

2020

DISCOVERY HEALTH MEDICAL SCHEME

GUIDE TO PRESCRIBED MINIMUM BENEFITS

Overview

All registered medical schemes in South Africa need to cover Prescribed Minimum Benefits (PMBs) on all the plans they offer to their members. 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.

Discovery Health Medical Scheme (The Scheme) plans are structured in such a way so as to maximise cover no matter which plan members choose. Some plans cost more but offer more comprehensive benefits, while others have lower contributions with fewer benefits. Regardless of this, all our plans cover more than just the minimum benefits required by law. Always consult your Health Plan Guide on www.discovery.co.za to see how you are covered.

This document tells you how we cover out-of-hospital Prescribed Minimum Benefits. For more information on your in-hospital PMB cover please visit our website www.discovery.co.za and click on Find documents.

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
Chronic Disease List (CDL)	A defined list of chronic conditions we cover according to the Prescribed Minimum Benefits.
Chronic Drug Amount (CDA)	Discovery Health Medical Scheme pays up to a monthly amount for a chronic medicine class subject to the member's plan type. This applies to chronic medicine that is not listed on the formulary or medicine list. The Chronic Drug Amount does not apply to the Smart and KeyCare plans, on these plans the cost of the lowest formulary listed drug will apply.
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 service provider charges is higher than the rate we cover. If the co-payment amount is higher than the amount charged for the healthcare service, you will have to pay for the cost of the healthcare service.
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 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.discovery.co.za or click on Find a healthcare provider on the Discovery app to view the full list of DSPs.
Diagnosis and treatment pair (DTP)	A diagnosis and treatment pair links a specific diagnosis to a treatment based on best practice healthcare and affordability of the treatment and broadly indicates how each of the 270 Prescribed Minimum Benefit conditions should be treated.
Discovery Health Rate	This is a rate set by us. We pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services at this rate.
Discovery Health Rate for Medicine	This is a rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services.

TERMINOLOGY	DESCRIPTION
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.
Member	The reference to member in this document also includes dependants, where applicable.
Reference Price	The price at which non-formulary medicine that falls in the same medicine category and generic group as the formulary medicine is paid by the Scheme.
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)?

PMBs are guided by a list of medical conditions as defined in the Medical Schemes Act 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:

- 1 | Any life-threatening emergency medical condition
- 2 | A defined set of 270 diagnoses
- 3 | 27 chronic conditions (Chronic Disease List conditions).

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

Requirements you must meet to benefit from PMBs

There are certain requirements before you can benefit from 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 defined benefits on the PMB list.
- 3 | You must use the Scheme's DSPs for full cover unless there is no DSP applicable to your plan.

If you do not use a DSP we will pay up to 80% of the Discovery Health Rate (DHR). 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 plan benefits.

Claims for services received outside of the borders of South Africa will be covered in accordance with your chosen plan benefits and rules. For more information on cover while travelling, please refer to the guide on the Cover for treatment received abroad, available on our [website www.discovery.co.za](http://www.discovery.co.za) and click on *Find documents*.

The medical condition must be part of the list of defined conditions for PMB

Members should send the Scheme the results of their medical tests and investigations that confirm the diagnosis of the condition. This will allow us to identify that the member's condition qualifies for the treatment. The member's treating doctor needs to provide the relevant documentation to assist us in confirming the diagnosis.

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

There are standard treatments, procedures, investigations and consultations for each PMB condition on the 270 diagnostic treatment (DT) 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.com for a full list of the 270 diagnostic treatment pairs.

An example of a PMB provision

Below is an example of a 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 PMB Provision is **236K**. This is one of the listed 270 Provisions (listed 270 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 PMB funding.
- The **Treatment** covered as a 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 (CoMS) also provides **ICD 10 codes** (eg. D50.8) that fall within the **236K Provision**, as per the last column in the above table. The ICD 10 codes are an industry guide as to which conditions may qualify for 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 PMB (OHPMB) funding, you or your healthcare professional may apply for medical management of life threatening iron deficiency; vitamin and other nutritional deficiencies. This criteria stated in the **Provision description** needs to be met to qualify for 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 PMB 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 is met before applying for PMB cover.

How we pay claims for PMBs and non-PMB benefits

We pay for confirmed PMBs in full 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 the amount we pay.

We pay for benefits not included in the PMBs from your appropriate and available plan benefits, according to the rules of your chosen health plan. Visit www.discovery.co.za or click on **Find a healthcare provider** using your Discovery app or call us on 0860 99 88 77 to find a participating DSP healthcare provider.

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 previous medical scheme membership. Also if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme will impose a

waiting period, during which you and your dependants will not have access to the PMBs, regardless of the conditions you may have. We will communicate with you at the time of applying for your membership if any waiting periods apply to you or your dependants.

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.

You and your dependants must register to get cover for PMBs and Chronic Disease List (CDL) conditions

How to register your chronic or PMB conditions to get cover from your risk benefits

There are different types of PMBs. These include PMB cover for in-hospital admissions, conditions covered under the Chronic Disease List, the out-of-hospital management of PMB conditions, and treatment of PMB conditions such as HIV and oncology.

To apply for out-of-hospital PMBs or cover for a Chronic Disease List (CDL) condition, you must complete the *Prescribed Minimum Benefit* or a *Chronic Illness Benefit* application form.

- Up to date forms are always available on www.discovery.co.za under Medical Aid > Find a document.
- You can also call 0860 99 88 77 to request any of the above forms.

For more information on the PMB Chronic Disease List conditions, HIV or Oncology and how to register please refer to the relevant benefit guides available on www.discovery.co.za under Medical Aid > Find a document.

To confirm your in-hospital cover for PMB conditions, you can call us on 0860 99 88 77 and request an authorisation. We will then tell you about your cover.

Why it is important to register your PMB or chronic condition

We pay for specific healthcare services related to each of your approved conditions. These services include approved treatment, medicine, consultations, blood tests and other defined investigative tests. We pay for these services from your Prescribed Minimum Benefits which will not affect your day-to-day benefits.

We will pay for treatment or medicines that fall outside the defined benefits and that are not approved, from your available day-to-day benefits, according to your chosen health plan. If your health plan does not cover these expenses, you will have to pay these claims.

Who must complete and sign the registration form when applying for PMB or chronic condition cover

The person with the PMB or chronic condition must complete the relevant application form with the help of their treating doctor. The main member must complete and sign the form if the patient is a minor.

Each person with PMB or chronic conditions must register their specific conditions separately. You only have to register once for a chronic condition. If your medicine or other treatment changes, your doctor can let us know about these changes.

For new conditions, you will have to register each new condition before we will cover the treatment and consultations from your Prescribed Minimum Benefits and not from your day-to-day benefits.

Additional documents needed to support your application

You must send the Scheme the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying for. This will help us to identify that your condition qualifies for PMB benefits.

Where you must send the completed application form(s) to

You must send the completed **PMB application form** using either of the following methods:

- 1 | Fax to: 011 539 2780
- 2 | Email to: PMB_APP_FORMS@discovery.co.za
- 3 | Post to: Discovery Health, PMB Department, PO Box 652919, Benmore, 2010.

You must send the completed **Chronic Illness Benefit application form** using either of the following methods:

- 4 | Fax to: 011 539 7000
- 5 | Email to: CIB_APP_FORMS@discovery.co.za
- 6 | Post to: Discovery Health, CIB Department, PO Box 652919, Benmore, 2010.

We will let you know if we approve your application for PMB or chronic condition cover and what you must do next

We will let you know about the outcome of your application and will send you a letter confirming your cover for the condition, using your preferred method of communication. If your application meets the requirements for cover from PMBs, we will automatically pay the associated approved blood tests and other defined investigative tests, treatment, medicine and consultations for that condition from your Prescribed Minimum benefits, and not from your day-to-day benefits.

The treatment needed must match the treatments in the published defined benefits on the PMB list as there are standard treatments, procedures, investigations and consultations for each condition on the PMB list. These defined benefits are supported by thoroughly researched evidence, based on clinical protocols, medicine lists (formularies) and treatment guidelines.

What happens if you need treatment that falls outside of the defined benefits

If you need treatment that falls outside of the defined benefits you and your healthcare professional can send additional clinical information with a detailed explanation of the treatment that is needed and we will review it. If this treatment is not approved as Prescribed Minimum Benefit, it can be paid from your available day-to-day benefits, according to your chosen health plan. If your health plan does not cover these expenses, you will have to pay the costs of these claims.

To appeal against the funding decision on PMB cover or cover for chronic medicine/treatment:

- 1 | Download the OHPMB *Appeal Form* or *Chronic Illness Benefit Appeal form*. Up to date forms are always available on www.discovery.co.za under Medical Aid > Find a document. You can also call 0860 99 88 77 to request any of the above forms.
- 2 | Complete the form with the assistance of your doctor/healthcare professional.
- 3 | Send the completed, signed form, along with any additional medical information, by email to PMB_APP_FORMS@discovery.co.za or by fax 011 539 2780 or by email to CIB_APP_FORMS@discovery.co.za or by fax to: 011 539 7000

If we approve the requested medicine/treatment on appeal, we will automatically pay these from either the PMB or Chronic Illness Benefit, whichever is applicable. If the appeal is unsuccessful and you are not satisfied with the outcome you may also lodge a formal dispute by following the Scheme's disputes process on www.discovery.co.za.

For more information on your cover for Chronic or PMB medicine please visit our website www.discovery.co.za and click on Find documents.

What happens if there is a change in your approved medicine

For chronic conditions, your treating doctor or dispensing pharmacist can make changes to your medicine telephonically by calling 0860 99 88 66 or by faxing an updated prescription to 011 539 7000 or emailing it to CIB_APP_FORMS@discovery.co.za

For other PMB conditions, the treating doctor or dispensing pharmacist can only make changes to medicine by sending the updated prescription by fax to 011 539 2780 or emailing it to PMB_APP_FORMS@discovery.co.za

If you get your medicine or treatment from a provider of your choice instead of the Scheme's DSPs

You must use doctors, specialists and other healthcare providers, including pharmacies, who we have a payment arrangement with, to avoid a co-payment. This does not apply in the event of an emergency or where the use of a non-DSP provider is involuntary or when no DSP is available. If you use a healthcare provider who we do not have a payment arrangement with, you will have to pay part of the treatment costs yourself.

In an emergency, you can go directly to hospital and notify the scheme as soon as possible of their admission. In the case of an emergency, members are covered in full for the first 24hrs or until you are stable enough to be transferred.

Go to www.discovery.co.za or click on Find a healthcare provider using your Discovery app **or** call us on 0860 99 88 77 to find a participating DSP healthcare provider.

What to do if there is no available DSP at the time of your request

There are some instances when you will still have full cover if you use a healthcare provider who we do not have a DSP arrangement with. An example of this is in an emergency, cases when the use of a non-DSP is involuntary or when there is no DSP available.

In cases where there are no services or beds available at a DSP when you or one of your dependants need treatment, you can contact us on 0860 99 88 77 and we will make arrangements for an appropriate facility or healthcare provider to accommodate you.

Cover for Cancer

Depending on your chosen health plan, once you are registered on the Oncology Programme, the Scheme covers your approved cancer treatment over a 12-month cycle up to the Discovery Health Rate, in accordance with your plan benefits.

Cancer treatment that is a Prescribed Minimum Benefit (PMB), is always covered in full. All PMB treatment costs add up to the oncology cover amount for your plan. If your treatment costs more than the cover amount we will continue to cover your PMB cancer treatment in full.

For more information on your cover for cancer please visit our website www.discovery.co.za and click on Find document.

Other PMB conditions

For other PMB conditions, you can apply for out-of-hospital Prescribed Minimum Benefits, as outlined above. For more information please visit our website www.discovery.co.za and click on Find Document.

Cover for HIV

When you register for our HIV Care Programme to manage your condition, you are covered for the care you need, which includes additional cover for social workers. You can be assured of confidentiality at all times.

For more information on your cover for HIV please visit our website www.discovery.co.za and select Find a document.

Cover for PMB admissions

You must pre-authorise all hospital admissions. When you call us to pre-authorise we will tell you how you are covered.

You must use designated services providers in our network. This does not apply in emergencies. 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 stabilized. If you do not use a DSP we will pay up to 80% of the Discovery Health Rate.

For more information on your in-hospital PMB cover please visit our website www.discovery.co.za and click on Find a document.

Contact us

Tel (Members): 0860 99 88 77, Tel (Health partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za,
1 Discovery Place, Sandton, 2196.

Complaints process

Discovery Health Medical Scheme is committed to providing you with the highest standard of service and your feedback is important to us. The following channels are available for your complaints and we encourage you to follow the process:

1 | STEP 1 – TO TAKE YOUR QUERY FURTHER:

If you have already contacted the Discovery Health Medical Scheme and feel that your query has still not been resolved, please complete our online complaints form on www.discovery.co.za. We would also love to hear from you if we have exceeded your expectations.

2 | STEP 2 – TO CONTACT THE PRINCIPAL OFFICER:

If you are still not satisfied with the resolution of your complaint after following the process in Step 1 you are able to escalate your complaint to the Principal Officer of the Discovery Health Medical Scheme. You may lodge a query or complaint with Discovery Health Medical Scheme by completing the online form on www.discovery.co.za or by emailing principalofficer@discovery.co.za.

3 | STEP 3 – TO LODGE A DISPUTE:

If you have received a final decision from Discovery Health Medical Scheme and want to challenge it, you may lodge a formal dispute. You can find more information of the Scheme's dispute process on the website.

4 | STEP 4 – TO CONTACT THE COUNCIL FOR MEDICAL SCHEMES:

Discovery Health Medical Scheme is regulated by the Council for Medical Schemes. You may contact the Council at any stage of the complaints process, but we encourage you to first follow the steps above to resolve your complaint before contacting the Council. Contact details for the Council for Medical Schemes: Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion 0157 | complaints@medicalschemes.com
0861 123 267 | www.medicalschemes.com