Bankmed
your good health

UNDERSTANDING MEDICAL TERMINOLOGY

The banking industry has its own special way of talking and so does Bankmed. While we are used to the jargon we use, we know all our special speak can sometimes mean less to you than it does to us. That is why we have put together a collection of terms we like to use and what they mean for you.

CHRONIC ILLNESS BENEFIT

The Chronic Illness Benefit gives cover for medication if you have a listed condition for which you have to take medicine for three months or longer. You have cover for 27 conditions (including HIV and AIDS) on the Chronic Disease List.

You have to register on the Chronic Illness Benefit and meet our clinical criteria before you can start claiming for chronic medicine. To apply, your healthcare professional must complete a ***Chronic Illness Benefit*** application form and send it to us.

CO-PAYMENT

We pay claims at the **Scheme Rate or negotiated rate**. If you use a provider that is not part of our network, they may charge more than the Scheme Rate or negotiated rate. You then have to pay the difference between what we pay and what they charge. We call this a co-payment.

PRESCRIBED MINIMUM BENEFITS

According to the Medical Schemes Act 131 of 1998, everyone who belongs to a medical scheme has the right to have cover for emergency medical treatment and the diagnosis and treatment of specific conditions. The Scheme must pay the cost without using your day-to-day benefits. If it is not an emergency, you should tell us about your condition before starting treatment.

You have to meet three conditions to get full cover for Prescribed Minimum Benefits:

1. **Be diagnosed with a listed condition**
   The condition must be part of the defined list of Prescribed Minimum Benefit conditions.
2. **Follow the treatment in the Prescribed Minimum Benefit guidelines**
   We only pay for specific treatment as a Prescribed Minimum Benefit. If you and your healthcare professional use another treatment, we pay for it from your available benefits.
3. **Make use of designated service providers**
   Designated service providers are healthcare professionals (for example, a doctor, pharmacist or hospital) with whom the Scheme has an agreement. You may also have to use medicine from a medicine list for full cover.

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SCHEME RATE

The Scheme Rate is the amount we pay for healthcare. The Scheme Rate is not necessarily the same as the cost of an item. You can make sure we pay your full claim from your available benefits by visiting Healthcare Professionals in our networks. These Healthcare Professionals charge at the negotiated rate.

If you use a Healthcare Professional we don't have an agreement with or use medicine that is not on our list, you may have a **co-payment**.

PROCEDURE CODE

A procedure code is a medical classification number. It is used to identify specific operations and procedures Healthcare Professionals do to diagnose or to treat a patient's condition. The structure of the code depends on the type of procedure. For example, some codes have numbers only while others have combinations of numbers and letters.

Example: Procedure code 0109: Hospital follow-up visit to patient in a ward or nursing facility.

The procedure code is not the same as your diagnosis code (ICD10 code).

We pay fixed rates (Scheme Rates) for procedure codes.

REASON CODE

Reason codes appear on your claim statements and claim summaries. We use these codes to explain the payment of the claims by the Healthcare Professional on a specific item on your claim. We place the code next to the amount we paid for each claim line (line of the claim statement containing one item or procedure).

At the end of your statement we give a list of reason codes used on your statement and the description for each of these codes. If we paid the full amount claimed on a line, then there is no reason code for that line.

Example: Reason code 326: We paid this item up to the agreed amount. You are responsible for paying the balance.

VALID CLAIM

For a claim to be valid, the claim must be for a valid and recognised medical service, procedure, treatment or product. The claim must be for a valid member of Bankmed.

A claim must include the following information to be deemed a valid claim:

- Main member's initials and surname
- Patient's initials and surname
- Membership number
- Healthcare provider's practice name
- Healthcare provider's practice number
- Treatment date

VALID CLAIM (CONTINUED)

- ICD-10 codes
- Procedure codes
- Authorisation number (if applicable)
- Referring Healthcare Professional (if applicable)

FOREIGN CLAIMS

Foreign claims are claims for treatment by qualified Healthcare Professionals **for medical emergencies** while you are travelling outside the borders of the Republic of South Africa.

An emergency is defined as the sudden and unexpected onset of a health condition. This condition must need immediate medical or surgical treatment to prevent impairment to bodily functions or serious dysfunction of a body organ or part, or to save the person's life.

EMERGENCY SERVICES

When we talk about emergency services, we refer to emergency medical services.

Emergency medical services are dedicated to giving out-of-hospital acute medical care and transporting patients who cannot transport themselves, due to illnesses and injuries.

The goal of most emergency medical services:

- To provide treatment to those in need of urgent medical care, with the goal of satisfactorily treating the presenting conditions
- To timely transport the patient to the next point of definitive care – most likely a casualty unit at a hospital.

PRE-AUTHORISATION

Pre-authorisation is a process where you apply to the Scheme for approval of payment for a procedure or treatment for which you need to be admitted to hospital. You must apply before you are admitted to hospital. We then assess the clinical necessity and appropriateness of the procedure according to Scheme's clinical protocols and guidelines. The approval also serves as confirmation of your available benefits.

If we give you pre-authorisation, we will give you an authorisation number to give to the relevant Healthcare Professional (like the hospital, doctors and specialists).