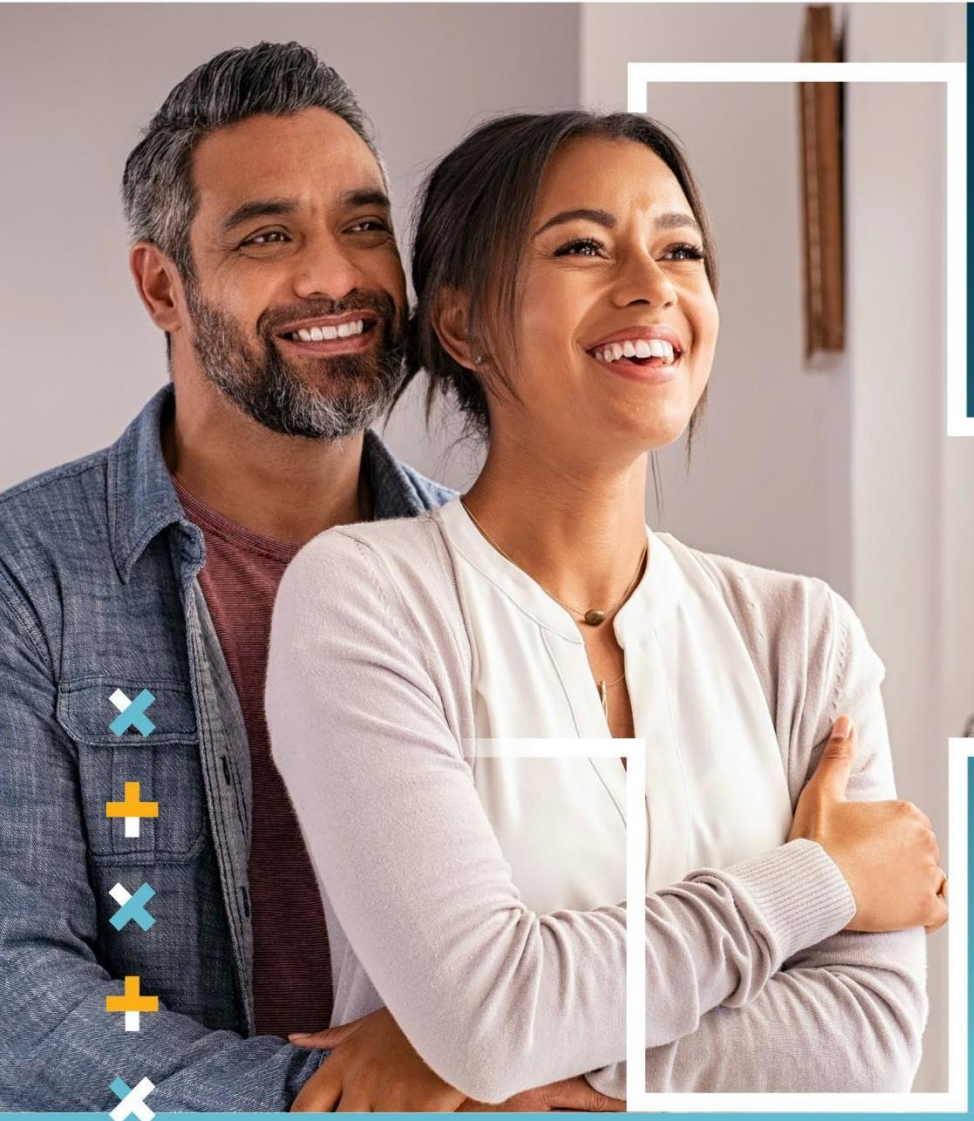

Bankmed
Yours in good health

PLUS 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), Mental Wellbeing, HIV Counselling and Testing (HCT), annual Flu Vaccination, Pap smear and Mammogram (amongst others) are all included. A complete list of your screening benefits is available in the 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.

MEDICAL SAVINGS ACCOUNT (MSA)

What is an MSA?

Your MSA pays for the healthcare you receive while you are not admitted to hospital. We use these funds to pay for medical costs like GP visits, x-rays (radiology), medication and blood tests (pathology).

At the beginning of the year, we give you full access to a yearly amount. Each month you pay part of this amount back without interest as part of your monthly contributions.

GENERAL PRACTITIONERS (GPs)

How do I find a GP?

Please log in to **www.bankmed.co.za > DOCTOR VISITS > Find a Healthcare Professional** or consult the Bankmed App for a complete list of the network GPs. To ensure that you avoid a co-payment, be sure to select a GP who provides total cover. If you visit a GP who provides partial cover, you may 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 a GP in their rooms?

While we strongly recommend that you opt for in-room procedures instead of 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.

PRESCRIBED MINIMUM BENEFITS (PMBs)

What is a Prescribed Minimum Benefit?

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 complete list of the PMB conditions is available at **www.bankmed.co.za** transplant is not a PMB and will, therefore, not be covered on your Plan.

How are Prescribed Minimum Benefits relevant to my Plan?

We pay the total cost of PMBs from network Healthcare Professionals. Reduced benefits apply if you use Healthcare Professionals who are not in our network, so you may have to pay part of the cost of treatment yourself. 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 a Plus 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 Prescribed Minimum Benefit (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***

CHRONIC MEDICATION

What is the Chronic Illness Benefit?

- You must apply for the Chronic Illness Benefit to receive cover.
- Once approved, we will start paying for your chronic medication.
- If you do not register, we pay for your chronic medication from your day-to-day benefits.
- The CDL specifies medication and treatment for the 27 chronic conditions that are covered in this section of the PMBs.

Am I covered for chronic medication?

Your chronic medication limit is R32 665 per benefit per annum (pbpa) (Insured Benefit) and paid as follows:

- 100% of the Scheme's Maximum Medical Aid Prices (MMAP) for Bankmed DSP
- 80% of the Scheme's Maximum Medical Aid Prices (MMAP) for non-DSPs
- Continued benefits for PMBs after depletion of annual limit, subject to PMB regulations

We pay less for the medication you obtain from pharmacies that are not in our network. You might have to pay part of the cost yourself. 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?

To get authorisation for chronic medication immediately, your Healthcare Professional or pharmacist can contact Bankmed on **0800 13 23 45**. Alternatively, ask your treating Healthcare Professional to fill in a registration form. Please e-mail the completed form to **chronic@bankmed.co.za.**

DISEASE MANAGEMENT PROGRAMMES

Which Disease Management Programmes do I qualify for?

You have access to Diabetes, HIV, Spinal Care, Mental Health, and Oncology Programmes.

How do I enrol in the Disease Management Programmes?

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

MATERNITY

What maternity benefits am I covered for?

We provide additional coverage from the Insured Benefit during pregnancy for services such as ultrasounds and further consultations. As a Plus Plan member, you can access the maternity basket of care. The basket has additional insured benefits subject to referral by a Bankmed Network GP and subject to registration on the Scheme's Baby-and-Me Maternity Programme.

HOSPITALISATION

What happens if I need to be hospitalised?

The Plus Plan offers comprehensive cover for hospitalisation and most in-hospital services via a restricted hospital network (DSPs).

This Plan has access to all Netcare, National Hospital Network (NHN), Life Healthcare, Mediclinic and Clinix hospitals, and any other independent private hospitals contracted to the Scheme. For a complete list of all the hospitals on the Bankmed Hospital Network, please visit **www.bankmed.co.za** or the **Bankmed App**

What is a day surgery upfront payment (deductible)?

Deductibles (Member to pay hospital or day clinic on admission). For specific procedures (table below) performed in-hospital or at a day clinic, a deductible will apply, except for emergencies, readmissions within six weeks of discharge, confinements, and PMB-related conditions:

- Day clinics: R310 per admission
- Private hospitals: R775 per admission
- Dental admissions to private hospitals: R2 295 per admission.
- Non-day surgery network for specific procedures: R4 100 per procedure

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	Sigmoidoscoy
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 **8.7%** in 2024.