ESSENTIAL PLAN
FAQs 2023

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 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 the 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 be liable for a co-payment.

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.

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 confirm with your GP to ensure that your procedure is on the list of in-room procedures that your Plan covers. The Essential Plan only covers treatment for Prescribed Minimum Benefit (PMB) conditions, at the legislated level of care for Prescribed Minimum Benefits. If your treatment, procedure or condition is NOT a Prescribed Minimum Benefit, you will have to pay for the treatment yourself.

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
- 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 only. This means that you will receive treatment and medication for only the conditions listed as a Prescribed Minimum Benefit. For example, cancer is a Prescribed Minimum Benefit condition, and you will be covered for Prescribed Minimum Benefit level of care if treated with oncology medication. Whereas a corneal transplant is not a Prescribed Minimum Benefit and will, therefore, not be covered on your Plan.

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 GP Entry Plan Network and use hospitals in the Bankmed Hospital Network to avoid co-payments.

MEDICATION

What medication is not covered by the Essential Plan?

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

CHRONIC MEDICATION

Am I covered for chronic medication?

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 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.**

In addition, you need to obtain your approved chronic medication from a pharmacy within the Bankmed Pharmacy Network, known as a Designated Service Provider (DSP).

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.

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). Alternatively, 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?

You only have cover for blood tests and X-rays that relate to a Prescribed Minimum Benefit condition.

SPECIALISTS

Do I have access to any specialists?

You have cover for specialists if your condition is related to a Prescribed Minimum Benefit condition and you have been referred to the specialist by your nominated GP.

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/or 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 visit **www.bankmed.co.za** or the **Bankmed App**.

Will I have to pay for anything while in the 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)?

Essential Plan members do not have access to the full list of treatments or procedures listed in the adjacent table, as cover is limited to Prescribed Minimum Benefits. If you need to have one of these procedures or treatments performed, and the underlying diagnosis is a Prescribed Minimum Benefit diagnosis, then you qualify for the procedure or treatment. However, if the listed procedure or treatment is performed in a non-network hospital, you will need to pay a R1 805 upfront payment (deductible) for each admission.

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.

For the conditions and procedures listed below, you do NOT have to pay an upfront payment (deductible) at a day surgery that falls within the Day Surgery Network. The facilities within the network are known as Designated Service Providers (DSPs). This list applies to Designated Service Providers only:

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

** Essential Plan members do not have access to the full list of treatments as cover is limited to Prescribed Minimum Benefits.*

Benefit **enhancements**

*Please read your **2023 Benefit and Contribution Schedule** for detailed information on updated limits, networks and benefits.*

What is the benefit limit increase?

Benefit limits will increase by approximately 6.5%.

Contribution **increase**

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 41% more value than the average comparable open-market Plan.

What is the contribution increase?

Your contribution increase will be **6.5%** in 2023.