2025

Guide to Prescribed Minimum Benefits (PMB)

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Contents

This document will take you through how Bestmed Medical Scheme (Scheme) covers each of its members for a list of conditions called Prescribed Minimum Benefits (PMBs).

Understanding the Prescribed Minimum Benefits

What are Prescribed Minimum Benefits (PMBs)?

In terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of all emergency conditions, and a defined list of 270 diagnoses, including 27 Chronic Disease List (CDL) conditions.

Why do we have PMBs?

There are two main reasons why PMBs were created:

- To ensure that medical scheme beneficiaries have continuous health care. This means that even if a member's benefits for a year have run out, the medical scheme has to pay for the treatment of PMB conditions.
- To ensure that healthcare is paid for by the correct parties. Medical scheme beneficiaries with PMB conditions are entitled to to specified treatments and these have to be covered by their medical scheme, even if the patients were treated at a state hospital.

Other valid reasons include:

- Ensuring that minimum healthcare is provided equitably to all who need it, regardless of their age, state of health or the medical scheme cover option they belong to.
- PMBs also have a part to play in ensuring that medical schemes remain financially healthy. When beneficiaries receive good and proper care on an ongoing basis, their general wellness improves, resulting in fewer serious conditions that are expensive to treat.

What is an emergency medical condition?

An emergency is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical and surgical treatment. A condition qualifies as an emergency if failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

An emergency does not necessarily require a hospital admission and the Scheme may require additional information to confirm the emergency.

How does Bestmed Medical Scheme pay claims for PMBs?

We pay for PMBs from the risk benefits if you receive treatment from a designated service provider (DSP) and as per the DSP agreement. A DSP is a healthcare provider (for example a doctor, specialist, pharmacist, or hospital) who we have a payment arrangement with. They will provide treatment or services at a contracted rate based on a negotiated arrangement with the Scheme. This will ensure that you will not have any co-payments when you use their services.

Bestmed has a network of over 15 000 service providers across the country on our DSP network. You can use the Bestmed App, the Provider Search function on our website or call our Contact Centre on 0860 00 2387 to find the nearest service providers on our DSP network using your home, work or current address as a starting point.

The treatment and care should be based on healthcare that has proven to work best, taking affordability into consideration. Minimum provision for PMBs as per the public sector will apply.

Treatment received from a non-DSP provider may be subject to a co-payment if the healthcare provider charges more than Bestmed's Scheme tariff. Funding for services that fall outside the PMB scope of care will be considered for funding from your day-to-day or savings benefits or for your own account, depending on the rules and benefits of your chosen option.

- No PMB-related claims may be paid from member's savings account.
- The Scheme may make use of protocols, formularies and DSPs to manage the costs associated with PMBs
- Therefore a structured PMB process that meets legislative requirements as well as supports cost containment has been implemented for Bestmed members and the following requirements have to be met.

Requirements you must meet to obtain PMB benefits

There are certain requirements that need to be met before you can access PMBs.

- The condition must qualify for cover in accordance with the Scheme protocol and be on the list of defined PMB conditions.
- The treatment needed must match the treatments in the published defined benefits on the PMB list.
- You must utilise services from one of the Scheme's DSPs. This does not apply in emergencies. However, even in these cases, where appropriate and according to the rules of the Scheme, you may be transferred to a DSP hospital or facility once the provider confirms you have been sufficiently stabilised for an inter-facility transfer.
- Pre-authorisation must be obtained for chronic benefits and in-hospital services and procedures.

If the treatment does not meet the above criteria, the Scheme will fund claims up to the Bestmed Scheme tariff, which is a set rate at which the Scheme pays service providers. If the service provider charges above this rate, you will have to fund the outstanding amount yourself. This amount will constitute a co-payment.

All Bestmed benefit options are enriched to cover more than the minimum benefits required by law.

Claims paid only as PMB

Sometimes, Bestmed Medical Scheme will only pay a claim as a PMB. This happens when you are in a waiting period or when you have treatments linked to conditions that are excluded by your plan. Waiting periods can either be a general three month waiting period or a 12-month condition-specific waiting period. Members can still have full cover if they meet the requirements stipulated by the PMB regulations.

When do you not have cover for PMBs?

There may be circumstances where you do not have cover for the PMBs. This can happen when you join a medical scheme for the first time, with no medical scheme membership before that. It can also happen if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme would impose a waiting period, during which you and your dependants will not have access to the PMBs, no matter what conditions you might have.

Exclusions and PMBs

Medical schemes are entitled to exclude services or treatment after certain events, e.g. cosmetic surgery, travel costs and examinations for insurance purposes etc.

In some circumstances, exclusions may not apply to PMBs, e.g. when a patient gets septicaemia after cosmetic surgery. The Scheme has to provide certain cover for septicaemia since septicaemia is a PMB. However, cosmetic surgery remains an exclusion.

How to register for CDL chronic or PMB benefits

You and your dependants must register for cover for PMBs and Chronic Disease List (CDL) conditions. Once your healthcare professional confirms the diagnosis as a PMB or CDL condition, you can apply for the benefits with the Scheme. You may have different types of claims for PMBs, including hospital admissions, chronic conditions and other conditions treated out of hospital.

If you want to apply for out-of-hospital PMBs or cover for a CDL condition, you must complete a PMB or a chronic medicine application form, accordingly. Both forms are available to download and print from www.bestmed.co.za> Benefits and Cover>PMB>Resources. You can also contact our Contact Centre at 0860 00 2378 or service@bestmed.co.za to request any of the above forms.

If you want to apply for in-hospital PMB cover, you can contact our Hospital Benefit Management department at 080 022 0106 or authorisations@bestmed.co.za.

Accounts are paid at the Bestmed tariff. If the diagnosis is a listed PMB and the account is incorrectly short paid (e.g. valid emergencies, involuntary use of DSPs) the practice or member can apply to have the shortfall covered as PMB. Contact Bestmed at 086 000 2378. You may be asked to provide relevant documents, which will be sent to the PMB department to process.

Once your application for out-of-hospital PMB or CDL benefits has been processed, we will let you know the outcome of the application and send you communication (by post or email, according to your preference indicated on your application form) confirming your cover for that condition.

Who must complete and sign the registration form when applying for PMB or chronic condition cover?

The member or dependant that was diagnosed with the PMB or chronic condition must complete the application form with the help of the treating doctor. The main member must complete and sign the form if the patient is a minor (younger than 18 years). The main member and all dependants with PMB or chronic conditions must register separately. Each individual must register for each of their specific conditions. This means that you have to register for each new condition before we will cover the treatment and consultations of that condition as a PMB or CDL condition.

However, you only have to register once for a chronic condition. If the medicines or strength changes for an already registered condition, we may need the updated prescription. Alternatively, the doctor can contact us with the details at 0860 00 2378. Repeat prescriptions for chronic conditions last for a period of up to six months. Thereafter, you will need a new repeat prescription for the next 6 months.

Additional documents needed to support the application

You may need to send the Scheme the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying for cover. This will help us to verify whether your condition qualifies for the chronic medicine in question.

Where do I submit the completed application form?

You can send the completed **PMB application form:**

- By email to: pmb@bestmed.co.za
- By fax to: 012 472 6760
- By post to: Bestmed Medical Scheme, PMB Department, PO Box 2297, Arcadia, Pretoria, 0001, South Africa

You can send the completed **chronic medicine application form:**

- By email to: medicine@bestmed.co.za
- By fax to: 012 472 6760
- By post to: Bestmed Medical Scheme, Chronic Department, PO Box 2297, Arcadia, Pretoria, 0001, South Africa

What happens after my PMB or CDL application is approved?

After your application has been approved, we will automatically pay for appropriate blood tests and other investigations, treatment, medicine and consultations for that condition from a defined basket of care out of Scheme risk. Claims for medical services will be sent by us to the claims department to be funded as PMBs. and channel the medical services claims to be funded as Prescribed Minimum Benefits. This means that these benefits will not be paid from your annual savings.

The treatment needed must match the treatments in the defined benefits on the PMB list as published by the CMS, as there are standard treatments, procedures, investigations and consultations for each condition on the PMB list. These defined benefits are supported by thoroughly researched evidence and detailed in clinical protocols and medicine lists (formularies) that we use to make funding decisions.

We will not pay for treatment or medicine that falls outside the defined benefits and that have not been approved as a PMB. Non-approved items will be funded from your available day-to-day benefits according to your chosen option. If your option does not cover these expenses, you will have to pay for the claims from your own account.

What happens if you need treatment that falls outside of the defined benefits?

The Scheme is only required to cover defined benefits. If treatment that falls outside the defined benefits is not approved, it will be paid from your available day-to-day benefits or annual savings, in line with your chosen option. If your option does not cover these expenses, you will be personally responsible to pay the claims.

Alternatively, if you need treatment that falls outside the Scheme's defined benefits and your treating physician submits additional clinical information with a detailed explanation of why the treatment is needed, the Scheme will review it and may choose to fund it in exceptional cases. If we decline the request, you may appeal this decision and lodge a complaint by submitting all the details of the dispute in writing to escalations@bestmed.co.za.

If we approve the requested medicine and treatment on appeal, we will automatically pay for the claims from Scheme risk. If the appeal is unsuccessful, the member can lodge another formal dispute by sending an email to escalations@bestmed.co.za.

What to do if there is no available designated service provider at the time of your request

There are some cases where it is not necessary to use designated service providers, but you will still have full cover. An example of this is if a medical emergency occurs. In cases where there are no services or beds available within the designated service provider when you or one of your dependants needs treatment, you must contact us on 0800 22 0106 and we will intervene and make arrangements for an appropriate facility or healthcare provider to accommodate you.

Responsibilites

Medical Schemes

- Educate their beneficiaries about PMBs and the benefits that are included in them.
- Inform beneficiaries of their DSPs and keep them updated should any changes occur.
- Empower their beneficiaries with information on matters such as formularies and protocols for specific conditions.

Beneficiaries

- Educate yourself about your medical scheme's rules, the listed medication, and treatments (formularies) for your specific condition, as well as who the Designated Service Providers (DSPs) are.
- Don't bypass the system: if you must use a GP to refer you to a specialist, then do so. Make use of your medical scheme's DSPs as far as possible. Stick with your scheme's listed drug for your medication unless it is proven to be ineffective.

- Ask questions and follow the complaints process if you are not treated fairly.
- Make sure your doctor submits a complete account to the medical scheme. It is especially important that the correct ICD-10 code is reflected.
- Follow up and check that your account is submitted within four months and paid within 30 days after the claim was received (accounts older than four months are not paid by medical schemes).

Healthcare Providers

- Providers should submit the correct ICD-10 codes on accounts to ensure that claims are paid from the correct benefit.
- Alert patients to the fact that their condition is a PMB and encourage them to engage their medical scheme on the matter.
- Keep proper clinical records of patients so that when a formulary drug or protocol is not effective, or causes adverse side-effects, you can justify your alternative recommendation.
- Advise members on their billing practice.
- Allow their practice to be listed as a DSP.

PMB Conditions covered

The 271 Diagnosis Treatment Pairs (DTPs)

A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximately 271 PMB conditions should be treated. The list is in the form of 271 Diagnosis and Treatment Pairs (DTPs) and can be divided into 15 broad categories. See below example.

For a more detailed list, please refer to Council of Medical Schemes (CMS) website.

PMB CATEGORY	EXAMPLE
Brain and nervous system	Stroke
Eye	Glaucoma
Ear, nose, mouth and throat	Cancer of oral cavity, pharynx, nose, ear and larynx
Respiratory system	Pneumonia, COVID-19
Heart and vasculature (blood vessels)	Heart attacks
Gastro-intestinal system	Appendicitis
Liver, pancreas and spleen	Gallstones with cholecystitis
Musculoskeletal system (muscles and bones); Trauma NOS	Fracture of the hip
Skin and breast	Treatable breast cancer
Endocrine, metabolic and nutritional	Disorders of the parathyroid gland
Urinary and male genital system	End-stage kidney disease
Female reproductive system	Cancer of the cervix, ovaries, and uterus
Pregnancy and childbirth	Antenatal and obstetric care requiring hospitalisation, including delivery
Haematological, infectious and miscellaneous systemic conditions	HIV/AIDS and TB
Mental illness	Schizophrenia

		BEAT1	BEAT2	BEAT3	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM1 & 2
Number of non-CDL conditions		0	0	5	9	7	20	20	29	0
Reimbursement for CDL & PMB		100% of Scheme tariff								
Reimbursement for non-CDL		N/A	N/A	80%	90%	90%	90%	90%	100%	N/A
Non-formulary co-payment for CDL and PMB conditions		30%	30%	30%	20%	25%	20%	15%	10%	30%
Formulary co-payment for non-CDL conditions		N/A	N/A	20%	10%	10%	10%	10%	0%	N/A
Non-formulary co-payment for non-CDL conditions		N/A	N/A	30%	20%	25%	20%	15%	10%	N/A
CDL										
CDL 1	Addison disease	√	√	√	√	√	√	√	√	√
CDL 2	Asthma	√	√	√	√	√	√	√	√	√
CDL 3	Bipolar disorder	√	√	√	√	√	√	√	√	√
CDL 4	Bronchiectasis	√	√	√	√	√	√	√	√	√
CDL 5	Cardiac failure	√	√	√	√	√	√	√	√	√
CDL 6	Cardiomyopathy	√	√	√	√	√	√	√	√	√
CDL 7	Chronic obstructive pulmonary disease (COPD)	√	√	√	√	√	√	√	√	√
CDL 8	Chronic renal disease	√	√	√	√	√	√	√	√	√
CDL 9	Coronary artery disease	√	√	√	√	√	√	√	√	√
CDL 10	Crohn disease	√	√	√	√	√	√	√	√	√
CDL 11	Diabetes insipidus	√	√	√	√	√	√	√	√	√
CDL 12	Diabetes mellitus type 1	√	√	√	√	√	√	√	√	√
CDL 13	Diabetes mellitus type 2	√	√	√	√	√	√	√	√	√
CDL 14	Dysrhythmias	√	√	√	√	√	√	√	√	√
CDL 15	Epilepsy	√	√	√	√	√	√	√	√	√
CDL 16	Glaucoma	√	√	√	√	√	√	√	√	√
CDL 17	Haemophilia	√	√	√	√	√	√	√	√	√
CDL 18	HIV/AIDS	√	√	√	√	√	√	√	√	√

CLIENT SERVICES
Tel: +27 (0)86 000 2378
Email: service@bestmed.co.za
Fax: +27 (0)12 472 6500

HIV/AIDS CARE PROGRAMME
Tel: +27 (0)12 472 6235/6249
Email: mhc@bestmed.co.za
Fax: +27 (0)12 472 6780

BESTMED HIV/AIDS MANAGED CARE ORGANISATION
LIFESENSE

Tel: +27 (0)86 050 6080
Email: enquiry@lifesense.co.za
Fax: +27 (0)86 080 4960

BESTMED DSP PHARMACIES
Please refer to the Bestmed website, www.bestmed.co.za, for network pharmacies in your area.

ONCOLOGY CARE PROGRAMME
Tel: +27 (0)12 472 6254/6234/6353
Email: oncology@bestmed.co.za
Fax: +27 (0)12 472 6770

ESCALATIONS
Tel: +27 (0)86 000 2378
Email: escalations@bestmed.co.za
(Subject box: Manager, escalated query)
Postal address:
PO Box 2297,
Pretoria, Gauteng, 0001

CMS ESCALATIONS
Should an issue remain unresolved with the Scheme, members can escalate to the Registrar's office:

Fax Complaints: 086 673 2466.

Email Complaints: complaints@medicalschemes.co.za

Postal Address:
Private Bag X34, Hatfield, 0028

Physical Address:
Block A, Eco Glades 2 Office Park,
420 Witch-Hazel Avenue, Eco Park,
Centurion, 0157

REGIONAL OFFICES

Pretoria (Head Office)
Tel: +27 (0)86 000 2378
Email: service@bestmed.co.za
Glenfield Office Park,
361 Oberon Avenue,
Faerie Glen, Pretoria, 0081

Cape Town
Tel: +27 (0)21 202 8808
Email: service@bestmed.co.za
Belvedere Office Park
Suite GE003, Portion Ground Floor
Block E, Bella Rosa Street
Bellville, Cape Town, 7550

Durban
Tel: +27 (0)31 279 5420
Email: service@bestmed.co.za
Unit 8, Office 1,
Pencarrow Park,
Pencarrow Crescent,
La Lucia Ridge, 4051

Gqeberha (Port Elizabeth)
Tel: +27 (0)41 363 8921
Email: service@bestmed.co.za
Building 3, Ground Floor,
Cnr of Carnarvon Place and
Humewood Road,
Humerail, Gqeberha, 6001

Nelspruit
Tel: +27 (0)13 101 0280
Email: service@bestmed.co.za
Crossing Office Block,
Level 1, Block E,
Crossing Shopping Centre,
Nelspruit, 1200.

Polokwane
Tel: +27 (0)86 000 2378
Email: service@bestmed.co.za
Unit 2 Tobara Place,
9 Watermelon Street,
Platinum Park, Bendor,
Polokwane, 0699

086 000 2378
service@bestmed.co.za
068 376 7212
012 472 6500
www.bestmed.co.za
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HOSPITAL AUTHORISATION
Tel: 080 022 0106
Email: authorisations@bestmed.co.za

CHRONIC MEDICINE
Tel: 086 000 2378
Email: medicine@bestmed.co.za
Fax: 012 472 6760

CLAIMS
Tel: 086 000 2378
Email: service@bestmed.co.za (queries)
claims@bestmed.co.za (claim submissions)

MATERNITY CARE
Tel: 012 472 6797
Email: maternity@bestmed.co.za

WALK-IN FACILITY
Block A, Glenfield Office Park,
361 Oberon Avenue, Faerie Glen,
Pretoria, 0081, South Africa

POSTAL ADDRESS
PO Box 2297, Arcadia,
Pretoria, 0001, South Africa

NETCARE 911
Tel: 082 911
Email: customer.service@netcare.co.za (queries)

INTERNATIONAL MEDICAL TRAVEL INSURANCE (EUROP ASSISTANCE)
Tel: 0861 838 333
Claims and emergencies: assist@europassistance.co.za
Travel registrations: bestmed-assist@linkham.com

PMB
Tel: 086 000 2378
Email: pmb@bestmed.co.za

BESTMED HOTLINE, OPERATED BY KPMG
Should you be aware of any fraudulent, corrupt or unethical practices involving Bestmed, members, service providers or employees, please report this anonymously to KPMG.

Hotline:	080 111 0210 toll-free from any Telkom line
Hotfax:	080 020 0796
Hotmail:	fraud@kpmg.co.za
Postal:	KPMG Hotpost, at BNT 371, PO Box 14671, Sinoville, 0129, South Africa

For a more detailed overview of your benefit option and to receive a membership guide please contact service@bestmed.co.za

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