Bankmed
your good health

GUIDE TO PRESCRIBED MINIMUM BENEFITS (PMB)

This document provides information regarding the way in which Bankmed Medical Scheme covers each member for a list of conditions that forms part of the Prescribed Minimum Benefits (PMBs).

Who we are

Bankmed Medical Scheme (referred to as 'the Scheme'), registration number 1279, 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) which takes care of the administration of your membership for the Scheme.

What are Prescribed Minimum Benefits (PMBs)?

PMBs are a set of minimum benefits which medical schemes are required to provide to all their members according to the law (Medical Schemes Act of 1998 – Act number 131 of 1998). The cover provided includes the diagnosis, treatment and cost of ongoing care for:

- Any life-threatening emergency medical condition
- A defined set of 270 diagnoses
- 25 chronic conditions.

All medical schemes in South Africa are required to include the Prescribed Minimum Benefits in the health plans they offer to their members.

Kindly note

- PMB regulations and their accompanying provisions do not apply to healthcare services obtained outside the borders of South Africa.
- PMB-related claims for services obtained outside the borders of South Africa shall be treated as normal (non-PMB) claims, subject to the relevant Scheme Rate and any other limitations applicable to normal (non-PMB) claims within the borders of South Africa.
- Pre-authorisation, medicine formularies (medicine lists) and Scheme protocols may apply. Please refer to the benefit schedule for details as to when pre-authorisation is needed.
- Diagnosis costs are only regarded as a PMB if the result of diagnostic investigations confirms a PMB diagnosis.

- When Insured Limits are specified in this schedule, the limit will first be used for the payment of relevant claims (including PMBs); thereafter continued funding will apply for PMB claims only, subject to PMB regulations.
- Claims for PMB conditions may not be funded from Medical Savings Accounts, in accordance with directives from the Council for Medical Schemes (CMS).
- Where a benefit is indicated as *payable from Medical Savings Account* or as *no benefit* in this schedule, Insured (Scheme) Benefits will nevertheless be provided for PMBs in South Africa, subject to PMB regulations.

How does Bankmed fund claims for PMBs and non-PMB benefits?

We cover PMBs in full from Insured Benefit when you receive treatment from a Designated Service Provider (DSP), where applicable. Treatment you receive from a non-DSP may be subject to a co- payment should the Healthcare Professional charge more than we fund. We fund non-PMB benefits from your available day-to-day benefits in accordance with your selected Plan.

Requirements you should meet to ensure you benefit from the PMBs

There are certain requirements before you may benefit from the Prescribed Minimum Benefits. The requirements are:

1. The condition must be on the list of defined PMB conditions.
2. The required treatment must match the treatments in the defined benefits on the PMB list.
3. The Scheme's Designated Service Providers (DSP) should be used, unless there is no DSP applicable to your selected Plan.

What are Designated Service Providers (DSPs)?

A Designated Service Provider (DSP) is a Healthcare Professional (for example, a doctor, specialist, pharmacist or hospital) with whom we have an agreement. According to this agreement they will provide you with treatment or services at a contracted rate. This will ensure you do not incur any co-payments when you use their services.

For a full list of our DSPs, visit **www.bankmed.co.za > DOCTOR VISTIS > Find a Healthcare Professional.**

You and your dependants are required to register to obtain cover for PMBs and Chronic Disease List (CDL) conditions

How to register your chronic or PMB conditions to receive cover from the Insured Benefit

Should you be on the Essential or Basic Plans and wish to apply for out-of-hospital Prescribed Minimum Benefits or cover for a chronic condition, you are required to obtain a *Prescribed Minimum Benefit or a Chronic Illness Benefit Application* form:

- Both forms are available to download and print from **www.bankmed.co.za**. Log in to the website using your username and password. Go to “Find a document” and click on application forms.
- You may also contact us on 0800 BANKMED (0800 226 5633) to request either of the above forms.

Once we receive the application form and it meets the Prescribed Minimum Benefit requirements, we will automatically cover the associated approved investigations, treatment and consultations for that condition from Insured Benefits (not from your day-to-day benefits). We will inform you of the outcome of the application.

Cover for out-of-hospital Prescribed Minimum Benefits and Chronic Illness Benefits on the other Bankmed Plans (Core Saver, Traditional, Comprehensive and Plus Plans) no application is required. The benefit will fund from the Insured Benefit, provided the correct PMB ICD-10 code is submitted on the claim.

Should you require to apply for in-hospital Prescribed Minimum Benefit cover, kindly contact us on 0800 BANKMED (0800 226 5633) to request authorisation.

What are Chronic Disease List conditions?

Chronic Disease List conditions are a list of chronic conditions we cover on all plans as defined in the Prescribed Minimum Benefit legislation.

Why it is important to register your PMB or chronic conditions?

Bankmed funds specific healthcare services related to each of your approved conditions. These services include consultations, blood tests and other investigative tests. We cover these services without decreasing your available day-to-day benefits, because we pay it from the Insured Benefit.

Treatment which falls outside the defined benefits and is not approved will be covered from your available day-to-day benefits, according to your selected Plan. Should your Plan not cover these expenses, you will be responsible for payment of the claims.

There are different types of claims for Prescribed Minimum Benefits. There are claims for hospital admissions, chronic conditions and other conditions treated out-of-hospital.

There may be times when you will be required to apply for cover under the Prescribed Minimum Benefits. Once your Healthcare Professional confirms the diagnosis as a Prescribed Minimum Benefit condition, you may apply for us to cover the claims from your Insured Benefit. Without using your day-to-day cover. Once approved, we will automatically recognise that the medical services for which you are claiming fall under the Prescribed Minimum Benefits.

What happens when your condition is not registered as a PMB or chronic condition?

We will fund all the consultations, blood tests, other investigative tests, medication and other treatment for the PMB or chronic condition from your available day-to-day benefit.

Who is required to register to receive chronic medication for their PMB or chronic conditions?

The Principal Member and all dependants with PMB or chronic conditions are required to register if you are on the **Essential and Basic Plans** only.

Members on the **other Bankmed Plans** (Core Saver, Traditional, Comprehensive and Plus Plans) are requested to register their medication with Bankmed Medicine Management by calling 0800 BANKMED (0800 226 5633), or your Healthcare Professional may contact them on 0800 132 345 or e-mail **chronic@bankmed.co.za**

Each member is required to register for their specific conditions. You only have to register once for a chronic condition. Should your medication or other treatment change, your doctor may simply inform us of the changes. Should you acquire another condition, it is essential for you to register for the new condition before we will cover the treatment and consultations from the Risk Benefit and not from your available day-to-day benefit.

Who is required to complete and sign the registration form when applying for chronic medication?

For the **Essential and Basic Plans** you or your dependant with the PMB or chronic condition, may complete the application form with the help of your Healthcare Professional.

Additional documentation required to support the application

You may be required to provide Bankmed with the results of the medical tests and investigations which confirm the diagnosis of the condition. This will assist us to assess whether your condition should qualify for the treatment.

We require additional clinical information from your Healthcare Professional should you request funding for any treatment which falls outside the standard treatment for the condition. Should treatment fall outside the defined benefits, it will not be approved and will be paid from your available day-to-day benefit, according to your selected Plan.

Should your Plan not cover these expenses, you will be responsible for payment of the claims.

Members on the Essential and Basic Plans may send the completed **PMB application form by**:

- E-mail:pmb_app_forms@bankmed.co.za
- Post: Bankmed, PO Box 1242, Cape Town 8000

Members on the Core Saver, Traditional, Comprehensive and Plus Plans are required to register their medication management with Bankmed Medicine Management. Any consultations and investigations related to your approved PMB condition will fund from Risk Benefits.

We will advise you should we approve your application

We will inform you of your entitlement to Prescribed Minimum Benefits when we approve your condition and treatment. We will do this by e-mail (as indicated on your application form).

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

What happens should there be a change in your treatment?

For members on the **Essential and Basic Plans,** your Healthcare Professional may contact 0800 BANKMED (0800 226 5633) to register changes to your medication for an approved condition. You are only required to complete an application form when applying for a new PMB or chronic condition.

How to obtain your medication from the appropriate Designated Service Provider?

We include this information in the decision letter which we send upon approval of your application.

Should your Healthcare Professional change the medication mid-month?

For members with chronic conditions on the **Essential and Basic Plans,** your Healthcare Professional or dispensing pharmacist may make changes to medication telephonically. Alternatively, you may send an updated prescription by e-mail **chronicBasicEssential@bankmed.co.za**

For PMB conditions your Healthcare Professional or dispensing pharmacist may make changes to medication by sending the updated prescription by e-mail **pmb_app_forms@bankmed.co.za**

The implications of obtaining your medication from a non-Designated Service Provider?

All medical schemes are required to ensure members do not experience co-payments when they use Designated Service Providers. You should use doctors, specialists or other Healthcare Professionals with whom we have a payment arrangement so you do not incur a co-payment.

Should you select not to use Healthcare Professional with whom we have a payment arrangement, you will be responsible for covering part of the treatment costs yourself. Contact us on 0800 BANKMED (0800 226 5633) for the latest copy of the treatment guidelines or visit **www.bankmed.co.za**

What are co-payments?

Bankmed Medical Scheme funds service providers at a set rate – this is called the Scheme Rate. Should the service provider charge above this rate, you may have to pay the outstanding amount from your pocket. This amount you have to pay is called a co-payment.

What is a waiting period?

A waiting period may be general or condition-specific and means that you are required to wait for a set time before you may claim from your selected Plan's cover.

What happens when you use medication that is not on the list for your particular Plan?

We pay for medication on the medicine list (formulary) up to the Scheme Rate for medication. There will be no co-payment for medication selected from the medicine list (formulary).

If we approve medication which is not on the medicine list, we will pay it up to a Scheme Medicine Reference Price. You may have a co-payment if the cost of the medication is greater than the Scheme Medicine Reference Price. This is unless the medication is a substitute for one that has been ineffective or has caused an adverse reaction. In that case, you and your Healthcare Professional can appeal and if the appeal is successful there will be no co-payment.

What happens when you require treatment that is not on the list?

The Scheme is only required to cover the treatments, procedures, investigations and consultations that are given for each specific condition on the list. Should you require treatment which is not on the list and you submit additional clinical information that thoroughly explains why you require the treatment, the Scheme will review it and may select to approve the treatment. Should we decline the appeal, you may contact us to lodge a formal dispute.

Is it possible to acquire benefits for more than one month's supply of medication?

You are able to obtain more than a month's supply of approved chronic medication in the event that you are travelling outside the borders of South Africa. You may complete an '*Extended supply of medication*' form which is available on **www.bankmed.co.za**

Our list of Designated Service Providers

You can use the Find a Healthcare Professional tool available on **www.bankmed.co.za** or contact us on 0800 BANKMED (0800 226 5633) to locate a Healthcare Professional with whom we have a Designated Service Provider payment arrangement

What to do when there is no available Designated Service Provider?

There are some instances where it is not necessary to use Designated Service Providers, however full cover will still be available to you. An example of this would be in the event of a life-threatening emergency.

In cases where there are no services or beds available within the Designated Service Provider when you or one of your dependants requires treatment, you may contact us on 0800 BANKMED (0800 226 5633) and we will intervene and make arrangements for an appropriate facility or Healthcare Professional to accommodate you.

Changes to the list

As there are regular changes to our list, we only inform affected members of the changes. For example, we will only communicate changes in the list for hypertension medication to patients who will be affected by the change.

Acquire pre-authorisation for hospitalisation and other procedures

What is pre-authorisation?

Pre-authorisation is the approval of certain procedures and any planned admission into a hospital before the procedure or admission takes place. It includes associated treatment or procedures performed during hospitalisation. You are also required to obtain specific pre-authorisation for MRI and CT scans, radio-isotope studies and for certain endoscopic procedures, whether conducted during hospitalisation or not.

Whenever your Healthcare Professional plans a hospital admission for you, you should advise us 48-hours prior to your admission into hospital.

Certain Plans provide full cover only if you use a Network hospital. Kindly confirm if the hospital you plan to use is part of the network applicable to your Plan.

Pre-authorisation is not a guarantee for payment of all claims

Your hospital cover is made up of:

- Cover for the account from the hospital (the ward and theatre fees) at the rate agreed with the hospital
- Cover for the accounts from your treating Healthcare Professionals (such as the admitting doctor, anaesthetist and any approved healthcare expenses such as radiology or pathology) is separate from the hospital account and we call this related accounts.

Remember: Limits, clinical guidelines and policies apply to some healthcare services and procedures in hospital.

There are some expenses you may incur while you are in hospital which we will not cover. Certain procedures, medications or new technologies require separate approval. Kindly discuss this with your Healthcare Professional or the hospital. Obtain additional information regarding our clinical rules and policies for cover by contacting us on 0800 BANKMED (0800 226 5633) or visit our website to view *What we cover*.

Benefits which require pre-authorisation

You need to obtain pre-authorisation from us for:

- Hospitalisation
- Day-clinic admissions
- Special procedures (such as scopes, MRI and CT scans).

Whom should you contact?

Contact us on 0800 BANKMED (0800 226 5633) for pre-authorisation. We will provide you with an authorisation number. Kindly ensure the authorisation number is handed to the relevant Healthcare Professional and request that they include it when they submit a claim.

Ensure you understand your authorisation

We will request the following information when you request pre-authorisation:

- Your membership number
- Details of the patient (name and surname, ID number, etc.)
- Reason for the procedure or hospitalisation
- Diagnostic codes (ICD-10 codes), tariff codes and procedure codes (ask your Healthcare Professional for this information).

The process when you are admitted to hospital?

We only fund medically appropriate claims. Your cover is subject to Scheme Rules, funding guidelines and clinical rules. There are some expenses you may receive in hospital as part of a planned admission that your Hospital Benefit does not cover. Certain procedures, medication and new technologies require separate approval. It is important that you discuss this with your doctor or the hospital.

Bankmed Plans offer benefits richer than Prescribed Minimum Benefits

All Bankmed Plans cover more than the minimum benefits required by law. Some Plans cost more, but offer more comprehensive benefits while others have lower contributions with fewer benefits.

Occasionally Bankmed will fund a claim as a Prescribed Minimum Benefit

This happens when you are in a waiting period or when you have treatments linked to conditions that are excluded from your plan. But you may still receive cover in full, if you meet the requirements stipulated by the Prescribed Minimum Benefit regulations.

Cases where you are not covered under Prescribed Minimum Benefits

There are some circumstances where you do not have cover for the Prescribed Minimum Benefits. This can happen when you join a medical scheme for the first time, with no medical scheme membership prior to that.

It may also happen should you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme may impose a waiting period, during which you and your dependents will not have access to the Prescribed Minimum Benefits, no matter what conditions you might have.

Contact us

You may contact us on 0800 BANKMED (0800 226 5633) or visit **www.bankmed.co.za** for additional information.

Complaints process

You may lodge a complaint or query with Bankmed Medical Scheme directly on 0800 BANKMED (0800 226 5633) or address a complaint in writing directly to the Principal Officer. Should your complaint remain unresolved, you may lodge a formal dispute by following Bankmed Medical Scheme's internal disputes process.

Members, who wish to approach the Council for Medical Schemes for assistance, may do so in writing to: Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 or via e-mail at complaints@medicalschemes.com. Customer care centre: 0861 123 267. Website: www.medicalschemes.com