

ANNEXURE D
PRESCRIBED MINIMUM BENEFITS (PMB's)

Definitions

“Prescribed minimum benefits”

the benefits contemplated in section 29(1)(o) of the Act and consist of the provision of the diagnosis, treatment and care costs of –

- (a) the Diagnosis and Treatment pairs listed in Annexure A of the regulations, subject to any limitations specified therein; and
- (b) any emergency medical condition

“Prescribed minimum benefit condition”

A condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations or any emergency medical condition.

1. Designation of service providers

The medical scheme designates the following service provider/s for the delivery of prescribed minimum benefits to its beneficiaries:

- (a) State hospitals (In those instances provided for in the Act where the service is not reasonably available from the designated service provider, the Society remains liable to cover the prescribed minimum benefits in whichever setting the member is compelled to seek treatment).
- (b) Any retail pharmacy or healthcare practitioner registered to dispense medication for chronic medication. The member must obtain pre-authorisation for such medication from Direct Medicines. HIV/AIDS treatment medication must be pre-authorised by Aid for Aids and medication is obtainable from any retail pharmacy or healthcare practitioner registered to dispense medication
- (c) Netcare 911 for Ambulance Services

The above service providers shall for the purpose of this appendix be referred to as “designated service provider”.

2. Prescribed minimum benefits obtained from a designated service provider

100% of the cost in respect of diagnosis, treatment and care costs of prescribed minimum benefit conditions if those services are obtained from a designated service provider.

3. Prescribed minimum benefits obtained from other providers

If a beneficiary voluntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the benefit payable in respect of such service is subject to such benefit limitations as are normally applicable in terms of the relevant option chosen by the member.

4. Prescribed minimum benefits involuntarily obtained from other providers

(a) If a beneficiary involuntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the medical scheme will pay 100% of the cost in relation to those prescribed minimum benefit conditions.

(b) For the purposes of paragraph a, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if -

- (i) the service was not available from the designated service provider or would not be provided without unreasonable delay;
 - (ii) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or
 - (iii) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.
- (c) Except in the case of an emergency medical condition, preauthorisation shall be obtained by a member prior to involuntarily obtaining a service from a provider other than a designated service provider in terms of this paragraph, to enable the scheme to confirm that the circumstances contemplated in paragraph b are applicable.

5. Medication

- (a) Where a prescribed minimum benefit includes medication, the Scheme will pay 100% of the cost of that medication if:
- (i) the medication is included on the applicable formulary in use by the Scheme; or
 - (ii) the formulary does not include a drug that is clinically appropriate and effective for the treatment of that prescribed minimum benefit condition.

- (b) Where a prescribed minimum benefit includes medication and that medication is voluntarily obtained from a provider other than a designated service provider, a co-payment equal to the difference between the cost of the drug and the reference price of the formulary drug will apply.

6. Diagnostic tests for an unconfirmed PMB diagnosis

Where diagnostic tests and examinations are performed but do not result in confirmation of a PMB diagnosis, such diagnosis tests or examinations are not considered to be a prescribed minimum benefit.

7. Prescribed minimum benefits obtained from a public hospital

Notwithstanding anything to the contrary contained in these rules, the Scheme shall pay 100% of the costs of prescribed minimum benefits obtained in a public hospital, without limitation.

8. Co-payments

Co-payments in respect of the costs for PMB's may not be paid out of the medical savings accounts.

9. Chronic conditions

Any benefit option covers the full cost of services rendered in respect of the prescribed minimum benefits which includes the diagnosis, medical management and medication to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specified chronic conditions, and obtained from the Scheme's designated service provider (DSP).

DIAGNOSIS	
Addison's disease	Asthma
Bipolar mood disorder	Bronchiectasis
Cardiac failure	Cardiomyopathy disease
Chronic renal disease	Coronary artery disease
Chronic obstructive pulmonary disorder	Crohn's disease
Diabetes insipidus	Diabetes mellitus type 1 & 2
Dysrhythmias	Epilepsy
Glaucoma	Haemophilia
Hyperlipidaemia	Hypertension
Hypothyroidism	Multiple sclerosis
Parkinson's disease	Rheumatoid arthritis
Schizophrenia	Systematic lupus erythematosus
Ulcerative colitis	

10. HIV/AIDS

Management of the HIV/AIDS disease will be dealt with by the Designated Service Provider (DSP) being state hospitals. HIV/AIDS medication is provided by the Designated Service Provider as communicated to members. (Refer to paragraph 1 iro HIV/AIDS medication)