2022

LA HEALTH MEDICAL SCHEME

GUIDE TO PRESCRIBED MINIMUM BENEFITS FOR IN-HOSPITAL TREATMENT

Overview

In terms of the Medical Schemes Act No. 131 of 1998, Prescribed Minimum Benefits (PMBs) are a set of defined benefits that all registered medical schemes in South Africa are obliged to provide for all their members. All members have access to these benefits, irrespective of their chosen option type. Prescribed Minimum Benefits (PMBs) ensure that all medical scheme members have access to continuous care to improve their health.

LA Health Medical Scheme , ("The Scheme"), options are structured in such a way that the member's chosen health option provides comprehensive cover. Some options cost more but offer more comprehensive cover, while others have lower contributions with fewer benefits. Irrespective of this, all our options cover more than just the minimum benefits required by law. Always consult your Health Guide to see how you are covered.

This document tells you how the Scheme covers the Prescribed Minimum Benefits (PMBs) for in-hospital treatment. Please refer to the Prescribed Minimum Benefit (PMB) guide on www.lahealth.co.za under Medical Aid > Manage your health option > Find important documents and certificates for more details about Prescribed Minimum Benefits (PMBs) and how they are covered.

About some of the terms we use in this document

There may be some terms we refer to in this document that you may not be familiar with. Here are the meanings of these terms.

TERMINOLOGY	DESCRIPTION
Co-payment	This is an amount that you need to pay towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service or if the amount the service provider charges is higher than the rate we cover. If the co-payment amount is higher than the amount charged for the healthcare service, you will have to pay for the cost of the healthcare service.
Day-to-day benefits	These are the available funds allocated to the Medical Savings Account (MSA), Extended Day-to-day benefit and Above Threshold Benefit. Depending on the option you choose, you may have cover for a defined set of day-to-day benefits. The level of day-to-day benefits depends on the option you choose.
Designated service provider (DSP)	A healthcare provider (for example doctor, specialist, allied healthcare professional, pharmacist or hospital), who we have an agreement with, to provide treatment or services at a contracted rate. Visit www.lahealth.co.za to view the full list of designated service providers (DSPs).
Scheme Rate (SR)	This is a rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health service.
Scheme Rate (SR) for Medicine	This is the rate at which LA Health Medical Scheme will pay for medicine. It is the Single Exit Price of medicine plus the relevant dispensing fee.
ICD-10 code	A clinical code that describes diseases and signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO).
Member	The reference to member in this document also includes dependants, where applicable.
Major Medical Benefit (MMB)	This is a Risk funding basket that covers in-hospital treatment and other major medical expenses.

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. We may ask you for additional information to confirm the emergency.
Related accounts	Any account other than the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology.

What is a Prescribed Minimum Benefit (PMB)?

Prescribed Minimum Benefits (PMBs) are guided by a list of medical conditions as defined in the Medical Schemes Act 131 of 1998

According to the Medical Schemes Act 131 of 1998 and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

1 | Any life-threatening emergency medical condition
2 | A defined set of 270 diagnostic treatment pairs
3 | 27 chronic conditions (Chronic Disease List conditions).

Please refer to the Council for Medical Schemes website www.medicalschemes.co.za for a full list of the 270 diagnostic treatment pairs. All medical schemes in South Africa have to include the Prescribed Minimum Benefits (PMBs) in the options they offer to their members.

Requirements you must meet to benefit from Prescribed Minimum Benefits (PMBs)

There are certain requirements before you can benefit from Prescribed Minimum Benefits (PMBs). The requirements are:

4 | The condition must qualify for cover and be on the list of defined Prescribed Minimum Benefit (PMB) conditions.
5 | The treatment needed must match the treatments in the defined benefits on the Prescribed Minimum Benefit (PMB) list.
6 | You must use the Scheme's designated service providers (DSPs) for full cover unless there is no designated service provider (DSP) applicable to your chosen health option.

If you do not use a designated service provider (DSP) we will pay up to 80% of the Scheme Rate (SR). You will be responsible for the difference between what we pay and the actual cost of your treatment. This does not apply in emergencies. However, even in these cases, where appropriate and according to Scheme Rules, you may be transferred to a hospital or other service providers in our network once your condition has stabilised, to avoid co-payments. If your treatment doesn't meet the above criteria, we will pay according to your health option benefits.

Important to note

- Prescribed Minimum Benefit (PMB) regulations and their accompanying provisions do not apply to healthcare services obtained outside the borders of South Africa.
- Prescribed Minimum Benefit (PMB) related claims for services obtained outside the borders of South Africa shall be treated as in accordance with your chosen health option benefits, subject to the relevant Scheme Rate and any other limitations applicable to your benefits within the borders of South Africa.

There are a few instances where you will only have Prescribed Minimum Benefit (PMB) cover

This happens when you have a waiting period or when you have treatments linked to conditions that are excluded by your health option. This can be a three-month general waiting period or a 12-month condition-specific waiting period. Depending on the category of waiting periods, you may still qualify for cover from the Prescribed Minimum Benefits.

There are some circumstances where you do not have cover for Prescribed Minimum Benefit (PMBs)

This can happen when you join a medical scheme for the first time, with no medical scheme membership before that. Also if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme could impose waiting periods, during which you and your dependants will not have access to the Prescribed Minimum Benefit (PMBs), regardless of the conditions you may have. We will communicate with you at the time of applying for membership, if waiting periods apply.

How we pay for In-Hospital Prescribed Minimum Benefits (PMBs)

We pay for confirmed Prescribed Minimum Benefits (PMBs) in full if you receive treatment from a designated service provider (DSP) and/or preferred supplier. Treatment received from a non-designated service provider (non-DSP) or medical items from a supplier who is not a preferred supplier may be subject to a co-payment if the healthcare provider or supplier charges more than the amount we pay.

There are some instances when you will still have full cover if you use a healthcare provider who we do not have a designated service provider (DSP) arrangement with:

- The in hospital event was an emergency.
- The use of a non-DSP was involuntary.
- There is no DSP available at the time of the event.

We may require additional supporting documents to confirm cover as a Prescribed Minimum Benefit (PMB). Documents may be requested confirming your Prescribed Minimum Benefit (PMB) diagnosis, for example Magnetic Resonance Imaging (MRI) scans and endoscopic procedure reports.

In cases where there are no services or beds available at a designated service provider (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.

We pay for benefits not included in the Prescribed Minimum Benefits (PMBs) from your appropriate and available Hospital Benefit and/or day-to-day benefits, according to the rules of your chosen health option.

Using the designated healthcare service providers

You must use healthcare providers who we have a payment arrangement with so that you do not experience co-payments. In an emergency, you can go directly to hospital and notify the Scheme of your admission as soon as possible. In the case of an emergency, members are covered in full for the first 24 hours or until you are stable enough to be transferred.

You can use **Find a healthcare provider** on www.lahealth.co.za to find designated service providers (DSPs) who we have a payment arrangement with, for your specific health option. Some examples of designated service providers (DSPs) when admitted to hospital, include hospitals, specialists, GPs, psychologists and social workers.

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 planned admission takes place. It includes associated treatment or procedures performed during hospitalisation. Whenever your doctor plans a hospital or day-clinic admission for you, you must let us know at least 48 hours before you go to the hospital or day-clinic.

You also need specific preauthorisation for Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans, radio-isotope studies, and for certain endoscopic procedures, whether done in hospital or not.

In an emergency you must go directly to a hospital and notify the Scheme as soon as possible of your admission. In the case of an emergency, you are covered in full for the first 24 hours or until you are stable enough to be transferred.

Contact us for preauthorisation

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 this when they submit their claims. Please make sure you understand what is included in the authorisation and how we will pay your claims.

We will ask for the following information when you request preauthorisation

- Your membership number
- Details of the patient (name and surname, ID number, and other relevant information)
- Date and time of the admission
- Practice number for the hospital or day clinic, and admitting doctor
- Reason for the procedure or hospitalisation
- Diagnostic codes (ICD-10 codes), tariff codes and procedure codes (you must get these from your treating doctor).

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

Preauthorisation does not guarantee payment of all claims

Your hospital cover

Your hospital cover includes:

- Cover for the **account from the hospital** which includes the ward and theatre fees
- Cover for the accounts from your treating healthcare professionals such as the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology, which are separate from the hospital account and are called **related accounts**.

There are some expenses you may have in hospital as part of a planned admission that your Hospital Benefit does not cover, for example certain procedures, medicine and new technologies, which may need separate approval. It is important that you discuss

this with your healthcare professional. Please take note that benefit limits, Scheme rules, treatment guidelines and managed care criteria may apply to some healthcare services and procedures in hospital. Find out more about these by contacting us on 0860 103 933 or visit www.lahealth.co.za under Medical Aid > Benefits and cover > Do we cover for more information on how you will be covered.

Contact us

Tel (members): 0860 103 933 or visit www.lahealth.co.za for more information.

PO Box 784262, Sandton, 2146. 1 Discovery Place, Sandton, 2196.

Complaints process

LA Health Medical Scheme is committed to providing you with the highest standard of service and your feedback is important to us. The following channels are available for your complaints and we encourage you to follow the process:

1 STEP 1 – TO TAKE YOUR QUERY FURTHER:

Contact the Scheme's Client Service Department during office hours and try to resolve your query.
If the result is not considered to be satisfactory by you, you may ask that it be escalated to more senior resources in the Administrator's Service Team, such as a Team Leader or Manager.

2 STEP 2 – TO CONTACT THE PRINCIPAL OFFICER:

If you are still not satisfied with the resolution of your complaint after following the process in Step 1 you are able to escalate your complaint in writing to the Principal Officer of the LA Health Medical Scheme.
You may send your query or complaint to the normal email or postal addresses of the Scheme ,but address it to the Principal Officer.

3 STEP 3 – TO LODGE A DISPUTE:

If you have received a final decision from LA Health Medical Scheme and want to challenge it, you may lodge a formal dispute. You can find more information of the Scheme's dispute process on the website www.lahealth.co.za.

4 STEP 4 – TO CONTACT THE COUNCIL FOR MEDICAL SCHEMES:

LA Health 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 first follow the steps above 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.co.za |Tel : 0861 123 267 | www.medicalschemes.co.za