Bankmed
Yours in good health

FREQUENTLY ASKED QUESTIONS **(FAQS) BY SENIORS**

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.

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