Bankmed
Yours in good health

BASIC PLAN
FAQs 2024

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

WELLNESS AND PREVENTATIVE CARE BENEFITS

What type of preventative care and screening benefits are covered?

All preventative care and screening benefits (health checks) are paid for from your Insured Benefit. This means that tests and screenings such as your Personal Health Assessment (PHA), HIV Counselling and Testing (HCT), Annual Flu Vaccination, Pap smear and Mammogram are all included. For a full list of your screening benefits, check your Benefit and Contribution Schedule under ***Wellness and Preventative Care Benefits.***

WELLNESS MANAGEMENT PROGRAMME

What is the post-engagement Wellness Management Programme?

If you are identified as a moderate- to high-risk member after completing the Personal Health Assessment (PHA), you have access to two dietitian and two biokineticist consultations to support you with managing and improving your lifestyle and health.

In 2024, this benefit is being enhanced to include members with an abnormal BMI of ≥ 30 and the dietitian consultation is being extended to 30 minutes.

GENERAL PRACTITIONERS (GPs)

How do I find a GP?

Please log in to ***www.bankmed.co.za > DOCTOR VISITS > Find a Healthcare Professional*** or you can use the Bankmed App for a full list of the network GPs. To ensure that you avoid a co-payment, be sure to select a primary and secondary GP who provides full cover. If you choose to visit a GP who provides partial cover, you may have to pay a co-payment yourself.

If you are visiting a GP who provides full cover (according to the website or App) and they charge more than what we pay for, resulting in a co-payment, please contact the Bankmed Call Centre on 0800 BANKMED (0800 226 5633) to inform us.

Are my GP visits limited?

No, you have access to unlimited GP visits within the Bankmed GP Entry Plan Network once you nominate a primary and secondary GP.

What happens if I fail to nominate a primary and secondary GP?

Your primary GP will automatically be allocated for you, based on the GP you have visited previously. We assign the GP based on your claims. We pay for GP consultations from your out-of-network benefit until a primary GP has been allocated.

How does this GP allocation take place?

The first GP you visit within the network is allocated as your primary GP from the beginning of the month following your initial consultation. We pay the initial GP claim from your out-of-network consultation benefit (because you did not nominate your primary GP upfront).

If you do not select a secondary GP in the network, a visit to this GP will be subject to your three out-of-network consultation limit (also subject to the rand limit). Any visit to a non-network GP is also subject to your three out-of-network consultation benefit limit (subject to the rand limit).

Am I covered for any procedures conducted by my GP in their rooms?

While we strongly recommend that you do opt for in-room procedures as opposed to in-hospital treatment, please ask your GP to ensure that your procedure is on the list of in-room procedures that your Plan covers.

Your GP will be able to check this list online, or they may contact the Bankmed Call Centre on **0800 BANKMED (0800 226 5633)**.
If your procedure is NOT on the list, you will be responsible for the payment.

PRESCRIBED MINIMUM BENEFITS (PMBs)

What is a Prescribed Minimum Benefit?

Prescribed Minimum Benefits (PMBs) are a feature of the Medical Schemes Act 131 of 1998, which states that, regardless of the Plan type the member has chosen, medical schemes are obliged by law to cover the costs related to the diagnosis, treatment, and care of:

- Any emergency medical condition
- A limited set of 271 medical conditions, and
- 27 chronic conditions

A full list of the Prescribed Minimum Benefit conditions is available on **www.bankmed.co.za**

How are Prescribed Minimum Benefits relevant to my Plan?

Treatment on your Plan is limited to PMBs. This means that you will receive treatment and medication for only the conditions listed as a PMB. For example, a heart transplant is a PMB procedure, whereas a corneal transplant is not a PMB procedure and will, therefore, not be covered on your Plan. PMBs will be covered in full on your Plan if you use Healthcare Professionals, hospitals, and pharmacies on the Bankmed Network, known as Designated Service Providers (DSPs).

While you are entitled by law to get cover for PMB conditions, it remains vital that you use Healthcare Professionals in the Bankmed Entry Plan GP Network, the Bankmed Entry Plan Specialist Network (following referral only), and hospitals in the Bankmed Hospital Network to avoid co-payments.

What cover do I have with a Designated Service Provider (DSP)

As a Basic Plan member, you are covered in full when you utilise the Healthcare Professionals in our network which are also known as Designated Service Providers (DSPs) when we refer to PMB treatment. We update the network list each year, which is available by logging in to the Bankmed website.
www.bankmed.co.za > DOCTOR VISITS > Find a Healthcare Professional or you can use the Bankmed App

MEDICATION

Do I have to pay for my medication?

Bankmed has a medicine list (formulary) that all GPs should use when prescribing medication to avoid out-of-pocket expenses. Please check with your GP that the medication they prescribe for you is on the Bankmed medicine list (formulary).

Over-the-counter medications such as vitamins, cough mixtures, and cold and flu medication are NOT covered on this Plan. No homoeopathic medications are covered on this Plan.

CHRONIC MEDICATION

Am I covered for chronic medication? If so, for which conditions?

You have cover for chronic medication for those conditions that form part of the Chronic Disease List (CDL). The CDL is a defined list of 27 chronic conditions we cover according to PMBs. These include conditions such as diabetes, hypertension, asthma, and epilepsy. The CDL does not include conditions such as attention deficit and hyperactivity disorder (ADHD), psoriasis, osteoarthritis, and allergic rhinitis.

You may view the CDL on **www.bankmed.co.za > FIND A DOCUMENT > Benefit Guides.**

How do I apply for chronic medication?

Your GP will need to complete the *Chronic Illness Benefit Application form* for you. You can download this form from **www.bankmed.co.za > FIND A DOCUMENT > Application forms** and take it with you to your consulting GP to complete.

Your GP must also ensure that the medication they prescribe forms part of the Chronic Illness Benefit medicine list (formulary) so that you avoid having to pay a shortfall. Once the form has been completed, please email it to chronicbasicessential@bankmed.co.za.

DENTISTRY

What dental procedures are covered by my Plan?

You are covered for basic dentistry only, such as scaling and polishing. You are NOT covered for any orthodontics, crowns, or implants.

To ensure you do not have any out-of-pocket expenses, you must ensure that you visit a dentist on the Bankmed Network.

OPTOMETRY

What optometry benefits are covered by my Plan?

You get cover for one set of spectacle frames (glasses) for each member, every two years (24 months from the date of the last claim for spectacles). As your vision ordinarily does not change drastically within two years, you also get cover for one set of prescription lenses (for glasses) for each member, every two years. Contact lenses are NOT covered by this Plan. Your optometry benefits are available only from the Bankmed Optometry Network. To view a full list of the optometrists that form part of this network, please log in to **www.bankmed.co.za > DOCTOR VISITS > Find a Healthcare Professional.**

DISEASE MANAGEMENT PROGRAMMES

Which Disease Management Programmes do I qualify for?

You have access to Diabetes, HIV, Oncology, and the Disease Prevention Programmes. Strict clinical entry criteria apply when considering all Disease Management Programme applications.

How do I enrol in the Disease Management Programmes?

You are required to register with the Disease Management Programmes. Your treating Healthcare Professional may contact the Bankmed Call Centre on **0800 BANKMED (0800 226 5633)**.

MATERNITY BENEFITS

What is the Bankmed Baby-and-Me Programme?

In 2024, as a Basic Plan member you will have access Bankmed's Baby-and-Me Programme which provides you with access to:

- Six ante-natal consultations per pregnancy
- Three x 2D ultrasounds per pregnancy
- R1 690 per pregnancy for ante-natal and post-natal classes
- Additional insured pathology benefits subject to the Baby-and-Me Basket of Care (BOC)

SPECIALISTS

Do I have access to any specialists?

GP referral is essential if you want to visit a specialist, such as an orthopaedic surgeon or a paediatrician. There is a list of Bankmed Network Specialists that you must use if you want to avoid having any out-of-pocket expenses. Your GP will need to refer you to a specialist on this network. Specialist visits are also limited to a rand value, which means there is a set limit up to which we will pay.

You also require pre-authorisation before you can consult a specialist. Your GP will get authorisation on your behalf.

HOSPITALISATION

What happens if I need to be hospitalised?

To be covered for in-hospital treatment, you must be admitted to a hospital that is in the Bankmed Hospital Network. Unless the admission is involuntary (it is an emergency, and you are unconscious), admission to any hospital that is NOT on the network will result in a co-payment. For a full list of all the hospitals on the Bankmed Hospital Network, please log in to **www.bankmed.co.za > DOCTOR VISITS > Find a Healthcare Professional or visit Bankmed App.**

Will I have to pay for anything while I am in hospital?

If you are admitted to a hospital that does not form part of the Bankmed Hospital Network, you will be required to pay 20% of the admission fee.

What is a day surgery upfront payment (deductible)?

Bankmed's Day Surgery Network comprises a defined list of contracted day surgery facilities, as well as contracted acute hospitals providing day surgery facilities at day surgery rates. Bankmed has defined a list of 27 procedures that do not incur a deductible if performed at a facility in the Bankmed Day Surgery Network.

You do NOT have to pay an upfront payment for the conditions and procedures listed in the adjacent table, (at a day surgery facility or hospital that falls within the Day Surgery Network (DSP). This list applies to DSP only. If you choose to have any of the 27 procedures listed in the adjacent table, performed at a facility not in the Bankmed Day Surgery Network, you will be liable for a R4 100 deductible per admission. The deductible amount will increase to R6 300 in 2025.

PATHOLOGY AND RADIOLOGY

Am I covered for all blood tests and X-rays?

There is a limited list of tests and X-rays that your Plan covers. Your GP must reference this list so that you do not have to pay the claim yourself. Anything outside of this list will not be covered, and you will be liable for payment.

Please check with your GP when referring you for these tests that they are on the list to avoid out-of-pocket expenses. It is important to note that you are NOT covered for CT scans and MRI scans, unless you have been hospitalised.

Adenoidectomy	Myringotomy with intubation (grommets)
Arthrocentesis	Nasal cautery
Cataract surgery	Nasal plugging for nose bleeds
Cautery of vulva warts	Proctoscopy
Circumcision	Prostate biopsy
Colonoscopy	Removal of pins and plates
Cystourethroscopy	Sigmoidoscopy
Diagnostic D and C	Tonsillectomy
Gastroscopy	Treatment of Bartholin's cyst/gland
Hysteroscopy	Vasectomy
Myringotomy	Vulva/cone biopsy
Oesophagoscopy	Eye Procedures
Simple Abdominal	Gynaecological Procedures
Hernia Repair	Orthopaedic Procedures

BENEFIT ENHANCEMENTS

*Please read your **2024 Benefit and Contribution Schedule** for detailed information on updated limits, networks, and benefits.*

What is the benefit limit increase?

Benefit limits will increase by approximately **5.5%** in 2024.

CONTRIBUTION INCREASES

How do you calculate contribution increases?

Our contribution increases are determined by each Plan's performance, legal requirements, demographics, and medical inflation. With increases in line with other medical schemes, our members still receive 35% more value than the average comparable open-market Plan.

How much is the contribution increase?

Your contribution increase will be **7.3%** in 2024.