Guide to Prescribed Miminum Benefits (PMB) 2023

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Content

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).

1. 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 an emergency medical condition, a defined list of 271 diagnoses and a defined list of 27 chronic conditions (CDL).

Why do we have PMBs?

There are two main reasons why PMBs were created:

To ensure that medical scheme beneficiaries have continuous healthcare. 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 the 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 medical condition, also referred to as an emergency, is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical and surgical treatment, where 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.

2. 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 designated service provider (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.

3. Requirements you must meet to obtain PMB benefits

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

The requirements are:

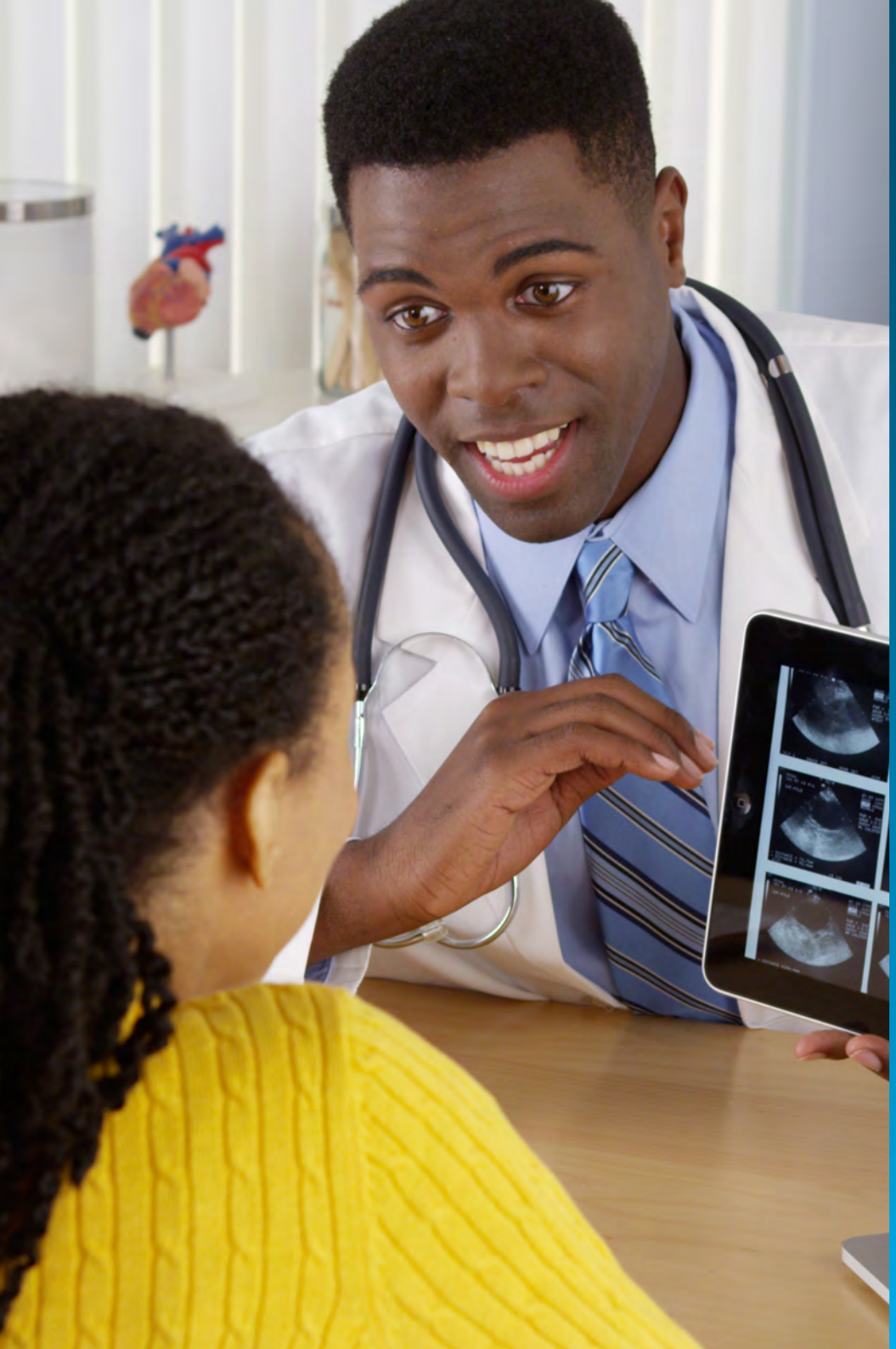
- The condition must qualify for cover in accordance with the Scheme Funding Guideline and be on the list of defined PMB conditions.
- The treatment needed must match the treatments in the published defined benefits on the PMB list.
- You must utilise services from one of the Scheme's designated service providers. 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 designated service provider hospital or facility once the provider confirms you have been sufficiently stabilised for an inter-facility transfer.
- The relevant pre-authorization 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.

Bestmed Medical Scheme plans offer benefits richer than that of the PMB and all Bestmed Medical Scheme options are enriched to cover more than the minimum benefits required by law.

4. Claims paid only as a Prescribed Minimum Benefit

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 you meet the requirements stipulated by the PMB regulations.



5. When do you not have cover for Prescribed Minimum Benefits?

There are some 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.

6. Exclusions and PMBs

Medical schemes are entitled to exclude specific services/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.

7. How to register for CDL chronic or PMB benefits

You and your dependants must register to get 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. There are different types of claims for PMBs. There are claims for 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 Bestmed tariff. If diagnosis is a listed PMB and account is shortpaid (e.g. valid emergencies, involuntary use of DSP`s) the practice/member can apply to have the shortfall on related in-hospital accounts to be covered as PMB. Contact Bestmed at 086 000 2378 relevant documents will be sent to 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 as you have 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 accordingly. 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 only 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 is approved, we will automatically pay for the approved associated blood tests and other investigative tests, treatment, medicine and consultations for that condition from the Scheme risk as a defined basket of care 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, based on clinical protocols, medicine lists (formularies) and treatment guidelines.

We will not pay for treatment or medicine that falls outside the defined benefits and that has 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.

8. 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 of 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 approve the treatment at its own discretion. If we decline the request, you may appeal this decision and lodge a formal dispute by submitting all the details of the dispute in writing to escalations@bestmed.co.za, and following the dispute process.

If we approve the requested medicine/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 e-mail 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.

9. 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.

10. 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 Website (CMS).

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

11. Chronic Disease List

Below is the list of CDL conditions that are covered as PMB.

CDL	
CDL 1	Addison's disease
CDL 2	Asthma
CDL 3	Bipolar mood 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's 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
CDL 19	Hyperlipidaemia
CDL 20	Hypertension
CDL 21	Hypothyroidism
CDL 22	Multiple sclerosis
CDL 23	Parkinson's disease
CDL 24	Rheumatoid arthritis
CDL 25	Schizophrenia
CDL 26	Systemic lupus erythematosus (SLE)
CDL 27	Ulcerative colitis

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BESTMED HIV/AIDS MANAGED CARE ORGANISATION

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

ONCOLOGY CARE PROGRAMME
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Fax: +27 (0)12 472 6770

COMPLAINTS
Tel: +27 (0)86 000 2378
E-mail: escalations@bestmed.co.za or Elmarie.Jooste@bestmed.co.za
(Subject box: Manager, escalated query)
Postal address: PO Box 2297, Pretoria, Gauteng, 0001

086 000 2378

service@bestmed.co.za

060 015 7696

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www.bestmed.co.za

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HOSPITAL AUTHORISATION
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E-mail: authorisations@bestmed.co.za

CHRONIC MEDICINE
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E-mail: medicine@bestmed.co.za
Fax: 012 472 6760

CLAIMS
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E-mail: service@bestmed.co.za (queries)
claims@bestmed.co.za (claim submissions)

MATERNITY CARE
Tel: 012 472 6797
E-mail: maternity@bestmed.co.za

WALK-IN FACILITY
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361 Oberon Avenue, Faerie Glen,
Pretoria, 0081, South Africa

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

ER24
Tel: 084 124

INTERNATIONAL 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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