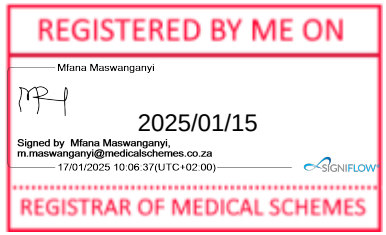


BANKMED

ANNEXURE B3: BANKMED CORE SAVER PLAN (WITH 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

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

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

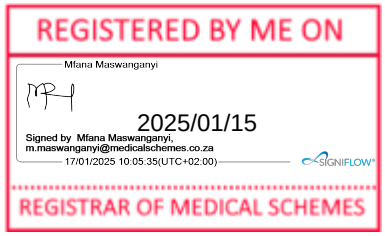
PMB claims shall not be funded from Savings

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

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

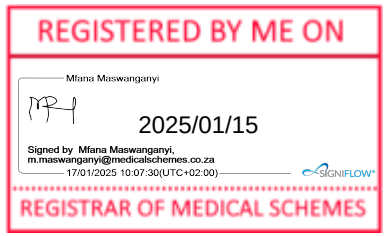


HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
OVERALL ANNUAL LIMIT		Unlimited	This plan has no overall annual limit.
HOSPITAL NETWORK/DSPs	Hospital Network DSPs are applicable on this plan. Reduced benefits apply for accommodation and associated fees charged by non-DSP hospitals, 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 100% of Scheme Rate 100% of Scheme Rate	 Unlimited (at general ward rates) Unlimited (at general ward rates) Unlimited (at general ward rates) Unlimited (at general ward rates)	Benefits subject to pre-authorisation and 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.
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.		

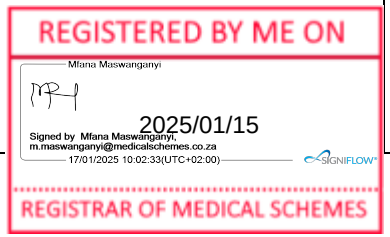
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Benefits provided on admission to:			
1. Hospital Network DSPs			
• Ward Fees (general ward rate) • ICU and high care unit fees • Theatre fees • Ward and theatre drugs, dressings, materials and equipment consumed / utilised in hospital • 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. Subject to available Medical Savings Account.
• 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	100% of Scheme Rate	Unlimited	PMBs limited to 100% 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 hospital non-DSPs)	100% of Scheme Rate	Unlimited	
3. Unattached Theatre Units (Private)			
• Theatre fees • Recovery beds	100% of cost at a DSP 100% 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 100% of Scheme Rate at a non-DSP	Unlimited	

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITION
OUTPATIENT CONSULTATIONS WITH GPs/SPECIALISTS AT HOSPITAL EMERGENCY ROOMS AND OUTPATIENT UNITS	See General Practitioners/ Specialists: out of hospital consultations in rooms	See General Practitioners/ Specialists: out of hospital consultations in rooms	Regarded as consultation authorised l
HOME-BASED HEALTHCARE **For clinically appropriate chronic and acute treatment and conditions, where treatment is possible at home**	100% of Scheme Rate	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.

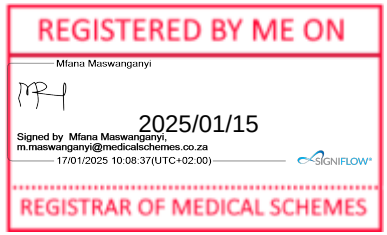
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
ONCOLOGY (CHEMOTHERAPY AND RADIOTHERAPY)			
In and out of hospital consultations, treatment and materials	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	Subject to: - Pre-authorisation and PMB regulations - Evidence-based 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) Excludes medicines administered in-hospital and medicines administered in-rooms by a dispensing provider.	100% of cost	Limited to PMBs	

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** **Associated Medicine/Drugs**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	Subject to pre-authorisation and PMB regulations.
• Medication via designated courier pharmacy (DSP)	100% of cost	Unlimited	
• Medication via non-DSP (voluntary use of non-DSP)	80% of Scheme Medicine Reference Price plus dispensing fee	Unlimited	
• Medication via non-DSP (involuntary use of non-DSP)	100% of cost	Unlimited	
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:	Over and above the PMB requirements. Up to a maximum of 100% of the Scheme Rate.	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

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
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	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.		- 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	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	Unlimited	Subject to pre-authorisation and PMB regulations.
Birthing facilities	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited (Cost of disposables limited to R1 440 per case)	Subject to pre-authorisation and PMB regulations. Only available where hospital services are not used (except for registered active birthing units).
GPs and Specialists	As specified elsewhere in this schedule	As specified elsewhere in this schedule	Benefits for General Practitioners and Specialists as specified elsewhere in this schedule.
Radiology and Pathology	As specified elsewhere in this schedule	As specified elsewhere in this schedule	Benefits for Radiology and Pathology specified elsewhere in this schedule.



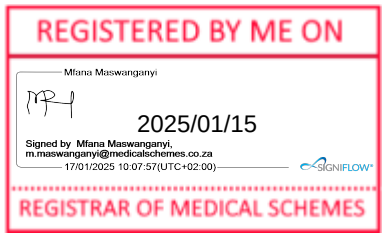
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Additional insured benefits at or subject to referral by a Bankmed Network GP and subject to registration on the Scheme's Maternity Programme (Baby and Me):			
• 6 ante-natal consultations per pregnancy	100% of cost for DSP 100% of Scheme Rate for non-DSP	As specified	Additional insured consultations covered at the applicable rate for General Practitioner/ Specialist consultations in rooms as specified elsewhere in this schedule.
• 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 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 subject to Care Plan.
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	



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 from the Insured Benefit Thereafter subject to available Savings Unlimited	
HomeCare Services	100% of cost at a DSP 100% of Scheme Rate at a non-DSP		For procedures not requiring admission to a day surgery facility or hospital. Subject to Scheme Clinical Entry Criteria. Subject to preauthorisation.
ADVANCED ILLNESS BENEFIT	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	Subject to pre-authorisation and the treatment meeting the Scheme's guidelines and managed care criteria.
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.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
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).
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 Network GP' 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 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 Network GP or Bankmed Prestige A&B 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. Should member not meet clinical entry criteria, and they are younger than age 50, the member may claim the bone

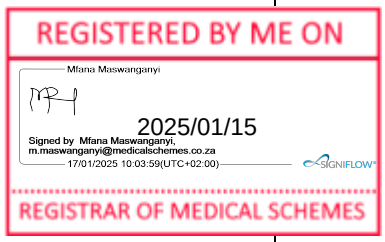
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
			densitometry test from their Radiology Benefit. Where the Radiology Benefit is exhausted, this test may be claimed from available Medical Savings Account on this Plan.
Tuberculosis (TB) screening	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	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.
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.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
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 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.
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 Network GP	100% of cost at a DSP Not covered at a non-DSP	Limited to one Bankmed Network GP visit pbpa Visit to Bankmed Network 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.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Mental Health 'At Risk' Benefit: Additional Consultation for Bankmed Network 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 Network GP or Network Psychologist to take place within 6 weeks of the Online Mental Wellbeing Assessment, otherwise funded from day-to-day benefits.	Limited to high-risk members. Consultations limited to Bankmed Network 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.
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. One assessment per beneficiary per pregnancy. Testing limited to services provided within the borders of South Africa. Applies to high-risk beneficiaries aged 35 years and older at delivery. If member does not meet clinical entry criteria, the screening test is covered from

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
			the available balance in the member's Medical Savings Account 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.
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	Limited to medium and high-risk 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
		the Child Obesity Screening, otherwise funded from day-to-day benefits	
Child Obesity Screening: Additional Consultation for Bankmed Network GP	100% of cost at a DSP Not covered at a non-DSP	Limited to one Bankmed Network GP visit. Visit to Bankmed Network 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	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 the basket of care set by the Scheme.	Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.

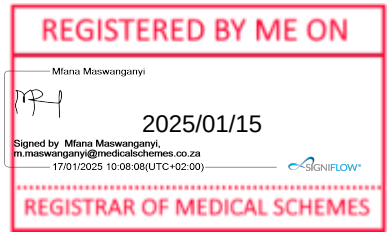


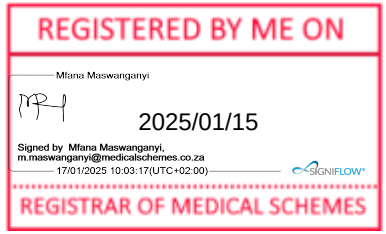
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
RADIOLOGY			
In Hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	
Out of hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Subject to Care Plan and referral by a Bankmed Network GP (DSP)	Out of hospital benefits approved for beneficiaries registered for PMB CDL conditions, subject to a Care Plan and referral by a Bankmed Network GP (DSP). Non-Care Plan benefits subject to available Savings, except for PMBs, subject to PMB regulations.
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	Subject to Care Plan and referral by a Bankmed Network GP (DSP)	Out of hospital benefits approved for beneficiaries registered for PMB CDL conditions, subject to a Care Plan and referral by a Bankmed Network GP (DSP). Non-Care Plan benefits subject to available Savings, except for PMBs, subject to PMB regulations.
MRI / CT SCANS AND RADIONUCLIDE SCANS			
In Hospital and out of hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	Subject to pre-authorisation (both in and out of hospital).
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 all other benefits as specified in this schedule, with continued funding for PMBs, subject to PMB regulations, after depletion of the relevant sub-limits.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Consultations and pathology	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Subject to benefits available in Scheme's Basket of Care	
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	Unlimited	A motivation is required for the use of a non-DSP for medication. Subject to Scheme's approved formulary.
• Medication via non-DSP (involuntary use of non-DSP)	100% of cost	Unlimited	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.
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)	

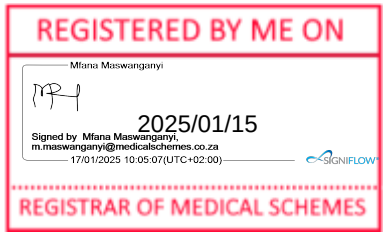
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Spinal fusions	100% of cost via a DSP 100% of Scheme Rate via non-DSP	R61 440	The prostheses accumulate to the limit. The balance of the hospital and related accounts do not accumulate to the annual limit.
Cardiac stents	100% of cost via a DSP 100% of Scheme Rate via non-DSP	R90 830	
Grafts	100% of cost via a DSP 100% of Scheme Rate via non-DSP	R49 170	
Cardiac Valves	100% of cost via a DSP 100% of Scheme Rate via non-DSP	R51 715	
Non-specified items	100% of cost via a DSP 100% of Scheme Rate via non-DSP	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	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
PACEMAKERS AND DEFIBRILLATORS	100% of cost of device if preferred provider used 100% of Scheme Rate if non-preferred provider used to purchase device	Unlimited	Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
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	Unlimited	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.
EXTERNAL PROSTHESIS Artificial limbs and eyes (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	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, Glucometers, Arch supports and Shoe Insoles) REGISTERED BY ME ON Mfana Maswanganyi 2025/01/15 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 17/01/2025 10:06:08(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES	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. Benefits for wheelchairs and large orthopaedic appliances subject to available Savings. Wheelchair accessories subject to the available balance in the member's Medical Savings Account. **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

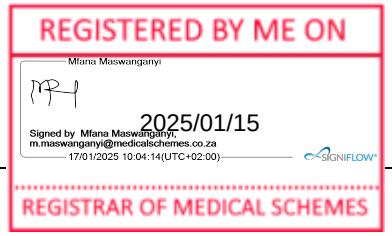
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
			Wig: one every 24 months Commodes: one every 36 months Wheelchairs: one every 36 months Walking frames: one every 24 months Surgical compression stockings: two pairs per 12-month period Sling/clavicle brace: one every 24 months Portable oxygen: one every 48 months Blood pressure monitors: one every 36 months Nebulisers: one every 36 months Glucometers: one every 36 months Arch supports: one pair every 24 months Shoe insoles: one pair every 24 months CPAP machine: one every 36 months Humidifier: one every 36 months
BLOOD PRESSURE MONITORS, NEBULISERS, GLUCOMETERS, ARCH SUPPORTS AND SHOE INSOLES (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	Subject to a combined limit of R4 005 pfpa Sub-limits apply as follows: R1 540 pfpa for blood pressure monitors (one every 36 months) R2 175 pfpa for nebulisers (one every 36 months) R1 085 pfpa for glucometers (one every 36 months)	Benefits subject to a doctor's prescription, the application of clinical and funding protocols, and pre-authorisation. 

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
		R1 125 for arch supports (per pair) (one pair every 24 months) R1 695 for shoe insoles (per pair) (one pair every 24 months)	
HEARING AIDS (SUPPLY AND FITMENT)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Subject to available Savings	**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	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Subject to available Savings	
BONE ANCHORED HEARING AIDS	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Subject to available Savings	
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)	 R85 215 pbpa (Combined limit with occupational therapy: psychiatric consultations /sessions in hospital)	 Subject to pre-authorisation. PMBs limited to 80% of Scheme Rate for non-DSPs, subject to 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.

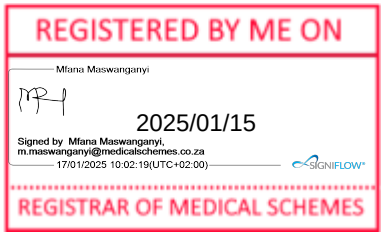
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Other hospitals (non-DSPS)			
PMB admission: involuntary use of non-DSP PMB admission: voluntary use of non-DSP Non-PMB admission	100% of cost 80% of Scheme Rate for non-DSPs 80% of Scheme Rate for non-DSPs		100% of cost for PMBs at Bankmed Prestige A&B Specialist Network (DSPs), subject to referral from a Bankmed Network GP (DSP) and pre-authorisation.
In-hospital consultations / sessions	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSPs		
Out of hospital consultations / sessions	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSPs	Subject to available Savings	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 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, thereafter, available funds in the Medical Savings Account.



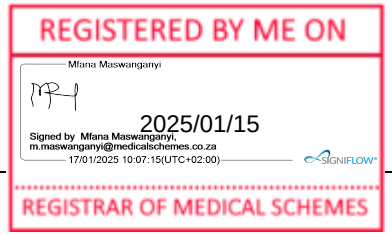
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
MENTAL HEALTH INTEGRATED DISEASE MANAGEMENT PROGRAMME Disease Management for specified mental health conditions for members registered on the Scheme's Mental Health Integrated Disease Management Programme	In addition to the cover provided 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 Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSPs	R85 215 pbpa (Combined limit with occupational therapy: psychiatric consultations /sessions in hospital)	Subject to pre-authorisation and PMB regulations.
Out of hospital	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of Scheme Rate for non-DSPs	Subject to available Savings	
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	Subject to available Savings	100% of cost for PMBs (insured benefit), subject to PMB regulations.



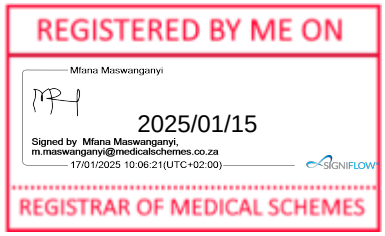
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
PHYSIOTHERAPY			
In hospital	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	Limited to PMBs	Subject to pre-authorisation and PMB regulations.
Post-hospitalisation treatment (within 6 weeks of discharge from hospital or approved day surgery facility)	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	Subject to available Savings	100% of cost for PMBs (insured benefit), subject to PMB regulations.
Out of hospital	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	Subject to available Savings	100% of cost for PMBs (insured benefit), subject to PMB regulations.
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	Subject to available Savings	100% of cost for PMBs (insured benefit), subject to 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.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
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	Subject to available Savings	**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. 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.
BIOLOGICS AND HIGH-COST SPECIALISED MEDICATION 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) and all Section 21 drugs (drugs not registered by MCC for use in SA). **PMB Algorithm Medication** **PMB Non-Algorithm Medication** **Non-PMB Medication**	 100% of cost 70% of Scheme Rate No Benefit	 Unlimited Subject to applicable benefit limits	Subject to PMB regulations. 

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
CHRONIC MEDICATION	Subject to Scheme approved formulary	Limited to Core Saver Formulary for PMB conditions	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 Network GPs and Bankmed Pharmacy Network (DSPs).
Medication via DSP (Bankmed Network GP and Bankmed Pharmacy Network)	100% of cost plus contracted dispensing fee	Unlimited	
Medication via non-DSP (voluntary use of non-DSP)	80% of Scheme Medicine Reference Price	Unlimited	
Medication via non-DSP (involuntary use of non-DSP)	100% of cost plus contracted dispensing fee	Unlimited	
PRESCRIBED ACUTE MEDICATION	100% of Scheme Rate	Subject to available Savings	
SELF-MEDICATION (OVER THE COUNTER MEDICINE) AND PHARMACY ADVISED THERAPY (PAT)	100% of Scheme Rate	Subject to Core Saver formulary for Pharmacy Advised Therapy	Insured benefit for acute medicine prescribed by a pharmacist in respect of a limited number of incidents and conditions, and subject to the Core Saver Formulary for Pharmacy Advised Therapy as communicated to members from time to time. All other over the counter/PAT medicine subject to available savings.
HOMEOPATHIC MEDICATION	Benefits as for prescribed acute/chronic medication	Benefits as for prescribed acute/chronic medication	On doctor's prescription only, and limited to items with NAPPI codes. No self-medication/PAT benefit for homeopathic medicines.



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
SPECIALISTS			
In hospital consultations, operations and procedures	100% of cost for Bankmed Prestige A&B Specialist Network: 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 in rooms	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 80% of cost if no pre-authorisation and no referral from Bankmed GP Network GP 100% of Scheme Rate for non-DSPs 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed GP Network GP	Subject to Care Plan and referral by a Bankmed Network GP	Specialist consultations approved for beneficiaries registered for PMB CDL conditions, subject to pre-authorisation/Care Plan and referral from a Bankmed Network GP. PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations, with further limitation to 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed Network GP.
Out-of-hospital procedures in rooms	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 80% of cost if no pre-authorisation and no referral from Bankmed GP Network GP	Limited to PMBs	Non-Care Plan benefits subject to available Savings, except for PMBs, subject to PMB regulations. PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.

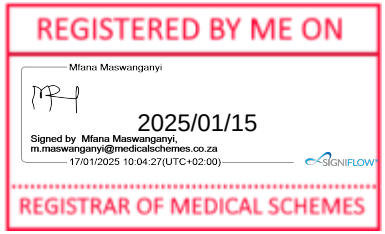


HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
GENERAL PRACTITIONERS (GPs)			
In hospital consultations	100% of cost for Bankmed Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	PMBs covered at 100% of cost, unlimited for Bankmed Network GPs: DSPs
In hospital operations and procedures	100% of cost for Bankmed Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	PMBs limited to 100% of Scheme Rate (paid from insured) for non-DSPs, subject to PMB regulations.
Out of hospital consultations in rooms			
• PMB treatment	100% of cost for Bankmed Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	
• Non-PMB treatment	100% of cost for Bankmed Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Limited to two visits pbpa from Insured Benefit, thereafter subject to available Savings	
Out of hospital procedures in rooms	100% of cost for Bankmed Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Unlimited Subject to available Savings	
Post hospital GP consultation within 30 days of discharge from hospital	100% of cost for Bankmed Network GPs: DSPs 100% of Scheme Rate for non-DSPs	One per authorised admission (excluding day cases)	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.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Virtual GP consultation	100% of cost for Bankmed Network GPs: DSPs 100% of Scheme Rate for non-DSPs	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.
MAXILLO-FACIAL AND ORAL SURGERY	100% of cost for Bankmed Prestige A&B Specialist Network: 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 and plain plastic dentures obtained at a preferred provider	100% of cost for DSPs 100% of Scheme Rate for non-DSPs	Subject to available Savings	
ADVANCED DENTISTRY Caps, crowns, bridges and cost of endosteal and ossea-integrated implants	100% of cost for DSPs 100% of Scheme Rate for non-DSPs	Subject to available Savings	100% of cost for PMBs (insured benefit), subject to PMB regulations.
ORTHODONTICS	100% of cost for DSPs 100% of Scheme Rate for non-DSPs	Subject to available Savings	
ALL OTHER DENTAL SERVICES Includes the cost of hospitalisation, medication and all other associated services	100% of cost for DSPs 100% of Scheme Rate for non-DSPs	Subject to available Savings	
OPTOMETRY **Subject to the Optometry Benefit Management program and clinical necessity**			
Consultations	100% of cost for DSPs 100% of Scheme Rate for non-DSPs	Subject to available Savings	Readymade readers via optometrists and Pharmacies as an OTC benefit subject to benefit availability
Frames and extras	100% of cost for DSPs 100% of Scheme Rate for non-DSPs		
Prescription lenses	100% of cost for DSPs 100% of Scheme Rate for non-DSPs		
Readymade readers	100% of cost for DSPs 100% of Scheme Rate for non-DSPs		

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Contact lenses	100% of cost for DSPs 100% of Scheme Rate for non-DSPs		
Fitting of contact lenses	100% of cost for DSPs 100% of Scheme Rate for non-DSPs		
Other optometric services Refractive surgery/excimer laser treatment, hospitalisation and associated costs	100% of cost for DSPs 100% of Scheme Rate for non-DSPs	Cost of hospitalisation, medication and all other associated services subject to available Savings	
Sunglasses	No benefit	No benefit	No benefit for sunglasses / prescription sunglasses / spectacles with a tint > 35%.
CLAIMS FOR SERVICES RENDERED OUTSIDE THE BORDERS OF SOUTH AFRICA REGISTERED BY ME ON Mfana Maswanganyi 2025/01/15 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 17/01/2025 10:05:20(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES	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.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
BENEFIT LIMITS EXHAUSTED/ABOVE SCHEME RATE PORTIONS OF CLAIMS			All benefits are covered at the specified rate (percentage benefit) up to the annual limit, as per this schedule. Once specified limits are exceeded, continued benefits are paid at the specified rate (percentage benefit), from available Savings (except for PMBs, which are covered at 100% of cost, unlimited, after specified sub-limits are depleted). Above Scheme Rate portions of claims are not automatically paid from Savings. Members may, however, apply in writing to have the above Scheme Rate portions of claims automatically paid from available Savings.



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