BANKMED

ANNEXURE B1: BANKMED ESSENTIAL PLAN (NO MEDICAL SAVINGS ACCOUNT)

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

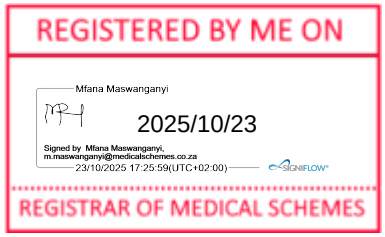
PRO RATING OF BENEFITS FOR MEMBERS JOINING DURING THE COURSE OF A FINANCIAL YEAR

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. However, benefits are limited to PMBs, except for wellness and preventative benefits (such as vaccinations and screenings), which are covered as specified herein.
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 specified list of conditions/procedures as set out in Appendix 3			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.
All admissions at network DSP	100% of cost	Limited to PMBs (at general ward rates)	No benefit for dental surgery except for PMBs. No benefit for auxiliary services except for PMBs.
Other hospitals (non-DSPS)			
PMB admission: involuntary use of non-DSP	100% of cost	Limited to PMBs (at general ward rates)	
PMB admission: voluntary use of non-DSP	80% of Scheme Rate	Limited to PMBs (at general ward rates)	PMBs limited to 80% of Scheme Rate for non-DSPs, subject to PMB regulations.
Non-PMB admission	No benefit		
Deductibles payable on admission Healthcare services reflected in Appendix 3	Beneficiary responsible for a Deductible in respect of the hospital account for certain hospital events, unless the admission is related to a Prescribed Minimum Benefit diagnosis typically as a result of an emergency. The Deductible will apply regardless of the whether the procedure attracting the deductible was the primary reason for the admission or not.		

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Benefits provided on admission to:			
1. Hospital Network DSPs			
• Ward Fees (general ward rate) • 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	Limited to PMBs	In accordance with a per diem or negotiated rate. Facility fees charged by hospitals for outpatient visits that do not result in authorised admissions are not covered on this plan, unless resulting in an authorised hospital admission (subject to PMB regulations).
• Ward and theatre drugs, dressings, materials, equipment and disposables consumed / utilised in the theatre (at hospital network DSPs)	100% of cost	Limited to PMBs	
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	Limited to PMBs	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 are not covered on this plan, unless resulting in an authorised hospital admission.
• Ward and theatre drugs, dressings, materials, equipment and disposables consumed / utilised in hospital (at non-DSP hospitals)	100% of cost	Limited to PMBs	
3. Unattached Theatre Units (Private)			
• Theatre fees • Recovery beds	100% of cost at a DSP 80% of Scheme Rate at a non-DSP	Limited to PMBs	The unattached theatre must be registered with the Department of Health. PMBs limited to 80% of Scheme Rate for non-DSPs, subject to PMB regulations.
• Ward and theatre drugs, dressings, materials, equipment and disposables consumed / utilised in hospital (at unattached theatre unit)	100% of cost	Limited to PMBs	

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	Limited to PMBs 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	Limited to PMBs	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.

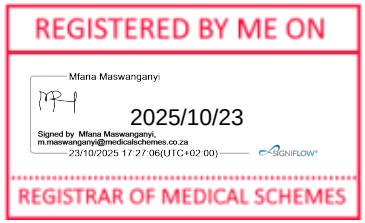
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
ONCOLOGY (CHEMOTHERAPY AND RADIOTHERAPY)			
In and out of hospital consultations, treatment and materials	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	Subject to: - Pre-authorisation and PMB regulations - Evidence-based medicine, cost-effectiveness and affordability - Scheme's oncology baskets of care, formularies and/or protocols - Meeting Scheme's Clinical Entry Criteria - Peer-review by external panel of specialists as appointed by the Scheme
Associated Medicine/Drugs **For medicines administered in-rooms:** (Injectable and infusional chemotherapy)			
• Medication via the Oncology Pharmacy Designated Service Provider (DSP) (Courier pharmacy)	100% of cost	Limited to PMBs	Subject to: - Pre-authorisation and PMB regulations - Evidence-based medicine, cost-effectiveness and affordability - Scheme's oncology baskets of care, 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 a designated service provider. 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)
• Medication via a non-DSP (voluntary use of non-DSP)	80% of Scheme Medicine Reference Price plus dispensing fee	Limited to PMBs	
• Medication via a non-DSP (involuntary use of non-DSP)	100% of cost	Limited to PMBs	
Excludes medicines administered in-hospital and medicines administered in-rooms by a dispensing provider.			

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)	100% of cost	Limited to PMBs	
• Medication via a non-DSP (voluntary use of non-DSP)	80% of Scheme Medicine Reference Price plus dispensing fee	Limited to PMBs	
• Medication via a non-DSP (involuntary use of non-DSP)	100% of cost	Limited to PMBs	
RENAL DIALYSIS			
Procedures and Treatment	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	Subject to pre-authorisation and PMB regulations.
Associated Medicine/Drugs			
• Medication via designated courier pharmacy (DSP)	100% of cost	Limited to PMBs	
• Medication via non-DSP (voluntary use of non-DSP)	80% of Scheme Medicine Reference Price plus dispensing fee	Limited to PMBs	
• Medication via non-DSP (involuntary use of non-DSP)	100% of cost	Limited to PMBs	

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)	As specified elsewhere in this schedule	Limited to PMBs	Subject to pre-authorisation and PMB regulations. Benefits for hospitalisation and other in hospital services as specified elsewhere in this schedule.
Midwife care and delivery	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	Subject to pre-authorisation and PMB regulations.
Birthing facilities	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs (Cost of disposables limited to R1 500 per case)	Subject to pre-authorisation and PMB regulations. Only available where hospital services are not used (except for registered active birthing units).
Antenatal and post-natal care	Limited to PMBs	Limited to PMBs	Benefits for General Practitioners, Specialists, radiology, pathology and other associated services as specified elsewhere in this schedule.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
ALTERNATIVES TO HOSPITALISATION			
Step-down facilities	100% of cost at DSP 100% Scheme Rate at non-DSP	Limited to PMBs	Step-down facilities: Subject to pre-authorisation and PMB regulations, 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.
Frail Care Facilities	No benefit	No benefit	
Home nursing services	No benefit	No benefit	
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.
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	Limited to PMBs	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, limited to PMBs	Subject to PMB regulations.
HomeCare Services	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	For procedures not requiring admission to a day surgery facility or hospital. Subject to Scheme Clinical Entry Criteria. Subject to preauthorisation.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
WELLNESS AND PREVENTATIVE CARE BENEFITS (ADDITIONAL INSURED BENEFITS)			Benefits in this section do not contribute to the depletion of any insured limits specified elsewhere in this schedule.
Influenza vaccine	100% of Scheme Medicine Reference Price	One pbpa	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.
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.

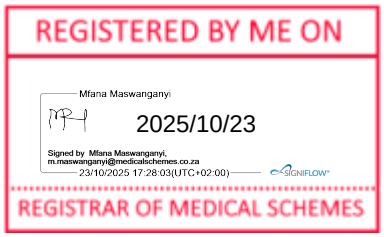


HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Cervical Cancer Screening: **Pap smear, or;**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa	One associated nurse, Bankmed GP Entry Plan Network GP or Bankmed Specialist Network consultation per beneficiary covered as 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.
Bone densitometry **Prostate specific antigen**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa One pbpa	For beneficiaries aged 50 years and older; Benefits for beneficiaries younger than 50 years, subject to motivation and prior approval.
Colorectal Cancer Screening: **Faecal occult blood test, or;**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One pbpa	For beneficiaries aged 50 years and older; Benefits for beneficiaries younger than 50 years, subject to motivation and prior approval.
Colorectal Cancer Self-Sampling Kit	100% of Scheme Rate for test code	One pbpa	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.
Tuberculosis (TB) screening	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	One chest x-ray pbpa	For TB screening requested by private nurse practitioners rendering onsite services at employer groups; All other TB screenings subject to available out of hospital radiology and/or pathology benefits, and PMB regulations.

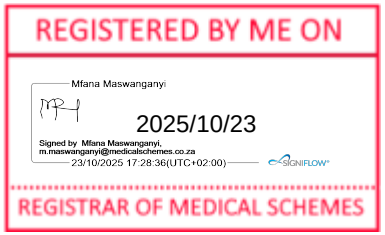
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Childhood vaccinations (BCG, Oral Polio, Rotavirus, Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio and Haemophilus influenza type B, Hepatitis B, Measles, Pneumococcal vaccine)	100% of Scheme Medicine Reference Price	Subject to EPI guidelines	For immunisations administered in accordance with the Department of Health's Expanded Programme on Immunisation (EPI) guidelines for children up to 12 years.
Pneumococcal vaccine	100% of Scheme Medicine Reference Price	Limited as follows:	One vaccination every five years for adults 60 years and older.
Personal Health Assessment (PHA)	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one pbpa	One assessment pbpa. Benefit limited to Bankmed GP Entry Plan Network GPs, Bankmed Pharmacy Network and contracted providers rendering onsite services at employer groups; subject to completion and follow up of the assessment. Applies to members and beneficiaries aged 16 years and older only.
Post-Personal Health Assessment (PHA): Additional Consultations for Dietician and Biokineticist	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 PHA and second visit within 12 months of the PHA, otherwise funded from day-to-day benefits	Limited to medium and high-risk members and/or members with a Body Mass Index (BMI) of 30 and more. Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA. Clinical Entry Criteria applies. Applies to members and beneficiaries aged 16 years and older only.

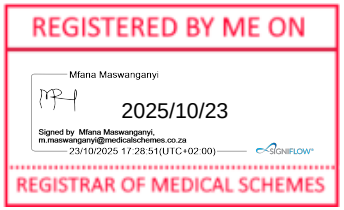
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Post-Personal Health Assessment (PHA): Additional Consultation for Bankmed Entry Plan Network GP	100% of cost at a DSP Not covered at a non-DSP	Limited to one Bankmed Entry Plan Network GP visit pbpa Visit to Bankmed Entry Plan Network GP to take place within 6 weeks of the PHA, otherwise funded from day-to-day benefits.	Limited to high-risk members. Members identified and risk-rated using results from the PHA, therefore subject to completion of the PHA. Clinical Entry Criteria applies. Applies to members and beneficiaries aged 16 years and older only.
Bankmed Mental Wellbeing Assessments			Free online assessment via www.bankmed.co.za; there is no limit on the number of assessments per beneficiary per annum.
Mental Health 'At Risk' Benefit: Additional Consultation for Bankmed Entry Plan Network GP or Network Psychologist	100% of cost at a DSP Not covered at a non-DSP	Limited to one consultation per qualifying beneficiary Visit to Bankmed Entry Plan Network 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 high-risk members. Consultations limited to Bankmed Entry Plan Network 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.
New-born Screening Test	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one per beneficiary	Testing limited to services provided within the borders of South Africa. Test funded only if performed within 72 hours of birth.

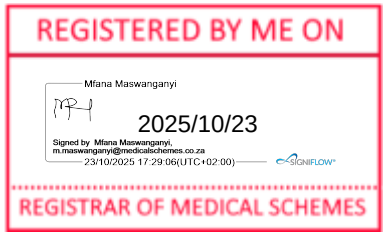
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
New-born Hearing Test	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to one per beneficiary	Testing limited to service provided by a registered Audiologist. Only the test is funded. Should the provider charge a consultation fee, the consultation fee will be funded from available consultation benefits. Test only funded if performed within eight weeks of birth. Thereafter funded from standard benefits.
T21 Chromosome Test or Non-Invasive Prenatal Test (NIPT) **(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	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

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
			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.
Child Obesity Screening: Additional Consultations for Dietician and Biokineticist	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 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 GP Entry Plan Network GP 	100% of cost at a DSP Not covered at a non-DSP	Limited to one Bankmed Entry Plan Network GP visit. Visit to GP Entry Plan Network 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.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
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.
DIABETES MANAGEMENT For members registered on the Scheme's Disease Management Programme	100% of cost for services covered in the Scheme's Basket of Care if referred by the Scheme's DSP and member utilises the Scheme's DSP as their service provider. 100% of Scheme Rate at a non-DSP	Unlimited	Basket of Care set by the Scheme, subject to PMB regulations.
Continuous Glucose Monitoring Device (CGM) Available to Type 1 and Type 2 diabetics meeting the Scheme's clinical entry criteria	Subject to authorisation and/or approval and the member meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.	Unlimited	Subject to the Scheme's protocols and clinical entry criteria. Members with a CGM device have limited glucose strip benefits, where approved.
DISEASE MANAGEMENT FOR CARDIO-METABOLIC RISK SYNDROME Disease Management for cardiometabolic risk syndrome for members registered on the Scheme's Disease Management Programme	Up to a maximum of 100% of the Scheme Rate. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.	Limited to PMBs and the basket of care set by the Scheme.	Subject to PMB regulations. Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria, treatment guidelines and protocols.
RADIOLOGY AND PATHOLOGY **In and out of hospital**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	Out of hospital benefits subject to care plan registration for PMB conditions.
MRI / CT SCANS AND RADIONUCLIDE SCANS **In and out of hospital**	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs via radiology facilities at Hospital Network DSPs	Subject to pre-authorisation. PMBs limited to 100% of Scheme Rate for radiology facilities at non-DSPs, subject to PMB regulations.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
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.		Subject to benefits available in Scheme's Basket of Care	Beneficiaries who do not register on the HIV/Aids Programme will be entitled to benefits for PMBs (only), subject to PMB regulations.
Consultations and pathology	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Unlimited	Subject to benefits available in Scheme's Basket of Care
Associated Medicine/Drugs			
• Medication via Bankmed Pharmacy Network (DSP)	100% of cost	Unlimited	Bankmed Pharmacy Network for HIV/Aids medication: as communicated to registered beneficiaries from time to time.
• Medication via non-DSP (voluntary use of non-DSP)	80% of Scheme Medicine Reference Price plus dispensing fee	Unlimited	A motivation is required for the use of a non-DSP for medication.
• Medication via non-DSP (involuntary use of non-DSP)	100% of cost	Unlimited	Subject to Scheme's approved formulary. Scheme's Medicine Reference Price applies to non-formulary medication.
INTERNAL PROSTHESIS 	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	Defined as appliances placed in the body as an internal adjuvant, during an operation. Benefits subject to clinical motivation, the application of clinical / funding protocols, Scheme approval and PMB regulations.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
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**  	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.
INTRAOCCULAR 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 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	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	Benefit for limbs and eyes. 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: two every 12 months Breast prosthesis: one/two per 24 months (one/two is patient dependent)

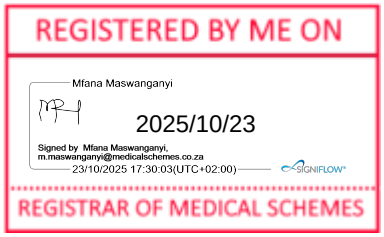
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
MEDICAL AND SURGICAL APPLIANCES 	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	Benefits subject to a doctor's prescription, the application of clinical and funding protocols, and Scheme approval. No benefit for 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
BLOOD PRESSURE MONITORS, NEBULISERS AND GLUCOMETERS	100% of cost at a DSP 100% of Scheme Rate at a non-DSP	Limited to PMBs	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	Subject to PMB regulations. **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	

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
COCHLEAR IMPLANTS	No benefit	No benefit	
UPGRADE OR REPLACEMENT OF SPEECH PROCESSORS	No benefit	No benefit	
PSYCHIATRY, CLINICAL PSYCHOLOGY, & RELATED OCCUPATIONAL THERAPY			
Hospitalisation:			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.
Hospital Network DSPs			
All admissions at network DSP	100% of cost for Bankmed Network Psychiatric facilities (DSPs)	Limited to PMBs	PMBs limited to 80% of Scheme Rate for non-DSPs, subject to PMB regulations.
Other hospitals (non-DSPS)			
PMB admission: involuntary use of non-DSP	100% of cost	Limited to PMBs	Subject to PMB regulations.
PMB admission: voluntary use of non-DSP	80% of Scheme Rate for non-DSPs	Limited to PMBs	Subject to PMB regulations
Non-PMB admission	No benefit		
In-hospital consultations / sessions	100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs	Subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP). Subject to PMB regulations.
Out of hospital consultations / sessions	100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs	Cover for 15 out-of-hospital psychotherapy sessions for PMBs, in line with PMB regulations.

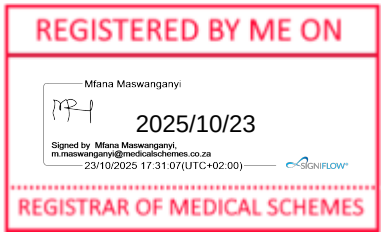
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Post-hospital psychiatric consultation within 30 days of discharge from hospital (excluding day cases) for a psychiatric admission (Related to Major Depression, Schizophrenia and Bipolar Mood Disorder only)	100% of cost for Bankmed Entry Plan Network Psychiatrist: DSPs 100% of Scheme Rate for non-DSP Psychiatrist	Limited to three consultations per beneficiary per annum	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). 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.
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: NON-PSYCHIATRIC CONSULTATIONS / SESSIONS			
In hospital	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	Limited to PMBs	Subject to pre-authorisation and PMB regulations.
Out of hospital	100% of cost at a DSP 100% of Scheme Rate at a Non-DSP	Limited to PMBs	Subject to pre-authorisation and referral from a Bankmed GP Entry Plan Network GP (DSP).

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
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).
SPEECH THERAPY, AUDIO THERAPY AND AUDIOLOGY **In and out of hospital**	Limited to PMBs	Limited to PMBs	Subject to pre-authorisation, referral from a Bankmed GP Entry Plan Network GP and PMB regulations. Out of hospital cover is subject to PMB application.
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)	Limited to PMBs	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 Out of hospital cover is subject to PMB application

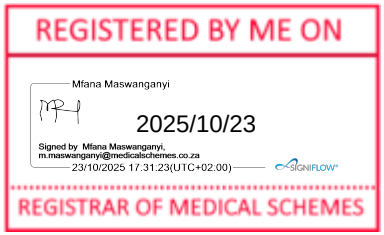
HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
CHRONIC MEDICATION	100% of cost via Bankmed GP Entry Plan Network and subject to Scheme approved formulary Dispensing fee limited to the contracted dispensing fee applicable to Bankmed GP Entry Plan Network GPs and Bankmed Pharmacy Network: DSPs	Limited to PMBs	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
PRESCRIBED ACUTE MEDICATION	100% of cost via Bankmed GP Entry Plan Network GPs and subject to Scheme approved formulary	Limited to PMBs	Subject to PMB regulations
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** REGISTERED BY ME ON Mfana Maswanganyi 2025/10/23 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 23/10/2025 17:29:46(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES	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. No benefit for dental surgery except for PMBs. PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Out-of-hospital consultations 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 PMBs	Subject to pre-authorisation, referral by Bankmed GP Entry Plan Network GP and Care Plan registration for PMB conditions 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
Out of hospital procedures in rooms	100% of cost for Bankmed Network Specialists: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs	PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations.
GENERAL PRACTITIONERS (GPs)			
In hospital consultations **In hospital operations and procedures**	100% of cost at contracted rate for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs	In-hospital benefits are Subject to pre-authorisation and PMB regulations. PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations. No benefit for dental surgery except for PMBs.
Out of hospital consultations and procedures in rooms	100% of cost at contracted rate for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs	At selected Bankmed GP Entry Plan Network GP (DSP) in accordance with preferred provider contract. PMBs limited to 100% of Scheme Rate for non-DSPs, subject to PMB regulations

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
Post hospital GP consultation within 30 days of discharge from hospital	100% of cost for Bankmed GP Entry Plan Network GPs: DSPs 100% of Scheme Rate for non-DSPs	Limited to PMBs	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	Limited to PMBs 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.
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		Limited to PMBs	Benefits subject to pre-authorisation and PMB regulations.
PMB: In-rooms: Designated Service Provider (DSP) (deductible does not apply)	100% of cost for Bankmed Network Specialists: DSPs 100% of cost for Bankmed Dental Network: DSPs	Unlimited (In-room tariffs)	Deductibles apply as set out in Appendix 3.
PMB: In-rooms: Non-DSP (voluntary use of non-DSP) (deductible applies in all instances)	80% of Scheme Rate Deductible applies	Unlimited (In-room tariffs)	
PMB: In-rooms: Non-DSP (involuntary use of non-DSP) (deductible does not apply)	100% of cost	Unlimited (In-room tariffs)	
Non-PMB: In-rooms:	No benefit	No benefit	

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
PREVENTATIVE AND BASIC DENTISTRY	No benefit	No benefit	
ADVANCED DENTISTRY Caps, crowns, bridges and cost of endosteal and ossea-integrated implants	No benefit	No benefit	
ORTHODONTICS	No benefit	No benefit	
ALL OTHER DENTAL SERVICES	No benefit	No benefit	
OPTOMETRY **Consultations** **Frames and extras** **Prescription lenses and readymade readers** **Contact lenses** **Fitting of contact lenses**	 No benefit No benefit No benefit No benefit No benefit	 No benefit No benefit No benefit No benefit No benefit	
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 	100% of Bankmed GP Entry Plan Network rate or Scheme Rate or contracted rate (whichever applies)	Limited to PMBs	As per Annexure D: Cover available for PMB conditions and life-threatening emergencies only. Associated benefits calculated as if the services were rendered in South Africa at the relevant Bankmed GP Entry Plan Network rate or Scheme Rate or other contracted rate (whichever would normally apply) for an equivalent non-PMB service covered by the Scheme in South Africa. In the case of internal prosthesis and/or medical and surgical appliances (cover for PMBs only), funding will be limited to the amount or rate at which the Scheme would

HEALTHCARE SERVICE	BASIS OF COVER	ANNUAL LIMITS	CONDITIONS/REMARKS
			normally fund or procure such a device within the borders of South Africa. No benefits for emergency/ambulance transport outside the borders of South Africa. Medical motivation and prior approval required for non-emergency surgery outside the borders of South Africa.



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