Bankmed
Yours in good health

ESSENTIAL 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 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 might be liable for a co-payment.

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.

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 confirm with your GP to ensure that your procedure is on the list of in-room procedures that your Plan covers. The Essential Plan only covers treatment for Prescribed Minimum Benefit (PMB) conditions, at the legislated level of care for Prescribed Minimum Benefits. If your treatment, procedure, or condition is NOT a Prescribed Minimum Benefit, you will have to pay for the treatment yourself.

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
- 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 PMB only. This means that you will receive treatment and medication for only the conditions listed as a Prescribed Minimum Benefit. For example, cancer is a PMB condition, and you will be covered for PMB level of care if treated with oncology medication. Whereas a corneal transplant is not a PMB and will, therefore, not be covered on your Plan.

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

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

As an Essential 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

What medication is not covered by the Essential Plan?

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

CHRONIC MEDICATION

Am I covered for chronic medication?

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 the Prescribed Minimum Benefits. 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 Chronic Disease List on **www.bankmed.co.za > FIND A DOCUMENT > Benefit Guides.**

In addition, you need to obtain your approved chronic medication from a pharmacy within the Bankmed Pharmacy Network, known as a DSP.

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.

DISEASE MANAGEMENT PROGRAMMES

Which Disease Management Programmes do I qualify for?

You have access to the Diabetes, HIV, and Oncology Programmes, but only for the treatment of PMB conditions.

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). Strict clinical entry criteria apply when considering all Disease Management Programme applications.

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/or 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 visit **www.bankmed.co.za** or the **Bankmed App**.

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)?

Essential Plan members do not have access to the full list of treatments or procedures listed in the adjacent table, as cover is limited to Prescribed Minimum Benefits. If you need to have one of these procedures or treatments performed and the underlying diagnosis is a Prescribed Minimum Benefit diagnosis, then you qualify for the procedure or Treatment.

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.

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 (day surgery facility or hospital), you will be liable for a R4 100 deductible per admission. The deductible amount will increase to R6 300 in 2025.

SPECIALISTS

Do I have access to any specialists?

You have cover for specialists if your condition is related to a PMB condition and you have been referred to the specialist by your nominated GP.

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.

For the conditions and procedures listed below, you do NOT have to pay an upfront payment (deductible) at a day surgery that falls within the Day Surgery Network. The facilities within the network are known as DSPs. This list applies to DSPs only:

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

** Essential Plan members do not have access to the full list of treatments as cover is limited to Prescribed Minimum Benefits.*

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 **6.1%** in 2024.