

BANKMED**ANNEXURE B2: BANKMED BASIC PLAN (NO SAVINGS)****Schedule of benefits with effect from 1 January 2026****STATUTORY PRESCRIBED MINIMUM BENEFITS**

Notwithstanding any provisions to the contrary in this schedule, the Scheme will fund:

- 100% of the diagnosis, treatment and care costs of the Statutory Prescribed Minimum Benefits (PMBs), subject to PMB regulations, if those services are obtained from a Designated Service Provider (DSP) in South Africa; or
 - the relevant Scheme Rate for the diagnosis, treatment and care costs of the Statutory Prescribed Minimum Benefits if a beneficiary voluntarily accesses PMBs via a non-DSP in South Africa, when provision is made for a DSP according to this schedule; or
 - 100% of cost for involuntary use of a non-DSP in South Africa, subject to PMB regulations.

Pre-authorisation, medicine formularies and Scheme protocols (also known as “Care Plans”, “Baskets of Care”, or “Treatment Baskets”) may apply.

Diagnosis costs are only regarded as a PMB if the result of diagnostic investigations confirms a PMB diagnosis.

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

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

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

STATUTORY PRESCRIBED MINIMUM BENEFITS**PRO RATING OF BENEFITS FOR MEMBERS JOINING DURING THE COURSE OF A FINANCIAL YEAR**

Beneficiaries admitted during the course of a financial year are entitled to the benefits set out in this schedule, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the financial year (rule 16.1.5), except for stated wellness and preventative care benefits, which shall not be subject to pro-ration.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
OVERALL ANNUAL LIMIT		Unlimited	This plan has no overall annual limit.
HOSPITAL NETWORK/DSPs	Hospital Network DSPs are applicable on this plan. Reduced benefits apply for accommodation and associated fees charged by non-DSP hospitals, subject to PMB regulations. Hospital Network DSPs on this plan are: Contracted private hospitals/facilities (restricted network) as communicated to members from time to time.		
HOSPITALISATION Hospital Network DSPs Deductibles apply to a <u>specified list</u> of conditions/procedures as set out in Appendix 3 All admissions at network DSP Other hospitals (non-DSPs) PMB admission: involuntary use of non-DSP (deductible does not apply) PMB admission: voluntary use of non-DSP (deductible applies to all admissions) Non-PMB admission (deductible applies to all admissions)	100% of cost 100% of cost 80% of Scheme Rate 80% of Scheme Rate	General ward rates General ward rates General ward rates General ward rates	Benefits subject to pre-authorisation, and only available on referral from a Bankmed GP Entry Plan Network GP or referred specialist, subject to PMB regulations. Emergencies must be authorised within 24 hours of admission. No benefit for dental surgery except for PMBs. No benefit for auxiliary services except for PMBs. PMBs limited to 80% of Scheme Rate for non-DSPs, subject to PMB regulations.
Deductibles payable on admission Healthcare services reflected in Appendix 3 REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES	Beneficiary responsible for a Deductible in respect of the hospital account for certain hospital events, unless the admission is related to a Prescribed Minimum Benefit diagnosis typically as a result of an emergency. The Deductible will apply regardless of the whether the procedure attracting the deductible was the primary reason for the admission or not.		

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Benefits provided on admission to:			
1. Hospital Network DSPs			
- Ward Fees (general ward rate) - ICU and high care unit fees - Theatre fees - Ward and theatre drugs, dressings, materials and equipment consumed / utilised in hospital - Outpatient services - Recovery beds	100% of cost	Unlimited	In accordance with a per diem or negotiated rate. Facility fees charged by hospitals for outpatient visits that do not result in authorised admissions to be paid from out of hospital specialist consultations and procedures limit.
Ward and theatre drugs, dressings, materials, equipment and disposables consumed / utilised in the theatre (at hospital network DSPs)	100% of cost	Unlimited	
2. Other hospitals (non-DSPs)			
- Ward Fees (general ward rate) - ICU and high care unit fees - Theatre fees - Outpatient services - Recovery beds	80% of Scheme Rate	Unlimited	PMBs limited to 80% of Scheme Rate for non-DSPs, subject to PMB regulations. Facility fees charged by hospitals for outpatient visits that do not result in authorised admissions to be paid from out of hospital specialist consultations and procedures limit.
Ward and theatre drugs, dressings, materials, equipment and disposables consumed / utilised in hospital (at non-DSP hospitals)	100% of cost	Unlimited	
3. Unattached Theatre Units (Private)			
- Theatre fees - Recovery beds	100% of cost at a DSP 80% of Scheme Rate at a non-DSP	Unlimited	The unattached theatre must be registered with the Department of Health.
Ward and theatre drugs, dressings, materials, equipment and disposables consumed / utilised in hospital (at unattached theatre unit)	100% of cost	Unlimited	

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HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
OUTPATIENT CONSULTATIONS WITH GPs/SPECIALISTS AT HOSPITAL EMERGENCY ROOMS AND OUTPATIENT UNITS		See General Practitioners/ Specialists: out of hospital consultations in rooms	Regarded as out of hospital GP/Specialist consultations in rooms, unless resulting in an authorised hospital admission.
HOME-BASED HEALTHCARE For clinically appropriate chronic and acute treatment and conditions, where treatment is possible at home	100% of Scheme Rate	Unlimited Subject to the Scheme's preferred provider (where applicable) and the treatment meeting the Scheme's treatment guidelines and clinical and benefit criteria.	Subject to pre-authorisation and PMB regulations. Basket of care as set by the Scheme.
TO TAKE OUT DRUGS	100% of cost	Limited to PMBs and a maximum of 7 days' supply per admission	Benefit for medicine supplied by the hospital when a patient is discharged. If procedure took place in a day surgery facility, a maximum of a seven-day supply will be funded from Insured Benefits if obtained from a retail pharmacy on the date of discharge only.
AMBULANCE SERVICES	100% of cost via the Scheme's DSP 100% of Scheme Rate through a non-DSP	Unlimited	Subject to pre-authorisation and PMB regulations. No benefit for services outside the borders of South Africa.
BLOOD TRANSFUSIONS Blood products, materials, apparatus and operator's fees	100% of cost	Unlimited	Subject to pre-authorisation and PMB regulations.
ORGAN AND BONE MARROW TRANSPLANTS Hospitalisation, and organ and patient preparation Medication (in and out of hospital) Harvesting and transporting of organs, and other donor costs	Benefits as for hospitalisation 100% of cost 100% of cost	Limited to PMBs Limited to PMBs Limited to PMBs	Subject to pre-authorisation and PMB regulations. The organ recipient must be a Bankmed beneficiary for benefits to apply. Benefits for Specialists will be as specified elsewhere this schedule. No benefit for travelling and non-hospital accommodation expenses.

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HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
For medicines scripted and dispensed at a retail pharmacy or via a courier pharmacy (scripted by treating provider): (Supportive medication, oral chemotherapy and hormonal therapy) - Medication via the Oncology Pharmacy Designated Service Provider (DSP) - Medication via a non-DSP (voluntary use of non-DSP) - Medication via a non-DSP (involuntary use of non-DSP)	100% of cost 80% of Scheme Medicine Reference Price plus dispensing fee 100% of cost	Limited to PMBs Limited to PMBs Limited to PMBs	REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES
RENAL DIALYSIS Procedures and Treatment Associated Medicine/Drugs - Medication via designated courier pharmacy (DSP) - Medication via non-DSP (voluntary use of non-DSP) - Medication via non-DSP (involuntary use of non-DSP)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost 80% of Scheme Medicine Reference Price plus dispensing fee 100% of cost	Limited to PMBs Limited to PMBs Limited to PMBs Limited to PMBs	Subject to pre-authorisation and PMB regulations.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
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: Out-of-hospital healthcare services related to COVID-19: - Screening consultation with a nurse or GP - Defined basket of pathology - Defined basket of x-rays and scans - Consultations with a nurse or GP - Supportive treatment - Contact tracing	Over and above the PMB requirements. Up to a maximum of 100% of the Scheme Rate. Cover for testing is subject to NICD protocol and referral. Subject to the Scheme's preferred provider (where applicable), protocols and the condition and treatment meeting the Scheme's entry criteria and guidelines.	Up to a 100% of the Scheme Rate for registered healthcare providers.	Basket of care as set by the Scheme Out-of-hospital healthcare services related to COVID-19: - Screening consultation with a nurse or GP: unlimited - Defined basket of pathology: unlimited tests per person per year subject to appropriate clinical referral for testing for registered healthcare providers except where covered as PMB.
PREGNANCY AND CHILDBIRTH Hospitalisation and associated in hospital services (hospital network rules apply) Midwife care and delivery Birthing facilities Antenatal and post-natal care	As specified elsewhere in this schedule 100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost at a DSP 100% of Scheme Rate at a non-DSP	 (Cost of disposables limited to R1 500 per case) As specified elsewhere in this schedule	Subject to pre-authorisation and PMB regulations. Benefits for hospitalisation and other in hospital services as specified elsewhere in this schedule. Subject to pre-authorisation and PMB regulations. Subject to pre-authorisation. Only available where hospital services are not used (except for registered active birthing units). Benefits for General Practitioners, Specialists, radiology, pathology and other associated services as specified elsewhere in this schedule.

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HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Additional insured benefits at or subject to referral by a Bankmed Entry Plan Network GP and subject to registration on the Scheme's Maternity Programme (Baby and Me): 6 ante-natal consultations per pregnancy 3 x 2D ultrasounds per pregnancy - R1 845 per pregnancy for ante-natal and post-natal classes Additional insured pathology benefits subject to Baby and Me Basket of Care Other Antenatal and post-natal care: Radiology and Pathology	100% of cost for DSP 100% of Scheme Rate for non-DSP 100% of cost for DSP 100% of Scheme Rate for non-DSP 100% of cost for DSP 100% of Scheme Rate for non-DSP 100% of cost for DSP 100% of Scheme Rate for non-DSP 100% of cost at a DSP 100% of Scheme Rate at a non-DSP	As specified As specified As specified As specified As specified elsewhere in this schedule	Additional insured consultations benefits limited to Bankmed GP Entry Plan Network GPs (DSPs) and Bankmed Specialist Network gynaecologists / obstetricians (DSPs). Additional insured pathology benefits subject to Baby-and-Me Basket of Care. Benefits for Radiology and Pathology as specified elsewhere in this schedule.
ALTERNATIVES TO HOSPITALISATION Step-down facilities Frail Care Facilities Home nursing services	100% of cost at a DSP 100% of Scheme Rate at a non-DSP No benefit No benefit	Unlimited No benefit No benefit	Step-down facilities: Subject to pre-authorisation and available only as an alternative to hospitalisation. Such service follows pre-authorised hospitalisation or operation and is in lieu of further hospitalisation. The facility must be registered with the Department of Health.
ADVANCED ILLNESS BENEFIT	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	Subject to pre-authorisation, PMB regulations, and the treatment meeting the Scheme's guidelines and managed care criteria.

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HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
REGISTERED PRIVATE NURSE PRACTITIONERS (registered with the S. A. Nursing Council or its legal successor)			
Procedures	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	For procedures not requiring admission to a day surgery facility or hospital; Includes the cost of vaccination and injection material administered by the Practitioner.
Consultations	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Three pbpa	
HomeCare Services	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	For procedures not requiring admission to a day surgery facility or hospital. Subject to Scheme Clinical Entry Criteria. Subject to preauthorisation.
WELLNESS AND PREVENTATIVE CARE BENEFITS (VACCINATIONS AND SCREENING)			Benefits in this section do not contribute to the depletion of any insured limits specified elsewhere in this schedule. Associated consultation fees are not provided for in this section, unless indicated. See General Practitioners (GPs): out of hospital consultations and procedures in rooms for consultation benefits.
Contraception: oral contraceptives, devices and injectables	100% of Scheme Medicine Reference Price	R2 615 pbpa	For female beneficiaries only. Oral contraceptives limited to one prescription or repeat prescription per beneficiary per month.
Influenza vaccine	100% of Scheme Medicine Reference Price	One pbpa	

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Human Papilloma Virus (HPV) vaccine	100% of Scheme Medicine Reference Price	Three doses pb	For male and female beneficiaries aged 9 to 25 years and limited to a total course of three doses (depending on product and age).
Cholesterol screening, blood sugar screening and blood pressure measurements	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R415 pbpa	At clinics, pharmacies or Bankmed GP Entry Plan Network GPs' consulting rooms.
HIV Counselling and Testing (HCT)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	HCT DSPs: Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted HCT providers rendering onsite services at employer groups, subject to PMB regulations.
Mammogram	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa	For beneficiaries aged 40 years and older; Benefits for beneficiaries younger than 40 years, subject to motivation and prior approval.
Breast MRI (breast cancer risk only)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa	For high-risk beneficiaries only. Subject to clinical entry criteria and pre-authorisation.
Cervical Cancer Screening: Pap smear, or;	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa	One associated nurse, Bankmed GP Entry Plan Network GP or Bankmed Specialist Network consultation per beneficiary covered as an additional insured benefit, limited to R655 pbpa.
Cervical Cancer Self-Sampling Kit	100% of Scheme Rate for test code	One pbpa	One per beneficiary per annum. Beneficiaries may select one of either a pap smear or cervical cancer self-sampling screening kit only, not both.

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HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Bone densitometry Prostate specific antigen Colorectal Cancer Screening: Faecal occult blood test, or; Colorectal Cancer Self-Sampling Kit REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES Tuberculosis (TB) screening Childhood vaccinations (BCG, Oral Polio, Rotavirus, Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio and Haemophilus influenza type B, Hepatitis B, Measles, Pneumococcal vaccine) Pneumococcal vaccine	100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of Scheme Rate for test code 100% of Scheme Rate 100% of Scheme Medicine Reference Price 100% of Scheme Medicine Reference Price	One pbpa One pbpa One pbpa One pbpa One chest x-ray pbpa Subject to EPI guidelines Limited as follows:	For beneficiaries aged 50 years and older; Benefits for beneficiaries younger than 50 years, subject to motivation and prior approval. For beneficiaries aged 50 years and older; Benefits for beneficiaries younger than 50 years, subject to motivation and prior approval. Limited to one per qualifying beneficiary per annum. Limited to beneficiaries aged 50 years and older. Beneficiaries may select one of either a faecal occult or colorectal cancer self-sampling screening kit only, not both. For TB screening requested by private nurse practitioners rendering onsite services at employer groups; All other TB screenings subject to available out of hospital radiology and/or pathology benefits, and PMB regulations. For immunisations administered in accordance with the Department of Health's Expanded Programme on Immunisation (EPI) guidelines for children up to 12 years. - One vaccination every five years for adults 60 years and older. - One vaccination every five years for beneficiaries younger than 60 years,

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Bankmed Mental Wellbeing Assessments Mental Health ‘At Risk’ Benefit: Additional Consultation for Bankmed Entry Plan GP or Network Psychologist New-born Screening Test New-born Hearing Test REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES	100% of cost at a DSP Not covered at a non-DSP 100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one consultation per qualifying beneficiary Visit to Bankmed Entry Plan GP or Network Psychologist to take place within 6 weeks of the Online Mental Wellbeing Assessment, otherwise funded from day-to-day benefits. Limited to one per beneficiary Limited to one per beneficiary	Free online assessment via www.bankmed.co.za ; There is no limit on the number of assessments per beneficiary per annum. Limited to high-risk members. Consultations limited to Bankmed Entry Plan GPs and Bankmed Network psychologists. Members identified and risk-rated using results from the Online Mental Wellbeing Assessment, therefore subject to completion of the Online Mental Wellbeing Assessment. Clinical Entry Criteria applies. Testing limited to services provided within the borders of South Africa. Test funded only if performed within 72 hours of birth. Testing limited to service provided by a registered audiologist. Only the test is funded. Should the provider charge a consultation fee, the consultation fee will be funded from available consultation benefits. Test only funded if performed within eight weeks of birth. Thereafter funded from standard benefits.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
T21 Chromosome Test or Non-Invasive Prenatal Test (NIPT) (Member may have either of the two tests, not both)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one per pregnancy	Subject to the Scheme's protocols and clinical entry criteria. Applies to high-risk beneficiaries only, who are aged 35 years and older at delivery. One assessment per beneficiary per pregnancy. Testing limited to services provided within the borders of South Africa. If member does not meet clinical entry criteria, the screening test is not covered on this Plan.
Amniocentesis	100% of cost for DSP 100% of Scheme Rate for non-DSP	Limited to one per pregnancy	Subject to gynaecologist referral. One assessment per beneficiary per pregnancy. Testing limited to services provided within the borders of South Africa.
Dementia Screening and Assessment Benefit REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one consultation and comprehensive cognitive assessment per qualifying beneficiary per year	One assessment per qualifying pbpa. Testing limited to service provided by a registered Occupational Therapist. Where an Occupational Therapist is not available, the member may consult a Bankmed Network psychologist for the assessment. Only the consultation and assessment are funded. Should the provider charge for additional services, these services will be funded from standard available benefits, where relevant. Applies to members and beneficiaries aged 65 years and older only.
Child Obesity Screening	100% of cost at a DSP Not covered at a non-DSP	Limited to one pbpa	One assessment pbpa. Applies to beneficiaries who are 9 years old to 15 years old only.

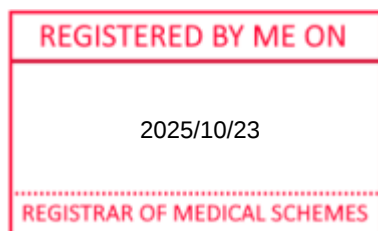
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Child Obesity Screening: Additional Consultations for Dietician and Biokineticist REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to two dietician visits per year plus two Biokineticist visits per year First visit to dietician and biokineticist to take place within 6 weeks of the Child Obesity Screening and second visit within 12 months of the Child Obesity Screening, otherwise funded from day-to-day benefits	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 Obesity Screening, therefore subject to completion of the Child Obesity Screening. Clinical Entry Criteria applies. Applies to beneficiaries who are aged 9 years to 15 years only.
Child Obesity Screening: Additional Consultation for Bankmed Entry Plan GP	100% of cost at a DSP Not covered at a non-DSP	Limited to one Bankmed Entry Plan GP visit. Visit to Bankmed Entry Plan GP to take place within 6 weeks of the Child Obesity Screening, otherwise funded from day-to-day benefits.	Limited to high-risk beneficiaries. Beneficiaries identified and risk-rated using results from the Child Obesity Screening, therefore subject to completion of the Child Obesity Screening. Clinical Entry Criteria applies. Applies to beneficiaries who are 9 years old to 15 years old only.
Preventative Childhood Dental Check	100% of cost at a DSP Not covered at a non-DSP	Limited to two per child per annum. At Bankmed Dental Network practitioner only, and according to Scheme approved formulary.	Limited to beneficiaries who are age 3 years old to 17 years old only.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
RADIOLOGY AND PATHOLOGY In Hospital Out of hospital REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES	100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited 	Out-of-hospital subject to Bankmed GP Entry Plan Network (DSP) and subject to the Scheme approved formulary. For radiology and pathology requested or carried out via a specialist, the benefit will be subject to the specialists out of hospital consultations and procedures limit as specified elsewhere in this schedule.
MRI / CT SCANS AND RADIONUCLIDE SCANS In Hospital Out of hospital	100% of cost at a DSP 100% of Scheme Rate at a non-DSP 100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited Limited to PMBs via radiology facilities at Hospital Network DSPs	Subject to pre-authorisation. Subject to pre-authorisation. PMBs limited to 100% of Scheme Rate for radiology facilities at non-DSPs, subject to PMB regulations.
HIV/AIDS PROGRAMME Additional benefits subject to registration on HIV/Aids Programme. These additional benefits do not contribute to the depletion of other insured benefits provided by the Scheme. Consultations and pathology	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited Out-of-network GP Benefit Limit applies if the doctor is not a DSP	Beneficiaries who do not register on the HIV/Aids Programme will be entitled to benefits for PMBs (only), subject to PMB regulations. Subject to benefits available in Scheme's Basket of Care

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Associated Medicine/Drugs - Medication via Bankmed Pharmacy Network (DSP) - Medication via non-DSP (voluntary use of non-DSP) - Medication via non-DSP (involuntary use of non-DSP)	100% of cost 80% of Scheme Medicine Reference Price plus dispensing fee 100% of cost	Unlimited Unlimited Unlimited	Bankmed Pharmacy Network for HIV/Aids medication: as communicated to registered beneficiaries from time to time. A motivation is required for the use of a non-DSP for medication. Subject to Scheme's approved formulary. Scheme's Medicine Reference Price applies to non-formulary medication.
INTERNAL PROSTHESIS Combined limit for all internal prostheses items Internal prosthesis sub-limits: Hip joint prostheses, knee joint prostheses and shoulder joint prostheses REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES Spinal fusions Cardiac stents	100% of cost via a DSP 100% of Scheme Rate via non-DSP 100% of cost via a DSP 100% of Scheme Rate via non-DSP 100% of cost via a DSP 100% of Scheme Rate via non-DSP 100% of cost via a DSP 100% of Scheme Rate via non-DSP	R95 065 pbpa R63 265 per prosthesis per admission if prosthesis is not supplied by the Scheme's network provider. If supplied by the Schemes network provider, unlimited (not subject to combined limit for all internal prosthesis items) R64 050 R94 690	Benefits subject to clinical motivation, the application of clinical / funding protocols, Scheme approval and PMB regulations. Defined as appliances placed in the body as an internal adjuvant, during an operation. Combined limit for all internal prosthesis items, excluding pacemakers and defibrillators; Sub-limits may apply depending on the prosthesis required. All sub-limits as indicated are further subject to the combined limit for all internal prosthesis items, excluding pacemakers, defibrillators. The sub-limits are not "in addition to" the combined limit. Dental implants of any nature are not included in the definition of internal prosthesis. The prostheses accumulate to the limit. The balance of the hospital and related accounts do not accumulate to the annual limit.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Grafts Cardiac Valves Non-specified items	100% of cost via a DSP 100% of Scheme Rate via non-DSP 100% of cost via a DSP 100% of Scheme Rate via non-DSP 100% of cost via a DSP 100% of Scheme Rate via non-DSP	R51 260 R53 915 R29 540	
SPINAL CARE (SPINAL CARE PROGRAMME) In-hospital and out-of-hospital management for spinal care and surgery. Limited to a defined list of clinically appropriate procedures which include Lumbar Fusion, Cervical Fusion, Laminectomy, Laminotomy REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES	100% of cost for the hospital account at a network facility. Network does not apply to any admissions related to trauma. 100% of the Scheme Rate for the hospital account if performed at a non-network facility. 100% of cost for related accounts at a DSP 100% of Scheme Rate for related accounts at a non-DSP	Limited to PMBs	Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria. Subject to PMB regulations. Unlimited at a network provider for in-hospital treatment Basket of care as set by the Scheme for out-of-hospital conservative treatment
PACEMAKERS AND DEFIBRILLATORS	100% of cost at hospital network DSPs 80% of cost at non-DSPs	Limited to PMBs	Subject to clinical motivation, the application of clinical / funding protocols, Scheme approval and PMB regulations.
INTRAOCULAR LENSES FOR CATARACT SURGERY (Permanent, implantable lenses, inclusive of basic and specialised lens varieties)	Up to a maximum of 100% of the Scheme Rate Scheme Rate is equal to the negotiated and agreed lens price plus 25% mark-up	Limited to PMBs	Subject to pre-authorisation and the treatment meeting the Scheme's criteria. Covered in full when supplied by the Scheme's preferred suppliers, otherwise covered up to the Scheme Rate for the lens. Scheme Rate is equal to the negotiated and agreed lens price plus 25% mark-up

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
			Where the provider marks up the lens cost in excess of the agreed rate, the Scheme will not be responsible for the shortfall.
EXTERNAL PROSTHESIS Artificial limbs and eyes (Combined limit with Medical and Surgical Appliances, Blood Pressure Monitors, Nebulisers and Glucometers)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R4 175 pfpa	Subject to clinical motivation, the application of clinical/funding protocols and Scheme approval. Benefit includes the repair of the prosthesis. Frequency limits apply: Breast prosthesis bra: no limit on number of bras that may be purchased in 12 months; Rand limit applies Breast prosthesis: one/two per 24 months (one/two is patient dependent)
MEDICAL AND SURGICAL APPLIANCES (Combined limit with External Prosthesis Benefit and Blood Pressure Monitors, Nebulisers and Glucometers)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R4 175 pfpa	Benefits subject to a doctor's prescription, the application of clinical and funding protocols, and Scheme approval. No benefit for wheelchairs and large orthopaedic appliances on this plan, except for PMBs. Frequency limits apply: Surgical/moonboot: one every 24 months Crutches: one set every 24 months Brace callipers: one set every 24 months Rigid back brace: one every 24 months Wig: one every 24 months Commodes: one every 36 months Walking frames: one every 24 months Surgical compression stockings: two pairs per 12-month period Sling/clavicle brace: one every 24 months Humidifier: one every 36 months



HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS (Combined limit with External Prosthesis Benefit and Medical and Surgical Appliances)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	R4 175 pfpa R1 605 pbpa for blood pressure monitors R2 265 pbpa for nebulisers R1 130 pbpa for glucometers	Benefits subject to a doctor's prescription, the application of clinical and funding protocols, and pre-authorisation. Frequency limits apply: Blood pressure monitors: one every 36 months Nebulisers: one every 36 months Glucometers: one every 36 months
HEARING AIDS (SUPPLY AND FITMENT)	No benefit, except for PMBs	No benefit, except for PMBs	Frequency limits apply: Benefit only available where the beneficiary has not claimed for hearing aid/s in the previous calendar year. Rolling limit every 24 months. No benefit for replacement batteries.
HEARING AID REPAIRS	No benefit	No benefit	
BONE ANCHORED HEARING AIDS	No benefit	No benefit	
COCHLEAR IMPLANTS	No benefit	No benefit	
UPGRADE OR REPLACEMENT OF SPEECH PROCESSORS	No benefit	No benefit	
PSYCHIATRY, CLINICAL PSYCHOLOGY, & RELATED OCCUPATIONAL THERAPY Hospitalisation: Hospital Network DSPs All admissions at network DSP	100% of cost for Bankmed Network Psychiatric facilities (DSPs)	Limited to PMBs	Subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP). Cover for 21 days in hospital in line with PMB regulations.

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REGISTRAR OF MEDICAL SCHEMES

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Other hospitals (non-DSPS) PMB admission: involuntary use of non-DSP PMB admission: voluntary use of non-DSP Non-PMB admission In-hospital consultations / sessions Out of hospital consultations / sessions Post-hospital psychiatric consultation within 30 days of discharge from hospital (excluding day cases) for a psychiatric admission (Related to Major Depression, Schizophrenia and Bipolar Mood Disorder only) REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES	100% of cost 80% of Scheme Rate for non-DSPs No benefit 100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs 100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs 100% of cost for Bankmed Entry Plan Network Psychiatrist: DSPs 100% of Scheme Rate for non-DSP Psychiatrist	Limited to PMBs Limited to PMBs Limited to PMBs Limited to PMBs Limited to three consultations per beneficiary per annum	Subject to PMB regulations. PMBs limited to 80% of Scheme Rate for non-DSPs, subject to PMB regulations. Subject to PMB regulations. Subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP). PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations. Cover for 15 out-of-hospital psychotherapy sessions for PMBs, in line with PMB regulations. An additional consultation will be granted as an insured benefit, per beneficiary visiting a psychiatrist within 30 days of discharge, following an authorised psychiatric hospital admission (excluding day cases). PMBs limited to 100% of Scheme rate for non-DSPs, subject to PMB regulations. In the event that the member exceeds the three-consultation limit (following three hospital admissions), the consultations will be subject to the standard psychiatry, clinical psychology and related occupational therapy benefit limits.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
MENTAL HEALTH INTEGRATED DISEASE MANAGEMENT PROGRAMME Disease Management for specified mental health conditions for members registered on the Scheme's Mental Health Integrated Disease Management Programme	In addition to the cover provided for under the PMB regulations, up to 100% of the Scheme Rate for services covered in the Scheme's basket of care if referred by the Scheme's DSP. 100% of Scheme Rate for services performed by the Scheme's DSP.	Limited to the basket of care set by the Scheme.	Subject to the treatment meeting the Scheme's treatment guidelines and managed care criteria. Subject to PMB regulations.
OCCUPATIONAL THERAPY: PSYCHIATRIC CONSULTATIONS / SESSIONS In hospital Out of hospital	100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs 100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs Limited to PMBs	Subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP). Subject to PMB regulations. Subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP). Subject to PMB regulations.
OCCUPATIONAL THERAPY: NON-PSYCHIATRIC CONSULTATIONS / SESSIONS In hospital Out of hospital	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP 100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	Limited to PMBs Limited to PMBs	Subject to pre-authorisation and PMB regulations. Subject to pre-authorisation and PMB regulations.
PHYSIOTHERAPY In hospital Out of hospital (including post-hospitalisation treatment)	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP 100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	Limited to PMBs Limited to PMBs	Subject to pre-authorisation and PMB regulations. Subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP).

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REGISTRAR OF MEDICAL SCHEMES

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
SPEECH THERAPY, AUDIO THERAPY AND AUDIOLOGY In and out of hospital	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	Limited to PMBs	Subject to pre-authorisation, referral from a Bankmed GP Entry Plan Network GP and PMB regulations.
ADDITIONAL BENEFITS FOR BENEFICIARIES WITH NEURODEVELOPMENTAL DISORDERS - Occupational therapy: psychiatric consultations/sessions (out of hospital) - Occupational therapy: non-psychiatric consultations/sessions (out of hospital) - Physiotherapy (out of hospital) - Speech therapy (out of hospital)	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	As approved	Additional discretionary insured benefits may be granted for beneficiaries with neurodevelopmental disorders, subject to clinical motivation and Scheme approval. The quantum of additional benefits, if approved, shall be decided on a case-for-case basis, and granted at 100% of the Scheme Rate or contracted rate, whichever applies. These discretionary benefits are in addition to any other insured benefits normally applicable to these services, as specified elsewhere in this schedule.
OTHER AUXILIARY SERVICES In and out of hospital - Chiropody/Podiatry - Dietetics/Nutritional Assessments - Orthotics - Massage - Chiropractors - Herbalists - Naturopaths - Family planning clinics - Homeopaths - Biokineticists (fitness assessments)	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES	Limited to PMBs	Subject to pre-authorisation, referral from a Bankmed GP Entry Plan Network GP and PMB regulations. Frequency limits apply: Foot orthotics: one every 24 months If prescribed by a medical practitioner and provided that the supplier of service is registered as such in terms of any law.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
			The fees must have been incurred for a definite complaint and treatment must be for curative purposes only. 100% of cost for PMBs (insured benefit), subject to PMB regulations.
CHRONIC MEDICATION Medication via DSP (Bankmed GP Entry Plan Network GP) Medication via non-DSP (voluntary use of non-DSP) Medication via non-DSP (involuntary use of non-DSP)	Subject to Scheme approved formulary 100% of cost plus contracted dispensing fee 80% of Scheme Medicine Reference Price 100% of cost plus dispensing fee	Unlimited Subject to out of network GP consultations and procedures limit of R2 870 pfpa Unlimited	Benefits for chronic medication, drugs and injection material subject to: • Prior application and approval of the Scheme • Each prescription or repeat prescription being limited to one month's supply per beneficiary • Such motivations and reports by appropriate medical practitioners, as are required by the Scheme • PMB regulations • Scheme approved formulary Dispensing fee limited to the contracted dispensing fee applicable to Bankmed GP Entry Plan Network GPs and Bankmed Pharmacy Network (DSPs).
PRESCRIBED ACUTE MEDICATION Medication via DSP (Bankmed GP Entry Plan Network GP and Bankmed Pharmacy Network) REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES	Subject to Scheme approved formulary 100% of cost plus contracted dispensing fee	Unlimited	Unlimited benefits for acute medication, drugs and injection material via selected Bankmed GP Entry Plan Network GP and Bankmed Pharmacy Network, subject to Scheme approved formulary.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Medication via non-DSP (voluntary use of non-DSP)	100% of cost plus dispensing fee	Subject to Out-of-Network GP Consultations and Procedures Limit of R2 870 pfpa	See General Practitioners: Out-of-hospital consultations and procedures in rooms at non-Bankmed Entry Plan Network GPs (non-DSPs). If prescribed by a non-DSP, medication will accumulate to the Out-of-Network GP Consultations and Procedures Limit, even if a DSP pharmacy is used.
Medication via non-DSP (involuntary use of non-DSP)	100% of cost plus contracted dispensing fee	Unlimited	
SELF-MEDICATION (OVER THE COUNTER MEDICINE) AND PHARMACY ADVISED THERAPY (PAT)	No benefit	No benefit	For member's own account
HOMEOPATHIC MEDICATION	No benefit	No benefit	For member's own account
SPECIALISTS			
In hospital consultations, operations and procedures	100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	Subject to pre-authorisation. No benefit for dental surgery except for PMBs. PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.
Out-of-hospital consultations and procedures in rooms	100% of cost for Bankmed Network Specialists: DSPs 80% of cost if no pre-authorisation and no referral from Bankmed GP Entry Plan Network GP 100% of Scheme Rate for non-DSPs 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed GP Entry Plan Network GP	Limited to: M = R4 650 pbpa M+ = R7 280 pfpa	Subject to pre-authorisation and referral by a Bankmed GP Entry Plan Network GP. Limit includes costs associated with an out of hospital specialist consultation/ procedure (e.g. basic radiology, scans, pathology and acute medicine prescribed by the specialist/appearing on the specialist's account), that are not already provided for elsewhere in this schedule. PMBs limited to 100% of Scheme Rate for non-DSPs (with further reduction to 80% of Scheme Rate if no pre-authorisation and no referral from Bankmed GP Entry Plan Network GP), subject to PMB regulations.

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HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
			Benefits for MRI/CT scans and radionuclide scans are as described elsewhere in this schedule.
GENERAL PRACTITIONERS (GPs)			
In hospital consultations	100% of cost for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	In-hospital benefits are subject to pre-authorisation.
In hospital operations and procedures	100% of cost for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Unlimited	PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.
Out of hospital consultations and procedures in rooms REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES	100% of cost for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Unlimited Limited to three visits and a maximum of R2 870 pfpa (subject to PMBs)	No benefit for dental surgery except for PMBs. All costs associated with the out of network GP visit will accumulate to this limit. Benefits for MRI/CT scans and radionuclide scans are as specified elsewhere in this schedule. PMBs limited to 100% of Scheme rate for non-DSPs, subject to PMB regulations.
Post hospital GP consultation within 30 days of discharge from hospital (excluding day cases)	100% of cost for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs Subject to out-of-network GP limit if non-DSP used	Unlimited	An additional consultation will be granted as an insured benefit, per beneficiary visiting a GP within 30 days of discharge, following an authorised hospital admission (excluding day cases). PMBs limited to 100% of Scheme rate for non-DSPs, subject to PMB regulations.
Virtual GP consultation	100% of cost for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs Subject to out-of-network GP limit if non-DSP used	Limited to three consultations pbpa	Subject to member and/or beneficiary having a prior consulting relationship with the GP. Verification notes to be submitted by claiming GP.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
MAXILLO-FACIAL AND ORAL SURGERY	100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs	Subject to pre-authorisation and PMB regulations.
EXTRACTION OF IMPACTED WISDOM TOOTH/ TEETH IN-ROOMS PMB: In-rooms: Designated Service Provider (DSP) (deductible does not apply) PMB: In-rooms: Non-DSP (voluntary use of non-DSP) (deductible applies in all instances) PMB: In-rooms: Non-DSP (involuntary use of non-DSP) (deductible does not apply) Non-PMB: In-rooms:	100% of cost for Bankmed Network Specialists: DSPs 100% of cost for Bankmed Dental Network: DSPs 80% of Scheme Rate Deductible applies 100% of cost No benefit	Limited to PMBs Unlimited (In-room tariffs) Unlimited (In-room tariffs) Unlimited (In-room tariffs) No benefit	Benefits subject to pre-authorisation and PMB regulations. Deductibles apply as set out in Appendix 3. REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES
PREVENTATIVE AND BASIC DENTISTRY Preventative and Basic Dentistry not covered in-hospital. Subject to PMB regulations. Scale and polish, routine extractions, x-rays to support diagnosis, restorations (amalgam and resin only), basic root canal therapy (including emergency), full and partial plain plastic dentures obtained at a preferred provider and clasps/repairing of dentures (plastic only)	100% of cost for DSPs	Unlimited	At Preferred Provider Network (Bankmed Dental Network), and according to Scheme approved formulary.
ADVANCED DENTISTRY Caps, crowns, bridges and cost of endosteal and ossea-integrated implants	No benefit	No benefit	
ORTHODONTICS	No benefit	No benefit	

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
ALL OTHER DENTAL SERVICES - Second and subsequent examinations in the same year; - X-rays	100% of cost for DSPs	Unlimited	At Preferred Provider Network (Bankmed Dental Network), and according to Scheme approved formulary.
OPTOMETRY Consultations Frames and extras Prescription lenses Contact lenses Fitting of contact lenses	100% of cost 100% of cost 100% of cost No benefit No benefit	One consultation pb every two years One frame pb every two years One pair of lenses pb every two years No benefit No benefit	Benefits via Preferred Provider Network (Iso Leso Optometry Network) only. No benefit for readymade readers on this plan.
Other optometric services Refractive surgery/excimer laser treatment, hospitalisation and associated costs	No benefit	No benefit	No benefit, including the cost of hospitalisation, medication and all other associated services.
CLAIMS FOR SERVICES RENDERED OUTSIDE THE BORDERS OF SOUTH AFRICA REGISTERED BY ME ON 2025/10/23 REGISTRAR OF MEDICAL SCHEMES	As per Annexure D	As per Annexure D	Foreign claims covered at the relevant Scheme Rate and/or Rand limit normally allowed for an equivalent non-PMB claim in South Africa. In the case of internal prosthesis and/or medical and surgical appliances, funding will be limited to the amount or rate at which the Scheme would normally fund or procure such device within the borders of South Africa. No benefits for emergency/ambulance transport outside the borders of South Africa.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
			Medical motivation and prior approval required for elective/non-emergency surgery outside the borders of South Africa. No benefits for services not normally covered at the Scheme's preferred provider network (Bankmed GP Entry Plan Network) for out of hospital consultations, medicine and treatment (except via Bankmed GP Entry Plan Network providers in Lesotho).

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LEGEND:

Contracted rate	=	The rate determined in terms of an agreement between the Scheme and a service provider or group of service providers in respect of payment of relevant services
Cost	=	The net cost (after discount) charged for a relevant health service or, in respect of a contracted or negotiated service, the contracted rate. In respect of surgical items and procedures provided in hospital, “cost” shall be the nett acquisition price (also see Annexure B)
DSP	=	Designated Service Provider (may also be referred to as Preferred Provider or Contracted Provider in this schedule): A healthcare provider or group of providers contracted by the Scheme as preferred provider/s to provide diagnosis, treatment and care to beneficiaries in respect of one or more prescribed minimum benefit conditions
M	=	Member without dependants
M+	=	Member plus dependants
pb	=	per beneficiary
pbpa	=	per beneficiary per annum
pfpa	=	per family per annum
pmpa	=	per member per annum
PMB	=	Prescribed Minimum Benefits - a set of minimum benefits to be funded by all medical schemes as per the Medical Schemes Act and Regulations, in respect of the Prescribed Minimum Benefit Conditions (A Prescribed Minimum Benefit Condition is “a condition contemplated in the Diagnosis and Treatment Pairs and Chronic Disease List conditions listed in Annexure A of the Regulations, or any emergency medical condition”)
Scheme Medicine Reference Price	=	the maximum price that the Scheme shall pay for a drug or a class of drugs, where cost-effective alternatives exist. In the event that a member voluntarily chooses a drug that is more expensive than an alternative available drug that falls within the Scheme Medicine Reference Price, the price difference shall be a co-payment payable by the member at point of sale, subject to PMB regulations, where applicable
Scheme Rate	=	the rate at which health services are reimbursed by the Scheme in accordance with the applicable benefit schedule and shall be determined by the Scheme from time to time

