Guide to Prescribed Minimum Benefits – 2020

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), 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). We take 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 (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.
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 amount from your 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 claim 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.
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 (PMBs)?

PMBs 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 270 diagnoses
3 | 27 chronic conditions (Chronic Disease List conditions).

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 Prescribed Minimum Benefits in the benefit options they offer to their members.

Requirements you must meet to benefit from PMBs

There are certain requirements before you can benefit from Prescribed Minimum Benefits. 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.
3 | You must use the Scheme's DSPs for full cover, unless there is no DSP applicable to your Benefit Option.

If you do not use a DSP we will pay up to 80% of the LA Health 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 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 Benefit Option's benefits.

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

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 your 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 PMB condition on the 270 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.com for a full list of the 270 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 270 Provisions (listed 270 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 etc.
- In addition to the above information, the Council for Medical Schemes (CoMS) also provides **ICD 10 codes** (eg. D50.8) that fall within the **236K 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, in order to qualify for the out-of-hospital PMB (OHPMB) funding, you or your healthcare professional may apply for medical management of life threatening iron deficiency; vitamin and other nutritional deficiencies. This criteria stated in the **Provision description** needs 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 it does not form part of the prescribed treatment that forms part of PMB level of care. Speak to your healthcare professional to ensure that all criteria for treatment is met before applying for PMB cover.

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

We pay for confirmed PMBs in full if you receive treatment from a Designated Service Provider (DSP). Treatment received from a non-DSP may be subject to a co-payment if the healthcare provider charges more than the amount we pay.

We pay 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 healthcare provider.

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

This can happen when you join the Scheme for the first time, with no previous medical scheme membership. Also if 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 PMBs, regardless of the conditions you may have. We will communicate with you at the time of applying for your membership if any waiting periods apply to you or your dependants.

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

This happens when you have a waiting period or when you have treatments linked to conditions that are excluded by your Benefit Option. This can be a three-month general waiting period or a 12-month condition-specific waiting period. During these waiting periods you might have cover in full, if you meet the requirements stipulated by the PMB regulations.

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

There are different types of PMBs. These include 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 PMBs or 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 us on 0860 103 933 and request an authorisation. We will then tell you about your cover.

Why is it important to register your PMB or chronic condition

We pay for specific healthcare services related to each of your approved conditions. These services include approved treatment, medicine, consultations, blood tests and other defined investigative tests. We pay for these services as Prescribed Minimum Benefits, which will not affect your day-to-day benefits.

We 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 your chosen Benefit Option. If your Benefit Option does not cover these expenses, you will have to pay these claims.

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

The person 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 PMB or chronic conditions 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 these changes.

For new conditions, you will have to register each new condition before we will cover the treatment and consultations from the Prescribed Minimum Benefits and not from your day-to-day benefits.

Additional documents needed to support the application

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

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 652509, 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 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, using your preferred method of communication. If your application meets the requirements for cover from PMBs, we 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, and not from your day-to-day benefits.

The treatment needed must match the treatments in the published defined benefits on the PMB list as 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 you need treatment that falls outside of the defined benefit

If you need treatment that falls outside of the Prescribed Minimum Benefits you and your healthcare professional 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 Prescribed Minimum Benefit, it can 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 have to pay the costs of these claims.

To appeal against the funding decision on PMB cover or cover for chronic medicine/treatment:

1 | Download the OHPMB *Appeal Form* or *Chronic Illness Benefit Appeal 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/healthcare professional.

3 | 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 or by email to CIB_APP_FORMS@discovery.co.za or by fax to: 011 539 7000

If we approve the requested medicine/treatment on appeal, we will automatically pay these from either the PMB or Chronic Illness Benefit, whichever is applicable. If the appeal is unsuccessful and you are not satisfied with the outcome you may also lodge a formal dispute by following the Scheme's disputes process on www.lahealth.co.za.

For more information on your cover for Chronic or PMB medicine please visit our website www.lahealth.co.za and click on Find documents.

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@discovery.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@discovery.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 24hrs or until you are stable enough to be transferred.

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

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 involuntary, 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 your Benefit Option benefits.

Cancer treatment that is a Prescribed Minimum Benefit (PMB), 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 document.

Other PMB conditions

For other PMB conditions, you can apply for out-of-hospital Prescribed Minimum Benefits, as outlined above. For more information please visit our website www.lahealth.co.za and click on Find Document.

Cover for HIV

When you register for our HIV Care Programme to manage your condition, 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 PMB admissions

You must pre-authorise all hospital admissions. When you call us to pre-authorise we will tell you how you are covered.

You must use designated services providers in our network. If you do not use 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 Medical Scheme directly, on 0860 103 933. If after having escalated the query or complaint to a Team Leader or Manager at the Scheme's administrator, you are not satisfied, you may address a complaint in writing to the Principal Officer at the Scheme's registered address.

Should your complaint remain unresolved, even after input from the Principal Officer and the Board of Trustees, 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. 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 / 0861 123 267 / complaints@medicalschemes.com / www.medicalschemes.com