BANKMED

ANNEXURE B: BENEFITS

PREAMBLE

1. Subject to paragraph 2 and 3 below the total aggregate monthly Contributions payable by or in respect of a member in accordance with the provisions of rule 13 shall be as indicated in the schedules in

- Annexure A1 hereof in respect of the Bankmed Essential Plan;
- Annexure A2 hereof in respect of the Bankmed Basic Plan;
- Annexure A3 hereof in respect of the Bankmed Core Saver Plan;
- Annexure A4 hereof in respect of Bankmed Traditional Plan;
- Annexure A5 hereof in respect of Bankmed Comprehensive Plan; and
- Annexure A6 hereof in respect of Bankmed Plus Plan.

(a) "Cost", shall mean –

(i) In respect of prescription medicines, the single exit price plus the dispensing fee (if applicable) as may be prescribed by regulation from time to time;

(ii) In respect of any other relevant health service, the net cost charged for such service; and

(iii) In respect of a contracted or negotiated service, the cost according to the contract, agreement or arrangement.

(iv) In respect of surgical items and procedures provided in hospital, the Nett Acquisition Price

(b) Subject to the provisions contained in these rules, members paying the contributions as specified in the relevant schedule of Annexure A shall be entitled to the benefits as set out in the corresponding schedule of benefits hereof, both for themselves and for their registered dependants.

(i) The diagnosis, treatment and care costs of the statutory Prescribed Minimum Benefit (PMB) conditions, in and out-of-hospital, subject to the Council for Medical Scheme's algorithms, will be paid in full if those services are obtained from the designated service provider in South Africa, or if involuntarily obtained from a provider in South Africa who is not the designated service provider.

(ii) The Scheme selects any contracted providers as its designated service provider (DSP). Other contracted providers as DSPs:

ESSENTIAL PLAN
• Hospital Network DSPs (a restricted network of contracted private hospitals/facilities as communicated to members from time to time) • Bankmed GP Entry Plan Network GPs (DSPs for in and out of hospital consultations and procedures) • Bankmed Network Specialists (DSPs for in and out of hospital consultations and procedures) • Bankmed GP Entry Plan Network GPs and Bankmed Pharmacy Network (DSPs for acute and chronic medication) • Bankmed Pharmacy Network for HIV medication (DSP for HIV medication for beneficiaries registered on the HIV/Aids Programme) • Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted PHA/HCT providers rendering onsite services at employer groups (DSPs for PHA/HIV Counselling and testing) • Bankmed Network practitioners for any other services as communicated to members from time to time

BASIC PLAN
• Hospital Network DSPs (a restricted network of contracted private hospitals/facilities as communicated to members from time to time) • Bankmed GP Entry Plan Network GPs (DSPs for in and out of hospital consultations and procedures) • Bankmed Network Specialists (DSPs for in and out of hospital consultations and procedures) • Bankmed GP Entry Plan Network GPs and Bankmed Pharmacy Network (DSPs for acute and chronic medication) • Bankmed Pharmacy Network for HIV medication (DSP for HIV medication for beneficiaries registered on the HIV/Aids Programme) • Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted PHA/HCT providers rendering onsite services at employer groups (DSPs for PHA/HIV Counselling and testing) • Bankmed Network practitioners for any other services as communicated to members from time to time

CORE SAVER PLAN
• Hospital Network DSPs (a wide network of contracted private hospitals/facilities as communicated to members from time to time) • Bankmed Network GPs (DSPs for in and out of hospital consultations and procedures) • Bankmed Network Specialists (DSPs for in and out of hospital consultations and procedures) • Bankmed Network GPs and Bankmed Pharmacy Network (DSPs for acute and chronic medication) • Bankmed Pharmacy Network for HIV medication (DSP for HIV medication for beneficiaries registered on the HIV/Aids Programme) • Bankmed Network GPs, Bankmed Pharmacy Network and contracted PHA/HCT providers rendering onsite services at employer groups (DSPs for PHA/HIV Counselling and testing)

TRADITIONAL PLAN
• Hospital Network DSPs (a restricted network of contracted private hospitals/facilities as communicated to members from time to time) • Bankmed Network GPs (DSPs for in and out of hospital consultations and procedures) • Bankmed Network Specialists (DSPs for in and out of hospital consultations and procedures) • Bankmed Network GPs and Bankmed Pharmacy Network (DSPs for acute and chronic medication) • Bankmed Pharmacy Network for HIV medication (DSP for HIV medication for beneficiaries registered on the HIV/Aids Programme) • Bankmed Network GPs, Bankmed Pharmacy Network and contracted PHA/HCT providers rendering onsite services at employer groups (DSPs for PHA/HIV Counselling and testing)

COMPREHENSIVE PLAN
• Hospital Network DSPs (a wide network of contracted private hospitals/facilities as communicated to members from time to time) • Bankmed Network GPs (DSPs for in and out of hospital consultations and procedures) • Bankmed Network Specialists (DSPs for in and out of hospital consultations and procedures) • Bankmed Network GPs and Bankmed Pharmacy Network (DSPs for acute and chronic medication) • Bankmed Pharmacy Network for HIV medication (DSP for HIV medication for beneficiaries registered on the HIV/Aids Programme) • Bankmed Network GPs, Bankmed Pharmacy Network and contracted PHA/HCT providers rendering onsite services at employer groups (DSPs for PHA/HIV Counselling and testing)

PLUS PLAN
• Hospital Network DSPs (a wide network of contracted private hospitals/facilities as communicated to members from time to time) • Bankmed Network GPs (DSPs for in and out of hospital consultations and procedures) • Bankmed Network Specialists (DSPs for in and out of hospital consultations and procedures) • Bankmed Network GPs and Bankmed Pharmacy Network (DSPs for acute and chronic medication) • Bankmed Pharmacy Network for HIV medication (DSP for HIV medication for beneficiaries registered on the HIV/Aids Programme) • Bankmed Network GPs, Bankmed Pharmacy Network and contracted PHA/HCT providers rendering onsite services at employer groups (DSPs for PHA/HIV Counselling and testing)

Where the Scheme has not previously appointed a Designated Service Provider or providers for the provision of Prescribed Minimum Benefit services in South Africa with regard to a specific plan or plans but subsequently contracts with such provider or providers during the year, the Scheme shall inform the affected members, in writing, of the appointment and application of such a DSP, subject to Prescribed Minimum Benefit regulations.

(i) A co-payment or deductible, equivalent to the amount by which the costs of providing diagnosis treatment and care of the prescribed minimum conditions in South Africa exceed the benefits provided for in Appendix 3, shall be imposed if these services are voluntarily obtained from a provider who is not the designated service provider. In the case of voluntary use of a non-formulary drug, a co-payment equal to the difference between the cost of the drug and the reference price of the formulary drug will apply, except where a percentage co-payment is specified in the rules of the Scheme, in which case the specified co-payment will apply.

(ii) A beneficiary will be deemed to have involuntarily obtained a Prescribed Minimum Benefit service from a provider other than the designated service provider, if:

(a) The service was not available from the designated service provider or would not be provided without unreasonable delay;

(b) Immediate medical or surgical treatment for a Prescribed Minimum Benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from the designated service provider, or

(c) There was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

(iii) If cover in terms of these rules, for a condition specified in the statutory Prescribed Minimum Benefits is exhausted while the patient is still undergoing or requires diagnosis, care or treatment for that condition in South Africa, the scheme will accept liability for all costs incurred, subject to (iii) above.

(c) Preauthorisation shall be required before hospitalisation, surgical procedures and other specified items may qualify for benefits. In the case of an emergency the Scheme must be notified thereof within 24 hours or on the first working day after such an emergency admission or treatment having been initiated, failing which paragraph (d) (iii) of this preamble will apply. Notwithstanding anything to the contrary, the Scheme shall not refuse such authorisation or preauthorisation for a Prescribed Minimum Benefit in a public hospital.

(d) In respect of benefits set out in this Annexure the following principles will apply in all cases where preauthorisation is required -

(i) if preauthorisation is obtained and the treatment does not exceed the authorisation, the treatment will qualify for the benefits as stated;

(ii) if preauthorisation is obtained and the authorisation is exceeded, benefits will only accrue for the authorised treatment. The cost pertaining to the treatment in excess of that preauthorised will be payable by the member. In exceptional cases the Board may agree to a retrospective authorisation, subject to such terms and conditions as the Board may determine.

(iii) if treatment is undergone without preauthorisation having been obtained, application may be made retrospectively for an authorisation. If authorisation is declined, no benefits will accrue, provided that authorisation for Prescribed Minimum Benefits will not be refused, but shall be covered in full as provided for in paragraph (b)(i) above, where these services are obtained within the borders of South Africa. Deductibles will not be applied to confinements and

readmissions within 6 weeks of discharge from hospital following complications directly related to a prior admission in respect of which a deductible was levied.

(e) Claims must be submitted in accordance with the instructions contained in Annexure D.

(f) Maximum annual benefits shall be calculated from 1 January to 31 December each year, based on the services rendered during that year; with provision, in accordance with 16.1.5 of these rules, for such maximum annual benefits to be adjusted (prorated) in proportion to the period of membership, calculated from date of admission, when a beneficiary is admitted later than 1 January of a given year.

(g) Benefits are not transferable from one financial year to another or from one category to another, except for the Medical Savings Account, where applicable.

(h) No preauthorisation is required in the case of treatment necessary for rape victims; benefits in respect of such treatment shall not be subject to a member's Medical Savings Account; and in respect of medicines, the benefit entitlement as for chronic medication, shall apply.

(i) The Scheme shall establish or cause to be established a programme to manage the treatment of immune deficiency related to HIV/AIDS. Benefit entitlement shall be 100% in respect of all the services, materials and medicines detailed in this Annexure, subject to preauthorisation and adherence to the said programme, subject to the Prescribed Minimum Benefits.

(j) The Scheme shall enter into or cause to be entered into such arrangements, agreements or contracts with private hospitals or hospital groups, including but not limited to per diem reimbursements, as may be considered appropriate. Benefit entitlements shall be 100% of the cost according to the arrangement, agreement or contract.

(k) In respect of benefits to private hospitals and day clinics set out in Annexures B1 to B6 hereof, the following principles will apply in all non-emergency admissions:

(a) an upfront payment or deductible, as quantified in the relevant Annexure, shall be imposed for all non-emergency private hospital admissions except for confinements, readmissions and Prescribed Minimum Benefits.

(b) "Emergency" is defined in rule 4.23.

2. Diagnostic tests for an unconfirmed PMB diagnosis

Where diagnostic tests and examinations are performed but do not result in confirmation of a PMB diagnosis, except for an emergency medical condition, such diagnostic tests or examinations are not considered to be a PMB. (Explanatory Note 7 in the Regulations)

3. Co-payments

Co- payments in respect of the costs for PMBs may not be paid out of medical savings accounts.

4. Chronic conditions or as otherwise specified under Diagnosis and Treatment Pairs

Any benefit option covers the full cost for services rendered in respect of the prescribed minimum benefits which includes the diagnosis, medical management, medication and care to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specified chronic conditions.