Netcare Medical Scheme Guide to Prescribed Minimum Benefits (PMBs) 2024

Who we are

Netcare Medical Scheme registration number 1584, 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 of Netcare Medical Scheme.

Contact us

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

About this document

This document tells you how Netcare Medical Scheme ("Scheme") covers each of its members for a list of conditions called Prescribed Minimum Benefits ("PMBs").

Here are some terminologies you need to know.

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.
Shortfall	Netcare Medical Scheme pays Service Providers at a set rate, known as the Scheme rate. If the Service Providers charge higher fees than this rate, you will have to pay the difference between the Scheme rate and what the providers charged, from your pocket.
Waiting period	A waiting period can be general or condition-specific and means that you or one of your dependants have to wait for a set time before Netcare Medical Scheme will provide benefits for your medical expenses.
Chronic Drug Amount (CDA)	The CDA is a maximum monthly amount we pay up to, for a medicine class. 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 (DTP PMB)	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 rate.

Understanding Prescribed Minimum Benefits

What are Prescribed Minimum Benefits (PMBs)?

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:

- A life-threatening emergency medical conditions
- A defined list of 271 diagnoses
- 27 chronic conditions (Chronic Disease List (CDL) conditions), including HIV.

Please refer to the Council for Medical Schemes website www.medicalschemes.co.za for a full list of the diagnoses and chronic conditions.

All medical schemes in South Africa have to include the Prescribed Minimum Benefits in the membership they offer to their members.

How Netcare Medical Scheme pays claims for PMBs and non-PMB benefits

We pay for PMBs in full from the Risk Benefits 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 what we pay. We pay for benefits not included in the PMBs from your day-to-day benefits, according to the rules and benefits of your membership.

Requirements you must meet to benefit from PMBs

There are certain requirements before you can benefit from the 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 published defined benefits on the PMB list.
3. You must use the Scheme's Designated Service Providers. This does not apply in life-threatening emergencies. However even in these cases, where appropriate and according to the rules of the Scheme, you may be transferred to a Designated Service Provider or facility.

If the treatment does not meet the above criteria, we will pay the claims up to the Netcare Medical Scheme rate, which is a set rate at which the Scheme pays service providers. If the service provider charges above this rate, you will have to pay the outstanding amount from your pocket. This amount you have to pay is called a co-payment.

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 will be covered in accordance with your membership benefit and rules.

The treatment needed must match the treatments included in the defined benefits

There are standard treatments, procedures, investigations and consultations for each Prescribed Minimum Benefit (PMB) condition on the 271 diagnostic treatment (DT) Prescribed Minimum Benefit (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.co.za for a full list of the 271 diagnostic treatment pairs.

An example of a Prescribed Minimum Benefit (PMB) provision

Below is an example of a Prescribed Minimum Benefit (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 Prescribed Minimum Benefit (PMB) Provision is 236K. This is one of the listed 271 Provisions (listed 271 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 Prescribed Minimum Benefit (PMB) funding.
- The Treatment covered as a Prescribed Minimum Benefit (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 (CMS) also provides ICD-10 codes (e.g., D50.8) that fall within the 236K Provision, as per the last column in the above table. The ICD-10 codes (diagnosis codes) are an industry guide as to which conditions may qualify for Prescribed Minimum Benefit (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 Prescribed Minimum Benefit (OHPMB) funding, you or your healthcare professional may apply for medical management of life-threatening iron deficiency, vitamin and other nutritional deficiencies. This criterion stated in the Provision description needs to be met to qualify for out-of-hospital Prescribed Minimum Benefit (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 Prescribed Minimum Benefit (PMB) as 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 are met before applying for Prescribed Minimum Benefit (PMB) cover.

Netcare Medical Scheme membership offers benefits richer than that of the Prescribed Minimum Benefits

Netcare Medical Scheme covers more than just the minimum benefits required by law.

Netcare Medical Scheme claims being paid as a Prescribed Minimum Benefit

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

No cover under Prescribed Minimum Benefits

In some circumstances you might not have cover for the Prescribed Minimum Benefits. This can happen when you join a medical scheme for the first time and have never belonged to one.

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 Prescribed Minimum Benefits, no matter what conditions you might have.

You and your dependants must register to get cover for PMB conditions

How to register your PMB condition to get cover from the risk benefits

There are different types of PMB claims such as claims for In Hospital admissions, Out of Hospital PMB's (OHPMBs), PMB CDL conditions, Oncology and HIV.

To apply for out-of-hospital Prescribed Minimum Benefits cover, you must complete a Prescribed Minimum Benefit application form.

- Forms are available to download and print from www.netcaremedicalscheme.co.za. Log on to the website using your username and password. Go to Find a document and click on Application forms.
- You can also call 0861 638 633 to request any of the above forms.

We will also let you know about the outcome of the application. We will send you a letter confirming your cover for that condition.

If your application meets the requirements to benefit from Prescribed Minimum Benefits, we will automatically pay the associated approved medicine for that condition from the risk benefits (not from your available day-to-day benefits).

More information on Out of Hospital PMB's (OHPMBs) and PMB CDL conditions is available on www.netcaremedicalscheme.co.za under Medical Aid > Find a document.

If you want to apply for in-hospital Prescribed Minimum Benefit cover, you must call us on 0861 638 633 to request an authorisation.

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

The individual with the PMB condition, must complete the application form with the help of the treating doctor. The main member must complete and sign the form if the patient is a minor (younger than 18 years).

The main member and all dependants with PMB conditions must register. Each individual must register their specific conditions.

You only have to register once for your condition. If your medicine changes, your doctor can just let us know about the changes.

For new conditions, you have to register for each new condition before we will cover the medicine from the risk benefits and not from your day-to-day benefits.

Where you must send the completed registration form

You can send the completed **PMB application form**:

- By fax to: 011 539 2780
- By email to: PMB_APP@netcaremedicalscheme.co.za
- By post to: Netcare Medical Scheme, PMB Department, PO Box 652509, Benmore, 2010.

Get the most out of your benefits

Elective admissions for Prescribed Minimum Benefit (PMB) conditions and procedures are covered in full if you choose to use a designated service provider (DSP) hospital and designated service provider (DSP) treating doctors. Where your primary treating doctor is a designated service provider (DSP), reimbursement will be made in full without any co-payment for any required anaesthetic services you may need during your admission.

The below conditions need to be met for full cover for these providers:

- You are being admitted for a procedure for a Prescribed Minimum Benefit (PMB) condition
- Your chosen hospital or day facility is on the Prescribed Minimum Benefit (PMB) network for your membership
- Your primary treating doctor is on the Prescribed Minimum Benefit (PMB) network for your membership.

If all of the above conditions are met your hospital, doctor and anaesthetist accounts will be covered in full.

Oncology

Depending on your membership, once you are registered on the Oncology Programme, the Scheme covers your approved cancer treatment over a 12-month cycle up to the Scheme Rate, in accordance with your membership benefits. For non-malignant PMB conditions, please follow the OHPMB process outlined previously. For more information, please visit the website on www.netcaremedicalscheme.co.za.

HIV

When you register for our HIV Care Programme to manage your condition, you are covered for the care you need. For more information, please visit the website on www.netcaremedicalscheme.co.za.

Cover for COVID-19

The WHO Global Outbreak Benefit provides cover for global disease outbreaks recognised by the World Health Organisation (WHO) such as COVID-19. This benefit offers cover for the vaccine, out-of-hospital management and appropriate supportive treatment in the event of you contracting COVID-19. Please visit our website www.netcaremedicalscheme.co.za under Find a document > Benefit guides.

Complaint process

You may lodge a complaint or query with Netcare Medical Scheme directly on 0861 638 633 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 on the following details for assistance.

Physical address: Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157
Telephone: 0861 123 267
Email: complaints@medicalschemes.co.za
Website: www.medicalschemes.co.za