



BENEFIT & CONTRIBUTION SCHEDULE 2025

MORE THAN A MEMBER. MORE **WITH BANKMED.**



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The Bankmed Benefit & Contribution Schedule is a summary of the benefits and features of your Plan. The registered Scheme Rules are on the website under 'About Us' > 'Registered Rules'. In all instances, the Scheme Rules apply as registered by the Council for Medical Schemes, and supersede any errors or omissions contained herein. Benefit access and use may be subject to clinical entry criteria, Scheme-determined protocols, limitations on funding, network provider utilisation, and so forth. Prescribed Minimum Benefit (PMB) regulations apply in all instances. Bankmed is administered by Discovery Health (Pty) Ltd. We are constantly improving our communication and the latest version of the Benefit & Contribution Schedule is available on our website (www.bankmed.co.za).

Please note that the 2025 benefits and contributions are subject to approval by the Council for Medical Schemes.



TERMINOLOGY EXPLAINED

A ABOVE THRESHOLD BENEFIT

Plus Plan members have access to the Above Threshold Benefit (ATB). This gives you extra cover when your claims add up to a set amount called the Annual Threshold. Once the claims you have sent to us add up to the Annual Threshold, we pay specific benefit claims from the ATB, at the Scheme Rate or a portion of it.

ADDITIONAL DISEASE LIST (ADL)

Depending on your Plan, and your approval for the CIB, you have cover for medication for an additional list of life-threatening or degenerative conditions, as defined by Bankmed.

ANNUAL THRESHOLD

We set the Annual Threshold amount at the beginning of each year. The number and type of dependants (spouse, adult, or child) on your Plan determines the amount. The Annual Threshold is the amount that your claims must add up to, before we pay your day-to-day claims from the ATB.

B BOARD OF HEALTHCARE FUNDERS (BHF)

All Healthcare Professionals seeking reimbursement from a medical scheme are required to register with the BHF and obtain a practice number.

C CHRONIC DISEASE LIST (CDL)

A defined list of chronic conditions we cover according to the PMBs.

CHRONIC ILLNESS BENEFIT (CIB)

The CIB covers you for a defined list of chronic conditions. You need to apply to have your medication and treatment covered for your chronic condition.

CONNECTED CARE

Connected Care is an integrated ecosystem of benefits, services, and digital capabilities to help you manage your health and wellness.

CO-PAYMENT

This is an amount that you may have to pay towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service or if the amount the Healthcare Professional charges is higher than the rate we cover. If the co-payment amount is higher than the amount charged for the healthcare service, you will have to pay this amount yourself.

COVER

Cover refers to the benefits you have access to and how we pay for these healthcare services such as consultations, medication, and hospitals, on your Plan.

CARE NAVIGATORS

A dedicated team who will help you to:

- Understand your diabetes-specific benefits.
- Register on our digital tools.
- Choose and engage with Healthcare Professionals on the full-care team (podiatrist, dietitian etc.).
- Get the most out of the programme by using the benefits available.

CARE COORDINATION NETWORK

The network of GPs and Specialists who have contracted with the Scheme to provide you with coordinated care for the Diabetes Care Programme.

COUNCIL FOR MEDICAL SCHEMES (CMS)

All medical schemes need to be registered with the CMS, which is a statutory body established by the Medical Schemes Act 131 of 1998, and regulates private health financing through medical schemes.

D DAY-TO-DAY BENEFITS

These are the available funds allocated to your MSA and ATB or defined benefits for day-to-day healthcare services. The level of day-to-day benefits depends on your Plan.

DEDUCTIBLE

A deductible is an upfront payment that you pay to a hospital, day clinic or other healthcare facility before you can receive treatment. The facility will not admit you until you pay the deductible. If the upfront amount is higher than the amount charged for the healthcare service, you will have to pay for the cost of the healthcare service.



TERMINOLOGY EXPLAINED

DEPENDANT

A dependant is a spouse, partner, child, or special dependant. Applications must be submitted to Bankmed for membership.

DESIGNATED SERVICE PROVIDER (DSP) OR NETWORK

We negotiate tariffs for you with hospitals, pharmacies, GPs, and specialists. When these Healthcare Professionals agree to charge the Scheme Rate, we contract with them as network Healthcare Professionals or DSPs. These Healthcare Professionals must meet our quality standards and charge you the agreed contracted rates. Visit www.bankmed.co.za or the Bankmed App and click on 'Find a Healthcare Professional' to view the full list of DSPs.

E EMERGENCY MEDICAL CONDITION

An emergency medical condition (also referred to as an emergency) is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical and/or surgical treatment, where failure to provide medical and/or surgical treatment would result in serious impairment to bodily functions, or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy. An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency.

F FIND A BENEFIT PLAN TOOL

This tool assists you to better understand your benefits and select a Plan that best meets your needs. Plan selection and quotes are based on your individual needs. This is not a benefit comparison tool.

FIND A HEALTHCARE PROFESSIONAL TOOL

Our [Find a Healthcare Professional](#) tool is a medical and provider search tool which is available on the Bankmed App or website.

H HOME CARE

Bankmed offers you access to care at home through HomeCare. HomeCare is an additional service offering which provides you with quality home-based care in the comfort of your home for healthcare services like IV infusions, wound care, post-natal care, and advanced illness care.

HEALTHID

HealthID is an online platform that gives your Healthcare Professional fast, up-to-date access to your health information. Once you provide consent, your Healthcare Professional can use HealthID to access your medical history, make referrals to other Healthcare Professionals and check your relevant test results.

I ICD-10 CODE

A clinical code that describes diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organisation (WHO).

INSURED BENEFIT

This is a benefit Bankmed pays from pooled contributions, instead of using your personal MSA, if you have one.

M MEDICAL SAVINGS ACCOUNT (MSA)

The MSA is an amount allocated to you at the beginning of each year or when you join the Scheme. You pay this amount back in equal portions as part of your monthly contribution. We pay your day-to-day medical expenses such as GP and specialist consultations, acute medication, radiology, and pathology from the available funds allocated to your MSA.

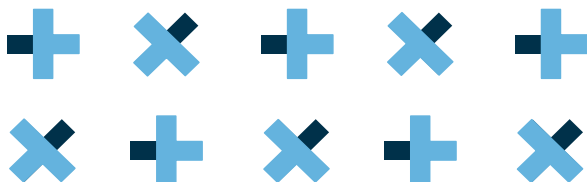
You can choose to have your claims paid from the MSA either at the Scheme Rate, or at cost. Any unused MSA funds will carry over to the next year. Should you leave the Scheme or change your Plan partway through the year, and if you have used more of the MSA than you have contributed, you will need to pay the difference to us. PMB claims cannot be funded from the MSA.

MEDICATION LIST (FORMULARY)

A list of medication we cover in full for the treatment of approved chronic condition(s). This list is also known as a 'formulary'.

MEMBERSHIP OR MEMBER

The Principal Member is the main member and membership contract holder, and is responsible for ensuring the monthly contribution is paid. In the case of Bankmed, the Principal Member is an employee of a participating employer or bank that has an agreement with Bankmed. Alternatively, membership may extend to continuation members such as retirees or surviving dependants.



TERMINOLOGY EXPLAINED

MEDICAL SCHEMES ACT & REGULATIONS

The Medical Schemes Act 131 of 1998 ('the Act') and its regulations consolidates the laws relating to registered medical schemes, serves to protect the interests of members of medical schemes, and provides measures to coordinate medical schemes.

N NETWORKS

Depending on your chosen Plan, you may need to make use of specific hospitals, pharmacies, doctors, specialists, or allied Healthcare Professionals in a network. We have payment arrangements with these Healthcare Professionals to ensure you get access to quality care at an affordable cost. By using network Healthcare Professionals, you can avoid having to pay additional costs and co-payments yourself.

P PARTICIPATING EMPLOYER

Rule 4.25 of the Bankmed main body rules defines an "Employer" as any bank as defined in the Banks Act (Act 94 of 1990), the Mutual Banks Act (Act 124 of 1993), or the Development Bank of Southern Africa Act (Act 13 of 1997), or a co-operative bank as defined in Section 1(1) of the Co-operative Banks Act (Act 40 of 2007), or any registered financial service provider as defined in the Financial Advisory and Intermediary Services Act (Act 37 of 2002), and any subsidiary or an associated company in which there is a shareholding by an organisation referred to above.

PAYMENT ARRANGEMENTS

The Scheme has payment arrangements with various Healthcare Professionals and service providers to ensure that you can get full cover with no co-payments.

PERSONAL HEALTH ASSESSMENT (PHA)

The PHA measures health indicators like blood pressure, cholesterol, blood sugar, waist circumference, and BMI. The PHA is paid by Bankmed and the results used to unlock additional benefits, where appropriate.

PREMIER PLUS GP

A Premier Plus GP is a network GP who has contracted with us to provide you with coordinated care and enrolment onto one of our Care Programmes for defined chronic conditions.

PRESCRIBED MINIMUM BENEFITS (PMBs)

According to the Medical Schemes Act, all medical schemes must pay for a minimum level of care for a list of defined medical conditions.

R RELATED ACCOUNTS

Any account besides the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology.

S SCHEME MEDICATION RATE

Like the Scheme Rate but applies to medication. Pharmacies in our network charge the Scheme Medication Rate. If you claim for medication that costs more than the Scheme Medication Rate, you will have to pay the difference yourself. The Scheme Medication Rate is made up of the SEP of medication plus the relevant dispensing fee.

SCHEME RATE

Healthcare Professionals in our network charge the Scheme Rate. If you visit a Healthcare Professional who is not in our network, they can charge you more than the Scheme Rate and you will have to pay the difference.

SINGLE EXIT PRICE (SEP)

The SEP is the price at which a manufacturer must sell to all pharmacies, irrespective of volume sold. The introduction of the SEP ensured that no person shall supply any medication according to a bonus system, rebate system or any other incentive scheme including sampling of medications. This price is regulated by the government and a medication may not be sold by a wholesaler at less than the published SEP. Pharmacies and dispensers may charge an additional dispensing fee depending on the price of the medication.

SELF-PAYMENT GAP (SPG)

If your MSA funds are depleted, you go into an SPG where you will have to pay all claims from your own pocket. These claims will go towards closing the SPG so that you can eventually access the ATB. Continue submitting claims to close the SPG and access the ATB.

W WHO GLOBAL OUTBREAK BENEFIT

The WHO Global Outbreak Benefit provides cover for approved global disease outbreaks recognised by the World Health Organisation (WHO) such as COVID-19 and Mpox. This benefit provides access to a defined Basket-of-Care per disease outbreak, which includes cover for the administration of vaccines, where applicable, and relevant out-of-hospital treatment.

ABOUT BANKMED

Who we are

Bankmed Medical Scheme (“Bankmed” or “the Scheme”) is an exclusive medical scheme and non-profit organisation that operates under the guidance of the Medical Schemes Act 131 of 1998, as amended, and is regulated by the CMS. Membership is limited to employees at participating employer groups. Participating employers are made up of registered banks and financial service providers that have partnered with Bankmed to provide health and wellness benefits for their employees.

The Scheme is governed by a Board of Trustees (BOT), which is appointed by the members of the Scheme. These dedicated individuals manage the affairs of the Scheme in accordance with the Act and the Scheme Rules. At least 50% of the BOT members are elected ++from the Scheme's members and they must be capable of fulfilling their duties responsibly. Their primary objective is to safeguard the interests of the members and ensure proper administration of the Scheme. Any misconduct or reckless trading on their part may result in their being held accountable for any losses incurred by the Scheme. The day-to-day operations of the Scheme are overseen by a Principal Officer (PO), who reports to the BOT.

Bankmed exists solely for the benefit of its members, with all funds pooled and protected to cover claims in accordance with the Scheme's Rules. Our utmost priority is to provide fair and compassionate care to all members, based on their chosen Plan.

WHAT DOES IT MEAN TO BE ADMINISTERED BY DISCOVERY HEALTH (PTY) LTD?

Discovery Health (Pty) Ltd (Discovery Health), a registered medical scheme administrator and managed care organisation, has been entrusted by Bankmed to oversee the management of administration and managed care services. Guided by Bankmed's rules, policies, and protocols, Discovery Health effectively executes these responsibilities. With expertise in developing efficient claims systems and staffing a dedicated call centre to address inquiries, Discovery Health manages the operational aspects of the Scheme.

WHAT IS THE DIFFERENCE BETWEEN BANKMED, DISCOVERY HEALTH (PTY) LTD AND DISCOVERY HEALTH MEDICAL SCHEME?

Bankmed and Discovery Health Medical Scheme are both registered medical schemes under the Medical Schemes Act 131 of 1998. They are regulated by the Council for Medical Schemes.

Bankmed is a restricted-access medical scheme, limited to people employed by a participating employer group in the banking or financial services industry.

Discovery Health Medical Scheme is an open medical scheme available to the public. It's important to note that Bankmed and Discovery Health Medical Scheme are separate legal entities and have no relationship with each other.

Discovery Health (Pty) Ltd is a registered medical scheme administrator and managed care organisation, also regulated by the Council for Medical Schemes. Discovery Health provides administration and managed care services to Bankmed, Discovery Health Medical Scheme, and numerous other restricted access medical schemes.



WHAT MAKES **BANKMED SPECIAL**

Bankmed Medical Scheme: your partner in health and wellness

 ***Bankmed's commitment to your health and wellness spans over a century, combining the expertise of the banking and healthcare industries. We understand that every individual has unique health needs and are here to provide you with tailored medical cover that prioritises your wellbeing.***

ACCESS TO QUALITY HEALTHCARE

Bankmed takes part in an annual survey commissioned by the Health Quality Assessment. The 2023 findings revealed that Bankmed members enjoy superior healthcare quality across various clinical indicators.

BALANCE — BANKMED'S BESPOKE WELLNESS PROGRAMME

As a Bankmed member you have access to Balance at no cost. Balance makes choosing to lead a healthy lifestyle even more rewarding, because it offers you a science-based behaviour change programme that helps you keep track of your progress towards a healthier you. It then rewards you for making better choices with a range of health, lifestyle, and leisure benefits. Join [Balance](#) today.

INNOVATION, UNRIVALLED VALUE, AND QUALITY

Bankmed offers exceptional quality of care through carefully designed networks and Centres of Excellence, providing unrivalled Wellness and Preventative Care benefits, innovative digital tools, and access to a vast array of Disease Management Programmes designed to improve your health.

COMPETITIVE CONTRIBUTIONS

Contributions remain exceptionally competitive, whilst continuing to offer innovative and enhanced benefits and services each year.

POWERFUL DIGITAL TOOLS

Bankmed has created a digital world inside our website and Bankmed App, bringing our members a superior user experience. Our digital tools and communication channels are expertly designed to provide seamless and effortless access to information, wellness benefits, rewards, and Healthcare Professionals.



35% MORE VALUE, BECAUSE YOU DESERVE MORE

Not all medical schemes are the same. At Bankmed, we offer members an average of 35% more value through lower contributions and enhanced benefits.

This translates into a better member experience, with consistently lower contributions, stable increases, and continuously improving benefits.

Our investment in you is reflected in innovative programmes like Hospital@Home, Advanced Illness Support, and Diabetes and Wellness Management, ensuring we're there for you and your family when it matters most.

FINANCIAL STRENGTH AND SUSTAINABILITY: WE'VE GOT YOU COVERED

Choosing a medical scheme is not just about healthcare; it's about financial strength and sustainability.

Bankmed's robust financial control and risk management ensure the Scheme maintains required solvency reserve levels, guaranteeing our ability to cover claims, even during unexpected peaks.

A remarkable 100,8% of member contributions are dedicated to funding benefits.



SIX PLANS TO SUIT YOUR UNIQUE NEEDS

Bankmed offers a range of Plans to suit everyone's healthcare needs and pockets. Have a look at our [Plan Comparison Tool](#) and [Find a Benefit Plan Tool](#) for more information.

AA+ GLOBAL CREDIT RATING: SOLID FOUNDATION FOR YOUR HEALTH

For 15 consecutive years, Bankmed has been awarded the prestigious AA+ Global Credit Rating, a testament to our solid financial foundation.

As one of the few closed medical schemes in South Africa with this rating, this allows us to provide you with more benefits and/or lower contributions compared to the market. Your financial wellbeing is as important to us as your physical health.

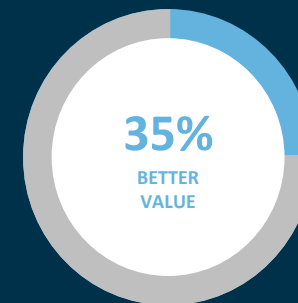
YOUR INVESTMENT IN MEMBERSHIP TAKES CARE OF YOU

Bankmed operates as a non-profit organisation, solely funded by member contributions and investment returns.

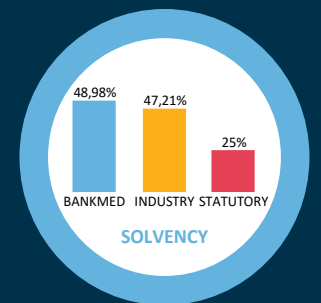
The Scheme pools all contributions to cover members' claims, and any additional funds go into Scheme reserves for the security and benefit of our members.

When setting contributions, we ensure they can cover all claims, generate a modest surplus for regulatory solvency, and provide a cushion against unexpected costs.

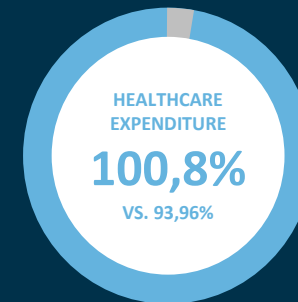
Bankmed gives you better benefits



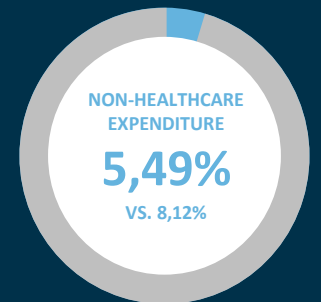
35% more value than the average comparable open scheme due to lower contributions and/or richer benefits



Bankmed's solvency ratio 48,98% (as at 31 December 2023) compared to the industry average of 47,21% (CMS Annual Report 2022*); 25% statutory requirement



Relevant healthcare expenditure, expressed as a percentage of risk contribution income, was 100,8% for 2023 (as at 31 December 2023) compared to the industry average of 93.96% (CMS Annual Report 2022*)



Bankmed non-healthcare expenditure limited to 5.49% of gross contribution income (as at 31 December 2023) compared to the industry average of 8.12% (CMS Annual Report 2022*)



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



For 15 consecutive years, Bankmed has been awarded the prestigious AA+ Global Credit Rating

**CMS Annual Report 2022 referenced as 2023 annexures have not yet been published.*



WHAT'S NEW IN 2025

2025 Contribution Increases

Medical inflation, legislative requirements, the aging of the Scheme's membership, enhancing benefits, new technology, aligning with clinical best practices, and the performance of each Plan type all influence contribution increases.

The Benefit and Contribution Schedule outlines the approved changes by the Board of Trustees, effective from 1 January 2025. The changes aim to maintain competitiveness, manage risks, and improve member experience.

Key points include:

- **Benefits and Contributions:** Adjustments to maintain competitiveness, considering membership changes, aging, inflation, and healthcare costs.
- **Annual Review Principles:** Enhancing benefits, optimising risk management, tiered differentiation in benefits, lowering out-of-pocket payments, improving member experience, and aligning with clinical best practices.

On average, contribution increases have been limited to 8.4% across all Plans in 2025, keeping contribution increases to a minimum while still improving benefits. Your individual Plan increase has been included in your Plan Guide.

Bankmed's contribution increases remain consistently more stable and lower than the industry average. This means you're still getting an average of 35% more value than the average comparable open medical scheme, thanks to better benefits and/or lower contributions.

Please note that the 2025 benefits and contributions are subject to approval by the Council for Medical Schemes.



Bankmed enhancements for 2025 — all Plans

 We have summarised benefit enhancements for 2025 below. The following enhancements apply to all Plans.

BENEFIT LIMIT INCREASES

Benefit limits across our Plans will see an average increase of 4.75%, ensuring you have the coverage you need, when you need it.

WELLNESS SCREENING AND PREVENTATIVE CARE BENEFITS

Personal Health Assessment (PHA) extended

The PHA screening assessment has always been made available to beneficiaries aged 18 years and older. From 2025, Bankmed is extending this screening assessment to include beneficiaries aged 16 years and older. The aim is to detect risks earlier, including high BMI, so that members flagged as high-risk can access additional benefits. These include consultations with a GP, biokineticist, and dietitian.

Post-PHA GP consultation for high-risk members

If a member's PHA screening shows a high-risk for hypertension, diabetes, or high cholesterol, they should consult with a GP to confirm the diagnosis. Ordinarily, this GP consultation would be funded from day-to-day benefits, where applicable. In 2025, Bankmed will cover one Bankmed Network GP consultation from the Wellness and Preventative Care Benefits so that your day-to-day benefits are not affected.

After a diagnosis is confirmed, the member can join the Chronic Illness Benefit (CIB) and a Bankmed Care Programme, where applicable. Additionally, a Basket-of-Care (BOC) will be activated to ensure ongoing support for the management of the chronic condition.

Important: Qualifying members must consult with a Bankmed Network GP within six weeks of their PHA. If the consultation takes place after the six-week period, the consultation will be paid from day-to-day benefits, where applicable.

Continuous Glucose Monitoring (CGM) for diabetics

The CGM benefit has been available to Type 1 diabetics previously. Bankmed is expanding care by incorporating new treatment methods and improving the quality and outcomes of healthcare. Starting in 2025, CGM will now also be offered to Type 2 Diabetics who require intensive insulin therapy.

Dementia screening

From 2025, Bankmed is offering members aged 65 years and older access to a Comprehensive Cognitive Assessment with an occupational therapist (OT), or network psychologist where an OT is not available.

Following the Comprehensive Cognitive Assessment, if a diagnosis of moderate to severe Alzheimer's is made, the member will be referred to a neurologist, physician, or psychiatrist for further evaluation. The specialist will determine the next steps in management, including whether the member qualifies for chronic medication. The costs associated with the specialist treatment will be covered by day-to-day benefits, where applicable.

BANKMED KIDS

Weight screening for children aged 9 to 15 years

Childhood obesity is a growing epidemic worldwide, affecting both physical and mental health. Overweight children are more likely to remain obese in adulthood, increasing their risk of early-onset diabetes and cardiovascular diseases.

To address this issue, a screening benefit will be made available to assess children for obesity risk. Those identified as high risk will receive follow-up care similar to that provided to adults. This includes consultations with a dietitian, biokineticist, and GP to help manage and mitigate their risk.

Please note that the 2025 benefits and contributions are subject to approval by the Council for Medical Schemes.

ADVANCED ILLNESS BENEFIT MANAGEMENT THROUGH EPILOG

Epilog has developed a digital tool for people living with advanced illnesses. Using behavioural science, this tool engages users online to build trust and, through behavioural economics, helps them move to palliative or needs-based care at the right time.

The tool provides early, personalised support based on each member's preferences and life situation. It focusses on managing life rather than just the illness, with a strong emphasis on improving quality of life.

Epilog's user-friendly technology is managed through a WhatsApp interface, making it easy for members to communicate and stay engaged.

ADDITIONAL DAY SURGERY PROCEDURES

We've expanded our day surgery procedures, including eye procedures, biopsies, anorectal procedures, nerve procedures, gynaecological procedures, orthopaedic procedures, simple hernia repairs, skin procedures and more.

Find the list of day surgery procedures in the **Day Surgery** section of your Benefit and Contribution Schedule.

CHANGE IN COVERAGE FOR TONICS & STIMULANTS — EFFECTIVE 2025

Up until 2024, Bankmed provided funding for tonics and stimulants, including weight loss remedies, when prescribed by a Healthcare Professional.

However, from 1 January 2025, these items will no longer be covered under the Scheme's benefits. Members will be responsible for the full cost of these products, regardless of whether they are prescribed by a Healthcare Professional.

IMPORTANT NOTE

In 2024, Bankmed introduced new benefits and enhancements, which are being implemented in two phases. The first phase was completed in 2024, and the second phase will take effect from 1 January 2025. Please read and familiarise yourself with the changes that take effect in 2025 to avoid unexpected out-of-pocket expenses. Details on the next page.

MENTAL HEALTH MANAGEMENT PROGRAMME ENHANCEMENTS

Generalised Anxiety Disorder

Currently, the Mental Health Management Programme only manages depression. From 2025, it will also cover Generalised Anxiety Disorder (GAD). Members diagnosed with anxiety, based on certain ICD-10 codes, can get care after their Premier Plus GP or a network psychologist enrolls them, and they complete the GAD-seven assessment. Once a member qualifies, they will be able to access the following benefits under the Basket-of-Care (BoC), which are funded from Insured Benefits:

- Three Premier Plus GP consultations.
- Prescribed medication subject to medication and prescription limitations.
- Up to three individual psychotherapy sessions or nine group therapy sessions.
- One course of Internet-based Cognitive Behavioural Therapy (iCBT).

"At-risk" consultation with network GP/psychologist

Members have access to unlimited online Mental Wellbeing Assessments available on our website. Where members meet specific clinical entry criteria upon completion of this assessment, specifically with regard to the PHQ-9 or GAD-7 assessment, they will have access to one consultation with a Premier Plus GP or network psychologist, funded from Insured Benefits.

This benefit is available to members who are not already registered on the Mental Health Care Programme or registered for Chronic Illness Benefits for depression and/or anxiety. Depending on the assessment scores, members may be eligible for a virtual consultation or face-to-face consultation.

The Premier Plus GP or network psychologist will evaluate the member, make a diagnosis, and enrol them in the appropriate benefit or programme, if needed. A mental health coach will support this process. Members will receive specific communication to guide them on how to access the consultation.





Important benefit reminders for 2025



In 2024, Bankmed introduced new benefits and enhancements, which are being implemented in two phases. The first phase was completed in 2024, and the second phase will take effect from 1 January 2025. Please read and familiarise yourself with the changes that take effect in 2025 to avoid unexpected out-of-pocket expenses.

ONCOLOGY MEDICATIONS PHARMACY DESIGNATED SERVICE PROVIDER (DSP) — 20% CO-PAYMENT APPLIES IN 2025

In 2024, Bankmed partnered with a leading Oncology Medications Pharmacy DSP to manage costs while ensuring comprehensive oncology benefits.

- The Oncology Pharmacy DSP was implemented in 2024, but with no penalties for using a non-network pharmacy this year.
- As communicated in 2024, a 20% co-payment applies when using non-network pharmacies from 2025.
- Please ensure that you speak with your Healthcare Professional about the DSP and use the [Find a Healthcare Professional](#) tool on our website to locate a DSP near you.

BANKMED DAY SURGERY DEDUCTIBLE — VALUE INCREASES IN 2025

Bankmed's Day Surgery Network comprises a defined list of contracted day surgery facilities, as well as contracted acute hospitals that provide day surgery facilities at day surgery rates.

- In 2024 when this initiative was launched, choosing to use a non-network facility, attracted a deductible of R4 100 per admission.
- As communicated in 2024, this deductible increases to R6 300 in 2025.
- Please use the [Find a Healthcare Professional](#) tool on our website to locate a DSP near you.

Please note that the 2025 benefits and contributions are subject to approval by the Council for Medical Schemes.



Bankmed enhancements for 2025 — specific Plans

 We have summarised specific benefit enhancements for 2025 according to Plan type

TRADITIONAL PLAN ENHANCEMENTS FOR 2025

ENHANCED DEMENTIA BENEFITS

As noted on page 10 Bankmed is offering members aged 65 years and older access to a Comprehensive Cognitive Assessment with an occupational therapist (OT), or network psychologist where an OT is not available.

Following the Comprehensive Cognitive Assessment, if a diagnosis of moderate to severe Alzheimer's/Dementia is made, the member will be referred to a neurologist, physician, or psychiatrist for further evaluation. The specialist will determine the next steps in management, including whether the member qualifies for chronic medication.

The costs associated with the specialist treatment will be covered by day-to-day benefits, where applicable.

In 2025, Traditional Plan members who meet the clinical entry criteria, may have access to Chronic Illness Benefit cover for chronic medications to treat Alzheimer's and/or Dementia, subject to clinical protocols. Currently, this cover is only available to members on the Comprehensive and Plus Plans.

TRADITIONAL, COMPREHENSIVE AND PLUS PLAN AMENDMENTS FOR 2025

MYASTHENIA GRAVIS CHRONIC COVER ENHANCEMENT

Myasthenia Gravis is a chronic autoimmune disorder where antibodies disrupt the communication between nerves and muscles, causing weakness in skeletal muscles.

It primarily affects voluntary muscles, including those in the eyes, mouth, throat, and limbs.

For 2025, chronic medication for Myasthenia Gravis will be fully covered, provided it meets clinical protocols and is deemed appropriate.

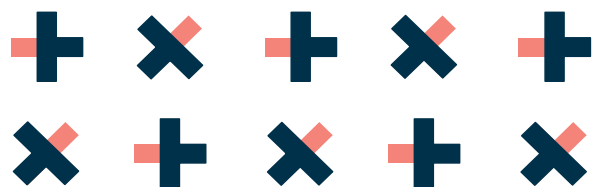
This medication will not count towards the Chronic Medication Benefit limit.

SPEECH PROCESSOR UPGRADE BENEFIT ENHANCEMENT

The Speech Processor Upgrade Benefit is only available to members on the Traditional, Comprehensive and Plus Plans.

The current benefit covers 80% of the Scheme Rate, up to a maximum of R161 470 over a three-year period.

In 2025, the benefit is being enhanced to cover 100% of the Scheme Rate, up to a maximum of R169 140 over a three-year period, thereby alleviating the financial burden associated with upgrading a speech processor.



Please note that the 2025 benefits and contributions are subject to approval by the Council for Medical Schemes.

KEY FEATURES & PLAN OVERVIEWS

Plan	Wellness and Preventative Care Benefits Determine your risk, detect conditions early, and improve your health	Networks For full cover, PMBs, and other treatment	Major medical expenses and hospital cover	Chronic medication	PMBs
Plus Plan	• PHA for members aged 16+ • Bankmed Mental Wellbeing 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 25 years • Herpes Zoster vaccine for members aged 60+ • Post-engagement Wellness Management Programme • Weight screening for children aged 9 to 15 years • Dementia screening for members aged 65+	• Bankmed GP Network • Bankmed Prestige A and B Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network	• Comprehensive cover for hospitalisation and most hospital care • Any private hospital • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 300% of the Scheme Rate	• R34 215 a year per member • We pay less for the medication you obtain from pharmacies that are not in our network • You might have to pay part of the cost yourself	• We pay the full cost of PMBs for 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 Plan	• PHA for members aged 16+ • Bankmed Mental Wellbeing 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 25 years • Herpes Zoster vaccine for members aged 60+ • Post-engagement Wellness Management Programme • Weight screening for children aged 9 to 15 years • Dementia screening for members aged 65+	• Bankmed GP Network • Bankmed Prestige A and B Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network	• Comprehensive cover for hospitalisation and most hospital care • Any private hospital • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 100% of the Scheme Rate	• R28 695 a year per member • We pay less for the medication you obtain from pharmacies that are not in our network • You might have to pay part of the cost yourself	• We pay the full cost of PMBs for 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
Traditional Plan	• PHA for members aged 16+ • Bankmed Mental Wellbeing 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 25 years • Herpes Zoster vaccine for members aged 60+ • Post-engagement Wellness Management Programme • Weight screening for children aged 9 to 15 years • Dementia screening for members aged 65+	• Traditional Plan Hospital Network • Bankmed GP Network • Bankmed Prestige A and B Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network	• Comprehensive cover for hospitalisation and most hospital care • Restricted hospital network • More extensive hospital network than the Essential and Basic Plans • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 100% of the Scheme Rate	• R26 500 a year per member • We pay less for the medication you obtain from pharmacies that are not in our network • You might have to pay part of the cost yourself	• We pay the full cost of PMBs for 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



Plan	Wellness and Preventative Care Benefits Determine your risk, detect conditions early, and improve your health	Networks For full cover, PMBs, and other treatment	Major medical expenses and hospital cover	Chronic medication	PMBs
Core Saver Plan	• PHA for members aged 16+ • Bankmed Mental Wellbeing 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 25 years • Herpes Zoster vaccine for members aged 60+ • Post-engagement Wellness Management Programme • Weight screening for children aged 9 to 15 years • Dementia screening for members aged 65+	• Bankmed GP Network • Bankmed Prestige A and B Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network	• Comprehensive cover for hospitalisation and most hospital care • Any private hospital • Organ transplants and oncology treatment is limited to PMBs • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 100% of the Scheme Rate	• No overall limit, but benefits subject to Core Saver medication list (formulary) for PMB conditions only • We pay less for the medication you obtain from pharmacies that are not in our network • You might have to pay part of the cost yourself	• We pay the full cost of PMBs for 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
Basic Plan	• PHA for members aged 16+ • Bankmed Mental Wellbeing 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 25 years • Herpes Zoster vaccine for members aged 60+ • Post-engagement Wellness Management Programme • Weight screening for children aged 9 to 15 years • Dementia screening for members aged 65+	• Basic Plan Hospital Network • Bankmed Entry Plan GP Network • Bankmed Entry Plan Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network • Bankmed Dental Network	• Comprehensive cover for hospitalisation and most hospital care from a restricted hospital network • Hospital network more limited than the Traditional Plan • Organ transplants, oncology treatment and renal dialysis, are limited to PMBs • Specific categories subject to rand limits • We pay for procedures performed in-hospital at 100% of the Scheme Rate	• No overall limit, but benefits subject to CIB medication list (formulary) • Network Healthcare Professionals only • We pay less for the medication you obtain from pharmacies that are not in our network • You might have to pay part of the cost yourself	• We pay the full cost of PMBs for 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
Essential Plan	• PHA for members aged 16+ • Bankmed Mental Wellbeing Assessment • Vaccinations and screenings • Pap smear consultation • Workplace-based TB screening • Human Papilloma Virus (HPV) vaccine for female and male members aged nine to 25 years • Herpes Zoster vaccine for members aged 60+ • Post-engagement Wellness Management Programme • Weight screening for children aged 9 to 15 years • Dementia screening for members aged 65+	• Essential Plan Hospital Network • Bankmed Entry Plan GP Network • Bankmed Entry Plan Specialist Network • Bankmed Pharmacy Network • Bankmed Pharmacy Network for HIV medication • Bankmed Emergency Services for ambulance services • Bankmed Day Surgery Network • Oncology Pharmacy Network	• Limited to PMBs from a restricted hospital network • Hospital network more limited than the Traditional Plan • Organ transplants, oncology treatment and renal dialysis, are limited to PMBs • Specific categories subject to rand limits • In-hospital procedures limited to PMBs	• No overall limit, but limited to PMBs • Covered at 100% of cost at Bankmed Entry Plan GP network • Subject to CIB medication list (formulary)	• We pay the full cost of PMBs for 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

MAXIMISING YOUR PLAN'S BENEFITS

Strategies for extracting the best value from your Plan and reducing out-of-pocket expenditure



USE BANKMED'S EXTENSIVE NETWORKS

- Look out for information in this guide to help you choose a network option wherever possible.
- This helps you avoid co-payments and helps your benefits last longer.



USE BANKMED'S 'FIND A HEALTHCARE PROFESSIONAL' TOOL

- Find a Healthcare Professional who has agreed to only charge you the Scheme Rate.
- We pay them in full.



SAVE YOUR MEDICAL SAVINGS ACCOUNT (MSA)

- Manage your MSA wisely.
- Strategise your spending and take advantage of our Wellness and Preventative Care Benefits that are paid by Bankmed to help your MSA last longer.



REGISTER ON THE CIB PROGRAMME

- Avoid using your day-to-day benefits by registering on the CIB for chronic medication.
- Use medication on the formulary list (where applicable) to ensure you don't pay co-payments.



BABY-AND-ME PROGRAMME

- Maximise your benefits with the Baby-and-Me Programme.
- If you're pregnant, consider enrolling in our Baby- and-Me Programme to preserve your out-of-hospital benefits for other medical treatments.



USE THE BANKMED DAY SURGERY NETWORK

- Extensive day surgery network.
- Use a facility in Bankmed's Day Surgery Network and avoid paying a deductible for a defined list of procedures and treatments.



UPDATE CONTACT DETAILS FOR YOU AND YOUR DEPENDANTS

- Ensure your contact details, including a current e-mail and mobile number, are up-to-date.
- Dependants aged 18+ must also have valid contact information on file. Without these, we can't confirm hospital authorisations, and the Scheme won't cover claim shortfalls for non-DSP use.
- Your pre-authorisation letter confirms the DSP status of your provider and facility.



OBTAIN PRE-AUTHORISATION BEFORE HAVING A PROCEDURE

- Confirm your benefits beforehand to avoid possible non-payment for a procedure or treatment.
- Check the authorisation letter sent to you to confirm whether your chosen Healthcare Professional and/or facility, are part of the Bankmed network.
- Remember that we e-mail the patient's pre-authorisation letter and SMS the pre-authorisation number. It is critical that we have your or the patient's contact details.



AVOID DEDUCTIBLES

- The deductible is an upfront payment that you must pay to a hospital, day surgery or other healthcare facility before you can receive treatment.
- You must contact us to get pre-authorisation before you go to a day surgery or hospital for a procedure.
 - Specific procedures can be performed in a day surgery instead of in a hospital.
 - By using our Day Surgery Network, you can avoid having to pay a deductible.



JOIN OUR CARE PROGRAMMES

- Participate in our Care Programmes and Wellness Programmes.
- Bankmed's Disease Management Programmes, Care Programmes, Wellness and Preventative Care Benefits, and Chronic Baskets-of-Care provide benefits and support without using your day-to-day benefits.



HOW TO CHOOSE A PLAN

Selecting the right Plan type can feel overwhelming, with your medical requirements, family situation, and budget all having to be considered. To assist you in this process, we have created intuitive interactive digital tools. Available on our website, they offer user-friendly features designed to guide you through the decision-making journey.

Digital tools

PLAN COMPARISON TOOL

- Compare Bankmed Plans.
- Side-by-side tabular summary of three Plans' main benefits.

FIND A BENEFIT PLAN TOOL

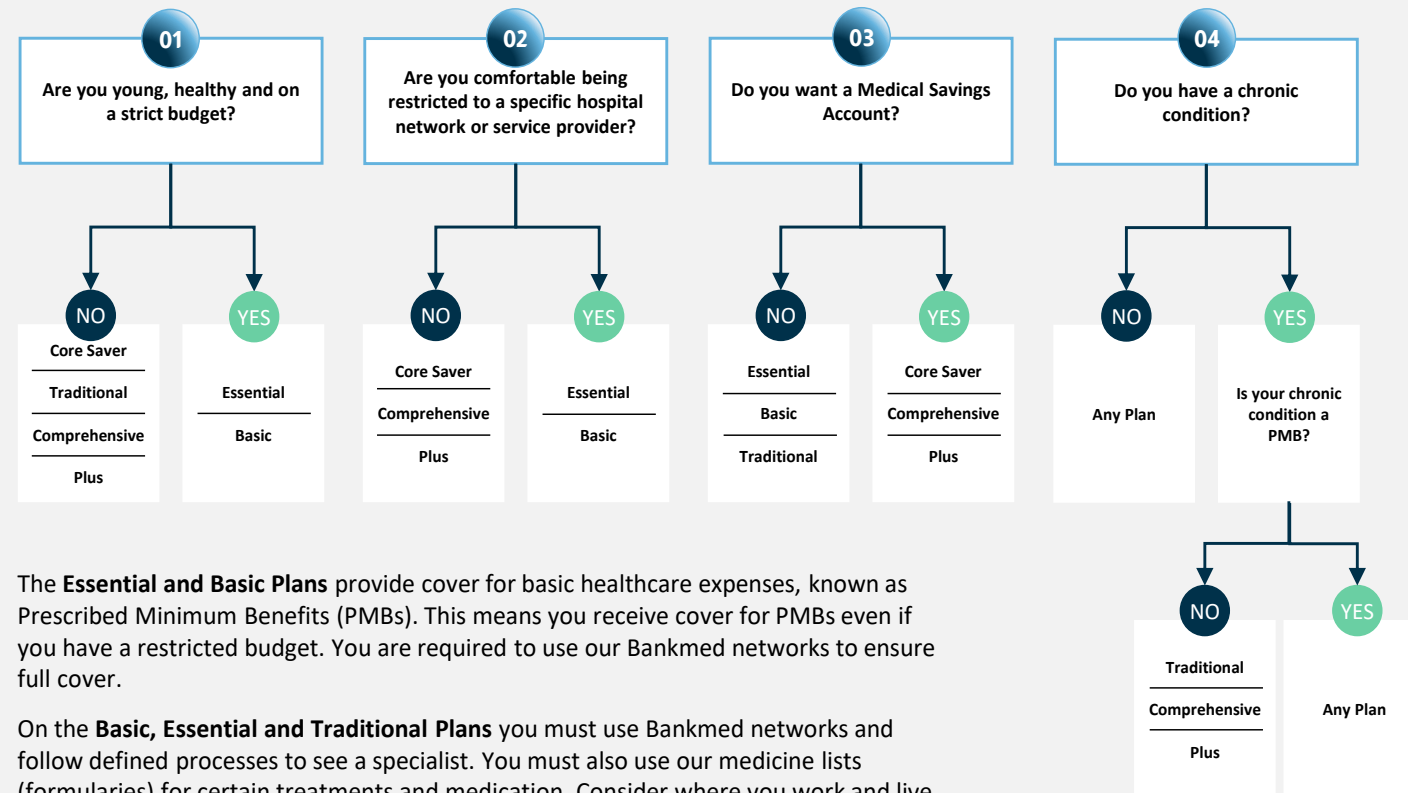
- This tool was developed to assist members to better understand their benefits and how to select a Plan that best meets their needs.
- Plan selection and quote based on individual needs. This is not a comparison tool.

LOOK-UP PLAN BENEFITS TOOL

- This page allows you to search the Benefit and Contribution Schedule to find details of the benefits provided.
- Plan-specific benefit table with limits presented in a single web page. This is not a comparison tool.

What to consider when choosing a Plan

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.



The **Essential and Basic Plans** provide cover for basic healthcare expenses, known as Prescribed Minimum Benefits (PMBs). This means you receive cover for PMBs even if you have a restricted budget. You are required to use our Bankmed networks to ensure full cover.

On the **Basic, Essential and Traditional Plans** you must use Bankmed networks and follow defined processes to see a specialist. You must also use our medicine lists (formularies) for certain treatments and medication. Consider where you work and live before choosing a Plan that restricts you.

EMERGENCY COVER

What is a medical emergency?

The Medical Schemes Act provides the criteria for what qualifies as a medical emergency. To ensure full cover from us, a medical condition must meet the following criteria:

- It must have a sudden and unexpected onset.
- Immediate treatment, potentially including surgery, is necessary.
- Failure to receive immediate treatment could result in weakened bodily functions, serious organ damage, impairment of limbs or body parts, or even death.

If you experience a sudden health issue, it may be unclear whether it constitutes a medical emergency. To ensure coverage under the PMB, we may request evidence that the situation indeed qualifies as a medical emergency.

ASSISTANCE DURING OR AFTER TRAUMA EVENTS

Should you experience a traumatic incident or find yourself dealing with the aftermath of trauma, know that dedicated assistance is available to you. By reaching out to Bankmed Emergency Services, you and your family can access 24-hour trauma support, including counselling and ambulance services.

Bankmed Emergency Services offers real-time emergency care for all members. Our 24/7 helpline is staffed by highly qualified emergency personnel who assess each case and provide immediate feedback and assistance.

If you require medically-equipped transport within South Africa, our Emergency Services will arrange for an ambulance or helicopter to transport you to hospital. This cost is covered by your Hospital Benefit, regardless of whether you are admitted. In an emergency you can obtain care at any hospital. We will cover your emergency hospital admission, even if it is not within our network.

WHAT WE COVER

We provide cover for all necessary medical services during emergencies, including:

- Ambulance or other forms of medical transport.
- Hospital expenses.
- Fees from the attending Healthcare Professional.
- Anaesthetist fees.
- Services provided by other approved Healthcare Professionals.

If you are admitted to hospital in an emergency, kindly reach out to us within 48 hours for authorisation.





PRESCRIBED MINIMUM BENEFITS (PMBs)

What are PMBs?

PMBs are essential medical services that medical schemes in South Africa are obligated to provide to all their members under the Medical Schemes Act number 131 of 1998.

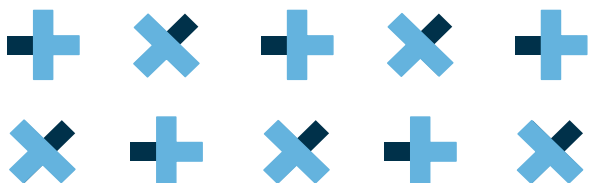
These benefits include the diagnosis, treatment, and ongoing care costs for life-threatening emergency medical conditions, a specified set of 270 medical conditions (defined in the Diagnosis Treatment Pairs), and 27 chronic conditions (defined in the CDL).

HOW BANKMED FUNDS PMBs AND NON-PMBs

- PMBs are covered in full from the Insured Benefit when treatment is received from a DSP.
- Treatment from non-DSPs may involve co-payments if charges exceed the funded amount.
- Non-PMB claims are funded from available day-to-day benefits according to the selected Plan.

IMPORTANT POINTS TO REMEMBER

- PMBs only apply to claims in South Africa. If you receive care or treatment outside of South Africa for a healthcare service that is listed as a PMB in South Africa, it will be treated as an ordinary claim and paid according to your Plan's benefits.
- To qualify for PMB cover, you must obtain pre-authorisation, use medication from our medication list (formulary), and receive the recommended treatment stated in your claim.
- Diagnostic tests or scans may not be covered as PMBs if they do not confirm that the medical condition being diagnosed is indeed a PMB.
- When this schedule sets out insured limits, we pay claims (including PMBs) up to the limit.
- Once the limit is reached, we will only pay for treatment as a PMB if you meet the criteria for cover.
- PMBs have specific conditions and treatment protocols, and exceeding limits may result in non-coverage.
- The CMS prohibits medical schemes from paying PMBs from your MSA. Once you register for a chronic PMB condition, we will not pay for treatment from your MSA.
- Even if we typically pay for care or treatment from your MSA or do not offer a particular benefit, we will still pay for PMBs if you meet the conditions for cover.
- Waiting periods may apply before accessing PMBs.



REQUIREMENTS FOR PMB COVERAGE

To benefit from PMBs, certain criteria must be met:

- The condition must be on the list of defined PMB conditions.
- The required treatment must match treatments in the defined benefits on the PMB list.
- Bankmed's DSPs should be used unless there is no applicable DSP for the selected Plan.

REGISTERING CHRONIC AND PMB CONDITIONS

- Members on Essential or Basic Plans need to register for out-of-hospital PMB or chronic conditions, by obtaining and submitting the prescribed form.
- Other Plans (Core Saver, Traditional, Comprehensive, and Plus) do not require application for in-hospital PMB cover.

WHAT CONDITIONS ARE COVERED AS PRESCRIBED MINIMUM BENEFITS?

A Healthcare Professional must diagnose you with a condition within the list of 270 PMB diagnoses for us to cover your healthcare costs. This diagnosis must include the correct ICD-10 code for the condition.

For chronic medical conditions, we offer coverage through our CIB. If you are diagnosed with a chronic PMB condition, you must register before gaining access to cover. Failure to register will result in us paying for your treatment from your day-to-day benefits. Once authorised, cover is available from date of authorisation. Benefit authorisation will not be backdated.

The CDL specifies the medication and treatment for the 27 chronic conditions covered under the PMBs.

- | | |
|-------------------------|---|
| • Addison's Disease | • Multiple Sclerosis |
| • Epilepsy | • Chronic Obstructive Pulmonary Disease |
| • Asthma | • Parkinson's Disease |
| • Glaucoma | • Coronary Artery Disease |
| • Bipolar Mood Disorder | • Rheumatoid Arthritis |
| • Haemophilia | • Crohn's Disease |
| • Bronchiectasis | • Schizophrenia |
| • Hyperlipidaemia | • Diabetes Insipidus |
| • Cardiac Failure | • Systemic Lupus Erythematosus |
| • Hypertension | • Diabetes Mellitus Type 1 & 2 |
| • Cardiomyopathy | • Ulcerative Colitis |
| • Hypothyroidism | • Dysrhythmias |
| • Chronic Renal Disease | • HIV/AIDS (anti-retroviral therapy) |

You must obtain pre-authorisation, ensure your treatment follows clinical protocols, and register on our CIB to gain access to PMB cover. Failure to do so means your treatment will be funded from your day-to-day benefits. After reaching the limit for chronic medication, we will only provide funding for medication for PMB conditions, in accordance with PMB regulations.



AUTHORISATION AND FUNDING GUIDELINES FOR YOUR HEALTH CONDITIONS

It is important to obtain pre-authorisation before hospital visits or specific medical procedures. Only claims for procedures and consultations listed in the PMB treatment baskets will be paid from the CIB. These are pro-rated based on the approval date of your chronic condition.

If you have recently been diagnosed and approved for a CDL condition, we will fully cover the tests, procedures, and consultation in the diagnostic basket. This coverage is provided if you were an active and eligible member at the time of diagnosis, and the relevant ICD-10 diagnosis codes are included on the claim.

Ongoing management of your condition, involving Healthcare Professionals such as radiologists, dietitians, and podiatrists, is fully covered from the treatment baskets.

Claims from pathologists are paid in full, up to the agreed rate or up to the Scheme Rate, if there is no payment arrangement. Claims from Diabetes Educators are covered up to the agreed rate, subject to the limit and network Healthcare Professional criteria.

- **Plus Plan:** GP and specialist consultations are paid at agreed rates for network Healthcare Professionals.
- **Comprehensive Plan:** GP and specialist consultations are covered at the agreed rates for network Healthcare Professionals.
- **Traditional and Core Saver Plans:** coverage is up to the Scheme Rate.
- **Basic and Essential Plans:** consultations are paid at agreed rates for network Healthcare Professionals or up to the Scheme Rate if not part of the network.

Claims must have the appropriate ICD-10 diagnosis codes for correct processing. Ensure your Healthcare Professionals include these codes on claims and referral forms. Failure to do so may result in non-payment from the CIB.

Designated Service Providers (DSP)

A DSP is a Healthcare Professional with whom we have an agreement, otherwise referred to as a network or network Healthcare Professional.

While you are allowed to use a non-DSP, please keep in mind that you may have to pay part of the claim yourself. By using DSPs, your PMB treatment is paid in full.

There are situations where we will pay for PMBs in full, even if you do not use a Healthcare Professional within our network, if you contact us for pre-authorisation beforehand. These situations include when the healthcare service is not available from someone in the Bankmed network, if there is an unreasonable wait for treatment or service, or if there is no network Healthcare Professional within reasonable proximity to your home or work.

WHAT IF I CANNOT USE A DSP?

If you find yourself unable to use a network Healthcare Professional, please remember; in a medical emergency, head straight to the nearest hospital. For non-emergencies, it is recommended that you use a Healthcare Professional, pharmacy, or hospital in our network for PMB care to ensure full cover.

WHAT IF I CHOOSE TO USE A HEALTHCARE PROFESSIONAL THAT IS NOT IN THE NETWORK OR A DSP?

If it is not a medical emergency and a network Healthcare Professional (DSP) is available, and you choose to use a non-DSP, we will cover the diagnosis, treatment, and care of PMBs at the Scheme Rate.

Additionally, if you need to go to the hospital and it isn't a medical emergency, we will only cover claims if you contacted us and arranged pre-authorisation before being hospitalised.



[FIND A HEALTHCARE PROFESSIONAL](#)





ALL THINGS WELLNESS!

Balance



As a Bankmed member, you have complimentary access to Balance, a comprehensive wellness platform designed to enhance your health journey. To explore this world of wellness, simply follow these easy steps:



1 KNOW YOUR HEALTH

- Start your health journey by completing the health assessments provided by Balance.
- These assessments are the first steps toward identifying areas for improvement and guiding you on the journey to better health.

2 IMPROVE YOUR HEALTH

- Use the Bankmed App to get personalised, weekly physical activity targets through the Active Rewards feature.
- Track your physical activity with a compatible fitness device, monitoring your progress towards the set weekly goals.

3 GET REWARDED

- As a valued Balance member, you qualify for a variety of rewards that recognise and celebrate your commitment to a healthy lifestyle.
- Rewards range from weekly incentives to exclusive discounts and savings, making your journey towards wellness both fulfilling and rewarding.

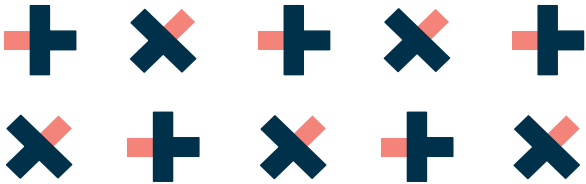
Balance focusses on incentivising your efforts to lead a healthier life through these three straightforward steps. The Bankmed App allows you to access and navigate the Balance platform, for a holistic approach to a healthier you.

Earn points by getting healthier

Earn points by getting active, eating well and doing all your health checks. You'll enjoy a variety of rewards at each status level and the healthier you get, the higher your Balance status.

	BLUE STATUS	BRONZE STATUS	SILVER STATUS	GOLD STATUS	DIAMOND STATUS
Single member		7,500	25,000	40,000	50,000
Main member + 1 member 18 years or older	You start at Blue Balance status	15,000	50,000	80,000	100,000
Main member + 2 members 18 years or older		18,750	62,000	100,000	125,000
For each additional member 18 years or older		+ 3,750	+ 12,500	+ 20,000	+ 25,000

All these points add towards reaching the next status level. You'll enjoy a variety of rewards at each status level and the healthier you get, the higher your status. At the start of every year, your points reset to zero, but you keep the rewards and status level that you earned the previous year. So, if you ended the year on Gold status, you start the new year on Gold status too. This is to encourage you to stay healthy year-on-year.



Your rewards in a snapshot

Balance makes a healthier lifestyle more accessible than ever before. Through the programme, you have access to a comprehensive network of healthy-lifestyle partners at significantly reduced costs.

Up to 15%

back on HealthyFood at Checkers or Woolworths.



Up to 15%

back on thousands of HealthyCare items at Clicks or Dis-Chem stores.



You get exclusive access to **Active Rewards** for free. Active Rewards is a free in-app wellness programme that encourages you to get active and rewards you for doing so.

Up to 15%

upfront discount on qualifying sports gear and equipment from Sportsmans Warehouse and Totalsports.



30% off

your monthly gym fees from Virgin Active or Planet Fitness.



Up to 80% off

Allen Carr's Easyway To Stop Smoking.



Track your workouts through Active Rewards using your device and earn points for step count, heart rate and speed. You may link multiple devices to your profile, however, we'll only award points for the highest points-earning fitness and health activity for the day.

Activate your Balance benefit today, get healthy and get rewarded. Visit www.balancesa.co.za for more.

**Terms and conditions apply*

IMPORTANT INFORMATION ABOUT BALANCE:

Bankmed Medical Scheme (Bankmed), registration number 1279, is an independent non-profit organisation registered with the Council for Medical Schemes. Balance is a separate health-management and wellness product developed specifically for Bankmed, offered to its members at no extra cost, and is administered by Discovery Vitality (Pty) Ltd (Vitality), registration number 1999/007736/07. Neither Balance nor Vitality are part of Bankmed.

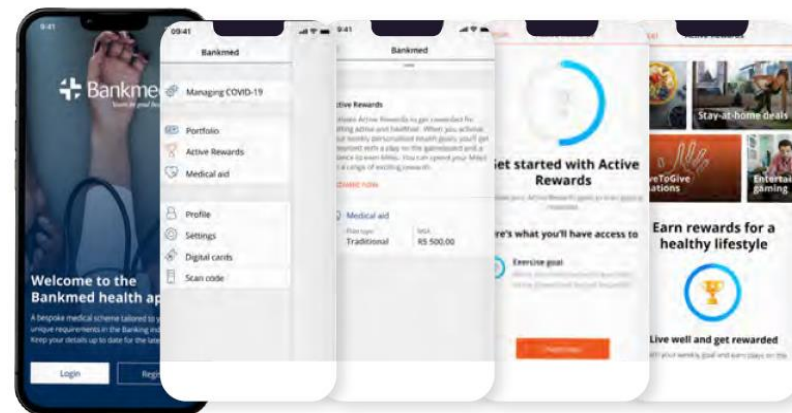
Active Rewards

As a Balance member, you get exclusive access to Active Rewards for free. Balance makes choosing to lead a healthy lifestyle even more rewarding. It offers you a science-based behaviour-change programme that helps you keep track of your progress towards a healthier you. All while rewarding you for making better choices with a range of health, lifestyle and leisure benefits.

How Active Rewards works

- Each week, you'll get a personalised exercise goal tailored to your unique fitness level.
- When you achieve your exercise goal, you'll get a play on your gameboard to reveal Miles.
- You can then redeem your Miles on a range of exciting rewards, from coffees, smoothies and snacks, to shopping and rewards.

Follow these steps to activate Active Rewards



Step 1

Log into the Bankmed App

Step 2

Select Active Rewards

Step 3

Click 'Get Started'

Step 4

Get Active and start earning points

Step 5

Reach your personalised exercise goals and earn rewards



Wellness and Preventative Care Benefits

We believe that good health is a true form of wealth, and understanding your health status is its foundation. Regular health screenings are essential for the early detection of medical conditions, allowing for timely and effective intervention that leads to better outcomes.

Optimal health extends beyond the absence of symptoms, as early signs of medical issues can be easily missed. If left untreated, conditions can worsen and eventually require costly surgeries or intensive medical care. Our Wellness and Preventative Care Benefits offer essential screenings for early detection and preventative care.

Key Points about Wellness and Preventative Care Benefits:

COVERAGE UNDER INSURED BENEFIT

- These benefits are covered by your Insured Benefits, and do not deplete your out-of-hospital insured sub-limits or your MSA, where applicable.
- Using a DSP ensures that you do not incur any co-payments.
- Healthcare Professional consultation costs are excluded and will be paid from your available day-to-day benefits.

ESSENTIAL SCREENING AND PREVENTATIVE CARE BENEFITS

- This benefit covers specific tests designed to detect early warning signs of serious illnesses.
- Screening tests include blood glucose, cholesterol, HIV, Pap smear for cervical screening, mammograms and/or ultrasounds, and prostate screenings.
- Tests are covered by the Screening and Preventative Care Benefit, ensuring proactive health management.
- Consultations not falling under PMBs are paid from available day-to-day benefits.

Our Wellness and Preventative Care Benefits give you the tools to proactively manage your health, ensuring early detection and intervention. These comprehensive screening benefits are part of our commitment to your long-term health.

We have summarised our screening benefits on the next page.



POSITIVE IMPACT OF WELLNESS INITIATIVES

- Beyond enhancing longevity and overall mental and physical wellbeing, wellness initiatives contribute to reducing healthcare costs.
- These initiatives lower absenteeism, boost productivity, decrease injuries, compensation, and disability-related costs.
- They foster a positive organisational culture by enhancing morale and loyalty.

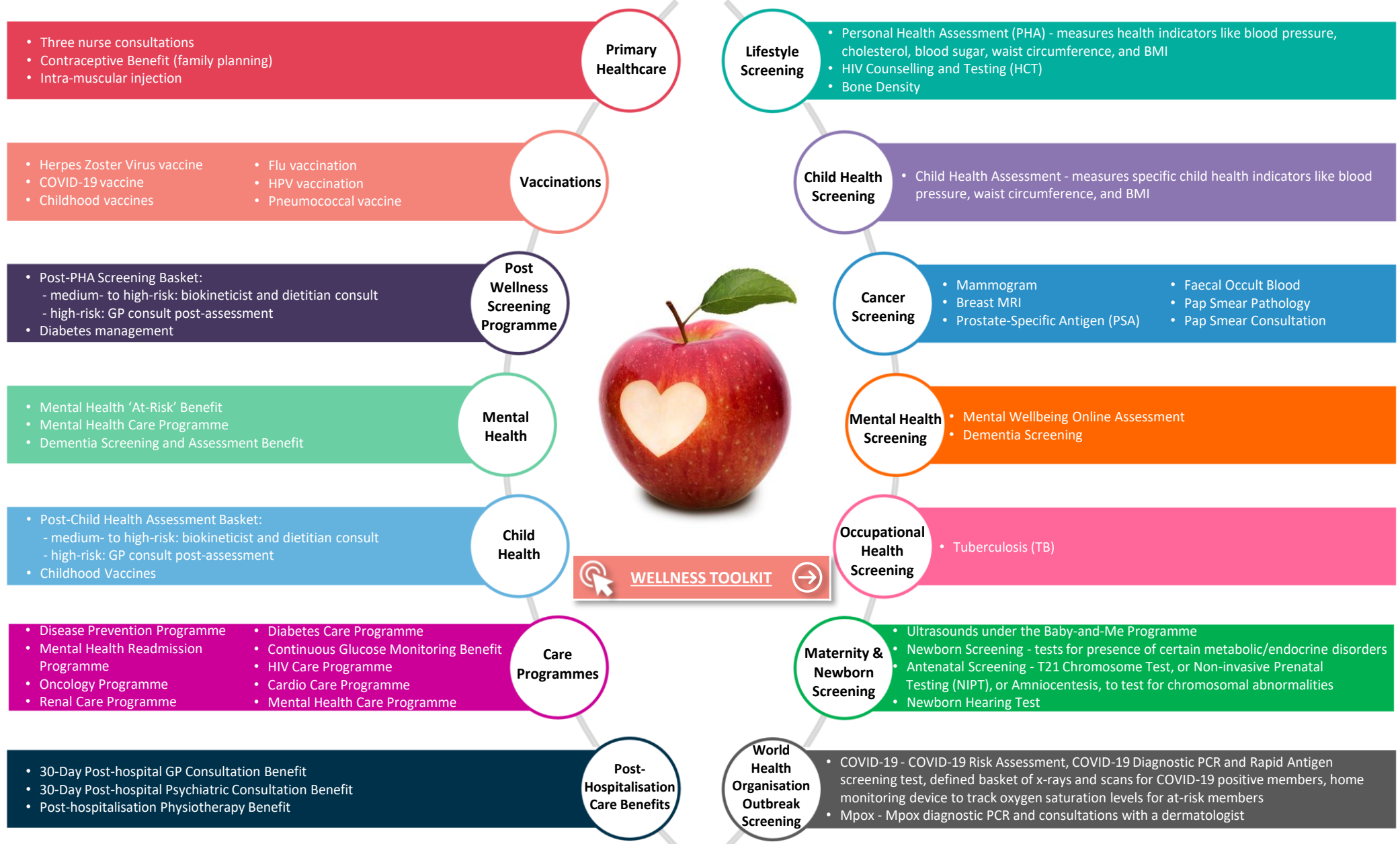
IMPORTANT

It is important to note that the Wellness and Preventative Care benefits are a proactive screening intervention to prevent and assist with early detection of an underlying medical condition. Bankmed Medical Scheme and our Administrator, Discovery Health (Pty) Ltd make every effort to ensure treatment and Disease Management Programmes are available to you post-screening based on your Plan of choice. Therefore, the Scheme, the Administrator or any other Healthcare Professional cannot accept responsibility or be held liable for any consequences that may result from neglect, non-compliance, and non-adherence to treatment. Participation is voluntary and at your own risk and therefore, Bankmed Medical Scheme, the Administrator, or any other Healthcare Professional will not be liable for any loss, damage, liability, claim, expense, or injury suffered or incurred by any person as a result of their participation in our Wellness and Preventative Care screening benefits.

Wellness and Preventative Screening, and Care Benefits Summary

PREVENTATIVE & CARE BENEFITS

SCREENING BENEFITS





DAY-TO-DAY BENEFITS AND COVER

We cover your day-to-day benefits from your Day-to-Day Insured Benefits, MSA and ATB, according to your Plan type.

WHAT ARE DAY-TO-DAY BENEFITS?

Day-to-day expenses include items such as medication, visits to your GP, X-rays, and blood tests.

- On the Plus, Comprehensive, and Core Saver Plans, we pay these expenses from your MSA.
- On the Traditional, Basic, and Essential Plans, we cover these expenses from the Insured Benefits, subject to limits.

WHAT ARE INSURED BENEFITS?

These are funded from the pool of member contributions, instead of using your personal MSA, if you have one.

MEDICAL SAVINGS ACCOUNT (MSA)

Available on Core Saver, Comprehensive and Plus Plans

The MSA is used to pay for day-to-day medical costs like GP visits, X-rays (radiology), medication and blood tests.

At the start of each 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 2025, we calculate your MSA amount for the rest of the year by multiplying the monthly amount you contribute towards your MSA, by the number of months left in the year.

If you leave Bankmed and have spent more of your MSA than what you have contributed during the year, you will need to pay a portion of the MSA back to Bankmed. We call this a clawback.

Choose your MSA reimbursement rate

You can choose between Cost or Scheme Rate. Cost fully covers eligible claims, including out-of-network ones. Scheme Rate limits coverage to the Scheme Rate and within benefit limits. New members default to the Scheme Rate if no choice is made, but they can switch between options anytime.





Above Threshold Benefit (ATB), Annual Threshold and Self-Payment Gap (SPG)

 *Plus Plan exclusive features*

ATB

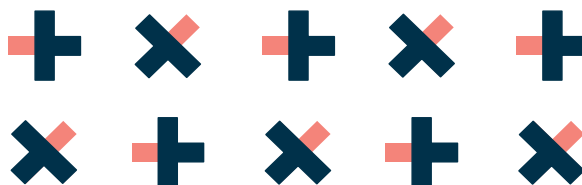
- Provides cover for out-of-hospital treatment for Plus Plan members who reach the Annual Threshold.
- This is an Insured Benefit which is accessed only after reaching the Annual Threshold with specified limits.
- ATB offers additional cover when the yearly MSA amount is depleted.

ANNUAL THRESHOLD

- Calculated based on the number of dependants on the membership, limited to three children.
- We use the Scheme Rate, instead of the cost of medication or treatment, to calculate when you reach the Annual Threshold. When claims are paid at 100% of the Scheme Rate from your MSA and add up to the Annual Threshold, you can access the ATB.
- Claims at 100% of the Scheme Rate from the MSA contribute to reaching the Annual Threshold, unlocking the ATB.

SPG

- An SPG will occur when your MSA is depleted, and you have not yet reached your Annual Threshold.
- You will need to pay claims during the SPG from your own pocket, until the Annual Threshold is reached.
- You must continue to submit claims to the Scheme during this period as these will accumulate towards reaching the Annual Threshold.
- Remember that claims accumulate to the Annual Threshold at 100% of the Scheme Rate. However, you can choose to fund claims at cost from your MSA. If your Healthcare Professional charges more than the Scheme Rate, the difference between the claimed amount and the paid amount contributes to your SPG.



LIMITS TO AMOUNTS ADDING UP AND BENEFIT CATEGORIES

There is a limit to how much of your MSA you can use to pay for specific categories of treatments, which adds up to the Annual Threshold. Some of the categories are:

- Prescribed acute medication (short-term medication).
- Claims for tooth and gum care (including preventative 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. Ask your Healthcare Professional about the available DSP lens options which are covered in full.

Your general limits for the categories can be more than the limits for the ATB. However, we do not pay out more than your family limit for the ATB.



IMPORTANT

Both the Annual Threshold and the ATB are pro-rated (reduced) if a member joins after 1 January each year. This is calculated by dividing the total Annual Threshold and ATB for the year by 12 and multiplying these amounts by the remaining number of months in the year. These amounts are recalculated when a dependant is added or removed during the year, or when a child dependant becomes an adult dependant (and will have to pay the rate for an adult dependant). There is no clawback (debt owing to the Scheme) on overspend on ATB if a dependant is removed or a member resigns during the year.

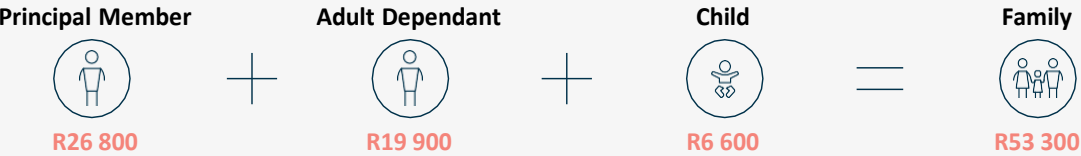
2025 ATB AND ANNUAL THRESHOLD

Annual Threshold			
	M	A	C
Threshold Level	R26 800	R19 900	R6 600
Threshold Amount	R24 000	R18 100	R6 000

*Limited to three children.

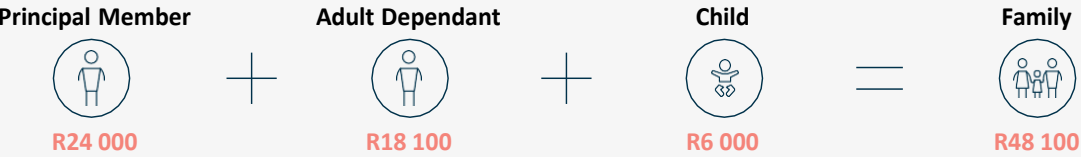
How to calculate the Annual Threshold

The Annual Threshold is a combined family threshold and is calculated by adding the threshold level amount for each family member together. See example below:



How to calculate the ATB

The ATB is a combined (family) limit and is calculated by adding the threshold amount for each family member together. See example below:



Please note that the 2025 benefits and contributions are subject to approval by the Council for Medical Schemes.

Day-to-day benefits

	Medical Savings Account (MSA)	Day-to-day benefit funding	How the funding works
Plus Plan	Yes	MSA ATB	- All day-to-day claims are paid from your MSA until the Annual Threshold is reached. After reaching the Annual Threshold, access to the ATB provides additional cover for high out-of-hospital expenses. - ATB covers GP and specialist consultations, in-room procedures, acute medication, blood tests, X-rays, basic and advanced dentistry, orthodontics, hearing aids, and other specified services. - Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
Comprehensive Plan	Yes	MSA	- Day-to-day claims, including GP and specialist consultations, acute medication, blood tests, and X-rays, are paid from your MSA. - In-room procedures by GPs or specialists, and basic dentistry, are funded from Insured Benefits with no set limits. - Advanced dentistry, orthodontics, hearing aids, and specific categories have limited coverage under Insured Benefits. Once limits are reached, expenses are covered from available MSA funds. - Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
Traditional Plan	No	Insured Benefits	- Day-to-day benefits, including GP and specialist consultations, acute medication, X-rays, blood tests, basic and advanced dentistry, orthodontics, hearing aids, and other categories, are covered by the Insured Benefit up to Plan limits. Unlimited coverage is provided for procedures performed by GPs and specialists in their rooms. - Limited cover is available for eye tests, glasses, or contact lenses every two years. - Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
Core Saver Plan	Yes	MSA	- Unlimited PMB cover when using network GPs or specialists and following the recommended care. Chronic Illness Benefit registration is required for chronic conditions. - Two non-PMB consultations covered by Insured Benefit, then day-to-day expenses use MSA funds. - MSA covers non-PMB expenses like dentistry, eye care, and acute medication. Limited cover for acute medication from pharmacists. - Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
Basic Plan	No	Insured Benefits	- Unlimited cover for GP consultations, acute medication from the formulary, and basic dentistry via the Bankmed Dental Network. No reimbursement for basic dentistry from non-preferred providers or treatments not on the formulary; advanced dentistry and orthodontics not covered. - Limited eye care benefits available every two years through the Bankmed Optometry Network. - Additional benefits up to a specified limit when using a Bankmed Entry Plan Network GP or with a referral to another network Healthcare Professional. - Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
Essential Plan	No	Insured Benefits	Cover limited to PMBs

Benefit Terminology:

- Acute medication (short-term prescriptions)
- Blood tests (pathology)
- X-rays (radiology)
- Basic dentistry (dentist consultations, teeth cleaning, and fillings)

MATERNITY BENEFITS

Cover for pregnancy and childbirth



IN-HOSPITAL COVER GUIDELINES

Hospitalisation and associated in-hospital services require pre-authorisation. Failure to obtain pre-authorisation may result in the loss of benefits or incurring co-payments.

- Hospitalisation and associated in-hospital services require pre-authorisation. Failure to obtain pre-authorisation may result in the loss of benefits or incurring co-payments.
- You must use a DSP to ensure full coverage at the contracted rate. If you do not use a DSP, claims may not be paid in full. Prior authorisation for admission is essential, and you should contact us at 0800 BANKMED (0800 226 5633).

MATERNITY BENEFITS COVERED BY BANKMED

- Midwife care and delivery.
- Birthing facilities as an alternative to hospitalisation.
- Cost of disposables are limited to R1 440 for each case.
- Out-of-hospital cover includes certain pregnancy-related expenses based on your Plan benefits.
- Antenatal and post-natal care includes services of GPs, specialist consultations, and procedures performed in the Healthcare Professional's rooms.
- Ultrasonic investigations are limited per Plan type.
- Pathology tests.
- Newborn screening test:
 - Available to all newborns to detect certain metabolic and endocrine disorders.
 - Clinical entry criteria and Plan limitations apply.

- Newborn hearing test:
 - Funding only covers the test, provided by a registered Audiologist.
- Plan limitations apply.
- T21 chromosome test or non-invasive prenatal test (NIPT):
 - Clinical entry criteria and Plan limitations apply; applicable to high-risk beneficiaries aged 35 years and older at delivery.
 - If a T21 test is positive, the Healthcare Professional may refer for NIPT, and Bankmed will fund both tests, subject to pre-authorisation.
- Amniocentesis:
 - Clinical entry criteria and Plan limitations apply.
 - Any registered pathologist may perform the test, subject to gynaecologist referral.

ITEMS NOT COVERED

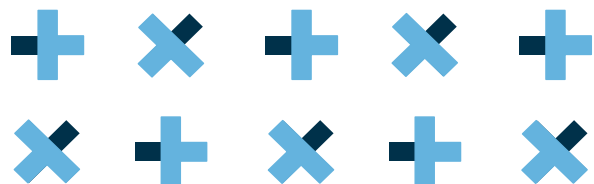
- Mother and baby packs supplied by the hospital.
- Bed-booking fees required by certain hospitals.
- Lodger or boarder fees if your baby needs an extended stay in the hospital and you choose to stay on.

ADDITIONAL INSURED BENEFITS

- Additional Insured Benefits are subject to registration on the Bankmed Baby-and-Me Programme.

IMPORTANT:

Please refer to the Plan Tables for specific limitations and requirements pertaining to maternity benefits on your Plan.





Bankmed's Baby-and-Me Programme

Bankmed's dedicated maternity programme, Baby-and-Me, offers enhanced coverage for pregnancy and childbirth. Access to this programme is exclusive to members on the Basic, Core Saver, Traditional, and Comprehensive Plans. Unfortunately, members on the Essential and Plus Plans are not eligible for the additional coverage provided by the Insured Benefit.

KEY BENEFITS AND REASONS TO JOIN

- Additional coverage from the Insured Benefit during pregnancy, for services such as ultrasounds and consultations.
- Guidance and support from a client relationship manager throughout your pregnancy and postpartum period.

UPON REGISTRATION, YOU RECEIVE

- A Bankmed baby hamper*, redeemable at any Toys R Us or Babies R Us store nationally.
- Extra coverage beyond the standard benefits.
- Regular communication at different milestones throughout your pregnancy.
- Assistance with hospital pre-authorisation.
- A comprehensive hospital checklist to prepare you for your hospital stay.

**Note: The contents of the Bankmed baby hamper are subject to change without notice based on stock availability.*

ADDITIONAL INSURED BENEFITS

Additional Insured Benefits are subject to registration on the Bankmed Baby-and-Me Programme. All additional Insured Benefits require a referral from a GP within the Bankmed GP Network.

Coverage details for Basic, Core Saver, Traditional, and Comprehensive Plans

- Six antenatal consultations per pregnancy at applicable rates for both GP and specialist in-room consultations.
- Three 2D ultrasounds covered at 100% of the Scheme Rate.
- A reimbursement of R1 770 (per pregnancy) for antenatal and postnatal classes.
- Additional pathology tests covered at 100% of the Scheme Rate, subject to the Baby-and-Me Programme Basket-of-Care.

HOW TO JOIN

Complete the Baby-and-Me application form to join the programme:

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



HIV NUTRITIONAL & MOTHER-TO-CHILD FORMULARY



CHRONIC ILLNESS BENEFIT

You are covered for 27 chronic conditions (including HIV and AIDS). You must register on the CIB. Once approved we will start paying for your chronic medication. If you do not register, we pay for your chronic medication from your day-to-day benefits.

MEDICATION ADVISORY SERVICES

Core Saver, Traditional, Comprehensive and Plus Plans

We aim to provide structure and ensure your chronic medication is effective. Our efficient pre-authorisation process combines advanced technology with medical expertise to assess applications according to clinical guidelines.

HOW TO REGISTER

We ask your treating Healthcare Professional about your condition and may request test results or additional proof to confirm eligibility for coverage.

Core Saver, Traditional, Comprehensive and Plus Plans

To get authorisation for immediate chronic medication, your Healthcare Professional or pharmacist can contact Bankmed on 0800 13 23 45.

Alternatively, ask your treating Healthcare Professional to fill in a registration form. E-mail the completed form to chronic@bankmed.co.za.

Essential and Basic Plans

Ask your treating Healthcare Professional to fill in a registration form. E-mail the completed form to chronicbasicesential@bankmed.co.za.

TIPS FOR EXTENDING YOUR BENEFITS

When applying to join the CIB, we recommend that your Healthcare Professional prescribes a generic version of your medication. Generics help lower your claim costs, extend your benefits, and reduce the chance of a co-payment at the pharmacy.

By law, only you and your Healthcare Professional can decide on your treatment. We will not change your medication without your Healthcare Professional's approval.

Essential and Basic Plans

To ensure coverage, you must use medication from our approved list (formulary). Please consult your Healthcare Professional and check the Bankmed website or App to confirm if the medication is on the formulary.

Core Saver, Traditional, Comprehensive and Plus Plans

Should the medication you require not be included in our approved medication list (formulary), you may be responsible for a portion of the expenses, even if it is a generic drug. Please speak to your Healthcare Professional and consult the Bankmed website or App to check if the medication is on our formulary.

CHOOSE MEDICATION WISELY

As per the International Generic Pharmaceutical Alliance, generics are 20 to 90 percent more cost-effective than original medications. Ask your pharmacist about generics and their costs.

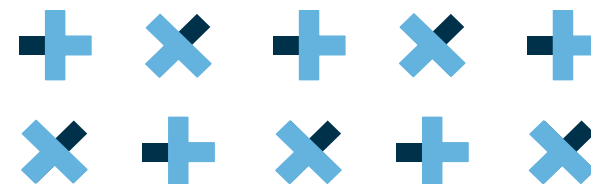
You can also save by choosing one medication that treats multiple symptoms.

What is generic medication?

A generic medication has the same active ingredients, dosage, strength, and intended use as the original but comes in different packaging and is usually more affordable. The original medication's higher cost is due to exclusive selling rights, which expire when the patent does, allowing generics to be produced.

For PMB conditions, medication is covered at 100% of the Scheme's Medication Reference Price if obtained from a Designated Service Provider (DSP), such as a Bankmed Network GP or Bankmed Pharmacy Network.

If voluntarily obtained from a non-DSP, it's covered at 80%. Involuntary non-DSP purchases are covered at cost, pending the Scheme's review. All medication must be on the Scheme's approved Condition Medication List (CML).



THE CDL COVERS SPECIFIC CONDITIONS

The CDL specifies the medication and treatment for the 27 chronic conditions covered under the PMBs. This list applies to all members on all Bankmed Plans.

- Addison's Disease
- Epilepsy
- Asthma
- Glaucoma
- Bipolar Mood Disorder
- Haemophilia
- Bronchiectasis
- Hyperlipidaemia
- Cardiac Failure
- Hypertension
- Cardiomyopathy
- Hypothyroidism
- Chronic Renal Disease
- Multiple Sclerosis
- Chronic Obstructive Pulmonary Disease
- Parkinson's Disease
- Coronary Artery Disease
- Rheumatoid Arthritis
- Crohn's Disease
- Schizophrenia
- Diabetes Insipidus
- Systemic Lupus Erythematosus
- Diabetes Mellitus Type 1 & 2
- Ulcerative Colitis
- Dysrhythmias
- HIV/AIDS (anti-retroviral therapy)

You must obtain pre-authorisation, ensure your treatment follows clinical protocols, and register on our CIB for PMB cover. If you do not, your treatment will be funded from your day-to-day benefits, where applicable. After reaching the limit for chronic medication, we will only provide funding for medication for PMB conditions, in accordance with PMB regulations.

Additional Disease List (ADL): Applies to Traditional, Comprehensive and Plus Plans

Prescribed medication will be covered in terms of the Scheme rules of the abovementioned Plans' ADL if the required criteria are met:

- Acne
- Allergic Rhinitis
- Alzheimer's Disease
- Ankylosing Spondylitis
- Anxiety Disorder (Chronic)
- Atopic Dermatitis (Eczema)
- Attention deficit disorder
- Cystic Fibrosis
- Depression
- Gastro-oesophageal reflux disease
- Gout
- Interstitial Lung Fibrosis (covered on Comprehensive and Plus Plans only)
- Meniere's Disease (covered on Comprehensive and Plus Plans only)
- Motor neuron disease
- Osteoarthritis
- Osteoporosis
- Paget's disease
- Psoriasis

Benefits for chronic medication, drugs, and injection material subject to:

- Prior application and approval by the Scheme.
- The conditions applicable to the Medicine Management Programme.
- Each prescription or repeat prescription limited to one month's supply per beneficiary.
- Motivations and reports by appropriate Healthcare Professionals, as required by Scheme.
- PMB regulations.
- Scheme-approved Condition Medication List (CML).

Dispensing fee limited to the contracted dispensing fee applicable to Bankmed GP Network GPs and Bankmed Pharmacy Network (DSPs). Continued benefits for PMBs, subject to the PMB Regulations. Benefits for non-PMB conditions are detailed in the applicable annexures, subject to PMB Regulations.

Additional Disease List (covered on the Basic Plan only)

- Major Depression.

Medication prescribed for the treatment of the PMB conditions are paid at 100% of Scheme Medicine Reference Price when the medication is obtained via the Scheme's DSP (Bankmed GP Entry Plan Network GP and Bankmed Pharmacy Network). This medication is paid at 80% of the Scheme Medicine Reference Price when the medication is obtained via a non-DSP on a voluntary basis. If the medication is obtained via a non-DSP on an involuntary basis, the medication will be funded at cost, subject to Scheme's review of a valid motivation. Medication is subject to the Scheme's approved Formulary/Condition Medication List.

Benefits for chronic medication, drugs, and injection material subject to:

- Prior application and approval by the Scheme.
- The conditions applicable to the Medicine Management Programme.
- Each prescription or repeat prescription being limited to one month's supply per beneficiary.
- Such motivations and reports by appropriate Healthcare Professionals, as are required by the Scheme.
- PMB regulations.
- Scheme-approved Formulary/Condition Medication List.

Dispensing fee limited to the contracted dispensing fee applicable to Bankmed GP Entry Plan Network GPs and Bankmed Pharmacy Network (DSPs).

BANKMED'S CARE PROGRAMMES

Spinal Conservative Care Programme

OVERVIEW

Back pain is one of the most common medical conditions experienced by our members. Appropriate out-of-hospital conservative management for back pain has proven to deliver good outcomes and could prevent the need for surgery. This programme will help you manage your condition with the support of a network of Healthcare Professionals that specialise in the treatment and rehabilitation of back and neck pain. The Spinal Conservative Care Programme is available on all Bankmed Plans.

SUBJECT TO CLINICAL ENTRY CRITERIA

- If you meet clinical entry criteria after a recent hospital stay or request for a spinal-related hospital admission and are deemed to be at high risk for spinal surgery. You are then eligible for an assessment, which will be performed by a chiropractor or physiotherapist in the conservative care network.
- If a GP refers you to a Spinal surgeon in the conservative care network, and the surgeon recommends you for non-surgical conservative treatment.
- The Healthcare Professional will enrol you on the programme using HealthID if you meet the clinical entry criteria after assessment.

To allow your chosen Healthcare Professional to access your medical records on HealthID, you need to provide consent under 'Digital Tools' by selecting 'Provide Your Doctor Consent'. This enables you and your doctor to set key goals and monitor your progress together through the programme.

MANAGING YOUR CONDITION WITH YOUR HEALTHCARE PROFESSIONAL

The Spinal Conservative Care Programme offers a defined Basket-of-Care for consultations with network physiotherapists or chiropractors over six to 12 weeks, either in person or via the Bankmed Connected Care platform. Your Healthcare Professional will determine the best treatment for you. Once enrolled, consultations are fully covered without affecting your day-to-day benefits. Additional conservative care services outside the approved Basket-of-Care will be covered according to your chosen Plan's benefits.

FIND A NETWORK PHYSIOTHERAPIST OR CHIROPRACTOR

1. Bankmed Website

On the Bankmed website, go to 'Digital Tools' and select 'Find a Healthcare Professional'. Enter the category (e.g. Physiotherapist) and your address, then click 'Search'. To filter for the Spinal Conservative Care Programme, tick the 'Care Programmes' filter and select 'Spinal Conservative Care'.

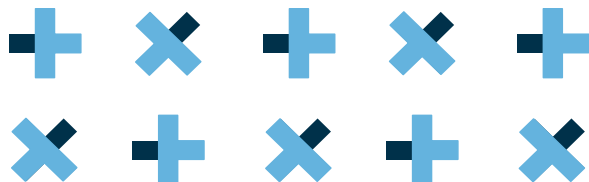
2. Log in to your Bankmed App

On the Bankmed App, go to 'Digital Tools' and select 'Find a Healthcare Professional'. Enter the name or category (e.g. Chiropractor), then choose 'Filters'. Under 'Care Programmes', select 'Spinal Conservative Care', return to the search page, and click 'Apply'.

YOUR COVER ON THE PROGRAMME

If you are enrolled on the Spinal Conservative Care Programme:

- Any additional conservative healthcare services, outside of the sessions approved as part of the defined Basket-of-Care, will be covered in accordance with your chosen Plan benefits.
- If you change conservative care network Healthcare Professionals, we continue counting the sessions from where you left off with your first Healthcare Professional. Your cover does not reset with the new Healthcare Professional.
- If you stop the programme, we do not pay further costs.
- Where clinically appropriate, your conservative care network Healthcare Professional can refer you for further assessment with a network spinal surgeon. If you need to have surgery, the Spinal Conservative Care Programme will end.
- You are eligible for the Spinal Conservative Care Programme only once per year, even if your condition recurs or a new area of concern arises.
- If you have had spinal surgery in the past 12 months, you do not qualify for the programme.



Advanced Illness Benefit (AIB)

The AIB provides access to comprehensive palliative care for members who have an advanced illness. A multidisciplinary team provides care in the comfort of the member's own home or in a hospice facility. The AIB is available on all Plans.

ENROLLING IN THE AIB

Your Healthcare Professional will initiate your AIB enrolment by completing the application form available on www.bankmed.co.za and e-mailing it to AIB@bankmed.co.za. Access is voluntary and subject to clinical entry criteria.

KEY FEATURES OF THE AIB

The AIB provides funding for palliative care for members in advanced stages of illness, where curative treatment has ended. It includes a comprehensive care plan focused on symptom management. Once approved, you will have access to the AIB benefits.

BENEFITS OVERVIEW

Support from a dedicated care coordinator:

Upon registration, a dedicated care coordinator, who is a registered nurse, will work with you or your family. They will provide support, collaborate with your GP and/or specialist, and ensure you receive optimal care.

Personalised support and counselling:

Members and their families enrolled in the AIB have access to counselling services for essential support during difficult times.

Comprehensive home-based care:

AIB members qualify for personalised home-based services, including medical care from palliative-trained Healthcare Professionals, rental of home oxygen concentrators, pain management, psychosocial support, and limited bereavement counselling for the family.

Specialised telephonic support:

Enrolled members can contact 011 529 6797 during working hours for assistance with AIB-related authorisations, oxygen, or benefit and claims-related inquiries.

COVER DETAILS

- The AIB covers services provided by a multidisciplinary team and will not impact your day-to-day benefits.
- Payments are made at the Scheme Rate from your Hospital Benefit.
- Palliative care services must be provided by registered Healthcare Professionals with valid BHF registration numbers and appropriate tariff codes. Ensure that accounts contain the correct ICD-10 (diagnosis) codes for smooth claims processing.

NOMINATION AND ASSISTANCE

You have the option to nominate someone to assist in managing your medical aid by completing a Third-Party Consent application form available on www.bankmed.co.za

ADVANCED ILLNESS MEMBER SUPPORT PROGRAMME (AIMSP)

The AIB provides members with advanced cancer access to a comprehensive range of out-of-hospital palliative care benefits. Through AIMSP, members engage with a dedicated team, including a social worker, counsellor, and palliative care GP, to understand their illness, explore care options, and create a personalised care plan. Research shows that early discussions about care plans increase the likelihood of members receiving appropriate end-of-life care when needed.

Disease Prevention Programme

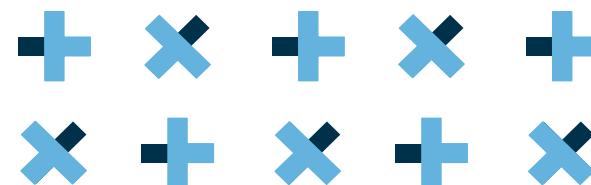
The Disease Prevention Programme aims to enhance access to care and improve health outcomes. All adult dependants across all Plans are eligible and identified through a PHA. High-risk members for diabetes may qualify for enrolment.

ENROLMENT PROCESS

Our predictive model assesses your PHA results, health claim patterns, family history, and other data to determine your diabetes risk. Eligible members are contacted by a Health Coach and referred to a Premier Plus GP for confirmation. Your GP will register you on HealthID and connect you with a dietitian.

Together, your GP, dietitian, and Health Coach will support you in preventing diabetes progression.

The Health Coach will assist with behavioural changes, and you'll have access to a Basket-of-Care for consultations and pathology tests. Coverage depends on clinical criteria, guidelines, protocols, and preferred providers, paid up to the Scheme Rate.





Kidney Care Programme

Chronic kidney disease manifests when the kidneys operate below expected levels, impacting crucial functions such as waste excretion, electrolyte balance, and hormone production. This condition can be congenital (you were born with it) or acquired due to factors like high blood pressure, diabetes, HIV, or ageing. Chronic kidney disease often progresses silently, without prominent symptoms. Diagnosis typically occurs at advanced stages, hindering early intervention.

HOW TO REGISTER

- If you are diagnosed with kidney disease, you must apply for Bankmed's CIB. The application form must be completed by your treating Healthcare Professional and can be returned to Bankmed via e-mail or via HealthID.

COVER FOR RENAL DIALYSIS SERVICES

- Coverage for renal dialysis services varies based on your chosen Plan type and is payable up to the Scheme Rate. By using Healthcare Professionals in the dialysis network, you can ensure full coverage and avoid co-payments. However, you can receive dialysis at any dialysis Healthcare Professional. We will pay your claims up to the Scheme Rate if you have pre-authorized your treatment.

Cardio Care Programme

WHAT IS CARDIOVASCULAR DISEASE

Cardiovascular disease (CVD) is a leading cause of death globally. Individuals at risk of CVD may have raised blood pressure, raised glucose levels, high cholesterol or be overweight or obese. Four lifestyle factors increase the risk of fatal complications of CVDs: tobacco use, physical inactivity, an unhealthy diet, and increased alcohol use.

THE CARDIO CARE PROGRAMME

The Cardio Care Programme is designed to offer you optimal cover that ensures the best quality care and outcomes. The Cardio Care Programme enables your Premier Plus GP to diagnose and initiate appropriate treatment, while managing your risk factors with the support of a high- functioning, multidisciplinary care team. To access the programme, you must consult with a Premier Plus GP and be registered for at least one of the following conditions as part of the CIB:

- Hypertension
- Ischaemic heart disease
- Hyperlipidaemia

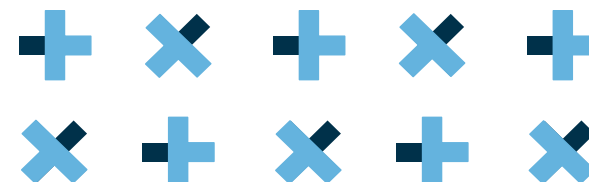
KIDNEY CARE PROGRAMME

Recognising the challenges of managing chronic kidney disease, Bankmed's Kidney Care Programme aligns with international best practice for enhanced care and quality of life. The programme benefits include:

- A calendar-based blood test schedule.
- Yearly reports with essential clinical information.
- An informative booklet for understanding and managing the condition.
- Additional support.

NOTE TO BASIC PLAN MEMBERS

You must choose a Healthcare Professional who is on both the Bankmed Entry Plan and Premier Plus GP networks.





COVER FOR CANCER

Bankmed's Oncology Programme: accessing cancer treatment coverage

 ***If you receive a cancer diagnosis and your cancer treatment is approved, the Oncology Programme provides comprehensive coverage. To benefit from this offering, you must enrol on the Oncology Programme.***

THE SCHEME COVERS APPROVED AND REGISTERED TREATMENT METHODS AND MEDICATION

The Scheme provides coverage for treatment methods and medications that are approved and registered. Cover excludes cancer treatment and related services that lack approval.

Unapproved or unregistered medications and treatments, as determined by the South African Health Products Regulatory Authority (SAHPRA), are not covered by the Scheme.

This includes treatments that haven't undergone sufficient testing and includes herbal or traditional remedies.

In unique circumstances where members may require such treatments, the Scheme allows for requests through an exception management process.

COVERAGE DETAILS ACCORDING TO YOUR PLAN

ESSENTIAL, BASIC, AND CORE SAVER PLANS

- Cover is extended only for approved PMB cancer treatments.
- Submission of your treatment Plan is required for cover approval.

TRADITIONAL, COMPREHENSIVE, AND PLUS PLANS

- Unlimited cover ensures continuous support for approved treatments.
- Submission of your treatment Plan is necessary for cover approval before your Healthcare Professional starts treatment.



COVERED TREATMENTS

We follow the guidelines established by the South African Oncology Consortium (SAOC), ensuring access to the most suitable treatment for your specific cancer stage.

Our coverage encompasses proven-effective treatments such as chemotherapy, radiotherapy, and other evidence-based healthcare services that align with cost-effectiveness.

AVOID CO-PAYMENTS BY USING OUR DSP NETWORKS AND NETWORK PROVIDERS

You can benefit by using Healthcare Professionals and other healthcare service providers such as hospitals, pharmacies, radiologists, and pathologists on our network, because the Scheme will cover their approved procedures/services in full.

If your Healthcare Professional charges more than the amount the Scheme pays, you will need to pay the difference.

ONCOLOGY MEDICATIONS PHARMACY DSP

Bankmed has partnered with a leading Oncology Medications Pharmacy DSP to manage costs while ensuring comprehensive oncology benefits.

Please use our pharmacy Oncology Medications Pharmacy DSP for approved oncology medications to avoid a co-payment. Speak to your treating Healthcare Professional and confirm that they are using our Oncology Medications Pharmacy DSP for your medication for treatment in their rooms or in a treatment facility.

For approved oncology-related medication where your Healthcare Professional has provided a prescription, please use the Oncology Medications Pharmacy DSP.

To find an Oncology Medications Pharmacy DSP, use the [Find a Healthcare Professional](#) tool on our website to locate a DSP near you.

Our Oncology Medications Pharmacy DSP is a convenient medication-ordering service that allows you to order prescribed medication via SMS, the Bankmed website, and the Bankmed App.

ONCOLOGY MEDICATIONS PHARMACY DESIGNATED SERVICE PROVIDER (DSP) — 20% CO-PAYMENT APPLIES IN 2025

In 2024, Bankmed partnered with a leading Oncology Medications Pharmacy DSP to manage costs while ensuring comprehensive oncology benefits.

- The Oncology Pharmacy DSP was implemented in 2024, but with no penalties for using a non-network pharmacy.
- As communicated in 2024, a 20% co-payment applies when using non-network pharmacies in 2025.
- Please ensure that you speak with your Healthcare Professional about the DSP and use the [Find a Healthcare Professional](#) tool on our website to locate a DSP near you.

TO REGISTER OR LEARN MORE

For additional information or to initiate registration, please reach out to us through the following channels:

- E-mail: oncology@bankmed.co.za
- Call: 0800 BANKMED (0800 226 5633)

IMPORTANT NOTE

We strictly adhere to predefined criteria and do not provide payment for healthcare services that fail to meet all established criteria.





BANKMED'S MENTAL HEALTH CARE PROGRAMME

**Make mental wellbeing part of your
holistic approach to health**

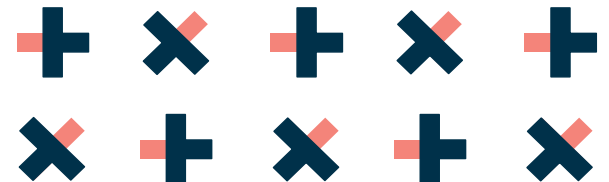
When you look after your body, you can ward off illness. The same goes for looking after your mind. Not taking care of your mental health could lead to the development of chronic illnesses such as diabetes, hypertension, anxiety, and depression, leaving you with long-term health damage.

Stress is a normal part of your daily life. However, stress left unmanaged over time can damage your mental and physical health and can impact on your family and work performance. Given the enormous role your mental health plays in your ability to function, it's important that you nurture it.

Scientific research and data tell us that we are much more productive, effective, happy, and healthy when we prioritise our own wellbeing. Bankmed offers you a comprehensive online Mental Wellbeing Assessment which includes:

- A psychological wellbeing assessment.
- A social support assessment.
- A stressor assessment.

Bankmed's Mental Health Care Programme, together with your Healthcare Professional, will help you actively manage episodes of Major Depression and Generalised Anxiety Disorder. This programme gives you and your Healthcare Professional access to tools and benefits to monitor and manage your condition and ensure you get high-quality, coordinated healthcare and the best outcomes. This programme is available on all Bankmed Plans.



Bankmed's Mental Health Care Programme

COMPLETE THE ONLINE MENTAL WELLBEING ASSESSMENT

Our online Mental Wellbeing Assessment is available at the click of a button on our website. Simply log in to www.bankmed.co.za and click on 'Manage your Plan' and then on 'Mental Wellbeing Assessment' to complete your Mental Wellbeing Assessment. If you are a Balance member, you can earn a total of 1 000 points — 500 points each time you do the assessment up to twice a year.



HOW TO JOIN THE MENTAL HEALTH CARE PROGRAMME

A Premier Plus GP or a psychologist in the Mental Health Care Programme network can enrol you on the programme, provided you give consent. Visit www.bankmed.co.za to find a Healthcare Professional on the network.



THE BANKMED MENTAL HEALTH CARE PROGRAMME OFFERING

On the Mental Health Care Programme, you and your Healthcare Professional have access to tools and benefits to monitor and manage your condition and to ensure you have access to coordinated care.

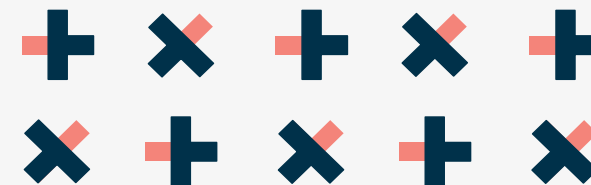
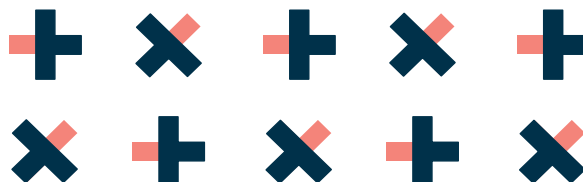
Your Healthcare Professional can track your progress on a personalised dashboard on HealthID. This will help to identify which areas may need attention so that your Healthcare Professional can improve the management of your condition.

The Mental Health Care Programme runs over a six-month period but can be extended to 12 months, where clinically appropriate.

BENEFITS AVAILABLE ON THE MENTAL HEALTH CARE PROGRAMME

When enrolled on the Mental Health Care Programme you will have access to the following benefits:

- Up to three consultations (virtual or face-to-face) with your enrolling Premier Plus GP.
- Psychotherapy consultations.
- When enrolled by a Premier Plus GP, you have access to antidepressant medication if you are on the Comprehensive, Traditional, Plus and Basic Plans.
- Members on the Essential and Core Saver Plans do not have access to antidepressant medication from this Programme.
- Members on the Comprehensive, Traditional and Plus Plans need to follow the MediKredit authorisation process so that their antidepressant medication can be funded from the Additional Disease List benefit.
- Members on the Basic Plan have access to selective serotonin re-uptake inhibitor (SSRI) antidepressant medication up to a monthly amount of R110.00.



Digital therapeutics: internet-based cognitive behavioural therapy (iCBT)

To improve access and quality of care, Bankmed introduced iCBT in 2024 for all members diagnosed with depression.

In 2025, this benefit is extended to those members who are diagnosed with Generalised Anxiety Disorder.

Digital therapeutics (DTx) is an emerging category of medical care where medical interventions, to treat, manage, and prevent a broad spectrum of diseases and disorders, are delivered directly to patients using evidence-based, clinically evaluated software (Digital Therapeutics Alliance).

The service is only available to members with diagnosed depression and/or Generalised Anxiety Disorder, and on the recommendation of a Healthcare Professional, where the diagnosis and treatment of depression and/or Generalised Anxiety Disorder are within their scope of practice (psychiatrist, psychologist, GP, and clinical social worker).

Benefits will be subject to your mental health benefits. You must be registered on the Mental Health Care Programme to access this benefit. Please refer to the Benefit Tables in this guide for details about limits.

BANKMED'S HIV CARE PROGRAMME

 **Bankmed's HIV Care Programme offers you comprehensive disease management if you are living with HIV and AIDS.**
Registration with the HIV Care Programme is required for access.

ACCESS TO CLINICALLY SOUND AND COST-EFFECTIVE TREATMENT

Bankmed's HIV protocols are based on the guidelines of the Southern African HIV Clinicians' Society and the South African Department of Health. Approval of HIV-related services is subject to PMB guidelines and individual benefits.

PREFERRED PHARMACY PROVIDER NETWORK FOR HIV MEDICATION

When registered on the HIV Care Programme you can obtain your monthly HIV medication from pharmacies within the preferred pharmacy provider network. Dispensing GPs are also an option. Any charges beyond the Scheme's coverage will require that you pay the difference.

CONFIDENTIALITY AND HOSPITALISATION

The HIV healthcare team ensures complete confidentiality in handling any HIV and AIDS-related queries or cases. When you register on the HIV Care Programme there are no limits on hospitalisation, but approval is necessary, and payment is governed by Bankmed Rules.

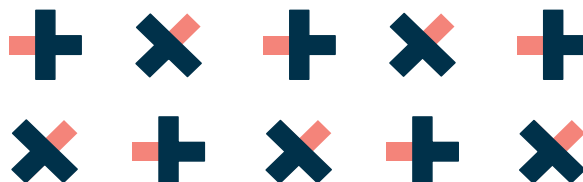
BANKMED COVERS A SPECIFIED NUMBER OF CONSULTATIONS AND HIV-SPECIFIC BLOOD TESTS

GP and specialist consultations

- When you register on the HIV Care Programme, Bankmed pays for four GP consultations and one specialist consultation per member per year for the management of HIV.

HIV monitoring blood tests

- Bankmed also pays for HIV-specific blood tests for you when you are registered on the HIV Care Programme. These tests measure how many copies of HIV (viral load) are present in the blood and how well the immune system is functioning and are instrumental in managing your response to treatment.



ANTIRETROVIRAL MEDICATION AND SUPPORTIVE TREATMENT

Bankmed covers antiretroviral medication from the HIV medication list (formulary) up to the Scheme Medication Rate or 100% of the MMAP (or Scheme Medication Rate if MMAP is unavailable). Supportive medication is funded based on clinical criteria.



PREVENTATIVE TREATMENT WITHOUT WAITING PERIODS

You have cover for preventative treatment in cases like sexual assault, mother-to-child transmission, trauma, or workmen's compensation without HIV waiting periods, provided treatment is pre-authorized.





NUTRITIONAL FEEDS FOR MOTHER-TO-CHILD PREVENTION

Bankmed covers nutritional feeds for babies born to HIV-positive mothers, following the HIV nutritional and mother-to-child prevention medication list (formulary).

PREMIER PLUS HIV GP NETWORK AND FULL COVER FOR HEALTHCARE PROFESSIONALS

Choosing a Premier Plus HIV GP within the network ensures additional cover, including social workers. Full cover is provided for GPs on the Premier Plus HIV GP Network and specialists with payment arrangements.

APPROVED MEDICATION AND PRESCRIPTION REQUIREMENTS

Bankmed covers approved medication on its HIV medication list, and you are responsible for any shortfall for unlisted medication or charges exceeding specified rates. Medication must be approved for coverage.

PRESCRIBED MINIMUM BENEFITS

HIV is a PMB condition. Full cover is ensured when using a DSP. Specific requirements must be met for accessing PMBs, and an appeals process is available for additional cover.

OUT-OF-HOSPITAL TREATMENTS AND APPEALS

Basic out-of-hospital treatments related to HIV infection are covered as PMBs. Additional cover can be appealed through a process outlined by Bankmed. Other out-of-hospital treatments are covered from available day-to-day benefits.

TO REGISTER OR LEARN MORE

For registration or additional information, please contact us through the following channels:

- E-mail: hiv@bankmed.co.za
- Call: 0800 BANKMED (0800 226 5633)



[HIV PROGRAMME APPLICATION FORM](#)



HIV self-testing

In line with the 1 December 2016 recommendation by the World Health Organisation that HIV self-testing be encouraged to help reach first-time testers and people with undiagnosed HIV, Bankmed provides you with access to an HIV self-testing screening benefit.

WHAT IS AN HIV SELF-TEST?

Self-testing is a quick, convenient, and confidential HIV-testing option which allows you to know your status in the privacy of your own home. HIV self-testing does not provide a final diagnosis or result. Instead, it is a screening test. A self-test is accurate, but a positive test needs to be verified with another blood-based test (confirmatory test). This can be done at a laboratory or with your Healthcare Professional. Order your kit on the website now.



[ORDER KIT NOW](#)



DISCLAIMER

The HIV/AIDS Programme is governed by Scheme Rules, and members must be familiar with these. Any medication instructions or advice should complement, not substitute, professional judgment. The Scheme retains the right to determine treatment coverage at any time.



DIABETES CARE PROGRAMME

Comprehensive Diabetes Care Programme

Living with diabetes requires continuous management and presents daily challenges. Our Diabetes Care Programme supports you with a dedicated team of Healthcare Professionals, offering high-quality, coordinated care to help improve your health outcomes.

Key Features:

- **Dedicated healthcare team:** A specialised team of Healthcare Professionals collaborates to deliver comprehensive care, tailored to your diabetes management needs.
- **Tools and additional benefits:** A range of tools and supplementary benefits aimed at monitoring and effectively managing your condition.
- **Dedicated care navigators:** Our programme includes dedicated care navigators, ready to assist with all your diabetes-related enquiries and needs.

PROGRAMME ENROLLMENT

If you are currently registered on the CIB for diabetes, access to our Diabetes Care Programme is a straightforward process facilitated by your chosen Premier Plus GP. For those not yet registered, simply approach your Healthcare Professional to enrol you.



FIND A HEALTHCARE PROFESSIONAL



HEALTHCARE PROFESSIONAL PARTNERSHIP IN MANAGING YOUR CONDITION

The Diabetes Care Programme follows internationally and locally-recognised clinical and lifestyle guidelines.

By collaborating with your network Healthcare Professional, you can:

- Set key health goals.
- Track progress via a personalised HealthID dashboard.
- View your Diabetes Management Score to identify areas needing attention.

We are dedicated to supporting you on your journey to effective diabetes management.

DIABETES CARE NAVIGATORS

Our Care Navigators guide you through your diabetes benefits

Managing diabetes is complex, but Bankmed's Diabetes Care Programme offers extra benefits and tools beyond the Chronic Illness Benefit. Research shows that coordinated care led by one Healthcare Professional, along with specialists like dietitians and podiatrists, delivers the best health outcomes. Our dedicated call centre is here to assist you.

How can your Care Navigator help you?

Our dedicated Care Navigator call centre is here to help you:

- Understand your cover for diabetes and diabetes-related care.
- Register for our digital tools and maximise your rewards.
- Choose and engage with allied Healthcare Professionals (such as dietitians and foot specialists - podiatrists).
- Remind you what benefits you have available.

To register, learn more, contact a care navigator, or check if your GP is on our network:

- E-mail: Members_DCP@bankmed.co.za
- Call: 0860 444 439

Please save these contact details if you are already registered for the Diabetes Care Programme. The care navigator call centre agents can answer any questions about your cover for diabetes.

COVER FOR CONTINUOUS GLUCOSE MONITORING (CGM) SENSORS

Continuous Glucose Monitoring (CGM) automatically tracks your blood glucose levels, allowing you to monitor them anytime for better management. Members with type-1 and type-2 diabetes are covered for CGM sensors when prescribed by a network Healthcare Professional, depending on your chosen Plan. Note that clinical entry criteria apply.

HOSPITAL BENEFITS & GOING TO HOSPITAL

Hospital care and procedures

HOSPITAL BUILDING VERSUS BEING IN HOSPITAL

We cover the costs of your treatment and care during a hospital stay through the Hospital Benefit. It's important to note that not all healthcare received within a hospital building is covered by the Hospital Benefit. A distinction is made between being hospitalised and visiting a Healthcare Professional with an office on the hospital premises.

When we refer to being 'in hospital', 'admitted to hospital', or 'hospitalised', it means you formally checked into the hospital at reception and have a designated hospital bed. In such cases, we cover the expenses for procedures and your entire hospital stay through the Hospital Benefit, without using your day-to-day benefits.

However, if you receive healthcare services within the hospital building (such as visits to the casualty unit, consultations with specialists, scans, and blood tests) without occupying a hospital bed, these are covered by your day-to-day benefits.

HOSPITAL PRE-AUTHORISATION

In case of an emergency hospital admission, please reach out to us for authorisation within 48 hours of the emergency admission. For planned procedures requiring hospitalisation, pre-authorisation is mandatory. As soon as you and your Healthcare Professional have finalised the admission date, contact us for pre-authorisation through one of the channels provided below:

- Call: 0800 BANKMED (0800 226 5633)
- E-mail: treatment@bankmed.co.za

You must provide the following information from your treating Healthcare Professional 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 cell phone number, we also send you an SMS with pre-authorisation details.

Pre-authorisation does not imply full coverage of all expenses during your hospital stay.

While pre-authorisation confirms that your hospital admission meets our clinical guidelines for funding, actual coverage depends on your Plan's limits and whether you use a Healthcare Professional within our network.

It's essential that you review your Plan's limits in this Benefit and Contribution Schedule and refer to the Scheme Rules on the website where required. If uncertain, please contact us at 0800 BANKMED (0800 226 5633) for benefit confirmation.

IT IS YOUR RESPONSIBILITY TO OBTAIN PRE-AUTHORISATION

If your Healthcare Professional obtains authorisation on your behalf, it is important to ensure that you receive comprehensive information about the authorisation directly from the Healthcare Professional. Bankmed cannot be held responsible if your Healthcare Professional fails to share this information with you. This includes information about:

- If your treating Healthcare Professional is a network Healthcare Professional or DSP.
- What we cover and what we do not cover.
- Upfront payments (deductibles) that need to be paid to the hospital before you receive treatment.
- How much you must pay yourself (co-payments and shortfalls).



HOW WE PAY YOUR TREATING HEALTHCARE PROFESSIONAL

The specifics of your benefits, including the rate of cover and limits, are outlined in this Benefit and Contribution Schedule. You must discuss the costs of the treatment with your treating Healthcare Professional and enquire if they charge the Scheme Rate.

In instances where they charge more than the Scheme Rate, you are responsible for covering the difference, known as a co-payment. Also, clarify whether other Healthcare Professionals, such as an anaesthetist or assistant, will be involved in your treatment and if they also charge the Scheme Rate.

PRE-ASSESSMENTS AHEAD OF PROCEDURES

Bankmed offers claim pre-assessments if you provide detailed quotes from your treating Healthcare Professional well in advance of your procedure.

Although a pre-assessment isn't a guarantee of cover, it helps identify potential cost differences between the professional's charges and the Bankmed Scheme Rate, highlighting possible shortfalls and co-payments.

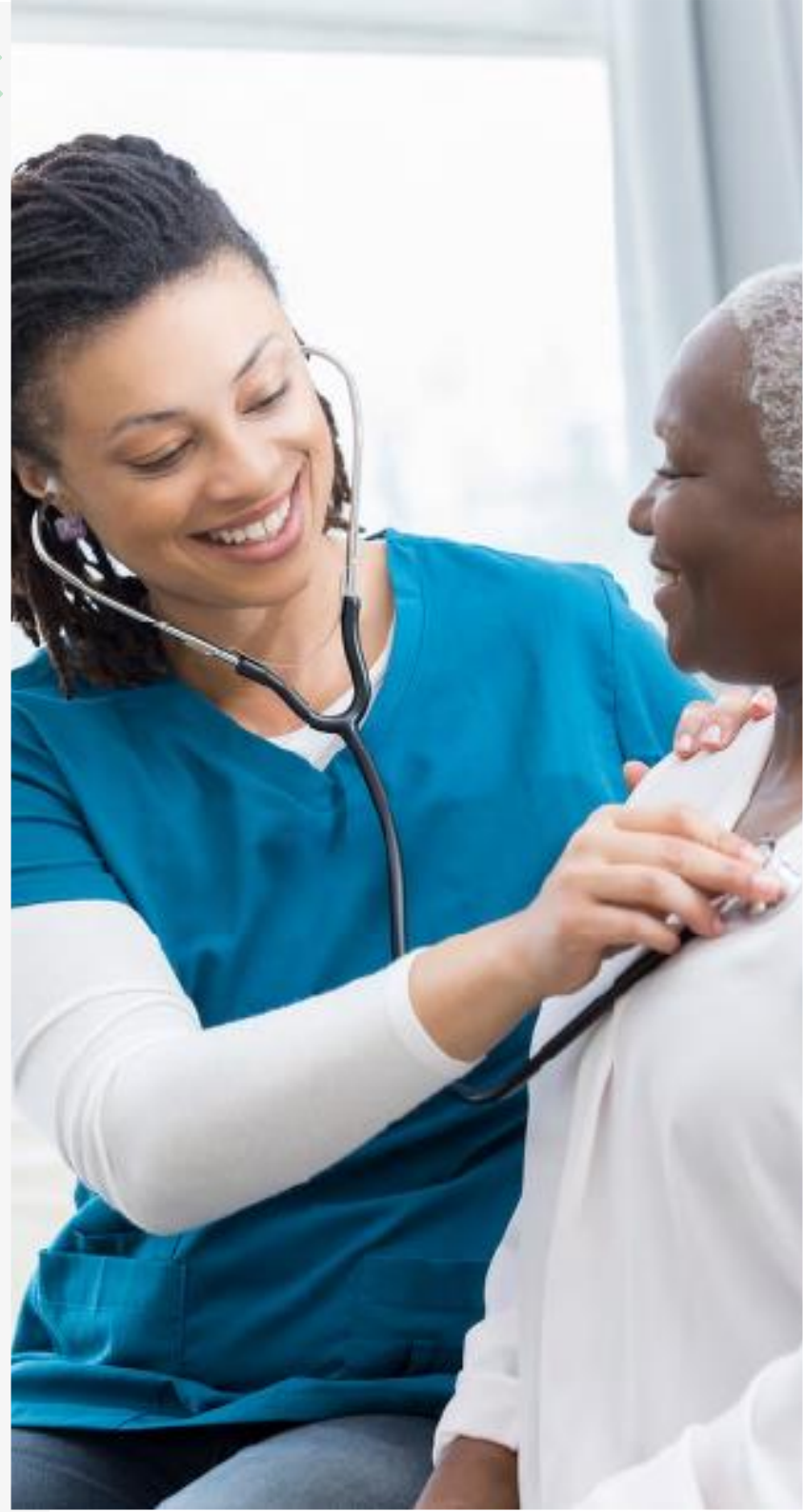
To avoid unexpected costs, we recommend negotiating tariffs upfront. When multiple procedures are done under one anaesthetic, Healthcare Professionals should apply reduced fees for subsequent procedures, according to industry guidelines. Ensure your Healthcare Professional follows these guidelines and discusses the charges with you beforehand.

UPDATE CONTACT DETAILS FOR YOU AND YOUR DEPENDANTS

- We send pre-authorisation letters to both you and your Healthcare Professional once approval is granted.
- The pre-authorisation letter we e-mail confirms the DSP status of your provider and facility.
- If your dependant is 18 or older, they will receive their own communication.
- These letters detail what Bankmed will and will not cover, so it's essential to ensure we have the correct e-mail addresses on file for both you and your dependants.
- Bankmed is not responsible for any issues arising from incorrect contact details.

DISCHARGE PLANNING

During your hospital stays, your Healthcare Professional and the hospital regularly inform us of any changes to your treatment plan and update your authorisation. If you require rehabilitation in other settings like step-down facilities or home nursing, a case manager will guide the transition. Cover for these services is based on your Plan's benefits.



DEDUCTIBLES

UPFRONT PAYMENT (DEDUCTIBLE)

You may have to pay an amount to a hospital or a day surgery facility before certain 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.

THE DAY SURGERY NETWORK DEDUCTIBLE

How the Day Surgery Procedure List and Day Surgery Network operate

- **Procedure performed is listed on the Bankmed Day Surgery Procedure List and is performed at a Bankmed Day Surgery Network Facility**
 - If you have one of the procedures listed on Bankmed's Day Surgery Procedure list performed in the Bankmed Day Surgery Network, you do not pay a deductible.
- **Procedure performed is listed on the Bankmed Day Surgery Procedure List and is NOT performed at a Bankmed Day Surgery Network Facility**
 - If you have one of the procedures listed on the Bankmed's Day Surgery Procedure list performed at a facility that is not in the Bankmed Day Surgery Network, you will pay a deductible of R4 100 per admission. This deductible will increase to R6 300 in 2025.



FIND A HEALTHCARE PROFESSIONAL



IMPORTANT NOTE FOR ESSENTIAL PLAN MEMBERS

If you are an Essential Plan member, you do not have access to the full list of treatments/procedures, as your cover is limited to PMB cover. As an Essential Plan member, if you have the PMB procedure/treatment performed at a facility not in the Bankmed Day Surgery Network (day surgery facility or hospital), you will be liable for a R6 300 deductible per admission.



Other hospitals (non-DSPS)

- PMB admission: involuntary use of a non-DSP: No deductible.
- PMB admission: voluntary use of a non-DSP: R6 300 per admission.
- Non-PMB admission: R6 300 per admission.
- The deductible is payable on admission.

Day surgery pre-authorisation

For planned procedures, pre-authorisation is mandatory. As soon as you and your Healthcare Professional have finalised the admission date, contact us for pre-authorisation through one of the channels provided below:

- Call: 0860 444 439
- E-mail: treatment@bankmed.co.za

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.

This deductible applies to all procedures not listed in the Bankmed Day Surgery Procedure List

BASIC, CORE SAVER, COMPREHENSIVE AND PLUS PLANS

- Day clinic: R325 for each admission.
- Hospital: R810 for each admission.

TRADITIONAL PLAN

- Day clinic: R325 for each admission.
- Hospital: R6 730 for each admission.

ESSENTIAL PLAN

- No cover outside our hospital and day clinic networks.



UPFRONT PAYMENTS (DEDUCTIBLES) FOR DENTAL ADMISSIONS

Cover for in-hospital tooth and gum (dental) treatment is only provided on the Traditional, Comprehensive, and Plus Plans. If you are on any other Plan, you are responsible for covering all procedures and associated costs.

TRADITIONAL, COMPREHENSIVE AND PLUS PLANS

- Day clinic: R325 for each admission.
- Hospital: R2 405 for each admission.

BASIC, ESSENTIAL AND CORE SAVER PLANS

No cover for dentistry performed in a hospital or day clinic.

ONLY ONE UPFRONT PAYMENT (DEDUCTIBLE) PER ADMISSION

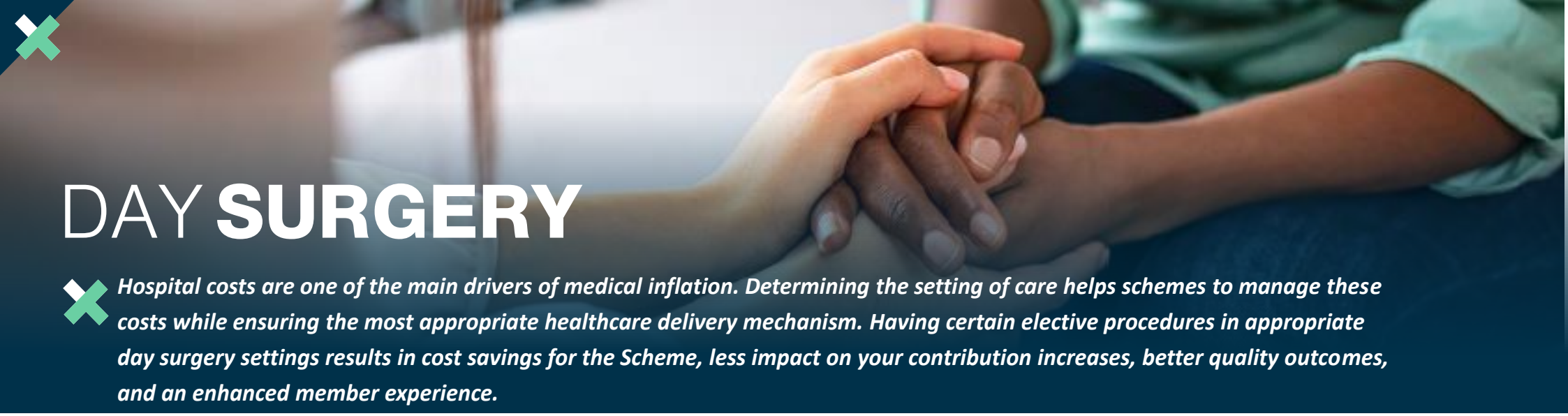
Example:

- A Traditional Plan member going to a non-network hospital (R6 730 upfront) for dental treatment (R2 405 upfront) pays R6 730 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 (R810 upfront) for dental treatment (R2 405) pays R2 405 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 PMB). If you do not use a network hospital or day clinic, and it is not a medical emergency, you must 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.





DAY SURGERY

 *Hospital costs are one of the main drivers of medical inflation. Determining the setting of care helps schemes to manage these costs while ensuring the most appropriate healthcare delivery mechanism. Having certain elective procedures in appropriate day surgery settings results in cost savings for the Scheme, less impact on your contribution increases, better quality outcomes, and an enhanced member experience.*

BANKMED HAS CREATED AN ENHANCED DAY SURGERY NETWORK

Bankmed's Day Surgery Network has been enhanced to include a defined list of contracted day surgery facilities as well as contracted acute hospitals providing day surgery facilities at day surgery rates.

You now have more choice when choosing a healthcare facility in our network.

Within the network, you have access to a defined list of medical and surgical procedures that can be performed on a same-day basis. A clinical exceptions process applies to all complex cases and those procedures that may need an extended length of stay.

Find a facility in our Day Surgery Network by using our 'Find a Healthcare Professional' tool on the website.

BANKMED'S DAY SURGERY PROCEDURE LIST

In 2025, our Day Surgery Procedure List has been expanded to include a host of additional procedures and treatments available at Bankmed's Day Surgery Network.

Our list has been published on the next page.

DAY SURGERY DEDUCTIBLE

If you have one of the procedures listed on Bankmed's Day Surgery Procedure list performed in the Bankmed Day Surgery Network, you do not pay a deductible.

However, if you have one of the procedures listed on the Bankmed's Day Surgery Procedure list performed at a facility that is not in the Bankmed Day Surgery Network, you will pay a deductible of R6 300 per admission in 2025.

Read more about deductibles in the Deductible section of this Benefit and Contribution Schedule.

DAY SURGERY PRE-AUTHORISATION

For planned procedures, pre-authorisation is mandatory. As soon as you and your Healthcare Professional have finalised the admission date, contact us for pre-authorisation through one of the channels provided below:

- Call: 0860 444 439
- E-mail: treatment@bankmed.co.za



Bankmed's Day Surgery Procedure list — 2025

1. Anorectal procedures
 - 1.1. Treatment of haemorrhoids, fissures, fistula
2. Biopsies
 - 2.1. Subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes
3. Colonoscopy
4. Cystourethroscopy
5. Ear, Nose and Throat Procedures
 - 5.1. Tonsillectomy and/or adenoidectomy
 - 5.2. Simple procedures for nosebleed (extensive cautery, nasal plugging)
 - 5.3. Scopes (laryngoscopy)
 - 5.4. Middle ear procedures (tympanoplasty, mastoidectomy, myringoplasty, stapedectomy, myringotomy and/or grommets)
6. Eye procedures
 - 6.1. Cataract surgery
 - 6.2. Treatment of glaucoma
 - 6.3. Other eye procedures: removal of foreign body, vitrectomy, conjunctivital surgery (repair laceration, pterygium), glaucoma surgery, probing and repair of tear ducts, retinal surgery, eyelid surgery, strabismus repair
7. Ganglionectomy
8. Gastroscopy
9. Gynaecological procedures
 - 9.1. Laparoscopic gynaecological procedures
 - 9.2. Cautery of vulva warts
 - 9.3. Colposcopy with LLETZ
 - 9.4. Diagnostic Dilation and Curettage (DandC)
 - 9.5. Endometrial ablation
 - 9.6. Diagnostic Hysteroscopy
 - 9.7. Examination under anaesthesia
 - 9.8. Diagnostic laparoscopy
 - 9.9. Simple vulva and introitus procedures: Simple hymenotomy, partial hymenectomy, simple vulvectomy, excision/treatment Bartholin's gland cyst
 - 9.10. Vaginal, cervix and oviduct procedures: excision vaginal septum, cyst or tumour, tubal ligation or occlusion, uterine cervix cerclage, removal cerclage suture
 - 9.11. Suction curettage
 - 9.12. Uterine evacuation and curettage
 - 9.13. Hysteroscopy
 - 9.14. Diagnostic hysteroscopy
10. Incision and drainage of abscess and/or cyst
 - 10.1. Subcutaneous tissue, soft tissue, bone, bursa, mouth, tonsil, pilonidal, ovary, Bartholin's gland, vagina
11. Nerve Procedures
 - 11.1. Neuroplasty median nerve, ulnar nerve, digital, nerve of hand or foot
12. Orthopaedic procedures
 - 12.1. Arthrocentesis
 - 12.2. Arthroscopy, arthrotomy, knee, shoulder, elbow, hand, wrist), arthrodesis (hand, wrist)
 - 12.3. Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty)
 - 12.4. Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy)
 - 12.5. Treatment of simple closed fractures and/or dislocations, removal of pins and plates
 - 12.6. Incision and drainage/excision of abscess and/or cyst/tumour: subcutaneous tissue, soft tissue, bone, bursa
 - 12.7. Biopsies: subcutaneous tissue, soft tissue, muscle, bone
 - 12.8. Treatment of closed fractures and/or dislocations, removal of pins and plates
13. Oesophagoscopy
14. Proctoscopy
15. Removal of foreign body
 - 15.1. Subcutaneous tissue, muscle, external auditory canal under general anaesthesia
16. Sigmoidoscopy
17. Simple Hernia Procedures
 - 17.1. Simple abdominal hernia repair
 - 17.2. Umbilical hernia repair
 - 17.3. Inguinal hernia repair
18. Simple superficial lymphadenectomy
19. Skin Procedures
 - 19.1. Debridement
 - 19.2. Simple repair of superficial wounds
20. Urological Procedures
 - 20.1. Cystoscopy
 - 20.2. Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocele vasectomy)





DIGITAL HEALTHCARE

We've gone digital!

 *Selecting the right Plan type can feel overwhelming, with your medical requirements, family situation, and budget all having to be considered. To assist you in this process, we have created intuitive interactive digital tools. Available on our website, they offer user-friendly features designed to guide you through the decision-making journey.*

BANKMED APP

Download the 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

FIND A BENEFIT PLAN TOOL

Selecting the right Plan type can feel overwhelming with your medical requirements, family situation, and budget all having to be considered. To assist you, we have created interactive digital tools. Available on our website, they offer user-friendly features designed to guide you through the decision-making journey.

Use the 'Find a Benefit' tool to help you select a Plan. This tool helps members to better understand their benefits and to select a Plan that best meets their needs. Plan selections and quotes are based on individual needs. This is not a comparison tool.



[FIND A BENEFIT PLAN TOOL](#)



Bankmed's digital tools

ASK FOR HELP

We have consolidated a list of our most popular topics along with their links. Choose from the popular links on our website to help you.



GET INSTANT HELP FROM OUR VIRTUAL ASSISTANT, 'ASK BANKMED'

'Ask Bankmed' now available on the Bankmed website, Bankmed app, and WhatsApp

Choose one of the popular questions below to start a conversation with 'Ask Bankmed' or ask your own question.

- Get my membership certificate.
- Get my medical aid tax certificate.
- What are my monthly contributions?
- What benefits do I have on my Plan?
- How do I get hospital authorisation?
- Membership card.
- Pregnancy and childbirth.



BANKMED NEWS

Our Bankmed news page is updated with information about topical issues like Gender-Based Violence, Emergency Services, and articles about health and wellness.



INTERACTIVE PLAN GUIDE

This page helps you to find a Plan that best suits you and your family's financial and healthcare needs. You must select a Plan when you apply to join Bankmed and if you decide to change your Plan during the Plan change period.



PLAN COMPARISON TOOL

Side-by-side summary of three Plans' main benefits.



LOOK-UP PLAN BENEFITS TOOL

Search the Benefit and Contribution Schedule for details of the benefits provided. This is not a comparison tool.



CONTRIBUTION CALCULATOR

Use the 'Contribution Calculator' to calculate your contributions on another Plan type or understand what it would cost to add another dependant.



DIGITAL MEMBERSHIP CARD

Do your bit for the environment - access your digital membership card on the Bankmed App.



DIGITAL CLAIMING

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

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 refunded.
- Make sure your membership number and 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.



Bankmed's digital tools

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.
- Be sure to send us a high-resolution image. If you send a low-resolution image, we cannot read and process your claim.
- Use your smartphone to scan the claim or 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.
- Please ensure that your image is a high-resolution image so that we can read the detail of the claim and are able to process it.

3. E-mail

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



FIND A HEALTHCARE PROFESSIONAL TOOL

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

Check whether a Healthcare Professional is on the Bankmed network

1. Log in to www.bankmed.co.za

2. Under 'Digital Tools' click on 'Find a Healthcare Professional'.

- Type their name under '1. Who or what'.
- Select their name from the drop-down list.
- If the system shows 'Partial cover' or the search does not find them, they are not part of our network.

If you want to find a specific kind of Healthcare Professional like a Dentist or GP;

- Under '1. Who or what', click on or choose a category of provider. This opens a list of categories.
- Select the category and specific kind of Healthcare Professional you need.
- Under '2. Where' start typing the area and click on the area you're looking for.
- Select 'Search' and scroll down to the results.
- If the system shows 'Full network' cover, the Healthcare Professional is part of our network.



SOCIAL MEDIA



KNOWLEDGE LIBRARY

Our knowledge library has been created to empower you with medical health information at your fingertips.



ELECTRONIC HEALTH RECORD

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.

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 results (such as blood tests). Our [privacy statement](#) explains how we use and protect your personal information.



Bankmed's digital tools

SMART DEVICES: SMART HEALTH

Wearable fitness devices and applications can inspire you to take charge of your health and fitness.

Different devices offer different features, but a basic step tracker counts how many steps you take a day. These devices synchronise with an application on your smartphone.

More advanced devices can monitor your heart rate and detect what kind of activity you are doing.

You do not need to buy an additional device to track your health. Any smartphone can be converted into a fitness-tracking and health-monitoring device.

Some smart devices come with a pre-installed health and fitness application, but there are many free applications you can download to help you track your health. Fitness devices and applications make sure that you have an accurate record of your physical activity.

Smartphones can help support good health

Applications have changed how people view and engage with their health and fitness. Applications are available to improve diet (for example the MyFitnessPal App) and track moods.

Some applications also give exercise advice. Productivity applications are becoming popular because they allow users to set realistic goals about eating, exercise, remembering to take medication, and sleep.

Get Balance and Active Rewards on your smartphone

Balance focusses on incentivising your efforts to lead a healthier life through these three straightforward steps. The Bankmed App allows you to access and navigate the Balance platform, for a holistic approach to a healthier you.

Use the Bankmed App to get personalised, weekly physical activity targets through the Active Rewards feature.

Track your physical activity with a compatible fitness device, monitoring your progress towards the set weekly goals.

Get rewarded

As a valued Balance member, you qualify for a variety of rewards that recognise and celebrate your commitment to a healthy lifestyle.

Rewards range from weekly incentives to exclusive discounts and savings, making your journey towards wellness both fulfilling and rewarding.



CONNECTED CARE

Access Connected Care in your browser or download it to your phone home screen. Bankmed members already have access to Connected Care - simply log in.

In-App booking

Book in-person, telephonic or online consultations in-app and easily keep track of your appointments.

Online consultations

Book an online Healthcare Professional consultation from the comfort of your home. Online consultations with a Healthcare Professional in the Connected Care GP network are covered by the available day-to-day benefits or Insured Benefits depending on your Plan choice.

Connected Care users can also access Healthcare Professionals who are online immediately, without having to make a booking.



Electronic Health Record (EHR)

With Connected Care you can access and share your Electronic Health Record with Healthcare Professionals.

Receive your diagnosis, instructions, and clinical readings, all in one place. Once you give consent, your Healthcare Professional can use the Electronic Health Record to access your medical history, gain insight into your Plan benefits, refer you to other Healthcare Professionals, study your blood test results and write electronic prescriptions and referrals.

E-scripting

Electronic prescriptions, seamless e-scripting to give you easy access to your medication.



BANKMED'S E-PHARM

Bankmed has partnered with Dis-Chem to bring you an easy and convenient way to order your medication online. Our e-Pharm offering is an innovative way for you to receive your medication effortlessly; delivered to your doorstep with no delivery charge, if you stay within a 15-kilometre radius of the nearest Dis-Chem. Alternatively, you can order your medication online and collect it at a Dis-Chem pharmacy, without having to wait in a queue.

Important: Please be aware that Bankmed is unable to assist with any queries pertaining to medication orders or deliveries. These may only be directed to the Dis-Chem Careline. E-mail careline@dischem.co.za or call 0869 347 243.



CONTRIBUTIONS 2025

Schedule of monthly contributions with effect from 1 January 2025.

ESSENTIAL PLAN (No MSA)

	2025 Total Contribution		
Income	M	A	C
> R5 000	R893	R801	R224
R5 001 – R6 000	R975	R879	R255
R6 001 – R7 000	R1 078	R970	R277
R7 001 – R8 000	R1 184	R1 065	R305
R8 001 – R9 000	R1 352	R1 220	R335
R9 001 – R10 000	R1 505	R1 352	R379
R10 001 +	R1 714	R1 545	R433

BASIC PLAN (No MSA)

	2025 Total Contribution		
Income	M	A	C
> R5 000	R1 399	R1 046	R352
R5 001 – R6 000	R1 537	R1 152	R396
R6 001 – R7 000	R1 694	R1 265	R437
R7 001 – R8 000	R1 858	R1 413	R479
R8 001 – R9 000	R2 123	R1 609	R532
R9 001 – R10 000	R2 363	R1 788	R594
R10 001 +	R2 690	R2 016	R674

TRADITIONAL PLAN (No MSA)

	2025 Total Contribution		
Income	M	A	C
> R5 000	R3 796	R2 842	R948
R5 001 – R10 000	R4 424	R3 315	R1 111
R10 000 +	R4 604	R3 458	R1 153

Important

Contributions for child dependants are limited to a maximum of three children.

CORE SAVER PLAN (With MSA)

	2025 Total Contribution			2025 Risk Contribution			2025 MSA Contribution		
Income	M	A	C	M	A	C	M	A	C
> R5 000	R2 276	R1 714	R571	R1 939	R1 460	R487	R337	R254	R84
R5 001 – R6 000	R2 439	R1 832	R610	R2 080	R1 561	R523	R359	R271	R87
R6 001 – R7 000	R2 611	R1 959	R652	R2 227	R1 670	R553	R384	R289	R99
R7 001 – R8 000	R2 743	R2 057	R689	R2 338	R1 752	R585	R405	R305	R104
R8 001 – R9 000	R2 955	R2 222	R746	R2 518	R1 895	R636	R437	R327	R110
R9 001 – R10 000	R3 107	R2 336	R779	R2 649	R1 994	R666	R458	R342	R113
R10 001 +	R3 426	R2 564	R861	R2 923	R2 185	R735	R503	R379	R126



COMPREHENSIVE PLAN (With MSA)

	2025 Total Contribution			2025 Risk Contribution			2025 MSA Contribution		
Income	M	A	C	M	A	C	M	A	C
R0 – R10 000	R5 057	R3 787	R1 272	R4 196	R3 143	R1 055	R861	R644	R217
R10 001 +	R5 266	R3 947	R1 318	R4 369	R3 275	R1 094	R897	R672	R224

PLUS PLAN (With MSA)

	2025 Total Contribution			2025 Risk Contribution			2025 MSA Contribution		
Income	M	A	C	M	A	C	M	A	C
All Incomes	R8 938	R6 692	R2 237	R6 923	R5 184	R1 733	R2 015	R1 508	R504

Important

Contributions for child dependants are limited to a maximum of three children.

We acknowledge that selecting the right Plan can be overwhelming due to various considerations, such as your medical requirements, family situation, and budget for medical scheme cover. To assist you in navigating this intricate decision-making process, we have created intuitive, interactive digital tools. These tools are available on our website and offer user-friendly features designed to guide you through the decision-making journey. Use the 'Find a Benefit' tool to help you select a Plan.



[FIND A BENEFIT PLAN TOOL](#)



This tool has been developed to assist you to better understand your benefits and select a Plan that meets your individual needs. The Plan selection and quote provided will be based on your individual needs. This is not a comparison tool.

LATE-JOINER PENALTY

The Medical Schemes Act recommends that medical schemes charge a late-joiner penalty if someone joins a medical scheme for the first time at the age of 35 or older, or if someone is a member and has a break in coverage for more than three months and then wants to join 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. The Board of Trustees can decide to charge a late joiner an extra percentage of their contribution depending on how long they have not belonged to a medical scheme. The penalty is permanent and will apply for the duration of the membership.

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

LATE JOINER PENALTY BANDS

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%

Please note that the 2025 benefits and contributions are subject to approval by the Council for Medical Schemes.

EXCLUSIONS

 *The following are examples of items typically not covered by Bankmed:*

- Operations, treatment, and procedures for cosmetic purposes.
- Sunscreens and tanning agents.
- Travel expenses.
- Accommodation in retirement homes or similar institutions.
- Sunglasses.
- Accommodation and/or treatment in headache or stress-relief clinics.
- The cost of holidays for recuperative purposes (for example spas and health resorts).
- Costs associated with vocational guidance, child guidance, marriage guidance or counselling, sex therapy, school readiness, school therapy or attendance at remedial education schools or clinics.
- Tonics and stimulants, including weight loss remedies.

View the complete list of the Scheme exclusions in accordance with Bankmed's Rules.

BANKMED PRIVACY STATEMENT

HOW WE WILL PROCESS AND DISCLOSE YOUR PERSONAL INFORMATION AND COMMUNICATE WITH YOU

The security of your personal information is extremely important to us. The Privacy Statement explains how we obtain, use, disclose and process your information in a manner that is compliant, ethical, adheres to industry best practice and the Protection of Personal Information legislation.

Access the [full Statement](#).

COMPLAINTS PROCESS

If you have a complaint about your membership, please let us know in writing:

- E-mail for members: enquiries@bankmed.co.za
- E-mail for pensioners: pensioners@bankmed.co.za
- Post: Complaints Bankmed, Private Bag X2, Rivonia, 2128

By law, we must respond to written complaints within 30 days, but we always 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 the outcome of the process, 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
- E-mail: complaints@medicalschemes.co.za
- 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



CONTACTS

Medical Emergencies: 0860 999 911

GENERAL INFORMATION

- Website: www.bankmed.co.za
- Call: 0800 BANKMED (0800 226 5633)
- Toll-free on a Telkom landline
- E-mail for members: enquiries@bankmed.co.za
- E-mail for pensioners: pensioners@bankmed.co.za
- 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 the member portal at www.bankmed.co.za
- Bankmed App: Download from your App store and log in
- Your username and password are the same for the website, mobile site, and App

CLAIMS

- Include your membership number and make sure the claim is easy to read
- Bankmed App: Download from the App Store or Google Play Store
- E-mail: claims@bankmed.co.za
- Post: Bankmed Claims, Private Bag X2, Rivonia 2128



PRE-AUTHORISATION

- For Hospital or Day Surgery facility admissions, MRI, CT scan or radionuclide scan
- Call: 0800 BANKMED (0800 226 5633)
- Toll-free on a Telkom landline
- E-mail: treatment@bankmed.co.za



REPORT FRAUD

- Call: 0800 004 500 / 0800 007 788
- SMS: 43477
- E-mail: bankmed@tip-offs.com
- Post: Freepost DN298, Umhlanga Rocks 4320



CHRONIC MEDICATION AUTHORISATION

- Register to gain access to these benefits
- 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
- Your pharmacist can call 0800 BANKMED (0800 226 5633)
- Healthcare Professionals can call 0800 132 345

ESSENTIAL AND BASIC PLANS

- E-mail: chronicbasicesential@bankmed.co.za
- Your pharmacist can call 0800 BANKMED (0800 226 5633)





BENEFIT TABLES 2025

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
Does this Plan have an MSA?		No	No	No	Yes	Yes	Yes
Percentage of gross contribution allocated to MSA		N/A	N/A	N/A	14.7%*	17%*	22.5%*
MSA reimbursement		N/A	N/A	N/A	*The percentage of Gross Contribution allocated to the MSA varies based on dependant type, income band, rounding, and contribution increases. The published percentage is an aggregate value.		
					Cost or Scheme Rate	Cost or Scheme Rate	Cost or Scheme Rate
					Members can choose between Cost or Scheme Rate. Cost covers eligible claims fully, including out-of-network claims. Scheme Rate limits coverage to the Scheme Rate and within benefit limits. If no choice is made, new members default to the Scheme Rate, but they can switch between options anytime.		
1.	OVERALL ANNUAL LIMIT						
1.1		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
2.	CLAIMS FOR SERVICES RENDERED OUTSIDE THE BORDERS OF SOUTH AFRICA (FOREIGN CLAIMS)						
Consider purchasing comprehensive travel insurance before travelling abroad as not all foreign claims may receive full coverage							
2.1		- PMB conditions and life-threatening emergencies only - No benefits for emergency/ ambulance transport outside borders of South Africa - No benefits for services not normally covered at the Scheme’s preferred provider network (Bankmed Entry Plan GP Network) for out-of-hospital consultations, medication, and treatment (except via Bankmed Entry Plan GP Network providers in Lesotho) - Medical motivation and prior approval required for non-emergency surgery outside borders of South Africa	- Foreign claims covered at Scheme Rate and/or Rand limit subject to benefits available - No benefits for emergency/ ambulance transport outside borders of South Africa - No benefits for services not normally covered at the Scheme’s preferred provider network (Bankmed Entry Plan GP Network) for out-of-hospital consultations, medication, and treatment (except via Bankmed Entry Plan GP Network providers in Lesotho) - Medical motivation and prior approval required for non-emergency surgery outside borders of South Africa	- Foreign claims covered at the Scheme Rate and/or Rand limit subject to benefits available - No benefits for emergency/ambulance transport outside borders of South Africa - Medical motivation and prior approval required for non-emergency surgery outside borders of South Africa			

Terminology Reminders:

DSP Designated Service Provider
ASA Accumulated Savings Account
pfpa per family per annum

PMB Prescribed Minimum Benefit
CIB Chronic Illness Benefit
pb per beneficiary

MSA Medical Savings Account
CDL Chronic Disease List
pbpa per beneficiary per annum

BOC Basket-of-Care
ATB Above Threshold Benefit
pbpm per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
3.	WELLNESS AND PREVENTATIVE CARE BENEFITS (INSURED BENEFITS) Wellness and Preventative Care Benefits are additional Insured Benefits and do not deplete other Insured Benefits or MSA. Consultation costs related to these benefits are not covered						
3.1	Flu vaccine	• 100% of Scheme Medicine Reference Price Limited to one vaccine pbpa					
3.2	Human Papilloma Virus (HPV) vaccine	• 100% of Scheme Medicine Reference Price • Limited three course dose (product and age dependent) per male or female beneficiary, aged nine to 25 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 Scheme Medicine Reference Price • For children up to age 12 • Limited to immunisations per the Department of Health’s Expanded Programme on Immunisation (EPI) guidelines					
3.4	Pneumococcal vaccine	• 100% of 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, 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 cost at DSP • 100% of Scheme Rate at non-DSP • 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 Limited to high-risk breast cancer beneficiaries Subject to clinical entry criteria Pre-authorisation required	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa • Breast Cancer Risk Calculator available on website					
3.8	Bone densitometry	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa aged 50 years and older • Benefits for beneficiaries younger than 50 years subject to motivation and prior approval • Where clinical entry criteria not met and member under age 50, test can be claimed from available radiology benefit or MSA, where applicable					
3.9	Prostate-specific antigen	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to one pbpa aged 50 years and older • Benefits for beneficiaries younger than 50 years subject to motivation and prior approval					

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
3.10	Faecal occult blood test	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to one pbpa aged 50 years and older - Benefits for beneficiaries younger than 50 years subject to motivation and prior approval					
3.11	Tuberculosis (TB) screening	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to one x-ray pbpa - For TB screening requested by onsite registered private nurse at Employer Groups - All other TB screenings subject to available out-of-hospital radiology and/or pathology benefits					
3.12	Bankmed mental wellbeing assessment	Unlimited online Mental Wellbeing Assessments					
3.13	Mental Health "At Risk" Benefit: post-online mental wellbeing assessment (Consultation with Premier Plus Network GP/network psychologist) Additional consultation for Network GP or network psychologist subject to clinical entry criteria	100% of cost at DSP only - DSP: Premier Plus GP Network or network psychologist - Not covered at non-DSP - Limited to one consultation per qualifying beneficiary Limited to: - High-risk members aged 18 years and older - High-risk members identified and risk-rated using results from the Online Mental Wellbeing Assessment, therefore subject to completion of the Online Mental Wellbeing Assessment Benefit use requirements: - Within three months of Online Mental Wellbeing Assessment - Otherwise not funded - Subject to PMB regulations	100% of cost at DSP only - DSP: Premier Plus GP Network or network psychologist - Not covered at non-DSP - Limited to one consultation per qualifying beneficiary Limited to: - High-risk members aged 18 years and older - High-risk members identified and risk-rated using results from the Online Mental Wellbeing Assessment, therefore subject to completion of the Online Mental Wellbeing Assessment Benefit use requirements: - Within three months of Online Mental Wellbeing Assessment - Otherwise funded from day-to-day benefits	100% of cost at DSP only - DSP: Premier Plus GP Network or network psychologist - Not covered at non-DSP - Limited to one consultation per qualifying beneficiary Limited to: - High-risk members aged 18 years and older - High-risk members identified and risk-rated using results from the Online Mental Wellbeing Assessment, therefore subject to completion of the Online Mental Wellbeing Assessment Benefit use requirements: - Within three months of Online Mental Wellbeing Assessment - Otherwise funded from day-to-day benefits			

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
3.14	Cholesterol screening, blood sugar screening and blood pressure measurements	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to R400 pbpa at DSP - DSP: clinics, pharmacies, or Bankmed Entry Plan GP Network consulting rooms		100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to R400 pbpa at DSP - DSP: clinics, pharmacies, or Bankmed Network GPs’ consulting rooms			
3.15	HIV counselling and testing (HCT)	- Unlimited 100% of cost for HCT DSP - DSP: Bankmed Entry Plan GP Network, Bankmed Pharmacy Network, contracted onsite HCT providers at Employer Groups 100% of Scheme Rate at non-DSP - Subject to PMB regulations		- Unlimited 100% of cost for HCT DSP - DSP: Bankmed GP Network, Bankmed Pharmacy Network, contracted onsite HCT providers at Employer Groups 100% of Scheme Rate at non-DSP			
3.16	Pap smear	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to one pbpa - One associated nurse, Bankmed Entry Plan GP Network GP, or Bankmed Entry Plan Specialist Network consultation pb covered as an additional Insured Benefit limited to R630 pbpa		100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to one pbpa - One associated nurse, Bankmed GP Network, or Bankmed Prestige A and B Specialist Network consultation pb covered as an additional Insured Benefit limited to R630 pbpa			
3.17	Personal Health Assessment (PHA) Limited to members and beneficiaries aged 16 years and older	100% of cost at DSP only - DSP: Bankmed Entry Plan GP Network, Bankmed Pharmacy Network and contracted onsite providers at Employer Groups - Not covered at non-DSP - Limited to one assessment pbpa		100% of cost at DSP only - DSP: Bankmed GP Network, Bankmed Pharmacy Network and contracted onsite providers at Employer Groups - Not covered at non-DSP - Limited to one assessment pbpa			
3.18	Post-Personal Health Assessment (PHA): additional consultations for biokineticist and dietitian - Limited to members and beneficiaries aged 16 years and older - Additional consultations for dietitian and biokineticist subject to clinical entry criteria - Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA	100% of cost at DSP 100% of Scheme Rate at a non-DSP - Benefit includes two 30-minute dietitian consultations pbpa and two biokineticist consultations pbpa - Limited to: - Medium- and high-risk members identified via the PHA - Members with a BMI ≥ 30 - Benefit use requirements: - Within 6 weeks of PHA: first visit to dietitian and biokineticist - Within 12 months of PHA: second visit to dietitian and biokineticist - Otherwise funded from day-to-day benefits, where available					

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
3.19	Post-Personal Health Assessment (PHA): Additional Consultation with Bankmed Network GP - Limited to members and beneficiaries aged 16 years and older - Additional consultations for Bankmed Network GP subject to clinical entry criteria	100% of cost at DSP only - DSP: Bankmed Entry Plan Network GP - Not covered at non-DSP - Limited to one consultation per qualifying beneficiary Limited to: - High-risk members aged 16 years and older - High-risk members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA Benefit use requirements: - Within 6 weeks of PHA - Otherwise not funded - Subject to PMB regulations	100% of cost at DSP only - DSP: Bankmed Entry Plan Network GP - Not covered at non-DSP - Limited to one consultation per qualifying beneficiary Limited to: - High-risk members aged 16 years and older - High-risk members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA Benefit use requirements: - Within 6 weeks of PHA - Otherwise funded from day-to-day benefits	100% of cost at DSP only - DSP: Bankmed Network GP - Not covered at non-DSP - Limited to one consultation per qualifying beneficiary Limited to: - High-risk members aged 16 years and older - High-risk members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA Benefit use requirements: - Within 6 weeks of PHA - Otherwise funded from day-to-day benefits			
3.20	Contraception Oral Contraceptives, Devices and Injectables	No benefit	100% of Scheme Medicine Reference Price - Limited to R2 510 per female beneficiary per annum - Oral contraceptives limited to one prescription/repeat prescription pbpm				
3.21	Antenatal screening T21 chromosome test or non-invasive prenatal testing (NIPT) To test for chromosomal abnormalities (South African testing only) Amniocentesis (South African testing only)	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to one test pb per pregnancy - Test to be conducted at 10 – 12 weeks of pregnancy - Subject to clinical entry criteria - Applies to high-risk beneficiaries only, who are aged 35 years and older at time of delivery - If member does not meet clinical entry criteria, the screening test is not covered by the Scheme 100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to one test pb per pregnancy - Subject to gynaecologist referral and pre-authorisation					

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
3.22	Newborn screening To test for the presence of certain metabolic and endocrine disorders (South African testing only)	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to one test pb per pregnancy - Test to be carried out within 72 hours of birth					
3.23	Newborn hearing test - Only hearing test covered from this benefit - Consultation costs related to this benefit covered from available consultation benefits	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to one test pb and must be carried out within eight weeks of birth - Test to be performed by a registered Audiologist					
3.24	Diabetes management - For members registered on the Scheme's Disease Management Programme - BOC set by the Scheme - Subject to PMB regulations	- Unlimited 100% of cost for services covered in the Scheme’s BOC - Subject to referral from DSP - Subject to member using a DSP 100% of Scheme Rate at non-DSP	- Unlimited 100% of cost for services covered in Scheme’s BOC - Subject to referral from DSP - Subject to member using a DSP 100% of Scheme Rate at non-DSP - The ‘Out-of-network GP Benefit’ limit applies to non-DSP	- Unlimited 100% of cost for services covered in Scheme’s BOC - Subject to referral from DSP - Subject to member using a DSP 100% of Scheme Rate at non-DSP			
3.25	Continuous Glucose Monitoring Device (CGM) - Available to Type 1 and Type 2 diabetics meeting the Scheme’s clinical entry criteria - Subject to PMB regulations	- Unlimited - Subject to authorisation and/or approval - Subject to the Scheme’s protocols, treatment guidelines and clinical entry criteria - Members with a CGM device have limited glucose strip benefits, where approved					
3.26	Disease Prevention Programme Programme designed to support members identified as being at risk of developing diabetes - Clinical entry criteria apply - BOC as specified by the Scheme - Subject to PMB regulations	- Limited to BOC determined by Scheme 100% of Scheme Rate - Subject to authorisation and/or approval - Limited to PMBs			- Limited to BOC determined by Scheme 100% of Scheme Rate - Subject to authorisation and/or approval		

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
3.27	Child Weight Assessment Applies to children aged 9 years to 15 years only	100% of cost at DSP - Not covered at a non-DSP - Limited to one assessment per qualifying beneficiary					
3.28	Post-Child Weight Assessment: additional consultations for biokineticist and dietitian - Applies to children aged 9 years to 15 years only - Additional consultations for dietitian and biokineticist subject to clinical entry criteria	100% of cost at DSP 100% of Scheme Rate at a non-DSP - Benefit includes two 30-minute dietitian consultations pbpa and two biokineticist consultations pbpa Limited to: - Medium and high-risk beneficiaries and/or beneficiaries based on Body Mass Index (BMI) - Beneficiaries identified and risk-rated using results from the Child Weight Assessment, therefore subject to completion of the Child Weight Assessment Benefit use requirements: - Within 6 weeks of Child Weight Assessment: first visit to dietitian and biokineticist - Within 12 months of Child Weight Assessment: second visit to dietitian and biokineticist - Otherwise not funded	100% of cost at DSP 100% of Scheme Rate at a non-DSP - Benefit includes two 30-minute dietitian consultations pbpa and two biokineticist consultations pbpa Limited to: - Medium and high-risk beneficiaries and/or beneficiaries based on Body Mass Index (BMI) - Beneficiaries identified and risk-rated using results from the Child Weight Assessment, therefore subject to completion of the Child Weight Assessment Benefit use requirements: - Within 6 weeks of Child Weight Assessment: first visit to dietitian and biokineticist - Within 12 months of Child Weight Assessment: second visit to dietitian and biokineticist - Otherwise funded from day-to-day benefits, where available				

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
3.29	Post- Child Weight Assessment: Additional Consultations for Network GP - Applies to children aged 9 years to 15 years only - Additional consultation for Bankmed Network GP subject to clinical entry criteria	100% of cost at DSP only - DSP: Bankmed Entry Plan Network GP - Not covered at non-DSP - Limited to one consultation per qualifying beneficiary Limited to: - Limited to high-risk beneficiaries and/or beneficiaries based on Body Mass Index (BMI) - Beneficiaries identified and risk-rated using results from the Child Weight Assessment, therefore subject to completion of the Child Weight Assessment Benefit use requirements: - Within 6 weeks of Child Weight Assessment: visit to Bankmed Entry Plan Network GP - Otherwise not covered	100% of cost at DSP only - DSP: Bankmed Entry Plan Network GP - Not covered at non-DSP - Limited to one consultation per qualifying beneficiary Limited to: - Limited to high-risk beneficiaries and/or beneficiaries based on Body Mass Index (BMI) - Beneficiaries identified and risk-rated using results from the Child Weight Assessment, therefore subject to completion of the Child Weight Assessment Benefit use requirements: - Within 6 weeks of Child Weight Assessment: visit to Bankmed Entry Plan Network GP - Otherwise funded from day-to-day benefits	100% of cost at DSP only - DSP: Bankmed Network GP - Not covered at non-DSP - Limited to one consultation per qualifying beneficiary Limited to: - Limited to high-risk beneficiaries and/or beneficiaries based on Body Mass Index (BMI) - Beneficiaries identified and risk-rated using results from the Child Weight Assessment, therefore subject to completion of the Child Weight Assessment Benefit use requirements: - Within 6 weeks of Child Weight Assessment: visit to Bankmed Network GP - Otherwise funded from day-to-day benefits			
3.30	Dementia Screening and Assessment Benefit Applies to members and beneficiaries aged 65 years and older only	100% of cost at DSP - DSP: registered Network occupational therapist - Where an occupational therapist is not available, the member may consult a Bankmed network psychologist for the assessment 100% of Scheme Rate at a non-DSP - Limited to one consultation per qualifying beneficiary Limited to: - Applies to members and beneficiaries aged 65 years and older only - Limited to one consultation and one comprehensive cognitive assessment per qualifying beneficiary per annum - Only the consultation and assessment are funded - Should the provider charge for additional services, these services will be funded from standard available benefits, where relevant					

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
4.	HIV/AIDS CARE PROGRAMME Enrollment in the Scheme’s HIV/AIDS Care Programme grants extra benefits that do not diminish any other Insured Benefits. Unregistered beneficiaries retain access to all standard benefits outlined in the Benefit Tables, including PMB coverage in accordance with regulations, even after respective sub-limits have been reached						
4.1	Consultations and pathology	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to benefits available in Scheme’s BOC					
4.2	Medication via DSP Bankmed Pharmacy Network	• Unlimited • 100% of cost at DSP • 100% of Scheme Medicine Reference Price for non-formulary medication • Subject to Scheme Medication Formulary (medicine list) • Motivation is required for the use of a non-DSP					
4.3	Medication via non-DSP Voluntary use of a non-DSP	• Unlimited • 80% of Scheme Medicine Reference Price • Subject to Scheme Medication Formulary (medicine list) • 100% of Scheme Medicine Reference Price for non-formulary medication • Motivation is required for the use of a non-DSP					
4.4	Medication via non-DSP Involuntary use of a non-DSP	• Unlimited • 100% of cost • 100% of Scheme Medicine Reference Price for non-formulary medication • Subject to Scheme Medication Formulary (medicine list) • Motivation is required for the use of a non-DSP					
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) Subject to pre-authorisation and PMB regulations						
6.1	BENEFITS FOR EMERGENCY SERVICES ARE SUBJECT TO USE OF THE SCHEME’S DSP. FAILURE TO USE THE DSP MAY LEAD TO CO-PAYMENTS BEING APPLIED CALL 0860 999 911 – 24 HOURS A DAY, SEVEN DAYS A WEEK AND YOU WILL BE CONNECTED WITH HIGHLY QUALIFIED INDIVIDUALS WHO WILL ASSIST WITH YOUR EMERGENCY • Unlimited • 100% of cost via the Scheme’s DSP • 100% of Scheme Rate via non-DSP • No benefit outside the borders of South Africa						

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
7.	HOSPITALISATION Subject to pre-authorisation and PMB regulations. 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 AND PMB REGULATIONS 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, DAY SURGERY PROCEDURE, 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 you, as the member, to ensure that the hospital, treatment facility or day surgery facility, as well as treating Healthcare Professionals are DSPs or in the Bankmed network to avoid co-payments - Benefits and limitations applicable to your Plan are set out in these Benefit Tables as well as in the Scheme Rules available on the Bankmed website. The benefits under the ‘Hospitalisation’ benefit section 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 and Scheme Rules under the relevant benefit categories You are responsible for ensuring the claims are submitted for payment by the Healthcare Professional - Please take care to determine the limits for your Plan (if any) and the rate at which the Scheme will reimburse 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 the doctor’s rooms as an alternative to hospitalisation						
7.1	Hospitalisation overall annual limit	- No overall annual limit - Limited to PMBs	No overall annual limit				
7.2	Hospital network (DSP) applicable	Bankmed Hospital Network DSP for the Essential Plan	Bankmed Hospital Network DSP for the Basic Plan	Bankmed Hospital Network DSP for the Traditional Plan	All contracted Netcare, National Hospital Network (NHN), Life Healthcare, Mediclinic and Clinix hospitals, and any other independent private hospitals contracted to the Scheme		
7.3	Hospitalisation at a DSP All admissions	100% of cost					
7.4	Hospitalisation at non-DSP for PMB admission Involuntary use of non-DSP	100% of cost					
7.5	Hospitalisation at non-DSP for PMB admission Voluntary use of non-DSP	80% of Scheme Rate - Deductible applies		100% of Scheme Rate - Deductible applies			
7.6	Hospitalisation at non-DSP for non-PMB admission	No benefit	80% of Scheme Rate - Deductible applies	100% of Scheme Rate - Deductible applies			
7.7	Ward rate	General ward					General and private wards
7.8	Referral requirement	Benefits only available on referral from GP in Bankmed Entry Plan GP Network, or referred specialist subject to PMB regulations			Not applicable		
7.9	Other	No benefit for dental surgery and auxiliary services, except for PMBs			Not applicable		
7.10	To-take-out (TTO) medication Supplied by the hospital when a patient is discharged	100% of cost - Limited to PMBs and a maximum of a seven-day 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 surgery facility, a maximum of a seven-day supply will be funded from Insured Benefits if obtained from a retail pharmacy on the date of discharge only					

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8.	DEDUCTIBLES (UPFRONT PAYMENT) A beneficiary will be responsible for a deductible for certain hospital and day surgery events, unless the admission is related to a PMB diagnosis, typically as a result of an emergency. This applies even if the procedure is not the main reason for admission. Payment is due directly to the facility at the time of admission						
8.1	Deductibles Deductible waiver conditions: • PMB 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 • Confinements are excluded from deductibles • 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 • Admissions to a State hospital or facility • Authorised day surgery admissions for specified procedures						
8.2	Day Surgery Network deductible Bankmed’s Day Surgery Network comprises a defined list of contracted day surgery facilities as well as contracted acute hospitals providing day surgery facilities at day surgery rates						
	Day surgery deductible waiver conditions • Applicable to Day Surgery Procedure List • Treatment/procedure performed at Bankmed Day Surgery Network facility PMB admission • Treatment/procedure NOT performed at Bankmed Day Surgery Network facility • Involuntary use of non-DSP PMB admission • Treatment/procedure NOT performed at Bankmed Day Surgery Network facility • Voluntary use of non-DSP Non-PMB admission • Treatment/procedure NOT performed at Bankmed Day Surgery Network facility	• Refer to ‘Bankmed Day Surgery Procedure List’ in 8.3 below • No deductible • Limited to PMBs • Refer to ‘Bankmed Day Surgery Procedure List’ in 8.3 below • No deductible • Limited to PMBs • Refer to ‘Bankmed Day Surgery Procedure List’ in 8.3 below • R6 300 per admission • Limited to PMBs • No benefit	• Refer to ‘Bankmed Day Surgery Procedure List’ in 8.3 below • No deductible • Refer to ‘Bankmed Day Surgery Procedure List’ in 8.3 below • No deductible • Refer to ‘Bankmed Day Surgery Procedure List’ in 8.3 below • R6 300 per admission • Refer to ‘Bankmed Day Surgery Procedure List’ in 8.3 below • R 6 300 per admission				

	ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
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8.3	Bankmed Day Surgery Procedure List Bankmed’s Day Surgery Procedure List comprises a defined list of procedures/treatments that can be safely performed at a contracted facility in the Bankmed Day Surgery Network without incurring a deductible					
	1. Anorectal procedures 1.1. Treatment of haemorrhoids, fissures, fistula 2. Biopsies 2.1. Subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes 3. Colonoscopy 4. Cystourethroscopy 5. Ear, Nose and Throat Procedures 5.1. Tonsillectomy and/or adenoidectomy 5.2. Simple procedures for nosebleed (extensive cautery, nasal plugging) 5.3. Scopes (laryngoscopy) 5.4. Middle ear procedures (tympanoplasty, mastoidectomy, myringoplasty, stapedectomy, myringotomy and/or grommets) 6. Eye procedures 6.1. Cataract surgery 6.2. Treatment of glaucoma 6.3. Other eye procedures: removal of foreign body, vitrectomy, conjunctivital surgery (repair laceration, pterygium), glaucoma surgery, probing and repair of tear ducts, retinal surgery, eyelid surgery, strabismus repair	7. Ganglionectomy 8. Gastroscopy 9. Gynaecological procedures 9.1. Laparoscopic gynaecological procedures 9.2. Cautery of vulva warts 9.3. Colposcopy with LLETZ 9.4. Diagnostic Dilation and Curettage (D&C) 9.5. Endometrial ablation 9.6. Diagnostic Hysteroscopy 9.7. Examination under anaesthesia 9.8. Diagnostic laparoscopy 9.9. Simple vulva and introitus procedures: Simple hymenotomy, partial hymenectomy, simple vulvectomy, excision/treatment Bartholin’s gland cyst 9.10. Vaginal, cervix and oviduct procedures: excision vaginal septum, cyst or tumour, tubal ligation or occlusion, uterine cervix cerclage, removal cerclage suture 9.11. Suction curettage 9.12. Uterine evacuation and curettage 9.13. Hysteroscopy 9.14. Diagnostic hysteroscopy	10. Incision and drainage of abscess and/or cyst 10.1. Subcutaneous tissue, soft tissue, bone, bursa, mouth, tonsil, pilonidal, ovary, Bartholin’s gland, vagina 11. Nerve Procedures 11.1. Neuroplasty median nerve, ulnar nerve, digital, nerve of hand or foot 12. Orthopaedic procedures 12.1. Arthrocentesis 12.2. Arthroscopy, arthrotomy, knee, shoulder, elbow, hand, wrist), arthrodesis (hand, wrist) 12.3. Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty) 12.4. Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy) 12.5. Treatment of simple closed fractures and/or dislocations, removal of pins and plates 12.6. Incision and drainage/excision of abscess and/or cyst/tumour: subcutaneous tissue, soft tissue, bone, bursa	12.7. Biopsies: subcutaneous tissue, soft tissue, muscle, bone 12.8. Treatment of closed fractures and/or dislocations, removal of pins and plates 13. Oesophagoscopy 14. Proctoscopy 15. Removal of foreign body 15.1. Subcutaneous tissue, muscle, external auditory canal under general anaesthesia 16. Sigmoidoscopy 17. Simple Hernia Procedures 17.1. Simple abdominal hernia repair 17.2. Umbilical hernia repair 17.3. Inguinal hernia repair 18. Simple superficial lymphadenectomy 19. Skin Procedures 19.1. Debridement 19.2. Simple repair of superficial wounds 20. Urological Procedures 20.1. Cystoscopy 20.2. Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocele vasectomy)		
8.4	Dental admission deductible Deductible applies to dental admissions at private hospitals and day surgery facilities (both DSPs and non-DSPs)					
	Dental admission deductible	• No benefit for in-hospital dental treatment, except PMBs	• Deductible: • Day surgery: R325 • Hospital: R2 405	• No benefit for in-hospital dental treatment, except PMBs	• Deductible: • Day surgery: R325 • Hospital: R2 405	

Terminology Reminders:

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pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

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		NON-MSA PLANS			MSA PLANS		
8.5	Non-DSP facility deductible Deductible applicable to a use of a non-DSP facility Applies to all procedures NOT listed in the Bankmed Day Surgery Procedure List in 8.3						
	PMB admission - Treatment/procedure NOT performed at Bankmed Network Facility - Involuntary use of non-DSP PMB admission - Treatment/procedure NOT performed at Bankmed Network Facility - Voluntary use of non-DSP Non-PMB admission - Treatment/procedure NOT performed at Bankmed Network Facility	- No deductible payable for PMBs - Applies to all admissions - Deductible: - Day surgery: R325 - Hospital: R810 - No benefit	- No deductible payable for PMBs - Applies to all admissions - Deductible: - Day surgery: R325 - Hospital: R810 - Applies to all admissions - Deductible: - Day surgery: R325 - Hospital: R810	- No deductible payable for PMBs - Applies to all admissions - Deductible: - Day surgery: R325 - Hospital: R6 730 - Applies to all admissions - Deductible: - Day surgery: R325 - Hospital: R6 730	- No deductible payable for PMBs - Applies to all admissions - Deductible: - Day surgery: R325 - Hospital: R810 - Applies to all admissions - Deductible: - Day surgery: R325 - Hospital: R810		
9.	OUTPATIENT CONSULTATIONS AND FACILITY FEES FOR OUTPATIENT VISITS						
9.1	Casualty and outpatient consultations GP or specialist consultation at hospital emergency unit, casualty unit or outpatient unit	- Regarded as an out-of-hospital GP/specialist consultation in rooms, unless resulting in an authorised hospital admission - Refer to ‘GP Consultations In-room or Out-of-hospital’, and ‘Specialist Consultations In-room or Out-of-hospital’ benefit sections					
9.2	Facility fees For casualty and outpatient consultations at a hospital emergency unit, casualty unit, or outpatient unit	Facility fees not covered, unless resulting in an authorised hospital admission	Facility fees subject to ‘Specialist Consultations In-room or Out-of-hospital’ benefit, unless resulting in an authorised hospital admission				
10.	GP CONSULTATION WITHIN 30 DAYS OF DISCHARGE FROM HOSPITAL						
10.1	Post-hospital GP consultation within 30 days of discharge from hospital	- Additional Insured Benefit - Refer to ‘30-Day Post-hospital GP Consultation Benefit’ section					

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11.	BLOOD TRANSFUSIONS Subject to pre-authorisation and PMB regulations						
11.1	Blood transfusions	100% of cost - Limited to PMBs	100% of cost - Unlimited				
12.	ORGAN AND BONE MARROW TRANSPLANTS Subject to pre-authorisation and PMB regulations. Organ recipient must be a Bankmed beneficiary for benefits to apply. No benefits for travelling and non-hospital accommodation expenses						
12.1	Hospitalisation/organ and patient preparation	- Refer to ‘Hospitalisation’ benefit section - Limited to PMBs		Refer to ‘Hospitalisation’ benefit section	- Refer to ‘Hospitalisation’ benefit section - Limited to PMBs	Refer to ‘Hospitalisation’ benefit section	
12.2	Medication In- and out-of-hospital	Limited to PMBs		Unlimited	Limited to PMBs	Unlimited	
	Medication via DSP Designated pharmacy	100% of cost				100% of cost	
	Medication via non-DSP Voluntary use of non-DSP	80% of Scheme Medicine Reference Price plus dispensing fee				80% of Scheme Medicine Reference Price plus dispensing fee	
	Medication via non-DSP Involuntary use of non- DSP	100% of cost				100% of cost	
12.3	Harvesting and transporting 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	
13.	ONCOLOGY						
	Subject to: - Pre-authorisation and PMB regulations - Evidence-based medicine, cost-effectiveness and affordability - Scheme’s oncology BOC, formularies and/or protocols - Meeting Scheme’s Clinical Entry Criteria - Peer-review by external panel of specialists as appointed by the Scheme - Medication must be dispensed through the DSP. Where a non-network provider is used, funding will be approved up to a maximum of 80% of the Scheme Medicine Reference Price and the balance will be for the member’s own pocket - Generic substitution and/or switching to cost-effective therapeutic equivalents (drug utilisation review)						
13.1	Consultations, treatment, and materials In- and out-of-hospital	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs		100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited	

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13.2	Radiotherapy fees, chemotherapy facility, and professional fees	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs		100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited	
13.3	Associated medication and drugs						
	For medicines administered in-rooms - Injectable and infusional chemotherapy - Excludes medicines administered in-hospital and medicines administered in-rooms by a dispensing provider						
	Medication via DSP Bankmed’s Oncology Pharmacy DSP (courier pharmacy)	- Limited to PMBs 100% of cost, limited to PMBs		- Unlimited 100% of cost	- Limited to PMBs 100% of cost, limited to PMBs	- Unlimited 100% of cost	
	Medication via a 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	
	For medicines scripted and dispensed at a retail pharmacy (scripted by treating provider) Supportive medication, oral chemotherapy and hormonal therapy						
	Medication via DSP Bankmed’s Oncology Pharmacy DSP	- Limited to PMBs 100% of cost, limited to PMBs		- Unlimited 100% of cost	- Limited to PMBs 100% of cost, limited to PMBs	- Unlimited 100% of cost	
	Medication via a 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	
14.	RENAL DIALYSIS Subject to pre-authorisation and PMB regulations						
14.1	Procedures and treatment	- Limited to PMBs 100% of cost at DSP 100% of Scheme Rate at non-DSP		- Unlimited 100% of cost at DSP 100% of Scheme Rate at non-DSP			

Terminology Reminders:

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pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

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		NON-MSA PLANS			MSA PLANS		
14.2	Medication In- and out-of-hospital Medication via DSP Bankmed Pharmacy Network Medication via a non-DSP Voluntary use of non-DSP Medication via non-DSP Involuntary use of non-DSP	- Limited to PMBs 100% of cost, limited to PMBs 80% of Scheme Medicine Reference Price plus dispensing fee, limited to PMBs 100% of cost, limited to PMBs		- Unlimited 100% of cost 80% of Scheme Medicine Reference Price plus dispensing fee 100% of cost			
15.	PREGNANCY AND CHILDBIRTH Subject to pre-authorisation and PMB regulations						
15.1	Baby-and-Me Programme for expectant mothers	No benefit	Call 0800 BANKMED (0800 226 5633) to register				No benefit
15.2	Hospitalisation and associated in-hospital services Subject to pre-authorisation	- Refer to 'Hospitalisation' benefit section - Hospital network rules apply - Limited to PMBs	- Refer to 'Hospitalisation' benefit section - Hospital network rules apply				
15.3	Midwife care and delivery Subject to pre-authorisation	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited				
15.4	Birthing facilities as an alternative to hospitalisation Subject to pre-authorisation Only available where hospital services are not used, except registered active birthing units	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs - Cost of disposables limited to R1 440 per case	100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited - Cost of disposables limited to R1 440 per case				
15.5	Antenatal and postnatal care GP and specialist consultations and procedures in-rooms	- Refer to 'GP Consultations In-room or Out-of-hospital', and 'Specialist Consultations In-room or Out-of-hospital' benefit sections - Limited to PMBs	- Refer to 'GP Consultations In-room or Out-of-hospital', and 'Specialist Consultations In-room or Out-of-hospital' benefit sections - Refer to additional Insured Benefits under Baby-and-Me Programme				Refer to 'GP Consultations In-room or Out-of-hospital', and 'Specialist Consultations In-room or Out-of-hospital' benefit sections

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
15.6	Antenatal and postnatal care Ultrasonic investigations Radiology	- Refer to ‘Radiology and pathology’ benefit section - Limited to PMBs	- Refer to ‘Radiology and pathology’ benefit section - Refer to additional Insured Benefits under Baby-and-Me Programme			Refer to ‘Radiology and pathology’ benefit section	
15.7	Antenatal and postnatal care Pathology	- Refer to ‘Radiology and pathology’ benefit section - Limited to PMBs	- Refer to ‘Radiology and pathology’ benefit section - Refer to additional Insured Benefits under Baby-and-Me Programme			Refer to ‘Radiology and pathology’ benefit section	
15.8	Additional Insured Benefits Subject to registration on the Baby-and-Me Programme	No benefit	- Additional Insured Benefits subject to referral by GP in Bankmed Entry Plan GP Network (Basic Plan member) or GP in Bankmed GP Network (Core Saver, Traditional and Comprehensive Plan members) - Six antenatal consultations per pregnancy at the contracted rate for Bankmed’s GP Network and Prestige A and B Specialist Network - Refer to ‘GP Consultations In-room or Out-of-hospital’, and ‘Specialist Consultations In-room or Out-of-hospital’ benefit sections - Three 2D ultrasounds at 100% of Scheme Rate - R1 770 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 BOC			- Additional Insured Benefits not applicable on this Plan - Members may register on the programme to obtain information, guidance and support throughout the pregnancy	
16.	RADIOLOGY AND PATHOLOGY						
16.1	Radiology In-hospital	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited				
16.2	Pathology In-hospital	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited				
16.3	MRI/CT scans, radionuclide scans In- and out-of-hospital Subject to pre-authorisation and PMB regulations						
	In-hospital Subject to pre-authorisation and PMB regulations	100% of cost for radiology facilities at hospital network DSP - Limited to 100% of Scheme Rate for voluntary use of radiology facilities at non-DSP - Limited to PMBs	100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited	100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited			

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
	Out-of-hospital Subject to pre-authorisation and PMB regulations	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited			
16.4	Radiology and pathology Out-of-hospital	- Limited to PMBs 100% of cost for PMBs - Benefits subject to a CDL (BOC) registration for PMB conditions	- Unlimited via DSP 100% of cost at DSP - DSP: Bankmed Entry Plan GP Network - Subject to Scheme Radiology and Pathology Formulary - Specialist requested/performed radiology/pathology subject to available 'Specialist Consultations In-room or Out-of-hospital' benefit	100% of cost at DSP for PMB 100% of Scheme Rate, limited to R7 520 pfpa for non-DSP or non-PMB - Combined limit for 'Radiology and pathology out-of-hospital'	100% of cost at DSP for PMB - Subject to referral by GP in Bankmed GP Network (DSP) 100% of Scheme Rate, subject to a CDL (BOC) and referral by GP in Bankmed GP Network (DSP) - Benefits approved for beneficiaries registered for PMB CDL conditions - Non-CDL benefits subject to available MSA	Radiology: 100% of cost at DSP for PMB 100% of Scheme Rate, limited to R5 040 pfpa (including a sub-limit of R3 195 pfpa for out-of-hospital pathology) - Thereafter subject to available MSA Pathology: 100% of cost at DSP for PMB 100% of Scheme Rate, limited to R3 195 pfpa (included in the annual limit of R5 040 pfpa for out-of-hospital radiology) - Thereafter subject to available MSA	100% of cost at DSP for PMB 300% of Scheme Rate, subject to available MSA - 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 R8 010 pfpa
17.	ALTERNATIVES TO HOSPITALISATION Subject to pre-authorisation and PMB regulations						
17.1	Step-down facilities	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited				
17.2	Advanced Illness Benefit End-of-life treatment Subject to pre-authorisation and PMB regulations and the treatment meeting the Scheme's guidelines and managed care criteria	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs		100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited			
17.3	Frail care facilities	No benefit		100% of cost, limited to R575 pb per day	No benefit	100% of cost, limited to R575 pb per day	

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
17.4	Home nursing	• No benefit		• 100% of cost, limited to R455 pb per day	• No benefit	• 100% of cost, limited to R455 pb per day	
17.5	HomeCare services For procedures not requiring admission to a day surgery or hospital. Subject to clinical entry criteria, pre-authorisation, and PMB regulations	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited				
17.6	Spinal Conservative Care Programme • In-hospital and out-of-hospital management for spinal care and surgery • Limited to a defined list of clinically appropriate procedures which include Lumbar Fusion, Cervical Fusion, Laminectomy, Laminotomy	• 100% of cost for the hospital account at a network facility • Network does not apply to any admissions related to trauma • 100% of the Scheme Rate for the hospital account if performed at a non-network facility • 100% of cost for related accounts at a DSP • 100% of Scheme Rate for related accounts at a non-DSP • Limited to PMBs • Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria • Subject to PMB regulations • BOC as set by the Scheme for out-of-hospital conservative treatment		• 100% of cost for the hospital account at a network facility • Network does not apply to any admissions related to trauma • 100% of the Scheme Rate for the hospital account if performed at a non-network facility • 100% of cost for related accounts at a DSP • 100% of Scheme Rate for related accounts at a non-DSP • Unlimited • Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria • Subject to PMB regulations • BOC as set by the Scheme for out-of-hospital conservative treatment			
18.	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 and not the hospital and related accounts. All sub-limits are subject to the combined Internal Prosthesis limit of R91 190 pbpa (excluding pacemakers and defibrillators)						
18.1	Internal prosthesis	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to the combined 'Internal prosthesis' limit of R91 190 pbpa for all internal prosthesis items				
18.2	Spinal fusions	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of Scheme Rate for device • Limited to R61 440 pbpa • Subject to the combined 'Internal prosthesis' limit				
18.3	Cardiac stents	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of Scheme Rate for device • Limited to R90 830 pbpa • Subject to the combined 'Internal prosthesis' limit				

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
18.4	Grafts	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of Scheme Rate for device - Limited to R49 170 pbpa - Subject to the combined 'Internal prosthesis' limit				
18.5	Cardiac valves	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of Scheme Rate for device - Limited to R 51 715 pbpa - Subject to the combined 'Internal prosthesis' limit				
18.6	Hip, knee and shoulder joints	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of Scheme Rate for device - If prosthesis is not supplied by Scheme's network provider (DSP): Limited to R60 685 per prosthesis per admission - If prosthesis is supplied by the Scheme's network provider (DSP): Unlimited and not subject to the combined 'Internal prosthesis' limit				
18.7	Non-specified Items	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of Scheme Rate for device - Limited to R28 335 pbpa - Subject to the combined 'Internal prosthesis' limit				
19.	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						
19.1	Pacemakers and defibrillators	- Limited to PMBs 100% of cost at hospital network DSP 80% of cost at non-DSP	100% of cost, unlimited, if preferred provider used 100% of Scheme Rate if non-preferred provider used to purchase device				
20.	INTRAOCULAR LENSES FOR CATARACT SURGERY Subject to pre-authorisation and PMB regulations and the treatment meeting the Scheme's criteria. Covered in full when supplied by the Scheme's preferred suppliers, otherwise covered up to 100% of the Scheme Rate for the lens						
20.1	Intraocular lenses for cataract surgery Permanent, implantable lenses, inclusive of basic and specialised lens varieties	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 - 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		

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
fpfa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

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21.	COCHLEAR IMPLANT Subject to pre-authorisation and PMB regulations and Scheme protocols. Once in a lifetime benefit. Funding only available in recognised Centres of Excellence. Bilateral cochlear implant benefits may be awarded to children under the age of 5 years, where clinical entry criteria are met. Subject to special motivation, clinical review and authorisation						
21.1	Hospitalisation	No benefit	Refer to ‘Hospitalisation’ benefit section	No benefit	Refer to ‘Hospitalisation’ benefit section		
21.2	Pre-operative evaluation and associated preparation costs	No benefit	- R21 605 pb per lifetime 100% of Scheme Rate	No benefit	- R21 605 pb per lifetime 100% of Scheme Rate		
21.3	Cochlear implant device	No benefit	- R452 990 pb per lifetime 100% of Scheme Rate	No benefit	- R452 990 pb per lifetime 100% of Scheme Rate		
21.4	Intra-operative audiology testing	No benefit	- R1 125 pb per lifetime 100% of Scheme Rate	No benefit	- R1 125 pb per lifetime 100% of Scheme Rate		
21.5	Post-operative evaluation costs	No benefit	- R45 370 pb per lifetime 100% of Scheme Rate	No benefit	- R45 370 pb per lifetime 100% of Scheme Rate		
22.	SPEECH PROCESSORS Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval						
22.1	Upgrade or replacement of speech processors	No benefit	100% of Scheme Rate - Limited to R169 140 pb over a three-year cycle	No benefit	100% of Scheme Rate - Limited to R169 140 pb over a three-year cycle		
23.	HEARING AIDS						
23.1	Hearing aids Supply and fitment	No benefit, except for PMBs	100% of Scheme Rate, limited to R36 335 pb every second year (rolling 24 months)	100% of Scheme Rate, subject to available MSA	100% of Scheme Rate, limited to R36 335 pb every second year (rolling 24 months)	100% of Scheme Rate, limited to R42 540 pb every second year (rolling 24 months)	
23.2	Hearing aid repairs	No benefit	100% of Scheme Rate - Limited to R1 885 pbpa	100% of Scheme Rate - Subject to available MSA	100% of Scheme Rate - Limited to R1 885 pbpa		
23.3	Bone anchored hearing aids	No benefit	90% of Scheme Rate - Limited to R194 345 pfpa	100% of Scheme Rate - Subject to available MSA	90% of Scheme Rate - Limited to R194 345 pfpa		

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

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		NON-MSA PLANS			MSA PLANS		
24.	EXTERNAL PROSTHESIS, MEDICAL AND SURGICAL APPLIANCES, BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS Benefit includes the repair of the prosthesis						
24.1	External prosthesis Benefit for limbs and eyes	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to R4 005 pfpa - Combined limit with 'Blood pressure monitors, nebulisers and glucometers' benefits	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to R31 110 pfpa	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to R4 005 pfpa - Combined limit with 'Medical and surgical appliances', 'Blood pressure monitors, nebulisers and glucometers', and 'Arch supports and shoe insoles' benefits	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to R31 110 pfpa	
24.2	Medical and surgical appliances Refer to claim 'Frequency limits' in 24.6 below	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs - No benefit for wheelchairs and large orthopaedic appliances on this Plan, except for PMBs - Only payable if claimed from a service provider with a valid BHF practice number	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs - Combined limit of R4 005 pfpa with 'External prosthesis', 'Blood pressure monitors', 'Nebulisers and glucometers' benefits - Subject to pre- authorisation and PMB regulations - No benefit for wheelchairs and large orthopaedic appliances on this Plan, except for PMBs - Only payable if claimed from a service provider with a valid BHF practice number	Post-surgery appliances: 100% of Scheme Rate - Limited to R9 145 pbpa Chronic appliances: 100% of cost - Limited to: - R28 720 pbpa for oxygen/ oxygen delivery systems - R28 720 pbpa for stoma products - R9 145 pbpa for 'Other chronic appliances', including wheelchairs - Sub-limits as follows: - R1 125 arch supports (Per pair) - R1 695 shoe insoles (Per pair) 'Other chronic appliances' limit extended to R13 380 for beneficiaries requiring a CPAP machine	- Limit of R4 005 pfpa - Combined limit with 'External prosthesis', 'Blood pressure monitors, nebulisers and glucometers', and 'Arch supports and shoe insoles' benefits - Benefits for wheelchairs and large orthopaedic appliances at 100% of Scheme Rate, subject to available MSA - Only payable if claimed from a service provider with a valid BHF practice number	Post-surgery appliances: 100% of Scheme Rate - Limited to R9 145 pbpa Chronic appliances: 100% of cost - Limited to: - R28 720 pbpa for oxygen/ oxygen delivery systems - R28 720 pbpa for stoma products - R9 145 pbpa for 'Other chronic appliances', including wheelchairs - Sub-limits as follows: - R1 125 arch supports (Per pair) - R1 695 shoe insoles (Per pair) 'Other chronic appliances' limit extended to R13 380 for beneficiaries requiring a CPAP machine	Post-surgery appliances: 100% of Scheme Rate - Limited to R9 145 pbpa Chronic appliances: 100% of cost - Limited to: - R28 720 pbpa for oxygen/ oxygen delivery systems - R28 720 pbpa for stoma products - R9 145 pbpa for 'Other chronic appliances', including wheelchairs - Sub-limits as follows: - R1 125 arch supports (Per pair) - R1 695 shoe insoles (Per pair) 'Other chronic appliances' limit extended to R13 380 for beneficiaries requiring a CPAP machine

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

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		NON-MSA PLANS			MSA PLANS		
			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, if members 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.	Appliances for acute conditions: 100% of Scheme Rate - Limited to R9 145 pbpa - Combined limit with ‘Other chronic appliances’ benefits - 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		Appliances for acute conditions: 100% of Scheme Rate - Subject to available MSA - 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	Appliances for acute conditions: 100% of Scheme Rate - Subject to available MSA - ATB applies once the Annual Threshold is reached 100% of Scheme Rate in ATB - 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
24.3	Blood pressure monitors (BPM), nebulisers and glucometers Refer to claim ‘Frequency limits’ in 24.6 below	- Subject to pre-authorisation and PMB regulations 100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs		- Subject to pre-authorisation and PMB regulations 100% of Scheme Rate - Limit of R4 005 pfpa - Combined limit with ‘External prosthesis’ and ‘Medical and surgical appliances’ benefits - Sub-limits as follows: - BPM: R1 540 pbpa - Nebulisers: R2 175 pbpa - Glucometers: R1 085 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 - Limit of R9 145 pbpa - Combined limit with ‘Other chronic appliances’ under ‘Medical and surgical appliances’ benefits - Sub-limits as follows: - BPM: R1 540 pbpa - Nebulisers: R2 175 pbpa - Glucometers: R1 085 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 - Limit of R4 005 pfpa - Combined limit with ‘External prosthesis’, ‘Medical and surgical appliances’, and ‘Arch supports and shoe insoles’ benefits - Sub-limits as follows: - BPM: R1 540 pbpa - Nebulisers: R2 175 pbpa - Glucometers: R1 085 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 - Limit of R9 145 pbpa - Combined limit with ‘External prosthesis’ and ‘Medical and surgical appliances’ benefits - Sub-limits as follows: - BPM: R1 540 pbpa - Nebulisers: R2 175 pbpa - Glucometers: R1 085 pbpa - Only payable if claimed from a service provider with a valid BHF practice number

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

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		NON-MSA PLANS			MSA PLANS																																																		
24.4	Arch supports and shoe insoles Refer to claim ‘Frequency limits’ in 24.6 below	• No benefit		• Refer to 24.3	• 100% of Scheme Rate • Limit of R4 005 pfpa • Combined limit with ‘External prosthesis’, ‘Medical and surgical appliances’, and ‘Blood pressure monitors, nebulisers and glucometers’ benefits • Sub-limits as follows: • R1 125 arch supports (Per pair) • R1 695 shoe insoles (Per pair) • Only payable if claimed from a service provider with a valid BHF practice number	• Refer to 24.3																																																	
24.5	Breast pumps and baby monitors	• No benefit		• Limit of R9 145 pbpa • Combined limit with ‘Other chronic appliances’ under ‘Medical and surgical appliances’ benefits • Only payable if claimed from a service provider with a valid BHF practice number	• Funded from available MSA • Only payable if claimed from a service provider with a valid BHF practice number																																																		
24.6	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: <table><tr><th>Appliance/device</th><th>Frequency</th><th>Appliance/device</th><th>Frequency</th><th>Appliance/device</th><th>Frequency</th></tr><tr><td>Blood pressure monitor</td><td>Once every three years</td><td>Breast prosthesis</td><td>Once every two years (single/pair)</td><td>Surgical boot/moon boot</td><td>Once every three years</td></tr><tr><td>Humidifier</td><td>Once every three years</td><td>Wheelchair</td><td>Once every three years</td><td>Brace/callipers</td><td>Once every three years</td></tr><tr><td>CPAP machine</td><td>Once every three years</td><td>Compression stockings</td><td>Two per year</td><td>Wig</td><td>Once every three years</td></tr><tr><td>Crutches</td><td>Once every two years</td><td>Portable oxygen</td><td>Once every four years</td><td>Breast prosthesis bra*</td><td>Once every three years</td></tr><tr><td>Rigid back brace</td><td>Once every two years</td><td>Glucometer</td><td>Once every three years</td><td>Commode</td><td>Once every three years</td></tr><tr><td>Foot orthotics</td><td>Once every two years</td><td>Nebuliser</td><td>Once every three years</td><td>Walking frame</td><td>Once every three years</td></tr><tr><td>Sling/clavicle brace</td><td>Once every two years</td><td></td><td></td><td></td><td></td></tr></table> • These 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						Appliance/device	Frequency	Appliance/device	Frequency	Appliance/device	Frequency	Blood pressure monitor	Once every three years	Breast prosthesis	Once every two years (single/pair)	Surgical boot/moon boot	Once every three years	Humidifier	Once every three years	Wheelchair	Once every three years	Brace/callipers	Once every three years	CPAP machine	Once every three years	Compression stockings	Two per year	Wig	Once every three years	Crutches	Once every two years	Portable oxygen	Once every four years	Breast prosthesis bra*	Once every three years	Rigid back brace	Once every two years	Glucometer	Once every three years	Commode	Once every three years	Foot orthotics	Once every two years	Nebuliser	Once every three years	Walking frame	Once every three years	Sling/clavicle brace	Once every two years				
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		NON-MSA PLANS			MSA PLANS		
25.	PSYCHIATRY, CLINICAL PSYCHOLOGY AND RELATED OCCUPATIONAL THERAPY						
25.1	Hospitalisation Subject to pre-authorisation and PMB regulations Hospital Network DSP • All admissions at network DSP Other hospitals (non-DSP) • 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 Entry Plan GP Network GP (DSP) • 100% of cost for Bankmed Network Psychiatric facilities (DSP) • 100% of cost • 80% of Scheme Rate • No benefit • 100% of cost for Bankmed Entry Plan Specialist Network (DSP) • 100% of Scheme Rate for non-DSP • Cover for 21 days in hospital in line with PMB regulations	• Limited to R85 215 pbpa • 100% of cost for Bankmed Network Psychiatric facilities (DSP) • 100% of cost • 80% of Scheme Rate • 80% of Scheme Rate • 100% of cost for Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for non-DSP • Cover for 21 days in hospital in line with PMB regulations, with dual accumulation to the Rand limit • Continued benefits for PMBs subject to pre-authorisation and PMB regulations • Combined limit with ‘Occupational therapy: psychiatric consultations/sessions in hospital’ benefit				
25.2	30-Day Post-hospital Psychiatric Consultation Benefit Access to psychiatric consultation within 30 days of hospital discharge 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 pb within 30 days of being discharged from hospital following an authorised psychiatric admission • Covered as an Insured Benefit • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Entry Plan Specialist Network for psychiatrist only • Limited to three consultations pbpa, following an authorised admission, thereafter, funded from ‘Specialist Consultations In-room or Out-of-hospital’ benefits	• One additional post-hospitalisation psychiatrist consultation covered pb within 30 days of being discharged from hospital following an authorised psychiatric admission • Covered as an Insured Benefit • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Prestige A and B Specialist Network for psychiatrist only • Limited to three consultations pbpa, following an authorised admission, thereafter, funded from ‘Specialist Consultations In-room or Out-of-hospital’ benefits or available MSA, as applicable per Plan				

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
25.3	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 and PMB regulations and referral from a Bankmed Entry Plan GP Network GP (DSP) 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSP) 100% of Scheme Rate for non-DSP	- Limited to R5 340 pbpa 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) 100% of Scheme Rate for non-DSP - Combined limit with ‘Occupational therapy: Psychiatric consultations/ sessions out-of-hospital’ benefit - Combined limit may be extended to R13 300 pbpa for Depression and/or Bipolar mood disorder, subject to pre-authorisation and PMB regulations	- Subject to available MSA - Benefits subject to pre-authorisation and PMB regulations and referral from a Bankmed Network GP (DSP) 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Prestige A and B Specialist Network (DSP) 100% of Scheme Rate for non-DSP, subject to available MSA	- Limited to R6 240 pbpa 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) 100% of Scheme Rate for non-DSP - Combined limit with ‘Occupational therapy: Psychiatric consultations/ sessions out-of-hospital’ benefit - Combined limit may be extended to R14 875 pbpa for Depression and/or Bipolar mood disorder, subject to pre-authorisation and PMB regulations	- Subject to available MSA - Benefits subject to PMB regulations and Bankmed Prestige A and B Specialist Network (DSP) 100% of cost at contracted rate from Insured Benefits for PMBs at Bankmed Prestige A and B Specialist Network (DSP) 300% of Scheme Rate for non-DSP, subject to available MSA - 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 R18 850 pfpa	
25.4	Mental Health Integrated Disease Management Programme Disease Management for specified mental health conditions for members registered on the Scheme’s Mental Health Integrated Disease Management Programme	- In addition to the cover provided under the PMB regulations 100% of the Scheme Rate for services covered in the Scheme’s BOC if referred by the Scheme’s DSP 100% of Scheme Rate for services performed by the Scheme’s DSP - Limited to the BOC set by the Scheme - Subject to the treatment meeting the Scheme’s treatment guidelines and managed care criteria - Subject to PMB regulations					

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
26.	OCCUPATIONAL THERAPY						
26.1	Psychiatric consultations/ sessions In-hospital Subject to pre-authorisation and PMB regulations	Refer to ‘Psychiatry, clinical psychology and related occupational therapy: Hospitalisation and in-hospital consultations/sessions’ benefit section					
26.2	Psychiatric consultations/ sessions Out-of-hospital	Refer to ‘Psychiatry, clinical psychology and related occupational therapy: Consultations/sessions out-of-hospital’ benefit section					
26.3	Non-psychiatric consultations/sessions In-hospital Subject to pre-authorisation and PMB regulations	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs	100% of cost at DSP 100% of Scheme Rate at non-DSP - Unlimited		
26.4	Non-psychiatric consultations/sessions Out-of-hospital	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to PMBs - Subject to pre-authorisation and PMB regulations, and referral from a Bankmed Entry Plan GP Network (DSP)	100% of cost for PMB at DSP 100% of Scheme Rate at non-DSP - Limited to R2 620 pfpa	100% of cost for PMB at DSP 100% of Scheme Rate at non-DSP 100% of Scheme Rate, subject to available MSA for non-PMBs	100% of cost for PMB at DSP 100% of Scheme Rate at non-DSP - Limited to R2 755 pfpa, from Insured Benefits - Thereafter subject to available MSA	100% of cost at DSP from Insured Benefits for PMBs 300% of Scheme Rate, subject to available MSA for non-PMBs - 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 R9 505 pfpa. - Subject to PMB regulation	

	ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025	
	NON-MSA PLANS			MSA PLANS			
27.	SPEECH THERAPY, AUDIO THERAPY AND AUDIOLOGY						
27.1	Speech therapy, audio therapy and audiology In- and out-of-hospital	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs • Subject to pre-authorisation and PMB regulations, and referral from a Bankmed Entry Plan GP Network (DSP) • Out-of-hospital cover is subject to PMB application	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs • Subject to pre-authorisation and PMB regulations, and referral from a Bankmed Entry Plan GP Network (DSP)	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R2 620 pfpa	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to available MSA • 100% of cost paid from Insured Benefits for PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R2 835 pfpa • 100% of cost paid from Insured Benefits for PMBs • Thereafter subject to available MSA	• 100% of cost at DSP • 300% of Scheme Rate at non-DSP • Subject to available MSA • 100% of cost paid from Insured Benefits for PMBs • 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 835 pfpa
28.	PHYSIOTHERAPY						
28.1	Physiotherapy In-hospital Subject to pre-authorisation	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited		
28.2	Post-hospitalisation Physiotherapy Benefit Applies within six weeks of discharge from hospital or approved day surgery facility, following an authorised hospital or approved day surgery facility admission	• Refer to ‘Physiotherapy out-of-hospital’ benefit section	• 100% of Scheme Rate • Limited to R3 795 pfpa • 100% of cost at DSP • 100% of Scheme Rate at non-DSP	• Refer to ‘Physiotherapy out-of-hospital’ benefit section	• 100% of Scheme Rate • Limited to R3 145 pbpa from Insured Benefits • Thereafter subject to available MSA • 100% of cost at DSP • 100% of Scheme Rate at non-DSP	• Refer to ‘Physiotherapy out-of-hospital’ benefit section	
28.3	Physiotherapy Out-of-hospital	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to pre-authorisation and PMB regulations, and referral from a Bankmed Entry Plan GP Network GP (DSP) • Limited to PMBs	• 100% of Scheme Rate • Subject to ‘GP Consultations In-room or Out-of-hospital’, and ‘Specialist Consultations In-room or Out-of-hospital’ benefits • 100% of cost at DSP • 100% of Scheme Rate at non-DSP	• 100% of Scheme Rate • Subject to available MSA for non-PMBs • 100% of cost for PMBs • 100% of cost at DSP • 100% of Scheme Rate at non-DSP		• 300% of Scheme Rate • Subject to available MSA for non-PMBs • 100% of cost for PMBs • 100% of cost at DSP • ATB applies once Annual Threshold is reached • The maximum amount that can jointly accumulate towards	

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
							reaching the Annual Threshold (at 100% of Scheme Rate) and/ or be paid as an ATB (always subject to available ATB) is R3 795 pbpa
29.	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						
29.1	Occupational therapy: psychiatric consultations/ sessions Out-of-hospital	No benefit	100% of Scheme Rate or contracted rate, whichever applies				
29.2	Occupational therapy: non-psychiatric consultations/ sessions Out-of-hospital	No benefit	100% of cost at DSP 100% of Scheme Rate at non-DSP				
29.3	Physiotherapy Out-of-hospital	No benefit	100% of cost at DSP 100% of Scheme Rate at non-DSP				
29.4	Speech therapy Out-of-hospital	No benefit	100% of cost at DSP 100% of Scheme Rate at non-DSP				
30.	OTHER AUXILIARY SERVICES In- and out-of-hospital						
30.1	Auxiliary allied services Chiropody, Podiatry, Dietetics (nutritional assessments), Orthotics, Massage, Chiropractors, Herbalists, Naturopaths, Family Planning Clinics, Homeopaths and Biokineticists (fitness assessments)	- Limited to PMBs and subject to PMB regulations 100% of cost at DSP 100% of Scheme Rate at non-DSP - Out-of-hospital cover is subject to PMB application, referral by GP in the Bankmed Entry Plan GP Network (DSP), and pre-authorisation - Frequency limits apply		- Limited to R4 005 pfpa 100% of cost at DSP 100% of Scheme Rate at non-DSP - Frequency limits apply	- Limited to available MSA for non-PMBs 100% of cost at DSP 100% of Scheme Rate at non-DSP - Frequency limits apply		- Limited to available MSA for non-PMBs 100% of cost at DSP - Frequency limits apply - 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 R4 005 pfpa

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
31.	MAXILLOFACIAL AND ORAL SURGERY Benefits for caps, crowns, bridges, endosteal and ossea-integrated implants are detailed under ‘Advanced dentistry’ whilst orthodontic benefits are detailed under ‘Orthodontics’						
31.1	Maxillofacial and oral surgery Procedures and treatment in- and out-of-hospital Subject to pre-authorisation and PMB regulation	- Limited to PMBs 100% of cost at contracted rate for Bankmed Entry Plan Specialist Network (DSP) 100% of Scheme Rate for non-DSP	- Unlimited 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) 100% of Scheme Rate for non-DSP - Benefit inclusive of elective treatment	- Limited to PMBs 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) 100% of Scheme Rate for non-DSP	- Unlimited 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP) 100% of Scheme Rate for non-DSP - Benefit inclusive of elective treatment		
32.	DENTISTRY Subject to pre-authorisation and PMB regulations.						
32.1	Preventative and basic dentistry	No benefit	- Unlimited 100% of cost at Bankmed Dental Network (DSP) - Bankmed Dental Formulary applies - No benefits for non-DSP or non-Formulary treatment	- Unlimited 100% of cost at DSP 100% of Scheme Rate at non-DSP - Sub-limits apply: - One oral examination pbpa - Amalgam and resin fillings only - Plastic dentures only - Two topical fluoride treatments pbpa (age 15 years and younger) - One topical fluoride treatment pfpa - Limited to eight molar teeth pb per lifetime - Scale and polish limited to two pbpa	- Limited to available MSA 100% of cost at DSP 100% of Scheme Rate at non-DSP	- Unlimited 100% of cost at DSP 100% of Scheme Rate at non-DSP - Funded from Insured Benefit - Sub-limits apply: - One oral examination pbpa - Amalgam and resin fillings only - Plastic dentures only - Two topical fluoride treatments pbpa (age 15 years and younger) - One topical fluoride treatment pfpa - Limited to eight molar teeth pb per lifetime - Scale and polish limited to two pbpa	100% of cost at DSP 300% of Scheme Rate, subject to available MSA - 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 R22 730 for a single member and R34 430 for a family

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
32.2	Advanced dentistry Caps, crowns, bridges and cost of endosteal and ossea-integrated implants	• No benefit		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to: • M: R8 770 pbpa • M + 1 +: R13 600 pfpa • Combined limit for ‘Advanced dentistry’, ‘Orthodontics’ and ‘All other dental services’	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • 100% of cost for PMBs • Subject to available MSA for non-PMBs	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to: • M: R6 830 pbpa • M + 1 +: R11 440 pfpa • Thereafter subject to available MSA	
32.3	Orthodontics Subject to orthodontic quotation and prior approval from Scheme	• No benefit		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to ‘Advanced dentistry’ limit	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to available MSA	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Limited to R11 440 pfpa • Thereafter subject to available MSA	
32.4	All other dental services	• No benefit	• 100% of cost at Bankmed Dental Network (DSP), and • Bankmed Dental Formulary applies to: • Second and subsequent exams in same year • X-rays	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to ‘Advanced dentistry’ limit	• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Subject to available MSA		
33.	GENERAL PRACTITIONERS (GPs)						
33.1	GP consultations In-hospital	• Limited to PMBs • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Entry Plan GP Network	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed Entry Plan GP Network	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP • DSP: Bankmed GP Network			
33.2	GP procedures In-hospital	• Limited to PMBs • 100% of cost at DSP • 100% of Scheme Rate for non-DSP (including PMBs) • DSP: Bankmed Entry Plan GP Network • No benefit for dental surgery, except for PMBs	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP (including PMBs) • DSP: Bankmed Entry Plan GP Network • No benefit for dental surgery, except for PMBs	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP (including PMBs) • DSP: Bankmed GP Network	• Unlimited • 100% of cost at DSP • 100% of Scheme Rate for non-DSP (including PMBs) • DSP: Bankmed GP Network • No benefit for dental surgery, except for PMBs	• Unlimited • 100% of cost at DSP • 125% of Scheme Rate for non-DSP (including PMBs) • DSP: Bankmed GP Network	• Unlimited • 100% of cost at DSP • 300% of Scheme Rate for non-DSP (including PMBs) • DSP: Bankmed GP Network

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
33.3	30-Day Post-hospital GP Consultation Benefit 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 pb visiting a GP within 30 days of discharge, following an authorised hospital admission 100% of cost at the contracted rate for Bankmed Entry Plan GP Network (DSP) 100% of Scheme Rate for non-DSP	- One additional post-hospitalisation GP consultation covered as an Insured Benefit pb visiting a GP within 30 days of discharge, following an authorised hospital admission 100% of cost at the contracted rate via Bankmed Entry Plan GP Network (DSP) 100% of Scheme Rate for non-DSP - Subject to the 'Out-of-network GP Benefit' limit	- One additional post-hospitalisation GP consultation covered as an Insured Benefit pb 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 (DSP) 100% of Scheme Rate for non-DSP			
33.4	GP consultations In-room or out-of-hospital	- Limited to PMBs 100% of cost at DSP 100% of Scheme Rate for non-DSP - DSP: Bankmed Entry Plan GP Network	- Unlimited 100% of cost at DSP 100% of Scheme Rate for non-DSP - DSP: Bankmed Entry Plan GP Network - Member to nominate primary GP within network Out-of-network GP Benefit - Limited to three visits, to a maximum of R2 755 pfpa (at DSP rate) for consultations, procedures and medication at non-network GP - When the nominated DSP GP is not available, or the beneficiary is out of town, the 'Out-of-network GP Benefit' includes all costs associated with out-of-network consultation	- Combined limit for 'GP Consultations In-room or Out-of-hospital', and 'Specialist Consultations In-room or Out-of-hospital' benefits: - M: R4 420 pbpa - M + 1: R8 005 pfpa - M + 2: R9 280 pfpa 100% of cost at DSP 100% of Scheme Rate for non-DSP - DSP: Bankmed GP Network - Unlimited if DSP used - Continued benefits for beneficiaries with PMB conditions, subject to PMB regulations	Bankmed GP Network benefits (DSP): - Unlimited for PMBs 100% of cost - Limited to two consultations from Insured Benefits for non-PMBs, thereafter subject to available MSA Non-network GP benefits (non-DSP): 100% of Scheme Rate from Insured Benefits for PMBs 100% of Scheme Rate, subject to available MSA for non-PMBs	Bankmed GP Network benefits (DSP): - Unlimited for PMBs 100% of cost - Non-PMBs subject to available MSA Non-network GP benefits (non-DSP): 100% of Scheme Rate from Insured Benefits for PMBs 100% of Scheme Rate, subject to available MSA for non-PMBs	Bankmed GP Network benefits (DSP): - Unlimited for PMBs 100% of cost - Non-PMBs subject to available MSA/ATB Non-network GP benefits (non-DSP): 100% of Scheme Rate from Insured Benefits for PMBs 300% of Scheme Rate, subject to available MSA/ATB for non-PMBs - ATB applies once Annual Threshold is reached

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
33.5	GP procedures In-room or out-of-hospital	- Limited to PMBs 100% of cost at DSP 100% of Scheme Rate for non-DSP - DSP: Bankmed Entry Plan GP Network	Refer to ‘GP Consultations In-room or Out-of-hospital’ benefit section	- Unlimited 100% of cost at DSP 100% of Scheme Rate for non-DSP - DSP: Bankmed GP Network	Bankmed GP Network benefits (DSP): - Unlimited for PMBs 100% of cost - Non-PMBs subject to available MSA Non-network GP benefits (non-DSP): 100% of Scheme Rate from Insured Benefits for PMBs 100% of Scheme Rate, subject to available MSA for non-PMBs	Bankmed GP Network benefits (DSP): - Unlimited for PMBs 100% of cost Non-network GP benefits (non-DSP): 100% of Scheme Rate from Insured Benefits for PMBs 125% of Scheme Rate from Insured Benefits for non-PMBs	Bankmed GP Network benefits (DSP): - Unlimited for PMBs 100% of cost Non-network GP benefits (non-DSP): 100% of Scheme Rate from Insured Benefits for PMBs 300% of Scheme Rate from Insured Benefits for non-PMBs
33.6	GP consultations Virtual or online Subject to verification notes submitted by claiming GP Subject to Out-of-hospital GP Benefits and Limits	100% of cost for Bankmed Entry Plan GP Network GPs (DSP) 100% of Scheme Rate for non-DSP - Limited to three consultations pbpa - Limited to PMBs	100% of cost for Bankmed Entry Plan GP Network GPs (DSP) 100% of Scheme Rate for non-DSP - Limited to three consultations pbpa - Subject to the ‘Out-of-network GP Benefit’ limit if non-DSP used	100% of cost for Bankmed Network GPs (DSP) 100% of Scheme Rate for non-DSP - Limited to three consultations pbpa	100% of cost for Bankmed Network GPs (DSP) 100% of Scheme Rate for non-DSP - Limited to three consultations pbpa - Subject to available MSA for non-PMBs		100% of cost for Bankmed Network GPs (DSP) 100% of Scheme Rate for non-DSP - Limited to three consultations pbpa - Subject to available MSA/ATB for non-PMBs
34.	SPECIALISTS NB: Psychiatrists, oncologists, radiologists, pathologists, and other dental practitioners are covered elsewhere in these Benefit Tables						
34.1	Specialist consultations and procedures In-hospital	- Limited to PMBs 100% of cost for Bankmed Entry Plan Specialist Network (DSP) 100% of Scheme Rate for non-DSP	- Unlimited 100% of cost for Bankmed Entry Plan Specialist Network (DSP) 100% of Scheme Rate for non-DSP	- Unlimited 100% of cost for Bankmed Prestige A and B Specialist Network (DSP) 100% of Scheme Rate for non-DSP			- Unlimited 100% of cost for Bankmed Prestige A and B Specialist Network (DSP) 300% of Scheme Rate for non-DSP

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
34.2	Specialist consultations In-room or out-of-hospital Pre-authorisation required for all Plans, excluding Comprehensive and Plus Make use of our DSP to limit or avoid co-payments	- Limited to PMBs - Benefits subject to referral by GP in Bankmed Entry Plan GP Network and approved BOC registration for PMB conditions 100% of cost for Bankmed Entry Plan Specialist Network (DSP) 80% of cost if no pre-authorisation and no referral from a Bankmed Entry Plan GP Network GP (DSP) 100% of Scheme Rate for non-DSP 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed Entry Plan GP Network GP (DSP)	- Limited to: - M: R4 460 pbpa - M + 1 +: R6 985 pfpa Combined limit with 'Specialist procedures: In-room or Out-of-hospital' benefit - Benefits subject to referral by a Bankmed Entry Plan GP Network GP 100% of cost for Bankmed Entry Plan Specialist Network (DSP) 80% of cost if no pre-authorisation and no referral from a Bankmed Entry Plan GP Network GP (DSP) 100% of Scheme Rate for non-DSP 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed Entry Plan GP Network GP (DSP) - Annual limit includes basic radiology, scans, and pathology prescribed by specialist/ appearing on specialist's claim - Continued benefits for PMBs, subject to PMB regulations and approval	- Combined limit for GP and specialist consultations in rooms: - M: R4 420 pbpa - M + 1: R8 005 pfpa - M + 2 +: R9 280 pfpa - Benefits subject to referral by a Bankmed GP Network GP 100% of cost at Bankmed Prestige A and B Specialist Network (DSP) 80% of cost if no pre-authorisation and no referral from Bankmed GP Network GP (DSP) 100% of Scheme Rate for non-DSP (including PMBs) 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed 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 - Benefits subject to approved BOC and referral by a Bankmed Network GP 100% of cost for Bankmed Prestige A and B Specialist Network (DSP) 80% of cost if no pre-authorisation and no referral from a Bankmed Network GP (DSP) 100% of Scheme Rate for non-DSP 80% of Scheme Rate if no pre-authorisation and no referral from a Bankmed Network GP (DSP) - Non-BOC benefits covered at 100% of Scheme Rate, subject to available MSA - Continued benefits for PMBs, subject to PMB regulations and approval	100% of Scheme Rate, subject to available MSA 100% of cost for Bankmed Prestige A and B Specialist Network (DSP) 100% of Scheme Rate for non-DSP	300% of Scheme Rate, subject to available MSA - ATB applies once Annual Threshold is reached 100% of cost for Bankmed Prestige A and B Specialist Network (DSP) 300% of Scheme Rate for non-DSP

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
34.3	Specialist procedures In-room or Out-of-hospital	- Limited to PMBs 100% of cost at DSP 100% of Scheme Rate for non-DSP - DSP: Bankmed Entry Plan Specialist Network	Refer to 'Specialist consultations In-room or Out-of-hospital' benefit section	- Unlimited 100% of cost at DSP 100% of Scheme Rate for non-DSP - DSP: Bankmed Prestige A and B Specialist Network	- Limited to PMBs Bankmed Prestige A and B Specialist Network benefits (DSP): 100% of cost 80% of cost if no pre-authorisation or no referral from Bankmed GP Network GP (DSP) - Non-PMBs subject to available MSA Non-network GP benefits (non-DSP): 100% of Scheme Rate for PMBs	- Unlimited Bankmed Prestige A and B Specialist Network benefits (DSP): 100% of cost Non-network GP benefits (non-DSP): 100% of Scheme Rate for PMBs	- Unlimited Bankmed Prestige A and B Specialist Network benefits (DSP): 100% of cost Non-network GP benefits (non-DSP): 300% of Scheme Rate for PMBs
35.	REGISTERED PRIVATE NURSE PRACTITIONERS						
35.1.	Consultations and procedures	- Limited to PMBs Procedures: 100% of cost at DSP 100% of Scheme Rate at non-DSP - For procedures not requiring admission to a day surgery or hospital, includes the cost of vaccination and injection material administered by the Healthcare Professional Consultations: 100% of cost at DSP 100% of Scheme Rate at non-DSP - Three consultations pbpa at 100% of Scheme Rate for PMBs	- Unlimited Procedures: 100% of Scheme Rate Consultations: - Three consultations pbpa at 100% of Scheme Rate	- Unlimited Procedures: 100% of Scheme Rate Consultations: - Three consultations pbpa at 100% of Scheme Rate - Thereafter, 100% of Scheme Rate, subject to out-of-hospital GP/Specialist limit	- Unlimited Procedures: 100% of Scheme Rate Consultations: - Three consultations pbpa at 100% of Scheme Rate from Insured Benefits - Thereafter, subject to available MSA	- Unlimited Procedures: 100% of Scheme Rate Consultations: - Three consultations pbpa at 100% of Scheme Rate from Insured Benefits - Thereafter, subject to available MSA	- Unlimited Procedures: 100% of Scheme Rate Consultations: - Three consultations pbpa at 300% of Scheme Rate from Insured Benefits - Thereafter, subject to available MSA/ATB - ATB applies once the Annual Threshold is reached

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pbpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

	ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025	
	NON-MSA PLANS			MSA PLANS			
36.	OPTOMETRY CONSULTATIONS, SPECTACLES, FRAMES, LENSES AND CONTACT LENSES						
36.1	Optometry consultations Subject to the Optometry Benefit Management Programme and clinical necessity	No benefit	- Limited to Iso Leso Optometry Network (DSP) - No benefit out of network 100% of cost at DSP - Limited to one consultation pb every two years - All services and products subject to selected Iso Leso Optometry Network Scheme-approved and contracted services and products	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 MSA	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 MSA - 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 R5 740 pbpa
36.2	Frames and extras	No benefit	- Limited to Iso Leso Optometry Network (DSP) - No benefit out of network 100% of cost at DSP - Limited to one frame pb every two years - All services and products, including frames, subject to selected Iso Leso Optometry Network Scheme-approved and contracted services and products	100% of Scheme Rate - Limited to R1 205 pb every 24 months from previous date of service - One frame pb every 24 months from previous date of service - Extras subject to pre-authorisation and PMB regulations and clinical necessity	100% of Scheme Rate - Subject to available MSA - One frame pb every 24 months from previous date of service - Extras subject to pre-authorisation and PMB regulations and clinical necessity	100% of Scheme Rate - Subject to available MSA - 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 PMB regulations and clinical necessity	

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

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Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
36.3	Prescription lenses Clear, standard/generic, single vision, bifocal or multi-focal lenses	No benefit	- Limited to Iso Leso Optometry Network (DSP) - No benefit out of network 100% of cost at DSP - Limited to one pair of prescription lenses pb every two years - All services and products, including frames, subject to selected Iso Leso Optometry Network Scheme-approved and contracted services and products	- Benefits for prescription lenses limited to one pair of lenses pb every 24 months from previous date of service 100% of the Scheme Rate - Limited to clear, standard/generic, single vision, bifocal or multi-focal lenses from an Opticlear Network optometrist	100% of Scheme Rate - Subject to available MSA	- Benefits for prescription lenses limited to one pair of lenses pb every 24 months from previous date of service 100% of the Scheme Rate - Limited to clear, standard/generic, single vision, bifocal or multi-focal lenses from an Opticlear Network optometrist	100% of Scheme Rate - Subject to available MSA
36.4	Readymade readers	No benefit		- Limited to two pairs of readymade readers pb every two years - Limited to R125 per pair 100% of Scheme Rate - Readymade readers via optometrists and pharmacies covered from the OTC benefit, subject to benefit availability	100% of Scheme Rate - Subject to available MSA - Readymade readers via optometrists and pharmacies covered from the OTC benefit, subject to available MSA	- Limited to two pairs of readymade readers pb every two years - Limited to R125 per pair 100% of Scheme Rate - Subject to available MSA - Readymade readers via optometrists and pharmacies covered from the OTC benefit, subject to benefit availability	- Limited to two pairs of readymade readers pb every two years - Limited to R125 per pair 100% of Scheme Rate - Subject to available MSA - Readymade readers via optometrists and pharmacies covered from the OTC benefit, subject to benefit availability
36.5	Contact lenses	No benefit		100% of Scheme Rate - Limited to R1 890 pbpa at an Opticlear Network optometrist - Limited to clear contact lenses - A beneficiary may not claim for spectacles (lenses/frame) AND contact lenses in same benefit year OR contact lenses within 24 months from previous date of service after receiving spectacles (lenses/frame)	100% of Scheme Rate - Subject to available MSA - 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 R2 100 pbpa for an Opticlear Network optometrist, paid from Insured Benefits - Limited to clear contact lenses - A beneficiary may not claim for spectacles (lenses/frame) AND contact lenses in same benefit year OR contact lenses within 24 months from previous date of service after receiving spectacles (lenses/frame)	Refer to 'Optometry consultation' benefit section
36.6	Fitting of contact lenses	No benefit		100% of Scheme Rate - One contact lens dispensing and/or assessment pb every 12 months	100% of Scheme Rate, subject to available MSA	100% of Scheme Rate - One contact lens dispensing and/or assessment pb every 12 months	Refer to 'Optometry consultation' benefit section



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.

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

	ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025	
	NON-MSA PLANS			MSA PLANS			
36.7	Sunglasses	• No benefit		• No benefit for sunglasses/prescription sunglasses/spectacles with a tint > 35%			
37.	REFRACTIVE SURGERY AND ASSOCIATED COSTS (INCLUDING HOSPITALISATION)						
37.1	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 R5 040 pfpa, including the cost of hospitalisation, medication and all other associated services		• 100% of Scheme Rate check for plus plan • Subject to available MSA, including the cost of hospitalisation, medication and all other associated services	
38.	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 pbpm						
38.1	Prescribed acute medication Refer to ‘Contraception’ benefit section for additional Insured Benefits	- Limited to PMBs - Subject to Scheme Medication Formulary (medicine list) 100% of cost for PMBs - Unlimited via Bankmed GP Entry Plan Network GP (DSP)	- Unlimited - Subject to Scheme Medication Formulary (medicine list) - Medication via DSP - Bankmed GP Entry Plan Network and Bankmed Pharmacy Network 100% of cost plus contracted dispensing fee, unlimited	- Limited to: - M: R5 010 pbpa - M + 1: R9 230 pfpa - M + 2 +: R10 020 pfpa - The above limits include a maximum allowance of R1 990 pfpa OTC - Medication via DSP - Bankmed GP Network and Bankmed Pharmacy Network 100% of 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)	100% of Scheme Medicine Reference Price - Subject to available MSA	100% of Scheme Medicine Reference Price - Subject to available MSA	100% of Scheme Medicine Reference Price plus contracted dispensing fee as applicable - to Bankmed GP Network or Bankmed Pharmacy Network (DSP) - Subject to available MSA - 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 R22 730 for a single member and R34 430 for a family

Important information

Pre-authorisation is required for PMB funding of treatment and care of PMB Chronic Disease List (CDL) conditions. Have your Healthcare Professional 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.

Important information

Pre-authorisation is required for PMB funding of treatment and care of PMB Chronic Disease List (CDL) conditions. Have your Healthcare Professional 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.

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
			• Medication via non-DSP • Voluntary use of non-DSP • 100% of Scheme Medicine Reference Price • Subject to the 'Out-of-network GP Benefit' limit of R2 755 pfpa • Medication via non-DSP • Involuntary use of non-DSP • 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 Benefit' limit of R2 755 pfpa	• Medication via non-DSP • Voluntary use of non-DSP • 80% of Scheme Medicine Reference Price for generic medication and original medication (medication where a generic alternative is available) • Medication via non-DSP • Involuntary use of non-DSP • 100% of 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)			
38.2	Self-medication Over-the-counter (OTC) medication/pharmacy advised therapy (PAT)	• No benefit		• 100% of Scheme Medicine Reference Price for Bankmed Pharmacy Network (DSP) • 80% of the Scheme Medicine Reference Price for non-DSP • Limited to R1 990 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 Formulary (medicine list) for PAT • All other acute and over-the-counter medication subject to available MSA	• 100% of Scheme Medicine Reference Price • Subject to available MSA	• 100% of Scheme Medicine Reference Price • Subject to available MSA • Self-medication/PAT does not accumulate towards the Annual Threshold and is not covered as an ATB benefit
38.3	Homeopathic medication On prescription only. Limited to items with NAPPI codes	• No benefit		• Refer to 'Prescribed acute medication' and 'Chronic medication' benefit sections • No self-medication benefit for homeopathic medication			

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
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pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
		NON-MSA PLANS			MSA PLANS		
38.4	Chronic medication Subject to prior application and approval	- Limited to PMBs 100% of cost for PMBs at DSP - Unlimited via Bankmed Entry Plan GP Network (DSP) - Subject to Scheme Medication Formulary (medicine list)	Medication via DSP - Bankmed GP Entry Plan Network and Bankmed Pharmacy Network 100% of cost at DSP - Unlimited via DSP - Subject to Scheme Medication Formulary (medicine list) Medication via non-DSP - Voluntary use of non-DSP 80% of Scheme Medicine Reference Price - Subject to 'Out-of-network GP Benefit' limit of R2 755 pfpa Medication via non-DSP - Involuntary use of non-DSP 100% of cost plus contracted dispensing fee	Medication via DSP - Bankmed GP Network and Bankmed Pharmacy Network - Limited to R26 500 pbpa 100% of Scheme Medicine Reference Price for DSP Medication via non-DSP - Voluntary use of non-DSP 80% of Scheme Medicine Reference Price Medication via non-DSP - Involuntary use of non-DSP 100% of cost plus contracted dispensing fee - Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations	Medication via DSP - Bankmed GP Network and Bankmed Pharmacy Network - Limited to Core Saver Medication Formulary (medicine list) for PMB conditions 100% of Scheme Medicine Reference Price for DSP Medication via non-DSP - Voluntary use of non-DSP 80% of Scheme Medicine Reference Price Medication via non-DSP - Involuntary use of non-DSP 100% of cost plus contracted dispensing fee	Medication via DSP - Bankmed GP Network and Bankmed Pharmacy Network - Limited to R28 695 pbpa (Insured Benefits) 100% of Scheme Medicine Reference Price for DSP Medication via non-DSP - Voluntary use of non-DSP 80% of Scheme Medicine Reference Price Medication via non-DSP - Involuntary use of non-DSP 100% of cost plus contracted dispensing fee - Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations	Medication via DSP - Bankmed GP Network and Bankmed Pharmacy Network - Limited to R34 215 pbpa (Insured Benefits) 100% of Scheme Medicine Reference Price for DSP Medication via non-DSP - Voluntary use of non-DSP 80% of Scheme Medicine Reference Price Medication via non-DSP - Involuntary use of non-DSP 100% of cost plus contracted dispensing fee - Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
ASA	Accumulated Savings Account	CIB	Chronic Illness Benefit	CDL	Chronic Disease List	ATB	Above Threshold Benefit
pfpa	per family per annum	pb	per beneficiary	pbpa	per beneficiary per annum	pbpm	per beneficiary per month

		ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025	
		NON-MSA PLANS			MSA PLANS			
38.5	Biologic and high-cost specialised medication Utilised in the management of PMB CDL and non-PMB chronic conditions	- Limited to PMBs - Subject to PMB regulations	- Limited to PMBs - Subject to PMB regulations	- Includes PMBs and non-PMBs - Subject to PMB regulations	- Includes PMBs and non-PMBs - Subject to PMB regulations	- Includes PMBs and non-PMBs - Subject to PMB regulations	- Includes PMBs and non-PMBs - Subject to PMB regulations	
	Includes off-label medications Request for medications not registered for the condition by the Medicines Control Council (MCC) Includes Section 21 medication Medications not registered by the MCC for use in South Africa							
	PMB algorithm medication							
	PMB non-algorithm medication							
	Non-PMB non-algorithm medication							
39.	WORLD HEALTH ORGANISATION (WHO) RECOGNISED DISEASE OUTBREAKS Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks							
	39.1	Out-of-hospital healthcare services related to COVID-19:	Benefits					
			BENEFITS AND LIMITATIONS				BENEFITS AND LIMITATIONS	
			Benefits in excess of the PMB requirements - Up to a maximum of 100% of the Scheme Rate. - Cover for testing is subject to NICD protocol and referral by a Healthcare Professional. - Subject to the Scheme’s preferred provider (where applicable), protocols and the condition and treatment meeting the Scheme’s entry criteria and guidelines.				BOC as defined by Bankmed Out-of-hospital healthcare services related to COVID-19: - Screening consultation with a nurse or GP: unlimited - Defined basket of pathology: unlimited tests per person per year subject to appropriate clinical referral for testing for registered Healthcare Professionals except where covered as PMB. - Defined basket of X-rays and scans - Supportive treatment - Contact tracing	

	ESSENTIAL PLAN 2025	BASIC PLAN 2025	TRADITIONAL PLAN 2025	CORE SAVER PLAN 2025	COMPREHENSIVE PLAN 2025	PLUS PLAN 2025
	NON-MSA PLANS			MSA PLANS		

40.

PLAN SPECIFIC INFORMATION

40.1

Core Saver Pharmacy Advised Therapy (PAT) Medication Formulary (medicine list)

- 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 Pharmacy Advised Therapy (PAT) Medication Formulary (medicine list) for the following conditions and up to the specified number of incidents pbpa, on pharmacist’s recommendation (PAT) only
- Visit www.bankmed.co.za, select ‘2025 Plan Information’ and then ‘Medicine Formularies 2025’ to view the Core Saver Pharmacy Advised Therapy (PAT) Medication Formulary (medicine list)
- Non-formulary medication and other acute medication subject to available MSA

Condition	Incidents covered
Abdominal pain/dyspepsia/heartburn/indigestion (includes reflux)	2
Helminthic (worms) infestation	2
Conjunctivitis, bacterial	2
Topical candidiasis (topical thrush)	2
Oral candidiasis (oral thrush)	2
Headache -analgesia	2

Condition	Incidents covered
Upper respiratory and lower respiratory tract infections	2
Gastroenteritis	2
Urticaria, insect bites and stings	2
Urinary tract infection	2
Treatment of wounds and/or infection of the skin/subcutaneous tissues (excluding post-operative wound care)	2



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