Netcare Medical Scheme Guide to Prescribed Minimum Benefits (PMBs) for In-Hospital Treatment 2022

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 type. PMB's ensure that all medical scheme members have access to continuous care to improve their health.

Netcare Medical Scheme benefits is structured to provide members comprehensive cover that is more than just the minimum benefits required by law. Always consult your Member Brochure to see how you are covered or contact the Scheme at 0861 638 633 or member@netcaremedicalscheme.co.za if you are unsure.

This document tells you how the Scheme covers Prescribed Minimum Benefits specifically for in-hospital treatment. You may also refer to the Prescribed Minimum Benefit guide on www.netcaremedicalscheme.co.za for more details in this regard.

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 or if the service provider charges in excess of the Netcare Medical Scheme (NMS) rate. You will be liable for the difference (co-payment).
Day-to-day benefits	These are the available funds allocated to the Medical Savings Account (MSA).
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.netcaremedicalscheme.co.za or click on Find a healthcare provider on the Discovery app to view the full list of DSPs.
Netcare Medical Scheme (NMS) Tariff	We pay for healthcare services from hospitals, pharmacies and healthcare professionals at this rate.
Overall Annual Limit (OAL)	A specific amount allocated and defined by either an individual member or per family unit. The OAL is the maximum amount that may be claimed by either member or the family unit. Different sub-limits apply in respect of major medical expenses.
At Cost	Fees charged by a provider that are more than the NMS Tariff.

ICD-10 code	An ICD-10 code is a clinical code that describes diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organisation.
Member	The reference to "member" in this document also includes dependants, where applicable.
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 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.

What is a Prescribed Minimum Benefit (PMB)?

Prescribed Minimum Benefits (PMBs) are guided by a list of medical conditions as defined in the Medical Schemes Act 131 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 diagnostic treatment pairs
- 27 chronic conditions (Chronic Disease List conditions)

Please refer to the Council for Medical Schemes website www.medicalschemes.co.za for a full list of the 270 diagnostic treatment pairs. All medical schemes in South Africa have to include the Prescribed Minimum Benefits (PMBs) in the plans they offer to their members.

Requirements you must meet to benefit from Prescribed Minimum Benefits (PMBs)

There are certain requirements you must meet before you can benefit from Prescribed Minimum Benefits (PMBs). The requirements are:

- The condition must qualify for cover and be on the list of defined Prescribed Minimum Benefit (PMB) conditions.

- The treatment needed must match the treatments in the defined benefits on the Prescribed Minimum Benefit (PMB) list.
- You must use the Scheme's designated service providers (DSPs) for full cover unless there is no designated service provider (DSP) applicable to your chosen health plan.

If you do not use a DSP facility, we will pay up to 75% of the NMS Tariff. 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 health plan benefits.

Important to note

- Prescribed Minimum Benefit (PMB) regulations and their accompanying provisions do not apply to healthcare services obtained outside the borders of South Africa.
- Prescribed Minimum Benefit (PMB) related claims for services obtained outside the borders of South Africa shall be treated as in accordance with your chosen health plan benefits, subject to the relevant Scheme Rate and any other limitations applicable to your benefits within the borders of South Africa.

There are a few instances where you will only have Prescribed Minimum Benefit (PMB) cover

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

There are some circumstances where you do not have cover for Prescribed Minimum Benefit (PMB)

This can happen when you join a medical scheme for the first time, with no medical scheme membership prior to joining the new scheme. 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, irrespective of the conditions you may have. We will communicate with you at the time of applying for the membership, if waiting periods apply to your membership.

How we cover In-Hospital Prescribed Minimum Benefits (PMBs)

We pay for confirmed PMBs in full from the insured or risk benefits if you receive treatment from a designated service provider (DSP). Treatment received from a non-designated service provider (non-DSP) may be subject to a co-payment if the healthcare provider charges more than what we pay.

There are some instances when you will still have full cover if you use a healthcare provider who we do not have a designated service provider (DSP) arrangement with:

- The in hospital event was an emergency.
- The use of a non-DSP was involuntary.
- There is no DSP available at the time of the event.

We may require additional supporting documents to confirm cover as a Prescribed Minimum Benefit (PMB). Documents may be requested confirming your Prescribed Minimum Benefit (PMB) diagnosis, for example Magnetic Resonance Imaging (MRI) scans and endoscopic procedure reports.

In cases where there are no services or beds available at a designated service provider (DSP) when you or one of your dependants needs treatment, you must contact us on 0861 638 633. We will intervene and make arrangements for an appropriate facility or healthcare provider to accommodate you.

We pay for benefits not included in the PMBs from your appropriate and available insured or risk and day-to-day benefits, according to the rules of your health plan.

Using the designated healthcare service providers

All medical schemes must ensure that their members do not experience shortfalls when they use DSPs. Members of the Scheme should use doctors, specialists or other healthcare providers who we have a payment agreement with so that they do not experience co-payments. In an emergency, you can go directly to hospital and notify the Scheme of your admission as soon as possible. In the case of an emergency, members are covered in full for the first 24 hours or until you are stable enough to be transferred.

To find a healthcare provider who is a designated service provider, please log in to www.netcaremedicalscheme.co.za or call us on 0861 638 633.

How your claims will be funded in hospital

Prescribed Minimum Benefit status	Service provider type	Hospital	Healthcare professional
Emergency	Designated service provider	• Hospital account is paid at the contracted rate	• Related accounts are paid in full at the agreed rate
	Not a designated service provider	• Hospital account is paid in full at cost	• Related accounts are paid in full at cost
Elective	Designated service provider	• Hospital account is paid at the contracted rate	• Related accounts are paid in full at the agreed rate
	Not a designated service provider	• Hospital account is paid up to a maximum of 75% of the NMS Tariff for voluntary use of a non-DSP.	• Related accounts are paid up to a maximum of 100% of the NMS Tariff for voluntary use of a non-DSP. The co-payment, which you are liable for, is equal to the amount that the provider charges above the NMS Tariff
Admission to a Netcare hospital (DSP) – Failure to make use of a DSP or failure to pre-authorise any hospital admission will result in a 25% hospital co-payment (including PMBs)			

Get preauthorisation for hospitalisation and other procedures

What preauthorisation is and what it means

Preauthorisation 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 doctor 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 preauthorisation for Magnetic Resonance Imaging (MRI) and Computed Tomography (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 you are stable enough to be transferred.

Contact us for preauthorisation

Call us on 0861 638 633 to get preauthorisation. We will give you an authorisation number. Please give the authorisation number to the relevant healthcare provider 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 for your claims.

We will ask for the following information when you request preauthorisation

- Your membership number
- Details of the patient (name and surname, ID number, and other relevant information)
- Date and time of the admission
- Practice number for the hospital or day clinic, and admitting doctor
- Reason for the procedure or hospitalisation
- Diagnostic codes (ICD-10 codes), tariff codes and procedure codes (you must get these from your treating doctor).

Preauthorisation does not guarantee payment of all claims

Your hospital cover

Your hospital cover includes:

- Cover for the **account from the hospital** which includes the ward and theatre fees
- 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, medicine and new technologies need separate approval. It is important that you discuss this with your healthcare provider. Please take note that Benefit limits, Scheme rules, treatment guidelines and managed care criteria may apply to some healthcare services and procedures done in hospital. Find out more about these by contacting us on 0861 638 633 or visit www.netcaremedicalscheme.co.za.

Contact us

You can call us on 0861 638 633 or visit www.netcaremedicalscheme.co.za for more information.

Complaints process

You may lodge a complaint or query with Netcare Medical Scheme directly on 0861 638 633 or address a complaint in writing to the Principal Officer at the Scheme's registered address. Should your complaint remain unresolved, you may lodge a formal dispute by following the Netcare 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.co.za / www.medicalschemes.co.za