Prescribed Minimum Benefits

2013
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No matter what plan or medical scheme you decide on, there are some common benefits that apply to all members on all plans. In terms of the Medical Schemes Act and its regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of any life-threatening emergency medical condition, a defined set of 270 diagnoses as well as 27 chronic conditions. These conditions and their treatments are known as the Prescribed Minimum Benefits (PMB).

This document tells you about how Altron Medical Aid covers each of its members for the prescribed list of conditions known as the Prescribed Minimum Benefits. Read further to understand what the Prescribed Minimum Benefits mean and how to get the most out of your benefits.

Understanding some of the terms we use in this document

There are a number of terms we use in this document that you may not be sure what they mean. Here are the terms with their meanings:

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tr>
<td>Prescribed Minimum Benefits (PMBs)</td>
<td>A set of minimum benefits that, by law, must be provided to all medical scheme members. The cover it gives includes the diagnosis, treatment and cost of ongoing care for a list of conditions.</td>
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<td>Shortfall</td>
<td>Altron Medical Aid pays service providers at a set rate, the Scheme Rate, if the service providers charge higher fees than this rate; the member will have to pay the outstanding amount from his or her pocket.</td>
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<td>Waiting period</td>
<td>A waiting period can be general or condition-specific and means that the member has to wait for a set time before he or she can benefit from his or her chosen plan’s cover.</td>
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Understanding the Prescribed Minimum Benefits and why it was created

The Prescribed Minimum Benefits are guided by a set list of medical conditions as defined in the Medical Schemes Act of 1998. These conditions include any life-threatening emergency, 270 defined diagnoses and their associated treatments as well as 27 chronic conditions. All medical schemes in South Africa have to include the Prescribed Minimum Benefits in the health plans they offer to their members. There are, however, certain requirements that a member must meet before he or she can benefit from the Prescribed Minimum Benefits. The three requirements are:

1. The condition must be part of the list of defined PMB conditions
2. The treatment needed must match the treatments in the defined benefits
3. Members must use the scheme’s designated healthcare service providers

All life threatening emergency medical conditions, 270 illnesses and 27 chronic conditions qualify for Prescribed Minimum Benefit as defined by the Medical Schemes Act of 1998
The Altron Medical Aid’s plans offer benefits far richer than that of the Prescribed Minimum Benefits

Altron Medical Aid’s plans are structured in such a way as to maximise cover and cover more than just the minimum benefits required by law.

There are a few instances when Altron Medical Aid will only pay a claim as a Prescribed Minimum Benefit. This happens when a member is in a waiting period or when a member has treatments linked to conditions that are excluded by their plan. Altron Medical Aid also pays day-to-day claims automatically from available benefits. In all of the above mentioned instances, you could still have cover in full, provided the three requirements as described above, stipulated by the Prescribed Minimum Benefit regulations are met.

More about meeting the Prescribed Minimum Benefit requirements

The medical condition must be part of the list of defined conditions for Prescribed Minimum Benefits

Medical scheme members can benefit from the Prescribed Minimum Benefits if they can provide the medical scheme with enough diagnostic information so that the condition can be identified, and the scheme can determine if the severity of the condition qualifies for the treatment requested.

Members may need to send Altron Medical Aid the results of their medical tests and investigations that confirm the diagnosis of the condition. This will allow Altron Medical Aid to identify that the member’s condition qualifies for the treatment. The member’s treating doctor needs to provide the relevant documentation to assist Altron Medical Aid in confirming the diagnosis.

The treatment needed must match the treatments included in the defined benefits

There are standard treatments, procedures, investigations and consultations for each condition on the Prescribed Minimum Benefit list. These defined benefits are supported by thoroughly-researched evidence, based on clinical protocols, medicine list (formularies) and treatment guidelines. The medical scheme is only required to provide cover for the treatments, procedures, investigations and consultations that is given for each specific condition on the list. If a member needs treatment that is not on the list and sends a clinical motivation that thoroughly explains why the treatment is needed, the scheme will review it and may choose to approve the treatment if necessary. If the appeal is declined the member may contact us if they would like to lodge a formal dispute.

Altron Medical Aid pays for specific healthcare services related to each of our members’ approved conditions, such as consultations, blood tests and other investigative tests, without lessening our members’ day-to-day benefits. We will inform our members of their entitlement to Prescribed Minimum Benefits when their condition and treatment has been approved.

How we cover medicine for the 27 chronic conditions

We pay medicine on the medicine list (formulary) up to the Scheme Rate for medicines. There will be no co-payment for medicine selected from the medicine list.

We pay medicines not on the medicine list up to the Chronic Drug Amount (CDA), which is the monthly amount we pay up to for a specific medicine class. The member may have a co-payment if the cost of the medicine is greater than the Chronic Drug Amount.
Using the scheme’s designated healthcare service providers

Medical schemes must ensure that their members do not experience shortfalls when their members make use of the scheme's designated service providers. Members of the Altron Medical Aid should use doctors, specialists or other healthcare providers the Scheme has an agreement with, so that they do not experience a shortfall.

Members can use our MaPS Advisor on www.altronmedicalaid.co.za or call us on 0860 222 999 to find healthcare service providers where you won’t have any shortfalls.

There are some cases where it is not necessary to meet these requirements, but you will still have full cover. An example of this is in a life-threatening emergency.

How Altron Medical Aid manages the different types of claims under Prescribed Minimum Benefits

There are different types of claims for Prescribed Minimum Benefits (PMB), such as claims for hospital admissions, chronic conditions and other conditions treated out-of-hospital, listed under the Prescribed Minimum Benefits. In most cases, Discovery Health automatically recognises that the member claiming for these medical services is entitled to cover under the Prescribed Minimum Benefits.

There are, however, times when a member needs to apply for cover under the Prescribed Minimum Benefits. Once the diagnosis is confirmed a healthcare professional as a PMB condition, the member can apply for cover.

We require a clinical motivation from the member’s healthcare professional for requests for funding of any treatment that falls outside the standard treatment for the condition requires a clinical motivation from the member’s healthcare professional. If a treatment that falls outside the defined benefits is not approved, it will be paid for from the available benefits according to the member’s chosen health plan. If the member’s health plan does not cover these expenses, the member will be responsible to pay the unpaid claims.

When the Prescribed Minimum Benefits don’t apply

There are some circumstances in which members do not have cover for the Prescribed Minimum Benefits by their medical scheme. This can happen when a person joins a medical scheme for the first time, with no medical scheme membership before that. This can also happen if someone joins a medical scheme more than 90 days after leaving his or her previous medical scheme. In both these cases, the medical scheme would impose a waiting period, during which these members will not have access to the Prescribed Minimum Benefits, no matter what conditions they might have.

The process to apply for PMB cover

If a member wants to apply for out of hospital PMB cover, he or she should:

1. Download and print a PMB application form, available on www.altronmedicalaid.co.za
2. Complete the application form with the assistance of his or her doctor
3. Send the completed, signed application form, along with any additional medical information, by email to PMB_APP_FORMS@discovery.co.za or by fax 011 539 2780
4. Once we receive the application and it meets the PMB requirements, we will automatically pay the associated investigations,
5. If a member wants to apply for in-hospital PMB cover, he or she should call us on 0860 222 999 to request an authorisation.