Guide to Prescribed Minimum Benefits

Who we are

LA Health Medical Scheme (referred to as 'LA Health', 'the Scheme', 'we' or 'us'), registration number 1145, is the medical scheme that you are a member of. This 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 and an authorised financial services provider (registration number 1997/013480/07). Discovery Health (Pty) Ltd takes care of the administration of your membership for the Scheme.

Contact us

For further information, call us on 0860 103 933 or visit us at www.lahealth.co.za.

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

About some of the terms we use in this document

There are a number of terms we refer to in the document that you might not know. These are:

Terminology	Description
Prescribed Minimum Benefits (PMB)	A set of minimum benefits that, by law, must be provided to all members of medical schemes in South Africa. The cover it gives includes the diagnosis, treatment and cost of ongoing care for a list of conditions.
Shortfalls	LA Health pays service providers at a set rate, the LA Health Rate. If your service providers charge higher fees than this rate, you will have to pay the shortfall amounts from your pocket.
Waiting period	A waiting period can be general or condition-specific and means as a new member you have to wait for a set time before you can claim from your chosen Benefit Option's cover.
Chronic Drug Amount (CDA)	The CDA is a maximum monthly amount the Scheme pays 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 a dispensing fee.
Diagnostic Treatment Pairs Prescribed Minimum Benefits (DTPPMB)	Links a specific diagnosis to a treatment and broadly indicates how each of the PMB conditions should be treated.
Designated Service Providers (DSP)	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. The services of these providers must be used to get full cover for PMB treatment and care.
Preferred suppliers	Suppliers we have a payment arrangement with for external medical items.
Reference Price	Non-formulary medication that falls in the same medicine category and generic group as the formulary medication are paid up to a Reference Price.

What are Prescribed Minimum Benefits (PMB)

PMB are guided by a list of medical conditions as defined in the Medical Schemes Act 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 271 diagnoses, 27 chronic conditions (Chronic Disease List conditions), including HIV.

Requirements you must meet to benefit from PMB

There are certain requirements before you can benefit from PMB. The requirements are:

1. The condition must qualify for cover and be on the list of defined PMB conditions.
2. The treatment needed, must match the treatments in the defined benefits on the PMB list.
   You must use the services of the Scheme's DSPs for full PMB cover.

If you do not use the services of a DSP, we will pay your claims up to 80% of the LA Health Rate. You will be responsible to pay the difference between what we pay, and the actual cost of your treatment. This does not apply in emergencies. However, even in those 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.

If your treatment doesn't meet the above criteria, we will pay according to your Benefit Option.

Claims for services received outside of the borders of South Africa will be covered in accordance with your chosen Benefit Option and rules. For more information on cover while travelling, please refer to the guide on *Cover for treatment received abroad*, available on our website **www.lahealth.co.za** at **Find a document.**

The medical condition must be part of the list of defined conditions for PMB

You should send the Scheme the results of your medical tests and investigations that confirm the diagnosis of the condition. This will enable us to identify whether your condition qualifies for the treatment. Your treating doctor needs to provide the relevant documents to assist us in confirming the diagnosis.

The treatment needed must match the treatments included in the PMB

There are standard treatments, procedures, investigations and consultations for each PMB condition on the 271 diagnostic treatment (DT) PMB list. These defined benefits are supported by thoroughly researched, evidence-based clinical protocols, medicine lists (formularies) and treatment guidelines.

Please refer to the Council for Medical Schemes website, www.medicalschemes.co.za, for a full list of the 271 diagnostic treatment pairs.

An example of a PMB provision

Below is an example of a PMB condition and the treatment that qualifies for PMB cover:

Provision	Provision description	Treatment	ICD-10 code
236K	Iron deficiency; vitamin and other nutritional deficiencies – life-threatening	Medical management	D50.8 Other iron deficiency anaemias

- The PMB Provision is **236K**. This is one of the listed 271 provisions (listed 271 conditions) as published in the Medical Schemes Act and Regulations.
- In this example the **Provision description** lists "Iron deficiency; vitamin and other nutritional deficiencies - life threatening". The provision states that the condition should be life-threatening. For this provision, if the diagnosis is not a life-threatening episode, the condition does not qualify for PMB funding.
- The **Treatment** covered as a PMB for this provision includes medical management for example medicine, doctor consultations, investigations and so on.
- In addition to the above information, the Council for Medical Schemes (CMS) also provides **ICD-10 codes** (for example, D50.8) for the **Provision,** as per the last column in the above table. The ICD 10 codes are an industry guide as to which conditions may qualify for PMB cover, subject to them still meeting the **Provision Description** and **treatment** criteria.

For this example, to qualify for the out-of-hospital PMB (OHPMB) funding, you or your healthcare provider may apply for medical management of life-threatening iron deficiency; vitamin and other nutritional deficiencies. The criteria stated in the **Provision description** need to be met to qualify for OHPMB funding related to the treatment as outlined.

Any application for treatment that is not listed in the "treatment" Provision for a condition, cannot be considered as PMB, as it does not form part of the prescribed treatment that forms part of PMB level of care. Speak to your healthcare provider to ensure that all criteria for treatment are met before applying for PMB cover.

How does LA Health pay claims for Prescribed Minimum Benefits (PMBs) and non-Prescribed Minimum Benefits (non-PMB)?

The Scheme pays for confirmed PMB treatment or procedures in full if you receive treatment from a Designated Service Provider (DSP). Treatment received from a provider that is not a DSP may be subject to a co-payment and you will also be responsible for the shortfall if the healthcare provider charges more than the LA Health Rate.

The Scheme has preferred suppliers for intermittent catheters, rental oxygen and other devices such as CPAP machines. Where a non-preferred supplier is used, you may have a co-payment.

LA Health pays for benefits not included in the PMBs from the appropriate and available benefits, according to the Rules of your chosen Benefit Option. Visit **www.lahealth.co.za** or call us on 0860 103 933 to find a participating DSP.

There are some circumstances where you do not have cover for PMB

This can happen when you join the Scheme for the first time, with no previous medical scheme membership, or when you join the Scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme will impose a waiting period during which you and your dependants will not have access to the PMB, regardless of the conditions you may have. We will communicate with you at the time of applying for your membership if any waiting periods will apply to you or your dependents.

There are a few instances when the Scheme will only pay PMB-related claims

This happens when you join the Scheme and have a waiting period, or when you have treatments linked to conditions that are excluded by your Benefit Option. When you join the Scheme, we may impose a three-month general, or a 12-month condition-specific waiting period. During these waiting periods you might have cover in full for PMB treatment and care, if you meet the requirements stipulated by the PMB regulations.

You and your dependents must register to get cover for the PMB and Chronic Disease List (CDL) conditions

How to register your chronic or PMB conditions to get cover from the Major Medical Benefits

There are different types of PMB:

- PMB cover for in-hospital admissions,
- conditions covered under the Chronic Disease List,
- the out-of-hospital management of PMB conditions, and
- treatment of specific PMB conditions, such as HIV or Oncology.

To apply for out-of-hospital PMB or for cover for a Chronic Disease List (CDL) condition, you must complete the *Prescribed Minimum Benefit* or a *Chronic Illness Benefit* application form.

- Up to date forms are always available on **www.lahealth.co.za** under **Medical Aid** > **Find a document**.
- You can also call 0860 103 933 to request any of the above forms.

For more information on the PMB Chronic Disease List conditions, HIV or Oncology and how to register, please refer to the relevant benefit guides available on **www.lahealth.co.za** under **Medical Aid** > **Find a document**.

To confirm your in-hospital cover for PMB conditions, you can call LA Health on 0860 103 933 and request an authorisation. We will then tell you about your benefits.

Why it is important to register your PMB or chronic illness condition

LA Health pays for specific healthcare services related to each of your approved conditions. These services may include approved treatment, medicine, consultations, blood tests and other defined investigative tests. The Scheme pays for these services as PMB and will not affect your day-to-day benefits.

The Scheme will pay for treatment or medicines that fall outside the defined benefits, and that are not approved, from your available day-to-day benefits according to the rules for your chosen Benefit Option. If your Benefit Option does not cover these expenses, you will have to pay the claims.

Who must complete and sign the registration form when applying for PMB or chronic condition cover

The patient with the PMB or chronic condition must complete the relevant application form with the help of their treating doctor. The main member must complete and sign the form if the patient is a minor.

Each person with a PMB or chronic condition must register their specific conditions separately. You only have to register once for a chronic condition. If your medicine or other treatment changes, your doctor can let us know about those changes.

For other, newly diagnosed PMB conditions, you will have to register each new condition before we will cover the treatment and consultations as PMB, not from your day-to-day benefits.

Additional documents needed to support the application

You must send the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying for to the Scheme. This will help us to identify whether your condition qualifies for PMB.

Where you must send the completed form

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

- By fax to 011 539 2780
- By email at PMB_APP_FORMS@discovery.co.za
- By post to LA Health Medical Scheme, PMB Department, PO Box 652509, Benmore, 2010.

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

- By fax to 011 539 7000
- By email at CIB_APP_FORMS@discovery.co.za
- By post to LA Health Medical Scheme, CIB Department, PO Box 652509, Benmore, 2010.

We will let you know if we approve your application for PMB or chronic condition cover and what you must do next

We will let you know about the outcome of your application and will send you a letter confirming your cover for the condition by using your preferred method of communication.

If your application meets the requirements for cover from PMBs, the Scheme will automatically pay the associated, approved blood tests and other defined investigative tests, treatment, medicine and consultations for the diagnosis and treatment of your condition from the Prescribed Minimum Benefits, not from your day-to-day benefits.

The treatment needed must match published defined 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 you need treatment that is not included in the defined benefits

If you need treatment that is not included in the PMB benefit definitions, you and your healthcare provider can send additional clinical information with a detailed explanation of the treatment that is needed and we will review it. If this treatment is not approved as a PMB, it can be paid from your available day-to-day benefits according to the Rules of your chosen Benefit Option. If your Benefit Option does not cover these expenses, you will have to pay the costs of these claims.

You can follow the below easy steps to apply for additional cover for out-of-hospital Prescribed Minimum Benefit (PMB) conditions or for Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB):

1. Download the "Request for additional cover for out-of-hospital Prescribed Minimum Benefit conditions" form or "Request for additional cover for Prescribed Minimum Benefit Chronic Disease List condition" form Up-to-date forms are always available on **www.lahealth.co.za** under **Medical Aid** > **Find a document**. You can also call 0860 103 933 to request any of the above forms.
2. Complete the form with the assistance of your doctor or healthcare provider.
3. Send the completed, signed form, along with any additional medical information, by email to PMB_APP_FORMS@lahealthms.co.za or by fax to 011 539 2780 or by email to CIB_APP_FORMS@lahealthms.co.za or by fax to 011 539 7000.
4. For more information on your cover for Chronic or PMB medicine, please visit our website **www.lahealth.co.za** and click on **Find a document**.

What happens if there is a change in your approved medicine

For approved chronic conditions, your treating doctor or dispensing pharmacist can make changes to your medicine telephonically by calling 0860 103 933, or by faxing an updated prescription to 011 539 7000 or emailing it to CIB_APP_FORMS@lahealthms.co.za.

For other PMB conditions, the treating doctor or dispensing pharmacist can only make changes to medicine by sending the updated prescription by fax to 011 539 2780 or emailing it to PMB_APP_FORMS@lahealthms.co.za.

If you get your medicine from a provider of your choice, instead of the Scheme's DSP

You must use doctors, specialists and other healthcare providers, including pharmacies, who we have a payment arrangement with, to avoid a co-payment. This does not apply in the event of an emergency or where the use of a non-DSP provider is involuntary, or when no DSP is available. If you voluntarily use a healthcare provider who we do not have a payment arrangement with, you will have to pay part of the treatment costs yourself.

In an emergency, you can go directly to hospital and notify the Scheme as soon as possible of the 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 to a DSP hospital.

Go to **www.lahealth.co.za** or call us on 0860 103 933 to find a participating DSP healthcare provider.

Get the most out of your benefits

Elective admissions for Prescribed Minimum Benefit (PMB) conditions and procedures are covered in full if you choose to use a designated service provider (DSP) hospital and designated service provider (DSP) treating doctors. Where your primary treating doctor is a designated service provider (DSP), reimbursement will be made in full without any co-payment for any required anaesthetic services you may need during your admission.

The below conditions need to be met for full cover for these providers:

- You are being admitted for a procedure for a Prescribed Minimum Benefit (PMB) condition
- Your chosen hospital or day facility is on the Prescribed Minimum Benefit (PMB) network for your benefit option
- Your primary treating doctor is on the Prescribed Minimum Benefit (PMB) network for your option.

If all of the above conditions are met your hospital, doctor and anaesthetist accounts will be covered in full.

Nominate a GP for the management of your PMB chronic conditions

If you are on LA Keyplus benefit option and approved for a chronic Prescribed Minimum Benefit (PMB) condition, you must nominate a General Practitioner (GP) in the Discovery Health GP network for your option to be your primary care doctor for the management of your chronic conditions. Where a GP has not been nominated for the treatment of a chronic condition you may incur a co-payment.

You can nominate your primary care doctor in three simple steps:

- Log in to the Discovery app or LA Health website
- Navigate to nominate your primary care provider
- Follow the prompts in the Care Portal and select your primary care doctor and their associated practice.

You can access your Care portal on the Discovery app or LA Health website to update your nominated GP should you need to do so.

What to do if there is no available DSP at the time of your request

There are some instances when you will still have full cover if you use a healthcare provider who we do not have a DSP arrangement with. An example of this is in an emergency, when the use of a non-DSP is unintentional or when there is no DSP available.

In cases where there are no services or beds available at a DSP when you or one of your dependants need treatment, you can contact us on 0860 103 933 and we will make arrangements for an appropriate facility or healthcare provider to accommodate you.

Cover for cancer

Depending on your chosen Benefit Option, once you are registered on the Oncology Programme, the Scheme covers your approved cancer treatment over a 12-month cycle up to the LA Health Rate, in accordance with the rules of your chosen Benefit Option.

PMB-related cancer treatment is always covered in full. All PMB treatment costs add up to the Oncology threshold for your Benefit Option. If your treatment costs are higher than the threshold amount, we will continue to cover your PMB cancer treatment in full.

For more information on your cover for cancer please visit our website **www.lahealth.co.za** and click on **Find a document**.

Cover for HIV

When you register on the HIV Care Programme, you are covered for the care you need, which includes additional cover for social workers. You can be assured of confidentiality at all times.

For more information on your cover for HIV please visit our website **www.lahealth.co.za** and select **Find a document**.

Cover for COVID-19

The WHO Global Outbreak Benefit provides cover for global disease outbreaks recognised by the World Health Organization (WHO), such as COVID-19. This benefit offers cover for the out-of-hospital management and appropriate supportive treatment in the event of you contracting COVID-19. The Scheme also pays for COVID-19 vaccines and the costs to administer the vaccine. Please visit our website **www.lahealth.co.za** and click on **Find a document**.

Cover for PMB admissions

You must preauthorise all hospital admissions. When you call the Scheme to preauthorise, we will tell you how you are covered.

You must use the services of a DSP in the Scheme's network. If you do not use the services of a DSP, we will pay up to 80% of the LA Health Rate.

This does not apply in emergencies. 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. For more information on your in-hospital PMB cover please visit our website **www.lahealth.co.za** and click on **Find a document**.

Complaints process

You may lodge a complaint or query with LA Health directly, on 0860 103 933. If you are not satisfied with the response you got after having escalated the query or complaint to a Team Leader or Manager at the Scheme's administrator, you may address a complaint in writing to the Principal Officer at the Scheme's registered address.

If your complaint remains unresolved even after input from the Principal Officer and the Board of Trustees, you may lodge a formal dispute by following the Scheme's internal disputes process.

You may, as a last resort, approach the Council for Medical Schemes for assistance. Their contact details are as follows:

Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157
Telephone number: 0861 123 267
Email address: complaints@medicalschemes.co.za
Website: www.medicalschemes.co.za