Bankmed
your good health

Dear Member

Your 2017 Bankmed Benefit Enhancements, Contributions and Plan Selection

Contribution increase for 2017 on the Basic Plan

We are proud to confirm that Bankmed has once again been able to increase your current benefits and add new benefits for 2017. At the same time, we have managed to limit your contribution increase to 6.5% as of 1 January 2017. This increase is significantly lower than the medical scheme industry average. This indicates that Bankmed remains extremely competitive from a benefit and contribution perspective when compared to other medical schemes.

Overview of Benefit Enhancements and Amendments

- Benefit limits will increase by 6.5%; these limits are displayed in your 2017 Bankmed Benefit & Contribution schedule enclosed with this communication.
- A standard deductible will apply to a specific list of conditions/procedures for treatments performed in a network hospital or day clinic. This new deductible or co-payment is to be paid to the hospital directly when you are admitted.
- Bankmed is introducing a new Specialised Lens Benefit on your Plan type. This benefit covers specialised lenses for PMB level of treatment, thus affording members additional benefits they may not have previously had access to.
- The External Prosthesis Benefit will cover repairs to your external prosthesis.
- The Internal Prosthesis Benefit is being enhanced from January 2017. Where the hip, knee and shoulder joint prosthetic device is obtained via our preferred providers, the device will be covered at cost. However, if the member chooses to utilise a non-preferred provider, cover for the prosthetic device is subject to the Hip, Knee and Shoulder Joint Prosthesis sub-limit.
- HIV and AIDS cover is being expanded to cover Antiretrovirals (ARVs) for all members diagnosed with HIV and AIDS. Regardless of your CD4 count, you may now obtain ARVs from the date of diagnosis. This is aligned to the Department of Health's "Test and Treat" protocol.

Unlimited GP Visits to your Allocated GP

Bankmed provides you with unlimited GP visits on the Basic Plan. This applies to GP's on the Bankmed Entry Plan Network only and you must ensure that you have the correct GP allocated to your membership in order for this benefit to apply.

Introduction of a Secondary GP

Bankmed has introduced additional benefits allowing you to select a secondary GP on your Plan. This means that you will be able to visit an alternate GP on the network and the visit will not be subject to your out-of-network GP benefit limit. You are, however, required to contact the Call Centre on 0800 BANKMED (0800 226 5633) to allocate your secondary GP. Please note that you MUST first select and allocate your secondary GP before you visit them. If you do not allocate your secondary GP prior to visiting them, this will count toward your out-of-network GP limit.

The Out-of-Network GP Limits Explained

You have three out-of-network GP visits allocated to you as a benefit. This benefit is also limited to R1 850 next year. Should you choose to use a GP that is not in the network and then claim for medication from a pharmacy thereafter, the pharmacy claim also counts toward the out-of-network limit. This applies even if you use a network pharmacy.

For example, should you visit a non-network GP and he provides you with a script for medication which you obtain from a pharmacy, both of these claims will count toward the out-of-network limit, thus reducing your out-of-network Rand limit of R1 850 by whatever the providers may have charged (GP claim and pharmacy claim). Only the GP visit reduces the out-of-network frequency limit of three out-of-network GP visits.
You are reminded that this is a network plan and the networks are designed to reduce costs, thus allowing Bankmed to offer you comprehensive cover for a lower contribution. It is therefore essential that you make use of the networks should you wish to avoid co-payments.

Updates to Formularies and Designated Service Providers (DSPs)

Remember that as a Basic Plan member, you are covered in full when you use the Bankmed network providers contracted to your Plan. We negotiate extensively with these providers so that you have access to benefits and avoid co-payments. It is therefore essential that you check that your provider is a member of the network contracted to the Basic Plan. We also refer to these network providers as "Designated Service Providers" (DSPs) when referencing Prescribed Minimum Benefit (PMB) treatment. The DSP list is updated annually and made available to members on the Bankmed website, www.bankmed.co.za. Kindly review this list to ensure that you avoid unnecessary co-payments that you may incur by visiting a doctor who does not form part of the DSP network.

Given that you are on a network plan, Scheme-approved medicine lists, radiology and pathology lists and dental lists (also known as formularies) apply to you as a Basic Plan member. The following formularies will be updated with effect from 1 January 2017 and apply to your Plan type.
Please visit the website, www.bankmed.co.za to view the updated formularies from 1 January 2017:

- Chronic Illness Benefit formulary
- Prescribed Acute Medicine formulary
- Radiology and Pathology formulary
- Dental formulary

Please note: It is important that you familiarise yourself with these formularies/medicine lists, the networks and the Designated Service Providers and any limit or benefit that applies to your Plan type. It is not possible to capture every detail about your plan in this communication. You are therefore encouraged to go through the 2017 Bankmed Benefit & Contribution Schedule for an in-depth understanding of all the benefits.

How to exercise a Plan change for 2017

Should you wish to exercise a Plan change for 2017, kindly submit your Plan selection **on or before 9 December 2016.** Please do not miss the cut-off date, as Plan selections are only available once a year and take effect from January of the following year. Mid-year plan selections are regrettably not allowed.

You may use one of the following convenient methods in order to submit your Plan selection, on or before 9 December 2016:

1. Online

Visit www.bankmed.co.za / LATEST INFO / Plan selection. You will be asked to log in, using your secure username and password.

2. E-mail

Complete the enclosed Plan selection form and e-mail the form to us at planselections@bankmed.co.za

Do not submit any other correspondence, queries or claims to this mailbox – only your completed Plan selection form.

3. Fax

Complete the enclosed Plan selection form and fax the form to us on 021 527 1926.

Do not submit any other correspondence, queries or claims to this fax line – only your completed Plan selection form.

4. Telephone

Alternatively, you may contact 0800 BANKMED (0800 226 5633) for assistance. Please select the "Plan change" option on the call and you will be routed to a Call Centre agent who will assist you with your Plan change.

5. Post

Complete the enclosed Plan selection form and post the form to us at Bankmed Plan Selections, PO Box 1242, Cape Town 8000. While we discourage the use of this Plan change method due to the unreliability of the postal service, should you choose to post your Plan selection form, kindly factor in sufficient time for your form to reach us by the deadline.

We look forward to providing you and your family with exceptional value and service during 2017 and thank you for your support in 2016.

Yours in good health

Teddy Mosomothane

Principal Officer

Bankmed Medical Scheme