Guide to Prescribed Minimum Benefits **2021**

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Contents

This document will take you through you 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 270 diagnoses and a defined list of 26 chronic conditions.

To access Prescribed Minimum Benefits, there are rules that apply:

- Your medical condition must be part of the defined list of PMB conditions and fall within the clinical parameters linked to that condition.
- The treatment needed must match the treatments in the defined benefits.
- You must use designated service providers (DSPs) in the Scheme's network. 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 hospital or other service providers in our network, once your condition has stabilised.

If your treatment does not meet the above criteria, we will fund treatment and/or services at Bestmed Scheme tariffs. In this scenario, you will be responsible for the difference between what we fund and the actual cost of your treatment. Please refer to the Council for Medical Schemes' (CMS) website for a full list of the diagnoses and Chronic Disease List conditions.

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 pays claims for PMBs and non-PMB benefits?

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.

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.

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.

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. How to register for 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>Menu>Plans>Forms. 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.

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.

What happens if you do not register your condition as a PMB or chronic condition?

If you are diagnosed with a PMB or CDL condition but do not register for these benefits, the consultations, blood tests, other investigative tests, medicine, and treatment for that PMB or chronic condition will be paid from your available day-to-day or savings benefits or from your own account.

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 day-to-day benefits or 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.

7. 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 a 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.

8. Getting pre-authorisation for hospitalisation

What is pre-authorisation and what does it mean?

Pre-authorisation is the approval of certain procedures and any planned admission to a hospital and should occur before the procedure or admission takes place. The pre-authorisation that is generated in this way contains details of the associated treatment or procedures that will be covered during the hospitalisation period.

All hospital and hospital-related benefits are subject to pre-authorisation. Services that fall under major medical expenses which require pre-authorisation are indicated in the Scheme rules, on the Bestmed website and are also detailed in your individual option brochure.

Comprehensive benefits are offered for all specified pre-authorised procedures and authorised emergency services rendered during hospitalisation, i.e. from the day of admission up to and including the day of discharge.

No benefits in a private hospital or day clinic shall be granted by the Scheme if pre-authorisation and an authorisation number have not been obtained in advance:

- In the event of planned major operations and dental procedures at least 14 (fourteen) days before the event or shorter period where clinically indicated.

OR

- In an emergency, on the first working day after admission to a hospital, or at the first reasonable opportunity as may be determined by the Scheme.

If a member or their dependant(s) receive treatment in a private hospital or day clinic without first obtaining pre-authorisation and an authorisation number due to either prior application not being made or because a prior application was refused, a R500 surcharge per admission may be imposed whenever an application is approved with retrospective effect.

If pre-authorisation and an authorisation number have been obtained for treatment in a private hospital or day clinic but the treatment cost exceeds the authorised benefits, only the authorised treatment cost shall be granted and the member shall be liable for payment of the excess amount to the service provider. The only exception to this is if the excess costs were as a direct result of accepted clinically necessary treatment received under circumstances where an authorisation could not be obtained in time.

Specific services, such as scans and MRIs, each require their own authorisation. No benefits, in respect of MRI scans and computer tomographic studies, shall be granted by the Scheme or its proxy if an authorisation number has not been obtained in advance or on the first working day after admission to a hospital in the case of an emergency,.

Who must you contact for pre-authorisation?

Contact Bestmed on 08000 22 0106 or authorisations@bestmed.co.za to apply for pre-authorisation. Once approved, an authorisation number will be generated by the Scheme and provided to the member or dependant. Please give this authorisation number to the relevant healthcare provider and ask them to include it when they submit their claim. The authorisation number will also be provided to relevant providers, such as the respective hospital and treating doctor.

We will ask for the following information when you request pre-authorisation:

- Your membership number.
- Details of the patient (name and surname, ID number, and more).
- Reason for the procedure or hospitalisation.
- Diagnostic codes (ICD-10 codes), tariff codes and procedure codes if necessary (you must get these from your treating doctor).

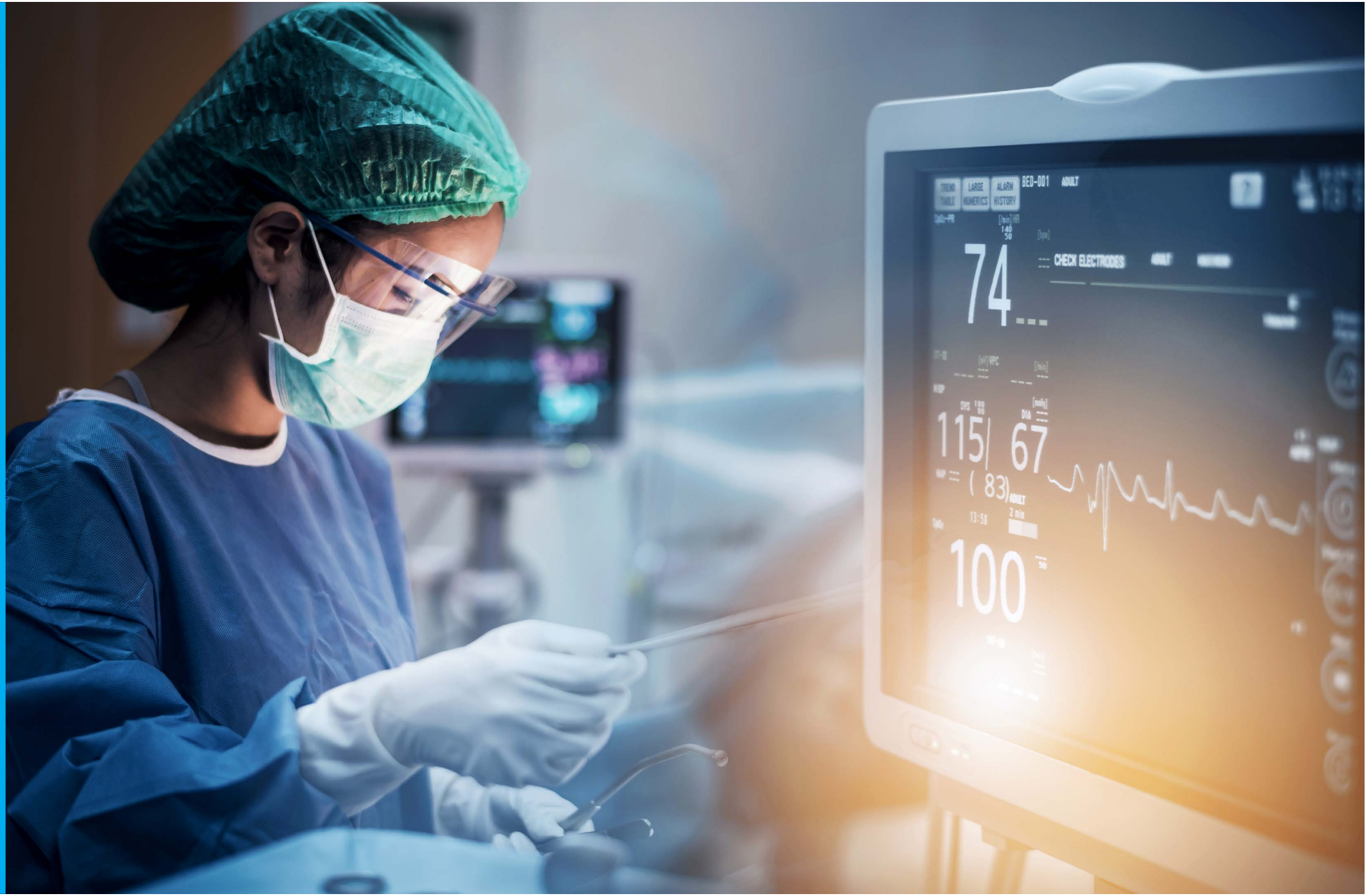
Your hospital cover is made up of the following:

- Cover for the account from the hospital (the ward and theatre fees) at the Bestmed Scheme tariff.
- Cover for the accounts from your treating healthcare professionals (such as the admitting doctor, anaesthetist and any approved healthcare in-hospital expenses like radiology or pathology), which are separate from the hospital account and are called related accounts.

Remember: Limits, clinical guidelines and policies apply to some in-hospital healthcare services and procedures, and there are some expenses, that you may incur while you are in hospital, that Bestmed or your selected Bestmed option does not cover. There are also certain procedures, medicines or new technologies that may require separate approval. Please discuss this with your doctor or the hospital.

Please note that obtaining pre-authorisation does not guarantee the payment of any and all claims. Please make sure that you understand all the information included in the authorisation communication and how we will pay for the claims.

Bestmed Medical Scheme is regulated by the Council for Medical Schemes. You may contact the Council at any stage of the complaints process, but we encourage you to follow the steps above first to resolve your complaint before contacting the Council. Contact details for the Council for Medical Schemes: Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion 0157 | complaints@medicalschemes.com | 0861 123 267 | www.medicalschemes.com.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ADULT
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74
115
67
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012 472 6500

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HOSPITAL AUTHORISATION
Tel: 080 022 0106
E-mail: authorisations@bestmed.co.za

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

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

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

INTERNATIONAL TRAVEL INSURANCE (BRYTE INSURANCE)
Tel: 0860 329 329 (RSA only) during office hours / 084 124 after hours
E-mail: er24@brytesa.com
Claims: travelclaims@brytesa.com

TEMPO WELLNESS PROGRAMME
Tel: 086 000 2378
E-mail: tempo@bestmed.co.za
Fax: 012 472 6760
www.bestmed.co.za/wellness

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

ER24
Tel: 084 124

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.

Bestmed Guide to Prescribed Minimum Benefits 2021 A4. This brochure was updated in September 2020. For the most recent version please visit our website at www.bestmed.co.za.

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