Out of Hospital Prescribed Minimum Benefits

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 and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

Contact us

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

Overview

This document provides information about your Out-of- Hospital Prescribed Minimum Benefits (OHPMBs). It tells you how the Scheme covers a list of conditions called OHPMB.

PMBs apply to all members of all medical schemes, on all benefit options.

All the LA Health benefit options cover more than just the minimum benefits required by law. You can find out how you are covered for the PMBs by reading about it in the "Your Benefits" booklet or the benefit schedule for your specific Option.

About some of the terms we use in this document

You might come across some terms in the document that you may not be familiar with. Here are the terms with their meaning.

Terminology	Description
Day-to-day benefits	These are the funds available in the Medical Savings Account or Above Threshold Benefit, if available on you benefit option.
Scheme Rate	This is the rate that the Scheme sets for paying claims from healthcare professionals.
Medicine Rate	This is the rate at which the Scheme will pay for medicine. It is the Single Exit Price of medicine plus the relevant dispensing fee.
Co-Payment	We pay service providers at a set scheme rate. If the accounts are higher than this rate, you will have to pay outstanding amount from your pocket.

Waiting period	A waiting period can be general or condition specific and means that you have to wait for a set time before you can benefit from your chosen benefit option's cover.
Designated Service Provider (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 rate. Visit www.lahealth.co.za to view a full list of DSPs.
Formulary	Approved Medicine List. If you make use of medicine on the list, it will be paid in full up to the medicine rate. Medicine that is not on the formulary is subject to a co-payment.
Reference Price	Non-formulary medicine that falls in the same medicine category and generic group as the formulary medicine is paid up to a Reference Price
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.

What is a Prescribed Minimum Benefit (PMB)?

PMB's are guided by a set 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:

- Any life-threatening emergency medical condition
- A defined set of 270 diagnoses
- 27 chronic conditions (Chronic Disease List conditions).

These defined benefits are supported by thoroughly researched evidence, based on clinical protocols, and treatment guidelines.

Please refer to the Council for Medical Schemes website (www.medicalschemes.com) for a full list of the 270 diagnostic treatment pairs.

All Medical schemes in South Africa have to include the PMB's in the benefit options they offer to their members.

Requirements you must meet to benefit from PMB's

There are certain requirements that need to be met before you can benefit from PMB's:

- The Condition must qualify for cover and be on the list of defined PMB conditions
- The treatment must match the treatments in the defined benefits on the PMB list.
- You must use the scheme's DSP's for full cover, unless there is no DSP applicable to your Option.

If you do not use a DSP, we will pay up to 80% of the Scheme Rate. 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 the rules of the Scheme, you may be transferred to a hospital or other service providers in our network, once your condition has stabilised should you want to avoid co-payments.

If your treatment doesn't meet the above criteria, we will pay according to the benefits of the Option you chose.

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 allow us to identify that the condition qualifies for the treatment. Your treating doctor needs to provide the relevant documentation to assist us 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 270 OH DTPMB list. These defined benefits are supported by thoroughly researched, evidence based clinical protocols, medicine lists (formularies) and treatment guidelines.

Below is an example of a PMB provision as listed in Annexure A of the Medical Schemes Act and the treatment that qualifies for PMB cover:

Provision	Provision Description	Treatment	ICD-10 code
6F	Hernia with obstruction and /or gangrene; uncomplicated hernias under age 18	Repair: bowel resection	K42.1- Umbilical hernia with gangrene

Based on the above example:

- The PMB provision is 6F, i.e. one of the listed 270 conditions provided for on the OH DTPMB list in the Medical Schemes Act.
- The Provision description includes cover for "Hernia with obstruction and /or gangrene; and for uncomplicated hernias for persons who are 18 years or younger
- The treatment that may be covered as a PMB is: "Repair: bowel resection"
- An example of a ICD-10 code that falls within the 6F Provision is: 'Umbilical hernia with gangrene' (K42.1)

To qualify for PMB funding, the member and provider must apply for Repair: bowel resection. This is performed in a hospital and classified as surgical management. All categories stipulated in the PMB provision have to be met to qualify for PMB funding. The ICD-10 code cannot be considered in isolation. In the above example, Hernias will be covered for members over the age of 18 if it is obstructed and/or has gangrene. Uncomplicated hernias will only be covered for members younger than 18 years of age.

Furthermore, out of hospital medical management for the condition (e.g. medication, doctor's consultations, investigations) does not fall within the scope of the PMB provision, and will therefore not be considered as a PMB.

The Scheme is only required to provide cover for the treatments, procedures, investigations and consultations that are listed for each of these conditions. If you need treatment that is not on the list, and send additional clinical information that thoroughly explains why the treatment is needed, the Scheme will review it, and may approve the treatment. If the appeal is declined, you may contact us to an appeal.

The Scheme pays for specific healthcare services related to each of your approved conditions, such as consultations, blood tests and other investigative tests, without affecting your day to day benefits. We will inform you of your entitlement to the applicable PMBs when your condition has been approved.

Using Designated Service Providers (DSPs)

All medical schemes must ensure that their members do not experience shortfalls when their members make use of DSPs. To avoid unnecessary payments from your own pocket, you should use doctors, specialists or other healthcare providers with whom the Scheme has agreements in place.

You can use Maps advisor on www.lahealth.co.za or call us on 0860 103 933 to find a DSP provider near you, for your specific benefit option.

There are some instances when it is not necessary to use the services of a DSP, but you will still have full cover. An example of this is in a life threatening emergency.

How the Scheme manages PMB claims

Once your healthcare professional confirms the diagnosis as a PMB condition, you can apply for cover for claims to be funded from risk, without using your day to day benefits. Please note, although the provider states the condition is a PMB, we must still review your application to approve that level of cover.

If you have been recently diagnosed with, and approved for an OHPMB condition, costs relating to the diagnosis of the condition can be paid from PMB risk benefits. To qualify. You must be an active and valid member of the Scheme when the PMB condition is diagnosed. Call us on 0860 103 933 or email service@discovery.co.za for us to review your claims.

We require additional clinical information from your healthcare professional for requests for funding of any treatment that falls outside the standard treatment for the condition. If the treatment falls outside the PMBs and is not approved, it will be paid for from your available day-to-day according to the benefits of your chosen Option. If your benefit option does not cover these expenses, you will be responsible to pay the unpaid claims.

Getting the most out of your benefits

Register for your Out of Hospital PMB (OHPMB) condition

To apply for OHPMBs you must complete an *Out of Hospital PMB* 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 a form.

Who must complete and sign the registration form when applying for PMB

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

Additional documents needed to support the application

When applying for cover, you may need to send the Scheme 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 PMB treatment.

Where to send the completed registration form

You must send the completed OHPMB application form:

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

We will let you know the outcome of your PMB application

We will inform you of our decision by fax or email (in line with your preference, indicated on the application form).

The treatment needed, must match the standard treatments, procedures, investigations and medicine lists (formularies) for each condition on the published PMB list. If the treatment meets the defined PMB requirements, we will automatically pay the associated approved blood tests and other defined investigative tests, treatments, medicine and consultations for that condition from the risk benefits (not from your day-to-day benefits).

What happens if you need treatment that falls outside the defined benefits

If you need treatment that falls outside of the defined benefits, or you require additional benefits, you may submit a PMB appeal application. Additional clinical information, with a detailed explanation of why the treatment is needed, must be submitted to the Scheme for review.

If your application is not approved, it will be paid from available day-to-day benefits according to your chosen Option. If your Option does not cover these expenses, you will be responsible to pay the claims.

To Submit a PMB appeal form:

- Download and print a "OHPMB Appeal form"
- Complete the form with the assistance of your doctor/healthcare professional
- Send the completed, signed form, along with any additional medical information, by email to
- PMB_APP_FORMS@discovery.co.za or by fax 011 539 2780.

If we approve the requested medicine/treatment on appeal, it will automatically be paid from the risk benefits. If the appeal is unsuccessful, and you remain unsatisfied, you can lodge a dispute by following the Scheme's internal disputes process, as described on www.lahealth.co.za

What happens if new medicine is prescribed for your condition

We will only be able to continue to provide cover for the newly prescribed medicine if the treating doctor or dispensing pharmacist sends us an updated prescription. They can send it by fax to 011 539 2780, or email it to PMB_APP_FORMS@discovery.co.za

How we pay your claims

We pay for confirmed PMBs in full from the risk benefits if you receive treatment from a DSP. Treatment received from a non-DSP may be subject to a co-payment if the healthcare provider charges more than the Scheme Rate.

If approved medication is not on the formulary list, we will pay up to a reference price where the non-formulary medicine falls within the same medicine category and generic group as the formulary medicine. You may have a co-payment if the cost of the medicine is higher than the reference price.

Once your PMB benefits have been depleted, further claims will be paid from your available day-to-day benefits, if applicable.

We pay for benefits not included in the PMBs from your appropriate and available day-to-day benefits, according to the rules and benefits of your chosen benefit option.

Complaints process:

You may lodge a first time complaint or query with LA Health Medical Scheme on 0860 103 933, or send an email to service@discovery.co.za. If the query or complaint is not resolved to your satisfaction, you may address a written complaint in writing to the Principal Officer at the Scheme's registered address, quoting your reference numbers from the process followed initially. 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