Benefit tables

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
	Does this Plan have a Medical Savings Account (MSA)?	No	No	No	Yes	Yes	Yes
	Percentage of Gross Contribution allocated to Medical Savings Account	N/A	N/A	N/A	14.7%*	17.6%*	23.4%*
					* The percentage of Gross Contribution allocated to the Medical Savings Account is not fixed per Plan. The percentage varies by dependant type, income band, rounding of values and manner in which contribution increases have been calculated. The percentage published in this Benefit and Contribution Schedule is, therefore, an aggregated value.		
1	**OVERALL ANNUAL LIMIT**						
		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
2	**CLAIMS FOR SERVICES RENDERED OUTSIDE THE BORDERS OF SOUTH AFRICA (FOREIGN CLAIMS)** **It is recommended that you consider taking out comprehensive travel insurance prior to travelling abroad, as not all foreign claims will be covered (or covered in full)**						
2.1		Cover available for PMB conditions and life-threatening emergencies only No benefits for emergency/ ambulance transport outside the borders of South Africa No benefits for services not normally covered at the Scheme's preferred provider network (Bankmed GP Entry Plan Network) for out-of- hospital consultations, medication and treatment (except via Bankmed GP Entry Plan Network providers in Lesotho) Medical motivation and prior approval required for non-emergency surgery outside the borders of South Africa	Foreign claims covered at the relevant Scheme Rate and/or Rand limit subject to benefits available on your selected Plan No benefits for emergency/ ambulance transport outside the borders of South Africa No benefits for services not normally covered at the Scheme's preferred provider network (Bankmed GP Entry Plan Network) for out-of-hospital consultations, medication and treatment (except via Bankmed GP Entry Plan Network providers in Lesotho) Medical motivation and prior approval required for non-emergency surgery outside the borders of South Africa	Foreign claims covered at the relevant Scheme Rate and/or Rand limit subject to benefits available on your selected Plan No benefits for emergency/ ambulance transport outside the borders of South Africa Medical motivation and prior approval required for non-emergency surgery outside the borders of South Africa			

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3	**WELLNESS AND PREVENTATIVE CARE BENEFITS (INSURED BENEFITS)** **Wellness and Preventative Care Benefits are provided as additional Insured Benefits, which do not contribute towards the depletion of any other insured limits (or Medical Savings Account) specified elsewhere in these Benefit Tables. The cost of associated consultations is not included in the Wellness and Preventative Care Benefits**						
3.1	**Flu Vaccine**	100% of the Scheme Medicine Reference Price, limited to one vaccine pbpa					
3.2	**Human Papilloma Virus** (HPV) Vaccine	100% of the Scheme Medicine Reference Price, limited to a total course of three doses (depending on product and age) per male and female beneficiary, aged nine to 16 years					
3.3	**Childhood Vaccines** BCG, oral polio, rotavirus, diphtheria, tetanus, acellular pertussis, inactivated polio and haemophilus influenza type B, hepatitis B, measles, pneumococcal vaccine	100% of the Scheme Medicine Reference Price, for immunisations administered in accordance with the Department of Health's Expanded Programme on Immunisation (EPI) guidelines for children up to 12 years					
3.4	**Pneumococcal Vaccine**	100% of the 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, who have been diagnosed with asthma, chronic obstructive pulmonary disease, diabetes, cardiovascular disease or HIV/AIDS					
3.5	**Herpes Zoster Virus vaccine** Reduces the rate of herpes zoster (shingles)	100% of Scheme Medicine Reference Price as follows: • One vaccination every five years for adults 60 years and older					
3.6	**Mammogram**	100% of cost at a DSP, limited to one pbpa age 40 years and older (benefits for beneficiaries younger than 40 years subject to motivation and prior approval) 100% of Scheme Rate at a non-DSP					
3.7	**Breast MRI** Only for Breast cancer high risk beneficiaries	100% of cost at a DSP, and one pbpa. For high risk beneficiaries only. Subject to clinical entry criteria and pre-authorisation Breast Cancer Risk Calculator available by logging in to the website and clicking on MANAGE YOUR PLAN > Breast Cancer Risk Assessment 100% of Scheme Rate at a non-DSP					
3.8	**Bone Densitometry**	100% of cost at a DSP, limited to one pbpa age 50 years and older (benefits for beneficiaries younger than 50 years subject to motivation and prior approval) Should member not meet clinical entry criteria, and they are younger than age 50, the member may claim the bone densitometry test from their Radiology Benefit Where the Radiology Benefit is exhausted, this test may be claimed from available Medical Savings Account, if applicable to their Plan type 100% of Scheme Rate at a non-DSP					
3.9	**Prostate-specific Antigen**	100% of cost at a DSP, limited to one pbpa age 50 years and older (benefits for beneficiaries younger than 50 years subject to motivation and prior approval) 100% of Scheme Rate at a non-DSP					
3.10	**Faecal Occult Blood Test**	100% of cost at a DSP, limited to one pbpa age 50 years and older (benefits for beneficiaries younger than 50 years subject to motivation and prior approval) 100% of Scheme Rate at a non-DSP					

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3.11	**Tuberculosis (TB) Screening**	100% of cost at a DSP, limited to one chest X-ray pbpa For TB screening requested by registered private nurse practitioners providing on-site services at Employer Groups All other TB screenings subject to out-of-hospital radiology and/or pathology benefits as indicated elsewhere in these Benefit Tables 100% of Scheme Rate at a non-DSP					
3.12	**Bankmed Mental Health Assessment**	Log in to the website and then click on MANAGE YOUR PLAN > Mental Wellbeing Assessments to complete your free online Bankmed Mental Health Assessment. There is no limit on the number of assessments per beneficiary per annum					
3.13	**Cholesterol Screening, Blood Sugar Screening and Blood Pressure Measurements**	100% of cost at a DSP, limited to R340 pbpa at clinics, pharmacies or Bankmed GP Entry Plan Network GPs' consulting rooms (DSP) 100% of Scheme Rate at a non-DSP		100% of cost at a DSP, limited to R340 pbpa at clinics, pharmacies or Bankmed Network GPs' consulting rooms (DSPs) 100% of Scheme Rate at a non-DSP			
3.14	**HIV Counselling and Testing (HCT)**	Unlimited, covered at 100% of cost for HCT DSPs namely Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering onsite services at Employer Groups, subject to PMB regulations 100% of Scheme Rate at a non-DSP		100% of cost, unlimited, for DSPs: Bankmed Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering on-site services at Employer Groups 100% of Scheme Rate at a non-DSP			
3.15	**Pap Smear**	100% of cost at a DSP, limited to one pbpa One associated nurse, Bankmed GP Entry Plan Network GP or Bankmed Entry Plan Specialist Network consultation pb covered as an additional Insured Benefit limited to R535 pbpa 100% of Scheme Rate at a non-DSP		100% of cost at a DSP, limited to one pbpa One associated nurse, Bankmed network GP or Bankmed Prestige A and B Specialist Network consultation pb covered as an additional Insured Benefit limited to R535 pbpa 100% of Scheme Rate at a non-DSP			
3.16	**Personal Health Assessment (PHA)** Applies to members and beneficiaries aged 18 years and older only	100% of cost, limited to one assessment pbpa, subject to use of DSP only Benefit limited to Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted providers rendering on-site services at Employer Groups		100% of cost, limited to one assessment pbpa, subject to use of DSP only Benefit limited to Bankmed Network GPs, Bankmed Pharmacy Network and contracted providers rendering on-site services at Employer Groups			
3.17	**Personal Health Assessment (PHA) Basket** Additional consultations for Dietician and Biokineticist subject to clinical entry criteria	100% of cost at a DSP only. Limited to two Dietician visits per year plus two Biokineticist visits per year Limited to medium and high risk members only. Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA. Clinical Entry Criteria applies First visit to dietician and biokineticist to take place within 6 weeks of the PHA and second visit within 12 months of the PHA, otherwise funded from day-to-day benefits Applies to members and beneficiaries aged 18 years and older only 100% of Scheme Rate at a non-DSP					

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3.18	**Contraception: Oral Contraceptives, Devices and Injectables**	No benefit	100% of Scheme Medicine Reference Price, limited to R2 130 per female beneficiary per annum Oral contraceptives limited to one prescription or repeat prescription pb per month				
3.19	**Antenatal Screening** T21 Chromosome Test or Non-invasive Prenatal Testing (NIPT) to test for chromosomal abnormalities. Clinical entry criteria apply. South African testing only. Applies to high risk beneficiaries only, who are aged 35 years and older at time of delivery	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to one test pb per pregnancy Test to be conducted at 10 – 12 weeks of pregnancy If member does not meet clinical entry criteria, the screening test is not covered by the Scheme					
3.20	**New-born Screening** To test for the presence of certain metabolic and endocrine disorders	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to one test pb per pregnancy – Test to be carried out within 72 hours of birth South African testing only					
3.21	**New-born Hearing Test**	100% of cost at a DSP, limited to one test per beneficiary and must be carried out within eight weeks of birth 100% of Scheme Rate at a non-DSP Only the hearing test is covered by the Wellness and Preventative Care Benefit with a registered Audiologist If consultation charged, the cost of the consultation will be for the member's own pocket	100% of cost at a DSP, limited to one test per beneficiary and must be carried out within eight weeks of birth 100% of Scheme Rate at a non-DSP Only the hearing test is covered by the Wellness and Preventative Care Benefit with a registered Audiologist If consultation charged, consultation fee to be funded from consultation benefits				

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3.22	**Diabetes Management** For members registered on the Scheme's Disease Management Programme Basket of Care set by the Scheme, subject to PMB regulations	Unlimited and 100% of cost for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP and member utilises the Scheme's DSP as their service provider 100% of Scheme Rate if non-DSP used	Unlimited and 100% of cost for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP and member utilises the Scheme's DSP as their service provider 100% of Scheme Rate if non-DSP used. Out-of-network GP benefit limit applies if the doctor is not the member's nominated GP	Unlimited and 100% of cost for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP and member utilises the Scheme's DSP as their service provider 100% of Scheme Rate if non-DSP used			
4	**HIV/AIDS PROGRAMME** **Additional benefits subject to registration on the Scheme's HIV/AIDS Programme. These additional benefits do not contribute to the depletion of other Insured Benefits provided by the Scheme. Beneficiaries who do not register on the HIV/AIDS Programme will be entitled to all other benefits as specified in these Benefit Tables, with continued funding for PMBs, subject to PMB regulations, after depletion of the relevant sub-limits**						
4.1	**Consultations and Pathology**	Subject to benefits available in Scheme's Basket of Care 100% of cost at a DSP 100% of Scheme Rate at a non-DSP					
4.2	**Medication via Bankmed Pharmacy Network (DSP)**	Unlimited 100% of cost via Bankmed Pharmacy Network (DSP), as communicated to registered beneficiaries from time to time A motivation is required for the use of a non-DSP for medication. Subject to Scheme's approved formulary Scheme Medicine Reference Price applies to non-formulary medication					
4.3	**Medication via non-DSP: Voluntary use of a non-DSP**	Unlimited 80% of Scheme Medicine Reference Price A motivation is required for the use of a non-DSP for medication. Subject to Scheme's approved formulary Scheme Medicine Reference Price applies to non-formulary medication					
4.4	**Medication via non-DSP: Involuntary use of a non-DSP**	Unlimited 100% of cost, unlimited A motivation is required for the use of a non-DSP for medication. Subject to Scheme's approved formulary Scheme Medicine Reference Price applies to non-formulary medication					

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5	**24-HOUR MEDICAL ADVICE LINE (CALL 0860 999 911)** **Free service to Bankmed members**						
5.1	Call 0860 999 911 for 24-hour medical advice from a registered nurse						
6	**AMBULANCE SERVICES (CALL 0860 999 911 FOR PRE-AUTHORISATION)** **Subject to pre-authorisation and PMB regulations**						
6.1	**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** 100% of cost via the Scheme's DSP and 100% of Scheme Rate via a non-DSP. Unlimited. No benefit outside the borders of South Africa Call 0860 999 911 – 24 hours a day, seven days a week for pre-authorisation and you will be connected with highly qualified Bankmed Emergency Services personnel						
7	**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, 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 the member to ensure that the Hospital and Healthcare Professionals are Designated Service Providers and within the Network to avoid co-payments • Benefits available for your Plan, as well as annual limits for individual benefit categories, are set out in these Benefit Tables. The benefits under "hospitalisation" refer only to the hospital account • Any Healthcare Professionals attending to you during your hospital stay must submit a valid account for payment. The payment will be subject to the benefits, limits and/or any special conditions set out in these Benefit Tables under the relevant benefit categories • The onus is on the member to ensure that the Healthcare Professional has submitted the account for payment • Please take care to determine the limits for your Plan (if any) and at what rate the Scheme will cover your claims • Always 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 a doctor's rooms as an alternative to hospitalisation					
7.1	**Hospital Network (DSP)**	Bankmed Hospital Network DSPs for the Essential Plan	Bankmed Hospital Network DSPs for the Basic Plan	Bankmed Hospital Network DSPs for the Traditional Plan	All contracted Netcare, National Hospital Network (NHN), Life Healthcare, Mediclinic and Clinix hospitals, any other independent private hospitals contracted to the Scheme		

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
7.2	**Hospitalisation**	Limited to PMBs • 100% of cost at network DSPs • 80% of Scheme Rate for voluntary use of non-DSPs • 100% of cost for involuntary use of non-DSPs • No benefit for non-PMB admissions Benefits limited to general ward rate No benefit for dental surgery and auxiliary services, except for PMBs Benefits only available on referral from a Bankmed GP Entry Plan Network GP or referred specialist subject to PMB regulations	Benefits for PMBs and non-PMBs • 100% of cost at contracted rate in-hospital network DSPs • 80% of Scheme Rate for voluntary use of non-DSPs • 100% of cost for involuntary use of non-DSPs Benefits limited to general ward rate No benefit for dental surgery and auxiliary services, except for PMBs Benefits only available on referral from a Bankmed GP Entry Plan Network GP or referred specialist subject to PMB regulations.	Benefit unlimited • 100% of cost in contracted private hospitals (DSPs) • 100% of cost in non-contracted private hospitals for a PMB admission (involuntary use of a non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a PMB admission (voluntary use of non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a non-PMB admission Benefits limited to general ward rate No benefit for dental surgery and auxiliary services, except for PMBs	Benefit unlimited • 100% of cost in contracted private hospitals (DSPs) • 100% of cost in non-contracted private hospitals for a PMB admission (involuntary use of a non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a PMB admission (voluntary use of non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a non-PMB admission Benefits limited to general ward rate		Benefit unlimited • 100% of cost in contracted private hospitals (DSPs) • 100% of cost in non-contracted private hospitals for a PMB admission (involuntary use of a non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a PMB admission (voluntary use of non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a non-PMB admission Benefits limited to general and private ward rates

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	NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		

7.3 Deductibles

A beneficiary will be responsible for a deductible in respect of the hospital account for certain hospital events, unless the admission is related to a Prescribed Minimum Benefit diagnosis, typically as a result of an emergency. The deductible will apply regardless of whether the procedure attracting the deductible was the primary reason for the admission or not. Member to pay hospital or day clinic directly upon admission. Deductibles are payable for all specified hospital admissions, except under the following circumstances:

1. Prescribed Minimum Benefit conditions where admission to a non-DSP is on an involuntary basis. In the case of other PMB conditions, where a DSP has been used on a voluntary basis, the deductible will be applied
2. Confinements are excluded from deductibles
3. Re-admissions to hospital within six weeks of discharge following complications directly related to a prior admission in respect of which a deductible was levied
4. Admissions to a State Hospital
5. Authorised day clinic admissions for specified procedures, as communicated to members from time to time

Detailed deductible information is set out on pages 21 – 22 of this 2022 Benefit and Contribution Schedule

7.3.1 Deductible applicable to a use of a non-DSP Facility

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

PMB admission: Involuntary use of non-DSP	No deductible payable for PMBs	No deductible	No deductible	No deductible
PMB admission: Voluntary use of non-DSP Applies to all admissions		Day clinic: R275 deductible Hospital: R690 deductible	Day clinic: R275 deductible Hospital: R5 720 deductible	Day clinic: R275 deductible Hospital: R1 805 deductible
Non-PMB admission Applies to all admissions		Day clinic: R275 deductible Hospital: R690 deductible	Day clinic: R275 deductible Hospital: R5 720 deductible	Day clinic: R275 deductible Hospital: R690 deductible

7.3.2 Deductible applicable to a specific list of treatment/procedures carried out in a Day Surgery Network

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

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

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

Important note for Essential Plan members: No access to full list of treatments/procedures listed above. Cover is limited to PMBs. If underlying diagnosis is a PMB, member qualifies for treatment

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	PMB admission: Involuntary use of a non-DSP	No deductible	No deductible				
	PMB admission: Voluntary use of non-DSP Applies to all admissions	Non-DSP: R1 805 deductible	Non-DSP: R1 805 deductible				
	Non-PMB admission Applies to all admissions	No benefit	Non-PMB: R1 805 deductible				
7.3.3	**Deductible applicable to Dental Admissions to Private Hospitals and Day Clinics** A deductible will apply to all beneficiaries on the below Plans when the beneficiary is admitted to hospital or a day clinic for dental treatment. The deductible applies upfront and will need to be settled at the facility prior to admission						
	Applies to both DSP and non-DSP Facilities	No benefit for in-hospital dental treatment, except PMBs		Day clinic: R275 deductible Hospital: R2 040 deductible	No benefit for in-hospital dental treatment, except PMBs	Day clinic: R275 deductible Hospital: R2 040 deductible	
7.3.4	**Deductible applicable to a specific list of treatment/procedures performed in Hospital Network DSPs** A deductible will apply to all beneficiaries on the below Plans when the beneficiary obtains treatment for the specified treatment/procedures set out below. The deductible applies when the beneficiary is admitted to hospital or a day clinic that falls within the list of DSP/network providers. The deductible applies upfront and will need to be settled at the facility prior to admission						
	The following procedures will always attract a deductible at a hospital/day clinic at a DSP facility: 1. Oesophagoscopy 2. Simple abdominal hernia repair *Applies to all admissions*	No deductible payable for PMBs	Day clinic: R275 deductible Hospital: R690 deductible				
7.4	**To-take-out drugs supplied by the hospital when a patient is discharged** 100% of cost, limited to PMBs and a maximum of seven days' supply per admission Must be charged on the hospital account where a hospital event has taken place. Not payable if obtained via a pharmacy after discharge If procedure took place in a day clinic, a maximum of a seven day supply will be funded from Insured Benefits if obtained from a retail pharmacy on the date of discharge only						
8	**OUTPATIENT CONSULTATIONS AND FACILITY FEES FOR OUTPATIENT VISITS**						
8.1	**Outpatient consultations with GPs and Specialists at hospital emergency rooms and outpatient units** Regarded as an out-of-hospital GP/specialist consultation in rooms, unless resulting in an authorised hospital admission See "GPs: Consultations in rooms'' and "Specialists: Consultations in rooms'', set out under 32.4 and 33.2						

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8.2	**Facility fees for outpatient visits to hospital emergency rooms**	Facility fees for outpatient visits not covered, unless resulting in an authorised hospital admission	Facility fees for outpatient visits subject to out-of-hospital Specialist Consultation in Rooms Limit, unless resulting in an authorised hospital admission				
9	**GP CONSULTATION WITHIN 30 DAYS OF DISCHARGE FROM HOSPITAL**						
9.1	**Post-hospital GP consultation within 30 days of discharge from hospital**	Additional Insured Benefits. See "General Practitioners (GPs): Post-hospital GP consultation within 30 days of Discharge from Hospital (excluding day cases) as set out in Section 32.3 of the Benefit Table					
10	**BLOOD TRANSFUSIONS** **Subject to pre-authorisation and PMB regulations**						
10.1	**Blood Transfusions**	100% of cost, limited to PMBs	100% of cost, unlimited				
11	**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**						
11.1	**Hospitalisation/Organ and patient preparation**	Benefits for hospitalisation as specified in Section 7 of the Benefit Tables, limited to PMBs		Benefits for hospitalisation as specified in Section 7 of the Benefit Tables	Benefits for hospitalisation as specified in Section 7 of the Benefit Tables, limited to PMBs	Benefits for hospitalisation as specified in Section 7 of the Benefit Tables	
11.2	**Medication** In- and out-of-hospital	Limited to PMBs		Unlimited	Limited to PMBs	Unlimited	
	• **Medication via designated pharmacy (DSP)**	• 100% of cost, limited to PMBs		• 100% of cost	• 100% of cost, limited to PMBs	• 100% of cost	
	• **Medication via 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	• 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	• 100% of cost, limited to PMBs	• 100% of cost	
11.3	**Harvesting and transporting of 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	

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12	**ONCOLOGY** **Subject to pre-authorisation and PMB regulations**						
12.1	**In- and out-of-hospital consultations, treatment and materials**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs		100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited	
12.2	**Radiotherapy fees, chemotherapy facility and professional fees**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs		100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited	
12.3	**Medication** In- and out-of-hospital	Limited to PMBs		Unlimited	Limited to PMBs	Unlimited	
	• **Medication via designated pharmacy (DSP)**	• 100% of cost, limited to PMBs		• 100% of cost	• 100% of cost, limited to PMBs	• 100% of cost	
	• **Medication via 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	• 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	• 100% of cost, limited to PMBs	• 100% of cost	
13	**RENAL DIALYSIS** **Subject to pre-authorisation and PMB regulations**						
13.1	**Procedures and treatment**	Limited to PMBs, 100% of cost at a DSP or 100% of Scheme Rate at non-DSP		100% of cost at a DSP or 100% of Scheme Rate at non-DSP, unlimited			
13.2	**Medication** In- and out-of-hospital	Limited to PMBs		Unlimited			
	• **Medication via designated pharmacy (DSP)**	• 100% of cost, limited to PMBs		• 100% of cost			
	• **Medication via 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			

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	• **Medication via non-DSP** Involuntary use of non-DSP	• 100% of cost, limited to PMBs		• 100% of cost			
14	**PREGNANCY AND CHILDBIRTH** **Subject to pre-authorisation and PMB regulations**						
14.1	**Baby-and-Me Programme for expectant mothers**	No benefit		Call 0800 BANKMED (0800 226 5633) to register			
14.2	**Hospitalisation and associated in-hospital services** Subject to pre-authorisation	Benefits as specified under Hospitalisation – see section 7, limited to PMBs and hospital network rules apply	Benefits as specified under Hospitalisation – see section 7 Hospital network rules apply				
14.3	**Midwife care and delivery** Subject to pre-authorisation	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs		100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited			
14.4	**Birthing facilities as an alternative to hospitalisation** Subject to pre-authorisation Only available where hospital services are not used (except for registered active birthing units)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs Cost of disposables limited to R1 225 per case		100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited Cost of disposables limited to R1 225 per case			
14.5	**Antenatal and postnatal care: GP and Specialist consultations and procedures in rooms**	Benefits for GPs and specialists as specified under section 32 and 33. Limited to PMBs	Benefits for GPs and specialists as specified under section 32 and 33	Benefits for GPs and specialists as specified under section 32 and 33 Additional Insured Benefits - see 14.8			Benefits for GPs and specialists as specified under section 32 and 33
14.6	**Antenatal and postnatal care: Ultrasonic investigations Radiology**	Benefits for radiology as specified under section 15 Limited to PMBs	Ultrasonic investigations limited to: • One first trimester 2D scan (per pregnancy) at contracted rate via Bankmed GP Entry Plan Network GP	Benefits for radiology as specified under section 15 Additional Insured Benefits – see 14.8			Benefits for radiology as specified under section 15

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	Antenatal and postnatal care: Ultrasonic investigations Radiology (continued)		• One second trimester 2D scan (per pregnancy) at contracted rate via a Bankmed Entry Plan Specialist Network (DSP) gynaecologist/obstetrician • Scans as per the above are covered at 100% of cost • All other/additional radiology benefits as specified under section 15				
14.7	**Antenatal and postnatal care: Pathology**	Benefits for pathology as specified under section 15 Limited to PMBs	Benefits for pathology as specified under section 15	Benefits for pathology as specified under section 15 Additional Insured Benefits - see 14.8			Benefits for pathology as specified under section 15
14.8	**Additional Insured Benefits subject to registration on the Baby-and-Me Programme**	No benefit		Additional Insured Benefits at, or subject to referral by, a Bankmed Network GP: • Six antenatal consultations per pregnancy, at the applicable rate/s for GP and specialist consultations in rooms as specified elsewhere in these Benefit Tables • Three 2D ultrasounds at 100% of Scheme Rate • R1 500 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 basket of care			Additional Insured Benefits not applicable on this Plan, however, members may benefit from valuable information, guidance and support throughout the pregnancy by registering on the Baby-and-Me Programme
15	**RADIOLOGY AND PATHOLOGY**						
15.1	**Radiology** In-hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited				
15.2	**Pathology** In-hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited				

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15.3	**MRI/CT scans, Radionuclide scans in- and out-of-hospital** Subject to pre-authorisation and PMB regulations						
	In-Hospital	100% of cost for radiology facilities at hospital network DSPs Limited to 100% of Scheme Rate for voluntary use of radiology facilities at non-DSPs Limited to PMBs Subject to pre-authorisation in-hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited Subject to pre-authorisation in-hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited Subject to pre-authorisation in-hospital			
	Out-of-hospital		100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs via radiology facilities at Hospital Network DSPs Subject to pre-authorisation out-of-hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited Subject to pre-authorisation out-of-hospital			
15.4	**Radiology and Pathology** Out-of-hospital	Limited to PMBs • Benefits subject to a CDL (baskets of care) registration for PMB conditions • 100% of cost for PMBs	• 100% of cost, unlimited via Bankmed GP Entry Plan Network and subject to Scheme-approved medicine list (formulary) • For radiology/pathology requested or carried out via a specialist, the benefit will be subject to the out-of- hospital "Specialists:	• 100% of Scheme Rate, limited to R6 390 pfpa • Combined limit for Radiology and Pathology out-of-hospital	Benefits approved for beneficiaries registered for PMB Chronic Disease List (CDL) conditions: • 100% of Scheme Rate, subject to a CDL (baskets of care) and referral by a Bankmed Network GP (DSP)	**Radiology:** • 100 % of Scheme Rate, limited to R4 280 pfpa (including a sub-limit of R1 425 pfpa for out-of- hospital pathology); thereafter subject to available Medical Savings Account	• 300% of Scheme Rate, subject to available Medical Savings Account • ATB applies once Annual Threshold is reached

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	Radiology and Pathology Out-of-hospital (continued)		Consultations/Procedures in rooms" limit, specified elsewhere in these Benefit Tables, except for one 2D scan in the second trimester via a Bankmed Entry Plan Specialist Network (DSP) gynaecologist/obstetrician, as specified in 33.2 and 33.3		• Non-CDL (baskets of care) benefits subject to available Medical Savings Account, except for PMBs (subject to PMB regulations)	**Pathology:** • 100% of Scheme Rate, limited to R1 425 pfpa (included in the annual limit of R4 280 pfpa for out-of-hospital radiology); thereafter subject to available Medical Savings Account	• 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 R6 805 pfpa
16	**ALTERNATIVES TO HOSPITALISATION** **Subject to pre-authorisation and PMB regulations**						
16.1	**Step-down Facilities**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited				
16.2	**Hospice** Ward fees and disposables	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited	See Compassionate Care Benefit as specified in 16.3			
16.3	**Compassionate Care Benefit: End-of-life care for non-oncology patients** In-patient care and homecare visits	No benefit See Hospice Benefit as specified in 16.2		100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited for PMB scope and level of treatment. Limited to R64 760 pb per lifetime for all claims Subject to pre-authorisation and PMB regulations and meeting the Scheme's guidelines			
16.4	**Advanced Illness Benefit: Defined list of out-of-hospital benefits for patients with advanced oncology conditions only** End-of-life treatment	No benefit See Hospice Benefit as specified in 16.2		100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited Subject to pre-authorisation and PMB regulations and the treatment meeting the Scheme's guidelines and managed care criteria			
16.5	**Frail Care Facilities**	No benefit		100% of cost, limited to R490 pb per day	No benefit	100% of cost, limited to R490 pb per day	

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16.6	**Home Nursing**	No benefit		100% of cost, limited to R385 pb per day	No benefit	100% of cost, limited to R385 pb per day	
16.7	**HomeCare Services** For procedures not requiring admission to a day clinic or hospital. Subject to Scheme Clinical Entry Criteria. Subject to pre-authorisation and PMB regulations.	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited				
16.8	**Spinal Conservative Care Programme** In-hospital and out-of-hospital management for spinal care and surgery. Limited to a defined list of clinically appropriate procedures which include Lumbar Fusion, Cervical Fusion, Laminectomy, Laminotomy.	100% of cost for the hospital account at a network facility Network does not apply to any admissions related to trauma 100% of the Scheme Rate for the hospital account if performed at a non-network facility 100% of cost for related accounts at a DSP 100% of Scheme Rate for related accounts at a non-DSP Limited to PMBs Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria Subject to PMB regulations Unlimited at a network provider for in-hospital treatment Basket of care as set by the Scheme for out-of-hospital conservative treatment		100% of cost for the hospital account at a network facility. Network does not apply to any admissions related to trauma 100% of the Scheme Rate for the hospital account if performed at a non-network facility 100% of cost for related accounts at a DSP 100% of Scheme Rate for related accounts at a non-DSP Unlimited Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria Subject to PMB regulations Unlimited at a network provider for in-hospital treatment Basket of care as set by the Scheme for out-of-hospital conservative treatment			
17	**INTERNAL PROSTHESIS** **Subject to clinical motivation, the application of clinical and funding protocols and Scheme approval. Bankmed reserves the right to obtain further quotations prior to granting approval.** **The prostheses accumulate to the limit. The balance of the hospital and related accounts do not accumulate to the annual limit. All sub-limits are further subject to the combined Internal Prosthesis limit of R77 480 pbpa, applicable to all internal prosthesis items, (excluding pacemakers and defibrillators) on the specified Plans. Dental implants are not regarded as internal prosthesis, for the purpose of the Rules. See "Dentistry and orthodontics: Advanced dentistry" for available implant benefits/limits for your Plan**						
17.1	**Internal Prosthesis**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP As per Internal Prosthesis List, subject to a combined limit of R77 480 pbpa for all internal prosthesis items				

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	Internal Prosthesis sub-limits:						
17.2	**Spinal Fusions**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of Scheme Rate of device, limited to R52 200 pbpa Subject to the combined Internal Prosthesis limit				
17.3	**Cardiac Stents**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of Scheme Rate of device, limited to R77 175 pbpa Subject to the combined Internal Prosthesis limit				
17.4	**Grafts**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of Scheme Rate of device, limited to R41 780 pbpa Subject to the combined Internal Prosthesis limit				
17.5	**Cardiac Valves**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of Scheme Rate of device, limited to R43 940 pbpa Subject to the combined Internal Prosthesis limit				
17.6	**Hip, Knee and Shoulder Joints**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of Scheme Rate for device, limited to R51 565 per prosthesis per admission if prosthesis is not supplied by the Scheme's network provider If supplied by the Scheme's network provider, unlimited and not subject to combined limit for all internal prosthesis items				
17.7	**Non-specified Items**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of Scheme Rate of device, limited to R24 075 pbpa Subject to the combined Internal Prosthesis limit				

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18	**PACEMAKERS AND DEFIBRILLATORS** **Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval. Bankmed reserves the right to obtain further quotations prior to granting approval**						
18.1	**Pacemakers and Defibrillators**	Limited to PMBs • 100% of cost at hospital network DSPs • 80% of cost at non-DSPs		• 100% of cost, unlimited, if preferred provider used • 100% of Scheme Rate if non-preferred provider used to purchase device			
19	**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 the Scheme Rate for the lens Scheme Rate is equal to the lens base price / lens reference price, plus an allowable 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**						
19.1	**Intraocular Lenses for Cataract Surgery** Permanent, implantable lenses, inclusive of basic and specialised lens varieties	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		• 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			
20	**COCHLEAR IMPLANTS** **Subject to pre-authorisation and PMB regulations and Scheme protocols. Once in a lifetime benefit. Funding only available in recognised Centres of Excellence. Visit www.bankmed.co.za; select "Network Providers" and then "Centres for Cochlear Implants 2022" for a comprehensive list**						
20.1	**Hospitalisation**	No benefit		Benefits as for hospitalisation	No benefit		Benefits as for hospitalisation
20.2	**Pre-operative Evaluation and Associated Preparation Costs**	No benefit		R18 355 pb per lifetime 100% of Scheme Rate	No benefit		R18 355 pb per lifetime 100% of Scheme Rate
20.3	**Cochlear Implant Device**	No benefit		R384 885 pb per lifetime 100% of Scheme Rate	No benefit		R384 885 pb per lifetime 100% of Scheme Rate
20.4	**Intra-operative Audiology Testing**	No benefit		R960 pb per lifetime 100% of Scheme Rate	No benefit		R960 pb per lifetime 100% of Scheme Rate
20.5	**Post-operative Evaluation Costs**	No benefit		R38 550 pb per lifetime 100% of Scheme Rate	No benefit		R38 550 pb per lifetime 100% of Scheme Rate

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21	**SPEECH PROCESSORS** **Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval**						
21.1	**Upgrade or Replacement of Speech Processors**	No benefit		80% of Scheme Rate, limited to R143 710 pb over a five-year cycle	No benefit	80% of Scheme Rate, limited to R143 710 pb over a five-year cycle	
22	**HEARING AIDS**						
22.1	**Hearing Aids** Supply and fitment	No benefit, except for PMBs		100% of Scheme Rate, limited to R30 870 per beneficiary every second year (rolling 24 months)	100% of Scheme Rate, subject to available Medical Savings Account	100% of Scheme Rate, limited to R30 870 per beneficiary every second year (rolling 24 months)	100% of Scheme Rate, limited to R36 145 per beneficiary every second year (rolling 24 months)
22.2	**Hearing Aid Repairs**	No benefit		100% of Scheme Rate, limited to R1 600 pbpa	100% of Scheme Rate, subject to available Medical Savings Account	100% of Scheme Rate, limited to R1 600 pbpa	
22.3	**Bone Anchored Hearing Aids**	No benefit		90% of Scheme Rate, limited to R165 125 pfpa	100% of Scheme Rate, subject to available Medical Savings Account	90% of Scheme Rate, limited to R165 125 pfpa	
23	**EXTERNAL PROSTHESIS, MEDICAL AND SURGICAL APPLIANCES, BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS** **Benefit includes the repair of the prosthesis**						
23.1	**External Prosthesis: Benefit for Limbs and Eyes**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to R3 405 pfpa Combined limit with medical and surgical appliances, blood pressure monitors, nebulisers and glucometers	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to R26 430 pfpa	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to R3 405 pfpa Combined limit with medical and surgical appliances, blood pressure monitors, nebulisers, glucometers, arch supports and shoe insoles	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to R26 430 pfpa	

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23.2	**Medical and Surgical Appliances** Claim frequency limits apply – refer to 23.6	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs No benefit for wheelchairs and large orthopaedic appliances on this Plan, except for PMBs	Combined limit of R3 405 pfpa with external prosthesis, blood pressure monitors, nebulisers and glucometers and subject to pre-authorisation and PMB regulations No benefit for wheelchairs and large orthopaedic appliances on this Plan, except for PMBs 100% of cost at a DSP 100% of Scheme Rate at a non-DSP	**Post-surgery appliances:** • 100% of Scheme Rate, limited to R7 770 pbpa **Chronic appliances 100% of cost, limited to:** • R24 405 pbpa for oxygen/ oxygen delivery systems • R24 405 pbpa for stoma products • R7 770 pbpa* for other chronic appliances, including wheelchairs • Sub-limits apply as follows: – R960 arch supports (per pair) – R1 440 shoe insoles (per pair) **Appliances for acute conditions:** • 100% of Scheme Rate, subject to other chronic appliances limit of R7 770 pbpa *Other chronic appliances limit extended to R11 370 for beneficiaries requiring a CPAP machine	Combined limit of R3 405 pfpa with external prosthesis, blood pressure monitors, nebulisers, glucometers, arch supports and shoe insoles Benefits for wheelchairs and large orthopaedic appliances at 100% of Scheme Rate, subject to available Medical Savings Account	**Post-surgery appliances:** • 100% of Scheme Rate, limited to R7 770 pbpa **Chronic appliances 100% of cost, limited to:** • R24 405 pbpa for oxygen/ oxygen delivery systems • R24 405 pbpa for stoma products • R7 770 pbpa* for other chronic appliances, including wheelchairs • Sub-limits apply as follows: – R960 arch supports (per pair) – R1 440 shoe insoles (per pair) **Appliances for acute conditions:** • 100% of Scheme Rate, subject to available Medical Savings Account *Other chronic appliances limit extended to R11 370 for beneficiaries requiring a CPAP machine	**Post-surgery appliances:** • 100% of Scheme Rate, limited to R7 770 pbpa **Chronic appliances 100% of cost, limited to:** • R24 405 pbpa for oxygen/ oxygen delivery systems • R24 405 pbpa for stoma products • R7 770 pbpa* for other chronic appliances, including wheelchairs • Sub-limits apply as follows: – R960 arch supports (per pair) – R1 440 shoe insoles (per pair) **Appliances for acute conditions:** • 100% of Scheme Rate, subject to available Medical Savings Account • ATB applies once the Annual Threshold is reached. 100% of Scheme Rate in ATB *Other chronic appliances limit extended to R11 370 for beneficiaries requiring a CPAP machine

Important Information

Claims for medical and surgical appliances can only be paid if the appliance has been purchased from a Healthcare Professional with a valid BHF practice number. Bankmed cannot refund members where the appliance has been purchased from a company or person that is not registered as a Healthcare Professional with the BHF. For example, members may purchase a wheelchair, breast pump, wheelchair batteries, commodes, crutches, arch supports, blood pressure monitors, nebulisers, etc., from Takealot, Gumtree, old age homes, battery suppliers, and other companies that offer these products to the public. These "claims" cannot be refunded by Bankmed. Please ensure that you have checked that the provider is registered with the BHF before ordering or paying for the appliance.

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	Medical and Surgical Appliances (continued)			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		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	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
23.3	**Blood Pressure Monitors, Nebulisers and Glucometers** Claim frequency limits apply – refer to 23.6	Subject to pre-authorisation and PMB regulations 100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	Subject to pre-authorisation and PMB regulations 100% of Scheme Rate, subject to the combined limit of R3 405 pfpa with external prosthesis and medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 310 pbpa • Nebulisers: R1 845 pbpa • Glucometers: R920 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, subject to the combined limit of R7 770 pbpa for "other chronic appliances" under medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 310 pbpa • Nebulisers: R1 845 pbpa • Glucometers: R920 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, subject to the combined limit of R3 405 pfpa with external prosthesis and medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 310 pfpa • Nebulisers: R1 845 pfpa • Glucometers: R920 pfpa 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, subject to the combined limit of R7 770 pbpa for "other chronic appliances" under medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 310 pbpa • Nebulisers: R1 845 pbpa • Glucometers: R920 pbpa Only payable if claimed from a service provider with a valid BHF practice number	

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23.4	**Arch Supports and Shoe Insoles** Claim frequency limits apply – refer to 23.6	No benefit		Refer to 23.2	Combined limit with External Prosthesis Benefit, medical and surgical appliances, blood pressure monitors, nebulisers and glucometers Subject to a combined limit of R3 405 pfpa Sub-limits apply as follows: • R960 arch supports (per pair) • R1 440 shoe insoles (per pair) Only payable if claimed from a service provider with a valid BHF practice number	Refer to 23.2	
23.5	**Breast Pumps and Baby Monitors**	No benefit		Funded from available "Other Chronic Appliances" limit of R7 770 pbpa Only payable if claimed from a service provider with a valid BHF practice number	Funded from available Medical Savings Account Only payable if claimed from a service provider with a valid BHF practice number		
23.6	**Frequency Limits Pertaining to Medical and Surgical Appliances, Blood Pressure Monitors, Nebulisers, Glucometers, etc.**	Appliances may be claimed once over a specified period. The following appliances may be claimed once per the specified period below:					

Appliance/Device	Frequency
BP Monitor	Once every three years
Humidifier	Once every three years
CPAP Machine	Once every three years
Crutches	Once every two years
Rigid Back Brace	Once every two years
Foot Orthotics	Once every two years
Sling/Clavicle Brace	Once every two years

Appliance/Device	Frequency
Breast Prosthesis	Once every two years (single/pair)
Wheelchairs	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 two years
Brace/Callipers	Once every two years
Wigs	Once every two years
Breast Prosthesis Bras	Two per annum*
Commodes	Once every three years
Walking Frames	Once every two years

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

* 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

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24	**PSYCHIATRY, CLINICAL PSYCHOLOGY AND RELATED OCCUPATIONAL THERAPY**						
24.1	**Hospitalisation:** Subject to pre-authorisation and PMB regulations	Limited to PMBs Subject to referral from a Bankmed GP Entry Plan Network GP (DSP)		R72 405 pbpa covered as follows:			
		• 100% of cost for Bankmed Network Psychiatric facilities (DSPs)		• 100% of cost for Bankmed Network Psychiatric facilities (DSPs)			
	Hospital Network DSPs • All admissions at network DSP	• 100% of cost		• 100% of cost			
	Other Hospitals (non-DSPS) • PMB admission: involuntary use of non-DSP	• 80% of Scheme Rate		• 80% of Scheme Rate			
	• PMB admission: voluntary use of non-DSP	• No benefit		• 80% of Scheme Rate			
	• Non-PMB admission	• 100% of cost for Bankmed Entry Plan Specialist Network: DSPs		• 100% of cost for Bankmed Prestige A and B Specialist Network: DSPs			
	In-hospital Consultations/ Sessions	• 100% of Scheme Rate for non-DSPs		• 100% of Scheme Rate for non-DSPs			
		Cover for 21 days in hospital in line with PMB regulations		Continued benefits for PMBs subject to pre-authorisation and PMB regulations Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the Rand limit Combined limit with “Occupational therapy: psychiatric consultations /sessions in hospital”			

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
24.2	**Post-hospital Psychiatric consultation within 30 days of discharge from hospital following a psychiatric admission** Applies for psychiatric admissions for Major Depression, Schizophrenia and Bipolar Mood Disorder only (excluding day cases)	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission: • 100% of cost at a contracted rate for Bankmed Entry Plan Specialist Network (Psychiatrist only)- DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission: • 100% of cost at a contracted rate for Bankmed Entry Plan Specialist Network (Psychiatrist only)- DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission: • 100% of cost at a contracted rate for Bankmed Prestige A and B Specialist Network (Psychiatrist only)- DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission: • 100% of cost at a contracted rate for Bankmed Prestige A and B Specialist Network (Psychiatrist only)- DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits and/or Medical Savings Account	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission: • 100% of cost at a contracted rate for Bankmed Prestige A and B Specialist Network (Psychiatrist only)- DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits and/or Medical Savings Account	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission: • 100% of cost at a contracted rate for Bankmed Prestige A and B Specialist Network (Psychiatrist only)- DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits and/or Medical Savings Account
24.3	**Consultations/Sessions out-of-hospital** **Important note:** Cover for 15 out-of-hospital psychotherapy sessions for PMBs	Limited to PMBs Benefits subject to pre-authorisation and PMB regulations and referral from a Bankmed GP Entry Plan Network GP (DSP):	Limited to PMBs Benefits subject to pre-authorisation and PMB regulations, and referral from a Bankmed GP Entry Plan Network GP (DSP):	R4 540 pbpa covered as follows: • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs)	100% of cost, subject to available Medical Savings Account • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Prestige A and B Specialist Network (DSPs), subject to pre-authorisation and PMB regulations and referral from a Bankmed Network GP (DSPs)	R5 300 pbpa covered as follows: • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs)	300% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
	Consultations/Sessions out-of-hospital (continued)	• 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of Scheme Rate for non-DSPs Combined limit with occupational therapy: psychiatric consultations/ sessions out-of-hospital Combined limit may be extended to R11 300 pbpa for depression and/or bipolar mood disorder, subject to pre-authorisation and PMB regulations	• 100% of Scheme Rate for non-DSPs	• 100% of Scheme Rate for non-DSPs Combined limit with occupational therapy: psychiatric consultations/ sessions out-of-hospital Combined limit may be extended to R12 640 pbpa for depression and/or bipolar mood disorder, subject to pre-authorisation and PMB regulations	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 R16 015 pfpa • 100% of cost at contracted rate from Insured Benefits for PMB, subject to PMB regulations at Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs
24.4	**Mental Health Integrated Disease Management Programme** Disease Management for specified mental health conditions for members registered on the Scheme's Mental Health Integrated Disease Management Programme	In addition to the cover provided for under the PMB regulations, up to 100% of the Scheme Rate for services covered in the Scheme's basket of care if referred by the Scheme's DSPs 100% of Scheme Rate for services performed by the Scheme's DSP Limited to the basket of care set by the Scheme Subject to the treatment meeting the Scheme's treatment guidelines and managed care criteria Subject to PMB regulations					
25	**OCCUPATIONAL THERAPY**						
25.1	**Psychiatric consultations/ sessions in-hospital** Subject to pre-authorisation and PMB regulations	See "Psychiatry, clinical psychology and related occupational therapy: Hospitalisation and in-hospital consultations/sessions" under 24.1					

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
25.2	**Psychiatric consultations/ sessions** Out-of-hospital	See "Psychiatry, clinical psychology and related occupational therapy: Consultations/Sessions out-of-hospital" under 24.1					
25.3	**Non-psychiatric consultations/ sessions in- hospital** Subject to pre-authorisation and PMB regulations	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited
25.4	**Non-psychiatric consultations/sessions** Out-of-hospital	Limited to PMBs and subject to pre-authorisation and PMB regulations and referral from a Bankmed GP Entry Plan Network GP (DSP) 100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	Limited to PMBs and subject to pre-authorisation and PMB regulations and referral from a Bankmed GP Entry Plan Network GP (DSP) 100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of Scheme Rate, limited to R2 225 pfpa 100% of cost for PMBs	100% of Scheme Rate, subject to available Medical Savings Account for non- PMBs 100% of cost for PMBs	100% of Scheme Rate, limited to R2 345 pfpa, from Insured Benefits 100% of cost for PMBs Thereafter subject to available Medical Savings Account	300% of Scheme Rate, subject to available Medical Savings Account 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Prestige A and B Specialist Network (DSPs) 100% of Scheme Rate for non-DSPs ATB applies once Annual Threshold is reached The maximum amount that can accumulate towards reaching the Annual Threshold at 100% of Scheme Rate and/or be paid as an ATB (always subject to available ATB) is R8 075 pfpa. Subject to PMB regulation

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		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
26	**SPEECH THERAPY, AUDIO THERAPY AND AUDIOLOGY**						
26.1	**Speech Therapy, Audio Therapy and Audiology** In- and out-of-hospital	100% of cost at a DSP, limited to PMBs and subject to pre-authorisation and PMB regulations and referral from a Bankmed GP Entry Plan Network GP (DSP) 100% of Scheme Rate at a non-DSP Limited to PMBs Out-of-hospital cover is subject to PMB application	100% of Scheme Rate, limited to PMBs and subject to pre- authorisation and PMB regulations and referral from a Bankmed GP Entry Plan Network GP (DSP) 100% of cost for PMBs	100% of Scheme Rate, limited to R2 225 pfpa 100% of cost for PMBs	100% of cost at a DSP, subject to available Medical Savings Account 100% of Scheme Rate at a Non-DSP 100% of cost paid from Insured Benefits for PMBs	100% of Scheme Rate, limited to R2 410 pfpa 100% of cost for PMBs Thereafter subject to available Medical Savings Account	300% of Scheme Rate, subject to available Medical Savings Account, thereafter: 100% of cost 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 R2 410 pfpa
27	**PHYSIOTHERAPY**						
27.1	**Physiotherapy** In-hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs		100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited. Subject to pre-authorisation	
27.2	**Post-hospitalisation physiotherapy within six weeks of discharge from hospital or approved day surgery facility, following an authorised hospital or approved day surgery facility admission**	See “Physiotherapy (out-of-hospital)” below under 27.3		100% of Scheme Rate, limited to R3 225 pfpa 100% of cost at a DSP 100% of Scheme Rate at a non-DSP	See “Physiotherapy (out-of-hospital)” below under 27.3	100% of Scheme Rate, limited to R2 670 pbpa from Insured Benefits and thereafter subject to available Medical Savings Account 100% of cost at a DSP 100% of Scheme Rate at a non-DSP	See “Physiotherapy (out-of-hospital)” below under 27.3

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
27.3	**Physiotherapy** Out-of-hospital	Limited to PMBs and subject to pre-authorisation and PMB regulations and referral from a Bankmed GP Entry Plan Network GP (DSP): 100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to PMBs		100% of Scheme Rate, subject to out-of-hospital "GP and Specialists: Consultations in rooms" limits as set out in these Benefit Tables 100% of cost at a DSP 100% of Scheme Rate at a non-DSP	100% of Scheme Rate, subject to available Medical Savings Account for non-PMBs 100% of cost for PMBs 100% of cost at a DSP 100% of Scheme Rate at a non-DSP	100% of cost, subject to available Medical Savings Account 100% of cost at a DSP 100% of Scheme Rate at a non-DSP	300% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/ or be paud as an ATB (always subject to available ATB) is R3 225 pbpa
28	**ADDITIONAL BENEFITS FOR BENEFICIARIES WITH NEURODEVELOPMENTAL DISORDERS** **Subject to approval. Additional discretionary Insured Benefits in the following categories may be granted for beneficiaries with neurodevelopmental disorders, subject to clinical motivation and Scheme approval** **The quantum of additional benefits, if approved, shall be decided on a case-for-case basis and granted at the applicable contracted rate or Scheme Rate as set out below**						
28.1	**Occupational Therapy: Psychiatric consultations/ sessions** Out-of-hospital	No benefit	100% of Scheme Rate or contracted rate, whichever applies				
28.2	**Occupational Therapy: Non-psychiatric consultations/sessions** Out-of-hospital	No benefit	100% of cost at a DSP 100% of Scheme Rate at a non-DSP				
28.3	**Physiotherapy** Out-of-hospital	No benefit	100% of cost at a DSP 100% of Scheme Rate at a non-DSP				
28.4	**Speech Therapy** Out-of-hospital	No benefit	100% of cost at a DSP 100% of Scheme Rate at a non-DSP				

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
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29	**OTHER AUXILIARY SERVICES** **In- and out-of-hospital**						
29.1	**Auxiliary Allied Services** Chiropody, Podiatry, Dietetics (nutritional assessments), Orthotics, Massage, Chiropractors, Herbalists, Naturopaths, Family Planning Clinics, Homeopaths and Biokineticists (fitness assessments)	100% of cost at a DSP, limited to PMBs and subject to pre-authorisation and PMB regulations and referral from a Bankmed GP Entry Plan Network GP (DSP) 100% of Scheme Rate at a non-DSP Limited to PMBs Out-of-hospital cover is subject to PMB application	100% of Scheme Rate, limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP) Out-of-hospital cover is subject to PMB application 100% of cost at a DSP	100% of Scheme Rate, limited to R3 405 pfpa 100% of cost at a DSP	100% of Scheme Rate, subject to available Medical Savings Account for non-PMBs 100% of cost at a DSP	100% of Scheme Rate, subject to available Medical Savings Account 100% of cost at a DSP	300% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/ or be paid as an ATB (always subject to available ATB) is R3 405 pfpa
30	**MAXILLOFACIAL AND ORAL SURGERY** **Subject to pre-authorisation and PMB regulations. NB: Benefits for caps, crowns, bridges and endosteal and ossea-integrated implants are dealt with under dentistry and orthodontics: Advanced dentistry- see 31.2 below**						
30.1	**Maxillofacial and Oral Surgery** Consultations, procedures and treatment in-and out-of- hospital	Limited to PMBs • 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs Benefit inclusive of elective treatment	Limited to PMBs • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs Benefit inclusive of elective treatment		

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
31	**DENTISTRY** **Subject to pre-authorisation and PMB regulations. NB: Benefits for caps, crowns, bridges and endosteal and ossea-integrated implants are dealt with under dentistry and orthodontics: Advanced dentistry- see 31.2 below**						
31.1	**Preventative and Basic Dentistry**	No benefit	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited, via Bankmed Dental Network Subject to Scheme-approved formulary	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited Limited to: • One oral examination pbpa • Amalgam and resin fillings only • Plastic dentures only • Two topical fluoride treatments per child per year (age 15 years and younger) • One topical fluoride treatment per year for all other beneficiaries • Limited to eight molar teeth pb per lifetime • Scale and polish limited to two pbpa	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Subject to available Medical Savings Account	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Unlimited; paid from Insured Benefit Limited to: • One oral examination pbpa • Amalgam and resin fillings only • Plastic dentures only • Two topical fluoride treatments per child per year (age 15 years and younger) • One topical fluoride treatment per year for all other beneficiaries • Limited to eight molar teeth pb per lifetime • Scale and polish limited to two pbpa	300% of Scheme Rate, subject to available Medical Savings Account 100% of cost at a 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 (always subject to available ATB), is R19 315 for a single member and R29 255 for a family
31.2	**Advanced Dentistry** Caps, crowns, bridges and cost of endosteal and ossea-integrated implants	No benefit	No benefit	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to: M: R7 450 pbpa M + 1 +: R11 560 pfpa Combined limit for advanced dentistry, orthodontics and all other dental services	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Subject to available Medical Savings Account for non- PMBs 100% of cost for PMBs	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to: M: R5 805 pbpa M + 1 +: R9 720 pfpa Thereafter subject to available Medical Savings Account	

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		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
31.3	**Orthodontics** Subject to orthodontic quotation and prior approval from Scheme	No benefit	No benefit	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Subject to advanced Dentistry limit	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Subject to available Medical Savings Account	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Limited to R9 720 pfpa Thereafter subject to available Medical Savings Account	
31.4	**All other Dental Services**	No benefit	100% of cost at the DSP via the Bankmed Dental Network and subject to Scheme-approved formulary for: • Second and subsequent examinations in the same year • X-rays • 100% of Scheme Rate at a non-DSP	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Subject to Advanced Dentistry Limit	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Subject to available Medical Savings Account	100% of cost at a DSP 100% of Scheme Rate at a non-DSP Subject to available Medical Savings Account	
32	**GENERAL PRACTITIONERS (GPs)**						
32.1	**GP Consultations** In-hospital	Limited to PMBs • 100% of cost at contracted rate, for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed GP Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs			
32.2	**GP Procedures** In-hospital	Limited to PMBs • 100% of cost at contracted rate for PMBs via Bankmed GP Entry Plan Network GPs (DSPs)	Benefit unlimited • 100% of cost at contracted rate via Bankmed GP Entry Plan Network GPs (DSPs)	Benefit unlimited • 100% of cost at contracted rate via Bankmed Network GPs (DSPs)	Benefit unlimited • 100% of cost at contracted rate via Bankmed Network GPs (DSPs)	Benefit unlimited • 100% of cost at contracted rate via Bankmed Network GPs (DSPs)	Benefit unlimited • 100% of cost at contracted rate via Bankmed Network GPs (DSPs)

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
	GP Procedures In-hospital (continued)	• 100% of Scheme Rate for non-DSPs (including PMBs) No benefit for dental surgery, except for PMBs	• 100% of Scheme Rate for non-DSPs (including PMBs) No benefit for dental surgery, except for PMBs	• 100% of Scheme Rate for non-DSPs	• 100% of Scheme Rate for non-DSPs (including PMBs) No benefit for dental surgery, except for PMBs	• 125% of Scheme Rate for non-DSPs	• 300% of Scheme Rate for non-DSPs
32.3	**Post-hospital GP Consultation within 30 days of discharge from hospital (excluding day cases)**	Limited to PMBs One additional post-hospitalisation GP consultation covered as an Insured Benefit (not payable from Medical Savings Account or other insured limits), per beneficiary visiting a GP within 30 days of discharge, following an authorised hospital admission (excluding day cases): • 100% of cost at contracted rate for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	One additional post-hospitalisation GP consultation covered as an Insured Benefit (not payable from Medical Savings Account or other insured limits), per beneficiary visiting a GP within 30 days of discharge, following an authorised hospital admission (excluding day cases): • 100% of cost at the contracted rate via Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs Subject to out-of-network limit for non-Bankmed GP Entry Plan Network GPs. See "GPs: Consultations in rooms" for details	One additional post-hospitalisation GP consultation covered as an Insured Benefit (not payable from Medical Savings Account or other insured limits), per beneficiary visiting a GP within 30 days of discharge, following an authorised hospital admission (excluding day cases): • 100% of cost at contracted rate for Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs			

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
32.4	**GPs: Consultations in rooms**	Limited to PMBs • 100% of cost at contracted rate, unlimited for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	Members must make use of Bankmed GP Entry Plan Network GPs (DSPs): • 100% of cost at contracted rate, unlimited for selected Bankmed GP Entry Plan Network GPs (DSP) in accordance with preferred provider contract • Limited to three visits, to a maximum of R2 345 pfpa (at Bankmed GP Entry Plan Network rate) for consultations, procedures and medicine at non Bankmed GP Entry Plan Network GPs, when the selected Bankmed GP Entry Plan Network GP is not available or the beneficiary is out of town; out-of-network limit includes all costs arising from the out- of-network consultation	Combined limit for GP and specialist consultations in rooms: • M: R3 755 pbpa • M + 1: R6 800 pfpa • M + 2 +: R7 885 pfpa GPs paid as follows: • 100% of cost at contracted rate for Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs • Unlimited if DSP used • Continued benefits for beneficiaries with PMB conditions, subject to PMB regulations	Benefits for a Bankmed Network GP (DSP): • 100% of cost at contracted rate, unlimited for PMBs • Two consultations at contracted rate from Insured Benefits, for non-PMBs (thereafter payable from available Medical Savings Account) Benefits for any other GP (non-DSP): • 100% of Scheme Rate from Insured Benefits for PMBs • 100% of Scheme Rate from the Medical Savings Account for non-PMBs	Benefits subject to available Medical Savings Account: • 100% of cost at contracted rate for Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs PMB treatment: • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	Benefits for a Bankmed Network GP (DSP): • 100% of cost, subject to available Medical Savings Account/ATB Benefits for any other GP (non-DSP): • 300% of Scheme Rate, subject to available Medical Savings Account/ATB ATB applies once Annual Threshold is reached PMB treatment: • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Network GPs (DSPs); • 100% of Scheme Rate for non-DSPs

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		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
32.5	**GPs: Procedures in rooms**	Limited to PMBs • 100% of cost at contracted rate, unlimited for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	See "GPs: Consultations in rooms" in section 32.4	• 100% of cost of contracted rate for Bankmed Network GPs (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate for Bankmed Network GPs (DSPs), unlimited • 100% of Scheme Rate, subject to available Medical Savings Account for non-DSPs	Paid from Insured Benefits: • 100% of cost of contracted rate for Bankmed Network GPs (DSPs) • 125% of Scheme Rate for non-DSPs	Paid from Insured Benefits: • 100% of cost of contracted rate for Bankmed Network GPs (DSPs) • 300% of Scheme Rate for non-DSPs
32.6	**GPs: Virtual consultations** Subject to member and/ or beneficiary consulting with GP face-to-face during prior six-month period and verification notes submitted by claiming GP Subject to Out-of-hospital GP Benefits and Limits	• 100% of cost for Bankmed GP Entry Plan Network GPs: DSPs • 100% of Scheme Rate for non-DSPs • Limited to three consultations pbpa • Limited to PMBs	• 100% of cost for Bankmed GP Entry Plan Network GPs: DSPs • 100% of Scheme Rate for non-DSPs • Limited to three consultations pbpa • Subject to Out-of-network GP Limit if non-DSP used	• 100% of cost for Bankmed Network GPs: DSPs • 100% of Scheme Rate for non-DSPs • Limited to three consultations pbpa	• 100% of cost for Bankmed Network GPs: DSPs • 100% of Scheme Rate for non-DSPs • Limited to three consultations pbpa • Subject to available Savings for non-PMBs	• 100% of cost for Bankmed Network GPs: DSPs • 100% of Scheme Rate for non-DSPs • Limited to three consultations pbpa • Subject to available Savings for non-PMBs	• 100% of cost for Bankmed Network GPs: DSPs • 100% of Scheme Rate for non-DSPs • Limited to three consultations pbpa • Subject to available Savings /ATB for non-PMBs
33	**SPECIALISTS NB:** **NB: Psychiatrists, oncologists, radiologists, pathologists, maxillofacial and oral surgeons and other dental practitioners are covered elsewhere in these Benefit Tables**						
33.1	**Specialist consultations and procedures** In-hospital	Limited to PMBs • 100% of cost of contracted rate at Bankmed Entry Plan Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Entry Plan Specialist Network (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Prestige A and B Specialist Network (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Prestige A and B Specialist Network (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Prestige A and B Specialist Network (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Prestige A and B Specialist Network (DSPs), unlimited • 300% of Scheme Rate for non-DSPs

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
33.2	**Specialists: Consultations in rooms** Pre-authorisation required for all Plans, excluding Comprehensive and Plus Be sure to obtain a referral from your GP and an authorisation number before seeing a specialist – for all Plans, excluding Comprehensive and Plus Plans Make use of our DSPs to limit or avoid co-payments	Limited to PMBs Benefits subject to referral by a Bankmed GP Entry Plan Network GP and approved basket of care registration for PMB conditions: • 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSPs) • 80% of cost if no pre-authorisation and no referral from a Bankmed GP Entry Plan Network GP (DSP) • 100% of Scheme Rate for non-DSPs • 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed GP Entry Plan Network GP (DSP)	Benefits subject to referral by a Bankmed GP Entry Plan Network GP, and limited to: M: R2 130 pbpa M + 1 +: R3 335 pfpa (combined limit with specialist procedures in rooms) • 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSPs) • 80% of cost if no pre-authorisation and no referral from a Bankmed GP Entry Plan Network GP (DSP) • 100% of Scheme Rate for non-DSPs • 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed GP Entry Plan Network GP (DSP) Annual limit includes basic radiology, scans, and pathology prescribed by specialist/ appearing on specialist's claim Continued benefits for PMBs, subject to PMB regulations and approval	Combined limit with GP consultations in rooms, and paid as follows: • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs) • 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed GP Network GP (DSP) • 100% of Scheme Rate for non-DSPs (including PMBs) • 80% of cost 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, subject to approved basket of care and referral by a Bankmed Network GP: • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs) • 80% of cost if no pre-authorisation and no referral from a Bankmed Network GP (DSP) • 100% of Scheme Rate for non-DSPs • 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed Network GP (DSP) Non-basket of care benefits covered at 100% of Scheme Rate, subject to available Medical Savings Account Continued benefits for PMBs, subject to PMB regulations and approval	100% of Scheme Rate, subject to available Medical Savings Account • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	300% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs) • 300% of Scheme Rate for non-DSPs

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
33.3	**Specialists: Procedures in rooms**	Limited to PMBs • 100% of cost of contracted rate at Bankmed Entry Plan Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	See "Specialists: Consultations in rooms" in section 33.2	• 100% of cost at contracted rate, unlimited for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	Limited to PMBs • 100% of cost at contracted rate, unlimited for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs • 80% of cost if no pre-authorisation or no referral from Bankmed GP Network GP (DSP)	• 100% of cost at contracted rate, unlimited for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed Prestige A and B Specialist Network (DSPs) • 300% of Scheme Rate for non-DSPs
34	**REGISTERED PRIVATE NURSE PRACTITIONERS**						
34.1	**Consultations and Procedures**	Limited to PMBs Procedures: • 100% of cost at a DSP • 100% of Scheme Rate at a non-DSP • Limited to PMBs • For procedures not requiring admission to a day clinic or hospital; includes the cost of vaccination and injection material administered by the Practitioner Consultations: • 100% of cost at a DSP • 100% of Scheme Rate at a non-DSP • Limited to PMBs • Three consultations pbpa at 100% of Scheme Rate for PMBs	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 100% of Scheme Rate	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 100% of Scheme Rate Thereafter, 100% of Scheme Rate, subject to out-of- hospital GP/Specialist limit	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 100% of Scheme Rate from Insured Benefits Thereafter subject to available Medical Savings Account	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 100% of Scheme Rate from Insured Benefits Thereafter subject to available Medical Savings Account	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 300% of Scheme Rate from Insured Benefits Thereafter subject to available Medical Savings Account ATB applies once the Annual Threshold is reached

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
35	**OPTOMETRY CONSULTATIONS, SPECTACLES, FRAMES, LENSES AND CONTACT LENSES**						
35.1	**Optometry: Consultations** Subject to the Optometry Benefit Management Programme and clinical necessity	No benefit	100% of cost, limited to one consultation pb every two years, via Iso Leso Optometry Network Out-of-network: No benefit	100% of 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 Medical Savings Account	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 Medical Savings Account, however accumulation to the Annual Threshold is limited to 100% of the Scheme Rate for spectacle lenses, contact lenses, eye tests and all other applicable services ATB applies once the Annual Threshold is reached The maximum amount that can jointly accumulate towards reaching the Annual Threshold and/or be paid as an ATB (always subject to available ATB), is R4 880 pbpa for optometric consultations, prescription lenses, readymade readers, contact lenses, fitting of contact lenses and other optometric services
35.2	**Frames and Extras**	No benefit	100% of cost, limited to one frame pb every two years, via Iso Leso Optometry Network Out-of-network: No benefit	100% of Scheme Rate, limited to R1 025 per beneficiary every 24 months from previous date of service One frame per beneficiary 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 Medical Savings Account One frame per beneficiary 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 Medical Savings Account One frame per beneficiary 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 Medical Savings Account 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

Did you know?

THE OPTICLEAR OPTOMETRY NETWORK AND HOW IT WORKS

Bankmed members receive optometry services and material, like spectacles and contact lenses, at a preferred and discounted rate from any Opticlear Network optometrist. This means that by visiting an Opticlear Network optometrist, you will receive services and items at a guaranteed reduced rate. The Opticlear Network incorporates 97% of all optometry providers in South Africa, making it more likely that your chosen optometrist is a member of this network. To find your nearest Opticlear Network optometrist, please visit their website at www.opticlear.co.za

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
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35.3	**Prescription Lenses** Clear, standard/generic, single vision, bifocal or multi- focal lenses	No benefit	100% of cost • Limited to one pair of prescription lenses pb every two years, via Iso Leso Optometry Network • Out-of-network: No benefit for readymade readers	Benefits for prescription lenses limited to one pair of lenses per beneficiary every 24 months from previous date of service and covered as follows: • 100% of Scheme Rate for Clear, standard/generic, single vision, bifocal or multi-focal lenses from an Opticlear optometrist	100% of Scheme Rate, subject to available Medical Savings Account	Benefits for prescription lenses limited to one pair of lenses per beneficiary every 24 months from previous date of service and covered as follows: • 100% of Scheme Rate for Clear, standard/generic, single vision, bifocal or multi-focal lenses from an Opticlear optometrist	100% of Scheme Rate, subject to available Medical Savings Account
35.4	**Readymade Readers**	No benefit	No benefit	100% of Scheme Rate, subject to available benefits Two pairs at R110 a pair, pb every two years Readymade readers via optometrists and pharmacies as an OTC benefit subject to benefit availability	100% of Scheme Rate, subject to available benefits Readymade readers via optometrists and pharmacies as an OTC benefit subject to benefit availability	100% of Scheme Rate, subject to available Medical Savings Account Two pairs at R110 a pair, pb every two years paid from available Savings Readymade readers via optometrists and pharmacies as an OTC benefit subject to benefit availability	
35.5	**Contact Lenses**	No benefit	No benefit	100% of Scheme Rate, limited to R1 605 pbpa for an Opticlear optometrist Limited to clear contact lenses A beneficiary may not claim for spectacles (lenses or frame) AND contact lenses in the same benefit year OR contact lenses within 24 months from previous date of service after receiving spectacles (lenses or frame)	100% of Scheme Rate, subject to available Medical Savings Account 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 R1 785 pbpa for an Opticlear optometrist, paid from Insured Benefits Limited to clear contact lenses A beneficiary may not claim for spectacles (lenses or frame) AND contact lenses in the same benefit year OR contact lenses within 24 months from previous date of service after receiving spectacles (lenses or frame)	See “Optometry: Consultations” in the Benefit Table

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
35.6	**Fitting of Contact Lenses**	No benefit		100% of Scheme Rate One contact lens dispensing and/or assessment per beneficiary every 12 months	100% of Scheme Rate, subject to available Medical Savings Account	100% of Scheme Rate One contact lens dispensing and/or assessment per beneficiary every 12 months	See "Optometry: Consultations" in the Benefit Table
35.7	**Sunglasses**	No benefit		No benefit for sunglasses / prescription sunglasses / spectacles with a tint > 35%			
36	**REFRACTIVE SURGERY AND ASSOCIATED COSTS (INCLUDING HOSPITALISATION)**						
36.1	**Other Optometric Services** Refractive surgery excimer laser treatment, hospitalisation and associated costs	No benefit, including the cost of hospitalisation, medication and all other associated services		100% of Scheme Rate, limited to R4 280 pfpa, including the cost of hospitalisation, medication and all other associated services	100% of Scheme Rate, subject to available Medical Savings Account, including the cost of hospitalisation, medication and all other associated services		See "Optometry: Consultations" Limit on accumulation to Annual Threshold and/or payment as an ATB includes the cost of hospitalisation, medication and all other associated services

Be a better-informed Bankmed member

You can make a difference to your healthcare costs, so next time you receive eye care keep the following in mind:

- Always confirm your available benefits with the optometrists as well as with Bankmed before you have your consultation. Bankmed will be able to assist you with questions regarding your benefits.
- Make 100% certain of the cost of the items that will not be covered by Bankmed and check with your optometrist why these services and/or materials are necessary.

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
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37	**MEDICATION NB** **NB: In the case of qualifying prescribed acute and chronic medication, each prescription or repeat prescription shall be limited to one month's supply per beneficiary per month**						
37.1	**Prescribed Acute Medication** See "Contraception: Oral contraceptives, devices and injectables" for additional Insured Benefits under section 3.18	Limited to PMBs 100% of cost for PMBs at contracted rate, unlimited via Bankmed GP Entry Plan Network GP (DSP) and subject to Scheme-approved formulary	Medication via DSP (Bankmed GP Entry Plan Network GP and Bankmed Pharmacy Network): • 100% of cost plus contracted dispensing fee, unlimited Medication via non-DSP (voluntary): • 100% of Scheme Medicine Reference Price • Subject to out-of-network GP consultations and procedures limit of R2 345 pfpa Medication via non-DSP (involuntary): • 100% of cost plus contracted dispensing fee, unlimited **Important note:** Medication obtained from a DSP or non-DSP, if prescribed by a non-DSP provider, will accumulate to the out-of-network GP consultations and procedures limit of R2 345 pfpa Subject to Scheme-approved formulary	Limited to: • M: R4 260 pbpa • M + 1: R7 840 pfpa • M + 2 +: R8 510 pfpa The above limits include a maximum allowance of R1 690 pfpa towards self- medication/ PAT Bankmed Network GPs/ Bankmed Pharmacy Network (DSPs): • 100% of the 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) Non-DSPs: • 80% of Scheme Medicine Reference Price for generic medication and original medication (medication where a generic alternative is available)	100% of Scheme Medicine Reference Price, subject to available Medical Savings Account	100% of the Scheme Medicine Reference Price plus contracted dispensing fee as applicable to Bankmed Network GPs or Bankmed Pharmacy Network (DSPs), subject to available Medical Savings Account ATB applies once Annual Threshold is reached The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/ or be paid as an ATB (always subject to available ATB), is R19 315 for a single member and R29 255 for a family

Important Information

Pre-authorisation is required for PMB funding of treatment and care of the PMB Chronic Disease List (CDL) conditions. Have your doctor and pharmacist call 0800 132 345 to register your chronic medication or send a motivation confirming your PMB diagnosis to pmb_app_forms@bankmed.co.za if chronic medication has not been prescribed for your condition.

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
37.2	**Self-medication: Over-the- counter Medication/ Pharmacy Advised Therapy (PAT)**	No benefit		100% of the Scheme Medicine Reference Price for Bankmed Pharmacy Network (DSP) 80% of the Scheme Medicine Reference Price for non-DSPs Limited to R1 690 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 medicine list (formulary) for PAT All other acute and over-the-counter medication subject to available Medical Savings Account	100% of Scheme Medicine Reference Price, subject to available Medical Savings Account	100% of Scheme Medicine Reference Price, subject to available Medical Savings Account Self-medication/PAT does not accumulate towards the Annual Threshold and is not covered as an ATB benefit
37.3	**Homeopathic Medication** On prescription only, and limited to items with NAPPI codes	No benefit		Benefits as for prescribed acute/chronic medication No self-medication benefit for homeopathic medication			
37.4	**Chronic Medication** Subject to prior application and approval	Limited to PMBs • 100% of cost for PMBs at contracted rate, unlimited via Bankmed GP Entry Plan Network (DSP) and subject to Scheme-approved medicine list (formulary)	• 100% of cost at contracted rate, unlimited via Bankmed GP Entry Plan Network GP (DSP) and subject to Scheme- approved medicine list (formulary) Medication via non-DSP (voluntary use of non-DSP): • 80% of Scheme Medicine Reference Price • Subject to out of network GP consultations and procedures limit of R2 345 pfpa Medication via non-DSP (involuntary use of non-DSP): • 100% of cost plus contracted dispensing fee	Limited to R22 515 pbpa and paid as follows: • 100% of the Scheme Medicine Reference Price for Bankmed Network GPs (DSPs) or Bankmed Pharmacy Network (DSP) • 80% of Scheme Medicine Reference Price for non- DSP • 100% of cost for medication via non-DSP (involuntary use of a non- DSP) Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations	Limited to Core Saver medicine list (formulary) for PMB conditions and paid as follows: • 100% of the Scheme Medicine Reference Price for Bankmed Network GPs (DSPs) or Bankmed Pharmacy Network (DSP) • 80% of Scheme Medicine Reference Price for non-DSP • 100% of cost for medication via non-DSP (involuntary use of a non-DSP)	Limited to R24 380 pbpa (Insured Benefits) and paid as follows: • 100% of the Scheme Medicine Reference Price for Bankmed Network GPs (DSPs) or Bankmed Pharmacy Network (DSP) • 80% of Scheme Medicine Reference Price for non-DSP • 100% of cost for medication via non-DSP (involuntary use of a non-DSP) Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations	Limited to R29 070 pbpa (Insured Benefits) and paid as follows: • 100% of the Scheme Medicine Reference Price for Bankmed Network GPs (DSPs) or Bankmed Pharmacy Network (DSP) • 80% of Scheme Medicine Reference Price for non-DSP • 100% of cost for medication via non-DSP (involuntary use of a non-DSP) Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations

		ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
37.5	**Biologics and High-cost Specialised Medication** Utilised in the management of PMB CDL and non-PMB chronic conditions **Includes all off-label drugs** (request for a drug not registered for the condition by the Medicines Control Council (MCC) **Includes all Section 21 drugs** (drugs not registered by MCC for use in SA)	PMB only Subject to PMB regulations	PMB only Subject to PMB regulations	Subject to PMB regulations	Subject to PMB regulations	Subject to PMB regulations	Subject to PMB regulations
	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
38	**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**						
38.1	**Out-of-hospital healthcare services related to COVID-19:** • Screening consultation with a nurse or GP • Defined basket of pathology • Defined basket of x-rays and scans • Consultations with a nurse or GP • Supportive treatment • Contact tracing	**BENEFITS & LIMITATIONS** **Over and above the PMB requirements.** Up to a maximum of 100% of the Scheme Rate. Cover for testing is subject to NICD protocol and referral 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.			**BENEFITS & LIMITATIONS** **Basket of care as set by the Scheme** Out-of-hospital healthcare services related to COVID-19: Screening consultation with a nurse or GP: unlimited Defined basket of pathology: unlimited tests per person per year subject to appropriate clinical referral for testing for registered Healthcare Professionals except where covered as PMB.		

	ESSENTIAL PLAN 2022	BASIC PLAN 2022	TRADITIONAL PLAN 2022	CORE SAVER PLAN 2022	COMPREHENSIVE PLAN 2022	PLUS PLAN 2022
	NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		

39 PLAN SPECIFIC INFORMATION

39.1 CORE SAVER MEDICINE LIST (FORMULARY) FOR PHARMACY ADVISED THERAPY (PAT)

Applicable to the medication on the Core Saver Plan only.

Acute medication covered at 100% of cost from Insured Benefits (subject to the Core Saver medicine list (formulary) for PAT) for the following conditions and up to the specified number of incidents per beneficiary per annum, on pharmacist's recommendation (PAT) only. Visit www.bankmed.co.za, select "2022 Plan Information" and then "Medicine Formularies 2022" to view the Core Saver medicine list (formulary) for PAT- non-formulary drugs and other acute medication subject to available Medical Savings Account.

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