BANKMED

ANNEXURE B2: BANKMED BASIC PLAN (NO SAVINGS)

Schedule of benefits with effect from 1 January 2025

STATUTORY PRESCRIBED MINIMUM BENEFITS

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

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

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

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

Where a benefit is indicated as “no benefit” in this schedule, insured benefits shall nevertheless be provided for PMBs in South Africa, subject to PMB regulations

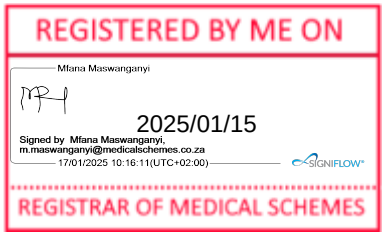
When insured limits are specified in this schedule, the limit will first be utilised for the payment of the relevant claims, and thereafter continued funding will apply for PMB claims only, subject to PMB regulations

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

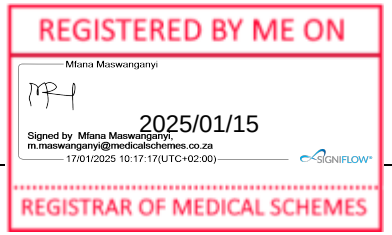
STATUTORY PRESCRIBED MINIMUM BENEFITS

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

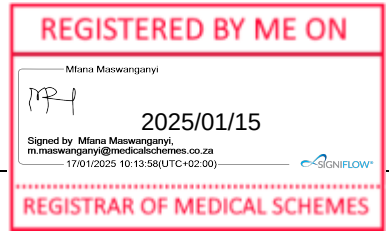
Beneficiaries admitted during the course of a financial year are entitled to the benefits set out in this schedule, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the financial year (rule 16.1.5), except for stated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

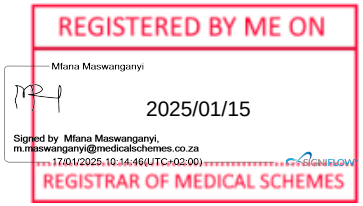


HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
OVERALL ANNUAL LIMIT		Unlimited	This plan has no overall annual limit.
HOSPITAL NETWORK/DSPs	Hospital Network DSPs are applicable on this plan. Reduced benefits apply for accommodation and associated fees charged by non-DSP hospitals, subject to PMB regulations. Hospital Network DSPs on this plan are: • Contracted private hospitals/facilities (restricted network) as communicated to members from time to time.		
HOSPITALISATION **Hospital Network DSPs** Deductibles apply to a specified list of conditions/procedures as set out in Appendix 3 All admissions at network DSP **Other hospitals (non-DSPS)** PMB admission: involuntary use of non-DSP (deductible does not apply) PMB admission: voluntary use of non-DSP (deductible applies to all admissions) Non-PMB admission (deductible applies to all admissions)	 100% of cost 100% of cost 80% of Scheme Rate 80% of Scheme Rate	 General ward rates General ward rates General ward rates General ward rates	Benefits subject to pre-authorisation, and only available on referral from a Bankmed GP Entry Plan Network GP or referred specialist, subject to PMB regulations. Emergencies must be authorised within 24 hours of admission. No benefit for dental surgery except for PMBs. No benefit for auxiliary services except for PMBs. PMBs limited to 80% of Scheme Rate for non-DSPs, subject to PMB regulations.
Deductibles payable on admission Healthcare services reflected in Appendix 3	Beneficiary responsible for a Deductible in respect of the hospital account for certain hospital events, unless the admission is related to a Prescribed Minimum Benefit diagnosis typically as a result of an emergency. The Deductible will apply regardless of the whether the procedure attracting the deductible was the primary reason for the admission or not.		

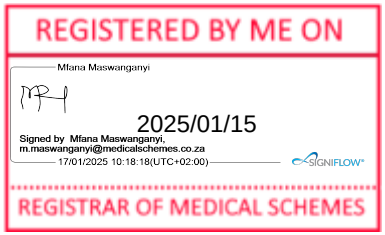


HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Benefits provided on admission to:			
1. Hospital Network DSPs			
• Ward Fees (general ward rate) • ICU and high care unit fees • Theatre fees • Ward and theatre drugs, dressings, materials and equipment consumed / utilised in hospital • Outpatient services • Recovery beds	100% of cost	Unlimited	In accordance with a per diem or negotiated rate. Facility fees charged by hospitals for outpatient visits that do not result in authorised admissions to be paid from out of hospital specialist consultations and procedures limit.
• Ward and theatre drugs, dressings, materials, equipment and disposables consumed / utilised in the theatre (at hospital network DSPs)	100% of cost	Unlimited	
2. Other hospitals (non-DSPs)			
• Ward Fees (general ward rate) • ICU and high care unit fees • Theatre fees • Outpatient services • Recovery beds	80% of Scheme Rate	Unlimited	PMBs limited to 80% of Scheme Rate for non-DSPs, subject to PMB regulations. Facility fees charged by hospitals for outpatient visits that do not result in authorised admissions to be paid from out of hospital specialist consultations and procedures limit.
• Ward and theatre drugs, dressings, materials, equipment and disposables consumed / utilised in hospital (at non-DSP hospitals)	80% of Scheme Rate	Unlimited	
3. Unattached Theatre Units (Private) • Theatre fees • Recovery beds	100% of cost at a DSP 80% of Scheme Rate at a non-DSP	Unlimited	The unattached theatre must be registered with the Department of Health.
• Ward and theatre drugs, dressings, materials, equipment and disposables consumed / utilised in hospital (at unattached theatre unit)	100% of cost at a DSP 80% of Scheme Rate at a non-DSP	Unlimited	

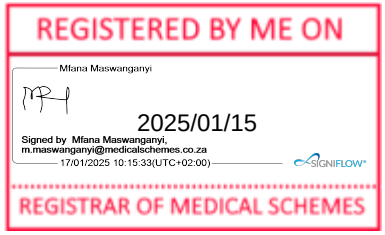


HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
OUTPATIENT CONSULTATIONS WITH GPs/SPECIALISTS AT HOSPITAL EMERGENCY ROOMS AND OUTPATIENT UNITS		See General Practitioners/ Specialists: out of hospital consultations in rooms	Regarded as out of hospital GP/Specialist consultations in rooms, unless resulting in an authorised hospital admission.
HOME-BASED HEALTHCARE **For clinically appropriate chronic and acute treatment and conditions, where treatment is possible at home**	100% of Scheme Rate 	Unlimited Subject to the Scheme's preferred provider (where applicable) and the treatment meeting the Scheme's treatment guidelines and clinical and benefit criteria.	Subject to pre-authorisation and PMB regulations. Basket of care as set by the Scheme.
TO TAKE OUT DRUGS	100% of cost	Limited to PMBs and a maximum of 7 days' supply per admission	Benefit for medicine supplied by the hospital when a patient is discharged. If procedure took place in a day surgery facility, a maximum of a seven-day supply will be funded from Insured Benefits if obtained from a retail pharmacy on the date of discharge only.
AMBULANCE SERVICES	100% of cost via the Scheme's DSP 100% of Scheme Rate through a non-DSP	Unlimited	Subject to pre-authorisation and PMB regulations. No benefit for services outside the borders of South Africa.
BLOOD TRANSFUSIONS **Blood products, materials, apparatus and operator's fees**	100% of cost	Unlimited	Subject to pre-authorisation and PMB regulations.
ORGAN AND BONE MARROW TRANSPLANTS			Subject to pre-authorisation and PMB regulations.
Hospitalisation, and organ and patient preparation	Benefits as for hospitalisation	Limited to PMBs	The organ recipient must be a Bankmed beneficiary for benefits to apply.
Medication (in and out of hospital)	100% of cost	Limited to PMBs	Benefits for Specialists will be as specified elsewhere this schedule.
Harvesting and transporting of organs, and other donor costs	100% of cost	Limited to PMBs	No benefit for travelling and non-hospital accommodation expenses.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
ONCOLOGY (CHEMOTHERAPY AND RADIOTHERAPY)			
In and out of hospital consultations, treatment and materials	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	Subject to: - Pre-authorisation and PMB regulations - Evidence-based medicine, cost-effectiveness and affordability - Scheme's oncology baskets of care, formularies and/or protocols - Meeting Scheme's Clinical Entry Criteria - Peer-review by external panel of specialists as appointed by the Scheme
Associated Medicine/Drugs **For medicines administered in-rooms:** (Injectable and infusional chemotherapy)			
• Medication via the Oncology Pharmacy Designated Service Provider (DSP) (Courier pharmacy)	100% of cost	Limited to PMBs	Subject to: - Pre-authorisation and PMB regulations - Evidence-based medicine, cost-effectiveness and affordability - Scheme's oncology baskets of care, formularies and/or protocols - Meeting Scheme's Clinical Entry Criteria - Peer-review by external panel of specialists as appointed by the Scheme - Medication must be dispensed through a designated service provider. Where a non-network provider is used, funding will be approved up to a maximum of 80% of the Scheme Medicine Reference price and the balance will be for the member's own pocket - Generic substitution and/or switching to cost-effective therapeutic equivalents (drug utilisation review)
• Medication via a non-DSP (voluntary use of non-DSP)	80% of Scheme Medicine Reference Price plus dispensing fee	Limited to PMBs	
• Medication via a non-DSP (involuntary use of non-DSP)	100% of cost	Limited to PMBs	
Excludes medicines administered in-hospital and medicines administered in-rooms by a dispensing provider.			



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
For medicines scripted and dispensed at a retail pharmacy or via a courier pharmacy (scripted by treating provider): (Supportive medication, oral chemotherapy and hormonal therapy)			
• Medication via the Oncology Pharmacy Designated Service Provider (DSP)	100% of cost	Limited to PMBs	
• Medication via a non-DSP (voluntary use of non-DSP)	80% of Scheme Medicine Reference Price plus dispensing fee	Limited to PMBs	
• Medication via a non-DSP (involuntary use of non-DSP)	100% of cost	Limited to PMBs	
RENAL DIALYSIS			
Procedures and Treatment	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	Subject to pre-authorisation and PMB regulations.
Associated Medicine/Drugs			
• Medication via designated courier pharmacy (DSP)	100% of cost	Limited to PMBs	
• Medication via non-DSP (voluntary use of non-DSP)	80% of Scheme Medicine Reference Price plus dispensing fee	Limited to PMBs	
• Medication via non-DSP (involuntary use of non-DSP)	100% of cost	Limited to PMBs	



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
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: 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	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. Subject to the Scheme's preferred provider (where applicable), protocols and the condition and treatment meeting the Scheme's entry criteria and guidelines.	Up to a 100% of the Scheme Rate for registered healthcare providers.	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 providers except where covered as PMB.
PREGNANCY AND CHILDBIRTH			
Hospitalisation and associated in hospital services (hospital network rules apply)	As specified elsewhere in this schedule		Subject to pre-authorisation and PMB regulations. Benefits for hospitalisation and other in hospital services as specified elsewhere in this schedule.
Midwife care and delivery	100% of cost at a DSP 100% of Scheme Rate at a non-DSP		Subject to pre-authorisation and PMB regulations.
Birthing facilities	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	(Cost of disposables limited to R1 440 per case)	Subject to pre-authorisation. Only available where hospital services are not used (except for registered active birthing units).
Antenatal and post-natal care	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	As specified elsewhere in this schedule	Benefits for General Practitioners, Specialists, radiology, pathology and other associated services as specified elsewhere in this schedule.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Additional insured benefits at or subject to referral by a Bankmed Entry Plan Network GP and subject to registration on the Scheme's Maternity Programme (Baby and Me):			
• 6 ante-natal consultations per pregnancy	100% of cost for DSP 100% of Scheme Rate for non-DSP	As specified	Additional insured consultations benefits limited to Bankmed GP Entry Plan Network GPs (DSPs) and Bankmed Specialist Network gynaecologists / obstetricians (DSPs).
• 3 x 2D ultrasounds per pregnancy	100% of cost for DSP 100% of Scheme Rate for non-DSP	As specified	
• R1 770 per pregnancy for ante-natal and post-natal classes	100% of cost for DSP 100% of Scheme Rate for non-DSP	As specified	
Additional insured pathology benefits subject to Baby and Me Basket of Care	100% of cost for DSP 100% of Scheme Rate for non-DSP	As specified	Additional insured pathology benefits subject to Baby-and-Me Basket of Care.
Other Antenatal and post-natal care: Radiology and Pathology	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	As specified elsewhere in this schedule	Benefits for Radiology and Pathology as specified elsewhere in this schedule.
ALTERNATIVES TO HOSPITALISATION			
Step-down facilities	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	Step-down facilities: Subject to pre-authorisation and available only as an alternative to hospitalisation. Such service follows pre-authorised hospitalisation or operation and is in lieu of further hospitalisation. The facility must be registered with the Department of Health.
Frail Care Facilities	No benefit	No benefit	
Home nursing services	No benefit	No benefit	
ADVANCED ILLNESS BENEFIT	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	Subject to pre-authorisation, PMB regulations, and the treatment meeting the Scheme's guidelines and managed care criteria.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
REGISTERED PRIVATE NURSE PRACTITIONERS (registered with the S. A. Nursing Council or its legal successor)			
Procedures	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	For procedures not requiring admission to a day surgery facility 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	Three pbpa	
HomeCare Services	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	For procedures not requiring admission to a day surgery facility or hospital. Subject to Scheme Clinical Entry Criteria. Subject to preauthorisation.
WELLNESS AND PREVENTATIVE CARE BENEFITS (VACCINATIONS AND SCREENING)			Benefits in this section do not contribute to the depletion of any insured limits specified elsewhere in this schedule. Associated consultation fees are not provided for in this section, unless indicated. See General Practitioners (GPs): out of hospital consultations and procedures in rooms for consultation benefits.
Contraception: oral contraceptives, devices and injectables	100% of Scheme Medicine Reference Price	R2 510 pbpa	For female beneficiaries only. Oral contraceptives limited to one prescription or repeat prescription per beneficiary per month.
Influenza vaccine	100% of Scheme Medicine Reference Price	One pbpa	
Human Papilloma Virus (HPV) vaccine	100% of Scheme Medicine Reference Price	Three doses pb	For male and female beneficiaries aged 9 to 25 years and limited to a total course of three doses (depending on product and age).

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Cholesterol screening, blood sugar screening and blood pressure measurements	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R400 pbpa	At clinics, pharmacies or Bankmed GP Entry Plan Network GPs' consulting rooms.
HIV Counselling and Testing (HCT)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	HCT DSPs: Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering onsite services at employer groups, subject to PMB regulations.
Mammogram	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa	For beneficiaries aged 40 years and older; Benefits for beneficiaries younger than 40 years, subject to motivation and prior approval.
Breast MRI (breast cancer risk only)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa	For high-risk beneficiaries only. Subject to clinical entry criteria and pre-authorisation.
Pap smear	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa	One associated nurse, Bankmed GP Entry Plan Network GP or Bankmed Specialist Network consultation per beneficiary covered as an additional insured benefit, limited to R630 pbpa.
Bone densitometry **Prostate specific antigen** **Faecal occult blood test**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa One pbpa One pbpa	For beneficiaries aged 50 years and older; Benefits for beneficiaries younger than 50 years, subject to motivation and prior approval.
Tuberculosis (TB) screening	100% of Scheme Rate	One chest x-ray pbpa	For TB screening requested by private nurse practitioners rendering onsite services at employer groups; All other TB screenings subject to available out of hospital radiology and/or pathology benefits, and PMB regulations.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Childhood vaccinations (BCG, Oral Polio, Rotavirus, Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio and Haemophilus influenza type B, Hepatitis B, Measles, Pneumococcal vaccine)	100% of Scheme Medicine Reference Price	Subject to EPI guidelines	For immunisations administered in accordance with the Department of Health's Expanded Programme on Immunisation (EPI) guidelines for children up to 12 years.
Pneumococcal vaccine	100% of Scheme Medicine Reference Price	Limited as follows:	• One vaccination every five years for adults 60 years and older. • One vaccination every five years for beneficiaries younger than 60 years, who have been diagnosed with Asthma, Chronic Obstructive Pulmonary Disease, Diabetes, Cardiovascular Disease, or HIV/Aids.
Herpes Zoster Virus vaccine (Reduces the rate of herpes zoster [shingles])	100% of Scheme Medicine Reference Price	Limited as follows:	One vaccination every five years for adults 60 years and older.
Personal Health Assessment (PHA)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one pbpa	One assessment pbpa. Benefit limited to Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted providers rendering onsite services at employer groups; subject to completion and follow up of the assessment. Applies to members and beneficiaries aged 16 years and older only.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Post-Personal Health Assessment (PHA): Additional Consultations for Dietician and Biokineticist	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to two dietician visits per year plus two Biokineticist visits per year. First visit to dietician and biokineticist to take place within 6 weeks of the PHA and second visit within 12 months of the PHA, otherwise funded from day-to-day benefits	Limited to medium and high-risk members and/or members with a Body Mass Index (BMI) of 30 and more. Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA. Clinical Entry Criteria applies. Applies to members and beneficiaries aged 16 years and older only.
Post-Personal Health Assessment (PHA): Additional Consultation for Bankmed Entry Plan GP	100% of cost at a DSP Not covered at a non-DSP	Limited to one Bankmed Entry Plan GP visit pbpa Visit to Bankmed Entry Plan GP to take place within 6 weeks of the PHA, otherwise funded from day-to-day benefits.	Limited to high-risk members. Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA. Clinical Entry Criteria applies. Applies to members and beneficiaries aged 16 years and older only.
Bankmed Mental Wellbeing Assessments			Free online assessment via www.bankmed.co.za; There is no limit on the number of assessments per beneficiary per annum.
Mental Health 'At Risk' Benefit: Additional Consultation for Bankmed Entry Plan GP or Network Psychologist	100% of cost at a DSP Not covered at a non-DSP	Limited to one consultation per qualifying beneficiary Visit to Bankmed Entry Plan GP or Network Psychologist to take place within 6 weeks of the Online Mental Wellbeing Assessment,	Limited to high-risk members. Consultations limited to Bankmed Entry Plan GPs and Bankmed Network psychologists. Members identified and risk-rated using results from the Online Mental Wellbeing Assessment, therefore subject to completion of the Online Mental Wellbeing Assessment. Clinical Entry Criteria applies.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
		otherwise funded from day-to-day benefits.	
New-born Screening Test	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one per beneficiary	Testing limited to services provided within the borders of South Africa. Test funded only if performed within 72 hours of birth.
New-born Hearing Test	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one per beneficiary	Testing limited to service provided by a registered audiologist. Only the test is funded. Should the provider charge a consultation fee, the consultation fee will be funded from available consultation benefits. Test only funded if performed within eight weeks of birth. Thereafter funded from standard benefits.
T21 Chromosome Test or Non-Invasive Prenatal Test (NIPT) **(Member may have either of the two tests, not both)**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one per pregnancy	Subject to the Scheme's protocols and clinical entry criteria. Applies to high-risk beneficiaries only, who are aged 35 years and older at delivery. One assessment per beneficiary per pregnancy. Testing limited to services provided within the borders of South Africa. If member does not meet clinical entry criteria, the screening test is not covered on this Plan.
Amniocentesis	100% of cost for DSP 100% of Scheme Rate for non-DSP	Limited to one per pregnancy	Subject to gynaecologist referral. One assessment per beneficiary per pregnancy. Testing limited to services provided within the borders of South Africa.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Dementia Screening and Assessment Benefit	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one consultation and comprehensive cognitive assessment per qualifying beneficiary per year	One assessment per qualifying pbpa. Testing limited to service provided by a registered Occupational Therapist. Where an Occupational Therapist is not available, the member may consult a Bankmed Network psychologist for the assessment. Only the consultation and assessment are funded. Should the provider charge for additional services, these services will be funded from standard available benefits, where relevant. Applies to members and beneficiaries aged 65 years and older only.
Child Obesity Screening	100% of cost at a DSP Not covered at a non-DSP	Limited to one pbpa	One assessment pbpa. Applies to beneficiaries who are 9 years old to 15 years old only.
Child Obesity Screening: Additional Consultations for Dietician and Biokineticist	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to two dietician visits per year plus two Biokineticist visits per year First visit to dietician and biokineticist to take place within 6 weeks of the Child Obesity Screening and second visit within 12 months of the Child Obesity Screening, otherwise funded from day-to-day benefits	Limited to medium and high-risk beneficiaries and/or beneficiaries based on Body Mass Index (BMI). Beneficiaries identified and risk-rated using results from the Child Obesity Screening, therefore subject to completion of the Child Obesity Screening. Clinical Entry Criteria applies. Applies to beneficiaries who are aged 9 years to 15 years only.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Child Obesity Screening: Additional Consultation for Bankmed Entry Plan GP	100% of cost at a DSP Not covered at a non-DSP	Limited to one Bankmed Entry Plan GP visit. Visit to Bankmed Entry Plan GP to take place within 6 weeks of the Child Obesity Screening, otherwise funded from day-to-day benefits.	Limited to high-risk beneficiaries. Beneficiaries identified and risk-rated using results from the Child Obesity Screening, therefore subject to completion of the Child Obesity Screening. Clinical Entry Criteria applies. Applies to beneficiaries who are 9 years old to 15 years old only.
DIABETES MANAGEMENT For members registered on the Scheme's Disease Management Programme	100% of cost for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP and member utilises the Scheme's DSP as their service provider. 100% of Scheme Rate if non-DSP used.	Unlimited Out-of-network GP Benefit Limit applies if the doctor is not the member's nominated GP.	Basket of Care set by the Scheme, subject to PMB regulations.
Continuous Glucose Monitoring Device (CGM) Available to Type 1 and Type 2 diabetics meeting the Scheme's clinical entry criteria	Subject to authorisation and/or approval and the member meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.	Unlimited	Subject to the Scheme's protocols and clinical entry criteria. Members with a CGM device have limited glucose strip benefits, where approved.
DISEASE MANAGEMENT FOR CARDIO-METABOLIC RISK SYNDROME Disease Management for cardiometabolic risk syndrome for members registered on the Scheme's Disease Management Programme	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.	Limited to PMBs and the basket of care set by the Scheme.	Subject to PMB regulations. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
RADIOLOGY AND PATHOLOGY			
In Hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	
Out of hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP		Out-of-hospital subject to Bankmed GP Entry Plan Network (DSP) and subject to the Scheme approved formulary. For radiology and pathology requested or carried out via a specialist, the benefit will be subject to the specialists out of hospital consultations and procedures limit as specified elsewhere in this schedule.
MRI / CT SCANS AND RADIONUCLIDE SCANS			
In Hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	Subject to pre-authorisation.
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. PMBs limited to 100% of Scheme Rate for radiology facilities at non-DSPs, subject to PMB regulations.
HIV/AIDS PROGRAMME Additional benefits subject to registration on HIV/Aids Programme. These additional benefits do not contribute to the depletion of other insured benefits provided by the Scheme.			Beneficiaries who do not register on the HIV/Aids Programme will be entitled to benefits for PMBs (only), subject to PMB regulations.
Consultations and pathology	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited Out-of-network GP Benefit Limit applies if the doctor is not a DSP	Subject to benefits available in Scheme's Basket of Care

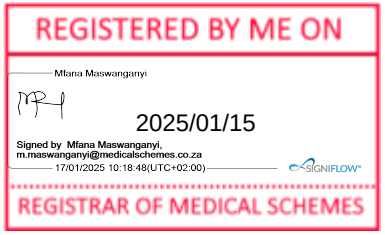
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Associated Medicine/Drugs • Medication via Bankmed Pharmacy Network (DSP)	100% of cost	Unlimited	Bankmed Pharmacy Network for HIV/Aids medication: as communicated to registered beneficiaries from time to time.
• Medication via non-DSP (voluntary use of non-DSP)	80% of Scheme Medicine Reference Price plus dispensing fee	Unlimited	A motivation is required for the use of a non-DSP for medication.
• Medication via non-DSP (involuntary use of non-DSP)	100% of cost	Unlimited	Subject to Scheme's approved formulary. Scheme's Medicine Reference Price applies to non-formulary medication.
INTERNAL PROSTHESIS			Benefits subject to clinical motivation, the application of clinical / funding protocols, Scheme approval and PMB regulations. Defined as appliances placed in the body as an internal adjuvant, during an operation. Combined limit for all internal prosthesis items, excluding pacemakers and defibrillators; Sub-limits may apply depending on the prosthesis required. All sub-limits as indicated are further subject to the combined limit for all internal prosthesis items, excluding pacemakers, defibrillators. The sub-limits are not "in addition to" the combined limit. Dental implants of any nature are not included in the definition of internal prosthesis. The prostheses accumulate to the limit. The balance of the hospital and related accounts do not accumulate to the annual limit.
Combined limit for all internal prostheses items	100% of cost via a DSP 100% of Scheme Rate via non-DSP	R91 190 pbpa	
Internal prosthesis sub-limits:			
Hip joint prostheses, knee joint prostheses and shoulder joint prostheses	100% of cost via a DSP 100% of Scheme Rate via non-DSP	R60 685 per prosthesis per admission if prosthesis is not supplied by the Scheme's network provider. If supplied by the Schemes network provider, unlimited (not subject to combined limit for all internal prosthesis items)	
Spinal fusions	100% of cost via a DSP 100% of Scheme Rate via non-DSP	R61 440	
Cardiac stents	100% of cost via a DSP 100% of Scheme Rate via non-DSP	R90 830	

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Grafts **Cardiac Valves** **Non-specified items**	100% of cost via a DSP 100% of Scheme Rate via non-DSP 100% of cost via a DSP 100% of Scheme Rate via non-DSP 100% of cost via a DSP 100% of Scheme Rate via non-DSP	R49 170 R51 715 R28 335	
SPINAL CARE (SPINAL 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
PACEMAKERS AND DEFIBRILLATORS	100% of cost at hospital network DSPs 80% of cost at non-DSPs	Limited to PMBs	Subject to clinical motivation, the application of clinical / funding protocols, Scheme approval and PMB regulations.
INTRAOCCULAR LENSES FOR CATARACT SURGERY (Permanent, implantable lenses, inclusive of basic and specialised lens varieties)	Up to a maximum of 100% of the Scheme Rate Scheme Rate is equal to the negotiated and agreed lens price plus 25% mark-up	Limited to PMBs	Subject to pre-authorisation and the treatment meeting the Scheme's criteria. Covered in full when supplied by the Scheme's preferred suppliers, otherwise covered up to the Scheme Rate for the lens. Scheme Rate is equal to the negotiated and agreed lens price plus 25% mark-up Where the provider marks up the lens cost in excess of the agreed rate, the Scheme will not be responsible for the shortfall.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
EXTERNAL PROSTHESIS Artificial limbs and eyes (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	R4 005 pfpa	Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval. Benefit includes the repair of the prosthesis. **Frequency limits apply:** Breast prosthesis bra: no limit on number of bras that may be purchased in 12 months; Rand limit applies Breast prosthesis: one/two per 24 months (one/two is patient dependent)
MEDICAL AND SURGICAL APPLIANCES (Combined limit with External Prosthesis Benefit and Blood Pressure Monitors, Nebulisers and Glucometers)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R4 005 pfpa	Benefits subject to a doctor's prescription, the application of clinical and funding protocols, and Scheme approval. No benefit for wheelchairs and large orthopaedic appliances on this plan, except for PMBs. **Frequency limits apply:** Surgical/moonboot: one every 24 months Crutches: one set every 24 months Brace callipers: one set every 24 months Rigid back brace: one every 24 months Wig: one every 24 months Commodes: one every 36 months Walking frames: one every 24 months Surgical compression stockings: two pairs per 12-month period Sling/clavicle brace: one every 24 months Humidifier: one every 36 months

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS (Combined limit with External Prosthesis Benefit and Medical and Surgical Appliances)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R4 005 pfpa R1 540 pbpa for blood pressure monitors R2 175 pbpa for nebulisers R1 085 pbpa for glucometers	Benefits subject to a doctor's prescription, the application of clinical and funding protocols, and pre-authorisation. **Frequency limits apply:** Blood pressure monitors: one every 36 months Nebulisers: one every 36 months Glucometers: one every 36 months
HEARING AIDS (SUPPLY AND FITMENT)	No benefit, except for PMBs	No benefit, except for PMBs	**Frequency limits apply:** Benefit only available where the beneficiary has not claimed for hearing aid/s in the previous calendar year. Rolling limit every 24 months. No benefit for replacement batteries.
HEARING AID REPAIRS	No benefit	No benefit	
BONE ANCHORED HEARING AIDS	No benefit	No benefit	
COCHLEAR IMPLANTS	No benefit	No benefit	
UPGRADE OR REPLACEMENT OF SPEECH PROCESSORS	No benefit	No benefit	
PSYCHIATRY, CLINICAL PSYCHOLOGY, & RELATED OCCUPATIONAL THERAPY **Hospitalisation:** **Hospital Network DSPs** All admissions at network DSP	 100% of cost for Bankmed Network Psychiatric facilities (DSPs)	 Limited to PMBs	 Subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP). Cover for 21 days in hospital in line with PMB regulations.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Other hospitals (non-DSPS)			
PMB admission: involuntary use of non-DSP	100% of cost	Limited to PMBs	Subject to PMB regulations.
PMB admission: voluntary use of non-DSP	80% of Scheme Rate for non-DSPs	Limited to PMBs	PMBs limited to 80% of Scheme Rate for non-DSPs, subject to PMB regulations.
Non-PMB admission	No benefit		
In-hospital consultations / sessions	100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs	Subject to PMB regulations.
Out of hospital consultations / sessions	100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs	Subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP). PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations. Cover for 15 out-of-hospital psychotherapy sessions for PMBs, in line with PMB regulations.
Post-hospital psychiatric consultation within 30 days of discharge from hospital (excluding day cases) for a psychiatric admission (Related to Major Depression, Schizophrenia and Bipolar Mood Disorder only)	100% of cost for Bankmed Entry Plan Network Psychiatrist: DSPs 100% of Scheme Rate for non-DSP Psychiatrist	Limited to three consultations per beneficiary per annum	An additional consultation will be granted as an insured benefit, per beneficiary visiting a psychiatrist within 30 days of discharge, following an authorised psychiatric hospital admission (excluding day cases). PMBs limited to 100% of Scheme rate for non-DSPs, subject to PMB regulations. In the event that the member exceeds the three-consultation limit (following three hospital admissions), the consultations will be subject to the standard psychiatry, clinical psychology and related occupational therapy benefit limits.



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
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 DSP. 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.
OCCUPATIONAL THERAPY: PSYCHIATRIC CONSULTATIONS / SESSIONS			
In hospital	100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs	Subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP). Subject to PMB regulations.
Out of hospital	100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs	Subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP). Subject to PMB regulations.
OCCUPATIONAL THERAPY: NON-PSYCHIATRIC CONSULTATIONS / SESSIONS			
In hospital	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	Limited to PMBs	Subject to pre-authorisation and PMB regulations.
Out of hospital	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	Limited to PMBs	
PHYSIOTHERAPY			
In hospital	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	Limited to PMBs	Subject to pre-authorisation and PMB regulations.
Out of hospital (including post-hospitalisation treatment)	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	Limited to PMBs	Subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP).

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

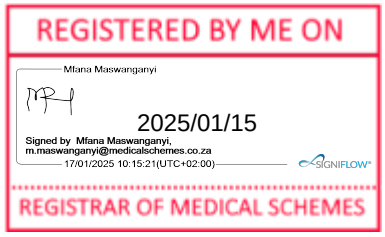
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
			The fees must have been incurred for a definite complaint and treatment must be for curative purposes only. 100% of cost for PMBs (insured benefit), subject to PMB regulations.
CHRONIC MEDICATION **Medication via DSP** **(Bankmed GP Entry Plan Network GP)** **Medication via non-DSP** **(voluntary use of non-DSP)** **Medication via non-DSP** **(involuntary use of non-DSP)**	Subject to Scheme approved formulary 100% of cost plus contracted dispensing fee 80% of Scheme Medicine Reference Price 100% of cost plus dispensing fee	 Unlimited Subject to out of network GP consultations and procedures limit of R2 755 pfpa Unlimited	Benefits for chronic medication, drugs and injection material subject to: • Prior application and approval of the Scheme • Each prescription or repeat prescription being limited to one month's supply per beneficiary • Such motivations and reports by appropriate medical practitioners, as are required by the Scheme • PMB regulations • Scheme approved formulary Dispensing fee limited to the contracted dispensing fee applicable to Bankmed GP Entry Plan Network GPs and Bankmed Pharmacy Network (DSPs).
PRESCRIBED ACUTE MEDICATION **Medication via DSP** **(Bankmed GP Entry Plan Network GP and Bankmed Pharmacy Network)** **Medication via non-DSP** **(voluntary use of non-DSP)**	Subject to Scheme approved formulary 100% of cost plus contracted dispensing fee 100% of cost plus dispensing fee	 Unlimited Subject to Out-of-Network GP Consultations and Procedures Limit of R2 755 pfpa	 Unlimited benefits for acute medication, drugs and injection material via selected Bankmed GP Entry Plan Network GP and Bankmed Pharmacy Network, subject to Scheme approved formulary. See General Practitioners: Out-of-hospital consultations and procedures in rooms at non-Bankmed Entry Plan Network GPs (non-DSPs). If prescribed by a non-DSP, medication will accumulate to the Out-of-

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Medication via non-DSP (involuntary use of non-DSP)	100% of cost plus contracted dispensing fee	Unlimited	Network GP Consultations and Procedures Limit, even if a DSP pharmacy is used.
SELF-MEDICATION (OVER THE COUNTER MEDICINE) AND PHARMACY ADVISED THERAPY (PAT)	No benefit	No benefit	For member's own account
HOMEOPATHIC MEDICATION	No benefit	No benefit	For member's own account
SPECIALISTS **In hospital consultations, operations and procedures**	100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	Subject to pre-authorisation. No benefit for dental surgery except for PMBs. PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.
Out-of-hospital consultations and procedures in rooms	100% of cost for Bankmed Network Specialists: DSPs 80% of cost if no pre-authorisation and no referral from Bankmed GP Entry Plan Network GP 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	Limited to: M = R4 460 pbpa M+ = R6 985 pfpa	Subject to pre-authorisation and referral by a Bankmed GP Entry Plan Network GP. Limit includes costs associated with an out of hospital specialist consultation/ procedure (e.g. basic radiology, scans, pathology and acute medicine prescribed by the specialist/appearing on the specialist's account), that are not already provided for elsewhere in this schedule. PMBs limited to 100% of Scheme Rate for non-DSPs (with further reduction to 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed GP Entry Plan Network GP), subject to PMB regulations. Benefits for MRI/CT scans and radionuclide scans are as described elsewhere in this schedule.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
GENERAL PRACTITIONERS (GPs)			
In hospital consultations	100% of cost for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	In-hospital benefits are subject to pre-authorisation.
In hospital operations and procedures	100% of cost for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.
Out of hospital consultations and procedures in rooms	100% of cost for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Unlimited Limited to three visits and a maximum of R2 755 pfpa (subject to PMBs)	No benefit for dental surgery except for PMBs. All costs associated with the out of network GP visit will accumulate to this limit. Benefits for MRI/CT scans and radionuclide scans are as specified elsewhere in this schedule. PMBs limited to 100% of Scheme rate for non-DSPs, subject to PMB regulations.
Post hospital GP consultation within 30 days of discharge from hospital (excluding day cases)	100% of cost for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs Subject to out-of-network GP limit if non-DSP used	Unlimited	An additional consultation will be granted as an insured benefit, per beneficiary visiting a GP within 30 days of discharge, following an authorised hospital admission (excluding day cases). PMBs limited to 100% of Scheme rate for non-DSPs, subject to PMB regulations.
Virtual GP consultation	100% of cost for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs Subject to out-of-network GP limit if non-DSP used	Limited to three consultations pbpa	Subject to member and/or beneficiary having a prior consulting relationship with the GP. Verification notes to be submitted by claiming GP.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
MAXILLO-FACIAL AND ORAL SURGERY	100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs	Subject to pre-authorisation and PMB regulations.
PREVENTATIVE AND BASIC DENTISTRY Scale and polish, routine extractions, x-rays to support diagnosis, restorations (amalgam and resin only), basic root canal therapy (including emergency), full and partial plain plastic dentures obtained at a preferred provider and clasps/repairing of dentures (plastic only)	100% of cost for DSPs	Unlimited	At Preferred Provider Network (Bankmed Dental Network), and according to Scheme approved formulary.
ADVANCED DENTISTRY Caps, crowns, bridges and cost of endosteal and ossea-integrated implants	No benefit	No benefit	
ORTHODONTICS	No benefit	No benefit	
ALL OTHER DENTAL SERVICES • Second and subsequent examinations in the same year; • X-rays	100% of cost for DSPs	Unlimited	At Preferred Provider Network (Bankmed Dental Network), and according to Scheme approved formulary.
OPTOMETRY **Consultations** **Frames and extras** **Prescription lenses** **Contact lenses** **Fitting of contact lenses**	 100% of cost 100% of cost 100% of cost No benefit No benefit	 One consultation pb every two years One frame pb every two years One pair of lenses pb every two years No benefit No benefit	 Benefits via Preferred Provider Network (Iso Leso Optometry Network) only. No benefit for readymade readers on this plan.
Other optometric services Refractive surgery/excimer laser treatment, hospitalisation and associated costs	No benefit	No benefit	No benefit, including the cost of hospitalisation, medication and all other associated services.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
CLAIMS FOR SERVICES RENDERED OUTSIDE THE BORDERS OF SOUTH AFRICA	As per Annexure D	As per Annexure D	Foreign claims covered at the relevant Scheme Rate and/or Rand limit normally allowed for an equivalent non-PMB claim in South Africa. In the case of internal prosthesis and/or medical and surgical appliances, funding will be limited to the amount or rate at which the Scheme would normally fund or procure such device within the borders of South Africa. No benefits for emergency/ambulance transport outside the borders of South Africa. Medical motivation and prior approval required for elective/non-emergency surgery outside the borders of South Africa. No benefits for services not normally covered at the Scheme's preferred provider network (Bankmed GP Entry Plan Network) for out of hospital consultations, medicine and treatment (except via Bankmed GP Entry Plan Network providers in Lesotho).



LEGEND:

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