

Bankmed member handbook



Important contact details

Please use the following contact details to get in touch. These are the official contact details for Bankmed and preferably the only ones that should be used.



For **emergency** ambulance services, contact Discovery 911 on 0860 999 911



To obtain **pre-authorisation** for a hospital admission, MRI/CT scan or radionucleotide scan:

0800 BANKMED (0800 226 5633)

021 527 1928 (Fax)

treatment@bankmed.co.za



For **customer services** enquiries, requests or complaints:

0800 BANKMED (0800 226 5633)

021 527 1926 (Fax)

Active employees:

enquiries@bankmed.co.za

Pensioners:

pensioners@bankmed.co.za

Bankmed Customer Services,

PO Box 1242, Cape Town, 8000



To **report fraud**:

0800 004 500

reportfraud@bankmed.co.za

0800 BANKMED (0800 226 5633)
is **toll free** from a Telkom landline.



To **submit a claim** (remember to include your membership number and ensure that all claims are legible):

claims@bankmed.co.za

021 527 1940 (Fax)

Bankmed Claims, PO Box 1242,
Cape Town, 8000



For **self-help enquiries**:

Try our easy-to-use self-help facilities to obtain information and to request claim statements, savings balances, membership cards and Bankmed forms, without having to speak to an agent. You will also be able to update contact details online, using our web-based facility (Customer Online).

Telephonic self-help facility:

0800 BANKMED (0800 226 5633)

Be sure to have your membership number and ID number on hand for member verification purposes.

Web-based self-help facility (Customer Online):

www.bankmed.co.za

Sign in with your username and password; you will be prompted to do so the first time you sign in.



To obtain authorisation and to register for **chronic medication** (Medicine Advisory Services Programme):

Telephone (toll free from a Telkom landline):
0800 BANKMED (0800 226 5633)

E-mail for Core Saver, Traditional, Comprehensive and Plus Plans
chronic@bankmed.co.za

E-mail for PMB and Basic Plans
chronicBasicPMB@bankmed.co.za

Core Saver, Traditional,
Comprehensive and Plus Plans
011 770 6247 (Fax)

PMB and Basic Plans
011 539 7000 (Fax)

Or have your doctor or pharmacist call on 0800 BANKMED (0800 226 5633) for all plans. Medical professionals may also call 0800 132 345 as a direct line for Core Saver, Traditional, Comprehensive and Plus Plans (this number is only available for medical professionals).



Mobi site

m.bankmed.co.za



Mobile App

Download the Bankmed mobile App to your smart phone and follow the prompts. You can download the App from the different App stores, or visit www.bankmed.co.za/app for instructions.

NB: If you have already created a username and password to view and update your personal information via the website, you will need to use the same credentials for the App.



To register for the **Baby and Me** maternity programme:

0800 BANKMED (0800 226 5633)

011 529 6485 (Fax)

babyandme@bankmed.co.za



To register for the **oncology** treatment programme:

0800 BANKMED (0800 226 5633)

011 539 5417 (Fax)

oncology@bankmed.co.za



To register for our **HIV/AIDS programme** (confidentiality guaranteed)

0800 226 5633

REGISTERED RULES

This handbook is a summary of the rules. A complete set of the registered rules can be found at www.bankmed.co.za. Please note that in the event of a dispute, the registered rules will apply. Bankmed is a medical scheme registered in terms of the Medical Schemes Act 131 of 1998.

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Change of address and other contact details

As it is important for us to be able to communicate with you effectively, please inform us immediately of any changes to your address and/or contact details by:



Calling us on 0800 BANKMED
(0800 226 5633)



Sending an e-mail to
enquiries@bankmed.co.za



Updating your contact
details online at
www.bankmed.co.za



Updating your contact details
by using the **Bankmed App**.
Download this via your App
store or at
www.bankmed.co.za/app.

In the event that you do not notify us of a change in your address and/or other contact details the Scheme can regrettably not be held liable should your rights be inadvertently prejudiced or forfeited.

Electronic Health Record

Our Electronic Health Record is a quick and easy way to track and manage your medical history. Visit www.bankmed.co.za, click on *Sign In*, select the *Register* option and follow the easy instructions. You can also give your healthcare provider access by:

- Signing in on *Customer Online* and granting access rights under the *Manage Access* option, or
- Asking your healthcare provider to request access through the Bankmed provider portal.

You will receive an "Access Requested" notification via SMS or e-mail with a One Time PIN (OTP). Give this OTP to your healthcare provider and they may instantly access your full medical history.

About Bankmed

Bankmed began as a vision to provide healthcare funding that was tailored exclusively to the employees of the banking industry.

From our inception in 1914, we have grown from five members to cover over 200 000 beneficiaries, over 100 years later – a milestone in any company's eyes and a testament to our dedication and unparalleled specialist insight into the management of health in this sector.

Our unique approach to healthcare is underpinned by our ability to support our employer clients with health solutions that have a measurable impact on the health of members and thereby on the health of an organisation. Our initiatives are designed to contribute to the wellbeing and productivity of our clients.

Bankmed is a closed medical scheme – only employees within banking institutions may become members. To explain this a little more:

Closed versus open schemes

There are two types of medical schemes in South Africa: open and closed (employer-based) medical schemes.

OPEN medical schemes:

Membership is open to anyone who wishes to join.

CLOSED medical schemes

Membership is restricted to a certain group of employees or professionals and is not open to the general public.

A closed scheme means we are able to offer you, the member, tailored benefits that are competitive, comprehensive and affordable. We can also provide you with wellness support programmes, preventative screenings, Managed Care Programmes and various tools to maintain and improve good health – all designed specifically with you, your needs and your circumstances in mind.

Our role in your life extends far beyond that of a traditional healthcare funder. We are an interactive partner and participant in the good health of each and every member, now and into the future.





You are a member of an exclusive club.

A club that is not for the average and that is not open to just anyone. You will never hear your club on the radio. You will never see your club on television or splashed across the city on a billboard. You have qualified to join the ranks of this club, to be in the presence of professionals like yourself – bankers, economists, actuaries, accountants – all standing as one to protect you, to support you, in times of need. With benefits that are beyond the average. With backing that is world-class. And with your needs as the sole consideration. Beyond profits, beyond the thin veneer of add-ons and incentives, is our exclusive commitment to you.

Because Bankmed is for you. For your family. For your good health.

Why Bankmed

The Scheme that is here for you, for your family, for your good health.

As a closed medical scheme that is tailored to the banking industry alone, we have invaluable experience and insights into your specific needs and threats and the ability to offer you a medical scheme that deals with what you need, when you need it.

Scheme overview

Bankmed is a closed medical scheme, registered in terms of the Medical Schemes Act 131 of 1998. All benefits are approved by the Council for Medical Schemes. We have been in existence since 1914 and, at more than a 100 years old, we are one of the longest lasting and most experienced medical schemes in South Africa.

Bankmed exists solely for your benefit. While other organisations report to shareholders looking for their profit, Bankmed does not pursue profits or the accumulation of reserves. The Scheme is governed by a Board of Trustees, which prioritises the interests of the members and the sustainability of the Scheme.

A few Bankmed facts and figures to illustrate the Bankmed Profile (as of Year End 2013).

Size of membership



106 309
Principal Members



213 557
Beneficiaries

Average age of members:



Percentage of pensioner members



What sets Bankmed apart

34%
better value in
2015

Compared to an average open scheme

AA+

Global Credit Rating - 2015
(Highest in the industry)

46%
vs
33,3%

Solvency Ratio vs Industry Average

9%
industry average of
11%

Non-healthcare Expenses Ratio
(Administration, Managed Healthcare and General Administration expenses)

6
Benefit options

A fair spread of benefit options providing for low to high healthcare needs and affordability

Our value proposition includes:



Preventative Care and Wellness

Good health starts with knowing your health. Bankmed offers all members Wellness initiatives and on-site (at your offices) Wellness Days and Care Plan Programmes that identify and manage your health.



PMBs

No matter what plan you can afford, you are covered for the Prescribed Minimum Benefits as laid out by the Medical Schemes Act.



Good Governance

Bankmed is governed by competent trustees who prioritise the interests of the members and the sustainability of the Scheme.



Sexual Health

Pap smears and birth control are available along with our circumcision benefit. In addition, members have access to HIV/ AIDS Screening and a full Treatment Programme.



Bankmed is always with you

With our Bankmed App and Electronic Health Record, you always have Bankmed by your side, wherever you or your family happen to be.



On-site Support

Bankmed offers on-site support that helps with any aspect of your medical scheme.

How does Bankmed work?

Under the Medical Schemes Act, medical schemes are registered as Section 21 companies and are therefore non-profit organisations. Bankmed's primary source of income is from contributions collected from its members. This income is then used to pay for healthcare claims submitted by members and providers for healthcare services.

Examples of healthcare claims that Bankmed pays on behalf of the member include:

- Hospitalisation
- Major medical expenses (e.g. cancer treatment)
- Medication (e.g. chronic medication, acute and other over-the-counter medication)
- Routine consultations with healthcare professionals.

The expenses listed above constitute the Scheme's healthcare expenditure.

A small percentage of the contribution income is used to fund administration costs associated with the management of the Scheme. This includes the costs associated with the financial management, running of the Bankmed Customer Services Department and provision of disease-medication- hospital- and clinical case-management services. These expenses are known as non-healthcare expenditure.

The Scheme's total expenditure = healthcare expenditure + non-healthcare expenditure.

An operating surplus is generated if the Scheme's total expenditure is less than the total contributions collected for the benefit year. Conversely, an operating loss is incurred should the total expenditure exceed the total contributions collected.

Once an operating surplus is generated, the funds are transferred to the Scheme's reserves pool. It is important to note that the Scheme's reserves belong to the members.

Regulation 29(2) of the Medical Schemes Act states that a medical scheme must maintain accumulated funds (reserves) expressed as a percentage of gross annual contributions for the accounting period under review, which may not be less than 25%. Reserves have to be maintained above 25% to ensure the financial sustainability of the Scheme.



Membership

Who may join Bankmed?

A) As a member

Membership is open to any person in the service of an employer who is contracted to Bankmed.

If you join Bankmed from your employment date or from the first of the month following your employment date, you will be entitled to benefits from your date of registration.

Waiting periods (during which time contributions will be payable) and/or late joiner penalties may apply if you join Bankmed on a date other (later) than your employment date. Please refer to the section titled "Waiting periods and later joiner penalties" for more information in this regard.

B) As a dependant

The following members of your immediate family may qualify as dependants:

- **A spouse**
Your spouse to whom you are legally married. If you are divorced, your former spouse cannot be registered as a dependant.
- **A partner**
A person with whom you have entered into a civil union in terms of the Civil Union Act, or a person with whom you have a committed and serious relationship, similar to a marriage, based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.

- **A dependent child***
"Dependent" in relation to a child (including a dependent grandchild), means that he/she is financially dependent on you for family care and support as he/she:
 - is unable to support himself/herself, or
 - is physically or mental disabled, or
 - is a student at a registered tertiary institution.
- **A parent, parent-in-law, parent of a civil union partner, brother or sister in respect of whom you are liable for family care and support (special dependants)**
Please note that the above family members do not automatically qualify as your dependants. You need to demonstrate to Bankmed's satisfaction that you are liable for family care and support of such a special dependant and that he/she is unable to take care of himself/herself, as opposed to your merely taking a decision to care for him/her

Proof of dependence in respect of a dependent child or grandchild must be supplied annually to the Scheme from the month prior to his/her 27th birthday.

Only dependent children (children who are unable to support themselves) may be registered as your dependants on Bankmed. This means that a child who is no longer dependent on you (whether it be due to marriage or through his/her having gained permanent employment), does not qualify, and you must inform Bankmed of any event that would no longer qualify your child as your dependant.

Adult contribution rates will apply to a brother/sister in respect of whom you are liable for family care and support, from the month following the month in which he/she turns 23. Proof of dependence in respect of a brother/sister (once recognised as your dependant) must be supplied annually to the Scheme from the month prior to his/her 27th birthday.

Who may not join Bankmed?

Grandparents, nephews, nieces and any other family members not listed above do not qualify as your dependants. A child who is not your biological child, stepchild, adopted child, dependent grandchild or legally fostered child will only qualify as your dependant if legal (court-appointed) guardianship exists, in which case he/she will be regarded as your "child".

*"Child" refers to your child, stepchild, legally adopted child, foster child or a child who has been placed (or is in the process of being placed) in your custody or the custody of your partner/spouse.

The following contributions are payable in respect of a dependent child (including a dependent grandchild):

- Child rates until the end of the month in which he/she turns 23.
- Adult rates from the month following his/her 23rd birthday.





How to join Bankmed

Obtain an application form either from your HR Department or from the Bankmed website at www.bankmed.co.za.

Complete the application form in full and submit it to your HR Department with:

- A certificate of membership, indicating the resignation date, from your previous medical scheme (if applicable)

PLUS

- Any additional documents/certificates as requested on the application form (where applicable).

Please note

It is essential that the application form be completed in full and that all supporting documentation is correctly submitted and certified by your employer. Please take extra care to provide full membership history and proof of cover with previous medical schemes, where requested to do so on the application form.

As it is against the law to belong to more than one medical scheme at a time, please ensure that you terminate membership with your previous medical scheme (if applicable) prior to joining Bankmed.

Membership card

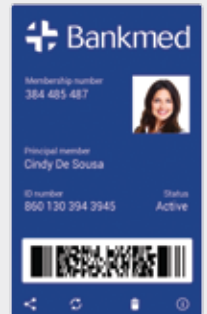


A membership card is provided to every new member upon joining Bankmed. This card is your proof of membership and must be presented to service providers on request. Please keep it in a safe place. No one may use your membership card (or benefits) besides you and your registered dependants.

You may request additional or replacement cards using our telephonic and web-based self-help facilities or via Customer Services. Please see "Important contact details" for contact information.

Membership card (Digital)

On the Bankmed mobile App you will have access to a digital card. Your digital card may be used as proof of membership and presented to service providers on request.



Retention of membership in the event of retirement, retrenchment or death

You may retain your membership in the event that you retire or become retrenched, provided you continue to pay the applicable contributions to the Scheme. You must however, notify us in writing should you wish to remain a member of the Scheme. Please be sure to notify us of your intention to remain a member as soon as your retirement/retrenchment date has been confirmed.

In the unfortunate event of your death, your family members who are registered as your dependants at the time of your death will be entitled to continued membership, provided that they continue to pay the required contributions to the Scheme.

Retention of membership whilst employed outside the borders of South Africa

You may retain your membership whilst living or working abroad, as long as you remain in the service of an employer who is contracted to Bankmed and provided that your employer continues to pay your contributions to the Scheme. Alternatively, you may elect to retain membership (and pay contributions) ONLY in respect of your registered dependants who live/remain in South Africa, whilst you are abroad. Please be sure to notify the Scheme in writing of your requirements.

Registration and deregistration of dependants

Please inform us within 30 days as to circumstances that may affect your membership or the eligibility of your registered dependants.

Examples of such changes include changes in marital status or domestic partnership arrangements, the birth or adoption of children or the registration of a dependant on another medical scheme (dual membership of two or more medical schemes is prohibited by law).

The necessary application forms for the registration of new dependants are available on our website at www.bankmed.co.za.

Please notify us in writing of any circumstances that would require the deregistration of a dependant (e.g. if you divorce) by completing and submitting a resignation form, which is available on our website (www.bankmed.co.za).



Termination or suspension of membership

In the event that it is not a condition of employment for you to belong to Bankmed, you may terminate membership by giving one month's advance written notice to the Scheme.

If it is a condition of employment (as per your employment contract) for you to belong to Bankmed, membership of Bankmed is compulsory and you may not resign from the Scheme unless you are registered as a dependant on a spouse or partner's medical scheme. Should you wish to resign from Bankmed in order to become a dependant on your spouse or partner's medical scheme, please notify us timeously to avoid dual membership of two medical schemes and to also ensure that we do not deduct contributions that are not due. You may be required to supply proof (because of the condition of employment arrangement) that you have joined your spouse/partner's medical scheme as a dependant.

Bankmed may suspend the payment of benefits or terminate your membership if:

- You owe money to the Scheme and do not settle the debt within 30 days of being notified thereof, or
- You are found to be guilty of abusing the privileges of the Scheme.

In the event that benefits are suspended, you will remain liable for the payment of contributions during the suspension. Your membership and benefits will be reinstated and any pending accounts will be processed once you have paid any amounts thus owing to the Scheme.

Waiting periods and late joiner penalties

Waiting periods

A waiting period is a fixed period during which contributions are payable, but some or all claims may be excluded from benefits.

Waiting periods form part of legislation and offer medical schemes and their members limited protection against the potential risk of anti-selection by new applicants. Anti-selection is a general term that, in the context of a medical scheme, refers to certain decisions or behaviours by prospective members that could impact negatively on the Scheme.

Bankmed's rules provide for two types of waiting periods when a member/dependant joins Bankmed:

- A general waiting period of three months, and/or
- A condition-specific waiting period of 12 months for certain pre-existing conditions (nine months for an existing pregnancy).

Upon joining the Scheme you will be notified of any waiting periods that may apply to you and/or any of your registered dependants.

Bankmed will not apply waiting periods to a member and his/her spouse, partner, child or dependent grandchild who joins the Scheme EITHER:

- From the date on which the member becomes eligible to join the Scheme, i.e. from the member's employment date, or the first of the month following the employment date,
- OR
- From the date of the event (or the first of the month following the event) e.g. marriage, birth or adoption, that qualifies the spouse/partner or child to be a dependant on Bankmed.

Please note that the above concession applies strictly to a member, and his/her spouse, partner, child or dependent grandchild. It does not include any other dependants who are eligible to join in terms of the rules of the Scheme, irrespective of the date on which they join.

Late joiner penalties

The law provides that a late joiner penalty may be imposed on a member or his/her adult dependant who is 35 years of age or older at the date of application AND who:

- Did not belong to a registered medical scheme on 1 April 2001,
- OR
- Belonged to a registered medical scheme on 1 April 2001, but had a break in cover of three or more consecutive months since 1 April 2001.

Bankmed will not impose a late joiner penalty on a new member meeting the definition of a late joiner, if he/she joins Bankmed from the date of employment or from the first of the month following his/her employment (member).

We will also not impose a late joiner penalty on a spouse/partner, adult child or dependent grandchild (who is dependent on the member) who joins Bankmed from his/her first date of eligibility. This concession applies strictly to a member and his/her spouse, partner or child. It does not include special dependants (e.g. parents, parents-in-law, parents of a civil union partner, brother or sister in respect of whom the member is liable for family care and support).

The late joiner penalty is provided for in legislation and depends on the number of years uncovered, which is determined as follows:

'Age upon application' minus '35 years' minus 'previous cover' = total years uncovered.

The penalty to be applied depends on the number of uncovered years (as indicated below) and is calculated as a percentage of the monthly contribution (excluding savings) applicable to the late joiner. If, for example, the total contribution for a late joiner is R1 000 and 25% of that (i.e. R250) is allocated to savings, the late joiner penalty will be calculated as a percentage of the balance, i.e. as a percentage of R750.

Uncovered years	Penalty to be applied
1 – 4 years	0.05 x contribution (excluding savings)
5 – 14 years	0.25 x contribution (excluding savings)
15 – 24 years	0.50 x contribution (excluding savings)
25+ years	0.75 x contribution (excluding savings)

See example on next page.

Example

- You are 50 years old.
- You are not joining Bankmed from the first date that you are eligible to do so.
- You are applying for membership in April 2014.
- The last time you were on a medical scheme was December 2013.
- You were previously on a medical scheme (or schemes) for a combined total period of four years.

It is important that you demonstrate membership of all previous medical schemes when you apply to join Bankmed, as this can affect the calculation of the late joiner penalty. The greater the period of cover you can demonstrate, the lower the penalty will be (if a penalty applies).

Calculation

50 years (age at application)
minus 35 years
minus 4 years (previous cover)
= 11 years (uncovered)

Late joiner penalty
= 0.25 x contribution (excluding savings)

Please Note

- To ensure that the correct contribution and/or penalty is charged (if applicable), we require the following:
 - your application form to be completed in full, and
 - proof of cover on all previous medical schemes, i.e. certificate(s) of membership to be provided if/ where requested on the application form.
- The penalty amount is percentage driven, therefore it will increase/decrease:
 - as and when the Scheme announces an overall contribution increase/decrease
 - if a salary adjustment results in a change in salary category of the principal member, or
 - when you change to a different plan (with different contributions).
- The percentage added to the contribution is not a once-off fee and will apply for the duration of a beneficiary's membership.

Contributions

How to calculate your monthly contribution

Please refer to your Benefit and Contribution Schedule for a table of contributions payable for the various plans and follow the steps provided to calculate your monthly contribution. A contribution calculator is also available on our website at www.bankmed.co.za to assist you with the calculation.

When and how your contributions are payable

Your contributions are payable monthly in arrears. Your employer will collect your contribution from your month-end salary and pay it over to Bankmed (for that month). This means that your January contribution will be deducted by your employer from your January salary, your February contribution from your February salary, etc.

If you join Bankmed on or before the 15th day of a month, a full month's contribution will be due for that month. If you join Bankmed after the 15th day of a month (e.g. if your employment date falls after the 15th), you will not be liable for a contribution for that month. Your first contribution will be due towards the end of the following month in respect of that month. For example, if you join on 20 February, your first contribution will be deducted from your March salary, for March, but you will already be entitled to claim benefits as from 20 February.

Please note that although the payment of contributions may be facilitated by your employer, you are fully responsible for the payment of any contributions owing to the Scheme.



Please inform us when circumstances change

Any of the following events (but not limited to) may affect your membership and/or contributions and you are requested to advise us immediately if:

- Any of your dependants are no longer eligible for dependant membership (e.g. due to divorce or termination of a domestic partnership)
- A dependant child is no longer dependent on you (e.g. due to marriage or full-time employment)
- You retire
- You are retrenched or made redundant
- There is a change in your marital or domestic status and you wish to add a dependant.

Should you leave your employer during the course of the month (i.e. other than at month-end), you will be entitled to membership until the end of the month concerned. A full month's contribution will be payable for your last month of membership (even if you leave your employer during the month).



Benefits

Benefits payable

When you join Bankmed, you must select one of the six available plans to which you wish to belong.

The benefit year of the Scheme runs from 1 January to 31 December and the benefits described in the Benefit and Contribution Schedule apply to the applicable benefit year only.

Benefits are not transferrable from one benefit year to the next, except for unused balances in the Medical Savings Account (where applicable).

Please refer to the Benefit and Contribution Schedule (available on www.bankmed.co.za) for more information on benefits and contributions per plan, how to choose your plan and for other relevant information that may impact your plan selection.

How to change your plan

Members are allowed to move from one plan to another on 1 January of any given year. No plan changes are allowed during the course of the year and it is therefore important that you choose carefully when selecting your plan.

In the last quarter of each year Bankmed will notify you of any changes to benefits and contributions for the following year. You will then have an opportunity to change your plan for the following benefit year should you wish.

Bankmed will notify you how to implement your plan change and will confirm the cut-off date for plan selections.





Recovery of benefits erroneously paid

In the event that Bankmed pays an account or a portion of an account or any benefit to which you are not entitled, irrespective of whether the payment was made to you or on your behalf, the amount of such overpayment may be recovered by the Scheme.

What does Bankmed NOT cover (Scheme exclusions)?

The following are some examples of items typically not covered by Bankmed:

- Operations, treatments and procedures for cosmetic purposes.
- Sun-screen and tanning agents.
- Travel expenses.
- Accommodation in old age homes or similar institutions.
- Sunglasses.
- Accommodation and/or treatment in headache and stress-relief clinics.
- The cost of holidays for recuperative purposes (for example spas and health resorts).
- Telephone consultations with medical practitioners.
- Costs associated with vocational guidance, child guidance, marriage guidance or counselling, sex therapy, school readiness, school therapy or attendance at remedial education schools or clinics.

Please visit www.bankmed.co.za and select "Registered Rules" for a complete set of Scheme exclusions.

How do Medical Savings Accounts work?

The Medical Savings Account (MSA) only applies to members who select the Core Saver Plan, Comprehensive Plan or Plus Plan. Savings do not apply to members on the PMB Plan, Basic Plan or Traditional Plan.

Your MSA is an excellent way to provide for your day-to-day healthcare expenses. What you do not use in one year, will be carried over to the next year or paid out to you (or to your new medical scheme) five months after you have terminated your membership or in the event you change to a plan that does not have a savings component.

The amount that is allocated to your MSA will depend on the plan you have selected.

The MSA has several benefits:

- It gives you control over your day-to-day healthcare expenses.
- Unused savings balances can be carried over from one year to the next.
- Bankmed awards interest (once a year) on positive savings balances.
- You may use savings to pay for valid claims when available insured benefits are depleted.

Note that as contributions are only payable for a maximum of three children, the MSA allocation will also be limited to a maximum of three children (even if you have four or more children registered as your dependants).

How the MSA works

On 1 January each year, you will have access to your full annual savings allocation, not just the contribution you have paid for the month.

The total amount to be set aside in your MSA for the year is calculated by multiplying the savings portion of your monthly contribution by 12 (or by the remaining number of months in the year, if you join later than 1 January). The Scheme automatically allocates that portion of your monthly contribution that applies to savings, to your MSA.

The maximum amount that you may pay into savings is limited by law to 25% of your total contribution (the actual percentages allocated will depend on the plan you have selected).

This 'upfront' allocation is recalculated when dependants are added (the allocation increases) or removed (the allocation decreases) during the year. If the amount claimed from MSA during the year exceeds the amount paid into MSA during the year (e.g. if a member or dependant resigns and the recalculated allocation is less than the money already claimed from MSA), the difference will be regarded as a debt that is repayable to the Scheme.

Who controls the money in your MSA?

Since the money in your MSA is your money to spend wisely, (subject to legislation around what this money may be used for) you may use a service provider of your choice for benefits that will be paid from your MSA.

However, claims will still be paid according to the rules of the Scheme, as long as there is money available in your MSA. If there is no money available in your MSA, you will have to pay the outstanding amount directly to the service provider.

What happens to the balance in your MSA at the end of the benefit year?

If there is money available in your MSA at the end of the benefit year, i.e. 31 December, the balance will be brought forward after all accounts have been settled for the previous year. This amount will then be credited to your account at the end of April/beginning May for use in the current benefit year. Interest will be credited at the end of May of the relevant benefit year, once the books for the past year have been finalised.

Payment of claims from MSA

Annual benefits are allocated according to the date of treatment and not the date on which Bankmed received the claim. Claims from the previous benefit year cannot be paid from the current year's MSA.

If you have a positive balance in your MSA, however, you may use the balance brought forward from the previous year to settle claims for the current benefit year. You may use your MSA to pay for excess amounts on any claim. Please notify the Scheme in writing should you wish to have above-tariff portions on claims paid from your MSA.

How to determine your MSA balance

You can find out your MSA balance through any one of the following channels:

- The Bankmed website (www.bankmed.co.za)
- The IVR/self-help telephone facility
- Your latest claim statement
- Via the Bankmed App on your smart phone or feature phone (download the App at www.bankmed.co.za/app)
- By calling Bankmed Customer Services on 0800 BANKMED (0800 226 5633)

What happens to your MSA if you leave the Scheme?

By law, providers may submit claims for services rendered to you up to four months after the date of service. Consequently, Bankmed has to provide for any claims you may have incurred and that may still be outstanding in this time. Therefore, any credit balance in your MSA (if applicable) will only be refunded to you or transferred to your new medical scheme five months after termination of your membership.

If you have remaining funds in your MSA five months after termination, Bankmed must (by law) transfer these to your new medical scheme, unless your new medical scheme/plan does not provide for a MSA, in which case the remaining funds must be paid directly to you. Please note that this payment amount is taxable.

Upon resigning from the Scheme you must, therefore, inform Bankmed, what to do with your savings balance after you have resigned.

If your new medical scheme/plan provides for a savings component, you must provide us with the banking details of such medical scheme and a reference to be used on the deposit slip when transferring these funds (for your benefit) to your new medical scheme.

It is possible that when you leave Bankmed, you may owe the Scheme money in respect of advances on your MSA (e.g. if you resign during the year and have already used the full year's savings allocation) or for any other amount owing to the Scheme. These amounts will be recovered from you by direct debit to your bank account in the month following your resignation.

Pre-authorisation

Pre-authorisation processes and Managed Care Programmes (managed care) ensure that members get the most cost-effective and appropriate care for their illness. This also allows the cost of hospitalisation, medication and treatment to be managed to the benefit of our members.



When is pre-authorisation required?

Pre-authorisation is required for planned hospital admissions, MRI/CT scans, radionucleotide scans, chronic medication and other major medical expenses as specified in the Benefit and Contribution Schedule for the various plans.

If you do not obtain pre-authorisation prior to incurring expenses for these specified events/costs, you may be exposed to unfunded liabilities (penalties/out-of-pocket payments), or you may even be liable for the full account.

It is therefore very important that, before incurring any expenses, you obtain pre-authorisation where indicated as a requirement in your Benefit and Contribution Schedule.

Contact details for pre-authorisation are provided under "Important contact details".

Important information to have on hand when requesting a hospital pre-authorisation

Before phoning for hospital pre-authorisation, you should have the following information available:

- Name and contact details of principal member
- Initials, surname and date of birth of the patient
- Bankmed membership number
- Name and practice number of treating doctor
- Name and practice number of hospital where you are to be admitted
- Proposed duration of hospitalisation
- Date and time of admissions
- CCSA (procedure) code – remember to ask your doctor for this, and
- ICD-10 (diagnosis) code – remember to ask your doctor for this.

Deductibles (co-payments) may apply to hospital admissions. Please refer to your Benefit and Contribution Schedule for details.

Pre-authorisation for hospital admission refers to the clinical appropriateness of the admission and to the length of stay. It is **not** a confirmation of available or unlimited benefits. You must always refer to your Benefit and Contribution Schedule for the benefit limits that may apply.

In the case of emergency admissions, the hospital will (if they are aware of your Bankmed membership), obtain authorisation on your behalf. However, it will still remain your responsibility to confirm that an authorisation has been obtained within 24 hours of admission to hospital, or (if the admission takes place over a weekend or public holiday) on the first working day after admission to hospital.

How to obtain pre-authorisation for a MRI/CT/radionucleotide scan

It is essential that you obtain pre-authorisation before a MRI/CT scan or a radionucleotide scan is performed.

Please phone for authorisation on the number listed under "Important contact details".

Before calling, you will need to have the following information available:

- Name and contact details of principal member
- Initials, surname and date of birth of the patient
- Bankmed membership number
- Name and practice number of referring doctor
- Name and practice number of treating doctor (radiologist)
- CCSA (procedure) code – remember to ask your doctor for this, and
- ICD-10 (diagnosis) code – remember to ask your doctor for this.

Emergency/ambulance services (Discovery 911)

Emergency/ambulance services are provided by Discovery 911.

Bankmed members may make use of Discovery's 24-hour medical advice line, which provides quick and professional advice should you be unsure of treatments for certain conditions or should you be interested in self-help care.

Where you require the emergency assistance of an ambulance service, you should contact Discovery 911 as soon as the service is required.

If you are in a crisis situation and need medical assistance, contact Discovery on 0860 999 911.





Chronic medication and Managed Care Programmes

If you or any of your dependants have been diagnosed with cancer or HIV/AIDS, you will benefit greatly from registering on one of our Managed Care Programmes.

Once you have registered, one of our Case Managers will contact you to assist with advice and counselling relevant to your condition. The Case Manager will interact with you and your doctor on an ongoing basis to facilitate the management of your condition and, wherever possible, to help improve your quality of life.

Please note that benefits for chronic medication (subject to available benefits as indicated in the Benefit and Contribution Schedule for your plan) are only available to members who have applied for– and obtained the necessary pre-authorisation.

Benefits are not provided retrospectively. It is therefore important that you apply for chronic medication benefits as soon as your doctor has diagnosed you with a chronic condition and provided you with a prescription for ongoing medication. Bankmed may require additional information from your doctor before authorising your medication.

If you do not qualify for chronic medication benefits (i.e. if the clinical and funding criteria applied by the Scheme for the payment of chronic medication benefits are not met) or if your chronic medication benefits are exhausted, you will still be able to claim benefits for medication from an alternative benefit category, e.g. acute medication or from MSA (subject to available limits) or as a Prescribed Minimum Benefit (PMB) if applicable.

Contact details for the various programmes are provided under "Important contact details" in this handbook.

Claims

Period for submission of claims

Claims must reach Bankmed within **FOUR MONTHS** of the treatment date otherwise Bankmed will not be liable to provide benefits.

Claims submitted electronically or directly by providers

The bulk of claims, including those of private hospitals, pharmacies, radiologists, pathologists and other medical practitioners are submitted electronically or directly to Bankmed on your behalf.

In such cases, the provider is required by law to provide you with a full copy of the claim. Bankmed will normally pay the benefit amount to the provider, but it remains your responsibility to ensure that the account reaches us on time, to check the account for accuracy and to verify payment thereof against your Bankmed claims statement.

Claims submitted by you

In those cases where claims are not submitted electronically, you will be required to personally submit your claim in the form of an invoice that you have received from the provider. Please read the following sections very carefully as they provide important information to ensure that your claims are processed speedily. If you have settled the claim, please include proof of payment when submitting the account.

Checking your claims prior to submission

All claims must be checked for accuracy and must be clearly legible.

On receipt of your account from the provider, check that the following information appears on the account:

- Your membership number
- Your surname and initials
- The patient's first name, surname and dependant code
- Name of the benefit plan
- The name and practice number of the supplier of the service
- The nature and cost of treatment
- The referring doctor's practice number on specialists' accounts
- The tariff code that relates to the health service you have received
- The ICD-10 (diagnostic) code that relates to the health service you have received, and
- Proof of payment, if you have paid it yourself.

Notification of processed claims and claims statements

Should you wish to receive notification whenever a claim has been received and processed, you can register for this service via our website at www.bankmed.co.za (sign in with your username and password). You can then choose to either receive your notification by e-mail or SMS. Once the claim has been processed and paid, you will receive a claims statement either in the post or by e-mail (if you have chosen that option).



Checking your claims statement

Your claims statement is one of the most important documents you will receive from Bankmed. It is as important as your bank statement and, in the same way that you would check your bank account very carefully, you should apply the same discipline to your Bankmed statement. By doing so, you will help us to control fraud and to manage your benefits in the most efficient way.

Please check your statement to ensure that:

- The claims on the statement are for services that you and/or your registered dependants received
- Bankmed has processed all claims for services rendered to you and your dependants (and that you have submitted all of your claims within four months), and
- The correct dependant code, as shown on your membership card, is reflected opposite each claim.

How to submit a claim to Bankmed



Fax to
021 527 1940



E-mail to
claims@bankmed.co.za



Post to
Bankmed Claims
**PO Box 1242,
Cape Town,
8000**

Income tax records

You should keep all your claims statements for income tax purposes.

Should you notice any errors or have a query, please contact Bankmed Customer Services on 0800 BANKMED (0800 226 5633).

Complaints and disputes

At Bankmed, we continuously strive to ensure that our service and communication to members is of the highest standard.

Errors may sometimes occur and there could be times when you are not satisfied with the service you received. Please feel free to lodge any queries and complaints as set out below and we will attempt to resolve these as quickly and effectively as possible:

Step 1: Call or e-mail us with your enquiry or complaint:

- Contact Bankmed Customer Services on *0800 BANKMED (0800 226 5633) to discuss your enquiry or complaint. Our skilled agents will be happy to assist.

OR

- E-mail your enquiry or complaint to enquiries@bankmed.co.za. When submitting a complaint, please include the word "Complaint" in the subject heading of your email.

E-mailed enquiries and complaints will generally be responded to within an average of one to two business days for simple enquiries and approximately five business days for more complex cases.

*Toll free from a Telkom landline

Step 3: Tell us!

In the unlikely event that you have followed steps 1 and 2 and still feel that your problem was not resolved to your satisfaction or that you have been treated unfairly in any way, please inform us by sending an e-mail (with the details of your experience) to Tellus@bankmed.co.za. We take complaints seriously and wish to ensure that every engagement with a Bankmed Customer Services agent is worthy of a compliment.

Step 2: Request an escalation

If you have followed the above process and feel that your enquiry or complaint was not dealt with to your satisfaction, or that the Scheme rules were not correctly applied, we encourage you to let us know where you feel we could improve:

- Explain the situation to a Bankmed Customer Services agent on 0800 BANKMED (0800 226 5633). Our agents are generally equipped to resolve any errors that may have occurred and/or to provide additional clarity and guidance needed to put your mind at rest where errors may not have occurred.

If you are not satisfied with the service or outcome provided by the agent concerned, you may ask to be transferred to a supervisor or manager. Should a supervisor or manager not be immediately available to take your call (e.g. if he/she is on another call), the agent will confirm your contact details and ensure that you are called back as a matter of urgency.



Complaints may also be submitted in writing to: Complaints, Bankmed, PO Box 1242 Cape Town, 8000

Although legislation provides that all complaints submitted in writing must be responded to within 30 days, we will always endeavour to respond to complaints within a much shorter timeframe than prescribed.

If you have provided us with a reasonable opportunity to address any concerns raised and feel that you have been treated unfairly by us in any way, you may lodge a formal complaint with the Council for Medical Schemes, as follows:



0861 123 267
(Sharecall from a Telkom landline) or 012 431 0500



012 430 7644



complaints@medicalschemes.com



Physical address:
Council for Medical Schemes
Block A
Eco Glades 2 Office Park
420 Witch-Hazel Avenue
Eco Park, Centurion
0157

Postal address:
Private Bag X34
Hatfield
0028



0800 BANKMED
(0800 226 5633)



enquiries@bankmed.co.za



www.bankmed.co.za



Bankmed App

