Guide to In-Hospital Prescribed Minimum Benefits

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 benefit option. PMB ensure that all medical scheme members have access to continuous care to improve their health.

The Retail Medical Scheme benefit options are structured in such a way that your chosen Option provides comprehensive cover. Always consult your Benefit Brochure 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.retailmedicalscheme.co.za under *Documents > Find a document* for more details about Prescribed Minimum Benefits (PMBs) and how they are covered.

About some of the terms we use in this document

There may be some terms we refer to in this document that you may not be familiar with. Here are the meanings of these terms.

Terminology	Description
Co-payment	This is an amount that you need to pay towards a healthcare service if the amount the service provider charges is higher than the rate we cover. The amount can vary by the type of covered healthcare service, place of service or the age of the patient.
Day-to-day benefits	These are the available funds allocated to the Medical Savings Account (MSA) and Above Threshold Benefit (ATB) on the Essential Plus Option or the Day-to-day benefits on the Essential Option.
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.retailmedicalscheme.co.za to view the full list of DSPs.
Scheme Rate	This is a rate set by us. We pay for healthcare services from hospitals, pharmacies and healthcare professionals at this rate.
ICD-10	A clinical code that describes diseases, signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO).
At Cost	Fees charged by a provider that are more than the Scheme Rate.
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 or 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.

Retail Medical Scheme

Administered by Discovery Health

What is Prescribed Minimum Benefits?

Prescribed Minimum Benefits (PMB) 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 271 diagnostic treatment pairs
- 27 chronic conditions including HIV and Aids (Chronic Disease List conditions).

Please refer to the Council for Medical Schemes website www.medicalschemes.co.za for a full list of the 271 diagnostic treatment pairs. All medical schemes in South Africa have to include the PMB in the benefit options they offer to their members.

Requirements you must meet to benefit from PMB

There are certain requirements before you can benefit from PMB. The requirements are:

- The condition must qualify for cover and be on the list of defined PMB conditions.
- The treatment needed, must match the treatments in the defined benefits on the PMB list.
- You must use the Scheme's Designated Service Providers (DSP) for full cover, where applicable.

If you do not use the services of the Scheme's DSP, we will pay up to 100% of the Scheme 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 those cases, where appropriate and according to Scheme Rules, you may be transferred to a hospital or other service providers in the 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 Option's benefits.

Important to 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 paid, 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 PMB cover

When you have a waiting period, or when you have treatments linked to conditions that are excluded by your benefit option, we may only pay for PMB treatment and care. When you join the Scheme, you may have a three-month general waiting period or a 12-month condition-specific waiting period. Depending on the category of waiting periods, you may still qualify for cover from the Prescribed Minimum Benefits.

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

This can happen when you are a first-time member, with no previous medical scheme membership before joining Retail Medical Scheme, or when you join the Scheme more than 90 days after leaving your

previous medical scheme. In both these cases, the Scheme could impose waiting periods, during which you and your dependants will not have access to PMB.

How we pay for In-Hospital Prescribed Minimum Benefits

We pay for confirmed PMB in full if you receive treatment from a DSP and/or preferred supplier. Treatment received from a non-DSP or medical items supplied by a non-preferred supplier may be subject to a co-payment if the healthcare provider or supplier charges more than the amount 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 the PMB cover. To confirm your PMB diagnosis, we may for example request copies of the Magnetic Resonance Imaging (MRI) scans and endoscopic procedure reports.

In cases where there are no services or beds available at a DSP Hospital when you or one of your dependants needs to be admitted, you must contact us on **0860 101 252**. We will intervene and make arrangements for an appropriate facility or healthcare provider to accommodate you.

If you are admitted into a DSP Hospital and your admitting doctor is a DSP provider, you will receive full cover if your condition is a PMB. Under these circumstances we will also fund all related accounts (where the provider does not have an agreement with us) at cost. All related accounts for healthcare providers that do have agreements with us will be funded at the agreed rates.

We pay for non-PMB benefits from your appropriate and available Hospital Benefit and/or day-to-day benefits, according to the rules of your benefit option.

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, the Scheme will pay in full for the first 24 hours treatment or care, or until you are stable enough to be transferred.

You can use Find a healthcare provider on www.retailmedicalscheme.co.za or call us on 0860 101 252 to find a DSP near you. Some DSP's related to in-hospital care, when you are admitted to hospital, are hospitals, specialists, GPs, psychologists, and social workers.

Get pre-authorisation for hospitalisation and other procedures

What pre-authorisation is and what it means

Pre-authorisation is the approval of any planned admission to a hospital before the procedure or planned admission takes place, or if you need other specific high-cost treatment and care. 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 pre-authorisation for Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans, radio-isotope studies, and for certain endoscopic procedures, whether done in hospital, or not.

Contact us for pre-authorisation

Call us on **0860 101 252** to get pre-authorisation. We will give you an authorisation number, which you must please give to the relevant healthcare provider and ask them to include it 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, 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).

Please note: If you don't preauthorise your admission within 48 hours of being admitted, we will only pay 70% of the costs that we would normally cover, for the hospital and related accounts Visit www.retailmedicalscheme.co.za to find a network hospital applicable to your benefit option.

Pre-authorisation does not guarantee we will pay 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 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, for example certain procedures, medicine and new technologies, which may need separate approval. It is important that you discuss this with your healthcare professional. Please take note that 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 **0860 101 252** or visit **www.retailmedicalscheme.co.za** under *Hospital and doctor visits > Hospital admission and emergencies* for more information on how you will be covered.

PMB 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	If your primary admitting doctor is a DSP, related accounts are paid in full at the agreed rate
	Not a designated service provider	Hospital account is paid up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The co-payment, which you will be liable for, is equal to the amount that the provider charges above the Scheme Rate	Related accounts are paid up to a maximum of 100% of the Scheme Rate 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 Scheme Rate

Contact us

You can call us on **0860 101 252** or visit www.retailmedicalscheme.co.za for more information.

Complaints process

You may lodge a complaint or query with Retail Medical Scheme directly on 0860 101 252 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 Retail 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.