

WE'RE
IN IT FOR
YOUR
HEALTH



Guide to Prescribed Minimum Benefits 2016

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as "the Administrator"), is a separate company who is registered as an authorised financial services provider (registration number 1997/013480/07), administers LA Health Medical Scheme.

Contact us

You can call us on **0860 103 933** or visit www.lahealth.co.za for more information.



This document tells you how LA Health covers a list of conditions called Prescribed Minimum Benefits (PMBs).

About some of the terms we use in this document

There are a number of terms we refer to in the document that you may not be familiar with. We give you the meaning of these terms.

Terminology	Description
Prescribed Minimum Benefits (PMBs)	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.
Shortfall	LA Health pays service providers at a set rate, the LA Health Rate. If the service providers charge higher fees than this Rate, you will have to pay the shortfall amount from his or her pocket.
Waiting period	A waiting period can be general or condition-specific and means you have to wait for a set time before you can benefit from your chosen benefit option's cover.
Chronic Drug Amount (CDA)	The CDA is a maximum monthly amount we pay up to for a medicine class for a specific condition. This applies to medicine that is not listed on the medicine list (formulary). The Chronic Drug Amount includes VAT and the dispensing fee.
Diagnostic Treatment Pairs Prescribed Minimum Benefit (DTPPMB)	Links a specific diagnosis to a treatment and broadly indicates how each of the PMB conditions should be treated.
Designated Service Provider	A healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have an agreement with to provide treatment or services at a contracted or negotiated rate.



Understanding the Prescribed Minimum Benefit

What are Prescribed Minimum Benefits (PMBs)?

They are a set of minimum benefits that medical schemes must give to all their members – according to the law [Medical Schemes Act of 1998 (Act number 131 of 1998)]. The cover it gives includes the diagnosis, treatment and cost of ongoing care for:

- 01 | Any life threatening emergency
- 02 | A defined set of 270 diagnoses
- 03 | 27 chronic conditions.

All medical schemes in South Africa have to include the Prescribed Minimum Benefits in the benefit options they offer to their members.

How does LA Health pay claims for PMBs and non-PMB benefits?

We cover PMBs in full from Risk benefits provided you receive treatment from a designated service provider (DSP). Treatment received from a non-DSP may be subject to a co-payment if the provider charges more than we pay. Non-PMB benefits are paid from your day-to-day benefits in accordance with your chosen benefit option.

Requirements you must meet to benefit from PMBs

There are certain requirements before you can benefit from the Prescribed Minimum Benefits. The requirements are:

1. The condition must be on the list of defined PMB conditions
2. The treatment needed must match the treatments in the defined benefits on the PMB list
3. You must use the Scheme's DSPs unless there is no DSP close to your home or usual workplace.

What are Designated Service Providers (DSPs)?

A designated service provider (DSP) is a healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have an agreement with. According to this agreement they will give you treatment or services at a contracted or negotiated rate. This is to make sure you do not have any co-payments when you use their services. For a full list of our DSPs, go to www.lahealth.co.za

You and your dependants must register to get cover for PMBs and Chronic Disease List (CDL) conditions

How to register your chronic or PMB conditions to get cover from the risk benefits

If you want to apply for out-of-hospital Prescribed Minimum Benefits or cover for a chronic condition, you must get a Prescribed Minimum Benefit or a Chronic Illness Benefit Application form:

- Both forms are available to download and print from www.lahealth.co.za. Log on to the website using your username and password. Go to “Find a document” and click on “application forms”.
- You can also call 0860 103 933 to request any of the above forms.



Once we receive the application form, and it meets the Prescribed Minimum Benefit requirements, the Scheme will pay for associated, approved investigations, treatment and consultations for that condition from risk benefits (not from your day-to-day benefits). We will also let you know about the outcome of the application.

If you want to apply for in-hospital Prescribed Minimum Benefit cover, you must call us on 0860 103 933 to request authorisation.

[We have explained what PMBs are, but what are Chronic Disease List conditions](#)

This is a list of chronic conditions covered on all benefit options that are defined in the Prescribed Minimum Benefit legislation.

[Why it is important for you and your dependents to register your PMB or chronic conditions](#)

LA Health pays for specific healthcare services related to each of your approved conditions. These services include consultations, blood tests and other investigative tests. The Scheme pays for the services so your day-to-day benefits are not affected.

Treatment that falls outside the defined benefits and is not approved, will be paid from your available benefits according to your chosen benefit option. If your Option does not cover these expenses, you will have to pay the claims.

There are different types of claims for Prescribed Minimum Benefits. There are claims for hospital admissions, chronic conditions and other conditions treated out of hospital.

There are times when you need to apply for cover under the Prescribed Minimum Benefits. Once your healthcare professional confirms the diagnosis as a Prescribed Minimum Benefit condition, you can apply for the Scheme to pay the claims from risk benefits without using your day-to-day cover. Once approved, we will automatically recognise that the medical services you are claiming for falls under the Prescribed Minimum Benefits.

[What happens when your condition is not registered as a PMB or chronic condition](#)

We will pay all the consultations, blood tests, other investigative tests, medicine and other treatment for the PMB or chronic condition from your day-to-day benefits.

[Who must register to receive chronic medicine for their PMB or chronic conditions](#)

Each of the beneficiaries on your membership who has been diagnosed with a PMB or chronic condition must register. Each beneficiary must register their specific conditions. You only have to register once for a chronic condition. If your medicine or other treatment changes, your healthcare professional can just let us know about the changes.

If you are diagnosed with another chronic or PMB condition, you have to register for the new condition before we will cover the treatment and consultations from the risk benefits and not from your day-to-day benefits.



Who must complete and sign the registration form when applying for chronic medicine

You, or your dependant, with the PMB or chronic condition, can complete the application form with the help of the treating healthcare professional.

Additional documents needed to support the application

You may need to send LA Health the results of the medical tests and investigations that confirm the diagnosis of the condition. This will help us to identify that your condition qualifies for the treatment. We need additional clinical information from your doctor if you request funding of any treatment that falls outside the standard treatment for the condition. If treatment that falls outside the defined benefits is not approved, it will be paid from your available day-to-day benefits according to your chosen benefit option. If your benefit option does not cover these expenses, you will be responsible to pay the claims.

Where you must send the completed form

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

- By fax to: 011 539 2780
- By email to: **PMB_APP_FORMS@discovery.co.za**
- By post to: LA Health Medical Scheme, PMB Department, PO Box 652919, Benmore, 2010.

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

- By fax to: 011 539 7000
- By email to: **CIB_APP_FORMS@discovery.co.za**
- By post to: LA Health Medical Scheme, CIB Department, PO Box 652919, Benmore, 2010.

We will let you know if we approve your application and what you must do next

We will inform you of your entitlement to PMBs when your condition and treatment has been approved. We will do this by fax or email (as you indicated on your application form).

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.

What happens if there is a change in your treatment

Your treating healthcare professional can call 0860 44 55 66 to register changes to your medicine for an approved condition. You only need to complete an application form when applying for a new PMB or chronic condition.

How to get your medicine from the appropriate designated service provider

We include this information in the decision letter that we send when we approve the application.

What happens if a healthcare professional changes you or your dependent's medicine in the middle of the month

For chronic conditions, the treating healthcare professional or dispensing pharmacist can make changes to medicines telephonically. You can also send an updated prescription by fax to 011 539 7000 or email it to **CIB_APP_FORMS@discovery.co.za**



For PMB conditions the treating healthcare professional or dispensing pharmacist can make changes to medicines by sending the updated prescription by fax to 011 539 2780 or email it to

PMB_APP_FORMS@discovery.co.za

What happens if you get your medicine from a provider of your choice instead of the Scheme's DSP

LA Health ensures its members do not experience co-payments when they use DSPs. You must use doctors, specialists or other healthcare providers who are the Scheme's DSPs, so you do not experience a co-payment.

If you do not use a healthcare provider who is one of the Scheme's DSPs, and your provider charges more than the LA Health Rate, you will have to pay part of the treatment costs yourself. Contact us for the latest copy of the treatment guidelines or go to www.lahealth.co.za

What are co-payments

LA Health pays service providers at a set rate – the LA Health Rate. If the service provider charges above this rate, you will have to pay the shortfall amount from your pocket. This amount you have to pay is called a co-payment.

What is a waiting period

A waiting period can be general or condition-specific and means you have to wait for a set time before you can claim from your chosen Option's cover.

What happens when you use medicine that is not on the formulary list for your particular benefit option

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

If we approve a medicine that is not on the medicine list, we will pay it up to a Chronic Drug Amount (CDA) for that condition. You may have a co-payment if the medicine you use to treat the condition cost more than the Chronic Drug Amount.

If the medicine that is not on the Scheme's list is a substitute for one that has been ineffective or has caused an adverse reaction you and your doctor can appeal, and if the appeal is successful there will be no co-payment.

The Chronic Drug Amount does not apply to the LA KeyPlus Option.

What happens when you need treatment that is not on the list

The Scheme is only required to cover the treatments, procedures, investigations and consultations that is given for each specific condition on the list. If you need treatment that is not on the list and you send additional clinical information that thoroughly explains why you need the treatment, the Scheme will review it and may choose to approve the treatment. If we decline the appeal, you may contact us to lodge a formal dispute.



Can you get benefits for more than one month's supply of medicine

Members can get more than a month's supply of approved chronic medicine in the case where they are travelling outside the borders of South Africa. You need to complete an Extended Supply of Medicine Form that you can find on www.lahealth.co.za

Our list of designated service providers

You can use MaPS Advisor on www.lahealth.co.za or call us on 0860 103 933 to find a healthcare provider who is on the Scheme's list of DSPs.

What we will cover if you do not use the DSP or treatment we will approve for the condition

We pay for treatment and services up to the LA Health Rate. If you do not use a DSP, you may have co-payments for services and treatment you receive.

What to do if a DSP is not available at the time of your request

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

In cases where there are no services or beds available from the DSP when you, or one of your dependants needs treatment, you must contact us on 0860 103 933. We will intervene and make arrangements for an appropriate facility or healthcare provider to accommodate you.

Changes on the formulary list

Because there are regular changes to our formulary list, we only inform affected members of the changes. This means we will only communicate changes to the formulary medicine to patients when the cover for their current medicine will change or when we will no longer cover that specific medicine.

Get preauthorisation for hospitalisation and other procedures

What preauthorisation is and what it means

Preauthorisation is the approval of certain procedures and any planned admission to a hospital before the procedure or admission takes place. It includes approval for associated treatment or procedures performed during hospitalisation.

You also need specific preauthorisation for MRI and CT scans, radio-isotope studies, and for certain endoscopic procedures, whether during hospitalisation, or not.

Whenever your doctor plans a hospital admission for you, you must let us know 48 hours before you go to hospital.

You can use HospitalXpress to plan and preauthorise most admissions and to find out how we will pay for your hospital stay.

Please note: If you don't preauthorise your admission, we will only pay 70% of the costs we would normally cover.

Certain benefit options give full cover only if you use a network hospital. Please find out if the hospital you plan to use, is part of the network applicable to your Option.



Preauthorisation does not guarantee payment of all claims

Your hospital cover is made up of:

- Cover for the account from the hospital (the ward and theatre fees), which we cover at the rate agreed with the hospital. If you are a LA Focus or LA KeyPlus member, you must use the services of a hospital in the Scheme's network of hospitals to have full cover.
- Cover for the accounts from your treating healthcare professionals (such as the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology), called related accounts, are covered in line with the specific benefits allowed by your Option. In some instances these benefits are limited, even if you use a DSP.

Remember: Limits, clinical guidelines and policies apply to some healthcare services and procedures performed in hospital.

There are some expenses you may incur while you are in hospital that we don't cover. Certain procedures, medicines or new technologies need separate approval. Please discuss this with your healthcare professional or the hospital.

Find out more about the Scheme's clinical rules and policies for cover by contacting us on 0860 103 933 or log in to our website to view "what we cover".

Benefits that require preauthorisation

You need to get preauthorisation from us for:

- Hospitalisation
- Day-clinic admissions
- Special procedures (like a scopes, MRI and CT scans).

Who you must contact

Call us on 0860 103 933 to get preauthorisation. We will give you an authorisation number. Please give the authorisation number to the relevant healthcare provider and ask them to include it when they submit a claim.

You can also use HospitalXpress to plan and preauthorise most admissions and to read the important information that tells you how we will pay for your hospital stay.

Please make sure you understand what is included in the authorisation and how we will pay the claim.

We will ask for the following information when you request preauthorisation:

- 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 (you must get these from your treating healthcare professional).



What happens once you are admitted to hospital

We only pay medically appropriate claims. Your cover is subject to LA Health's Rules, payment guidelines and clinical rules. There are some expenses you may have in hospital, as part of a planned admission, which your Hospital Benefit does not cover. Certain procedures, medicines and new technologies need separate approval. It is important that you discuss this with your healthcare professional or the hospital.

LA Health Medical Scheme offers benefits that are far richer than that of the Prescribed Minimum Benefits

All the LA Health benefit options cover more than just the minimum benefits required by law. Some Options cost more, but offer more comprehensive benefits, while others have lower contributions with lesser benefits.

Sometimes LA Health will only pay a claim as a Prescribed Minimum Benefit

This happens when you are in a waiting period or when you have treatments linked to conditions that are excluded by your Option. But you can still have cover in full, if you meet the requirements stipulated by the Prescribed Minimum Benefit regulations.

Instances where you do not have cover under Prescribed Minimum Benefits

Sometimes you do not have cover for the Prescribed Minimum Benefits. This can happen when you join the Scheme with no medical scheme membership before that.

It can also happen when you join the 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 dependents will not have access to the Prescribed Minimum Benefits, no matter what conditions you might have.

Complaints process

You may lodge a complaint or query with LA Health Medical Scheme directly on 0860 103 933 address a complaint in writing to the Principal Officer at the Scheme's registered address. Should your complaint remain unresolved, you may lodge a formal dispute by following the LA Health Medical Scheme internal disputes process.

You may, as a last resort, approach the Council for Medical Schemes for assistance.

Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 / 0861 123 267 / complaints@medicalschemes.com / www.medicalschemes.com

