Bankmed
Yours in good health

BASIC PLAN **FAQs**

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 for from your Insured Benefit. This means that tests and screenings such as your Personal Health Assessment (PHA), HIV Counselling and Testing (HCT), annual flu vaccination, Pap smear and mammogram are all included. For a full list of your screening benefits, check your Benefit and Contribution Schedule under ***Wellness and Preventative Care Benefits.***

GENERAL PRACTITIONERS (GPS)

How do I find a GP?

Please log in to ***www.bankmed.co.za / DOCTOR VISITS / Find a Healthcare Professional or Bankmed App*** for a full list of the network GPs. To ensure that you avoid a co-payment, be sure to select a primary and secondary GP who provides full cover. If you choose to visit a GP who provides partial cover, you may have to pay a co-payment yourself.

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.

GENERAL PRACTITIONERS (GPS)

Are my GP visits limited?

No, you have access to unlimited GP visits within the Bankmed GP Entry Plan Network, once you nominate a primary and secondary GP.

What happens if I fail to nominate a primary and secondary GP?

Your primary GP will automatically be allocated for you, based on the GP you have visited previously. We assign the GP based on your claims. We pay for GP consultations from your out-of-network benefit until a primary GP has been allocated.

How does this GP allocation take place?

The first GP you visit within the network is allocated as your primary GP from the beginning of the month following your initial consultation. We pay the initial GP claim from your out-of-network consultation benefit (because you had not nominated your primary GP upfront). If you do not select a secondary GP in the network, a visit to this GP will be subject to your three out-of-network Consultation Limit (also subject to the rand limit). Any visit to a non-network GP is also subject to your three out-of-network consultation benefit limit (subject to the rand limit).

Is the Bank City GP group practice on the network?

Yes, they are. For you to get full cover when visiting a Bank City GP, you must nominate this GP as your primary or secondary GP before visiting them. If you visit a third GP, whether on the network or outside of the Bankmed GP Entry Plan Network, the visit will be subject to your three out-of-network consultations (subject to the rand limit).

Am I covered for any procedures conducted by my GP in their rooms?

While we strongly recommend that you do opt for in-room procedures as opposed to in-hospital treatment, please ask your GP to ensure that your procedure is on the list of in-room procedures that your Plan covers. Your GP will be able to check this list online, or they may contact the Bankmed Call Centre on **0800 BANKMED (0800 226 5633)**. If your procedure is NOT on the list, you will be responsible for the payment.

PRESCRIBED MINIMUM BENEFITS (PMBS)

What is a Prescribed Minimum Benefit?

Prescribed Minimum Benefits (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 270 medical conditions, and
- 26 chronic conditions

A full list of the Prescribed Minimum Benefit conditions is available on **www.bankmed.co.za**

How are Prescribed Minimum Benefits relevant to my Plan?

Treatment on your Plan is limited to Prescribed Minimum Benefits. This means that you will receive treatment and medication for only the conditions listed as a Prescribed Minimum Benefit. For example, a heart transplant is a Prescribed Minimum Benefit procedure, whereas a corneal transplant is not a Prescribed Minimum Benefit procedure and will, therefore, not be covered on your Plan. Prescribed Minimum Benefits will be covered in full on your Plan provided that you use Healthcare Professionals, hospitals and pharmacies on the Bankmed Network, known as Designated Service Providers (DSPs).

While you are entitled by law to get cover for Prescribed Minimum Benefit conditions, it remains vital that you use Healthcare Professionals in the Bankmed Entry Plan GP Network, the Bankmed Entry Plan Specialist Network (following referral only), and hospitals in the Bankmed Hospital Network to avoid co-payments.

MEDICATION

Do I have to pay for my medication?

Bankmed has a medicine list (formulary) that all GPs should use when prescribing medication to avoid out-of-pocket expenses. Please check with your GP that the medication they prescribe for you is on the Bankmed medicine list (formulary).

Over-the-counter medications such as vitamins, cough mixtures, and cold and flu medication are NOT covered on this Plan. No homoeopathic medications are covered on this Plan.

Is Bank City Pharmacy on the Network?

Yes, the pharmacy is on the Network. However, the prescription must also be from either your primary or secondary GP. If not, the medication will not be covered, and you will have to pay for the medication yourself.

CHRONIC MEDICATION

Am I covered for chronic medication? If so, for which conditions?

You have cover for chronic medication for those conditions that form part of the Chronic Disease List (CDL). The Chronic Disease List is a defined list of 26 chronic conditions we cover according to the Prescribed Minimum Benefits. These include conditions such as depression, diabetes, hypertension, asthma and epilepsy. The Chronic Disease List does not include conditions such as attention deficit and hyperactivity disorder (ADHD), psoriasis, osteoarthritis, and allergic rhinitis.

You may view the Chronic Disease List on **www.bankmed.co.za / FIND A DOCUMENT / Benefit Guides.**

How do I apply for chronic medication?

Your GP will need to complete the *Chronic Illness Benefit Application form* for you. You can download this form from **www.bankmed.co.za / FIND A DOCUMENT / Application forms** and take it with you to your consulting GP to complete. Your GP must also ensure that the medication they prescribe forms part of the Chronic Illness Benefit medicine list (formulary) so that you avoid having to pay a shortfall.

DENTISTRY

What dental procedures are covered by my Plan?

You are covered for basic dentistry only, such as scaling and polishing. You are NOT covered for any orthodontics, crowns or implants.

To ensure you do not have any out-of-pocket expenses, you must ensure that you visit a dentist on the Bankmed Network.

OPTOMETRY

What optometry benefits are covered by my Plan?

You get cover for one set of spectacle frames (glasses) for each member, every two years (24 months from the date of the last claim for spectacles). As your vision ordinarily does not change drastically within two years, you also get cover for one set of prescription lenses (for glasses) for each member, every two years.

Contact lenses are NOT covered by this Plan.

Your optometry benefits are available only from the Bankmed Optometry Network. To view a full list of the optometrists that form part of this network, please log in to **www.bankmed.co.za / DOCTOR VISITS / Find a Healthcare Professional.**

DISEASE MANAGEMENT PROGRAMMES

Which Disease Management Programmes do I qualify for?

You have access to the Diabetes, HIV and Oncology Programmes, but only for the treatment of Prescribed Minimum Benefit conditions.

How do I enrol in the Disease Management Programmes?

You are required to register with the Disease Management Programmes. Your treating Healthcare Professional may contact the Bankmed Call Centre on **0800 BANKMED (0800 226 5633)**. Or, you may download the *Chronic Illness Benefit Application form* from **www.bankmed.co.za / FIND A DOCUMENT / Application forms** and take it along to your Healthcare Professional for completion. Strict clinical entry criteria apply when considering all Disease Management Programme applications.

PATHOLOGY AND RADIOLOGY

Am I covered for all blood tests and X-rays?

There is a limited list of tests and X-rays that your Plan covers. Your GP must reference this list so that you do not have to pay the claim yourself. Anything outside of this list will not be covered, and you will be liable for payment.

Please check with your GP when referring you for these tests that they are on the list to avoid out-of-pocket expenses.

It is important to note that you are NOT covered for CT scans and MRI scans unless you have been hospitalised.

SPECIALISTS

Do I have access to any specialists?

GP referral is essential if you want to visit a specialist, such as an orthopaedic surgeon or a paediatrician. There is a list of Bankmed Network Specialists that you must use if you want to avoid having any out-of-pocket expenses. Your GP will need to refer you to a specialist on this network. Specialist visits are also limited to a rand value, which means there is a set limit up to which we will pay.

You also require pre-authorisation before you can consult a specialist. Your GP will get authorisation on your behalf.

HOSPITALISATION

What happens if I need to be hospitalised?

To be covered for in-hospital treatment, you must be admitted to a hospital that is in the Bankmed Hospital Network. Unless the admission is involuntary (it is an emergency, and you are unconscious), admission to any hospital that is NOT on the network will result in a co-payment.

For a full list of all the hospitals on the Bankmed Hospital Network, please log in to **www.bankmed.co.za / DOCTOR VISITS / Find a Healthcare Professional** or **Bankmed App.**

Will I have to pay for anything while I am in hospital?

If you are admitted to a hospital that does not form part of the Bankmed Hospital Network, you will be required to pay 20% of the admission fee.

What is a day surgery upfront payment (deductible)?

If you choose to have one of the procedures or treatments listed in the adjacent table, performed in a hospital or in a facility that is not in the Day Surgery Network, you will have to pay an upfront payment (deductible) of R1 805 for each admission.

If you choose to have one of these procedures or treatments performed in a Day Surgery, you will NOT have to pay the upfront payment (deductible) as described above. The facilities within the network are known as Designated Service Providers (DSPs). This list applies to Designated Service Providers only.

SPINAL CARE

The programme is targeted at members who have had multiple consultations with a diagnosis of back pain, have been admitted for medical treatment for back pain or who are referred by their neurosurgeon or orthopaedic surgeon. Members on the programme will receive treatment from a physiotherapist or chiropractor trained in the conservative treatment of back pain and supervised by a specialist.

The initiative has integrated approach that includes a conservative care programme and network, together with Spinal Care Centres of Excellence (COE).

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	Sigmoidoscopy
Diagnostic D and C	Tonsillectomy
Gastroscopy	Treatment of Bartholin's cyst/gland
Hysteroscopy	Vasectomy
Myringotomy	Vulva/cone biopsy

MATERNITY

What maternity benefits am I covered for?

You, your partner, or the surrogate, will have cover for two ultrasound scans during the pregnancy. The benefit covers one scan in the first trimester (first three months) performed by your GP and one scan during your second trimester performed by a Bankmed Entry Plan Network Specialist.

If you, your partner, or the surrogate, experience a high-risk pregnancy, your treating Healthcare Professional will have to motivate for additional ultrasound scans and treatments

2022 MATERNITY ENHANCEMENTS

T21 Chromosome Test or Non-Invasive Prenatal Test (NIPT)

The Non-Invasive Prenatal Test (NIPT) approved as a benefit enhancement for 2019, is a valid screening test for chromosomal abnormalities namely T13, T18 and Downs Syndrome.

The T21 test which is also a non-invasive test can detect Downs Syndrome in early pregnancy. Down Syndrome is the most common chromosomal abnormality and the T21 test is specific for Down Syndrome. The T21 Chromosome Test is being added to the current Non-Invasive Prenatal Test (NIPT) benefit. The T21 test should be performed before the NIPT test as the T21 tests for Downs Syndrome (only one chromosome). Most Healthcare Professionals should choose this test if they believe you are at risk of Downs Syndrome. However, should your Healthcare Professional believe that you are at high risk of other chromosomal abnormalities they may choose the NIPT test first instead of the T21 test. This will be at the Healthcare Professionals discretion.

To the extent that your Healthcare Professional performs the T21 test, and the test is positive, your Healthcare Professional may refer you for the NIPT test for additional assurance. In this case, Bankmed will fund both the T21 and the NIPT tests which will exceed the one test per pregnancy limit. The T21 test will be covered on all Plans. Clinical entry criteria, clinical protocols and guidelines will apply.

2022 Benefit **enhancements**

*Please read your **2022 Benefit and Contribution Schedule** for detailed information on updated limits, networks and benefits.*

What is the benefit limit increase for 2022?

Benefit limits will increase by approximately 4.5%.

HOMEBASED HEALTHCARE - VIRTUAL GP HOUSE CALL

This benefit is aimed to reach out to high risk or vulnerable patients with chronic conditions to ensure they are optimally managed in the out-patient setting.

The COVID-19 pandemic has resulted in a dramatic drop in the number of admissions and has provided an opportunity to shift care to the out-of-hospital setting while protecting and enhancing quality of care.

All members registered for the Chronic Illness Benefit (excluding Oncology) or HIV Programme will have access to the benefit.

High risk members: defined as members with a predicted high risk of admission and where an intervention is reasonably expected to prevent the admission will also be eligible for the benefit. Bankmed GP Network and/or Premier Plus Network GPs will proactively reach out to high risk patients and set up time for a virtual house call.

2022 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 for 2022?

Bankmed has been able to limit the increase to single digits for all Plans in 2021 while enhancing our benefits and continuing to offer our members the best value for money. We are delighted to confirm that your contribution increase will be limited to **1.0%** in 2022.