Bankmed
Yours in good health

Guide to Prescribed Minimum Benefits

This document provides information regarding the way in which Bankmed covers you for a list of conditions that forms part of the Prescribed Minimum Benefits (PMBs).

Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, is a non-profit organisation, registered with the Council for Medical Schemes (CMS). Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07) which takes care of the administration of your membership for the Scheme.

What are Prescribed Minimum Benefits (PMBs)?

PMBs are a set of minimum benefits which medical schemes are required to provide to all their members according to the Medical Schemes Act number 131 of 1998. The cover provided includes the diagnosis, treatment, and cost of ongoing care for:

- Any life-threatening emergency medical condition
- A limited set of 271 medical conditions (defined in the Diagnosis Treatment Pairs)
- 27 chronic conditions (defined in the Chronic Disease List), including HIV & Aids

All medical schemes in South Africa are required to include the PMBs in Plans they offer to their members.

Kindly note:

- PMB regulations and their accompanying provisions do not apply to healthcare services obtained outside the borders of South Africa
- PMBs only apply to claims in South Africa
- If you claim for a healthcare service that is a PMB in South Africa, but you received the care or treatment outside the borders of South Africa, we treat them as ordinary claims and pay them according to your Plan benefits
- If you need to have tests or scans to confirm a diagnosis, these tests or scans might not be covered as PMB if the medical condition that is diagnosed is not a PMB

- These diagnostic tests need to confirm that the medical condition is a PMB condition for it to be covered as a PMB
- When the Scheme refers to limits, we pay claims (including PMBs) up to the limit. When you reach the limit, we only pay for treatment as a PMB if you meet the conditions for cover
- The CMS instructs medical schemes not to pay for PMBs from your Medical Savings Account (MSA)
- Once you register for a chronic PMB condition, we do not pay for treatment from your MSA
- Even if we usually pay for care or treatment from your MSA or do not offer a benefit, we pay for PMBs as long as members meet the conditions for cover
- Pre-authorisation, medicine lists (formularies) and Scheme protocols may apply. Please refer to the Benefit and Contribution Schedule for the details as to when pre-authorisation is needed
- Where a benefit is indicated as payable from your MSA or no benefit is mentioned in the Benefit and Contribution Schedule, PMB treatment will be provided according to the PMB regulations

An example of a PMB provision

Below is an example of a PMB condition and the treatment that qualifies for PMB cover:

PROVISION	PROVISION DESCRIPTION	TREATMENT	ICD-10 CODE
236K	Iron deficiency; vitamin and other nutritional deficiencies – life-threatening	Medical management	D50.8- Other iron deficiency anaemias

- The PMB Provision is 236K. This is one of the listed 271 Provisions (listed 271 conditions) as published in the Medical Schemes Act and Regulations
- In this example the Provision description lists "iron deficiency; vitamin and other nutritional deficiencies - life threatening". The Provision states that the condition should be life threatening. For this provision, if the diagnosis is not a life-threatening episode, the condition does not qualify for PMB funding
- The treatment covered as a PMB for this provision includes medical management for example medication, Healthcare Professional consultations, investigations etc.
- In addition to the above information, the CMS also provides ICD-10 codes (e.g., D50.8) that fall within the 236K Provision, as per the last column in the above table. The ICD-10 codes (diagnosis codes) are an industry guide as to which conditions might qualify for PMB cover, subject to them meeting the Provision Description and treatment criteria
- For this example, to qualify for the out-of-hospital Prescribed Minimum Benefit (OHPMB) funding, you, or your Healthcare Professional may apply for medical management of life-threatening iron deficiency, vitamin, and other nutritional deficiencies. This criterion stated in the Provision description needs to be met to qualify for OHPMB funding related to the treatment as outlined
- Any application for treatment that is not listed in the "treatment" Provision for a condition, cannot be considered as PMB as it does not form part of the prescribed treatment that forms part of PMB level of care. Speak to your Healthcare Professional to ensure that all criteria for treatment are met before applying for PMB cover

How does Bankmed fund claims for PMBs and non-PMBs?

We cover PMBs in full, from your Insured Benefit when you receive treatment from a Designated Service Provider (DSP), where applicable. Treatment you receive from a non-DSP might be subject to a co-payment should the Healthcare Professional charge more than what we fund. We fund non-PMB claims from your available day-to-day benefits in accordance with your selected Plan.

Requirements you should meet to ensure you benefit from the PMBs

There are certain requirements before you benefit from PMBs. The requirements are:

- The condition must be on the list of defined PMB conditions
- The required treatment must match the treatments in the defined benefits on the PMB list
- Bankmed's DSP should be used, unless there is no DSP applicable to your selected Plan

What are Designated Service Providers (DSPs)?

A DSP is a Healthcare Professional (for example, a GP, specialist, pharmacist, or hospital) with whom we have an agreement. According to this agreement they will provide you with treatment or services at a contracted rate. This will ensure you do not incur any co-payments when you use their services.

To find a Healthcare Professional in our network visit www.bankmed.co.za> DOCTOR VISITS > Find a Healthcare Professional.

You and your dependants are required to register to obtain cover for PMBs and Chronic Disease List (CDL) conditions

How to register your chronic or PMB conditions to receive cover from your Insured Benefit

Should you be on the Essential or Basic Plans and wish to apply for out-of-hospital PMBs or cover for a chronic condition, you are required to obtain a *Prescribed Minimum Benefit or a Chronic Illness Benefit Application* form:

- Both forms are available to download and print from www.bankmed.co.za > FIND A DOCUMENT > Application forms
- You may also contact us on **0800 BANKMED (0800 226 5633)** to request either of the above forms

Once we receive the application form and it meets the PMB requirements, we will automatically cover the associated approved investigations, treatment, and consultations for that condition from your Insured Benefits (not from your day-to-day benefits). We will inform you of the outcome of the application.

Cover for out-of-hospital PMBs and Chronic Illness Benefits on the other Bankmed Plans (Core Saver, Traditional, Comprehensive and Plus Plans) no application is required. The benefit will fund from your Insured Benefit, provided the correct PMB ICD-10 code is submitted on the claim.

Should you require to apply for in-hospital PMB cover, kindly contact us on **0800 BANKMED (0800 226 5633)** to request authorisation.

What is a Chronic Disease List (CDL) condition?

CDL conditions are a list of chronic conditions we cover on all Plans as defined in the PMB legislation.

Why it is important to register your PMB or chronic conditions?

Bankmed funds specific healthcare services related to each of your approved conditions. These services include consultations, blood tests and other investigative tests. We cover these services without decreasing your available day-to-day benefits, because we pay it from your Insured Benefit.

Treatment which falls outside the defined benefits and is not approved will be covered from your available day to-day benefits, according to your selected Plan. Should your Plan not cover these expenses, you will be responsible for payment of the claims.

There are several types of claims for PMBs. There are claims for hospital admissions, chronic conditions and other conditions treated out-of-hospital.

There might be times when you will be required to apply for cover under PMBs. Once your Healthcare Professional confirms the diagnosis as a PMB condition, you may apply for us to cover the claims from your Insured Benefit, without using your day-to-day cover. Once approved, we will automatically recognise that the medical services for which you are claiming fall under PMBs.

What happens when your condition is not registered as a PMB or chronic condition?

We will fund all the consultations, blood tests, other investigative tests, medication, and other treatment for the PMB or chronic condition from your available day-to-day benefit.

Who is required to register to receive chronic medication for your PMB or chronic conditions?

The Principal Member and all dependants with PMB or chronic conditions are required to register if you are on the Essential and Basic Plans only.

Members on the other Bankmed Plans (Core Saver, Traditional, Comprehensive and Plus Plans) are requested to register their medication with Bankmed Medicine Management by calling **0800 BANKMED (0800 226 5633)**, or your Healthcare Professional may contact them on 0800 132 345 or e-mail chronic@bankmed.co.za

Each member is required to register for their specific conditions. You only have to register once for a chronic condition. Should your medication or other treatment change, your Healthcare Professional may simply inform us of the changes. Should you acquire another condition, it is essential for you to register for the new condition before we cover the treatment and consultations from your Insured Benefit and not from your available day-to-day benefit.

Who is required to complete and sign the registration form when applying for chronic medication?

For members on the Essential and Basic Plans you or your dependant with the PMB or chronic condition, may complete the application form with the help of your Healthcare Professional.

Additional documentation required to support the application?

You may be required to provide Bankmed with the results of the medical tests and investigations which confirm the diagnosis of the condition. This will assist us to assess whether your condition should qualify for the treatment.

We require additional clinical information from your Healthcare Professional should you request funding for any treatment which falls outside the standard treatment for the condition. Should treatment fall

outside the defined benefits, it will not be approved and will be paid from your available day-to-day benefit, according to your selected Plan.

Any consultations and investigations related to your approved PMB condition will fund from your Insured Benefits.

We will advise you should we approve your application

We will inform you of your entitlement to PMBs when we approve your condition and treatment. We will do this by e-mail (as indicated on your application form).

There are standard treatments, procedures, investigations, and consultations for each condition on the PMB list. These defined benefits are supported by thoroughly researched evidence, based on clinical protocols, medicine lists (formularies) and treatment guidelines.

What happens if there is a change in your treatment?

For members on the Essential and Basic Plans, your Healthcare Professional may contact **0800 BANKMED (0800 226 5633)** to register changes to your medication for an approved condition. You are only required to complete an application form when applying for a new PMB or chronic condition.

How to obtain your medication from the appropriate DSP?

We include this information in the decision letter which we send on approval of your application.

Should your Healthcare Professional change the medication mid-month?

For members with chronic conditions on the Essential and Basic Plans, your Healthcare Professional or dispensing pharmacist may make changes to your medication telephonically. Alternatively, you may send an updated prescription by e-mail to chronicBasicEssential@bankmed.co.za.

For PMB conditions your Healthcare Professional or dispensing pharmacist may make changes to medication by sending the updated prescription by e-mail to pmb_app_forms@bankmed.co.za.

The implications of obtaining your medication from a non-DSP?

All medical schemes are required to ensure members do not experience co-payments when they use DSPs. You should see specialists or other Healthcare Professionals with whom we have a payment arrangement, so you do not incur a co-payment.

Should you select not to use a Healthcare Professional with whom we have a payment arrangement, you will be responsible for covering part of the treatment costs yourself. Contact us on **0800 BANKMED (0800 226 5633)** for the latest copy of the treatment guidelines.

What are co-payments?

Bankmed funds Healthcare Professionals at a set rate – this is called the Scheme Rate. Should the Healthcare Professional charge above this rate, you might have to pay the outstanding amount from your pocket. This amount you have to pay is called a co-payment.

What is a waiting period?

A waiting period may be general or condition-specific and means that you are required to wait for a set time before you can claim from your selected Plan’s cover.

What happens when you use medication that is not on the list for your Plan?

We pay for medication on the medicine list (formulary) up to the Scheme Medicine Reference Price for medication. There will be no co-payment for medication selected from the medicine list (formulary).

If we approve medication which is not on the medicine list, we will pay it up to a Scheme Medicine Reference Price. You may have a co-payment if the cost of the medication is greater than the Scheme Medicine Reference Price. This is unless the medication is a substitute for one that has been ineffective or has caused an adverse reaction. In that case, you and your Healthcare Professional can appeal and if the appeal is successful there will be no co-payment.

What happens when you require treatment that is not on the list?

Bankmed is only required to cover the treatments, procedures, investigations, and consultations that are given for each specific condition on the list. Should you require treatment which is not on the list, and you submit additional clinical information that thoroughly explains why you require the treatment, Bankmed will review it and might select to approve the treatment. Should we decline the appeal, you can contact us to lodge a formal dispute.

Is it possible to acquire benefits for more than one month's supply of medication?

You can obtain more than a month's supply of approved chronic medication if you are travelling outside the borders of South Africa. You will have to complete an *Extended supply of medication* form which is available on www.bankmed.co.za.

Our list of DSPs

You can use the Find a Healthcare Professional tool available on www.bankmed.co.za or contact us on **0800 BANKMED (0800 226 5633)** to locate a Healthcare Professional with whom we have a direct payment arrangement.

Get the most out of your benefits

Elective admissions for PMB conditions and procedures are covered in full if you choose to use a DSP.

The below conditions need to be met for full cover with these providers:

- You are being admitted for a procedure for a PMB condition
- Your chosen hospital or day facility is on the PMB network specific to your Plan
- Your primary treating Healthcare Professional is on the PMB network for your Plan

What to do when there is no available DSPs?

There are some instances where it is not necessary to use DSPs, however full cover will still be available to you. An example of this would be in the event of a life-threatening emergency.

In cases where there are no services or beds available within the DSP when you or one of your dependants require treatment, you may contact us on **0800 BANKMED (0800 226 5633)**, and we will intervene and make arrangements for an appropriate facility or Healthcare Professional to accommodate you.

Changes to the list?

As there are regular changes to our list, we only inform affected members of the changes. For example, we will only communicate changes in the list for hypertension medication to patients who will be affected by the change.

Obtain pre-authorisation for hospitalisation and other procedures

What is pre-authorisation?

Pre-authorisation is the approval of certain procedures and any planned admission into a hospital before the procedure or admission takes place. It includes associated treatment or procedures performed during hospitalisation. You are also required to obtain specific pre-authorisation for MRI and CT scans, radio-isotope studies and for certain endoscopic procedures, whether conducted during hospitalisation or not.

Whenever your Healthcare Professional plans a hospital admission for you, you should advise us 48-hours prior to your admission into hospital.

Certain Plans provide full cover only if you use a network hospital. Before admission, kindly confirm if the hospital you plan to use is part of the network applicable to your Plan.

Pre-authorisation is not a guarantee for payment of all claims

Your hospital cover is made up of:

- Cover for the account from the hospital (the ward and theatre fees) at the rate agreed with the hospital
- Cover for the accounts from your treating Healthcare Professionals (such as the admitting Healthcare Professional, anaesthetist, and any approved healthcare expenses such as radiology or pathology) is separate from the hospital account and we call this 'related accounts'

Remember: Limits, clinical guidelines and policies apply to some healthcare services and procedures in hospital.

We only fund medically appropriate claims. Your cover is subject to Scheme Rules, funding guidelines and clinical rules. There are some expenses you might incur while you are in hospital which we will not cover. Certain procedures, medications or new technologies require separate approval. Kindly discuss this with your Healthcare Professional or the hospital. Obtain additional information regarding our clinical rules and policies for cover by contacting us on 0800 BANKMED (0800 226 5633).

Benefits which require pre-authorisation

You need to obtain pre-authorisation from us for:

- Hospitalisation
- Day-clinic admissions
- Special procedures (such as scopes, MRI, and CT scans)

Who should you contact?

Contact us on 0800 BANKMED (0800 226 5633) for pre-authorisation. We will provide you with an authorisation number. Kindly ensure the authorisation number is handed to the relevant Healthcare Professional and request that they include it when they submit a claim.

If your Healthcare Professional contacts us and obtains authorisation on your behalf, you must make sure you receive all the information about the authorisation from the Healthcare Professional. **You cannot hold Bankmed responsible if your Healthcare Professional does not share this information with you.**

This includes information about:

- What we cover and what we do not cover
- Upfront payments (deductibles) to the hospital before you receive treatment
- How much you have to pay yourself (co-payments and shortfalls)

Ensure you understand your authorisation

We will request the following information when you request pre-authorisation:

- Your membership number
- Details of the patient (name and surname, ID number, etc.)
- Reason for the procedure or hospitalisation
- Diagnostic codes (ICD- 10 codes), tariff codes and procedure codes (ask your Healthcare Professional for this information)

Bankmed Plans offer benefits richer than PMBs

All Bankmed Plans cover more than the minimum benefits required by law. Some Plans cost more but offer more comprehensive benefits while others have lower contributions with fewer benefits.

Occasionally Bankmed will fund a claim as a PMB

This happens when you are in a waiting period or when you have treatments linked to conditions that are excluded from your Plan. But you might still receive cover in full, if you meet the requirements stipulated by the PMB regulations.

Cases where you are not covered under PMBs?

There are some circumstances where you do not have cover for PMBs. This can happen when you join a medical scheme for the first time, with no medical scheme membership prior to that.

It might also happen if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme might impose a waiting period, during which you and your dependants will not have access to the PMBs, no matter what conditions you might have.

Cover for COVID-19

The WHO Global Outbreak Benefit provides cover for global disease outbreaks recognised by the World Health Organization (WHO) such as COVID-19. This benefit offers cover for the vaccine, out-of-hospital management and appropriate supportive treatment related to the management of acute COVID-19 and long COVID.

Contact us

You may contact us on **0800 BANKMED (0800 226 5633)** or visit www.bankmed.co.za for additional information.

Complaints Process

You may lodge a complaint or query with Bankmed directly on 0800 BANKMED (0800 226 5633) or address a complaint in writing directly to the Principal Officer. Should your complaint remain unresolved, you may lodge a formal dispute by following Bankmed's internal disputes process.

Members, who wish to approach the Council for Medical Schemes for assistance, may do so in writing to: Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 or via e-mail at complaints@medicalschemes.co.za. Customer care centre: 0861 123 267. Website: www.medicalschemes.co.za.