Bankmed
Yours in good health

Benefit

AND CONTRIBUTION SCHEDULE 2020

Contents

Contact us

MEDICAL EMERGENCIES: 0860 999 911

GENERAL QUESTIONS

Website: www.bankmed.co.za

Call: 0800 BANKMED (0800 226 5633) – toll-free on a Telkom landline

E-mail for employees: enquiries@bankmed.co.za

E-mail for pensioners: pensioners@bankmed.co.za

Fax: 021 527 1926

Post: Bankmed Customer Services, Private Bag X2, Rivonia 2128

DIGITAL TOOLS

View information about your membership and update your contact details:

- **Website: Log in to www.bankmed.co.za**
- **Mobile site: Log in to m.bankmed.co.za**
- **Bankmed App: Download and log in**

You use the same username and password for website, mobile site and App.

FIND A HEALTHCARE PROFESSIONAL IN OUR NETWORK

CLAIMS

Include your membership number and make sure the claim is easy to read

CLAIM USING THE BANKMED APP OR THE WEBSITE

E-mail: claims@bankmed.co.za

Fax: 021 527 1940

Post: Bankmed Claims, Private Bag X2, Rivonia 2128

PRE-AUTHORISATION FOR HOSPITAL ADMISSION, MRI, CT SCAN OR RADIONUCLIDE SCAN

Call: 0800 BANKMED (0800 226 5633) – toll-free on a Telkom landline

Fax: 021 527 1928

E-mail: treatment@bankmed.co.za

HOSPITAL CARE AND PROCEDURES

COMPLAINTS AND DISPUTES

Should you have a complaint or a concern about your membership, please let us know in writing:

E-mail for employees: enquiries@bankmed.co.za

E-mail for pensioners: pensioners@bankmed.co.za

Post: Complaints Bankmed, Private Bag X2, Rivonia 2128

By law, we have to respond to written complaints within 30 days, but we always to try to respond much sooner.

Lodge a formal complaint

If you have given us a reasonable chance to address your concerns, and you are still not satisfied with our decision, you can lodge a formal complaint with the Council for Medical Schemes:

Customer Care line: 0861 123 267 – ShareCall from a Telkom landline

Reception: 012 431 0500

Fax: 086 673 2466

E-mail: complaints@medicalschemes.com

Post: Council for Medical Schemes, Block A, Eco Glades 2 Office Park, 420 Witch Hazel Avenue, Eco Park, Centurion 0157 or Council for Medical Schemes, Private Bag X34, Hatfield 0028

REPORT FRAUD

Call: 0800 004 500 / 0800 007 788

SMS: 43477

E-mail: bankmed@tip offs.com

Post: Freepost DN298, Umhlanga Rocks 4320

AUTHORISATION FOR CHRONIC MEDICATION

Call: 0800 BANKMED (0800 226 5633) – toll-free on a Telkom landline

Core Saver, Traditional, Comprehensive and Plus Plans

E-mail: chronic@bankmed.co.za

Fax: 011 770 6247

Your pharmacist can call 0800 BANKMED (0800 226 5633)

Healthcare Professionals can call 0800 132 345

Essential and Basic Plans

E-mail: chronicbasicessential@bankmed.co.za

Fax: 011 539 7000

Your pharmacist can call 0800 BANKMED (0800 226 5633)

Register to gain access to these benefits:

- HIV PROGRAMME FOR HIV AND AIDS (CONFIDENTIALITY GUARANTEED)
- BABY-AND-ME PROGRAMME FOR PREGNANCY AND CHILDBIRTH
- ONCOLOGY PROGRAMME FOR CANCER TREATMENT
- CHRONIC ILLNESS BENEFIT FOR LASTING CONDITIONS

Glossary

Annual Threshold: This is a rand amount for the Plus Plan. We use the number of adult and child dependants on the membership to calculate the Annual Threshold for the year.

Claims are paid out at 100% of Scheme Rate from your Medical Savings Account, once this is exhausted you are able to access the **Above Threshold Benefit.**

Above Threshold Benefit: The Above Threshold Benefit gives Plus Plan members cover for healthcare they receive without being hospitalised when they reach their Annual Threshold. It is an Insured Benefit.

Day-to-day benefits: On the **Plus, Comprehensive, and Core Saver Plans,** we pay from your Medical Savings Account for items such as medication, GP visits, X-rays and blood tests.

On the **Traditional, Basic, and Essential Plans,** we cover for everyday medical expenses and depends on your Plan.

Deductible: The upfront payment is an amount you have to pay to a hospital, day clinic or other healthcare facilities **before** you can receive treatment. The facility will not admit you until you pay the amount.

Dependants: A dependant is either the spouse, partner, child, or special dependant. Applicants will need to be submitted to Bankmed for membership.

Insured Benefit: This is a benefit Bankmed pays from pooled contributions, instead of using your personal Medical Savings Account (if you have one).

Membership or member: The Principal Member is the person who pays the monthly contribution. In the case of Bankmed, the Principal Member is an employee of a bank that has an agreement with Bankmed.

Networks and Healthcare Professionals: We negotiate prices for you with hospitals, pharmacies, GPs and specialists. We call them Healthcare Professionals who meet our quality standards and agree to join our networks and agreed rates.

Prescribed Minimum Benefits (PMBs): According to the Medical Schemes Act, all medical schemes have to pay for a minimum level of care for a list of medical conditions. There is a specific treatment called Diagnosis and Treatment Pairs.

Scheme Rate: Healthcare Professionals charge at Scheme Rate. If you visit a Healthcare Professional who is not in our network, they can charge you more than the Scheme Rate. You will be liable for the difference.

Get TO KNOW BANKMED

We care about your health

Bankmed has over 100 years of experience in the Banking and Healthcare industry. As such, we are experts in providing insights into your wellness needs and have the ability to offer you a medical scheme tailored to your unique requirements.

We offer tools to measure and improve your health through the Wellness and Preventive Care Benefits. Our communication engine provides you with information, news and tips on how to create and maintain a healthy lifestyle. Your health and wellbeing is our number one priority!

HOW BANKMED WORKS

Bankmed is registered according to the Medical Schemes Act 131 of 1998. The Council for Medical Schemes has approved all our rules and benefits.

A Board of Trustees manages the Scheme for you. They put your interests first, and make sure we can keep paying claims now and into the future. You choose half of the trustees by voting, and your employers appoint the other trustees.

WE GIVE YOU COVER SO YOU CAN ACCESS QUALITY HEALTHCARE

Bankmed takes part in a yearly survey commissioned by the Health Quality Assessment. This survey measures the quality of the medical care members of medical schemes receive. Based on the Health Quality Assessment 2018 findings, Bankmed members are ahead of the industry as stated in the report in most clinical quality indicators.

AA+ GLOBAL CREDIT RATING

Bankmed has been awarded the AA+ Global Credit Rating for the eighth year in a row! We are the only closed medical scheme in South Africa to have achieved this rating.

Bankmed is built on a solid financial base. We aim to give you benefits that exceed the market average.

Bankmed gives you better benefits

35%
better value in
2018

Compared to the average open scheme*

AA+

Global Credit Rating – 2017

38.8%
vs
33.2%

Bankmed's Solvency Ratio as at 31 December 2017 vs. Industry Average (CMS Annual Report 2017)

4.9%
vs
8.3%

Non-healthcare Expenses Ratio (Administration, Managed Care and General Administration Expenses)

Bankmed as at 31 December 2017 vs. Industry Average (CMS Annual Report 2017)

6
PLANS

We offer a range of Plans to suit our members' healthcare needs and pockets

*based on independent actuarial analysis.

WHAT SETS BANKMED APART?

Preventive screening tests and wellness initiatives

Our wellness initiatives at your work place, help you to identify any conditions before they become a problem. We pay for your screening tests and ensure that you get the best possible treatment.

Cover for sexual health and female birth control

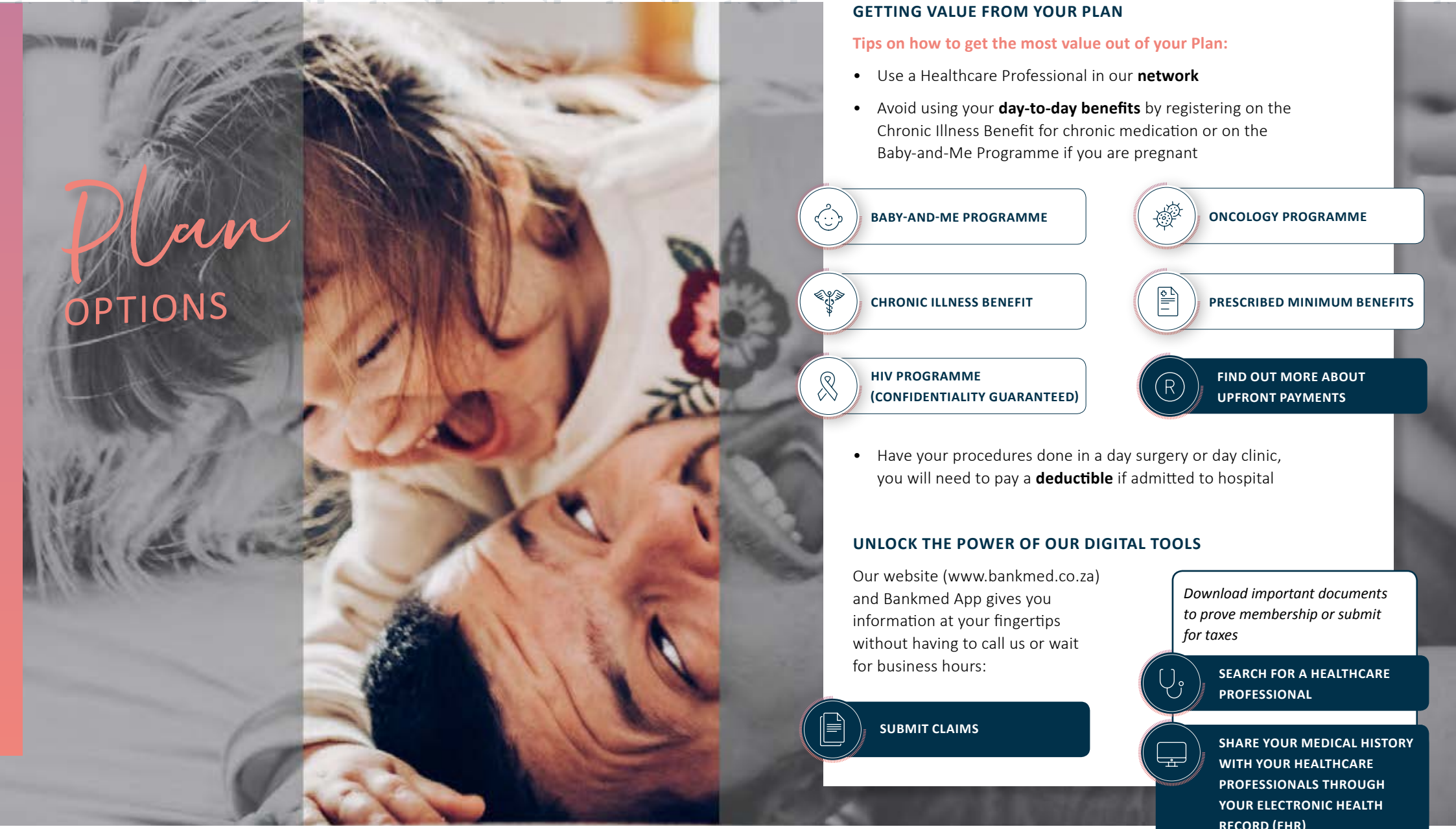
We pay for specific screening tests and procedures without using your **day-to-day benefits**. We pay for Pap smears, offer a circumcision benefit and female birth control on all Plans except the Essential Plan. You also have cover for HIV counselling and testing as well as a **full HIV treatment programme** should you need it.

We come to you

Bankmed comes to your workplace to help you with any questions about your benefits and services.

Plans designed specifically for you

All our Plans, benefits and contributions are designed to reflect our intimate knowledge of your challenges, workplace environment and health risks.



Plan OPTIONS

GETTING VALUE FROM YOUR PLAN

Tips on how to get the most value out of your Plan:

- Use a Healthcare Professional in our **network**
- Avoid using your **day-to-day benefits** by registering on the Chronic Illness Benefit for chronic medication or on the Baby-and-Me Programme if you are pregnant

BABY-AND-ME PROGRAMME

ONCOLOGY PROGRAMME

CHRONIC ILLNESS BENEFIT

PRESCRIBED MINIMUM BENEFITS

HIV PROGRAMME (CONFIDENTIALITY GUARANTEED)

FIND OUT MORE ABOUT UPFRONT PAYMENTS

- Have your procedures done in a day surgery or day clinic, you will need to pay a **deductible** if admitted to hospital

UNLOCK THE POWER OF OUR DIGITAL TOOLS

Our website (www.bankmed.co.za) and Bankmed App gives you information at your fingertips without having to call us or wait for business hours:

SUBMIT CLAIMS

Download important documents to prove membership or submit for taxes

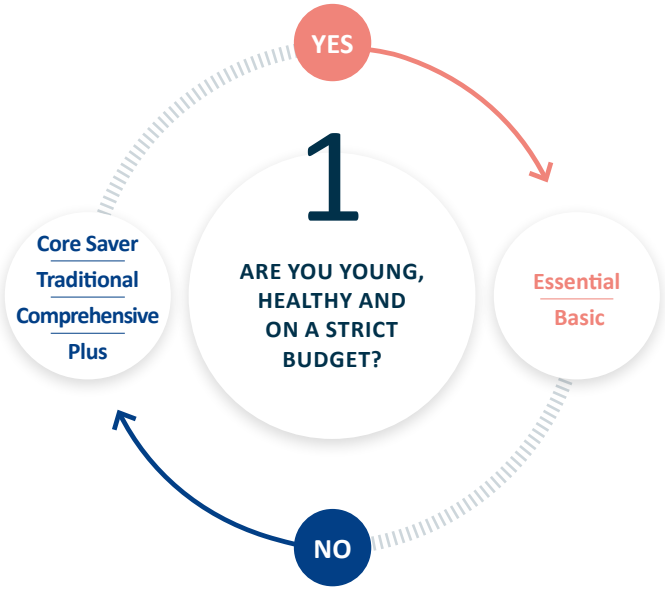
SEARCH FOR A HEALTHCARE PROFESSIONAL

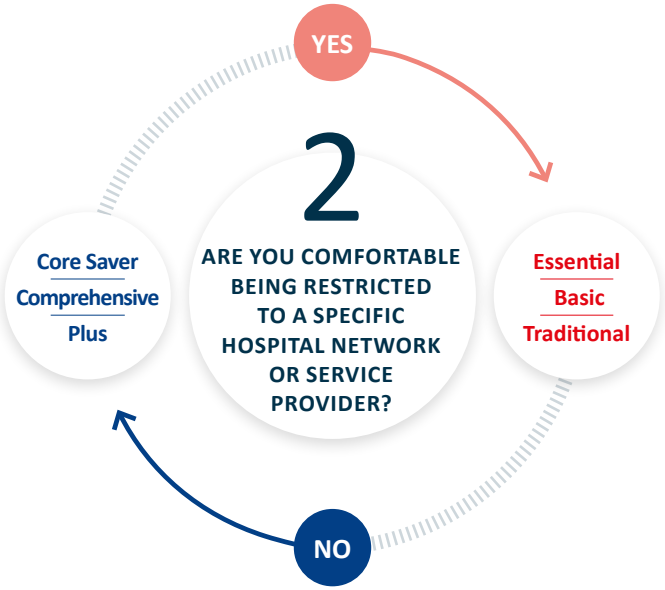
SHARE YOUR MEDICAL HISTORY WITH YOUR HEALTHCARE PROFESSIONALS THROUGH YOUR ELECTRONIC HEALTH RECORD (EHR)

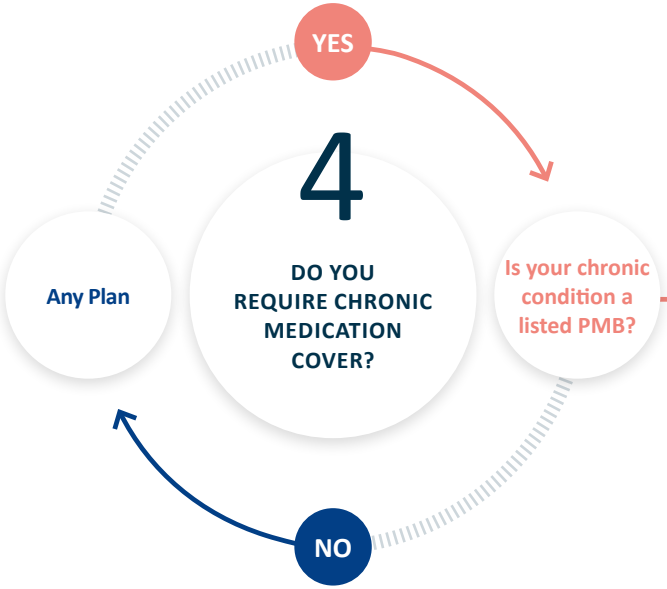
Choosing the Plan for you

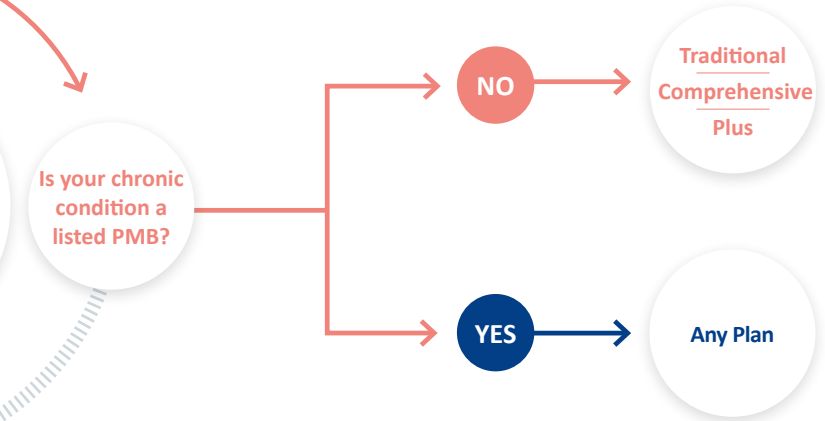
Make sure your healthcare cover suits your needs and budget.

This infographic gives a broad overview of things you need to keep in mind when choosing your Plan:









COMPARE THE DIFFERENT PLANS

Plan Benefits

Plan	Wellness and Preventive Care Benefits (Determine your risk, detect conditions early, and improve your health)	Use this network for full cover (Prescribed Minimum Benefits and other benefits)	Treatment while admitted to hospital and other major medical expenses	Chronic medication	Prescribed Minimum Benefits (PMBs)
Plus	Personal Health Assessment Bankmed Stress Assessment Vaccinations and screenings Pap smear consultation Female contraception Workplace-based TB screening Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 16 Herpes Zoster vaccine for members 60+ Post-engagement Wellness Management Programme	Bankmed GP Network Bankmed Prestige A and B Specialist Network Bankmed Pharmacy Network Courier pharmacy for HIV medication Bankmed Emergency Services for ambulance services	Comprehensive cover for hospitalisation and most hospital care in any private hospital Specific categories subject to rand limits We pay for procedures performed in hospital at 300% of the **Scheme Rate**	R26 620 for each member a year We pay less for the medication you collect from pharmacies that are not in our network. You might have to pay part of the cost yourself	We pay the full cost of Prescribed Minimum Benefits from network Healthcare Professionals Reduced benefits if you use Healthcare Professionals who are not in our network. You may have to pay part of the treatment cost yourself
Comprehensive	Personal Health Assessment Bankmed Stress Assessment Vaccinations and screenings Pap smear consultation Female contraception Workplace-based TB screening Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 16 Herpes Zoster vaccine for members 60+ Post-engagement Wellness Management Programme	Bankmed GP Network Bankmed Prestige A and B Specialist Network Bankmed Pharmacy Network Courier pharmacy for HIV medication Bankmed Emergency Services for ambulance services	Comprehensive cover for hospitalisation and most hospital care in any private hospital Specific categories subject to rand limits In hospital GP procedures covered at 100% of **Scheme Rate** In-hospital specialist procedures covered at 100% of **Scheme Rate**	R22 325 for each member a year We pay less for the medication you collect from pharmacies that are not in our network. You might have to pay part of the cost yourself	We pay the full cost of Prescribed Minimum Benefits from network Healthcare Professionals Reduced benefits if you use Healthcare Professionals who are not in our network. You may have to pay part of the cost of treatment yourself

Plan	Wellness and Preventive Care Benefits (Determine your risk, detect conditions early, and improve your health)	Use this network for full cover (Prescribed Minimum Benefits and other benefits)	Treatment while admitted to hospital and other major medical expenses	Chronic medication	Prescribed Minimum Benefits (PMBs)
Traditional	Personal Health Assessment Bankmed Stress Assessment Vaccinations and screenings Pap smear consultation Female contraception Workplace-based TB screening Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 16 Herpes Zoster vaccine for members 60+ Post-engagement Wellness Management Programme	Bankmed Hospital Network Bankmed GP Network Bankmed Prestige A and B Specialist Network Bankmed Pharmacy Network Courier pharmacy for HIV medication Bankmed Emergency Services for ambulance services	Comprehensive cover for hospitalisation and most hospital care in a restricted hospital network Specific categories subject to rand limits More extensive hospital network than for Essential and Basic Plans GP procedures performed in hospital covered at 100% of **Scheme Rate** Procedures specialists do in the hospital are covered at 100% of **Scheme Rate**	R20 615 for each member a year We pay less for the medication you collect from pharmacies that are not in our network. You might have to pay part of the cost yourself	We pay the full cost of Prescribed Minimum Benefits from network Healthcare Professionals Reduced benefits if you use Healthcare Professionals who are not in our network. You may have to pay part of the cost of treatment yourself
Core Saver	Personal Health Assessment Bankmed Stress Assessment Vaccinations and screenings Pap smear consultation Female contraception Workplace-based TB screening Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 16 Herpes Zoster vaccine for members 60+ Post-engagement Wellness Management Programme	Bankmed GP Network Bankmed Prestige A and B Specialist Network Bankmed Pharmacy Network Courier pharmacy for HIV medication Bankmed Emergency Services for ambulance services	Comprehensive cover for hospitalisation and most hospital care in an unrestricted network of hospitals Specific categories subject to rand limits Organ transplants and oncology treatment is limited to Prescribed Minimum Benefits We pay for procedures performed in hospital at 100% of **Scheme Rate**	No overall limit, but benefits subject to Core Saver medicine list (formulary) for Prescribed Minimum Benefit conditions only We pay less for the medication you collect from pharmacies that are not in our network. You might have to pay part of the cost yourself	We pay the full cost of Prescribed Minimum Benefits from network Healthcare Professionals Reduced benefits if you use Healthcare Professionals who are not in our network. You may have to pay part of the cost of treatment yourself

Plan	Wellness and Preventive Care Benefits (Determine your risk, detect conditions early, and improve your health)	Use this network for full cover (Prescribed Minimum Benefits and other benefits)	Treatment while admitted to hospital and other major medical expenses	Chronic medication	Prescribed Minimum Benefits (PMBs)
Basic	Personal Health Assessment Bankmed Stress Assessment Vaccinations and screenings Pap smear consultation Female contraception Workplace-based TB screening Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 16 Herpes Zoster vaccine for members 60+ Post-engagement Wellness Management Programme	Bankmed Hospital Network Bankmed GP Entry Plan Network Bankmed Entry Plan Specialist Network Bankmed Pharmacy Network Courier pharmacy for HIV medication Bankmed Emergency Services for ambulance services	Comprehensive cover for hospitalisation and most hospital care in a restricted hospital **network** Specific categories subject to rand limits Hospital **network** more limited than for the Traditional Plan Organ transplants, oncology treatment and renal dialysis, are limited to Prescribed Minimum Benefits We pay for procedures performed in hospital at 100% of **Scheme Rate**	No overall limit, but benefits from Bankmed Network Healthcare Professionals and subject to Scheme approved medicine list (formulary)	We pay the full cost of Prescribed Minimum Benefits from network Healthcare Professionals Reduced benefits if you use Healthcare Professionals who are not in our network. You may have to pay part of the cost of treatment yourself
Essential	Personal Health Assessment Bankmed Stress Assessment Vaccinations and screenings Pap smear consultation Workplace-based TB screening Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 16 Herpes Zoster vaccine for members 60+ Post-engagement Wellness Management Programme	Bankmed Hospital Network Bankmed GP Entry Plan Network Bankmed Entry Plan Specialist Network Bankmed Pharmacy Network Courier pharmacy for HIV medication Bankmed Emergency Services for ambulance services	Limited to Prescribed Minimum Benefits from a restricted hospital **network** (Designated Service Providers) Hospital **network** more restricted than for the Traditional Plan Procedures performed in hospital are limited to Prescribed Minimum Benefits	Limited to Prescribed Minimum Benefits, covered at 100% of cost from Bankmed GP Entry Plan Network and subject to Scheme approved medicine list (formulary)	We pay the full cost of Prescribed Minimum Benefits from network Healthcare Professionals Reduced benefits if you use Healthcare Professionals who are not in our network. You may have to pay part of the cost of treatment yourself

Day-to-day benefits on different Plans

MEDICAL SAVINGS ACCOUNT (MSA)

Core Saver, Comprehensive and Plus Plans

A Medical Savings Account is used to pay for healthcare you receive while you are not admitted to hospital. We use these funds to pay for medical costs like GP visits, X-rays, short-term medication, and blood tests.

At the beginning of the year, we give you full access to a yearly amount. You pay the amount back without interest as part of your **monthly contributions.**

If you join Bankmed after 1 January, we work out your Medical Savings Account amount for the rest of the year by multiplying the monthly amount you contribute towards your Medical Savings Account by the number of months left in the year.

Plan	Medical Savings Account	Day-to-day benefits
Plus	Yes	We pay day-to-day claims from your Medical Savings Account until you reach the **Annual Threshold** Once you reach the Annual Threshold, you gain access to the **Above Threshold Benefit,** which gives more cover if you have high out-of-hospital expenses
Comprehensive	Yes	We use the funds in your Medical Savings Account to pay for GP and specialist consultations, acute medication (short-term medication), pathology (blood tests) and radiology (X-rays) Unlimited cover from the **Insured Benefit** for procedures performed by GPs or specialists in their rooms, and basic dentistry (such as dentist consultations, teeth cleaning and fillings) We only pay the full cost if you use Healthcare Professionals in our **network**; otherwise you may have to pay part of the cost yourself Cover from the **Insured Benefit** up to a set limit for advanced dentistry, orthodontics and other specified categories. When you reach the limit, we start paying from the available funds in your Medical Savings Account
Traditional	No	We pay from the **Insured Benefit** for GP and specialist consultations, acute medication (short-time medication), radiology (X-rays), pathology (blood tests), basic dentistry, advanced dentistry and orthodontics up to the Plan limit Unlimited cover from the **Insured Benefit** for procedures performed by GPs and specialists in their rooms We only pay the full cost if you use Healthcare Professionals in our **network**; otherwise you may have to pay part of the cost yourself Limited cover for eye test and glasses or contact lenses every two years

ANNUAL THRESHOLD AND ABOVE THRESHOLD BENEFIT

MAKING YOUR MEDICAL SAVINGS ACCOUNT (MSA) LAST

Only you and your treating Healthcare Professional can decide what treatment you need. Discuss with your Healthcare Professional to make sure you get the best value for money and the treatment you need.

PACE YOURSELF

Work out a budget just as you would with a savings account at the bank.

Know how much you have available for the year, and plan for important check-ups over the year. Use pharmacies or clinic services that offer free blood pressure tests or give flu shots.
(We pay for the vaccine from your **Insured Benefit**, so you do not use the funds in your Medical Savings Account).

Plan	Medical Savings Account	Day-to-day benefits
Core Saver	Yes	Unlimited cover for **Prescribed Minimum Benefits** (PMBs) if you use GPs or specialists in our networks and get the recommended care for the condition. You have to register on the Chronic Illness Benefit for chronic conditions We pay for two consultations for non-PMB conditions from the **Insured Benefit.** Once this is used up, we pay for day-to-day benefits from the available funds in your Medical Savings Account We use the available funds to pay for non-PMBs such as dentistry, orthodontics, eye care, and acute medication (short-term medication) that a Healthcare Professional prescribes Members on this Plan have limited cover from the **Insured Benefit** for acute medication a pharmacist prescribes
Basic	No	Unlimited cover for primary healthcare services such as GP consultations, acute medication (short-term medication) on our medicine list (formulary) and basic dentistry from Healthcare Professionals in our **network**. Limited benefits for eye care from the Bankmed Optometry Network every two years We offer other benefits up to a limit if you get them from a Bankmed Entry Plan Network GP or this GP refers you to someone else (writes a letter saying you should see another Healthcare Professional in our **network**) No benefit for advanced dentistry or orthodontic treatment
Essential	No	Only **Prescribed Minimum Benefits**

PRESCRIBED MINIMUM BENEFITS

PRESCRIBED MINIMUM BENEFITS

Annual Threshold vs Above Threshold Benefit

PLUS PLAN ONLY

The Above Threshold Benefit (ATB) gives you additional cover if you use up the **yearly amount we pay into your Medical Savings Account** at the beginning of the year. The Above Threshold Benefit gives you more cover than the **Prescribed Minimum Benefits.**

An **Insured Benefit** can only be accessed once you reach the Annual Threshold. There are limits to how much we pay from the Above Threshold Benefit.

THE ANNUAL THRESHOLD

We use the number of adult and child **dependants** on a **membership** to calculate the Annual Threshold for the year.

We use the **Scheme Rate** instead of the cost of medication or treatment to calculate when you reach the Annual Threshold. When claims pay out at 100% of the Scheme Rate from your Medical Savings Account and add up to the Annual Threshold, you can access the Above Threshold Benefit.

Self-payment Gap

If you do not use network Healthcare Professionals, and your Healthcare Professional charges more than the Scheme Rate, you could run out of funds in your Medical Savings Account before you reach the Annual Threshold. This means that you will have a Self-payment Gap.

If you have a Self-payment Gap, you have to pay all claims. If you do not have benefits available, please still send your claims to us, so we know when you have reached the Annual Threshold, in order for you to access the Above Threshold Benefit.

LIMITS TO AMOUNTS ADDING UP AND BENEFIT CATEGORIES

There is a limit to how much of your Medical Savings Account is used to pay for specific categories of treatments, which adds up to the Annual Threshold. Some of the categories not limited to:

- Prescribed acute medication (medication you have to take for a limited time)
- Claims for tooth and gum care (including preventive and basic dentistry, advanced dentistry and all other dental services)
- Optometry consultations, prescription lenses and readymade readers, contact lenses, fitting of contact lenses and other eye-care such as refractive surgery

Your general limits for the categories can be more than the limits for the Above Threshold Benefit. However, we do not pay out more than your family's limits for the Above Threshold Benefit.

Contributions 2020

ESSENTIAL PLAN (NO MEDICAL SAVINGS ACCOUNT)

Schedule of monthly contributions with effect from 1 January 2020

Income	Member	Adult dependant	Child dependant
R0 – R5 000	R727	R652	R182
R5 001 – R6 000	R795	R716	R208
R6 001 – R7 000	R878	R790	R226
R7 001 – R8 000	R964	R867	R247
R8 001 – R9 000	R1 101	R993	R273
R9 001 – R10 000	R1 225	R1 101	R308
R10 001+	R1 395	R1 257	R351

BASIC PLAN (NO MEDICAL SAVINGS ACCOUNT)

Schedule of monthly contributions with effect from 1 January 2020

Income	Member	Adult dependant	Child dependant
R0 – R5 000	R1 116	R834	R280
R5 001 – R6 000	R1 225	R919	R317
R6 001 – R7 000	R1 350	R1 009	R348
R7 001 – R8 000	R1 482	R1 126	R381
R8 001 – R9 000	R1 694	R1 284	R424
R9 001 – R10 000	R1 884	R1 425	R473
R10 001+	R2 145	R1 609	R538

CORE SAVER PLAN (WITH MEDICAL SAVINGS ACCOUNT)

Schedule of monthly contributions with effect from 1 January 2020

Income	Total Contribution (including Medical Savings Account)			Medical Savings Account (included in Total Contribution)		
	Member	Adult dependant	Child dependant	Member	Adult dependant	Child dependant
R0 – R5 000	R1 666	R1 254	R418	R246	R185	R62
R5 001 – R6 000	R1 785	R1 340	R446	R263	R198	R65
R6 001 – R7 000	R1 910	R1 434	R477	R281	R212	R72
R7 001 – R8 000	R2 006	R1 505	R503	R296	R223	R76
R8 001 – R9 000	R2 162	R1 625	R546	R320	R240	R80
R9 001 – R10 000	R2 273	R1 708	R570	R335	R250	R83
R10 001+	R2 506	R1 875	R630	R368	R277	R93

TRADITIONAL PLAN (NO MEDICAL SAVINGS ACCOUNT)

Schedule of monthly contributions with effect from 1 January 2020

Income	Member	Adult dependant	Child dependant
R0 – R5 000	R2 777	R2 079	R693
R5 001 – R10 000	R3 237	R2 425	R813
R10 001+	R3 368	R2 529	R843

COMPREHENSIVE PLAN (WITH MEDICAL SAVINGS ACCOUNT)

Schedule of monthly contributions with effect from 1 January 2020

Income	Total Contribution (including Medical Savings Account)			Medical Savings Account (included in Total Contribution)		
	Member	Adult dependant	Child dependant	Member	Adult dependant	Child dependant
R0 - R10 000	R3 685	R2 760	R926	R650	R486	R164
R10 001+	R3 837	R2 877	R960	R677	R508	R169

PLUS PLAN (WITH MEDICAL SAVINGS ACCOUNT)

Schedule of monthly contributions with effect from 1 January 2020

Income	Total Contribution (including Medical Savings Account)			Medical Savings Account (included in Total Contribution)		
	Member	Adult dependant	Child dependant	Member	Adult dependant	Child dependant
All incomes	R6 496	R4 863	R1 626	R1 520	R1 138	R380

IMPORTANT

CONTRIBUTIONS FOR CHILD DEPENDANTS ARE LIMITED TO A MAXIMUM OF THREE CHILDREN, WITHOUT LIMITING THE NUMBER OF CHILDREN THAT MAY BE REGISTERED.

CALCULATE YOUR CONTRIBUTION ON DIFFERENT PLANS

Late-Joiner Penalty

The Medical Scheme Act instructs medical schemes to charge a late-joiner penalty if someone joins a medical scheme for the first time when they're 35 years or older, or if someone isn't a member and has a break in coverage for more than 3 months then joins a medical scheme again.

The Act calls this person a late joiner. This does not apply to **members** or their **dependants** who were members of a medical scheme before 1 April 2001 and who have not had a break in coverage for more than three months consecutively.

The Board of Trustees can decide to charge a late joiner an extra percentage of their contribution depending on how long they have not been a member of a medical scheme. The penalty is permanent and will apply for the duration of the membership.

Penalty bands	Maximum penalty
1 to 4 uncovered years	5%
5 to 14 uncovered years	25%
15 to 24 uncovered years	50%
25+ uncovered years	75%

If you can prove that you've been a member of a South African medical scheme before, we subtract the years of membership from your current age when we work out your late-joiner penalty.

Cover for medical emergencies

In an emergency, contact Bankmed Emergency Services on 0860 999 911. This number is on your membership card, but we also suggest you save it on your cellphone.

If you are admitted to hospital in an emergency, please contact us for authorisation within 48 hours.

EMERGENCY SERVICES

Bankmed Emergency Services offers real-time emergency care for all members. This number is available 24 hours a day, seven days a week for any emergency calls. Highly qualified emergency personnel manage this line. They assess each case and provide immediate feedback and help.

If you need medically equipped transport in South Africa, our Emergency Services will send an ambulance or helicopter to take you to hospital. We pay for the cost from your Hospital Benefit; it does not matter if you are admitted to hospital or not.

You can go to any hospital in a medical emergency. We will pay for your emergency hospital admission at any hospital, even if it is not in our network.

The Medical Schemes Act sets out what an emergency medical condition is. Even if a Healthcare Professional tells you it's a medical emergency, we only pay in full for a medical condition if:

- The medical condition starts suddenly and is unexpected
- The condition has to be treated at once (treatment could involve an operation)
- If treatment does not start at once, the condition could cause weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death

If you have a sudden health problem, it is not always clear if the condition is a medical emergency or not. To pay for treatment as a Prescribed Minimum Benefit, we may ask you to send us proof that the situation was a medical emergency.

CALLING FROM OUTSIDE SOUTH AFRICA

IF YOU ARE OUTSIDE THE BORDERS OF SOUTH AFRICA, CALL **+27 11 529 6616** IN AN EMERGENCY OR IF YOU HAVE ANY BENEFIT RELATED QUESTIONS.

This line is only for international callers. If you are travelling outside South Africa, we suggest that you save this number on your mobile device, so you have it on hand in an emergency.

Prescribed Minimum Benefits (PMBs)

According to the Medical Schemes Act, all medical schemes have to pay for a specific minimum level of care for a list of medical conditions. These are called Prescribed Minimum Benefits.

You have cover for Prescribed Minimum Benefit conditions, no matter which Plan you choose. However, there are conditions and limits to this cover.

Medical schemes have to pay the costs related to the diagnosis, treatment and care of:

- Any emergency medical condition
- A limited set of 270 medical conditions (defined in the Diagnosis Treatment Pairs)
- 25 chronic conditions (defined in the Chronic Disease List)

CONDITIONS FOR COVER

You must meet three requirements to have your treatment paid in full:

1. **Your condition must be on the Prescribed Minimum Benefit lists**
2. **You must use the recommended treatment and medication for your condition**

You must use medication from our medicine list (formulary), or you may have to pay part of the cost yourself.

3. **You must use our Designated Service Providers**

A Designated Service Provider is the same as a **network** Healthcare Professional. In other words, they are a Healthcare Professional we have an agreement with. You are allowed to use a non-Designated Service Provider, but this may mean you have to pay part of the claim yourself.

If you need to go to the hospital and it is not a medical emergency, we only cover claims if you contacted us and got authorisation before you were hospitalised.

HOW WE PAY

We pay for the cost of the diagnosis, treatment and care of Prescribed Minimum Benefits in South Africa, in full as an **Insured Benefit** if you meet the three requirements for full coverage. We always pay for emergency medical treatment, even if you use a non-network Healthcare Professional.

If it is not a medical emergency, a network Healthcare Professional is available, and you use a non-network Healthcare Professional, we cover the diagnosis, treatment and care of Prescribed Minimum Benefits at the **Scheme Rate.**

You have to get pre-authorisation, your treatment has to follow the clinical protocols, and you have to register on our Managed Care Programmes for Prescribed Minimum Benefit cover. This means you must apply for these benefits or we pay for treatment from your **day-to-day benefits**. After you reach the rand limit for chronic medication, we only provide funding for medication as a Prescribed Minimum Benefit.


HEALTHCARE PROFESSIONALS IN OUR NETWORK


OVERVIEW OF NETWORKS ON DIFFERENT PLANS

PLEASE NOTE:

- Prescribed Minimum Benefits only apply to claims in South Africa. If you claim for a healthcare service that is a Prescribed Minimum Benefit in South Africa, but you received the care or treatment outside the borders of South Africa, we treat them as ordinary claims and pay them according to your Plan's benefits
- You have to get pre-authorisation, use medication on our medicine list (formulary) and get the recommended treatment for the claim to qualify for Prescribed Minimum Benefit cover
- We only pay for the cost of diagnosis as a Prescribed Minimum Benefit if the test confirms that the medical condition is a Prescribed Minimum Benefit condition
- When this schedule sets out insured limits, we pay claims (including Prescribed Minimum Benefits) up to the limit. When you reach the limit, we only pay for treatment as a Prescribed Minimum Benefit if you meet the conditions
- The Council for Medical Schemes tells medical schemes not to pay for Prescribed Minimum Benefits from your Medical Savings Account. Once you register for a chronic Prescribed Minimum Benefit condition, we do not pay for treatment from your Medical Savings Account
- Even if we usually pay for care or treatment from your Medical Savings Account or do not offer a benefit, we pay for Prescribed Minimum Benefits as long as members meet the conditions for cover

WHAT IF I CANNOT USE A NETWORK HEALTHCARE PROFESSIONAL?

In a medical emergency, go straight to the nearest hospital. If it is not an emergency, you should use a Healthcare Professional, pharmacy or hospital in our **network** for Prescribed Minimum Benefit care to make sure we pay for the cost of care in full.

There are other situations in which we pay for Prescribed Minimum Benefits in full even if you do not use a Healthcare Professional in our network, as long as you contact us for permission (pre-authorisation) beforehand. Examples of these situations are:

- The healthcare service is not available from someone in the Bankmed Network, or you would have to wait for an unreasonably long time to receive the treatment or service
- You need immediate medical or surgical treatment for a Prescribed Minimum Benefit condition, and the circumstances or location means you cannot reasonably use a network provider
- No network provider is within a reasonable proximity to your home or work address

IS MY CONDITION COVERED?

A Healthcare Professional must diagnose you with a condition on the list of **270 Prescribed Minimum Benefit diagnoses.** For us to cover your healthcare costs, your Healthcare Professional must use the correct ICD 10 code for the condition.

We cover **chronic medical conditions** through our **Chronic Illness Benefit**. If you are diagnosed with a chronic Prescribed Minimum Benefit condition, **you must register before you have access to cover.** If you do not register, we pay for your treatment from your day-to-day benefits.

The Chronic Disease List (CDL) specifies medication and treatment for the 25 chronic conditions that are covered in this section of the Prescribed Minimum Benefits:

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disease
- Chronic renal disease
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus types 1 and 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

For more information on Prescribed Minimum Benefits, visit the

COUNCIL FOR MEDICAL SCHEMES' WEBSITE ADDRESS

Chronic Illness Benefit

*You are covered for **25 chronic conditions** (including HIV and AIDS).*

You must register on the Chronic Illness Benefit, once approved we will start paying for chronic medication. If you do not register we pay for your chronic medication from your day-to-day benefits.

MEDICINE ADVISORY SERVICES

Core Saver, Traditional, Comprehensive and Plus Plans

Our aim is to provide structure and make sure your chronic medication works for you.

We provide an efficient pre-authorisation process for you when taking chronic medication, and combine advanced technology with pharmacological and medical expertise to assess applications for medication in line with clinical guidelines.

HOW TO REGISTER

We ask your treating Healthcare Professional about your medical condition, and may require test results or additional proof to confirm that your medical condition qualifies for cover.

Core Saver, Traditional, Comprehensive or Plus Plan

To get authorisation for chronic medication at once, your Healthcare Professional or pharmacist can contact Bankmed 0800 132 345.

Alternatively, ask your treating Healthcare Professional to fill in a registration form **download it here.** E-mail the completed form to **chronic@bankmed.co.za**, or fax it to 011 770 6247.

Essential or Basic Plan

Ask your treating Healthcare Professional to fill in a registration form **download here.** E-mail the completed form to **chronicbasicessential@bankmed.co.za** or fax it to 011 539 7000.

TIPS FOR EXTENDING YOUR BENEFITS

When you apply to join the Chronic Illness Benefit, and Bankmed reviews your application, we suggest that your treating Healthcare Professional prescribes the generic version of the medication. We do this to make sure you have the best cover for your condition.

By law, only you and your treating Healthcare Professional can decide what treatment is best for you. We will not change your medication without your Healthcare Professional's permission.

Essential and Basic Plans

You have to use medication on our medicine list (formulary) for us to cover it. Please speak to your Healthcare Professional and consult the Bankmed website to check if medication is on our list.

Core Saver, Traditional, Comprehensive and Plus Plans

If the medication you use is not on our medicine list (formulary), you may have to pay part of the cost yourself. This is true even if the medication is a generic. Please speak to your Healthcare Professional and consult the Bankmed website to check if the medication is on our list.

Choose medication wisely

According to the International Generic Pharmaceutical Alliance, generics can be between 20 and 90 percent cheaper than the original medication. When you collect your medication from the pharmacy, ask the pharmacist if a generic is available and the cost implication.

You can save by using a single medication to treat a number of symptoms. For example, if you have a runny nose, congestion and headache.

What is generic medication?

A generic contains the same active ingredients as the original medication, but comes in different packaging. They have the same dosage, strength, quality, performance characteristics and intended use as the original. They are usually less expensive than the original medication.

Original medication is more expensive since only the company that developed it can sell it just after they produce it. Generics are made when the patent runs out, and different companies can manufacture the medication.

Hospital care and procedures

HOSPITAL BUILDING VS BEING IN HOSPITAL

We pay for treatment and care you receive while admitted to hospital from the Hospital Benefit. We do not pay for all healthcare you receive in a hospital building from the Hospital Benefit. There is a difference between being hospitalised and visiting a Healthcare Professional who has an office inside the hospital building.

When we say you are ***in hospital, admitted to hospital, or hospitalised,*** we mean that you had to sign in to hospital at reception and that you have a hospital bed. We pay for procedures, and your hospital stay in this case from the Hospital Benefit without using your day-to-day benefits.

We pay for healthcare you receive in the hospital building (like visits to the casualty unit, visits to specialists, scans and blood tests) from your day-to-day benefits if you do not have a hospital bed.

IF YOU ARE ADMITTED TO HOSPITAL IN AN EMERGENCY,
PLEASE CONTACT US FOR AUTHORISATION WITHIN 48 HOURS.

HOSPITAL PRE-AUTHORISATION

You must get authorisation before you are admitted to hospital for a planned procedure. Contact us for pre-authorisation as soon as you and your Healthcare Professional have agreed on a date for admission:

- **E-mail: treatment@bankmed.co.za**
- **Call:** 0800 BANKMED (0800 226 5633)
- **Fax:** 021 527 1928

If your Healthcare Professional contacts us and gets authorisation on your behalf, you have to make sure you receive all the information about the authorisation from the Healthcare Professional. You cannot hold Bankmed responsible if your Healthcare Professional does not share this information with you. This includes information about:

- What we cover and what we do not cover
- **Upfront payments (deductibles)** to the hospital before you receive treatment
- How much you have to pay yourself (co-payments and shortfalls)

Ask your treating Healthcare Professional for the following information and give it to us when you contact us for pre-authorisation:

- Your treating Healthcare Professional's practice number
- Name of the hospital to which you or your **dependant** will be admitted
- The date of admission
- The diagnosis code (ICD 10 code)
- Any tariff and procedure codes

We send you and the hospital an authorisation letter as soon as the admission is approved. If we have your cellphone number, we also send you an SMS with pre-authorisation details.

Pre-authorisation does not mean we pay all the costs for your hospital stay

When we give you pre-authorisation, we confirm that your hospital admission meets our clinical guidelines for funding. It does not guarantee we will cover all the costs related to the hospitalisation as this depends on your Plan's limits.

Always check your Plan limits in this Benefit and Contribution Schedule and call us on 0800 BANKMED (0800 226 5633) for benefit confirmation if you are unsure.

Upfront payment (deductible)

You may have to pay an amount to a hospital or a day clinic before specific procedures or if you do not use a network hospital if you are on a Plan that makes use of hospital networks. We call this amount an upfront payment or deductible. The facility will not admit you until you pay the amount. You do not have any upfront payments for emergency admissions, readmissions within six weeks of discharge or childbirth.

ONLY ONE UPFRONT PAYMENT (DEDUCTIBLE) FOR EACH ADMISSION

For example:

- A Traditional Plan member going to a non-network hospital (R5 240 upfront) for dental treatment (R1 865 upfront) pays R5 240 upfront for not using a network hospital as this is more than the dental upfront payment
- A Comprehensive Plan member going to a non-network hospital (R650 upfront) for dental treatment (R1 865) pays R1 865 upfront for the dental procedure as this is more than the non-network upfront payment

You do not have to pay an amount upfront if:

- You are admitted to a non-network hospital in a **medical emergency** (as a Prescribed Minimum Benefit). If you do not use a network hospital or day clinic, and it is not a medical emergency, you have to make an upfront payment
- You are admitted to hospital for childbirth
- You are admitted to hospital again within six weeks of being sent home if you have complications from a procedure that you already paid an amount upfront for
- You are admitted to a state hospital
- We inform you that you do not have an upfront payment if you are admitted to a day clinic for specific procedures

UPFRONT PAYMENT (DEDUCTIBLE) FOR NOT USING A NETWORK FACILITY

Unless it is a medical emergency, you have an **upfront payment** before you can receive treatment or care in a day clinic or hospital that is not in our network.

Basic, Core Saver, Comprehensive and Plus Plans

Day clinic: R250 for each admission

Hospital: R630 for each admission

Traditional Plan

Day clinic: R250 for each admission

Hospital: R5 240 for each admission

Essential Plan

No cover outside our hospital and day clinic networks.

AVOID UPFRONT PAYMENTS (DEDUCTIBLES) FOR SPECIFIC PROCEDURES

You have to contact us to get authorisation before you go to a day clinic or hospital for a procedure. Specific procedures can be performed in a day clinic instead of in hospital so you can avoid having an **upfront payment** by using a day clinic in our network.

Basic, Core Saver, Traditional, Comprehensive and Plus Plans

Network day clinic: No upfront payment

Non-network day clinic or network hospital: R1 650 for each admission

Essential Plan

Network day clinic: No upfront payment for Prescribed Minimum Benefit conditions

Non-network day clinic or network hospital: R1 650 for each admission for Prescribed Minimum Benefit conditions

You **only** have cover for procedures to treat **Prescribed Minimum Benefit** conditions. If the condition is not a Prescribed Minimum Benefit, you have to pay for all the procedure and related costs yourself.

No upfront payment for following procedures in a network day clinic:

- Adenoidectomy
- Arthrocentesis
- Cataract surgery
- Cautery of vulva warts
- Circumcision
- Colonoscopy
- Cystourethroscopy
- Diagnostic dilation and curettage
- Gastroscopy
- Hysteroscopy
- Myringotomy
- Myringotomy with intubation (grommets)
- Nasal cautery
- Nasal plugging for nose bleeds
- Proctoscopy
- Prostate biopsy
- Removal of pins and plates
- Sigmoidoscopy
- Tonsillectomy
- Treatment of Bartholin's cyst or gland
- Vasectomy
- Vulva or cone biopsy

UPFRONT PAYMENTS (DEDUCTIBLES) FOR DENTAL ADMISSIONS

Only the Traditional, Comprehensive and Plus Plans offer cover for tooth and gum (dental) treatment in hospital. If you are on another Plan, you have to pay for all the procedure and related costs yourself.

Traditional, Comprehensive and Plus Plans

Day clinic: R250 for each admission

Hospital: R1 865 for each admission

Basic, Essential and Core Saver Plans

No cover for dentistry performed in a hospital or day clinic

UPFRONT PAYMENTS (DEDUCTIBLES) FOR OESOPHAGOSCOPY AND SIMPLE ABDOMINAL HERNIA REPAIR

You always have an **upfront payment** for:

- Oesophagoscopy
- Simple abdominal hernia repair

Basic, Core Saver, Traditional, Comprehensive and Plus Plans

Day clinic: R250 for each admission

Hospital: R650 for each admission

HOW WE PAY YOUR TREATING HEALTHCARE PROFESSIONAL

Your benefits (rate of cover and limits) are set out in this Benefit and Contribution Schedule.

Always discuss costs with the treating Healthcare Professional and ask if they charge the **Scheme Rate**. If they charge more than the Scheme Rate, you have to pay the difference.

Ask if the other Healthcare Professionals (such as an anaesthetist or an assistant) will be involved in your treatment and if they charge the Scheme Rate.

If you negotiate tariffs upfront, you can avoid unexpectedly having to pay a substantial amount yourself.

We pay a lower fee if more than one procedure is performed while under one anaesthetic

Industry guidelines require that Healthcare Professionals charge lower fees for second and subsequent procedures performed under one anaesthetic than they would charge if they perform each procedure separately.

Your treating Healthcare Professional is aware of these guidelines and should follow them. Ask them to go through any planned charges with you before the procedure and discuss the cost. Make sure that you are not billed the full amount if you have more than one procedure under one anaesthetic.

MAKE SURE YOUR CONTACT DETAILS ARE ALWAYS UP TO DATE

We send pre-authorisation letters to you (the **member**) and your Healthcare Professional if we give you pre-authorisation. If your **dependant** is 18 years or older, we send them their own pre-authorisation. These letters contain important information about what Bankmed will and will not cover.

Please make sure that we always have your correct e-mail address. If your dependant is 18 years or older, please make sure we have their e-mail address as well.

You and your dependants cannot hold Bankmed responsible for any consequences if you or your dependants do not receive letters because we do not have your correct contact details.

DISCHARGE PLANNING

While you are in hospital, your Healthcare Professional and the hospital stay in contact with us to make sure we can update your authorisation if your treatment plan changes. A case manager also helps you with leaving the hospital if you need rehabilitation in another setting such as a step-down facility, or if you need home nursing. Cover for step down facilities and home nursing depends on your Plan's benefits.

Cover for pregnancy and childbirth

CORE SAVER, TRADITIONAL AND COMPREHENSIVE PLANS

Baby-and-Me Programme

Bankmed's pregnancy programme Baby-and-Me, provides additional cover for pregnancy and childbirth. Only members on the Core Saver, Traditional and Comprehensive Plans can access this programme. Members on the Plus Plan do not qualify for the additional coverage from the **Insured Benefit.**

REASONS TO JOIN

We provide additional coverage from the Insured Benefit during pregnancy for services such as ultrasounds and further consultations. A client relationship manager can help you to register on the programme and give you advice throughout your pregnancy and after the birth of your baby.

When you register, you receive:

- A Bankmed baby hamper*, which can be redeemed at any Toys R Us / Babies R Us stores nationally
- Additional cover
- Regular communication at different milestones throughout your pregnancy
- Help with hospital pre-authorisation
- A hospital checklist to prepare you for your hospital stay

HOW TO JOIN

You have to complete the Baby-and-Me application form to register on the programme.

- **E-mail: babyandme@bankmed.co.za**
- **Call:** 0800 BANKMED (0800 226 5633)
- **Website: www.bankmed.co.za**

* The contents of the Bankmed baby hamper can be changed without notice depending on available stock.

Cover for cancer

If you are diagnosed with cancer and your cancer treatment is approved, you have access to cover through the Oncology Programme. You must register on the Oncology Programme to access this benefit.

ESSENTIAL, BASIC AND CORE SAVER PLANS

You only have cover for approved **Prescribed Minimum Benefit** cancer treatment. We do need your treatment Plan, in order to approve your cover.

TRADITIONAL, COMPREHENSIVE AND PLUS PLANS

You have unlimited cover this means that we do not stop paying for approved treatments. You will need to send us your treatment Plan, in order to approve your cover before your Healthcare Professional commences treatment.

TREATMENT COVERED

We follow the South African Oncology Consortium's guidelines to make sure you have access to the most appropriate level of treatment for your particular stage of cancer.

We pay for chemotherapy, radiotherapy and other healthcare services based on proven effectiveness, evidence-based healthcare, and cost-effectiveness.

We will not pay for healthcare services that do not meet all criteria.

To register or find out more, contact us on:

- **E-mail: oncology@bankmed.co.za**
- **Call:** 0800 BANKMED (0800 226 5633)
- **Fax:** 011 539 5417

Cover for HIV and AIDS

For members living with HIV and AIDS, Bankmed's HIV Programme provides comprehensive disease management. You must register on the HIV Programme to get access.

We take the utmost care to protect your right to privacy and confidentiality. Once registered you will have cover for all-inclusive care

All medication on our medicine list (formulary) is paid in full as long as you collect your medication from a network pharmacy. We pay for approved medication that is not on our list up to a set monthly amount.

To register or find out more, contact us on:

- **E-mail: hiv@bankmed.co.za**
- **Call:** 0800 BANKMED (0800 226 5633)
- **Fax:** 011 539 3151

General exclusions:

WHAT BANKMED DOES NOT COVER

BANKMED EXCLUSIONS

This brochure is a summary of the benefits and features of Bankmed, pending approval from the Council for Medical Schemes (CMS).

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
	Does this Plan have a Medical Savings Account (MSA)?	No	No	No	Yes	Yes	Yes
	Percentage of Gross Contribution allocated to Medical Savings Account	N/A	N/A	N/A	14.7%*	17.6%*	23.4%*
					* The percentage of Gross Contribution allocated to the Medical Savings Account is not fixed per Plan. The percentage varies by dependant type, income band, rounding of values and manner in which contribution increases have been calculated. The percentage published in this Benefit and Contribution Schedule is, therefore, an aggregated value.		
1	OVERALL ANNUAL LIMIT						
		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
2	CLAIMS FOR SERVICES RENDERED OUTSIDE THE BORDERS OF SOUTH AFRICA (FOREIGN CLAIMS) It is recommended that you consider taking out comprehensive travel insurance prior to travelling abroad, as not all foreign claims will be covered (or covered in full)						
2.1		Cover available for PMB conditions and life-threatening emergencies only No benefits for emergency/ ambulance transport outside the borders of South Africa No benefits for services not normally covered at the Scheme's preferred provider network (Bankmed GP Entry Plan Network) for out-of-hospital consultations, medication and treatment (except via Bankmed GP Entry Plan Network providers in Lesotho) Medical motivation and prior approval required for non-emergency surgery outside the borders of South Africa	Foreign claims covered at the relevant Scheme Rate and/or Rand limit subject to benefits available on your selected Plan No benefits for emergency/ ambulance transport outside the borders of South Africa No benefits for services not normally covered at the Scheme's preferred provider network (Bankmed GP Entry Plan Network) for out-of-hospital consultations, medication and treatment (except via Bankmed GP Entry Plan Network providers in Lesotho) Medical motivation and prior approval required for non-emergency surgery outside the borders of South Africa	Foreign claims covered at the relevant Scheme Rate and/or Rand limit subject to benefits available on your selected Plan No benefits for emergency/ ambulance transport outside the borders of South Africa Medical motivation and prior approval required for non-emergency surgery outside the borders of South Africa			

ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		

3 WELLNESS AND PREVENTATIVE CARE BENEFITS (INSURED BENEFITS)

Wellness and Preventative Care Benefits are provided as additional Insured Benefits, which do not contribute towards the depletion of any other insured limits (or Medical Savings Account) specified elsewhere in these Benefit Tables. The cost of associated consultations is not included in the Wellness and Preventative Care Benefits

3.1	**Flu Vaccine**	100% of the Scheme Medicine Reference Price, limited to one vaccine pbpa
3.2	**Human Papilloma Virus (HPV) Vaccine**	100% of the Scheme Medicine Reference Price, limited to a total course of three doses (depending on product and age) per male and female beneficiary, aged nine to 16 years
3.3	**Childhood Vaccines** BCG, oral polio, rotavirus, diphtheria, tetanus, acellular pertussis, inactivated polio and haemophilus influenza type B, hepatitis B, measles, pneumococcal vaccine	100% of the Scheme Medicine Reference Price, for immunisations administered in accordance with the Department of Health's Expanded Programme on Immunisation (EPI) guidelines for children up to 12 years
3.4	**Pneumococcal Vaccine**	100% of the Scheme Medicine Reference Price, limited as follows: • One vaccine every five years for adults 60 years and older • One vaccine every five years for beneficiaries younger than 60 years, who have been diagnosed with asthma, chronic obstructive pulmonary disease, diabetes, cardiovascular disease or HIV/AIDS
3.5	**Herpes Zoster Virus vaccine** Reduces the rate of herpes zoster (shingles)	100% of Scheme Medicine Reference Price as follows: • One vaccination every five years for adults 60 years and older
3.6	**Mammogram**	100% of Scheme Rate, limited to one pbpa age 40 years and older (benefits for beneficiaries younger than 40 years subject to motivation and prior approval)
3.7	**Breast MRI** Only for Breast cancer high risk beneficiaries	100% of Scheme Rate, and one pbpa. For high risk beneficiaries only. Subject to clinical entry criteria and pre-authorisation. Breast Cancer Risk Calculator available by logging in to the website and clicking on MANAGE YOUR PLAN / Breast Cancer Risk Assessment
3.8	**Bone Densitometry**	100% of Scheme Rate, limited to one pbpa age 50 years and older (benefits for beneficiaries younger than 50 years subject to motivation and prior approval) Should member not meet clinical entry criteria, and they are younger than age 50, the member may claim the bone densitometry test from their Radiology Benefit. Where the Radiology Benefit is exhausted, this test may be claimed from available Medical Savings Account, if applicable to their Plan type
3.9	**Prostate-specific Antigen**	100% of Scheme Rate, limited to one pbpa age 50 years and older (benefits for beneficiaries younger than 50 years subject to motivation and prior approval)
3.10	**Faecal Occult Blood Test**	100% of Scheme Rate, limited to one pbpa age 50 years and older (benefits for beneficiaries younger than 50 years subject to motivation and prior approval)
3.11	**Tuberculosis (TB) Screening**	100% of Scheme Rate, limited to one chest X-ray pbpa For TB screening requested by registered private nurse practitioners providing on-site services at Employer Groups All other TB screenings subject to out-of-hospital radiology and/or pathology benefits as indicated elsewhere in these Benefit Tables
3.12	**Bankmed Stress Assessment**	Log in to the website and then click on MANAGE YOUR PLAN / Mental Wellbeing Assessments to complete your free online Bankmed Stress Assessment. There is no limit on the number of assessments per beneficiary per annum

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
3.13	**Cholesterol Screening, Blood Sugar Screening and Blood Pressure Measurements**	100% of Scheme Rate, limited to R310 pbpa at clinics, pharmacies or Bankmed GP Entry Plan Network GPs' consulting rooms (DSP)		100% of Scheme Rate, limited to R310 pbpa at clinics, pharmacies or Bankmed Network GPs' consulting rooms (DSPs)			
3.14	**HIV Counselling and Testing (HCT)**	Unlimited, covered at 100% of cost for HCT DSPs namely Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering onsite services at Employer Groups, subject to PMB regulations		100% of cost, unlimited, for DSPs: Bankmed Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering on-site services at Employer Groups			
3.15	**Pap Smear**	100% of Scheme Rate, limited to one pbpa One associated nurse, Bankmed GP Entry Plan Network GP or Bankmed Entry Plan Specialist Network consultation pb covered as an additional Insured Benefit limited to R490 pbpa		100% of Scheme Rate, limited to one pbpa One associated nurse, Bankmed network GP or Bankmed Prestige A and B Specialist Network consultation pb covered as an additional Insured Benefit limited to R490 pbpa			
3.16	**Personal Health Assessment (PHA)** Applies to members and beneficiaries aged 18 years and older only	100% of cost, limited to one assessment pbpa, subject to use of DSP only Benefit limited to Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted providers rendering on-site services at Employer Groups		100% of cost, limited to one assessment pbpa, subject to use of DSP only Benefit limited to Bankmed Network GPs, Bankmed Pharmacy Network and contracted providers rendering on-site services at Employer Groups			
3.17	**Personal Health Assessment (PHA) Basket** Additional consultations for Dietician and Biokineticist subject to clinical entry criteria	100% of Scheme Rate at a DSP only. Limited to two Dietician visits per year plus two Biokineticist visits per year Limited to medium and high risk members only. Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA. Clinical Entry Criteria applies. First visit to dietician and biokineticist to take place within 6 weeks of the PHA and second visit within 12 months of the PHA, otherwise funded from day-to-day benefits Applies to members and beneficiaries aged 18 years and older only.					
3.18	**Contraception: Oral Contraceptives, Devices and Injectables**	No benefit	100% of Scheme Medicine Reference Price, limited to R1 950 per female beneficiary per annum Oral contraceptives limited to one prescription or repeat prescription pb per month				
3.19	**Antenatal Screening** Non-invasive Prenatal Testing (NIPT) to test for chromosomal abnormalities. Clinical entry criteria apply. South African testing only. Applies to high risk beneficiaries only, who are aged 35 years and older at delivery	100% of Scheme Rate Limited to one test pb per pregnancy Test to be conducted at 10 - 12 weeks of pregnancy					

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
3.20	**New-born Screening** To test for the presence of certain metabolic and endocrine disorders	100% of Scheme Rate Limited to one test pb per pregnancy. Test to be carried out within 72 hours of birth South African testing only					
3.21	**New-born Hearing Test**	100% of Scheme Rate, limited to one test per beneficiary and must be carried out within eight weeks of birth Only the hearing test is covered by the Wellness and Preventative Care Benefit with a registered Audiologist If consultation charged, the cost of the consultation will be for the member's own pocket	100% of Scheme Rate, limited to one test per beneficiary and must be carried out within eight weeks of birth Only the hearing test is covered by the Wellness and Preventative Care Benefit with a registered Audiologist If consultation charged, consultation fee to be funded from consultation benefits				
3.22	**Diabetes Management** For members registered on the Scheme's Disease Management Programme Basket of Care set by the Scheme, subject to PMB regulations	Unlimited and 100% of cost for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP and member utilises the Scheme's DSP as their service provider 100% of Scheme Rate if non-DSP used	Unlimited and 100% of cost for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP and member utilises the Scheme's DSP as their service provider 100% of Scheme Rate if non-DSP used. Out-of-network GP benefit limit applies if the doctor is not the member's nominated GP	Unlimited and 100% of cost for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP and member utilises the Scheme's DSP as their service provider 100% of Scheme Rate if non-DSP used			
4.	**HIV/AIDS PROGRAMME** **Additional benefits subject to registration on the Scheme's HIV/AIDS Programme. These additional benefits do not contribute to the depletion of other Insured Benefits provided by the Scheme. Beneficiaries who do not register on the HIV/AIDS Programme will be entitled to all other benefits as specified in these Benefit Tables, with continued funding for PMBs, subject to PMB regulations, after depletion of the relevant sub-limits**						
4.1	**Consultations and Pathology**	Subject to benefits available in Scheme's Basket of Care 100% of cost at a DSP 100% of Scheme Rate at a non-DSP					

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
4.2	Medication via Designated Courier Pharmacy (DSP)	Unlimited 100% of cost via Designated Courier Pharmacy (DSP), as communicated to registered beneficiaries from time to time A motivation is required for the use of a non-DSP for medication. Subject to Scheme's approved formulary Scheme Medicine Reference Price applies to non-formulary medication					
4.3	Medication via non-DSP: Voluntary use of a non-DSP	Unlimited 80% of Scheme Medicine Reference Price A motivation is required for the use of a non-DSP for medication. Subject to Scheme's approved formulary Scheme Medicine Reference Price applies to non-formulary medication					
4.4	Medication via non-DSP: Involuntary use of a non-DSP	Unlimited 100% of cost, unlimited A motivation is required for the use of a non-DSP for medication. Subject to Scheme's approved formulary Scheme Medicine Reference Price applies to non-formulary medication					
5.	24-HOUR MEDICAL ADVICE LINE (CALL 0860 999 911) Free service to Bankmed members						
5.1	Call 0860 999 911 for 24-hour medical advice from a registered nurse						
6	AMBULANCE SERVICES (CALL 0860 999 911 FOR PRE-AUTHORISATION)						
6.1	BENEFITS FOR EMERGENCY SERVICES ARE SUBJECT TO USE OF THE PREFERRED PROVIDER. FAILURE TO USE THE PREFERRED PROVIDER MAY LEAD TO CO-PAYMENTS BEING APPLIED OR BENEFITS BEING DECLINED UPON REVIEW 100% of cost, unlimited. No benefit outside the borders of South Africa Call 0860 999 911 - 24 hours a day, seven days a week for pre-authorisation and you will be connected with highly qualified Bankmed Emergency Services personnel						
7.	HOSPITALISATION Subject to pre-authorisation. Bankmed reserves the right to obtain a second opinion prior to granting authorisation for spinal surgery						
	HOSPITALISATION AND ASSOCIATED IN-HOSPITAL BENEFITS ARE SUBJECT TO PRE-AUTHORISATION; FAILURE TO OBTAIN PRE-AUTHORISATION MAY LEAD TO CO-PAYMENTS BEING APPLIED OR BENEFITS BEING DECLINED UPON REVIEW CONTACT US ON 0800 226 5633 FOR AUTHORISATION PRIOR TO ANY PLANNED HOSPITAL ADMISSION, MRI SCAN, CT SCAN OR RADIONUCLIDE SCAN, OR WITHIN 24 HOURS OF AN EMERGENCY ADMISSION • Pre-authorisation for a hospital admission **does not guarantee** that all claims related to the hospital event will be **covered in full** • The onus is on the member to ensure that the Hospital **and** Healthcare Professionals are Designated Service Providers and within Network to avoid co-payments • Benefits available for your Plan, as well as annual limits for individual benefit categories, are set out in these Benefit Tables. The benefits under "hospitalisation" refer only to the hospital account • Any Healthcare Professionals attending to you during your hospital stay must submit a valid account for payment. The payment will be subject to the benefits, limits and/or any special conditions set out in these Benefit Tables under the relevant benefit categories • The onus is on the member to ensure that the Healthcare Professional has submitted the account for payment • Please take care to determine the limits for your Plan (if any) and at what rate the Scheme will cover your claims • Always understand the fees to be charged by your Healthcare Professional, and where necessary, negotiate fees with your attending Healthcare Professionals before incurring costs to avoid out-of-pocket payments. Please log in to the website for a list of procedures that can be safely performed in a doctor's rooms as an alternative to hospitalisation.						

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
7.1	**Hospital Network (DSP)**	Bankmed Hospital Network DSPs for the Essential Plan	Bankmed Hospital Network DSPs for the Basic Plan	Bankmed Hospital Network DSPs for the Traditional Plan	All contracted Netcare, National Hospital Network (NHN), Life Healthcare, Mediclinic and Clinix hospitals, any other independent private hospitals contracted to the Scheme		
7.2	**Hospitalisation** Subject to pre-authorisation	Limited to PMBs • 100% of cost at network DSPs • 80% of Scheme Rate for voluntary use of non-DSPs • 100% of cost for involuntary use of non-DSPs • No benefit for non-PMB admissions Benefits limited to general ward rate No benefit for dental surgery and auxiliary services, except for PMBs Benefits only available on referral from a Bankmed GP Entry Plan Network GP or referred specialist subject to PMB regulations	Benefits for PMBs and non-PMBs • 100% of cost at contracted rate in-hospital network DSPs • 80% of Scheme Rate in non-DSPs • 100% of cost for involuntary use of non-DSP Benefits limited to general ward rate No benefit for dental surgery and auxiliary services, except for PMBs Benefits only available on referral from a Bankmed GP Entry Plan Network GP or referred specialist	Benefit unlimited • 100% of cost in contracted private hospitals (DSPs) • 100% of cost in non-contracted private hospitals for a PMB admission (involuntary use of a non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a PMB admission (voluntary use of non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a non-PMB admission Benefits limited to general ward rate No benefit for dental surgery and auxiliary services, except for PMBs	Benefit unlimited • 100% of cost in contracted private hospitals (DSPs) • 100% of cost in non-contracted private hospitals for a PMB admission (involuntary use of a non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a PMB admission (voluntary use of non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a non-PMB admission Benefits limited to general ward rate	Benefit unlimited • 100% of cost in contracted private hospitals (DSPs) • 100% of cost in non-contracted private hospitals for a PMB admission (involuntary use of a non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a PMB admission (voluntary use of non-DSP) • 100% of Scheme Rate in non-contracted private hospitals for a non-PMB admission Benefits limited to general and private ward rates

	ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
	NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		

7.3 Deductibles

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

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

Detailed deductible information is set out on page 25 of the 2020 Benefit and Contribution Schedule

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

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

PMB admission: Involuntary use of non-DSP	No deductible payable for PMBs	No deductible	No deductible	No deductible
PMB admission: Voluntary use of non-DSP Applies to all admissions		Day clinic: R250 deductible Hospital: R630 deductible	Day clinic: R250 deductible Hospital: R5 240 deductible	Day clinic: R250 deductible Hospital: R630 deductible
Non-PMB admission Applies to all admissions		Day clinic: R250 deductible Hospital: R630 deductible	Day clinic: R250 deductible Hospital: R5 240 deductible	Day clinic: R250 deductible Hospital: R630 deductible

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

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

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

If the member chooses to have the abovementioned procedures/treatments performed in a non-network Day Surgery facility or in a hospital, the member will be liable for a deductible per admission
Important note for Essential Plan members: No access to full list of treatments/procedures listed above. Cover is limited to PMBs. If underlying diagnosis is a PMB, member qualifies for treatment

Deductible values continued on next page

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
	PMB admission: Involuntary use of a non-DSP **PMB admission: Voluntary use of non-DSP** Applies to all admissions **Non-PMB admission** Applies to all admissions	No deductible Non-DSP: R1 650 deductible No benefit	No deductible Non-DSP: R1 650 deductible Non-PMB: R1 650 deductible				
7.3.3	**Deductible applicable to Dental Admissions to Private Hospitals and Day Clinics** A deductible will apply to all beneficiaries on the below Plans when the beneficiary is admitted to hospital or a day clinic for dental treatment. The deductible applies upfront and will need to be settled at the facility prior to admission						
	Applies to both DSP and non-DSP Facilities	No benefit for in-hospital dental treatment, except PMBs		Day clinic: R250 deductible Hospital: R1 865 deductible	No benefit for in-hospital dental treatment, except PMBs	Day clinic: R250 deductible Hospital: R1 865 deductible	
7.3.4	**Deductible applicable to a specific list of treatment/procedures performed in Hospital Network DSPs** A deductible will apply to all beneficiaries on the below Plans when the beneficiary obtains treatment for the specified treatment/procedures set out below. The deductible applies when the beneficiary is admitted to hospital or a day clinic that falls within the list of DSP/network providers. The deductible applies upfront and will need to be settled at the facility prior to admission						
	The following procedures will always attract a deductible at a hospital/day clinic at a DSP facility: 1. Oesophagoscopy 2. Simple abdominal hernia repair *Applies to all admissions*	No deductible payable for PMBs	Day clinic: R250 deductible Hospital: R630 deductible				
7.4	**To-take-out drugs supplied by the hospital when a patient is discharged** 100% of cost, limited to PMBs and a maximum of seven days' supply per admission Must be charged on the hospital account where a hospital event has taken place. Not payable if obtained via a pharmacy after discharge If procedure took place in a day clinic, a maximum of a seven day supply will be funded from Insured Benefits if obtained from a retail pharmacy on the date of discharge only						
8	OUTPATIENT CONSULTATIONS AND FACILITY FEES FOR OUTPATIENT VISITS						
8.1	**Outpatient consultations with GPs and Specialists at hospital emergency rooms and outpatient units** Regarded as an out-of-hospital GP/specialist consultation in rooms, unless resulting in an authorised hospital admission See "GPs: Consultations in rooms" and "Specialists: Consultations in rooms", set out under 32.4 and 33.2						

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
8.2	**Facility fees for outpatient visits to hospital emergency rooms**	Facility fees for outpatient visits not covered, unless resulting in an authorised hospital admission	Facility fees for outpatient visits subject to out-of-hospital Specialist Consultation in Rooms Limit, unless resulting in an authorised hospital admission				
9	GP CONSULTATION WITHIN 30 DAYS OF DISCHARGE FROM HOSPITAL						
9.1	**Post-hospital GP consultation within 30 days of discharge from hospital**	Additional Insured Benefits. See "General Practitioners (GPs): Post-hospital GP consultation within 30 days of Discharge from Hospital (excluding day cases) as set out in the Benefit Table					
10	BLOOD TRANSFUSIONS						
10.1	**Blood Transfusions**	100% of cost, limited to PMBs	100% of cost, unlimited				
11	ORGAN AND BONE MARROW TRANSPLANTS Subject to pre-authorisation. Organ recipient must be a Bankmed beneficiary for benefits to apply; no benefits for travelling and non-hospital accommodation expenses						
11.1	**Hospitalisation/Organ and patient preparation**	Benefits for hospitalisation as specified elsewhere in these Benefit Tables, limited to PMBs		Benefits for hospitalisation as specified elsewhere in these Benefit Tables	Benefits for hospitalisation as specified elsewhere in these Benefit Tables, limited to PMBs	Benefits for hospitalisation as specified elsewhere in these Benefit Tables	
11.2	**Medication** In-and out-of-hospital	Limited to PMBs		Unlimited	Limited to PMBs	Unlimited	
	• **Medication via designated pharmacy (DSP)**	• 100% of cost, limited to PMBs		• 100% of cost	• 100% of cost, limited to PMBs	• 100% of cost	
	• **Medication via non-DSP** Voluntary use of non-DSP	• 80% of Scheme Medicine Reference Price plus dispensing fee, limited to PMBs		• 80% of Scheme Medicine Reference Price plus dispensing fee	• 80% of Scheme Medicine Reference Price plus dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus dispensing fee	
	• **Medication via non-DSP** Involuntary use of non-DSP	• 100% of cost, limited to PMBs		• 100% of cost	• 100% of cost, limited to PMBs	• 100% of cost	
11.3	**Harvesting and transporting of organs and other donor costs**	100% of cost, limited to PMBs		100% of cost, unlimited	100% of cost, limited to PMBs	100% of cost, unlimited	

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
12	**ONCOLOGY** **Subject to pre-authorisation**						
12.1	**In- and out-of-hospital consultations, treatment and materials**	Limited to PMBs, 100% of cost at a DSP or 100% of Scheme Rate at non-DSP		100% of cost at a DSP or 100% of Scheme Rate at non-DSP, unlimited	Limited to PMBs, 100% of cost at a DSP or 100% of Scheme Rate at non-DSP	100% of cost at a DSP or 100% of Scheme Rate at non-DSP, unlimited	
12.2	**Radiotherapy fees, chemotherapy facility and professional fees**	100% of Scheme Rate					
12.3	**Medication** In-and out-of-hospital	Limited to PMBs		Unlimited	Limited to PMBs	Unlimited	
	• **Medication via designated pharmacy (DSP)**	• 100% of cost, limited to PMBs		• 100% of cost	• 100% of cost, limited to PMBs	• 100% of cost	
	• **Medication via non-DSP** Voluntary use of non-DSP	• 80% of Scheme Medicine Reference Price plus dispensing fee, limited to PMBs		• 80% of Scheme Medicine Reference Price plus dispensing fee	• 80% of Scheme Medicine Reference Price plus dispensing fee, limited to PMBs	• 80% of Scheme Medicine Reference Price plus dispensing fee	
	• **Medication via non-DSP** Involuntary use of non-DSP	• 100% of cost, limited to PMBs		• 100% of cost	• 100% of cost, limited to PMBs	• 100% of cost	
13	**RENAL DIALYSIS** **Subject to pre-authorisation**						
13.1	**Procedures and treatment**	Limited to PMBs, 100% of cost at a DSP or 100% of Scheme Rate at non-DSP		100% of cost at a DSP or 100% of Scheme Rate at non-DSP, unlimited			
13.2	**Medication** In-and out-of-hospital	Limited to PMBs		Unlimited			
	• **Medication via designated pharmacy (DSP)**	• 100% of cost, limited to PMBs		• 100% of cost			
	• **Medication via non-DSP** Voluntary use of non-DSP	• 80% of Scheme Medicine Reference Price plus dispensing fee, limited to PMBs		• 80% of Scheme Medicine Reference Price plus dispensing fee			
	• **Medication via non-DSP** Involuntary use of non-DSP	• 100% of cost, limited to PMBs		• 100% of cost			

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
14	**PREGNANCY AND CHILDBIRTH**						
14.1	**Baby-and-Me Programme for expectant mothers**	No benefit		Call 0800 BANKMED (0800 226 5633) to register			
14.2	**Hospitalisation and associated in-hospital services** Subject to pre-authorisation	Benefits as specified under Hospitalisation – see section 7, limited to PMBs and hospital network rules apply	Benefits as specified under Hospitalisation – see section 7 Hospital network rules apply				
14.3	**Midwife care and delivery** Subject to pre-authorisation	100% of cost Limited to PMBs	100% of Scheme Rate Limited to PMBs	100% of Scheme Rate Unlimited			
14.4	**Birthing facilities as an alternative to hospitalisation** Subject to pre-authorisation	100% of cost for PMBs, limited to PMBs Cost of disposables limited to R1 120 per case	100% of Scheme Rate, limited to PMBs Cost of disposables limited to R1 120 per case	100% of Scheme Rate, unlimited Cost of disposables limited to R1 120 per case			
14.5	**Antenatal and postnatal care: GP and Specialist consultations and procedures in rooms**	Benefits for GPs and specialists as specified under section 32 and 33. Limited to PMBs	Benefits for GPs and specialists as specified under section 32 and 33	Benefits for GPs and specialists as specified under section 32 and 33 Additional Insured Benefits - see 14.8			Benefits for GPs and specialists as specified under section 32 and 33
14.6	**Antenatal and postnatal care: Ultrasonic investigations Radiology**	Benefits for radiology as specified under section 15 Limited to PMBs	Ultrasonic investigations limited to: • One first trimester 2D scan (per pregnancy) at contracted rate via Bankmed GP Entry Plan Network GP • One second trimester 2D scan (per pregnancy) at contracted rate via a Bankmed Entry Plan Specialist Network (DSP) gynaecologist/obstetrician • Scan as per the above are covered at 100% of cost All other/additional radiology benefits as specified under section 15	Benefits for radiology as specified under section 15 Additional Insured Benefits - see 14.8			Benefits for radiology as specified under section 15
14.7	**Antenatal and postnatal care: Pathology**	Benefits for pathology as specified under section 15 Limited to PMBs	Benefits for pathology as specified under section 15	Benefits for pathology as specified under section 15 Additional Insured Benefits - see 14.8			Benefits for pathology as specified under section 15

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
14.8	**Additional Insured Benefits subject to registration on the Baby-and-Me Programme**	No benefit		Additional Insured Benefits at, or subject to referral by, a Bankmed Network GP: • Five antenatal consultations per pregnancy, at the applicable rate/s for GP and specialist consultations in rooms as specified elsewhere in these Benefit Tables • Two 2D ultrasounds at 100% of Scheme Rate • R1 375 per pregnancy for antenatal and postnatal classes at 100% of Scheme Rate • Additional pathology at 100% of Scheme Rate, subject to Baby-and-Me approved basket of care			Additional Insured Benefits not applicable on this Plan, however, members may benefit from valuable information, guidance and support throughout the pregnancy by registering on the Baby-and-Me Programme
15	RADIOLOGY AND PATHOLOGY						
15.1	**Radiology** In-hospital	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate, unlimited				
15.2	**Pathology** In-hospital	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate, unlimited				
15.3	**MRI/CT scans, Radionuclide scans in- and out-of-hospital** Subject to pre-authorisation	100% of cost for radiology facilities at hospital network DSPs Limited to 100% of Scheme Rate for voluntary use of radiology facilities at non-DSPs Limited to PMBs	In-hospital at 100% of Scheme Rate, unlimited Out-of-hospital at 100% of cost, limited to PMBs via radiology facilities at hospital network DSPs only	100% of Scheme Rate, unlimited			

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
15.4	**Radiology and Pathology** Out-of-hospital	Limited to PMBs • Benefits subject to a CDL (baskets of care) registration for PMB conditions • 100% of cost for PMBs	• 100% of cost, unlimited via Bankmed GP Entry Plan Network and subject to Scheme-approved medicine list (formulary) • For radiology/pathology requested or carried out via a specialist, the benefit will be subject to the out-of-hospital "Specialists: Consultations/Procedures in rooms" limit, specified elsewhere in these Benefit Tables, except for one 2D scan in the second trimester via a Bankmed Entry Plan Specialist Network (DSP) gynaecologist/obstetrician, as specified in 33.2 and 33.3	• 100% of Scheme Rate, limited to R5 850 pfpa • Combined limit for Radiology and Pathology out-of-hospital	Benefits approved for beneficiaries registered for PMB Chronic Disease List (CDL) conditions: • 100% of Scheme Rate, subject to a CDL (baskets of care) and referral by a Bankmed Network GP (DSP) • Non-CDL (baskets of care) benefits subject to available Medical Savings Account, except for PMBs (subject to PMB regulations)	**Radiology:** • 100% of Scheme Rate, limited to R3 920 pfpa (including a sub-limit of R1 305 pfpa for out-of-hospital pathology); thereafter subject to available Medical Savings Account **Pathology:** • 100% of Scheme Rate, limited to R1 305 pfpa (included in the annual limit of R3 920 pfpa for out-of-hospital radiology); thereafter subject to available Medical Savings Account	• 300% of Scheme Rate, subject to available Medical Savings Account • ATB applies once Annual Threshold is reached • The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an ATB (always subject to available ATB) is R6 230 pfpa
16	**ALTERNATIVES TO HOSPITALISATION** **Subject to pre-authorisation**						
16.1	**Step-down Facilities**	100% of cost at DSP 100% Scheme Rate at non-DSP Limited to PMBs	100% of Scheme Rate Unlimited				
16.2	**Hospice** Ward fees and disposables	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate Unlimited	See Compassionate Care Benefit as specified in 16.3			
16.3	**Compassionate Care Benefit: End-of-life care for non-oncology patients** In-patient care and homecare visits	No benefit See Hospice Benefit as specified in 16.2		100% of Scheme Rate Unlimited for PMB scope and level of treatment. Limited to R59 300 pb per lifetime for all claims Subject to pre-authorisation and meeting the Scheme's guidelines			

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
16.4	**Advanced Illness Benefit: Defined list of out-of-hospital benefits for patients with advanced oncology conditions only** End-of-life treatment	No benefit See Hospice Benefit as specified in 16.2		100% of Scheme Rate Unlimited Subject to pre-authorisation and the treatment meeting the Scheme's guidelines and managed care criteria			
16.5	**Frail Care Facilities**	No benefit		50% of cost, limited to R470 pb per day	No benefit	50% of cost, limited to R470 pb per day	
16.6	**Home Nursing**	No benefit		100% of cost, limited to R355 pb per day	No benefit	100% of cost, limited to R355 pb per day	
16.7	**HomeCare Services** For procedures not requiring admission to a day clinic or hospital. Subject to Scheme Clinical Entry Criteria. Subject to pre-authorisation.	100% of Scheme Rate Limited to PMBs	100% of Scheme Rate Unlimited				
17	**INTERNAL PROSTHESIS** **Subject to clinical motivation, the application of clinical and funding protocols and Scheme approval. Bankmed reserves the right to obtain further quotations prior to granting approval.** **The prostheses accumulate to the limit. The balance of the hospital and related accounts do not accumulate to the annual limit. All sub-limits are further subject to the combined Internal Prosthesis limit of R70 950 pbpa, applicable to all internal prosthesis items, (excluding pacemakers and defibrillators) on the specified Plans. Dental implants are not regarded as internal prosthesis, for the purpose of the Rules. See "Dentistry and orthodontics: Advanced dentistry" for available implant benefits/limits for your Plan**						
17.1	**Internal Prosthesis**	Limited to PMBs 100% of Scheme Rate for PMBs	100% of Scheme Rate as per Internal Prosthesis List, subject to a combined limit of R70 950 pbpa for all internal prosthesis items				
	Internal Prosthesis sub-limits:						
17.2	**Spinal Fusions**	Limited to PMBs 100% of Scheme Rate for PMBs	100% of Scheme Rate of device, limited to R47 800 pbpa Subject to the combined Internal Prosthesis limit				
17.3	**Cardiac Stents**	Limited to PMBs 100% of Scheme Rate for PMBs	100% of Scheme Rate of device, limited to R70 670 pbpa Subject to the combined Internal Prosthesis limit				
17.4	**Grafts**	Limited to PMBs 100% of Scheme Rate for PMBs	100% of Scheme Rate of device, limited to R38 260 pbpa Subject to the combined Internal Prosthesis limit				

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
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17.5	Cardiac Valves	Limited to PMBs 100% of Scheme Rate for PMBs	100% of Scheme Rate of device, limited to R40 240 pbpa Subject to the combined Internal Prosthesis limit				
17.6	Hip, Knee and Shoulder Joints	Limited to PMBs 100% of Scheme Rate for PMBs	100% of Scheme Rate for device, limited to R47 220 per prosthesis per admission if prosthesis is not supplied by the Scheme's network provider If supplied by the Scheme's network provider, unlimited and not subject to combined limit for all internal prosthesis items				
17.7	Non-specified Items	Limited to PMBs 100% of Scheme Rate for PMBs	100% of Scheme Rate of device, limited to R22 050 pbpa Subject to the combined Internal Prosthesis limit				
18	PACEMAKERS AND DEFIBRILLATORS Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval. Bankmed reserves the right to obtain further quotations prior to granting approval						
18.1	Pacemakers and Defibrillators	Limited to PMBs • 100% of cost at hospital network DSPs • 80% of cost at non-DSPs		• 100% of cost, unlimited, if preferred provider used • 100% of Scheme Rate if non-preferred provider used to purchase device			
19	INTRAOCULAR LENSES FOR CATARACT SURGERY Subject to pre-authorisation and the treatment meeting the Scheme's criteria. Covered in full when supplied by the Scheme's preferred suppliers, otherwise covered up to the Scheme Rate for the lens Scheme Rate is equal to the lens base price / lens reference price, plus an allowable 25% mark-up. Where the provider marks up the lens cost in excess of the agreed rate, the Scheme will not be responsible for the shortfall						
19.1	Intraocular Lenses for Cataract Surgery Permanent, implantable lenses, inclusive of basic and specialised lens varieties	Limited to PMBs • 100% of cost, unlimited, if preferred supplier's lens is used • 100% of Scheme Rate if lens used is not a preferred supplier lens • Scheme Rate is equal to the lens base price / lens reference price, plus 25% mark-up Where the provider marks up the lens cost in excess of the agreed rate, the Scheme will not be responsible for the shortfall		• 100% of cost, unlimited, if preferred supplier's lens is used • 100% of Scheme Rate if lens used is not a preferred supplier lens • Scheme Rate is equal to the lens base price / lens reference price, plus 25% mark-up Where the provider marks up the lens cost in excess of the agreed rate, the Scheme will not be responsible for the shortfall			

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
20	**COCHLEAR IMPLANTS** Subject to pre-authorisation and Scheme protocols. Once in a lifetime benefit. Funding only available in recognised Centres of Excellence. Visit www.bankmed.co.za; select "Network Providers" and then "Centres for Cochlear Implants 2020" for a comprehensive list						
20.1	Hospitalisation	No benefit		Benefits as for hospitalisation	No benefit	Benefits as for hospitalisation	
20.2	Pre-operative Evaluation and Associated Preparation Costs	No benefit		R16 810 pb per lifetime 100% of Scheme Rate	No benefit	R16 810 pb per lifetime 100% of Scheme Rate	
20.3	Cochlear Implant Device	No benefit		R352 450 pb per lifetime 100% of Scheme Rate	No benefit	R352 450 pb per lifetime 100% of Scheme Rate	
20.4	Intra-operative Audiology Testing	No benefit		R880 pb per lifetime 100% of Scheme Rate	No benefit	R880 pb per lifetime 100% of Scheme Rate	
20.5	Post-operative Evaluation Costs	No benefit		R35 300 pb per lifetime 100% of Scheme Rate	No benefit	R35 300 pb per lifetime 100% of Scheme Rate	
21	**SPEECH PROCESSORS** Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval						
21.1	Upgrade or Replacement of Speech Processors	No benefit		80% of Scheme Rate, limited to R131 600 pb over a five-year cycle	No benefit	80% of Scheme Rate, limited to R131 600 pb over a five-year cycle	
22	**HEARING AIDS**						
22.1	Hearing Aids Supply and fitment	No benefit, except for PMBs		100% of Scheme Rate, limited to R28 270 per beneficiary every second year (rolling 24 months)	100% of Scheme Rate, subject to available Medical Savings Account	100% of Scheme Rate, limited to R28 270 per beneficiary every second year (rolling 24 months)	100% of Scheme Rate, limited to R33 100 per beneficiary every second year (rolling 24 months)
22.2	Hearing Aid Repairs	No benefit		100% of Scheme Rate, limited to R1 465 pbpa	100% of Scheme Rate, subject to available Medical Savings Account	100% of Scheme Rate, limited to R1 465 pbpa	
22.3	Bone Anchored Hearing Aids	No benefit		90% of Scheme Rate, limited to R151 210 pfpa	100% of Scheme Rate, subject to available Medical Savings Account	90% of Scheme Rate, limited to R151 210 pfpa	

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23	EXTERNAL PROSTHESIS, MEDICAL AND SURGICAL APPLIANCES, BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS Benefit includes the repair of the prosthesis						
23.1	**External Prosthesis:** **Benefit for Limbs and Eyes**	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate Limited to R3 120 pfpa Combined limit with medical and surgical appliances, blood pressure monitors, nebulisers and glucometers	100% of Scheme Rate Limited to R24 200 pfpa	100% of Scheme Rate Limited to R3 120 pfpa Combined limit with medical and surgical appliances, blood pressure monitors, nebulisers, glucometers, arch supports and shoe insoles	100% of Scheme Rate Limited to R24 200 pfpa	
23.2	**Medical and Surgical Appliances** Claim frequency limits apply – refer to 23.6	Limited to PMBs 100% of Scheme Rate No benefit for wheelchairs and large orthopaedic appliances on this Plan, except for PMBs	Combined limit of R3 120 pfpa with external prosthesis, blood pressure monitors, nebulisers and glucometers and subject to pre-authorisation No benefit for wheelchairs and large orthopaedic appliances on this Plan, except for PMBs 100% of Scheme Rate	**Post-surgery appliances:** • 100% of Scheme Rate, limited to R7 115 pbpa **Chronic appliances 100% of cost, limited to:** • R22 350 pbpa for oxygen/ oxygen delivery systems • R22 350 pbpa for stoma products • R7 115 pbpa* for other chronic appliances, including wheelchairs • Sub-limits apply as follows: - R880 arch supports (per pair) - R1 320 shoe insoles (per pair) **Appliances for acute conditions:** • 100% of Scheme Rate, subject to other chronic appliances limit of R7 115 pbpa	Combined limit of R3 120 pfpa with external prosthesis, blood pressure monitors, nebulisers, glucometers, arch supports and shoe insoles Benefits for wheelchairs and large orthopaedic appliances at 100% of Scheme Rate, subject to available Medical Savings Account	**Post-surgery appliances:** • 100% of Scheme Rate, limited to R7 115 pbpa **Chronic appliances 100% of cost, limited to:** • R22 350 pbpa for oxygen/ oxygen delivery systems • R22 350 pbpa for stoma products • R7 115 pbpa* for other chronic appliances, including wheelchairs • Sub-limits apply as follows: - R880 arch supports (per pair) - R1 320 shoe insoles (per pair) **Appliances for acute conditions:** • 100% of Scheme Rate, subject to available Medical Savings Account	**Post-surgery appliances:** • 100% of Scheme Rate, limited to R7 115 pbpa **Chronic appliances 100% of cost, limited to:** • R22 350 pbpa for oxygen/ oxygen delivery systems • R22 350 pbpa for stoma products • R7 115 pbpa* for other chronic appliances, including wheelchairs • Sub-limits apply as follows: - R880 arch supports (per pair) - R1 320 shoe insoles (per pair) **Appliances for acute conditions:** • 100% of Scheme Rate, subject to available Medical Savings Account • ATB applies once the Annual Threshold is reached. 100% of Scheme Rate in ATB.

Important Information

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

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
	Medical and Surgical Appliances (continued)	Only payable if claimed from a service provider with a valid BHF practice number	Only payable if claimed from a service provider with a valid BHF practice number	*Other chronic appliances limit extended to R10 410 for beneficiaries requiring a CPAP machine Additional discretionary benefits may be granted for wheelchairs, subject to occupational therapist or physiotherapist motivation, at least two cost quotations and Scheme approval Only payable if claimed from a service provider with a valid BHF practice number	Only payable if claimed from a service provider with a valid BHF practice number	*Other chronic appliances limit extended to R10 410 for beneficiaries requiring a CPAP machine Additional discretionary benefits may be granted for wheelchairs, subject to occupational therapist or physiotherapist motivation, at least two cost quotations and Scheme approval Only payable if claimed from a service provider with a valid BHF practice number	*Other chronic appliances limit extended to R10 410 for beneficiaries requiring a CPAP machine Additional discretionary benefits may be granted for wheelchairs, subject to occupational therapist or physiotherapist motivation, at least two cost quotations and Scheme approval Only payable if claimed from a service provider with a valid BHF practice number
23.3	**Blood Pressure Monitors, Nebulisers and Glucometers** Claim frequency limits apply – refer to 23.6	Subject to pre-authorisation 100% of Scheme Rate Limited to PMBs	Subject to pre-authorisation 100% of Scheme Rate, subject to the combined limit of R3 120 pfpa with external prosthesis and medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 200 pbpa • Nebulisers: R1 690 pbpa • Glucometers: R840 pbpa Only payable if claimed from a service provider with a valid BHF practice number	Available on prescription without additional motivation or Scheme approval 100% of Scheme Rate, subject to the combined limit of R7 115 pbpa for "other chronic appliances" under medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 200 pbpa • Nebulisers: R1 690 pbpa • Glucometers: R840 pbpa Only payable if claimed from a service provider with a valid BHF practice number	Available on prescription without additional motivation or Scheme approval 100% of Scheme Rate, subject to the combined limit of R3 120 pfpa with external prosthesis and medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 200 pbpa • Nebulisers: R1 690 pfpa • Glucometers: R840 pfpa Only payable if claimed from a service provider with a valid BHF practice number	Available on prescription without additional motivation or Scheme approval 100% of Scheme Rate, subject to the combined limit of R7 115 pbpa for "other chronic appliances" under medical and surgical appliances, and further limited as follows: • Blood pressure monitors: R1 200 pbpa • Nebulisers: R1 690 pbpa • Glucometers: R840 pbpa Only payable if claimed from a service provider with a valid BHF practice number

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
23.4	**Arch Supports and Shoe Insoles** Claim frequency limits apply– refer to 23.6	No benefit		Refer to 23.2	Combined limit with External Prosthesis Benefit, medical and surgical appliances, blood pressure monitors, nebulisers and glucometers Subject to a combined limit of R3 120 pfpa Sub-limits apply as follows: • R880 arch supports (per pair) • R1 320 shoe insoles (per pair) Only payable if claimed from a service provider with a valid BHF practice number	Refer to 23.2	
23.5	**Breast Pumps and Baby Monitors**	No benefit		Funded from available "Other Chronic Appliances" limit of R7 115 pbpa Only payable if claimed from a service provider with a valid BHF practice number	Funded from available Medical Savings Account Only payable if claimed from a service provider with a valid BHF practice number		

23.6 Frequency Limits Pertaining to Medical and Surgical Appliances, Blood Pressure Monitors, Nebulisers, Glucometers, etc.

Appliances may be claimed once over a specified period. The following appliances may be claimed once per the specified period below:

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

Appliance/Device	Frequency
Breast Prosthesis	Once every two years (single/pair)
Wheelchairs	Once every three years
Compression Stockings	Two per year
Portable Oxygen	Once every four years
Glucometer	Once every three years
Nebuliser	Once every three years

Appliance/Device	Frequency
Surgical Boot/Moon Boot	Once every two years
Brace/Callipers	Once every two years
Wigs	Once every two years
Breast Prosthesis Bras	Two per annum*
Commodes	Once every three years
Walking Frames	Once every two years

The above limits apply to members who qualify for the abovementioned benefits per their Plan Type. Should a member not qualify for the benefit, the frequency limit is not applicable.
*Where Plans have Rand limits in place, members may claim for more than two breast prosthesis bras, provided that the Rand limit is not exceeded.

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS		MEDICAL SAVINGS ACCOUNT PLANS			
24	PSYCHIATRY, CLINICAL PSYCHOLOGY AND RELATED OCCUPATIONAL THERAPY						
24.1	**Hospitalisation:** Subject to pre-authorisation **Hospital Network DSPs** • All admissions at network DSP **Other Hospitals (non-DSPS)** • PMB admission: involuntary use of non-DSP • PMB admission: voluntary use of non-DSP • Non-PMB admission **In-hospital Consultations/ Sessions**	Limited to PMBs Subject to referral from a Bankmed GP Entry Plan Network GP (DSP) • 100% of cost for Bankmed Network Psychiatric facilities (DSPs) • 100% of cost • 80% of Scheme Rate • No benefit • 100% of cost for Bankmed Entry Plan Specialist Network: DSPs • 100% of Scheme Rate for non-DSPs Cover for 21 days in hospital in line with PMB regulations		R66 300 pbpa covered as follows: • 100% of cost for Bankmed Network Psychiatric facilities (DSPs) • 100% of cost • 80% of Scheme Rate • 80% of Scheme Rate • 100% of cost for Bankmed Prestige A and B Specialist Network: DSPs • 100% of Scheme Rate for non-DSPs Continued benefits for PMBs subject to pre-authorisation and PMB regulations Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the Rand limit Combined limit with "Occupational therapy: psychiatric consultations /sessions in hospital"			
24.2	**Post-hospital Psychiatric consultation within 30 days of discharge from hospital following a psychiatric admission** Applies for psychiatric admissions for Major Depression, Schizophrenia and Bipolar Mood Disorder only (excluding day cases)	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission:	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission:	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission:	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission:	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission:	One additional post-hospitalisation Psychiatrist consultation covered as an Insured Benefit (not payable from other day-to-day benefits), per beneficiary visiting a Psychiatrist within 30 days of discharge, following an authorised hospital admission:

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
	Post-hospital Psychiatric consultation within 30 days of discharge from hospital following a psychiatric admission (continued)	• 100% of cost at a contracted rate for Bankmed Entry Plan Specialist Network (Psychiatrist only) - DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits	• 100% of cost at a contracted rate for Bankmed Entry Plan Specialist Network (Psychiatrist only) - DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits	• 100% of cost at a contracted rate for Bankmed Prestige A and B Specialist Network (Psychiatrist only) - DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits	• 100% of cost at a contracted rate for Bankmed Prestige A and B Specialist Network (Psychiatrist only) - DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits and/or Medical Savings Account	• 100% of cost at a contracted rate for Bankmed Prestige A and B Specialist Network (Psychiatrist only) - DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits and/or Medical Savings Account	• 100% of cost at a contracted rate for Bankmed Prestige A and B Specialist Network (Psychiatrist only) - DSPs • 100% of Scheme Rate for non-DSPs Limited to three consultations per beneficiary per year, following an authorised admission, thereafter funded from standard specialist benefits and/or Medical Savings Account
24.3	Consultations/Sessions out-of-hospital Important note: Cover for 15 out-of-hospital psychotherapy sessions for PMBs	Limited to PMBs Benefits subject to pre-authorisation, PMB regulations and referral from a Bankmed GP Entry Plan Network GP (DSP): • 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	Limited to PMBs Benefits subject to pre-authorisation, PMB regulations and referral from a Bankmed GP Entry Plan Network GP (DSP): • 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	R4 160 pbpa covered as follows: • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs Combined limit with occupational therapy: psychiatric consultations/ sessions out-of-hospital Combined limit may be extended to R10 350 pbpa for depression and/or bipolar mood disorder, subject to pre-authorisation and PMB regulations	100% of cost, subject to available Medical Savings Account • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Prestige A and B Specialist Network (DSPs), subject to pre-authorisation, PMB regulations and referral from a Bankmed Network GP (DSPs) • 100% of Scheme Rate for non-DSPs	R4 850 pbpa covered as follows: • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs Combined limit with occupational therapy: psychiatric consultations/ sessions out-of-hospital Combined limit may be extended to R11 575 pbpa for depression and/or bipolar mood disorder, subject to pre-authorisation and PMB regulations	300% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached The maximum amount that can accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an ATB (always subject to available ATB) is R14 665 pfpa • 100% of cost at contracted rate from Insured Benefits for PMB, subject to PMB regulations at Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
25	**OCCUPATIONAL THERAPY**						
25.1	**Psychiatric consultations/ sessions in-hospital** Subject to pre-authorisation	See "Psychiatry, clinical psychology and related occupational therapy: Hospitalisation and in-hospital consultations/sessions" under 24.1					
25.2	**Psychiatric consultations/ sessions** Out-of-hospital	See "Psychiatry, clinical psychology and related occupational therapy: Consultations/Sessions out-of-hospital" under 24.1					
25.3	**Non-psychiatric consultations/sessions in-hospital** Subject to pre-authorisation	Limited to PMBs 100% of cost for PMBs	Limited to PMBs and subject to pre-authorisation 100% of cost for PMBs	100% of Scheme Rate, unlimited	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate, unlimited	100% of Scheme Rate, unlimited
25.4	**Non-psychiatric consultations/sessions** Out-of-hospital	Limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP) 100% of cost for PMBs	Limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP) 100% of cost for PMBs	100% of Scheme Rate, limited to R2 040 pfpa	100% of Scheme Rate, subject to available Medical Savings Account for non-PMBs 100% of cost for PMBs Thereafter subject to available Medical Savings Account	100% of Scheme Rate, limited to R2 150 pfpa, from Insured Benefits	300% of Scheme Rate, subject to available Medical Savings Account 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Prestige A and B Specialist Network (DSPs) 100% of Scheme Rate for non-DSPs ATB applies once Annual Threshold is reached The maximum amount that can accumulate towards reaching the Annual Threshold at 100% of Scheme Rate and/or be paid as an ATB (always subject to available ATB) is R7 390 pfpa Subject to PMB regulation

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
26	SPEECH THERAPY, AUDIO THERAPY AND AUDIOLOGY						
26.1	**Speech Therapy, Audio Therapy and Audiology** In- and out-of-hospital	100% of Scheme Rate, limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP) Out-of-hospital cover is subject to PMB application	100% of Scheme Rate, limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP)	100% of Scheme Rate, limited to R2 040 pfpa	100% of cost, subject to available Medical Savings Account 100% of cost paid from Insured Benefits for PMBs	100% of Scheme Rate, limited to R2 205 pfpa Thereafter subject to available Medical Savings Account	300% of Scheme Rate, subject to available Medical Savings Account, thereafter ATB applies once Annual Threshold is reached The maximum amount that can jointly accumulate towards reaching the Annual Threshold at 100% of Scheme Rate and/ or be paid as an ATB (always subject to available ATB) is R2 205 pfpa
27	PHYSIOTHERAPY						
27.1	**Physiotherapy** In-hospital	Limited to PMBs 100% of cost for PMBs		100% of Scheme Rate, unlimited	Limited to PMBs 100% of cost for PMBs	100% of Scheme Rate, unlimited	
27.2	**Post-hospitalisation physiotherapy within six weeks of discharge from hospital, following an authorised hospital admission**	See "Physiotherapy (out-of-hospital)" below under 27.3		100% of Scheme Rate, limited to R2 950 pfpa	See "Physiotherapy (out-of-hospital)" below under 27.3	100% of Scheme Rate, limited to R2 445 pbpa from Insured Benefits and thereafter subject to available Medical Savings Account	See "Physiotherapy (out-of-hospital)" below under 27.3
27.3	**Physiotherapy** Out-of-hospital	Limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP): • 100% of cost for PMBs		100% of Scheme Rate, subject to out-of-hospital "GP and Specialists: Consultations in rooms" limits as set out in these Benefit Tables	100% of Scheme Rate, subject to available Medical Savings Account for non-PMBs • 100% of cost for PMBs	100% of cost, subject to available Medical Savings Account	300% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/ or be paid as an ATB (always subject to available ATB) is R2 950 pbpa

	ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
	NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
28	**ADDITIONAL BENEFITS FOR BENEFICIARIES WITH NEURODEVELOPMENTAL DISORDERS** **Subject to approval. Additional discretionary Insured Benefits in the following categories may be granted for beneficiaries with neurodevelopmental disorders, subject to clinical motivation and Scheme approval** **The quantum of additional benefits, if approved, shall be decided on a case-for-case basis and granted at the applicable contracted rate or Scheme Rate as set out below**					
28.1	**Occupational Therapy: Psychiatric consultations/ sessions** Out-of-hospital	No benefit	100% of Scheme Rate or contracted rate, whichever applies			
28.2	**Occupational Therapy: Non-psychiatric consultations/ sessions** Out-of-hospital	No benefit	100% of Scheme Rate or contracted rate, whichever applies			
28.3	**Physiotherapy** Out-of-hospital	No benefit	100% of Scheme Rate or contracted rate, whichever applies			
28.4	**Speech Therapy** Out-of-hospital	No benefit	100% of Scheme Rate or contracted rate, whichever applies			
29	**OTHER AUXILIARY SERVICES** **In- and out-of-hospital**					
29.1	**Auxiliary Allied Services** Chiropody, Podiatry, Dietetics (nutritional assessments), Orthotics, Massage, Chiropractors, Herbalists, Naturopaths, Family Planning Clinics, Homeopaths and Biokineticists (fitness assessments)	100% of Scheme Rate, limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP) Out of hospital cover is subject to PMB application	100% of Scheme Rate, limited to PMBs and subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP) Out of hospital cover is subject to PMB application	100% of Scheme Rate, limited to R3 120 pfpa 100% of cost for PMBs	100% of Scheme Rate, subject to available Medical Savings Account for non-PMBs	100% of Scheme Rate, subject to available Medical Savings Account	300% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/or be paid as an ATB (always subject to available ATB) is R3 120 pfpa

	ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
	NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
30	**MAXILLOFACIAL AND ORAL SURGERY** **Subject to pre-authorisation. NB: Benefits for caps, crowns, bridges and endosteal and ossea-integrated implants are dealt with under dentistry and orthodontics: Advanced dentistry- see 31.2 below**					
30.1	**Maxillofacial and Oral Surgery** Consultations, procedures and treatment in-and out-of-hospital	Limited to PMBs • 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs		• 100% of cost at contracted rate, unlimited for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs Benefit inclusive of elective treatment	Limited to PMBs • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs Benefit inclusive of elective treatment
31	**DENTISTRY** **Subject to pre-authorisation. NB: Benefits for caps, crowns, bridges and endosteal and ossea-integrated implants are dealt with under dentistry and orthodontics: Advanced dentistry- see 31.2 below**					
31.1	**Preventative and Basic Dentistry**	No benefit	100% of Scheme Rate, unlimited, via Bankmed Dental Network Subject to Scheme-approved formulary	100% of Scheme Rate, unlimited Limited to: • One oral examination pbpa • Amalgam and resin fillings only • Plastic dentures only • Two topical fluoride treatments per child per year (age 15 years and younger)	100% of Scheme Rate, subject to available Medical Savings Account	100% of Scheme Rate, unlimited; paid from Insured Benefit Limited to: • One oral examination pbpa • Amalgam and resin fillings only • Plastic dentures only • Two topical fluoride treatments per child per year (age 15 years and younger) • One topical fluoride treatment per year for all other beneficiaries • Limited to eight molar teeth pb per lifetime • Scale and polish limited to two pbpa	300% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/ or be paid as an ATB (always subject to available ATB), is R17 690 for a single member and R26 790 for a family

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
31.2	**Advanced Dentistry** Caps, crowns, bridges and cost of endosteal and ossea-integrated implants	No benefit	No benefit	100% of Scheme Rate, limited to: M: R6 825 pbpa M + 1 +: R10 585 pfpa Combined limit for advanced dentistry, orthodontics and all other dental services	100% of Scheme Rate, subject to available Medical Savings Account for non-PMBs 100% of cost for PMBs	100% of Scheme Rate, limited to: M: R5 315 pbpa M + 1 +: R8 900 pfpa Thereafter subject to available Medical Savings Account	
31.3	**Orthodontics** Subject to orthodontic quotation and prior approval from Scheme	No benefit	No benefit	100% of Scheme Rate, subject to advanced dentistry limit	100% of Scheme Rate, subject to available Medical Savings Account	100% of Scheme Rate, limited to R8 900 pfpa Thereafter subject to available Medical Savings Account	
31.4	**All other Dental Services**	No benefit	100% of Scheme Rate via Bankmed Dental Network and subject to Scheme-approved formulary for: • Second and subsequent examinations in the same year • X-rays	100% of Scheme Rate, subject to Advanced Dentistry Limit	100% of Scheme Rate, subject to available Medical Savings Account	100% of Scheme Rate, subject to available Medical Savings Account	
32	**GENERAL PRACTITIONERS (GPs)**						
32.1	**GP Consultations** In-hospital	Limited to PMBs • 100% of cost at contracted rate, for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed GP Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs			

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
32.2	**GP Procedures** In-hospital	Limited to PMBs • 100% of cost at contracted rate for PMBs via Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs (including PMBs) No benefit for dental surgery, except for PMBs	Benefit unlimited • 100% of cost at contracted rate via Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs (including PMBs) No benefit for dental surgery, except for PMBs	Benefit unlimited • 100% of cost at contracted rate via Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	Benefit unlimited • 100% of cost at contracted rate via Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs (including PMBs) No benefit for dental surgery, except for PMBs	Benefit unlimited • 100% of cost at contracted rate via Bankmed Network GPs (DSPs) • 125% of Scheme Rate for non-DSPs	Benefit unlimited • 100% of cost at contracted rate via Bankmed Network GPs (DSPs) • 300% of Scheme Rate for non-DSPs
32.3	**Post-hospital GP Consultation within 30 days of discharge from hospital (excluding day cases)**	Limited to PMBs One additional post-hospitalisation GP consultation covered as an Insured Benefit (not payable from Medical Savings Account or other insured limits), per beneficiary visiting a GP within 30 days of discharge, following an authorised hospital admission (excluding day cases): • 100% of cost at contracted rate for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	One additional post-hospitalisation GP consultation covered as an Insured Benefit (not payable from Medical Savings Account or other insured limits), per beneficiary visiting a GP within 30 days of discharge, following an authorised hospital admission (excluding day cases): • 100% of cost at the contracted rate via Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs Subject to out-of-network limit for non-Bankmed GP Entry Plan Network GPs. See "GPs: Consultations in rooms" for details	One additional post-hospitalisation GP consultation covered as an Insured Benefit (not payable from Medical Savings Account or other insured limits), per beneficiary visiting a GP within 30 days of discharge, following an authorised hospital admission (excluding day cases): • 100% of cost at contracted rate for Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs			

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
32.4	GPs: Consultations in rooms	Limited to PMBs • 100% of cost at contracted rate, unlimited for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	Members must make use of Bankmed GP Entry Plan Network GPs (DSPs): • 100% of cost at contracted rate, unlimited for selected Bankmed GP Entry Plan Network GPs (DSP) in accordance with preferred provider contract • Limited to three visits, to a maximum of R2 150 pfpa (at Bankmed GP Entry Plan Network rate) for consultations, procedures and medicine at non-Bankmed GP Entry Plan Network GPs, when the selected Bankmed GP Entry Plan Network GP is not available or the beneficiary is out of town; Out-of-network limit includes all costs arising from the out-of- network consultation	Combined limit for GP and specialist consultations in rooms: • M: R3 440 pbpa • M + 1: R6 225 pfpa • M + 2 +: R7 220 pfpa GPs paid as follows: • 100% of cost at contracted rate for Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs • Unlimited if DSP used • Continued benefits for beneficiaries with PMB conditions, subject to PMB regulations	Benefits for a Bankmed Network GP (DSP): • 100% of cost at contracted rate, unlimited for PMBs • Two consultations at contracted rate from Insured Benefits, for non-PMBs (thereafter payable from available Medical Savings Account) Benefits for any other GP (non-DSP): • 100% of Scheme Rate from Insured Benefits for PMBs • 100% of Scheme Rate from the Medical Savings Account for non-PMBs	Benefits subject to available Medical Savings Account: • 100% of cost at contracted rate for Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs PMB treatment: • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	Benefits for a Bankmed Network GP (DSP): • 100% of cost, subject to available Medical Savings Account/ATB Benefits for any other GP (non-DSP): • 300% of Scheme Rate, subject to available Medical Savings Account/ATB ATB applies once Annual Threshold is reached PMB treatment: • 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Network GPs (DSPs); • 100% of Scheme Rate for non-DSPs

Important Information

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

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
32.5	**GPs: Procedures in rooms**	Limited to PMBs • 100% of cost at contracted rate, unlimited for Bankmed GP Entry Plan Network GPs (DSPs) • 100% of Scheme Rate for non-DSPs	See "GPs: Consultations in rooms" in section 32.4	• 100% of cost of contracted rate for Bankmed Network GPs (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate for Bankmed Network GPs (DSPs), unlimited • 100% of Scheme Rate, subject to available Medical Savings Account for non-DSPs	Paid from Insured Benefits: • 100% of cost of contracted rate for Bankmed Network GPs (DSPs) • 125% of Scheme Rate for non-DSPs	Paid from Insured Benefits: • 100% of cost of contracted rate for Bankmed Network GPs (DSPs) • 300% of Scheme Rate for non-DSPs
32.6	**GPs: Virtual consultations** Subject to member and/or beneficiary consulting with GP face-to-face during prior six-month period and verification notes submitted by claiming GP Subject to Out-of-hospital GP Benefits and Limits	• 100% of cost for Bankmed GP Entry Plan Network GPs: DSPs • 100% of Scheme Rate for non-DSPs • Limited to three consultations pbpa • Limited to PMBs	• 100% of cost for Bankmed GP Entry Plan Network GPs: DSPs • 100% of Scheme Rate for non-DSPs • Limited to three consultations pbpa • Subject to Out-of-network GP Limit if non-DSP used	• 100% of cost for Bankmed Network GPs: DSPs • 100% of Scheme Rate for non-DSPs • Limited to three consultations pbpa	• 100% of cost for Bankmed Network GPs: DSPs • 100% of Scheme Rate for non-DSPs • Limited to three consultations pbpa • Subject to available Savings for non-PMBs	• 100% of cost for Bankmed Network GPs: DSPs • 100% of Scheme Rate for non-DSPs • Limited to three consultations pbpa • Subject to available Savings for non-PMBs	• 100% of cost for Bankmed Network GPs: DSPs • 100% of Scheme Rate for non-DSPs • Limited to three consultations pbpa • Subject to available Savings /ATB for non-PMBs
33	**SPECIALISTS** **NB: Psychiatrists, oncologists, radiologists, pathologists, maxillofacial and oral surgeons and other dental practitioners are dealt with elsewhere in these Benefit Tables**						
33.1	**Specialist consultations and procedures** In-hospital	Limited to PMBs • 100% of cost of contracted rate at Bankmed Entry Plan Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Entry Plan Specialist Network (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Prestige A and B Specialist Network (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Prestige A and B Specialist Network (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Prestige A and B Specialist Network (DSPs), unlimited • 100% of Scheme Rate for non-DSPs	• 100% of cost of contracted rate at Bankmed Prestige A and B Specialist Network (DSPs), unlimited • 300% of Scheme Rate for non-DSPs

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
33.2	**Specialists: Consultations in rooms** Pre-authorisation required for all Plans, excluding Comprehensive and Plus Be sure to obtain a referral from your GP and an authorisation number before seeing a specialist – for all Plans, excluding Comprehensive and Plus Make use of our DSPs to limit or avoid co-payments	Limited to PMBs Benefits subject to referral by a Bankmed GP Entry Plan Network GP and approved basket of care registration for PMB conditions: • 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSPs) • 80% of cost if no pre-authorisation and no referral from a Bankmed GP Entry Plan Network GP (DSP) • 100% of Scheme Rate for non-DSPs • 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed GP Entry Plan Network GP (DSP)	Benefits subject to referral by a Bankmed GP Entry Plan Network GP, and limited to: M: R1 950 pbpa M + 1 +: R3 055 pfpa (combined limit with specialist procedures in rooms) • 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSPs) • 80% of cost if no pre-authorisation and no referral from a Bankmed GP Entry Plan Network GP (DSP) • 100% of Scheme Rate for non-DSPs • 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed GP Entry Plan Network GP (DSP) Annual limit includes basic radiology, scans, pathology and acute medication prescribed by specialist/ appearing on specialist's claim Continued benefits for PMBs, subject to PMB regulations and approval	Combined limit with GP consultations in rooms, and paid as follows: • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs) • 80% of cost if no pre-authorisation and no referral from a Bankmed Network GP (DSP) • 100% of Scheme Rate for non-DSPs (including PMBs) • 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed GP Network GP (DSP) Continued benefits for PMBs, subject to PMB regulations and approval	Specialist consultations approved for beneficiaries registered for PMB Chronic Disease List (CDL) conditions, subject to approved basket of care and referral by a Bankmed Network GP: • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs) • 80% of cost if no pre-authorisation and no referral from a Bankmed Network GP (DSP) • 100% of Scheme Rate for non-DSPs • 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed Network GP (DSP) Non-basket of care benefits covered at 100% of Scheme Rate, subject to available Medical Savings Account Continued benefits for PMBs, subject to PMB regulations and approval	100% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	300% of Scheme Rate, subject to available Medical Savings Account ATB applies once Annual Threshold is reached • 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSPs) • 300% of Scheme Rate for non-DSPs

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
33.3	**Specialists: Procedures in rooms**	Limited to PMBs • 100% of cost of contracted rate at Bankmed Entry Plan Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	See "Specialists: Consultations in rooms" in section 33.2	• 100% of cost at contracted rate, unlimited for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	Limited to PMBs • 100% of cost at contracted rate, unlimited for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs • 80% of cost if no pre-authorisation or no referral from Bankmed GP Network GP (DSP)	• 100% of cost at contracted rate, unlimited for Bankmed Prestige A and B Specialist Network (DSPs) • 100% of Scheme Rate for non-DSPs	• 100% of cost at contracted rate, unlimited for Bankmed Prestige A and B Specialist Network (DSPs) • 300% of Scheme Rate for non-DSPs
34	REGISTERED PRIVATE NURSE PRACTITIONERS						
34.1	**Consultations and Procedures**	Limited to PMBs Procedures: • 100% of Scheme Rate, limited to PMBs Consultations: • Three consultations pbpa at 100% of Scheme Rate for PMBs	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 100% of Scheme Rate	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 100% of Scheme Rate Thereafter, 100% of Scheme Rate, subject to out-of-hospital GP/Specialist limit	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 100% of Scheme Rate from Insured Benefits Thereafter subject to available Medical Savings Account	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 100% of Scheme Rate from Insured Benefits Thereafter subject to available Medical Savings Account	Procedures: • 100% of Scheme Rate, unlimited Consultations: • Three consultations pbpa at 300% of Scheme Rate from Insured Benefits Thereafter subject to available Medical Savings Account ATB applies once the Annual Threshold is reached

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
35	OPTOMETRY CONSULTATIONS, SPECTACLES, FRAMES, LENSES AND CONTACT LENSES						
35.1	**Optometry: Consultations** Subject to the Optometry Benefit Management Programme and clinical necessity	No benefit	100% of cost, limited to one consultation pb every two years, via Iso Leso Optometry Network Out of network: No benefit	100% of Scheme Rate Benefits limited to one eye test or one re-examination or one composite examination pb every 24 months from previous date of service	100% of Scheme Rate, subject to available Medical Savings Account	100% of Scheme Rate Benefits limited to one eye test or one re-examination or one composite examination pb every 24 months from previous date of service	100% of Scheme Rate, subject to available Medical Savings Account, however accumulation to the Annual Threshold is limited to 100% of the Scheme Rate for spectacle lenses, contact lenses, eye tests and all other applicable services ATB applies once the Annual Threshold is reached The maximum amount that can jointly accumulate towards reaching the Annual Threshold and/or be paid as an ATB (always subject to available ATB), is R4 470 pbpa for optometric consultations, prescription lenses, readymade readers, contact lenses, fitting of contact lenses and other optometric services
35.2	**Frames and Extras**	No benefit	100% of cost, limited to one frame pb every two years, via Iso Leso Optometry Network Out of network: No benefit	100% of Scheme Rate, limited to R940 per beneficiary every 24 months from previous date of service One frame per beneficiary every 24 months from previous date of service Extras subject to pre-authorisation and clinical necessity	100% of Scheme Rate, subject to available Medical Savings Account One frame per beneficiary every 24 months from previous date of service Extras subject to pre-authorisation and clinical necessity	100% of Scheme Rate, subject to available Medical Savings Account One frame per beneficiary every 24 months from previous date of service Extras subject to pre-authorisation and clinical necessity	100% of Scheme Rate, subject to available Medical Savings Account Frames and extras do not accumulate towards reaching the Annual Threshold and are not covered as an ATB benefit Extras subject to pre-authorisation and clinical necessity

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
35.3	**Prescription Lenses** Clear, standard/generic, single vision, bifocal or multi-focal lenses	No benefit	100% of cost • Limited to one pair of prescription lenses pb every two years, via Iso Leso Optometry Network • Out of network: No benefit for readymade readers	Benefits for prescription lenses limited to one pair of lenses per beneficiary every 24 months from previous date of service and covered as follows: • 100% of Scheme Rate for Clear, standard/generic, single vision, bifocal or multi-focal lenses from an Opticlear optometrist	100% of Scheme Rate, subject to available Medical Savings Account	Benefits for prescription lenses limited to one pair of lenses per beneficiary every 24 months from previous date of service and covered as follows: • 100% of Scheme Rate for Clear, standard/generic, single vision, bifocal or multi-focal lenses from an Opticlear optometrist	100% of Scheme Rate, subject to available Medical Savings Account
35.4	**Readymade Readers**	No benefit	No benefit	100% of Scheme Rate, subject to available benefits Two pairs at R100 a pair, pb every two years Readymade readers via optometrists and pharmacies as an OTC benefit subject to benefit availability	100% of Scheme Rate, subject to available benefits Readymade readers via optometrists and pharmacies as an OTC benefit subject to benefit availability	100% of Scheme Rate, subject to available Medical Savings Account Two pairs at R100 a pair, pb every two years paid from available Savings Readymade readers via optometrists and pharmacies as an OTC benefit subject to benefit availability	
35.5	**Contact Lenses**	No benefit	No benefit	100% of Scheme Rate, limited to R1 470 pbpa for an Opticlear optometrist Limited to clear contact lenses A beneficiary may not claim for spectacles (lenses or frame) AND contact lenses in the same benefit year OR contact lenses within 24 months from previous date of service after receiving spectacles (lenses or frame)	100% of Scheme Rate, subject to available Medical Savings Account Limited to clear contact lenses A beneficiary may not claim for spectacles (lenses or frame) AND contact lenses in the same benefit year	100% of Scheme Rate, limited to R1 635 pbpa for an Opticlear optometrist, paid from Insured Benefits Limited to clear contact lenses A beneficiary may not claim for spectacles (lenses or frame) AND contact lenses in the same benefit year OR contact lenses within 24 months from previous date of service after receiving spectacles (lenses or frame)	See "Optometry: Consultations" in the Benefit Table

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
35.6	**Fitting of Contact Lenses**	No benefit		100% of Scheme Rate One contact lens dispensing and/or assessment per beneficiary every 12 months	100% of Scheme Rate, subject to available Medical Savings Account	100% of Scheme Rate One contact lens dispensing and/or assessment per beneficiary every 12 months	See "Optometry: Consultations"
35.7	**Sunglasses**	No benefit		No benefit for sunglasses / prescription sunglasses / spectacles with a tint > 35%			
36	REFRACTIVE SURGERY AND ASSOCIATED COSTS (INCLUDING HOSPITALISATION)						
36.1	**Other Optometric Services** Refractive surgery/excimer laser treatment, hospitalisation and associated costs	No benefit, including the cost of hospitalisation, medication and all other associated services		100% of Scheme Rate, limited to R3 920 pfpa, including the cost of hospitalisation, medication and all other associated services	100% of Scheme Rate, subject to available Medical Savings Account, including the cost of hospitalisation, medication and all other associated services		See "Optometry: Consultations" Limit on accumulation to Annual Threshold and/or payment as an ATB includes the cost of hospitalisation, medication and all other associated services

Be a better-informed Bankmed member

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

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

Did you know?

The Opticlear Optometry Network and how it works

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

	ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
	NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
37	**MEDICATION** **NB: In the case of qualifying prescribed acute and chronic medication, each prescription or repeat prescription shall be limited to one month's supply per beneficiary per month**					
37.1	**Prescribed Acute Medication** See "Contraception: Oral contraceptives, devices and injectables" for additional Insured Benefits under section 3.18	Limited to PMBs 100% of cost for PMBs at contracted rate, unlimited via Bankmed GP Entry Plan Network GP (DSP) and subject to Scheme-approved formulary	Medication via DSP (Bankmed GP Entry Plan Network GP and Bankmed Pharmacy Network): • 100% of cost plus contracted dispensing fee, unlimited Medication via non-DSP (voluntary): • 100% of Scheme Medicine Reference Price • Subject to out-of-network GP consultations and procedures limit of R2 150 pfpa Medication via non-DSP (involuntary): • 100% of cost plus contracted dispensing fee, unlimited **Important note:** Medication obtained from a DSP or non-DSP, if prescribed by a non-DSP provider, will accumulate to the out-of-network GP consultations and procedures limit of R2 150 pfpa Subject to Scheme-approved formulary	Limited to: • M: R3 900 pbpa • M + 1: R7 175 pfpa • M + 2 +: R7 795 pfpa The above limits include a maximum allowance of R1 545 pfpa towards self-medication/ PAT Bankmed Network GPs/ Bankmed Pharmacy Network (DSPs): • 100% of the Scheme Medicine Reference Price plus contracted dispensing fee for generic medication • 80% of Scheme Medicine Reference Price plus contracted dispensing fee for original medication (medication where a generic alternative is available) Non-DSPs: • 80% of Scheme Medicine Reference Price for generic medication and original medication (medication where a generic alternative is available)	100% of Scheme Medicine Reference Price, subject to available Medical Savings Account	100% of the Scheme Medicine Reference Price plus contracted dispensing fee as applicable to Bankmed Network GPs or Bankmed Pharmacy Network (DSPs), subject to available Medical Savings Account ATB applies once Annual Threshold is reached The maximum amount that can jointly accumulate towards reaching the Annual Threshold (at 100% of Scheme Rate) and/ or be paid as an ATB (always subject to available ATB), is R17 690 for a single member and R26 790 for a family

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
37.2	**Self-medication: Over-the-counter Medication/ Pharmacy Advised Therapy (PAT)**	No benefit		100% of the Scheme Medicine Reference Price for Bankmed Pharmacy Network (DSP) 80% of the Scheme Medicine Reference Price for non-DSPs Limited to R1 545 pfpa, and further subject to the annual limit for prescribed acute medication	100% of Scheme Medicine Reference Price paid from Insured Benefits for acute medication prescribed and dispensed by a pharmacist (PAT) for a limited number of conditions and events, subject to the Core Saver medicine list (formulary) for PAT All other acute and over-the-counter medication subject to available Medical Savings Account	100% of Scheme Medicine Reference Price, subject to available Medical Savings Account	100% of Scheme Medicine Reference Price, subject to available Medical Savings Account Self-medication/PAT does not accumulate towards the Annual Threshold and is not covered as an ATB benefit
37.3	**Homeopathic Medication** On prescription only, and limited to items with NAPPI codes	No benefit		Benefits as for prescribed acute/chronic medication No self-medication benefit for homeopathic medication			
37.4	**Chronic Medication** Subject to prior application and approval	Limited to PMBs 100% of cost for PMBs at contracted rate, unlimited via Bankmed GP Entry Plan Network (DSP) and subject to Scheme-approved medicine list (formulary)	• 100% of cost at contracted rate, unlimited via Bankmed GP Entry Plan Network GP (DSP) and subject to Scheme-approved medicine list (formulary) Medication via non-DSP (voluntary use of non-DSP): • 80% of Scheme Medicine Reference Price • Subject to out of network GP consultations and procedures limit of R2 150 pfpa Medication via non-DSP (involuntary use of non-DSP): • 100% of cost plus contracted dispensing fee	Limited to R20 615 pbpa and paid as follows: • 100% of the Scheme Medicine Reference Price for Bankmed Network GPs (DSPs) or Bankmed Pharmacy Network (DSP) • 80% of Scheme Medicine Reference Price for non-DSPs • 100% of cost for medication via non-DSP (involuntary use of a non-DSP) Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations	Limited to Core Saver medicine list (formulary) for PMB conditions and paid as follows: • 100% of the Scheme Medicine Reference Price for Bankmed Network GPs (DSPs) or Bankmed Pharmacy Network (DSP) • 80% of Scheme Medicine Reference Price for non-DSPs • 100% of cost for medication via non-DSP (involuntary use of a non-DSP)	Limited to R22 325 pbpa (Insured Benefits) and paid as follows: • 100% of the Scheme Medicine Reference Price for Bankmed Network GPs (DSPs) or Bankmed Pharmacy Network (DSP) • 80% of Scheme Medicine Reference Price for non-DSPs • 100% of cost for medication via non-DSP (involuntary use of a non-DSP) Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations	Limited to R26 620 pbpa (Insured Benefits) and paid as follows: • 100% of the Scheme Medicine Reference Price for Bankmed Network GPs (DSPs) or Bankmed Pharmacy Network (DSP) • 80% of Scheme Medicine Reference Price for non-DSPs • 100% of cost for medication via non-DSP (involuntary use of a non-DSP) Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations

		ESSENTIAL PLAN 2020	BASIC PLAN 2020	TRADITIONAL PLAN 2020	CORE SAVER PLAN 2020	COMPREHENSIVE PLAN 2020	PLUS PLAN 2020
		NON-MEDICAL SAVINGS ACCOUNT PLANS			MEDICAL SAVINGS ACCOUNT PLANS		
37.5	**Biologics and High-cost Specialised Medication** Utilised in the management of PMB CDL and Non-PMB chronic conditions **Includes all off-label drugs** (request for a drug not registered for the condition by the Medicines Control Council (MCC) **Includes all Section 21 drugs** (drugs not registered by MCC for use in SA)	PMB only Subject to PMB regulations	PMB only Subject to PMB regulations	Subject to PMB regulations	Subject to PMB regulations	Subject to PMB regulations	Subject to PMB regulations
	PMB Algorithm Medication	100% of cost	100% of cost	100% of cost	100% of cost	100% of cost	100% of cost
	PMB Non-Algorithm Medication	No benefit	No benefit	70% of Scheme Rate	70% of Scheme Rate	100% of Scheme Rate	100% of Scheme Rate
	Non-PMB Non-Algorithm Medication	No benefit	No benefit	No benefit	70% of Scheme Rate	100% of Scheme Rate	100% of Scheme Rate

38 PLAN SPECIFIC INFORMATION

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

Applicable to the medication on the Core Saver Plan only.

Acute medication covered at 100% of cost from Insured Benefits (subject to the Core Saver medicine list (formulary) for PAT) for the following conditions and up to the specified number of incidents per beneficiary per annum, on pharmacist's recommendation (PAT) only. Visit www.bankmed.co.za, select "2020 Plan Information" and then "Medicine Formularies 2020" to view the Core Saver medicine list (formulary) for PAT - non-formulary drugs and other acute medication subject to available Medical Savings Account.

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

Submit a claim

Healthcare Professionals, hospitals and pharmacies in our networks usually send us your claims directly. If you use a network provider, you do not have to send us a claim.

You only need to submit a claim if you have paid the Healthcare Professional and you need to claim the money back from us.

SUBMITTING CLAIMS

- You must submit your claim within **four months** from the date of service. After this, the claim expires, and you will not be reimbursed.
- Make sure your **membership number** and the **Healthcare Professional's details,** including their practice number, are clear on the claim.
- Submit a **detailed claim** and not just a receipt. We need the details of the treatment or medication for which you are claiming.

HOW TO CLAIM

1. Bankmed App

Download the Bankmed App and:

- Use the camera on your smartphone to take a photo of the claim and submit it using the App, or
- Use your smartphone to scan the QR code on the claim (if the claim has a block QR code)

2. Bankmed website

- Log in to **www.bankmed.co.za**
- Go to **Claims** and click on **Submit a claim**
- Once there, go to **UPLOAD** and click on **Upload now**
- Select the file you want to upload and then click on **Send claim**
- Once the claim has been successfully uploaded, you should receive a reference number

3. E-mail

Scan your claim and e-mail it to **claims@bankmed.co.za**

Electronic Health Record (EHR)

Once you give consent, your Healthcare Professional can use the Electronic Health Record to access your medical history, gain insight into the benefits of your Plan, refer you to other Healthcare Professionals, study your blood test results and write electronic prescriptions and referrals.

CONSENT

Healthcare Professionals need your permission to view your confidential medical information. Your personal information is protected. We only give Healthcare Professionals access to your medical records on your consent.

When you give consent, you agree that you understand the Electronic Health Record contains details about any chronic conditions you may have, as well as pathology (such as blood tests) results.

READ OUR PRIVACY STATEMENT

to find out how we use and protect your personal information.

HOW TO GIVE CONSENT

Your Healthcare Professional has to use HealthID to request permission to view your records. You can give them consent to see your information while you are in their office, or you can log in later to provide them with permission to view your health record with Bankmed.

Bankmed App

On the **Health** tab in the Bankmed App, select **Doctor(s) Consent** and follow the prompts on the screen to give permission to view your medical record.

Bankmed website

Log in to **www.bankmed.co.za / DOCTOR VISITS / Provide your doctor consent**

Find a Healthcare Professional

You can use our website or the Bankmed App to find a Healthcare Professional close to you or in a specific area, and find out if they are part of our network.

BANKMED WEBSITE

1. **Log in to www.bankmed.co.za**
2. **Click on Find a Healthcare Professional under DOCTOR VISITS**
3. **If you want to check if your Healthcare Professional is part of our network:**
   - 3.1. Type their name under **1. Who or what**
   - 3.2. Select their name from the drop-down list
   - 3.3. If the system shows **Partial cover** or the search does not find them, they are not part of our network
4. **If you want to find a specific kind of Healthcare Professional like a dentist or GP:**
   - 4.1. Under **1. Who or what**, click on or choose a category of provider. This opens a list of categories
   - 4.2. Select the category and specific kind of Healthcare Professional you want to find
   - 4.3. Under **2. Where** start typing the area and click on the area you're looking for
   - 4.4. Choose **search** and scroll down to the results
   - 4.5. If the system shows **Full network cover**, the Healthcare Professional is part of our network

Bankmed

PRIVACY STATEMENT

This document reflects the Privacy Statement for Bankmed, administered by Discovery Health (Pty) Ltd.

1. Application of requirements of the Protection of Personal Information Act ("POPI")

1.1. This Privacy Statement explains how Bankmed and its administrator and managed care service provider (currently Discovery Health (Pty) Ltd) (we/us) obtain, use, disclose and otherwise process personal information, which may include health and financial information ("Personal Information"), in a manner that is compliant, ethical, adheres to industry best practice and applicable protection of personal information legislation as enacted from time to time. Any other party, including the administrator and managed care service provider, that may have access to your Personal Information via Bankmed, is prohibited from using such information for any other purpose not approved by Bankmed. The administrator and managed care service provider, in particular, can only use the information strictly in compliance with the agreement between Bankmed and the administrator and managed care service provider.

1.2. We have a duty to take all reasonably practicable steps to ensure your personal information is complete, accurate, not misleading and updated on a regular basis. To enable this, we will always endeavour to obtain personal information from you directly. Where we are unable to do so, we will make use of verifiable independent third party data sources.

1.3. Please note:

- We may amend this Notice from time to time. Please check our website periodically to remain informed of any changes;
- You have the right to object to the processing of your Personal Information;
- Should you believe that we have utilised your Personal Information contrary to applicable law, you shall first resolve any concerns with us. Should you not be satisfied with the process, you have the right to lodge a complaint with the Information Regulator, under POPIA.

1.4. Any information, including Personal Information relating to yourself and your dependents and/or beneficiaries, supplied to us or collected from other sources ("Your Personal Information") will be kept confidential.

- You confirm that when you provide us with your Personal Information, your dependant/s and/or beneficiaries have provided you with the appropriate permission to disclose their Personal Information to us for the purposes set out below and any other related purposes. In the event that you are providing information and signing consent on behalf of a minor (person younger than 18 years old) you confirm that you are a competent person and authorised do so on their behalf.
- You understand that when you include your spouse and/or dependents on your application, we will process their personal information for the activation of the policy/benefit and to pursue their legitimate interest. We will furthermore process their information for the purposes set out in this Privacy Statement.
- Each party accepts responsibility to the extent that the processing activities of personal information fall under the control of that party, and agrees to indemnify the other party/ies against any loss or damage, direct or indirect, that a member or his/her dependant may suffer because of any unauthorised use of the member's or dependant's personal information, or if a breach of the member's or dependant's personal information occur, but only if the processing of that personal information is controlled by that party.

1.5. You agree to our processing and disclosing Your Personal Information in the following manner:

We may collect, collate, process, store and disclose your Personal Information:

- For the administration of your health plan;
- For the provision of managed care services to you or any dependant/s on your health plan;

- For the provision of relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s on your health plan;
- In the event of any member ceasing to be a member, any amount still owing by such member in respect of himself or his dependants shall be a debt due to the Scheme and recoverable by it. Therefore, for the provision of information to a contracted third party who performs a debt collection service to the Scheme, where you owe the Scheme an outstanding debt;
- To profile and analyse risk;
- For academic research only where this is specifically approved by Bankmed.

Examples of how this will happen includes:

a. Obtaining your Personal Information from other relevant sources, including any entity that is related to the administrator, medical practitioners, contracted service providers, health information exchanges, employers, credit bureaus or industry regulatory bodies ("Sources"), and further processing of such Information to consider your membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses. We may (at any time and on an ongoing basis) verify with the Sources that your Personal information is true, correct and complete. This, amongst other things, will allow the Scheme and the administrator (although to a limited extent) to ensure that a member is not a member of more than one medical scheme as this is prohibited by the Medical Schemes Act;

b. Communicating with you regarding any changes in your health plan, including your contributions or changes and enhancements to the benefits you are entitled to on the health plan you have selected;

c. Transferring your Personal Information outside the borders of the Republic of South Africa where appropriate, if you provide an e-mail address which is hosted outside the borders of South Africa, or for processing, storage or academic research (where such research is specifically approved by Bankmed). We will ensure that anyone to whom we pass your Personal Information agrees to treat your information with the same level of protection as we are obliged to;

d. Utilising external health specialists to assess or evaluate certain clinical information. Your Personal Information will be shared with such specialist/s in the event that you or your dependant/s are subject to such a clinical assessment.

1.6. We may process your information using automated means (without human intervention in the decision making process) to make a decision about you or your application for any product or service. You may query the decision made about you.

1.7. If asked to do so, we will share your Personal Information with a third party if you have already given your consent for the disclosure of this information to such third party or if a contractual relationship exists in terms of which we are obliged to provide the information to such third party.

1.8. You consent and agree that:

- We may process your information, including personal and special personal information, to conduct sanction screening against all mandatory and non-mandatory sanctions lists and to perform transaction monitoring activities;
- We may communicate such personal information to local and international Regulatory Bodies if you are matched to one of these sanctions lists.

1.9. Should you wish to share your information for any other reason, we will do so only with your permission.

1.10. You have the right to request a copy of the Personal Information we hold about you. To do this, simply complete the 'Access Request Form' on www.bankmed.co.za/legal and specify what information you would like. We will take all reasonable steps to confirm your identity before providing details of your Personal Information. Please note that any such Data Subject Request may be subject to a payment of a legally allowable fee.

1.11. You have the right to contact and ask us to update, correct or delete your Personal Information. Bankmed and its administrator have the right to communicate with you electronically about any changes on your health plan, including your contributions or changes to the benefits you are entitled to on the health plan you have chosen.

1.12. You agree that we may retain your Personal Information until such time as you request us to destroy it (unless we are obliged by law to retain it, regardless of

such request). Where we cannot delete your personal information, we will take all practical steps to depersonalise it.

1.13. Bankmed and its administrator and managed care service provider are required to collect and retain information in terms of the following legislation (amongst others):

- The Medical Schemes Act, 1998
- The Consumer Protection Act, 2008
- The Protection of Personal Information Act, 2013
- Electronic Communications and Transactions Act, 2002
- Promotion of Access to Information Act, 2000
- Legislation specific to the administrator and managed care service provider only:
- Financial Advisory and Intermediary Services Act, 2002
- Companies Act, 2008

1.14. You agree that Bankmed and its administrator may transfer your personal information outside South Africa:

- if you give us an email address that is hosted outside South Africa; or
- for processing, storage or academic research, only where this is specifically approved by Bankmed; or
- to administer certain services, for example, cloud services.

When we share your information to administer certain services, we will ensure that any country, company or person that we pass your personal information to agrees to treat your information with the same level of protection as we are obliged to do in South Africa. Unless you specifically give us consent to share your personal information with such person (or company).

1.15. Bankmed may change this Privacy Statement at any time. The current version is available on the Bankmed website (www.bankmed.co.za). Scroll to the bottom of the webpage once you have logged in and select the "Legal" tab. Alternatively, you may click on this link to access the document: https://www.bankmed.co.za/assets/medical-schemes/bankmed/bankmed-fair-collections-notice-final.pdf

1.16. If you believe that Bankmed or its administrator have used your personal information contrary to this Privacy Statement, you have the right to lodge a complaint with the Information Regulatory, under POPIA, but we encourage you to first follow our internal complaints process to resolve the complaint. We explain the complaints and disputes process on the Bankmed website. You may click on this link to access the complaints and escalations process: https://www.bankmed.co.za/medicalschemes_za/bankmed/web/health/linked_content/documents/latest_info/complaints_and_escalations.pdf

If you are not satisfied after this process, you have the right to lodge a complaint with the Information Regulator, under POPIA.

CONTACT DETAILS FOR THE INFORMATION REGULATOR ARE:

The Information Regulator (South Africa)

SALU Building

316 Thabo Sehume Street

PRETORIA

E-mail: inforeg@justice.gov.za

Call: 012 406 4818

Fax: 086 500 3351