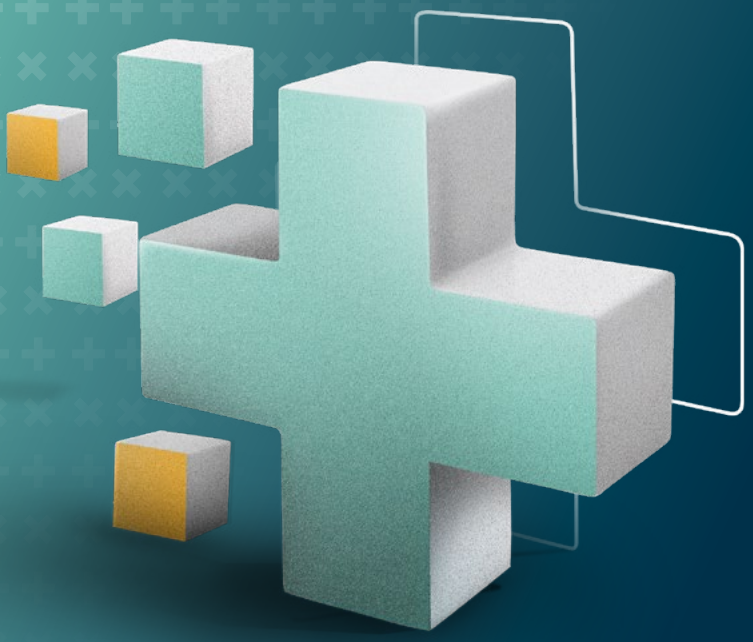
Bankmed
Yours in good health



BANKMED

AGM 2024

FREQUENTLY ASKED QUESTIONS (FAQS)

BENEFITS

1. How does a medical scheme work?

Medical schemes are the main funders of private healthcare in South Africa. Members of a medical scheme such as Bankmed pay contributions to the Scheme each month.

This money is pooled and then used to pay healthcare expenses in accordance with the Scheme's Rules and the member's choice of Plan, protecting members against the possibility of facing significant unexpected medical costs. All medical schemes in South Africa operate in accordance with the Medical Schemes Act, and are regulated by the Council for Medical Schemes.

The Bankmed Board of Trustees, appointed by the members of the Scheme, manage the affairs of the Scheme on behalf of the members according to the Act and the Scheme Rules.

2. Can medical schemes make a profit?

A medical scheme is a non-profit organisation, governed by a Board of Trustees and must be registered with the Council for Medical Schemes. This means it does not have shareholders and does not pay dividends and all surpluses that may be generated are invested on behalf of the members in accordance with Regulations. A medical scheme therefore does not make any profits, but is expected to be sustainable. Schemes exist for their members as all funds are pooled and safeguarded, to be used to pay claims in accordance with the Scheme's Rules and ensure that all members are equitably and fairly cared for (relative to their choice of benefit Plan).

3. Why can Bankmed not increase my benefit limit because I need additional cover?

Bankmed members have access to six Plans, each offering a varying degree of cover. Each of these Plans need to be managed to ensure long-term sustainability for all members. Members need to choose a Plan type that will provide them with the cover they need.

The benefits that apply on each Plan type are applicable to all members that have chosen that Plan type and cannot be amended for small groups of individuals. All limits are carefully monitored throughout the year and only a small percentage of members exhaust the limits. Bankmed will continue to monitor limit usage on an ongoing basis to ensure that all members are equitably cared for relative to their chosen Plan. Where benefits are considered too low for a member's specific needs, these members should explore another Plan type that may provide additional cover for their needs.

4. Can I receive a reduced monthly contribution or subsidy

This has been attended to at previous AGMs. The Medical Schemes Act prohibits discrimination based on age i.e. contributions and benefits may not be differentiated based on age.

Section 24(2)(e) of the Medical Schemes Act 131 of 1998 prescribes that medical schemes do not or will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds including race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health.

5. Why can't I have flexible benefits and carryover benefit limits?

Although we agree that it would be convenient for benefits and contributions to be modularised, thereby allowing members to select (and pay for) only those benefits they wish to purchase, this is regrettably not possible in terms of the Medical Schemes Act and Regulations. Bankmed, as a medical scheme, is governed by this legislation and as such we are limited in terms of the way in which our Plans are structured. Except for claims that are payable from Savings, it is regrettably not possible for unused (insured) benefits to be transferred from one benefit category to another, or from one benefit year to another.

Certain minimum benefits are prescribed by law and must be covered by all medical schemes, irrespective of the plan to which a member belongs. These minimum benefits are referred to as the Prescribed Minimum Benefits (PMBs), and include, amongst others, hospital-based maternity benefits (subject to PMB Regulations).

We do, however, attempt to address the diverse needs of our members, by providing six Plan types from which members may choose, each offering a varying degree of cover. Each of these Plans need to be managed to ensure long-term sustainability for all members. Members need to choose a Plan type that will provide them with the cover they need.

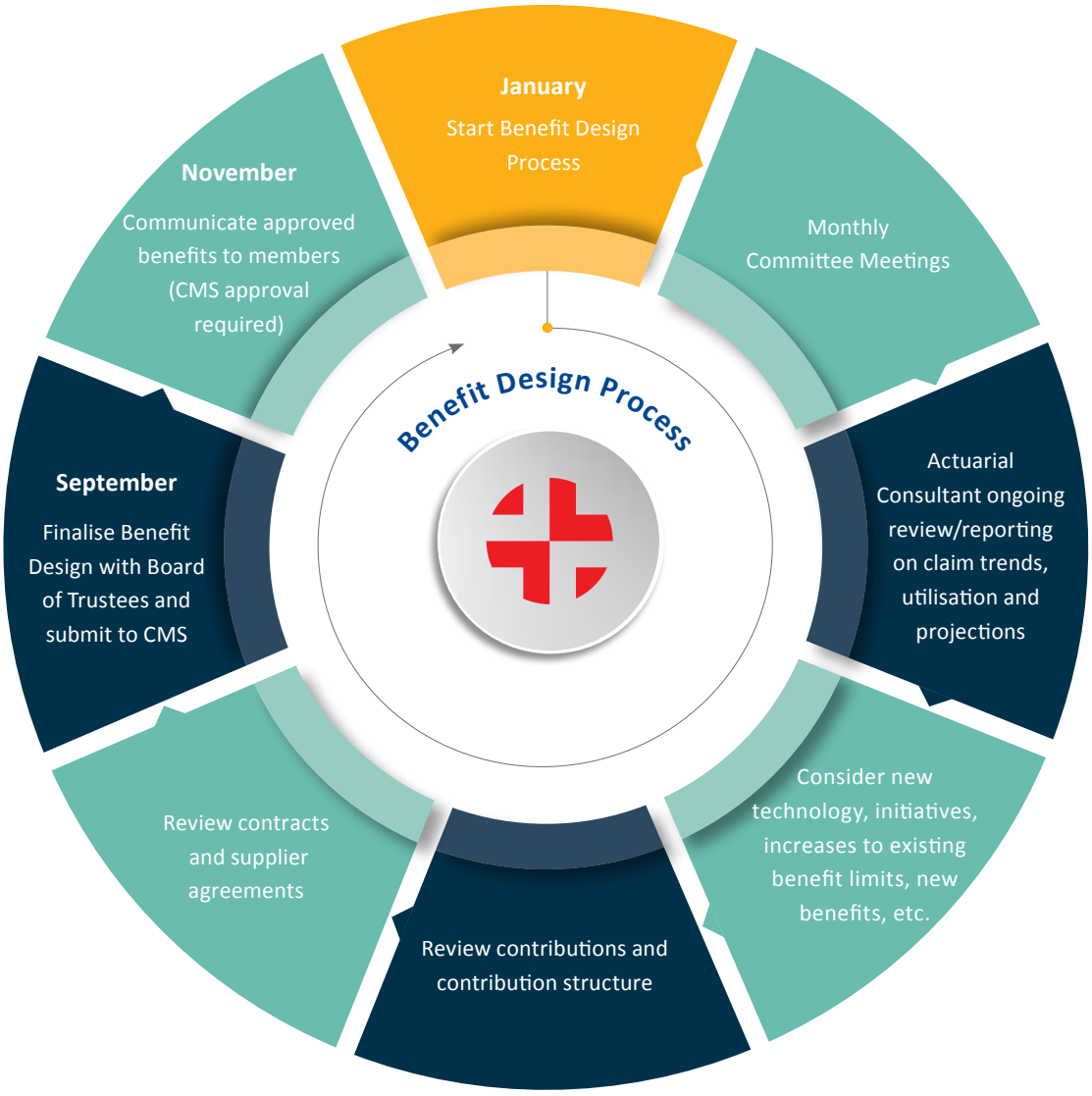
6. Benefit design process

In January every year, Bankmed starts the Benefit Design process for the following benefit year. Bankmed works with the Administrator and the Actuarial Consultants to review member expenditure and utilisation as well as market-related information in order to project costs into the following benefit year. Feedback sent by members is included in the Benefit Design process.

All benefit limits are reviewed relative to annual spend. Tariffs and contracts are revised with providers to adjust for annual increases. New technology and innovative treatments are considered too.

Basic levels of cover (PMBs) are to be maintained, increases to limits considered and the overall contribution to be determined for the following year. Bankmed must carefully balance the reimbursement of claims, administrative costs and reserves in order to offer members sustainable benefits and contributions. What this means is that Bankmed needs to potentially delay higher increases to certain benefits if the impact to the entire scheme's contribution increase is too high. This does not mean that the benefit changes are not considered though.

The introduction of new benefits and enhancements of existing benefits above inflation is weighed against the impact of these changes on contribution increases. As a result, a fine balance needs to be struck.



ADMINISTRATOR VERSUS SCHEME

1. What is the difference between Bankmed, Discovery Health (Pty) Ltd and Discovery Health Medical Scheme?

Bankmed (the Scheme) and Discovery Health Medical Scheme are both registered medical schemes under the Medical Schemes Act 131 of 1998 (the Act) and are regulated by the Council for Medical Schemes. Bankmed is registered as a restricted access medical scheme where membership is limited to persons employed by an institution with a banking licence. Discovery Health Medical Scheme is registered as an open medical scheme and access is open to the public as a whole. Bankmed and Discovery Health Medical Scheme are two separate legal entities. No relationship exists between Bankmed and Discovery Health Medical Scheme. Discovery Health (Pty) Ltd is a registered medical scheme administrator and managed care organisation, also registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd provides administration and managed care services to both Bankmed and Discovery Health Medical Scheme as well as other restricted access medical schemes.

2. What does it mean to be administered by Discovery Health (Pty) Ltd?

Discovery Health (Pty) Ltd is a registered medical scheme administrator and managed care organisation. They have been appointed by Bankmed to manage administration and managed care services on behalf of Bankmed. The Bankmed rules, policies and protocols are applied and managed, on Bankmed's instructions, by Discovery Health (Pty) Ltd. Discovery Health (Pty) Ltd develops the systems that manage the claims and are the people that take the calls in the call centre and answer queries, for example. As a medical scheme, Bankmed benefits from this administration by taking advantage of Discovery Health's healthcare resources, clinical risk management practices, digital tools, wellness offering, economies of scale, data analytics and continuous innovations in medical scheme administration. Discovery Health (Pty) Ltd does not amend or change Bankmed benefits. They merely act on behalf of Bankmed.

CLAIMS AND CLAIM PAYMENTS

1. How do I understand and read my claims statement and claims notification?

In April 2017, Bankmed issued a communication to members setting out the differences between a claims statement and a claims notification. This communication also contained detailed explanations about the claims statement and what the information means. We have attached this communication for your reference. Please refer to Annexure 1.

We would like to remind you to avoid printing the claims notification; these e-mails are not designed for printing. The claims statement is designed for printing.

NETWORKS AND PROVIDERS

1. Why does Bankmed make use of Networks and Designated Service Providers (DSPs)?

There are three main reasons why Bankmed makes use of Networks and DSPs:

- Networks and DSPs assist in ensuring long-term sustainability of the Scheme and controls increasing healthcare costs;
- Should the rising cost of healthcare not be managed, contributions are likely to increase and benefits may remain unchanged or be reduced;
- Through these partnerships Bankmed is in a stronger position to negotiate competitive tariffs and reduce member co-payments, thereby allowing members to maximise their benefits and reduce out-of-pocket expenses. These networks provide cover according to the members' specific chosen Plan. Members must familiarise themselves with the networks and DSPs that apply to their particular Plan. Members may find additional information in the Benefit and Contribution Schedule. By using DSPs, members will not incur out-of-pocket expenses, provided that benefits are available.

2. What happens if I do not use a Bankmed network?

Members may choose to use the services of any Healthcare Professional. However, should members choose to obtain healthcare services from a Healthcare Professional that is not a member of the relevant Bankmed Network, co-payments may apply, which members will need to settle themselves.

To find out which networks (DSPs) are available per Plan type, visit **www.bankmed.co.za**.

3. When a hospital forms part of the network, why do the service providers that work at the hospital not automatically form part of the network?

Negotiations are carried out at a provider group level, for example, hospitals are negotiated with via their head office and GPs may be negotiated with individually. Healthcare Professionals are free to choose their rate of reimbursement and as such, may choose not to participate in a network structure. This means that members may find a network hospital, but the treating provider at this hospital may not be a network provider, and vice versa. Bankmed continues to work towards negotiating with these Healthcare Professionals in order to expand the network as far as possible.

4. Where do I find lists of covered medications?

We make our medicine lists (formularies) available on **www.bankmed.co.za > FIND A DOCUMENT > Application Forms** and members may download them from there.

SCHEME COSTS

1. Is the Scheme able to eliminate paper and printing in the organisation to reduce costs (issue e-mail and website communication only)?

All registered medical schemes in South Africa are obliged to communicate key information with their members. Whilst we aim to reduce printing, paper and postal costs as far as possible, it is not possible to completely do away with this requirement as yet. There are still many members that do not have access to e-mail and the internet and thus request that we post communication to them.

We continue to encourage all members to update their details with a valid e-mail address. E-mail remains the most effective and efficient communication method.

SPECIAL SENIOR BENEFITS AND CONTRIBUTIONS

1. Can I replace my monthly contribution or subsidy?

The Medical Schemes Act prohibits discrimination based on age i.e. contributions and benefits may not be differentiated based on age.

Section 24(2)(e) of the Medical Schemes Act 131 of 1998 prescribes that medical schemes do not or will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds including race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health.

As a result of the need to comply with legislation that governs medical schemes, contributions and benefits may not be amended specifically for seniors. Bankmed cannot subsidise seniors at all.

2. Why can Bankmed not increase my benefit limit because I need additional cover?

Bankmed members have access to six benefit Plans, each offering a varying degree of cover. Each of these Plans need to be managed to ensure long-term sustainability for all members. Members need to choose a Plan type that will provide them with the cover they need.

The benefits that apply on each Plan type are applicable to all members that have chosen that Plan type and cannot be amended for seniors. All limits are carefully monitored throughout the year and only a small percentage of members exhaust the limits. Bankmed will continue to monitor limit usage on an ongoing basis to ensure that all members are equitably cared for relative to their chosen Plan.

Where benefits are considered too low for a member's specific needs, these members should explore another Plan type that may provide additional cover for their needs.

3. Are my benefits flexible and can I carry over my benefit limits?

Although we agree that it would be convenient for benefits and contributions to be modularised, thereby allowing members to select (and pay for) only those benefits they wish to purchase, this is regrettably not possible in terms of the Medical Schemes Act and Regulations. Bankmed, as a medical scheme, is governed by this legislation and as such we are limited in terms of the way in which our Plan types are structured. Except for claims that are payable from Savings, it is regrettably not possible for unused (insured) benefits to be transferred from one benefit category to another, or from one benefit year to another.

Certain minimum benefits are prescribed by law and must be covered by all medical schemes, irrespective of the plan to which a member belongs. These minimum benefits are referred to as the Prescribed Minimum Benefits (PMBs), and include, amongst others, hospital-based maternity benefits (subject to PMB Regulations).

We do, however, attempt to address the diverse needs of our members, by providing six Plan types from which members may choose, each offering a varying degree of cover. Each of these Plans need to be managed to ensure long-term sustainability for all members. Members need to choose a Plan type that will provide them with the cover they need.