Annual General Meeting: Frequently Asked Questions (FAQ)

Administrator versus Scheme

1. What is the difference between Bankmed, Discovery Health (Pty) Ltd and Discovery Health Medical Scheme?

Bankmed ("the Scheme") and Discovery Health Medical Scheme are both registered medical schemes under the Medical Schemes Act 131 of 1998 ("the Act), and are regulated by the Council for Medical Schemes.

Bankmed is registered as a restricted access medical scheme where membership is limited to persons employed by a registered bank. Discovery Health Medical Scheme is registered as an open medical scheme and access is open to the public as a whole. Bankmed and Discovery Health Medical Scheme are two separate legal entities. No relationship exists between Bankmed and Discovery Health Medical Scheme.

Discovery Health (Pty) Ltd is a registered medical scheme administrator and managed care organisation, also registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd provides administration and managed care services to both Bankmed and Discovery Health Medical Scheme as well as other restricted access medical schemes.

2. Is Bankmed part of Discovery Health Medical Scheme?

No. Bankmed is not a part of Discovery Health Medical Scheme. The two medical schemes are separate legal entities and operate independently of one another.

3. What does it mean to be administered by Discovery Health (Pty) Ltd?

Discovery Health (Pty) Ltd is a registered medical scheme administrator and managed care organisation. They have been appointed by Bankmed to manage administration and managed care services on behalf of Bankmed.

The Bankmed rules, policies and protocols are applied and managed, on Bankmed's instructions, by Discovery Health (Pty) Ltd. They develop the systems that manage the claims and are the people that take the calls in the call centre and answer queries, for example. As a medical scheme, Bankmed benefits from this administration by taking advantage of Discovery Health's healthcare resources, clinical risk management practices, digital tools, economies of scale, data analytics and continuous innovations in medical scheme administration.

Benefits

4. How does a medical scheme work?

Medical schemes are the main funders of private healthcare in South Africa. Members of a medical scheme such as Bankmed pay contributions to the Scheme each month.

This money is pooled and then used to pay healthcare expenses in accordance with the Scheme's Rules and the member's choice of Plan, protecting members against the possibility of facing significant unexpected medical costs.

All medical schemes in South Africa operate in accordance with the Act, and are regulated by the Council for Medical Schemes.

The Bankmed Board of Trustees, appointed by the members of the Scheme, manage the affairs of the Scheme on behalf of the members according to the Act and the Scheme Rules.

5. Can medical schemes make money?

A medical scheme is a non-profit organisation, governed by a Board of Trustees and must be registered with the Council for Medical Schemes. This means it does not have shareholders or pays dividends and all surpluses that may be generated are invested on behalf of the members in accordance with regulations. A medical scheme therefore does not make any profits, but is expected to be sustainable.

Schemes exist for their members as all funds are pooled and safeguarded, to be used to pay claims in accordance with the Scheme's Rules and ensure that all members are equitably and fairly cared for (relative to their choice of benefit Plan).

6. 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 small groups of individuals.

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.

7. Request to provide members with a reduced monthly contribution or subsidy

This has been attended to at previous AGMs. 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 pensioners.

Claims and Claim Payments

8. How to understand and read your Claims Statement and Claims Notifications?

In April 2017, Bankmed issued a communication to members setting out the differences between a claims statement and a claims notification. This communication also contained detailed explanations about the claims statement and what the information means.

We have attached this communication for your reference. Please refer to Annexure 1.

We would like to remind you to avoid printing the claim notification; these e-mails are not designed for printing. The claims statement is designed for printing.

9. I want Bankmed to pay my claim refunds into my credit card. Why is this not possible?

Bankmed outsources the payment of claims function to Discovery Health (Pty) Ltd as the administrator. The administrator may not hold credit card details for members in the medical scheme system.

This is due to the Payment Card Industry Security Standards Council* requiring that all issuers, merchants, banks and payment service providers comply with the PCI Data Security Standards. Apart from this compliance burden, there are other risks involved with holding the member's credit card details. In some cases, banks may change the PAN data (16-digit credit card number) when a client has lost his/her card, if the card was compromised or if the card is replaced due to the card expiring. This means that members would need to update their banking details each time this occurs.

Changing banking details requires additional controls before the changes are made, due to the risk associated with the change. We have to make sure that we have the correct information (data integrity) to pay claims.

Fraudsters normally target financial systems to add their banking details. Claims are conveniently paid into their accounts before they disappear. We aim to prevent this at all costs, and so we do not keep credit card details in the administration system for the medical scheme at all.

* For more information about the Payment Card Industry Security Standards Council, please visit their website https://www.pcisecuritystandards.org/

10. I don't want to be paid directly by Bankmed. I want Bankmed to pay all my claims directly to the Healthcare Professional

Bankmed pays Healthcare Professionals directly in most instances. All network providers and non-network providers are paid directly, except where the member has paid the provider upfront for a service and provided proof of payment when submitting their claim for payment or where a practice has been blocked for direct claim payment. It is important to note that Bankmed does not have control over a Healthcare Professional's payment management structure. If a Healthcare Professional requires an upfront payment, members will be required to fund the claim themselves and claim back from Bankmed, if they choose to use the services of this Healthcare Professional.

Escalation Channels

11. What must members do if they are not happy with the manner in which their escalation or complaint has been managed?

At Bankmed, we continuously strive to ensure that our service and communication to members is of the highest standard. Occasionally errors do occur and there could be times when members may not be satisfied with the service received.

Please feel free to lodge any queries or complaints and we will attempt to resolve these as quickly and effectively as possible.

We have created a comprehensive guide which explains the correct steps members need to take in order to get complaints resolved. Please refer to Annexure 2.

Medical Savings Account (MSA)

12. What is a Medical Savings Account (MSA)?

Bankmed provides members with an upfront savings allocation for out-of-hospital medical expenses. This is allocated on 1 January each year. This amount is pro-rated by the number of months left in the year if members join after 1 January.

The MSA is used to fund day-to-day medical expenses that fall outside of the Insured Benefit limits, such as consultations for doctors, blood tests, certain acute medical appliances, x-rays and dental treatment.

In other instances, the MSA is designed to fund the benefit from the first claim submitted, such as frames for spectacles. Refer to your Benefit & Contribution Schedule for more information about your Plan type and what benefits fund from the MSA.

This advanced amount is paid back to Bankmed by members as part of their monthly contribution. Any funds left in the MSA at the end of the year are carried over to the next benefit year and are not lost.

13. Which Bankmed Plans have access to an MSA?

Only members who have chosen the Core Saver, Comprehensive and Plus Plans have access to an MSA component.

14. Why is interest calculated on your MSA?

In 2011, the Council for Medical Schemes issued a Circular (38/2011) confirming that Schemes were required to hold the MSA in a separate account (trust account) and that interest earned must be transferred to members for positive balances held in this account. In February 2012, a clarifying Circular (05/2012) was issued setting out further requirements in respect of MSA interest. A recent Constitutional Court ruling (12 June 2017), however, has overturned previous directives in this regard. There are industry discussions underway about the implications of the recent ruling, and these include discussions with the Council for Medical Schemes. When these discussions are finalised, members will be advised about any changes that will be applicable going forward.

15. How is interest calculated on your MSA?

In May 2017, Bankmed issued a communication to members with an MSA, detailing the manner in which interest is calculated. Please refer to Annexure 3.

Networks (DSPs) and Providers

16. Why does Bankmed make use of Networks and Designated Service Providers (DSPs)?

There are three main reasons why Bankmed makes use of Networks and DSPs:

- Networks and DSPs assist in ensuring long-term sustainability of the Scheme and controls increasing healthcare costs;
- Should the rising cost of healthcare not be managed, contributions are likely to increase and benefits may remain unchanged or be reduced;
- Through these partnerships Bankmed is in a stronger position to negotiate competitive tariffs and reduce member co-payments, thereby allowing members to maximise their benefits and reduce out-of-pocket expenses.

These networks provide cover according to the members' specific chosen Plan. Members must familiarise themselves with the networks and DSPs that apply to their particular Plan. Members may find additional information in the Benefit & Contribution Schedule. By using DSPs, members will not incur out-of-pocket expenses, provided that benefits are available.

17. What happens if members do not use a Bankmed network?

Members may choose to use the services of any Healthcare Professional. However, should members choose to obtain healthcare services from a Healthcare Professional that is not a member of the relevant Bankmed Network, co-payments may apply, which members will need to settle themselves.

To find out which networks (DSPs) are available per Plan type, visit www.bankmed.co.za.

18. Why is the casualty unit at a hospital not necessarily part of the hospital?

In some instances, hospitals "sub-lease" or "sub-contract" their casualty unit to another Healthcare Provider. The Healthcare Provider who manages the casualty unit will send an account to members directly and this may not be sent by the hospital itself. Given that the Healthcare Provider managing the casualty is a separate practice, they may choose not to participate in the network. For this reason, members may find that the hospital is a network hospital, but the casualty is not a network provider. Sometimes the casualty practices insist on cash upfront and they are entitled to do so. Bankmed continues to work towards negotiating with these Healthcare Providers in order to expand the network as far as possible.

19. When a hospital forms part of the network, why do the service providers that work at the hospital not automatically form part of the network?

Negotiations are carried out at a provider group level, for example, hospitals are negotiated with via their head office and GPs may be negotiated with individually. Healthcare Professionals are free to choose their rate of reimbursement and as such, may choose not to participate in a network structure. This means that members may find a network hospital, but the treating provider at this hospital may not be a network provider, and vice versa. Bankmed continues to work towards negotiating with these Healthcare Professionals in order to expand the network as far as possible.

20. Where do members find lists of covered medications?

We make our medicine lists (formularies) available on www.bankmed.co.za / COVER AND SAVINGS / List of covered medications and members may download them from there.

Scheme Costs

21. Is the Scheme able to eliminate paper and printing in the organisation to reduce costs (issue e-mail and website communication only)?

All registered medical schemes in South Africa are obliged to communicate key information with their members. Whilst we aim to reduce printing, paper and postal costs as far as possible, it is not possible to do away with this requirement as yet. There are still many members that do not have access to e-mail and the internet and thus request that we post communication to them.

We continue to encourage all members to update their details with a valid e-mail address. E-mail remains the most effective and efficient communication method.

Bankmed Medical Scheme. Registration number 1279.
Administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

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