**BANKMED**

**ANNEXURE B4: BANKMED TRADITIONAL PLAN**

**Schedule of benefits with effect from 1 January 2022**

**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 “no benefit” in this schedule, insured benefits shall nevertheless be provided for PMBs in South Africa, 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.<br>Reduced benefits apply for accommodation and associated fees charged by non-DSP hospitals, subject to PMB regulations.<br><br>Hospital Network DSPs on this plan are:<br>• Contracted private hospitals/facilities (restricted network) as communicated to members from time to time. | | |
| **HOSPITALISATION**<br><br>**Hospital Network DSPs**<br>Deductibles apply to a specified list of conditions/procedures as set out in Appendix 3<br><br>All admissions at network DSP<br><br>**Other hospitals (non-DSPS)**<br><br>PMB admission: involuntary use of non-DSP (deductible does not apply)<br><br>PMB admission: voluntary use of non-DSP (deductible applies to all admissions)<br><br>Non-PMB admission (deductible applies to all admissions) | <br><br><br><br>100% of cost<br><br><br>100% of cost<br><br>100% of Scheme Rate<br><br>100% of Scheme Rate | <br><br><br><br>Unlimited (at general ward rates)<br><br><br>Unlimited (at general ward rates)<br><br>Unlimited (at general ward rates)<br><br>Unlimited (at general ward rates) | Benefits subject to pre-authorisation and PMB regulations.<br>Emergencies must be authorised within 24 hours of admission. |
| **Deductibles payable on admission**<br>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)<br>• ICU and high care unit fees<br>• Theatre fees<br>• Ward and theatre drugs, dressings, materials and equipment consumed / utilised in hospital<br>• Outpatient services<br>• Recovery beds | 100% of cost | Unlimited | In accordance with a per diem or negotiated rate.<br>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)<br>• ICU and high care unit fees<br>• Theatre fees<br>• Outpatient services<br>• Recovery beds | 100% of Scheme Rate | Unlimited | PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.<br>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) | 100% of Scheme Rate | Unlimited | |
| **3. Unattached Theatre Units (Private)** | | | |
| • Theatre fees<br>• Recovery beds | 100% of cost at a DSP<br>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<br>100% 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 | 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**<br>**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.<br>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 clinic, a maximum of a seven-day supply will be funded from Insured Benefits if obtained from a retail pharmacy on the date of discharge only. |
| **AMBULANCE SERVICES** | 100% of cost via the Scheme's DSP<br>100% of Scheme Rate through a non-DSP | Unlimited | Subject to pre-authorisation and PMB regulations.<br>No benefit for services outside the borders of South Africa. |
| **BLOOD TRANSFUSIONS**<br>**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 | Benefits as for hospitalisation | The organ recipient must be a Bankmed beneficiary for benefits to apply.<br>Benefits for Specialists will be as specified elsewhere this schedule. |
| **Medication (in and out of hospital)**<br>• Medication via designated pharmacy (DSP) | 100% of cost | Unlimited | No benefit for travelling and non-hospital accommodation expenses. |
| • Medication via non-DSP (voluntary use of non-DSP) | 80% of Scheme Medicine Reference Price plus dispensing fee | Unlimited | |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| • Medication via non-DSP (involuntary use of non-DSP) | 100% of cost | Unlimited | |
| **Harvesting and transporting of organs, and other donor costs** | 100% of cost | Unlimited | |
| **ONCOLOGY (CHEMOTHERAPY AND RADIOTHERAPY)** | | | |
| **In and out of hospital consultations, treatment and materials** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Unlimited | Subject to pre-authorisation and PMB regulations. |
| **Associated Medicine/Drugs** | | | |
| • 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 | |
| **RENAL DIALYSIS** | | | |
| **Procedures and Treatment** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Unlimited | Subject to pre-authorisation and PMB regulations. |
| **Associated Medicine/Drugs** | | | |
| • 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 | |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **WORLD HEALTH ORGANISATION (WHO) RECOGNISED DISEASE OUTBREAKS**<br>Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks:<br>Out-of-hospital healthcare services related to COVID-19:<br>- Screening consultation with a nurse or GP<br>- Defined basket of pathology<br>- Defined basket of x-rays and scans<br>- Consultations with a nurse or GP<br>- Supportive treatment<br>- Contact tracing | Over and above the PMB requirements.<br><br>Up to a maximum of 100% of the Scheme Rate.<br><br>Cover for testing is subject to NICD protocol and referral.<br><br>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<br><br>Out-of-hospital healthcare services related to COVID-19:<br>- Screening consultation with a nurse or GP: unlimited<br>- 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.<br>Benefits for hospitalisation and other in hospital services as specified elsewhere in this schedule. |
| **Midwife care and delivery** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Unlimited | Subject to pre-authorisation and PMB regulations. |
| **Birthing facilities** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Unlimited<br>(Cost of disposables limited to R1 225 per case) | Subject to pre-authorisation.<br>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. |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **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. |
| **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<br>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 at a DSP<br>100% of Scheme Rate at a non-DSP | As specified | |
| • R1 500 per pregnancy for ante-natal and post-natal classes | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | As specified | |
| • Additional pathology benefits subject to Baby and Me Basket of Care | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | As specified | Additional insured pathology subject to Care Plan. |
| **ALTERNATIVES TO HOSPITALISATION** | | | |
| **Frail Care Facilities** | 100% of cost | R490 per beneficiary per day | Frail care facilities: Subject to pre-authorisation. Available to permanently chronic sick or geriatric patients for accommodation in a registered nursing home or hospital.<br>No Benefits for accommodation in old age homes.<br>Available as alternative to home nursing not in addition hereto. |
| **Step-down facilities** | 100% of cost at a DSP<br>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 |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| | | | hospitalisation. The facility must be registered with the Department of Health. |
| **Home nursing services** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R385 per beneficiary per day | Home nursing services: Subject to pre-authorisation. Rendered at the patient's residence by a registered nurse or a person from a registered nursing institution.<br>For such periods as the Scheme may determine as reasonable. |
| **REGISTERED PRIVATE NURSE PRACTITIONERS**<br>(registered with the S. A. Nursing Council or its legal successor) | | | |
| **Procedures** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Unlimited | For procedures not requiring admission to a day clinic or hospital; Includes the cost of vaccination and injection material administered by the Practitioner. |
| **Consultations** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Three pbpa from the Insured Benefit<br>Thereafter at 100% of Scheme Rate, subject to out of hospital GP and Specialist consultation limit | |
| **HomeCare Services** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Unlimited | For procedures not requiring admission to a day clinic or hospital. Subject to Scheme Clinical Entry Criteria. Subject to preauthorisation. |
| **COMPASSIONATE CARE BENEFIT FOR NON-ONCOLOGY PATIENTS (IN-PATIENT CARE AND HOMECARE VISITS)** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Unlimited for PMB scope and level of treatment.<br>R64 760 per person per lifetime for all claims, payment of PMB claims accumulate to this threshold. | Subject to authorisation and meeting the Scheme's guidelines and managed care criteria. |

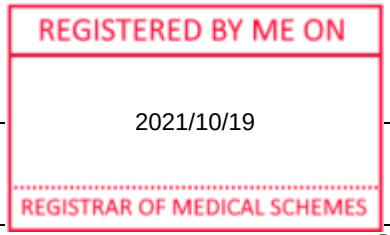
| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **ADVANCED ILLNESS BENEFIT FOR ONCOLOGY PATIENTS** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Unlimited | Subject to authorisation and the treatment meeting the Scheme's guidelines and 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.<br>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 130 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 16 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<br>100% of Scheme Rate at a non-DSP | R340 pbpa | At clinics, pharmacies or Bankmed GP Network GPs' consulting rooms. |
| **HIV Counselling and Testing (HCT)** | 100% of cost at a DSP<br>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<br>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. |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **Breast MRI (breast cancer risk only)** | 100% of cost at a DSP<br>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<br>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 R535 pbpa. |
| **Bone densitometry**<br>**Prostate specific antigen**<br>**Faecal occult blood test** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | One pbpa<br>One pbpa<br>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 densitometry test from their Radiology Benefit. Where the Radiology Benefit is exhausted, this will not be funded. |
| **Tuberculosis (TB) screening** | 100% of cost at a DSP<br>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. |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **Pneumococcal vaccine** | 100% of Scheme Medicine Reference Price | Limited as follows: | • One vaccination every five years for adults 60 years and older.<br>• 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**<br>**(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<br>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.<br>Applies to members and beneficiaries aged 18 years and older only. |
| **Personal Health Assessment (PHA) Additional Consultations for Dietician and Biokineticist** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Limited to two dietician visits per year plus two Biokineticist visits per year<br>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 only. Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA.<br>Clinical Entry Criteria applies.<br>Applies to members and beneficiaries aged 18 years and older only. |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **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. |
| **New-born Screening Test** | 100% of cost at a DSP<br>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<br>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)**<br>**(Member may have either of the two tests, not both)** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Limited to one per pregnancy | Subject to the Scheme's protocols and clinical entry criteria.<br>One assessment per beneficiary per pregnancy.<br>Testing limited to services provided within the borders of South Africa.<br>Applies to high risk beneficiaries aged 35 years and older at delivery.<br>If member does not meet clinical entry criteria, the screening test is not covered on this Plan. |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **DIABETES MANAGEMENT**<br>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.<br><br>100% of Scheme Rate if non-DSP used. | Unlimited | Basket of Care set by the Scheme, subject to PMB regulations. |
| **RADIOLOGY**<br><br>**In Hospital**<br><br>**Out of hospital** | <br><br>100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP<br><br>100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | <br><br>Unlimited<br><br>R6 390 pfpa<br>(Combined limit with pathology out of hospital) | |
| **PATHOLOGY**<br><br>**In Hospital**<br><br>**Out of hospital** | <br><br>100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP<br><br>100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | <br><br>Unlimited<br><br>R6 390 pfpa<br>(Combined limit with radiology out of hospital) | |
| **MRI / CT SCANS AND RADIONUCLIDE SCANS**<br><br>**In Hospital and out of hospital** | <br><br>100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | <br><br>Unlimited | <br><br>Subject to pre-authorisation (both in and out of hospital). |

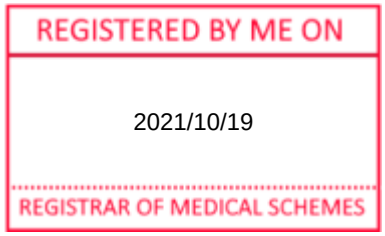


| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **HIV/AIDS PROGRAMME**<br>Additional benefits subject to registration on HIV/Aids Programme. These additional benefits do not contribute to the depletion of other insured benefits provided by the Scheme. | | | 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. |
| **Consultations and pathology** | 100% of cost at a DSP<br>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. |
| • 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. |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **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 prostheses items** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R77 480 pbpa | |
| **Internal prosthesis sub-limits:** | | | |
| **Hip joint prostheses, knee joint prostheses and shoulder joint prostheses** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R51 565 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) | Combined limit for all internal prosthesis items, excluding pacemakers and defibrillators; Sub-limits may apply depending on the prosthesis required.<br>All sub-limits as indicated are further subject to the combined limit for all internal prosthesis items, excluding pacemakers, defibrillators.<br>The sub-limits are not "in addition to" the combined limit.<br><br>Dental implants of any nature are not included in the definition of internal prosthesis. |
| **Spinal fusions** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R52 200 | |
| **Cardiac stents** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R77 175 | The prostheses accumulate to the limit. The balance of the hospital and related accounts do not accumulate to the annual limit. |
| **Grafts** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R41 780 | |
| **Cardiac Valves** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R43 940 | |
| **Non-specified items** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R24 075 | |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **SPINAL CARE (SPINAL CARE PROGRAMME)**<br>**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.<br><br>100% of the Scheme Rate for the hospital account if performed at a non-network facility.<br><br>100% of cost for related accounts at a DSP<br><br>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.<br><br>Subject to PMB regulations.<br><br>Unlimited at a network provider for in-hospital treatment<br><br>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<br>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. |
| **INTRAOCCULAR LENSES FOR CATARACT SURGERY**<br>(Permanent, implantable lenses, inclusive of basic and specialised lens varieties) | Up to a maximum of 100% of the Scheme Rate<br>Scheme Rate is equal to the negotiated and agreed lens price plus 25% mark-up | | Subject to pre-authorisation and the treatment meeting the Scheme's criteria.<br>Covered in full when supplied by the Scheme's preferred suppliers, otherwise covered up to the Scheme Rate for the lens.<br>Scheme Rate is equal to the negotiated and agreed lens price plus 25% mark-up<br>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**<br>Artificial limbs and eyes<br>(Combined limit with Medical and Surgical Appliances, Blood Pressure Monitors, Nebulisers, Glucometers, Arch supports and Shoe Insoles) | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R26 430 pfpa | Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval.<br>Benefit includes the repair of the prosthesis. |

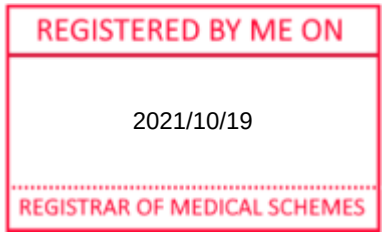
| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **MEDICAL AND SURGICAL APPLIANCES**<br><br>**Post-surgery appliances**<br>• Purchase or hire of: Braces, Splints, Slings, Corsets, Cervical collars, Post-op footwear (sandals and boots), Air-casts, Pressure garments, Compression "hose", Cushions, Mastectomy brassiere/breast prosthesis.<br>• Hire of: Wheelchairs, Walking frames, Crutches, Traction equipment, Toilet/bath riser, Bath swivel stool<br><br>**Chronic appliances**<br>• Oxygen and oxygen delivery systems, i.e. items required for its delivery and administration (e.g. delivery tube, nasal cannulas and mask)<br><br>**Chronic appliances**<br>• Stoma products, including indwelling catheters and colostomy bags<br><br>**Other chronic appliances**<br>• Other chronic appliances includes Braces/Callipers/Surgical boots (in combination), Lumbar Sacral Corsets, Splints, Compression hose, "Be-sure" products, Heel pads/insoles/metatarsal bars, CPAP machines, Sleep apnoea monitor for infants (hire thereof), Suction machine and catheters, Nebulisers, Glucometers, Peak flow meters<br>• Purchase of: Crutches, Wheelchairs, Walking frames, Toilet/bath risers, Commodes, Urinal bottles, Bed pans | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP<br><br>100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP<br><br>100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP<br><br>100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP<br><br>REGISTERED BY ME ON<br>2021/10/19<br>REGISTRAR OF MEDICAL SCHEMES | R7 770 pbpa<br><br>R24 405 pbpa<br><br>R24 405 pbpa<br><br>R7 770 pbpa<br>Limit may be extended to R11 370 for beneficiaries requiring a CPAP machine<br><br>Sub-limits apply as follows:<br>R960 for arch supports (per pair)<br>R1 440 for shoe insoles (per pair) | Benefits subject to a doctor's prescription, the application of clinical and funding protocols, and Scheme approval.<br><br>Additional benefits may be provided for wheelchairs, subject to motivation, from occupational therapist and/or physiotherapist, a minimum of two cost quotations and Scheme approval.<br><br>**Frequency limits apply:**<br>Surgical/moonboot: one every 24 months<br>Crutches: one set every 24 months<br>Brace callipers: one set every 24 months<br>Rigid back brace: one every 24 months<br>Wig: one every 24 months<br>Breast prosthesis bra: no limit on number of bras that may be purchased in 12 months; Rand limit applies for post-surgery appliances<br>Breast prosthesis: one/two per 24 months (one/two is patient dependent)<br>Commodes: one every 36 months<br>Wheelchairs: one every 36 months<br>Walking frames: one every 24 months<br>Surgical compression stockings: two pairs per 12-month period<br>Sling/clavicle brace: one every 24 months<br>Portable oxygen: one every 48 months<br>Blood pressure monitors: one every 36 months<br>Nebulisers: one every 36 months<br>Glucometers: one every 36 months<br>Arch supports: one pair every 24 months<br>Shoe insoles: one pair every 24 months<br>CPAP machine: one every 36 months<br>Humidifier: one every 36 months |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **Appliances for acute conditions** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Subject to other chronic appliances limit of<br>R7 770 pbpa | For conditions not covered under the post-surgery appliance benefit and the chronic appliances benefit.<br>Repairs and maintenance of any appliances provided under any of these benefit categories. |
| **BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS**<br>(Combined limit with medical and surgical appliances: other chronic appliances) | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R7 770 pbpa<br>Sub-limits apply as follows:<br><br>R1 310 pbpa for blood pressure monitors<br><br>R1 845 pbpa for nebulisers<br><br>R920 pbpa for glucometers | Benefits available on doctor's prescription without additional motivation or Scheme approval.<br><br>**Frequency limits apply:**<br>Blood pressure monitors: one every 36 months<br>Nebulisers: one every 36 months<br>Glucometers: one every 36 months |
| **HEARING AIDS (SUPPLY AND FITMENT)** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R30 870 per beneficiary every 24 months | **Frequency limits apply:**<br>Benefit only available where the beneficiary has not claimed for hearing aid/s in the previous calendar year. Rolling limit every 24 months.<br>No benefit for replacement batteries. |
| **HEARING AID REPAIRS** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R1 600 pbpa | |
| **BONE ANCHORED HEARING AIDS** | 90% of Scheme Rate | R165 125 pfpa |  |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **COCHLEAR IMPLANTS** | | | Once in a lifetime benefit. |
| **Hospitalisation** | Benefits for hospitalisation as specified elsewhere in this schedule | As specified | Subject to pre-authorisation and Scheme protocols. |
| **Pre-operative evaluation and associated preparation costs** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R18 355 pb<br>per lifetime | Funding only available in recognised Centres of Excellence. |
| **Cochlear implant device** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R384 885 pb per lifetime | Once in a lifetime benefit available to:<br>• Children under 8 years of age<br>• Persons over the age of 8 diagnosed as suffering from profound bilateral sensory neural hearing loss |
| **Intra-operative audiology testing** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R960 pb per lifetime | |
| **Post-operative evaluation costs** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R38 550 pb per lifetime | |
| **UPGRADE OR REPLACEMENT OF SPEECH PROCESSORS** | 80% of Scheme Rate | R143 710 pb<br>over a five-year cycle | Subject to clinical motivation, the application of clinical / funding protocols and Scheme approval. |
| **PSYCHIATRY, CLINICAL PSYCHOLOGY, & RELATED OCCUPATIONAL THERAPY** | | | |
| **Hospitalisation:** | | R72 405 pbpa<br>(Combined limit with occupational therapy: psychiatric consultations /sessions in hospital) | Subject to pre-authorisation.<br>Continued benefits for PMBs subject to pre-authorisation and PMB regulations.<br>PMBs limited to 80% of Scheme Rate for non-DSPs, subject to PMB regulations.<br>Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the rand limit. |
| **Hospital Network DSPs** | | | |
| All admissions at network DSP | 100% of cost for Bankmed Network Psychiatric facilities (DSPs) | | |
| **Other hospitals (non-DSPS)** | | | |
| PMB admission: involuntary use of non-DSP | 100% of cost | | |
| PMB admission: voluntary use of non-DSP | 80% of Scheme Rate for non-DSPs | | |
| Non-PMB admission | 80% of Scheme Rate | | |

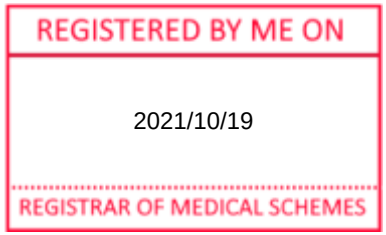
| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **In-hospital consultations / sessions** | 100% of cost for Bankmed Prestige<br>A&B Specialist Network: DSPs<br>100% of Scheme Rate for non-DSPs | | |
| **Out of hospital consultations / sessions** | 100% of cost for Bankmed Prestige<br>A&B Specialist Network: DSPs<br>100% of Scheme Rate for non-DSPs | R4 540 pbpa<br>(Combined limit with occupational therapy: psychiatric consultations/sessions out of hospital)<br><br>Combined limit may be extended to<br>R11 300 for Depression and/or Bipolar Mood Disorder, subject to pre-authorisation and PMB regulations | PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.<br>Cover for 15 out-of-hospital psychotherapy sessions for PMBs, in line with PMB regulations with dual accumulation to the rand limit.<br><br>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. |
| **Post-hospital psychiatric consultation within 30 days of discharge from hospital (excluding day cases) for a psychiatric admission**<br>(Related to Major Depression, Schizophrenia and Bipolar Mood Disorder only) | 100% of cost for Bankmed Network Psychiatrist: DSPs<br>100% of Scheme Rate for non-DSP Psychiatrist | Limited to three consultations per beneficiary per annum | 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. |

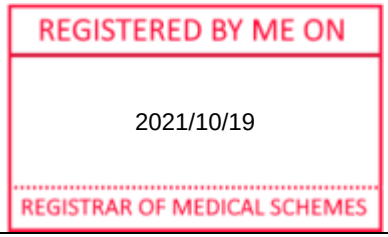
| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **MENTAL HEALTH INTEGRATED DISEASE MANAGEMENT PROGRAMME**<br>Disease Management for specified mental health conditions for members registered on the Scheme's Mental Health Integrated Disease Management Programme | 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.<br>Subject to PMB regulations. |
| **OCCUPATIONAL THERAPY: PSYCHIATRIC CONSULTATIONS / SESSIONS** | | | |
| **Hospitalisation and in-hospital consultations / sessions** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R72 405 pbpa<br>(Combined limit with occupational therapy: psychiatric consultations /sessions in hospital) | Subject to pre-authorisation.<br>Continued benefits for PMBs subject to pre-authorisation and PMB regulations.<br>PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations. |
| **Out of hospital** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R4 540 pbpa<br>(Combined limit with occupational therapy: psychiatric consultations/sessions out of hospital)<br><br>Combined limit may be extended to<br>R11 300 for Depression and/or Bipolar Mood Disorder, subject to pre-authorisation and 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 |
|---|---|---|---|
| **OCCUPATIONAL THERAPY:**<br>**NON-PSYCHIATRIC CONSULTATIONS / SESSIONS** | | | |
| **In hospital** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Unlimited | Subject to pre-authorisation. |
| **Out of hospital** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R2 225 pfpa | |
| **PHYSIOTHERAPY** | | | |
| **In hospital** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Unlimited | Subject to pre-authorisation. |
| **Post-hospitalisation treatment (within 6 weeks of discharge from hospital or approved day surgery facility)** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R3 225 pfpa | Following a pre-authorised admission. |
| **Out of hospital** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Subject to combined limit for GP and Specialist out of hospital consultations in rooms | |
| **SPEECH THERAPY, AUDIO THERAPY AND AUDIOLOGY**<br>**In and out of hospital** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R2 225 pfpa | |
| **ADDITIONAL BENEFITS FOR BENEFICIARIES WITH NEURODEVELOPMENTAL DISORDERS**<br>• Occupational therapy: psychiatric consultations/sessions (out of hospital)<br>• Occupational therapy: non-psychiatric consultations/sessions (out of hospital)<br>• Physiotherapy (out of hospital)<br>• Speech therapy (out of hospital) | 100% of cost at a DSP<br>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.<br><br>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. |

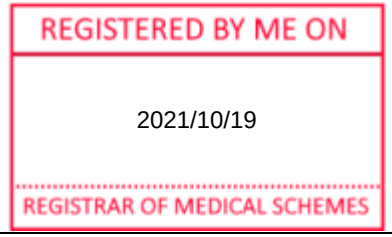
| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| | | | These discretionary benefits are in addition to any other insured benefits normally applicable to these services, as specified elsewhere in this schedule. |
| **BIOLOGICS AND HIGH-COST SPECIALISED MEDICATION**<br>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). | | | Subject to PMB regulations. |
| **PMB Algorithm Medication** | 100% of cost | Unlimited | |
| **PMB Non-Algorithm Medication** | 70% of Scheme Rate | Subject to applicable benefit limits | |
| **Non-PMB Non-Algorithm Medication** | 70% of Scheme Rate | Subject to applicable benefit limits | |
| **OTHER AUXILIARY SERVICES**<br>**In and out of hospital**<br><br>• Chiropody/Podiatry (consultations)<br>• Dietetics/Nutritional Assessments<br>• Orthotics (consultations)<br>• Massage<br>• Chiropractors<br>• Herbalists<br>• Naturopaths<br>• Family planning clinics<br>• Homeopaths<br>• Biokineticists (fitness assessments) | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R3 405 pfpa | **Frequency limits apply:**<br>Foot orthotics: one every 24 months<br><br>If prescribed by a medical practitioner and provided that the supplier of service is registered as such in terms of any law.<br><br>The fees must have been incurred for a definite complaint and treatment must be for curative purposes only. |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **CHRONIC MEDICATION**<br><br>**Medication via DSP**<br>(Bankmed Network GP and Bankmed Pharmacy Network)<br><br>**Medication via non-DSP**<br>(voluntary use of non-DSP)<br><br>**Medication via non-DSP**<br>(involuntary use of non-DSP) | Subject to Chronic Medicine List<br><br>100% of Scheme Medicine Reference Price<br><br>80% of Scheme Medicine Reference Price<br><br>100% of cost | R22 515 pbpa | Benefits for chronic medication, drugs and injection material subject to:<br>• Prior application and approval of the Scheme<br>• Each prescription or repeat prescription being limited to one month's supply per beneficiary<br>• Such motivations and reports by appropriate Medical practitioners, as are required by the Scheme<br>• PMB regulations<br>• Scheme approved Chronic Medicine List<br>Dispensing fee limited to the contracted dispensing fee applicable to Bankmed GP Network GPs and Bankmed Pharmacy Network (DSPs).<br>Continued benefits for PMBs, subject to PMB Regulations. |
| **PRESCRIBED ACUTE MEDICATION**<br><br>**Medication via DSP**<br>(Bankmed Network GP and Bankmed Pharmacy Network)<br><br>• Generic Medicine<br><br>• Original Medicines (medicine where a generic alternative is available) | <br><br><br><br>100% of Scheme Medicine Reference Price plus contracted dispensing fee<br><br>80% of Scheme Medicine Reference Price plus contracted dispensing fee | M = R4 260<br>M+1 = R7 840<br>M+2+ = R8 510<br>(including a sub-limit of R1 690 pfpa for self-medication / PAT) | Dispensing fee limited to the contracted dispensing fee for DSPs.<br><br>  |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **Medication via non-DSP**<br>(voluntary use of non-DSP)<br><br>• Generic Medicine<br><br>• Original Medicines (medicine where a generic alternative is available)<br><br>**Medication via non-DSP**<br>(involuntary use of non-DSP)<br><br>• Generic Medicine<br><br>• Original Medicines (medicine where a generic alternative is available) | <br><br>80% of Scheme Medicine Reference Price plus contracted dispensing fee<br><br>80% of Scheme Medicine Reference Price plus contracted dispensing fee<br><br><br><br>100% of Scheme Medicine Reference Price plus contracted dispensing fee<br><br>80% of Scheme Medicine Reference Price plus contracted dispensing fee | | |
| **SELF-MEDICATION (OVER THE COUNTER MEDICINE) AND PHARMACY ADVISED THERAPY (PAT)** | 100% of Scheme Medicine Reference Price via Bankmed Pharmacy Network: DSP<br>80% of Scheme Medicine Reference Price for non-DSPs | R1 690 pfpa and further subject to prescribed acute medication limit | Covering medicines which a pharmacist is entitled to prescribe and dispense.<br>Dispensing fee limited to the contracted dispensing fee for DSPs. |
| **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.<br>No self-medication/PAT benefit for homeopathic medicines.<br><br>  |

| 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<br>100% of Scheme Rate for non-DSPs | Unlimited | Subject to pre-authorisation.<br>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<br>80% of cost if no pre-authorisation and no referral from Bankmed GP Network GP<br><br>100% of Scheme Rate for non-DSPs<br>80% of Scheme Rate if no pre-authorisation and no referral from Bankmed GP Network GP | Combined limit with GP consultations in rooms | Subject to pre-authorisation.<br>Limit includes the cost of vaccination and injection material administered by the Specialist, except where indicated as a specified benefit under Vaccinations and Screening. Limit would exclude procedures that are covered unlimited.<br>Continued benefits for PMBs, subject to PMB regulations.<br>PMBs limited to 100% of Scheme Rate for non-DSPs, with further limitation if no referral from a Bankmed Network GP. |
| **Out-of-hospital procedures in rooms** | 100% of cost for Bankmed Prestige A&B Specialist Network: DSPs<br>100% of scheme Rate for non-DSPs | Unlimited | Subject to pre-authorisation.<br>PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations. |
| **GENERAL PRACTITIONERS (GPs)** | | | In-hospital benefits are subject to pre-authorisation. |
| **In hospital consultations** | 100% of cost for Bankmed Network GPs: DSPs<br>100% of Scheme Rate for non-DSPs | Unlimited | PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations. |
| **In hospital operations and procedures** | 100% of cost for Bankmed Network GPs: DSPs<br>100% of Scheme Rate for non-DSPs | Unlimited | |
| | 100% of cost for Bankmed Network GPs: DSPs<br>100% of Scheme Rate for non-DSPs | Unlimited if DSP used | |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **Out of hospital consultations in rooms** | 100% of cost for Bankmed Network GPs: DSPs<br>100% of Scheme Rate for non-DSPs | If no DSP used, limited as follows:<br>M = R3 755<br>M+1 = R6 800<br>M+2+ = R7 885<br>(Combined limit with Specialist consultations in rooms) | Includes the cost of vaccination and injection material administered by the GP except where indicated as a specified benefit under Vaccinations and Screening.<br>Limits would exclude procedures that are covered unlimited.<br>Continued benefits for PMBs, subject to PMB Regulations.<br>PMBs covered at 100% of cost for Bankmed Network GPs (DSPs). |
| **Out of hospital procedures in rooms** | 100% of cost for Bankmed Network GPs: DSPs<br>100% of Scheme Rate for non-DSPs | Unlimited | 100% of cost for PMBs at Bankmed Network GPs: DSPs.<br>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 Network GPs: DSPs<br>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. |
| **Virtual GP consultation** | | 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**<br><br>**Primary Treatment**<br>Benefits cover:<br>• Treatment of cysts, tumours and salivary gland conditions including complications.<br>• Intra and extra-oral drainage of abscesses and surgery to infected bone<br>• Treatment of trauma including fractures of jaws and facial structures as well as associated skeletal complications.<br>• Treatment of conditions of the tempero-mandibular (jaw) joint, excluding orthognatic surgery<br>• Surgical extraction of teeth, removal of roots, and associated complications where there is no need for reflecting of a flap and removing of bone including suturing<br>• Surgical extraction and exposure of impacted teeth<br>• Repair of cleft palate, cleft lip and associated soft tissue repair | 100% of cost for Bankmed Prestige A&B Specialist Network: DSPs<br>100% of Scheme Rate for non-DSPs | Unlimited | Subject to pre-authorisation.<br>Hospital and general anaesthesia costs associated with dental treatment and oral surgery are subject to pre-authorisation and PMB regulations. |
| **Elective Treatment**<br>Benefits cover:<br>• Orthognatic surgery (surgical repositioning of jaws)<br>• Surgical placement and exposure of implants excluding the cost of all components and transmucosal healing abutments<br>• Surgical preparation of jaws for prosthetics<br>• Functional corrections of malocclusions | 100% of cost for Bankmed Prestige A&B Specialist Network: DSPs<br>100% of Scheme Rate for non-DSPs | Unlimited | Subject to pre-authorisation.<br>  |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **PREVENTATIVE AND BASIC DENTISTRY**<br><br>**Benefits for all members and beneficiaries:**<br><br>• First dental examination per beneficiary per financial year<br>• Scale and Polish<br>• Limited x-rays to support diagnosis<br>• Restorations (fillings)<br>• Basic root canal therapy (including emergency root canal therapy)<br>• Routine extractions<br>• Full and partial dentures (restricted to plastic) and clasps<br>• Repairing of dentures<br><br>**Additional benefits for children below the age of 16 years:**<br>• Topical fluoride treatment<br><br>• Fissure sealant on first and second permanent molar teeth but subject to a maximum of 8 molar teeth per beneficiary per lifetime | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Unlimited<br><br>**Sub-limits apply as follows:**<br>One dental exam pbpa<br><br>Two pbpa<br><br>Fillings: Amalgam and resin only<br><br>Plastic dentures only<br><br>Two topical fluoride treatments per child per year (age 15 years and younger). One topical fluoride treatment per year for all other beneficiaries.<br><br>Limited to 8 molar teeth pb per lifetime | |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **ADVANCED DENTISTRY**<br>Caps, crowns, bridges and cost of endosteal and ossea-integrated implants | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | M = R7 450 pbpa<br>M+ = R11 560 pfpa<br>(Combined limit with orthodontics and all other dental services) | |
| **ORTHODONTICS** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Subject to advanced dentistry limit | Subject to orthodontic quotation and prior approval of the Scheme. |
| **ALL OTHER DENTAL SERVICES**<br>• Second and subsequent examination in the same financial year<br>• X-rays<br>• Composite restorations/fillings<br>• Metal/ceramic and/or resin restorations/inlays<br>• Crowns and bridges<br>• Bleaching of endodontically treated teeth<br>• Periodontal treatment (includes both consultation, non-surgical and surgical procedures<br>• Prosthodontics<br>• Complete/partial dentures other than plastic including soft bases<br>• Miscellaneous prosthetic procedures e.g. rebases, adjustment and relines<br>• Restorative/Prosthodontic phase of implants<br>• Oral surgery<br>• Other surgical procedures i.e. Biopsy/soft tissue injuries<br>• Bite plate for TMJ dysfunction<br>• Other general services not classified but included in the Scheme Rate as relevant services | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Subject to advanced dentistry limit | Benefits are not available for metal inlays in anterior teeth. |

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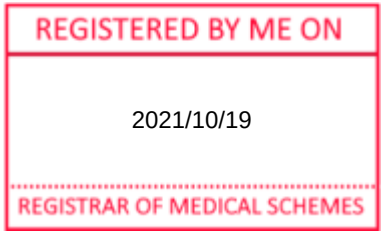
|---|---|---|---|
| **OPTOMETRY**<br>**Subject to the Optometry Benefit Management program and clinical necessity** | | | |
| **Consultations** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | 100% of Scheme Rate | Benefit only available every two years and limited to one eye test or one re-examination or one composite examination per beneficiary every 24 months from previous date of service. |
| **Frames and Extras** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R1 025 per beneficiary every 24 months from previous date of service | Extras subject to pre-authorisation and clinical necessity. One frame per beneficiary every 24 months from previous date of service. |
| **Prescription Lenses**<br>Clear, standard/generic, single vision, bifocal or multi-focal lenses | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | 100% of Scheme Rate | One pair of standard / generic lenses per beneficiary every 24 months from previous date of service. |
| **Readymade Readers** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | Two pairs at R110 a pair, pb every two years | Readymade readers via optometrists and Pharmacies as an OTC benefit subject to benefit availability |
| **Contact Lenses** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R1 605 pbpa | Clear contact lenses. A beneficiary may not claim for spectacles (lenses or frame) AND contact lenses in the same benefit year OR contact lenses within 24 months from previous date of service after receiving spectacles (lenses or frame). |
| **Fitting of contact lenses** | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | One contact lens dispensing and/or assessment per beneficiary every 12 months | |
| **Other optometric services**<br>Refractive surgery/Excimer laser treatment, hospitalisation and associated costs | 100% of cost at a DSP<br>100% of Scheme Rate at a non-DSP | R4 280 pfpa | Benefit via ophthalmologist. Limit includes the cost of hospitalization, medication and all other associated services. |

| HEALTHCARE SERVICE | BASIS OF COVER | ANNUAL LIMITS | CONDITIONS/REMARKS |
|---|---|---|---|
| **Sunglasses** | | No benefit | No benefit for sunglasses / prescription sunglasses / spectacles with a tint > 35% |
| **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.<br>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.<br>No benefits for emergency/ambulance transport outside the borders of South Africa.<br>Medical motivation and prior approval required for elective/non-emergency surgery outside the borders of South Africa. |



**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 |