DAY-TO-DAY BENEFITS AND COVER

We cover your day-to-day benefits from your Day-to-Day Insured Benefits, MSA and ATB, according to your Plan type.

WHAT ARE DAY-TO-DAY BENEFITS?

Day-to-day expenses include items such as medication, visits to your GP, X-rays, and blood tests.

- On the Plus, Comprehensive, and Core Saver Plans, we pay these expenses from your MSA.
- On the Traditional, Basic, and Essential Plans, we cover these expenses from the Insured Benefits, subject to limits.

WHAT ARE INSURED BENEFITS?

These are funded from the pool of member contributions, instead of using your personal MSA, if you have one.

MEDICAL SAVINGS ACCOUNT (MSA)

Available on Core Saver, Comprehensive and Plus Plans

The MSA is used to pay for day-to-day medical costs like GP visits, X-rays (radiology), medication and blood tests.

At the start of each year, we give you full access to a yearly amount.

You pay the amount back without interest as part of your monthly contributions.

If you join Bankmed after 1 January 2025, we calculate your MSA amount for the rest of the year by multiplying the monthly amount you contribute towards your MSA, by the number of months left in the year.

If you leave Bankmed and have spent more of your MSA than what you have contributed during the year, you will need to pay a portion of the MSA back to Bankmed. We call this a clawback.

Choose your MSA reimbursement rate

You can choose between Cost or Scheme Rate. Cost fully covers eligible claims, including out-of-network ones. Scheme Rate limits coverage to the Scheme Rate and within benefit limits. New members default to the Scheme Rate if no choice is made, but they can switch between options anytime.

Above Threshold Benefit (ATB), Annual Threshold and Self-Payment Gap (SPG)

Plus Plan exclusive features

ATB

- Provides cover for out-of-hospital treatment for Plus Plan members who reach the Annual Threshold.
- This is an Insured Benefit which is accessed only after reaching the Annual Threshold with specified limits.
- ATB offers additional cover when the yearly MSA amount is depleted.

ANNUAL THRESHOLD

- Calculated based on the number of dependants on the membership, limited to three children.
- We use the Scheme Rate, instead of the cost of medication or treatment, to calculate when you reach the Annual Threshold. When claims are paid at 100% of the Scheme Rate from your MSA and add up to the Annual Threshold, you can access the ATB.
- Claims at 100% of the Scheme Rate from the MSA contribute to reaching the Annual Threshold, unlocking the ATB.

SPG

- An SPG will occur when your MSA is depleted, and you have not yet reached your Annual Threshold.
- You will need to pay claims during the SPG from your own pocket, until the Annual Threshold is reached.
- You must continue to submit claims to the Scheme during this period as these will accumulate towards reaching the Annual Threshold.
- Remember that claims accumulate to the Annual Threshold at 100% of the Scheme Rate. However, you can choose to fund claims at cost from your MSA. If your Healthcare Professional charges more than the Scheme Rate, the difference between the claimed amount and the paid amount contributes to your SPG.

LIMITS TO AMOUNTS ADDING UP AND BENEFIT CATEGORIES

There is a limit to how much of your MSA you can use to pay for specific categories of treatments, which adds up to the Annual Threshold. Some of the categories are:

- Prescribed acute medication (short-term medication).
- Claims for tooth and gum care (including preventative and basic dentistry, advanced dentistry, and all other dental services).
- Optometry consultations, prescription lenses and readymade readers, contact lenses, fitting of contact lenses and other eye care such as refractive surgery. Ask your Healthcare Professional about the available DSP lens options which are covered in full.

Your general limits for the categories can be more than the limits for the ATB. However, we do not pay out more than your family limit for the ATB.

IMPORTANT

Both the Annual Threshold and the ATB are pro-rated (reduced) if a member joins after 1 January each year. This is calculated by dividing the total Annual Threshold and ATB for the year by 12 and multiplying these amounts by the remaining number of months in the year. These amounts are recalculated when a dependant is added or removed during the year, or when a child dependant becomes an adult dependant (and will have to pay the rate for an adult dependant). There is no clawback (debt owing to the Scheme) on overspend on ATB if a dependant is removed or a member resigns during the year.

2025 ATB AND ANNUAL THRESHOLD

Annual Threshold			
	M	**A**	**C**
Threshold Level	R26 800	R19 900	R6 600
Threshold Amount	R24 000	R18 100	R6 000

**Limited to three children.*

How to calculate the Annual Threshold

The Annual Threshold is a combined family threshold and is calculated by adding the threshold level amount for each family member together. See example below:

Principal Member		Adult Dependant		Child		Family
R26 800	+	R19 900	+	R6 600	=	R53 300

How to calculate the ATB

The ATB is a combined (family) limit and is calculated by adding the threshold amount for each family member together. See example below:

Principal Member		Adult Dependant		Child		Family
R24 000	+	R18 100	+	R6 000	=	R48 100

Please note that the 2025 benefits and contributions are subject to approval by the Council for Medical Schemes.

Day-to-day benefits

	Medical Savings Account (MSA)	Day-to-day benefit funding	How the funding works
Plus Plan	Yes	MSA ATB	• All day-to-day claims are paid from your MSA until the Annual Threshold is reached. After reaching the Annual Threshold, access to the ATB provides additional cover for high out-of-hospital expenses. • ATB covers GP and specialist consultations, in-room procedures, acute medication, blood tests, X-rays, basic and advanced dentistry, orthodontics, hearing aids, and other specified services. • Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
Comprehensive Plan	Yes	MSA	• Day-to-day claims, including GP and specialist consultations, acute medication, blood tests, and X-rays, are paid from your MSA. • In-room procedures by GPs or specialists, and basic dentistry, are funded from Insured Benefits with no set limits. • Advanced dentistry, orthodontics, hearing aids, and specific categories have limited coverage under Insured Benefits. Once limits are reached, expenses are covered from available MSA funds. • Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
Traditional Plan	No	Insured Benefits	• Day-to-day benefits, including GP and specialist consultations, acute medication, X-rays, blood tests, basic and advanced dentistry, orthodontics, hearing aids, and other categories, are covered by the Insured Benefit up to Plan limits. Unlimited coverage is provided for procedures performed by GPs and specialists in their rooms. • Limited cover is available for eye tests, glasses, or contact lenses every two years. • Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
Core Saver Plan	Yes	MSA	• Unlimited PMB cover when using network GPs or specialists and following the recommended care. Chronic Illness Benefit registration is required for chronic conditions. • Two non-PMB consultations covered by Insured Benefit, then day-to-day expenses use MSA funds. • MSA covers non-PMB expenses like dentistry, eye care, and acute medication. Limited cover for acute medication from pharmacists. • Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
Basic Plan	No	Insured Benefits	• Unlimited cover for GP consultations, acute medication from the formulary, and basic dentistry via the Bankmed Dental Network. No reimbursement for basic dentistry from non-preferred providers or treatments not on the formulary; advanced dentistry and orthodontics not covered. • Limited eye care benefits available every two years through the Bankmed Optometry Network. • Additional benefits up to a specified limit when using a Bankmed Entry Plan Network GP or with a referral to another network Healthcare Professional. • Full payment is made for Network Healthcare Professionals. For non-network providers, payment is up to the Scheme Rate, with members covering any shortfalls.
Essential Plan	No	Insured Benefits	• Cover limited to PMBs

Benefit Terminology:

- Acute medication (short-term prescriptions)
- Blood tests (pathology)
- X-rays (radiology)
- Basic dentistry (dentist consultations, teeth cleaning, and fillings)