

BENEFIT TABLES 2026

		ESSENTIAL PLAN 2026	BASIC PLAN 2026	TRADITIONAL PLAN 2026	CORE SAVER PLAN 2026	COMPREHENSIVE PLAN 2026	PLUS PLAN 2026
		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	10%*	15%*	20%*
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			
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					

Terminology Reminders:

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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

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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	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					
3.6	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					
3.10	Colorectal cancer screening Faecal occult blood test, or	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 100% of Scheme Rate for test code					

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	Colorectal cancer self-sampling kit	- Limited to one pbpa aged 50 years and older - Benefits for beneficiaries younger than 50 years subject to motivation and prior approval - Beneficiaries may select one of either a faecal occult or colorectal cancer self-sampling screening kit only, not both					
3.11	Cholesterol screening, blood sugar screening and blood pressure measurements	100% of cost at DSP 100% of Scheme Rate at non-DSP - Limited to R415 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 R415 pbpa at DSP - DSP: clinics, pharmacies, or Bankmed GP Network consulting rooms		
3.12	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 - Subject to PMB regulations		
3.13	Bankmed mental wellbeing assessment	Unlimited online Mental Wellbeing Assessments					
3.14	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			

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3.15	Cervical cancer screening • Pap smear; or <						

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	Additional consultations for Bankmed Network GP subject to clinical entry criteria	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	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	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			
3.19	Antenatal screening T21 chromosome test or non-invasive prenatal testing (NIPT) To test for chromosomal abnormalities (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					
	Amniocentesis (South African testing only)	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					
3.20	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					
3.21	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					
3.22	Contraception Oral Contraceptives, Devices and Injectables	No benefit	100% of Scheme Medicine Reference Price - Limited to R2 615 per female beneficiary per annum - Oral contraceptives limited to one prescription/repeat prescription pbpm				

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3.23	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 80% 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		
3.24	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					
3.25	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		
3.26	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					
3.27	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)	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				

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		- 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	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				
3.28	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			

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3.29	Preventative Childhood Dental Check Applies to children and adolescents aged 3 years up to 17 years of age only	100% of cost at DSP - DSP: Bankmed Dental Network - Not covered outside of the Bankmed Dental Network Limited to: - Limited to two dental check-ups per qualifying beneficiary per annum - Benefits as set out in the Scheme approved formulary - Should the provider charge for additional services, these services will be funded from standard available benefits, where applicable		100% of Scheme Rate Limited to: - Limited to two dental check-ups per qualifying beneficiary per annum - Benefits as set out in the Scheme approved formulary - Should the provider charge for additional services, these services will be funded from standard available benefits, where applicable			
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					
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					

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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						
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

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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					
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	- 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				
	PMB admission - Treatment/procedure NOT performed at Bankmed Day Surgery Network facility - Involuntary use of non-DSP	- 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				
	PMB admission - Treatment/procedure NOT performed at Bankmed Day Surgery Network facility - Voluntary use of non-DSP	- Refer to ‘Bankmed Day Surgery Procedure List’ in 8.3 below - R6 570 per admission - Limited to PMBs	- Refer to ‘Bankmed Day Surgery Procedure List’ in 8.3 below - R6 570 per admission				
	Non-PMB admission Treatment/procedure NOT performed at Bankmed Day Surgery Network facility	No benefit	- Refer to ‘Bankmed Day Surgery Procedure List’ in 8.3 below - R6 570 per admission				

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		NON-MSA PLANS			MSA PLANS		
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. Skin, 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 (nasal endoscopy, laryngoscopy) 5.4. Repair nasal turbinates, nasal septum 5.5. Sinus lavage 5.6. Middle ear procedures (mastoidectomy, myringoplasty, 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. Diagnostic laparoscopy 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. Simple vulva and introitus procedures: Simple hymenotomy, partial hymenectomy, simple vulvectomy, excision/treatment Bartholin’s gland cyst 9.9. Vaginal, cervix and oviduct procedures: excision vaginal septum, cyst or tumour, tubal ligation or occlusion, uterine cervix cerclage, removal cerclage suture 9.10. Suction curettage 9.11. Uterine evacuation and curettage 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, ankle, foot, temporomandibular joint, elbow, hand, wrist), arthrodesis (hand, wrist, foot) 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. Repair bunion or toe deformity 12.6. Treatment of simple closed fractures and/or dislocations, removal of pins and plates 12.7. Incision and drainage/excision of abscess and/or cyst/tumour: subcutaneous tissue, soft tissue, bone, bursa 12.8. Biopsies: subcutaneous tissue, soft tissue, muscle, bone	12.9. 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. Removal of lesions (dependent on site and diameter) 19.3. Simple repair of superficial wounds 20. Urological Procedures 20.1. Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocele vasectomy) 21. Lumpectomy (fibroadenoma)			
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: R340 • Hospital: R2 505	• No benefit for in-hospital dental treatment, except PMBs	• Deductible: • Day surgery: 340 • Hospital: R2 505	
8.5	Deductible applicable to Extraction of Impacted Wisdom Tooth/Teeth In-rooms Deductible applies to events in-rooms (both DSPs and non-DSPs)						
	PMB: In-rooms: • Designated Service Provider (DSP) PMB: In-rooms: • Non-DSP (voluntary use of non-DSP)	Limited to PMBs • Deductible in-rooms: None • Deductible in-rooms: R1 750	• Deductible in-rooms: None • Deductible in-rooms: R1 750		Limited to PMBs • Deductible in-rooms: None • Deductible in-rooms: R1 750	• Deductible in-rooms: None • Deductible in-rooms: R1 750	

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 2026	BASIC PLAN 2026	TRADITIONAL PLAN 2026	CORE SAVER PLAN 2026	COMPREHENSIVE PLAN 2026	PLUS PLAN 2026
		NON-MSA PLANS			MSA PLANS		
	PMB: In-rooms: - Non-DSP (involuntary use of non-DSP) Non-PMB: In-rooms: - Bankmed Network Provider Not Used	- Deductible in-rooms: None - No benefit		- Deductible in-rooms: None - Deductible in-rooms: R1 750	- Deductible in-rooms: None - No benefit	- Deductible in-rooms: None - Deductible in-rooms: R1 750	
8.6	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: 340 - Hospital: R845 - No benefit	- No deductible payable for PMBs - Applies to all admissions - Deductible: - Day surgery: R340 - Hospital: R845 - Applies to all admissions - Deductible: - Day surgery: R340 - Hospital: R845	- No deductible payable for PMBs - Applies to all admissions - Deductible: - Day surgery: 340 - Hospital: R7 015 - Applies to all admissions - Deductible: - Day surgery: R340 - Hospital: R7 015	- No deductible payable for PMBs - Applies to all admissions - Deductible: - Day surgery: R340 - Hospital: R845 - Applies to all admissions - Deductible: - Day surgery: R340 - Hospital: R845		
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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		NON-MSA PLANS			MSA PLANS		
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	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	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	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 80% 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		
13.2	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 80% 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		

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
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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 80% of Scheme Rate at non-DSP	- Unlimited 100% of cost at DSP 100% of Scheme Rate at non-DSP			
14.2	Medication In- and out-of-hospital	Limited to PMBs	Unlimited				
	Medication via DSP Bankmed Pharmacy Network	100% of cost, limited to PMBs	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				

Terminology Reminders:

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	Medication via non-DSP Involuntary use of non-DSP	• 100% of cost, limited to PMBs		• 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 500 per case		• 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Unlimited • Cost of disposables limited to R1 500 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
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 845 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

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		NON-MSA PLANS			MSA PLANS		
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			
	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 255 pfpa (including a sub-limit of R3 330 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 330 pfpa (included in the annual limit of R5 255 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 350 pfpa

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		NON-MSA PLANS			MSA PLANS		
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 R600 pb per day	
17.4	Home nursing	No benefit		100% of cost, limited to R455 pb per day	No benefit	100% of cost, limited to R475 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		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 80% 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	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		

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		NON-MSA PLANS			MSA PLANS		
		- Subject to PMB regulations - BOC as set by the Scheme for out-of-hospital conservative treatment		- Subject to PMB regulations - BOC as set by the Scheme for out-of-hospital conservative treatment	- 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 R64 050 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 R94 690 pbpa - Subject to the combined ‘Internal prosthesis’ limit				
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 R51 260 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 R53 915 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 R63 265 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 R29 540 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				

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		NON-MSA PLANS			MSA PLANS		
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			
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		- R22 525 pb per lifetime 100% of Scheme Rate	No benefit	- R22 525 pb per lifetime 100% of Scheme Rate	
21.3	Cochlear implant device	No benefit		- R472 240 pb per lifetime 100% of Scheme Rate	No benefit	- R472 240 pb per lifetime 100% of Scheme Rate	
21.4	Intra-operative audiology testing	No benefit		- R1 175 pb per lifetime 100% of Scheme Rate	No benefit	- R1 175 pb per lifetime 100% of Scheme Rate	
21.5	Post-operative evaluation costs	No benefit		- R47 300 pb per lifetime 100% of Scheme Rate	No benefit	- R47 300 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 R244 000 pb over a three-year cycle	No benefit	100% of Scheme Rate - Limited to R244 000 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 R37 880 pb every second year (rolling 24 months)	100% of Scheme Rate, limited to R44 350 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 965 pbpa	
23.3	Bone anchored hearing aids	No benefit		90% of Scheme Rate - Limited to R202 605 pfpa	100% of Scheme Rate - Subject to available MSA	90% of Scheme Rate - Limited to R202 605 pfpa	

Terminology Reminders:

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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 2026	BASIC PLAN 2026	TRADITIONAL PLAN 2026	CORE SAVER PLAN 2026	COMPREHENSIVE PLAN 2026	PLUS PLAN 2026	
		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 175 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 175 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 R32 430 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 175 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 Appliances for acute conditions: 100% of Scheme Rate - Limited to R9 145 pbpa	- Limit of R4 175 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 - Sub-limits as follows: - R1 175 arch supports (Per pair) - R1 765 shoe insoles (Per pair)	Post-surgery appliances: 100% of Scheme Rate - Limited to R9 535 pbpa Chronic appliances: 100% of cost - Limited to: - R29 940 pbpa for oxygen/ oxygen delivery systems - R29 940 pbpa for stoma products - R9 535 pbpa for ‘Other chronic appliances’, including wheelchairs - Sub-limits as follows: - R1 175 arch supports (Per pair) - R1 765 shoe insoles (Per pair) ‘Other chronic appliances’ limit extended to R13 950 for beneficiaries requiring a CPAP machine Appliances for acute conditions: 100% of Scheme Rate - Subject to available MSA	Post-surgery appliances: 100% of Scheme Rate - Limited to R9 535 pbpa Chronic appliances: 100% of cost - Limited to: - R29 940 pbpa for oxygen/ oxygen delivery systems - R29 940 pbpa for stoma products - R9 535 pbpa for ‘Other chronic appliances’, including wheelchairs - Sub-limits as follows: - R1 175 arch supports (Per pair) - R1 765 shoe insoles (Per pair) ‘Other chronic appliances’ limit extended to R13 950 for beneficiaries requiring a CPAP machine Appliances for acute conditions: 100% of Scheme Rate - Subject to available MSA	

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 2026	BASIC PLAN 2026	TRADITIONAL PLAN 2026	CORE SAVER PLAN 2026	COMPREHENSIVE PLAN 2026	PLUS PLAN 2026
		NON-MSA PLANS			MSA PLANS		
		Important information - Claims for medical and surgical appliances are payable only if purchased from a Healthcare Professional with a valid BHF practice number. - Bankmed cannot refund claims for items bought from non-BHF-registered companies or individuals. - This includes purchases from Takealot, Gumtree, old age homes, battery suppliers, or other general retailers (e.g. wheelchairs, breast pumps, crutches, blood pressure monitors, nebulisers, etc.). - Members must confirm the provider's BHF registration before ordering or making payment.		- 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		- 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	- 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 175 pbpa - Combined limit with 'External prosthesis' and 'Medical and surgical appliances' benefits - Sub-limits as follows: - BPM: R1 605 pbpa - Nebulisers: R2 265 pbpa - Glucometers: R1 130 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 605 pbpa - Nebulisers: R2 265 pbpa - Glucometers: R1 130 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 175 pbpa - Combined limit with 'External prosthesis', 'Medical and surgical appliances', and 'Arch supports and shoe insoles' benefits - Sub-limits as follows: - BPM: R1 605 pbpa - Nebulisers: R2 265 pbpa - Glucometers: R1 130 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 535 pbpa - Combined limit with 'External prosthesis' and 'Medical and surgical appliances' benefits - Sub-limits as follows: - BPM: R1 605 pbpa - Nebulisers: R2 265 pbpa - Glucometers: R1 130 pbpa - Only payable if claimed from a service provider with a valid BHF practice number	
24.4	Arch supports and shoe insoles Refer to claim 'Frequency limits' in 24.6 below	No benefit		Refer to 24.2	Refer to 24.2	Refer to 24.2	
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		

Terminology Reminders:

DSP	Designated Service Provider	PMB	Prescribed Minimum Benefit	MSA	Medical Savings Account	BOC	Basket-of-Care
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		NON-MSA PLANS			MSA PLANS																																											
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></tr><tr><td>Blood pressure monitor</td><td>Once every three years</td></tr><tr><td>Humidifier</td><td>Once every three years</td></tr><tr><td>CPAP machine</td><td>Once every three years</td></tr><tr><td>Crutches</td><td>Once every two years</td></tr><tr><td>Rigid back brace</td><td>Once every two years</td></tr><tr><td>Foot orthotics</td><td>Once every two years</td></tr><tr><td>Sling/clavicle brace</td><td>Once every two years</td></tr></table>	Appliance/device	Frequency	Blood pressure monitor	Once every three years	Humidifier	Once every three years	CPAP machine	Once every three years	Crutches	Once every two years	Rigid back brace	Once every two years	Foot orthotics	Once every two years	Sling/clavicle brace	Once every two years	<table><tr><th>Appliance/device</th><th>Frequency</th></tr><tr><td>Breast prosthesis</td><td>Once every two years (single/pair)</td></tr><tr><td>Wheelchair</td><td>Once every three years</td></tr><tr><td>Compression stockings</td><td>Two per year</td></tr><tr><td>Portable oxygen</td><td>Once every four years</td></tr><tr><td>Glucometer</td><td>Once every three years</td></tr><tr><td>Nebuliser</td><td>Once every three years</td></tr></table>	Appliance/device	Frequency	Breast prosthesis	Once every two years (single/pair)	Wheelchair	Once every three years	Compression stockings	Two per year	Portable oxygen	Once every four years	Glucometer	Once every three years	Nebuliser	Once every three years	<table><tr><th>Appliance/device</th><th>Frequency</th></tr><tr><td>Surgical boot/moon boot</td><td>Once every three years</td></tr><tr><td>Brace/callipers</td><td>Once every three years</td></tr><tr><td>Wig</td><td>Once every three years</td></tr><tr><td>Breast prosthesis bra*</td><td>Once every three years</td></tr><tr><td>Commode</td><td>Once every three years</td></tr><tr><td>Walking frame</td><td>Once every three years</td></tr></table>	Appliance/device	Frequency	Surgical boot/moon boot	Once every three years	Brace/callipers	Once every three years	Wig	Once every three years	Breast prosthesis bra*	Once every three years	Commode	Once every three years	Walking frame	Once every three years
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Commode	Once every three years																																															
Walking frame	Once every three years																																															
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																																																
24.7	Insulin Pump Must be prescribed by Physician/Endocrinologist	No benefit		- Limit of R40 000 pfpa - Only payable if claimed from a service provider with a valid BHF practice number - Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols. Frequency Limit: - One pump pfpa every 36-month cycle																																												
25.	PSYCHIATRY, CLINICAL PSYCHOLOGY AND RELATED OCCUPATIONAL THERAPY																																															
25.1	Hospitalisation Subject to pre-authorisation and PMB regulations	- Limited to PMBs - Subject to referral from a Bankmed Entry Plan GP Network GP (DSP)		Limited to R88 835 pbpa		Limited to R88 835 pbpa																																										
	Hospital Network DSP All admissions at network DSP	100% of cost for Bankmed Network Psychiatric facilities (DSP)		100% of cost for Bankmed Network Psychiatric facilities (DSP)		100% of cost for Bankmed Network Psychiatric facilities (DSP)																																										
	Other hospitals (non-DSP) PMB admission Involuntary use of non-DSP	100% of cost		100% of cost		100% of cost																																										
	PMB admission Voluntary use of non-DSP	80% of Scheme Rate		80% of Scheme Rate		80% of Scheme Rate																																										
	Non-PMB admission	No benefit		80% of Scheme Rate		80% of Scheme Rate																																										
	In-hospital consultations/sessions	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		100% of cost for Bankmed Prestige A and B Specialist Network (DSP) 80% of Scheme Rate for non-DSP		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																																										

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		NON-MSA PLANS			MSA PLANS		
				- 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 80% 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		- 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	
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)		- Limited to R5 340 pbpa 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP)	- 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)	- Limited to R6 505 pbpa 100% of cost at contracted rate for Bankmed Prestige A and B Specialist Network (DSP)	- 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)

Terminology Reminders:

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		NON-MSA PLANS			MSA PLANS		
		100% of Scheme Rate for non-DSP		80% 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	100% of Scheme Rate for non-DSP, subject to available MSA	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 R15 505 pbpa for Depression and/or Bipolar mood disorder, subject to pre-authorisation and PMB regulations	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 R19 650 pfpa
25.4	Mental Health Integrated Disease Management Programme Management of specified mental health conditions for members registered on the Scheme’s 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					
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 Subject to PMB regulations	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 870 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

Terminology Reminders:

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		NON-MSA PLANS			MSA PLANS		
							as an ATB (always subject to available ATB) is R9 910 pfpa.
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 955 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 955 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 280 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 reaching the Annual Threshold (at 100% of Scheme Rate) and/ or be paid as an ATB (subject to available ATB) is R3 955 pbpa

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 2026	BASIC PLAN 2026	TRADITIONAL PLAN 2026	CORE SAVER PLAN 2026	COMPREHENSIVE PLAN 2026	PLUS PLAN 2026
		NON-MSA PLANS			MSA PLANS		
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 175 pfpa
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) 80% 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	

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 2026	BASIC PLAN 2026	TRADITIONAL PLAN 2026	CORE SAVER PLAN 2026	COMPREHENSIVE PLAN 2026	PLUS PLAN 2026
		NON-MSA PLANS			MSA PLANS		
32.	DENTISTRY Subject to pre-authorisation and PMB regulations.						
32.1	Preventative and basic dentistry Preventative and Basic Dentistry not covered in-hospital. Subject to PMB regulations	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 80% 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 R23 695 for a single member and R35 895 for a family
32.2	Advanced dentistry Caps, crowns, bridges and cost of endosteal and ossea-integrated implants	No benefit		100% of cost at DSP 80% 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: R7 120 pbpa - M + 1 +: R11 925 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 80% 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 925 pfpa, thereafter subject to 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, and X-rays	100% of cost at DSP 80% 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		

Terminology Reminders:

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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 2026	BASIC PLAN 2026	TRADITIONAL PLAN 2026	CORE SAVER PLAN 2026	COMPREHENSIVE PLAN 2026	PLUS PLAN 2026
		NON-MSA PLANS			MSA PLANS		
32.4	Extraction of impacted wisdom tooth/teeth in-rooms Subject to pre-authorisation and PMB regulations PMB: In-rooms: - Designated Service Provider (DSP) PMB: In-rooms: - Non-DSP (voluntary use of non-DSP) PMB: In-rooms: - Non-DSP (involuntary use of non-DSP) Non-PMB: In-rooms: - Bankmed Network Provider Not Used	Limited to PMBs 100% of cost for Bankmed Specialist Network: DSPs 100% of cost for Bankmed Dental Network: DSPs - Deductible does not apply 80% of Scheme Rate - Deductible applies 100% of cost - Deductible does not apply - No benefit		100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of cost for Bankmed Dental Network: DSPs - Deductible does not apply 80% of Scheme Rate - Deductible applies 100% of cost - Deductible does not apply 80% of Scheme Rate - Deductible applies	Limited to PMBs 100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of cost for Bankmed Dental Network: DSPs - Deductible does not apply 80% of Scheme Rate - Deductible applies 100% of cost - Deductible does not apply - No benefit	100% of cost for Bankmed Prestige A&B Specialist Network: DSPs 100% of cost for Bankmed Dental Network: DSPs - Deductible does not apply 80% of Scheme Rate - Deductible applies 100% of cost - Deductible does not apply 80% of Scheme Rate - Deductible applies	
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 80% of Scheme Rate for non-DSP - DSP: Bankmed 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 80% 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
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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		
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) 80% 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 (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, up to R2 870 pfpa (at DSP rate) for consultations, procedures and medication at non-network GP - When nominated DSP GP is unavailable or beneficiary is out of town, 'Out-of-network GP Benefit' includes all related consultation costs	- 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 80% 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
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 80% 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	Bankmed GP Network benefits (DSP): - Unlimited for PMBs 100% of cost	Bankmed GP Network benefits (DSP): - Unlimited for PMBs 100% of cost

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 2026	BASIC PLAN 2026	TRADITIONAL PLAN 2026	CORE SAVER PLAN 2026	COMPREHENSIVE PLAN 2026	PLUS PLAN 2026
		NON-MSA PLANS			MSA PLANS		
					• 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	• 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	• 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) • 80% 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) • 80% 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	
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)	• Limited to: • M: 4 650 pbpa • M + 1 +: R7 280 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)	• 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 a Bankmed GP Network GP (DSP)	• 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, subject to available MSA • 100% of cost for Bankmed Prestige A and B Specialist Network (DSP) • 100% of Scheme Rate for 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		
		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)	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	80% 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	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		
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 80% 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	- Unlimited Procedures: 100% of Scheme Rate	- Unlimited Procedures: 100% of Scheme Rate	- Unlimited Procedures: 100% of Scheme Rate	- Unlimited Procedures: 100% of Scheme Rate	- Unlimited Procedures: 100% of Scheme Rate

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

		ESSENTIAL PLAN 2026	BASIC PLAN 2026	TRADITIONAL PLAN 2026	CORE SAVER PLAN 2026	COMPREHENSIVE PLAN 2026	PLUS PLAN 2026
		NON-MSA PLANS			MSA PLANS		
		• Consultations: • 100% of cost at DSP • 100% of Scheme Rate at non-DSP • Three consultations pbpa at 100% of Scheme Rate for PMBs	• Consultations: • Three consultations pbpa at 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	• Consultations: • Three consultations pbpa at 100% of Scheme Rate from Insured Benefits • Thereafter, subject to available MSA	• Consultations: • Three consultations pbpa at 100% of Scheme Rate from Insured Benefits • Thereafter, subject to available MSA	• 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
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 985 pbpa
36.2	Frames and extras Did you know? THE OPTICLEAR OPTOMETRY NETWORK • Bankmed members enjoy discounted rates on eye tests, spectacles, and contact lenses when visiting an Opticlear Network optometrist. • The network includes 97% of optometrists in South Africa, so your preferred provider is likely part of it. • Find your nearest Opticlear optometrist at www.opticlear.co.za	• 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	
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	• 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	• 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	• 100% of Scheme Rate • Subject to available MSA

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 2026	BASIC PLAN 2026	TRADITIONAL PLAN 2026	CORE SAVER PLAN 2026	COMPREHENSIVE PLAN 2026	PLUS PLAN 2026
		NON-MSA PLANS			MSA PLANS		
			All services and products, including frames, subject to selected Iso Leso Optometry Network Scheme-approved and contracted services and products	multi-focal lenses from an Opticlear Network optometrist		multi-focal lenses from an Opticlear Network optometrist	
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 R130 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 R130 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 190 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
Be a better-informed Bankmed member You can play an active role in managing your healthcare costs. When visiting your optometrist, remember to: - Confirm your available benefits with both your optometrist and Bankmed before your consultation. Bankmed can assist with any benefit-related queries. - Check the cost of any items not covered by Bankmed and ask your optometrist to explain why these services or materials are needed.							
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
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		

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		
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 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 870 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 870 pfpa	- 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) 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)	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 R23 695 for a single member and R35 895 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

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Terminology Reminders:

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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			
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 870 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 R29 915 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 R35 670 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:

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38.5	Biologic and high-cost specialised medication Utilised in the management of PMB CDL and non-PMB chronic conditions - 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	- 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
	- PMB algorithm medication - PMB non-algorithm medication - Non-PMB non-algorithm medication	100% of cost - No benefit - No benefit	100% of cost - No benefit - No benefit	100% of cost 70% of Scheme Rate 70% of Scheme Rate	100% of cost 70% of Scheme Rate - No benefit	100% of cost 100% of Scheme Rate 100% of Scheme Rate	100% of cost 100% of Scheme Rate 100% of Scheme Rate

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:	<table><tr><th>Benefits</th></tr><tr><th>BENEFITS AND LIMITATIONS</th></tr><tr><th>Benefits in excess of the PMB requirements</th></tr><tr><td> - 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. </td></tr></table>	Benefits	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.	<table><tr><th>BENEFITS AND LIMITATIONS</th></tr><tr><th>BOC as defined by Bankmed</th></tr><tr><td>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 </td></tr></table>	BENEFITS AND LIMITATIONS	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
Benefits										
BENEFITS AND LIMITATIONS										
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		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 ‘2026 Plan Information’ and then ‘Medicine Formularies 2026’ 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

Terminology Reminders:

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