Guide to Prescribed Minimum Benefits for In-hospital Treatment

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.

Overview

In terms of the Medical Schemes Act No. 131 of 1998, Prescribed Minimum Benefits (PMB) are a set of defined benefits that all registered medical schemes in South Africa are obliged to provide for all their members. All members have access to these benefits, irrespective of their chosen Plan. PMB's ensure that all medical scheme members have access to continuous care to improve their health.

Bankmed Plans are structured in such a way that your chosen Plan type provides comprehensive cover. Some Plans cost more but offer more comprehensive cover, while others have lower contributions with fewer benefits. Irrespective of this, all our Plans cover more than just the minimum benefits required by law. Always consult the Benefit and Contribution Schedule to see how you are covered.

This document tells you how the Scheme covers the Prescribed Minimum Benefits specifically for in-hospital treatment. Please refer to the Prescribed Minimum Benefits guide on www.bankmed.co.za for more details about PMBs and how they are covered.

TERMINOLOGY	DESCRIPTION
Co-payment	This is an amount that you need to pay towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service, the age of the patient or if the amount the Healthcare Professional charges is higher than the rate we cover.
Day-to-day benefits	These are the available funds allocated to the Medical Savings Account (MSA) and Above Threshold Benefit (ATB). Depending on the Plan you choose, you may have cover for a defined set of day-to-day benefits. The level of day-to-day benefits depends on the Plan you choose.
Designated Service Provider (DSP)	A Healthcare Professional (for example doctor, specialist, pharmacist or hospital) who we have an agreement with to provide treatment or services at a contracted rate. Visit www.bankmed.co.za and use the **Find a Healthcare Professional** tool to find a DSP.
Scheme Rate (SR)	This is a rate set by us. We pay for healthcare services from hospitals, pharmacies and Healthcare Professionals at this rate.
Member	The reference to member in this document also includes dependants, where applicable.
Prescribed Minimum Benefits (PMBs)	In terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of: • An emergency medical condition • A defined list of 270 diagnoses • A defined list of 27 chronic conditions To access Prescribed Minimum Benefits, there are rules defined by the Council for Medical Schemes (CMS) that apply: • Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit conditions • The treatment needed must match the treatments in the defined benefits • You must use Designated Service Providers (DSPs) in our network. 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. If you do not use a DSP, you will be responsible for the difference between what we pay and the actual cost of your treatment, depending on your chosen Plan If your treatment doesn't meet the above criteria, we will pay according to your Plan benefits.
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.
Related accounts	Any account other than the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology.

How we cover In-Hospital PMB and non-PMB 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 what we pay.

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

Using the Designated Service Providers (DSPs)

All medical schemes must ensure that their members do not experience shortfalls. You should use doctors, specialists or other Healthcare Professionals who we have a payment agreement with so that they do not experience co-payments.

Depending on your chosen Plan, we will fund the hospital account at either 100% or 80% of the Scheme Rate for voluntary use of a non-DSP facility. The co-payment, which the member is liable for is equal to any amount the provider charges above 80% of the Scheme Rate. You can use the **Find a Healthcare Professional** tool on www.bankmed.co.za or call us on **0800 BANKMED (0800 226 5633)** to find Healthcare Professionals or providers who we have an agreement with for your specific Plan and to confirm how your hospital account will be funded based on your specific Plan.

There are some cases where it is not necessary to meet these requirements but you will still have full cover. An example of this is in a life-threatening emergency.

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

This can happen when you join a medical scheme for the first time, with no medical scheme membership before that. It can also happen if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme would impose a waiting period, during which you and your dependants will not have access to the PMBs, no matter what conditions you might have. We will communicate with you at the time of applying for membership if waiting periods apply.

There are a few instances when the Scheme will only pay a claim as a PMB

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

Get pre-authorisation for hospitalisation and other procedures

What pre-authorisation is and what it means

Pre-authorisation is the approval of certain procedures and any planned admission to a hospital before the procedure or planned admission takes place. It includes associated treatment or procedures performed during hospitalisation. Whenever your Healthcare Professional plans a hospital or day-clinic admission for you, you must let us know before you go to the hospital or day-clinic.

You also need specific pre-authorisation for MRI and CT scans, radio-isotope studies, and for certain endoscopic procedures, whether done in hospital or not.

In an emergency you must go directly to a hospital and notify the Scheme as soon as possible of your admission. In cases of emergency, you are covered at cost for the first 24hrs or until stable.

Contact us for pre-authorisation

Call us on 0800 BANKMED (0800 226 5633) to get pre-authorisation. We will give you an authorisation number. Please give the authorisation number to the relevant Healthcare Professional and ask them to include this when they submit their claims.

Please make sure you understand what is included in the authorisation and how we will pay your claims.

We will ask for 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 (you must get these from your treating Healthcare Professional)

Pre-authorisation does not guarantee 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 Scheme Rate, and cover for the accounts from your treating Healthcare Professionals (such as the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology), which are separate from the hospital account and are called related accounts.

There are some expenses you may have in hospital as part of a planned admission that your Hospital Benefit does not cover. Certain procedures, medication and new technologies need separate approval. It is important that you discuss this with your Healthcare Professional.

How we pay your in-hospital PMB claims

We pay for confirmed PMBs in full from the Risk Benefit if you receive treatment from a DSP. Treatment received from a non-DSP may be subject to a co-payment if the Healthcare Professional charges more than what we pay.

In order for some claims to qualify for cover as a PMB, supporting documents may be requested confirming your PMB diagnosis. Examples of such claims include MRI scans and endoscopic procedures.

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

We pay for benefits not included in PMBs according to the Rules and benefits of your chosen Plan. There are some in-hospital expenses you may have as part of a planned admission that your Hospital Benefit does not cover. An example of this would be certain procedures, medication and new technologies which need separate approval. It is important that you discuss this with your Healthcare Professional. Remember: Benefit limits, Scheme Rules, treatment guidelines and managed care criteria may apply to some healthcare services and procedures in hospital. Find out more about these by contacting us on 0800 BANKMED (0800 226 5633) or visit www.bankmed.co.za

Contact us

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

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.co.za. Customer Care Centre: 0861 123 267.
Website: www.medicalschemes.co.za