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		

37.3.	**Specialist procedures**
	• In-room or Out-of-hospital
		• Limited to PMBs
		• 100% of cost at DSP
		• 100% of Scheme Rate for non-DSP
		• DSP: Bankmed Entry Plan Specialist Network
			• Refer to 'Specialist consultations In-room or Out-of-hospital' benefit section	• Unlimited
				• 100% of cost at DSP
				• 80% of Scheme Rate for non-DSP
				• DSP: Bankmed Prestige A and B Specialist Network
					• Limited to PMBs
					• **Bankmed Prestige A and B Specialist Network benefits (DSP):**
					  • 100% of cost
					  • 80% of cost if no pre-authorisation or no referral from Bankmed GP Network GP (DSP)
					  • Non-PMBs subject to available MSA
					• **Non-network GP benefits (non-DSP):**
					  • 100% of Scheme Rate for PMBs
						• Unlimited
						• **Bankmed Prestige A and B Specialist Network benefits (DSP):**
						  • 100% of cost
						• **Non-network GP benefits (non-DSP):**
						  • 100% of Scheme Rate for PMBs
							• Unlimited
							• **Bankmed Prestige A and B Specialist Network benefits (DSP):**
							  • 100% of cost
							• **Non-network GP benefits (non-DSP):**
							  • 300% of Scheme Rate for PMBs

38.	**REGISTERED PRIVATE NURSE PRACTITIONERS**						

38.1.	**Consultations and procedures**	• Limited to PMBs
		• **Procedures:**
		  • 100% of cost at DSP
		  • 100% of Scheme Rate at non-DSP
		  • For procedures not requiring admission to a day surgery or hospital, includes the cost of vaccination and injection material administered by the Healthcare Professional
		• **Consultations:**
		  • 100% of cost at DSP
		  • 100% of Scheme Rate at non-DSP
		  • Three consultations pbpa at 100% of Scheme Rate for PMBs
			• Unlimited
			• **Procedures:**
			  • 100% of Scheme Rate
			• **Consultations:**
			  • Three consultations pbpa at 100% of Scheme Rate
				• Unlimited
				• **Procedures:**
				  • 100% of Scheme Rate
				• **Consultations:**
				  • Three consultations pbpa at 100% of Scheme Rate
				  • Thereafter, 100% of Scheme Rate, subject to out-of-hospital GP/Specialist limit
					• Unlimited
					• **Procedures:**
					  • 100% of Scheme Rate
					• **Consultations:**
					  • Three consultations pbpa at 100% of Scheme Rate from Insured Benefits
					  • Thereafter, subject to available MSA
						• Unlimited
						• **Procedures:**
						  • 100% of Scheme Rate
						• **Consultations:**
						  • Three consultations pbpa at 100% of Scheme Rate from Insured Benefits
						  • Thereafter, subject to available MSA
							• Unlimited
							• **Procedures:**
							  • 100% of Scheme Rate
							• **Consultations:**
							  • Three consultations pbpa at 300% of Scheme Rate from Insured Benefits
							  • Thereafter, subject to available MSA/ATB
							  • ATB applies once the Annual Threshold is reached

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
39.	**OPTOMETRY CONSULTATIONS, SPECTACLES, FRAMES, LENSES AND CONTACT LENSES**						

39.1.	**Optometry consultations**
	Subject to the Optometry Benefit Management Programme and clinical necessity
		• No benefit	• Limited to Iso Leso Optometry Network (DSP)
			• No benefit out of network
			• 100% of cost at DSP
			• Limited to one consultation pb every two years
			• All services and products subject to selected Iso Leso Optometry Network Scheme-approved and contracted services and products
				• 100% of Scheme Rate
				• Benefits limited to:
				  • One eye test, or
				  • One re-examination, or
				  • One composite examination pb every 24 months from previous date of service
					• 100% of Scheme Rate
					• Subject to available MSA
						• 100% of Scheme Rate
						• Benefits limited to:
						  • One eye test, or
						  • One re-examination, or
						  • One composite examination pb every 24 months from previous date of service
							• 100% of Scheme Rate
							• Subject to available MSA
							• Accumulation to the Annual Threshold is limited to 100% of the Scheme Rate for spectacle lenses, contact lenses, eye tests and all other applicable services
							• ATB applies once the Annual Threshold is reached
							• The maximum amount that can jointly accumulate towards reaching the Annual Threshold and/or be paid as an ATB (always subject to available ATB), is R6 255 pbpa

39.2.	**Frames and extras**	• No benefit	• Limited to Iso Leso Optometry Network (DSP) • No benefit out of network • 100% of cost at DSP • Limited to one frame pb every two years • All services and products, including frames, subject to selected Iso Leso Optometry Network Scheme-approved and contracted services and products	• 100% of Scheme Rate • Limited to R1 260 pb every 24 months from previous date of service • One frame pb every 24 months from previous date of service • Extras subject to pre-authorisation and PMB regulations and clinical necessity	• 100% of Scheme Rate • Subject to available MSA • One frame pb every 24 months from previous date of service • Extras subject to pre-authorisation and PMB regulations and clinical necessity		• 100% of Scheme Rate • Subject to available MSA • Frames and extras do not accumulate towards reaching the Annual Threshold and are not covered as an ATB benefit • Extras subject to pre-authorisation and PMB regulations and clinical necessity
39.3.	**Prescription lenses** • Clear, standard/generic, single vision, bifocal or multi-focal lenses	• No benefit	• Limited to Iso Leso Optometry Network (DSP) • No benefit out of network • 100% of cost at DSP • Limited to one pair of prescription lenses pb every two years • All services and products, including frames, subject to selected Iso Leso Optometry Network Scheme-approved and contracted services and products	• Benefits for prescription lenses limited to one pair of lenses pb every 24 months from previous date of service • 100% of the Scheme Rate • Limited to clear, standard/ generic, single vision, bifocal or multi-focal lenses from an Opticlear Network optometrist	• 100% of Scheme Rate • Subject to available MSA	• Benefits for prescription lenses limited to one pair of lenses pb every 24 months from previous date of service • 100% of the Scheme Rate • Limited to clear, standard/ generic, single vision, bifocal or multi-focal lenses from an Opticlear Network optometrist	• 100% of Scheme Rate • Subject to available MSA

SAVE WITH THE OPTICLEAR NETWORK
Access discounted eye tests, spectacles and contact lenses through a network covering 97% of South African optometrists. Find a provider at Opticlear.

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
39.4.	**Readymade readers**	• No benefit		• Limited to two pairs of readymade readers pb every two years • Limited to R130 per pair • 100% of Scheme Rate • Readymade readers via optometrists and pharmacies covered from the OTC benefit, subject to benefit availability	• 100% of Scheme Rate • Subject to available MSA • Readymade readers via optometrists and pharmacies covered from the OTC benefit, subject to available MSA	• Limited to two pairs of readymade readers pb every two years • Limited to R135 per pair • 100% of Scheme Rate • Subject to available MSA • Readymade readers via optometrists and pharmacies covered from the OTC benefit, subject to benefit availability	• Limited to two pairs of readymade readers pb every two years • Limited to R135 per pair • 100% of Scheme Rate • Subject to available MSA • Readymade readers via optometrists and pharmacies covered from the OTC benefit, subject to benefit availability
39.5.	**Contact lenses** **BE A BETTER-INFORMED BANKMED MEMBER** Before your optometry consultation: • **Check your available benefits** with Bankmed and your optometrist. • **Ask about costs not covered by Bankmed** and why any additional services or materials are needed.	• No benefit		• 100% of Scheme Rate • Limited to R1 975 pbpa at an Opticlear Network optometrist • Limited to clear contact lenses • A beneficiary may not claim for spectacles (lenses/frame) AND contact lenses in same benefit year OR contact lenses within 24 months from previous date of service after receiving spectacles (lenses/frame)	• 100% of Scheme Rate • Subject to available MSA • Limited to clear contact lenses • A beneficiary may not claim for spectacles (lenses or frame) AND contact lenses in the same benefit year	• 100% of Scheme Rate • Limited to R2 290 pbpa for an Opticlear Network optometrist, paid from Insured Benefits • Limited to clear contact lenses • A beneficiary may not claim for spectacles (lenses/frame) AND contact lenses in same benefit year OR contact lenses within 24 months from previous date of service after receiving spectacles (lenses/frame)	• Refer to 'Optometry consultation' benefit section
39.6.	**Fitting of contact lenses**	• No benefit		• 100% of Scheme Rate • One contact lens dispensing and/or assessment pb every 12 months	• 100% of Scheme Rate, subject to available MSA	• 100% of Scheme Rate • One contact lens dispensing and/or assessment pb every 12 months	• Refer to 'Optometry consultation' benefit section
39.7.	**Sunglasses**	• No benefit		• No benefit for sunglasses/prescription sunglasses/spectacles with a tint > 35%			
40.	**REFRACTIVE SURGERY AND ASSOCIATED COSTS (INCLUDING HOSPITALISATION)**						
40.1.	**Other optometric services** • Refractive surgery excimer laser treatment, hospitalisation and associated costs	• No benefit, including the cost of hospitalisation, medication and all other associated services		• 100% of Scheme Rate • Limited to R5 265 pfpa, including the cost of hospitalisation, medication and all other associated services	• 100% of Scheme Rate check for plus plan • Subject to available MSA, including the cost of hospitalisation, medication and all other associated services		
41.	**MEDICATION** NB: In the case of qualifying prescribed acute and chronic medication, each prescription or repeat prescription shall be limited to one month's supply pbpm						
41.1.	**Prescribed acute medication** • Refer to 'Contraception' benefit section for additional Insured Benefits	• Limited to PMBs • Subject to Scheme Medication Formulary (medicine list) • 100% of cost for PMBs • Unlimited via Bankmed GP Entry Plan Network GP (DSP)	• Unlimited • Subject to Scheme Medication Formulary (medicine list)	• Limited to: • M: R5 235 pbpa • M + 1: R9 645 pfpa • M + 2 +: R10 470 pfpa • The above limits include a maximum allowance of R2 080 pfpa OTC	• 100% of Scheme Medicine Reference Price • Subject to available MSA	• 100% of Scheme Medicine Reference Price • Subject to available MSA	• 100% of Scheme Medicine Reference Price plus contracted dispensing fee as applicable to Bankmed GP Network or Bankmed Pharmacy Network (DSP) • Subject to available MSA

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		

			• **Medication via DSP**
			  • Bankmed GP Entry Plan Network and Bankmed Pharmacy Network
			  • 100% of cost plus contracted dispensing fee, unlimited
			• **Medication via non-DSP**
			  • Voluntary use of non-DSP
			  • 100% of Scheme Medicine Reference Price
			  • Subject to the 'Out-of-network GP Benefit' limit of R3 000 pfpa
			• **Medication via non-DSP**
			  • Involuntary use of non-DSP
			  • 100% of cost plus contracted dispensing fee, unlimited
			• **Important note:** Medication obtained from a DSP or non-DSP, if prescribed by a non-DSP provider, will accumulate to the 'Out-of-network GP Benefit' limit of R3 000 pfpa
				• **Medication via DSP**
				  • Bankmed GP Network and Bankmed Pharmacy Network
				  • 100% of Scheme Medicine Reference Price plus contracted dispensing fee for generic medication
				  • 80% of Scheme Medicine Reference Price plus contracted dispensing fee for original medication (medication where a generic alternative is available)
				• **Medication via non-DSP**
				  • Voluntary use of non-DSP
				  • 80% of Scheme Medicine Reference Price for generic medication and original medication (medication where a generic alternative is available)
				• **Medication via non-DSP**
				  • Involuntary use of non-DSP
				  • 100% of Scheme Medicine Reference Price plus contracted dispensing fee for generic medication
				  • 80% of Scheme Medicine Reference Price plus contracted dispensing fee for original medication (medication where a generic alternative is available)
					IMPORTANT: PMB CHRONIC CONDITIONS
					Pre-authorisation is required for PMB funding of Chronic Disease List (CDL) conditions. Ask your Healthcare Professional or pharmacist to call 0800 132 345 to register your chronic medication. If no chronic medication is prescribed, send confirmation of your PMB diagnosis to pmb_app_forms@bankmed.co.za.
							• 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 R24 760 for a single member and R37 510 for a family

41.2.	**Self-medication** • Over-the-counter (OTC) medication/pharmacy advised therapy (PAT)	• No benefit		• 100% of Scheme Medicine Reference Price for Bankmed Pharmacy Network (DSP) • 80% of the Scheme Medicine Reference Price for non-DSP • Limited to R2 080 pfpa, and further subject to the annual limit for prescribed acute medication	• 100% of Scheme Medicine Reference Price paid from Insured Benefits for acute medication prescribed and dispensed by a pharmacist (PAT) for a limited number of conditions and events, subject to the Core Saver Formulary (medicine list) for PAT	• 100% of Scheme Medicine Reference Price • Subject to available MSA	• 100% of Scheme Medicine Reference Price • Subject to available MSA • Self-medication/PAT does not accumulate towards the Annual Threshold and is not covered as an ATB benefit

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
					• All other acute and over-the-counter medication subject to available MSA		
41.3.	**Homeopathic medication** • On prescription only. Limited to items with NAPPI codes	• No benefit		• Refer to 'Prescribed acute medication' and 'Chronic medication' benefit sections • No self-medication benefit for homeopathic medication			

41.4.	**Chronic medication**
	• Subject to prior application and approval
		• Limited to PMBs
		• 100% of cost for PMBs at DSP
		• Unlimited via Bankmed Entry Plan GP Network (DSP)
		• Subject to Scheme Medication Formulary (medicine list)
			• **Medication via DSP**
			  • Bankmed GP Entry Plan Network and Bankmed Pharmacy Network
			  • 100% of cost at DSP
			  • Unlimited via DSP
			  • Subject to Scheme Medication Formulary (medicine list)
			• **Medication via non-DSP**
			  • Voluntary use of non-DSP
			  • 80% of Scheme Medicine Reference Price
			  • Subject to 'Out-of-network GP Benefit' limit of R3 000 pfpa
			• **Medication via non-DSP**
			  • Involuntary use of non-DSP
			  • 100% of cost plus contracted dispensing fee
				• **Medication via DSP**
				  • Bankmed GP Network and Bankmed Pharmacy Network
				  • Limited to R27 695 pbpa
				  • 100% of Scheme Medicine Reference Price for DSP
				• **Medication via non-DSP**
				  • Voluntary use of non-DSP
				  • 80% of Scheme Medicine Reference Price
				• **Medication via non-DSP**
				  • Involuntary use of non-DSP
				  • 100% of cost plus contracted dispensing fee
				  • Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations
				• **Primary care GP requirement for members registered for Chronic Illness Benefits**
				• Upon registration for Chronic Illness Benefits, the member must nominate a primary care GP participating in the Bankmed GP Network
				• All applicable benefits, limits, nomination requirements and
					• **Medication via DSP**
					  • Bankmed GP Network and Bankmed Pharmacy Network
					  • Limited to Core Saver Medication Formulary (medicine list) for PMB conditions
					  • 100% of Scheme Medicine Reference Price for DSP
					• **Medication via non-DSP**
					  • Voluntary use of non-DSP
					  • 80% of Scheme Medicine Reference Price
					• **Medication via non-DSP**
					  • Involuntary use of non-DSP
					  • 100% of cost plus contracted dispensing fee
					• **Primary care GP requirement for members registered for Chronic Illness Benefits**
					• Upon registration for Chronic Illness Benefits, the member must nominate a primary care GP participating in the Bankmed GP Network
					• All applicable benefits, limits, nomination requirements and
						• **Medication via DSP**
						  • Bankmed GP Network and Bankmed Pharmacy Network
						  • Limited to R31 260 pbpa (Insured Benefits)
						  • 100% of Scheme Medicine Reference Price for DSP
						• **Medication via non-DSP**
						  • Voluntary use of non-DSP
						  • 80% of Scheme Medicine Reference Price
						• **Medication via non-DSP**
						  • Involuntary use of non-DSP
						  • 100% of cost plus contracted dispensing fee
						  • Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations
							• **Medication via DSP**
							  • Bankmed GP Network and Bankmed Pharmacy Network
							  • Limited to R37 275 pbpa (Insured Benefits)
							  • 100% of Scheme Medicine Reference Price for DSP
							• **Medication via non-DSP**
							  • Voluntary use of non-DSP
							  • 80% of Scheme Medicine Reference Price
							• **Medication via non-DSP**
							  • Involuntary use of non-DSP
							  • 100% of cost plus contracted dispensing fee
							Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations

IMPORTANT: TRADITIONAL AND CORE SAVER PLAN members registered for Chronic Illness Benefits must nominate a primary care GP in the Bankmed GP Network

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		
				changes, and consequences of using a GP other than the nominated primary care GP are specified under General Practitioners (GPs): Primary Care Provider for members registered with a chronic condition elsewhere in this schedule	changes, and consequences of using a GP other than the nominated primary care GP are specified under General Practitioners (GPs): Primary Care Provider for members registered with a chronic condition elsewhere in this schedule		
41.5.	**Biologic and high-cost specialised medication** • Utilised in the management of PMB CDL and non-PMB chronic conditions • **Includes off-label medications** Request for medications not registered for the condition by the Medicines Control Council (MCC) • **Includes Section 21 medication** Medications not registered by the MCC for use in South Africa	• Limited to PMBs • Subject to PMB regulations	• Limited to PMBs • Subject to PMB regulations	• Includes PMBs and non-PMBs • Subject to PMB regulations • Excludes cover available under the 'Oncology Innovation Benefit'	• Includes PMBs and non-PMBs • Subject to PMB regulations	• Includes PMBs and non-PMBs • Subject to PMB regulations • Excludes cover available under the 'Oncology Innovation Benefit'	• Includes PMBs and non-PMBs • Subject to PMB regulations • Excludes cover available under the 'Oncology Innovation Benefit'
	• **PMB algorithm medication**	• 100% of cost	• 100% of cost	• 100% of cost	• 100% of cost	• 100% of cost	• 100% of cost
	• **PMB non-algorithm medication**	• No benefit	• No benefit	• 70% of Scheme Rate	• 70% of Scheme Rate	• 100% of Scheme Rate	• 100% of Scheme Rate
	• **Non-PMB non-algorithm medication**	• No benefit	• No benefit	• 70% of Scheme Rate	• No benefit	• 100% of Scheme Rate	• 100% of Scheme Rate
42.	**WORLD HEALTH ORGANISATION (WHO) RECOGNISED DISEASE OUTBREAKS** Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks						
42.1.	**Out-of-hospital healthcare services related to COVID-19:**	**Benefits**					

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

Terminology Reminders:

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

Benefits and contributions are subject to Council for Medical Schemes (CMS) approval.

		ESSENTIAL PLAN 2027	BASIC PLAN 2027	TRADITIONAL PLAN 2027	CORE SAVER PLAN 2027	COMPREHENSIVE PLAN 2027	PLUS PLAN 2027
		NON-MSA PLANS			MSA PLANS		

43. PLAN SPECIFIC INFORMATION

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

- Applicable to the medication on the Core Saver Plan only
- Acute medication covered at 100% of cost from Insured Benefits subject to the Core Saver Pharmacy Advised Therapy (PAT) Medication Formulary (medicine list) for the following conditions and up to the specified number of incidents pbpa, on pharmacist's recommendation (PAT) only
- Visit www.bankmed.co.za, select '2027 Plan Information' and then 'Medicine Formularies 2027' to view the Core Saver Pharmacy Advised Therapy (PAT) Medication Formulary (medicine list)
- Non-formulary medication and other acute medication subject to available MSA

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

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

Important: This table summarises your benefits and should be read together with the Scheme Rules, which contain additional detail. While every effort has been made to ensure accuracy, the Scheme Rules prevail in the event of any error, omission or inconsistency.

Terminology Reminders:

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

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