Guide to Prescribed Minimum Benefits

2016

No matter what plan you decide on, there are some common benefits that apply to all members on all plans

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

Understanding the 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 condition
- A defined list of 270 diagnoses
- A defined list of 27 chronic conditions ("Chronic Disease List conditions").

Please refer to the Council for Medical Schemes website (http://www.medicalschemes.com) for a full list of the diagnoses and chronic disease list conditions.

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

How Discovery Health 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). A designated service provider (DSP) is a healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have a payment arrangement with. According to this arrangement, they will provide treatment or services at a contracted rate. This will make sure that you do not have any co-payments when you use their services.

You can use the MaPS Advisor on www.discovery.co.za, the Discovery app or call us on 0860 99 88 77 to find a healthcare service provider we have a DSP payment arrangement with.

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 chosen health plan.

Requirements you must meet to benefit from PMBs

There are certain requirements before you can benefit from the Prescribed Minimum Benefits. The requirements are:

01 | The condition must qualify for cover and be on the list of defined PMB conditions

02 | The treatment needed must match the treatments in the published defined benefits on the PMB list

03 | 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 hospital or facility.

If the treatment does not meet the above criteria, we will pay the claims up to the Discovery Health 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.

Discovery Health Medical Scheme plans offer benefits richer than that of the Prescribed Minimum Benefits

All Discovery Health Medical Scheme plans cover more than just the minimum benefits required by law.

Sometimes Discovery Health Medical Scheme will only pay a claim as a Prescribed Minimum Benefit

This happens when you are in a waiting period or when you have treatments linked to conditions that are excluded by your plan. 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.

There may be times when you do not have cover under Prescribed Minimum Benefits

There are some circumstances where you do not have cover for the Prescribed Minimum Benefits. 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 Prescribed Minimum Benefits, no matter what conditions you might have.

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

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

There are different types of claims for Prescribed Minimum Benefits. There are claims for hospital admissions, chronic conditions and other conditions treated out of hospital.

If you want to apply for out-of-hospital Prescribed Minimum Benefits or cover for a Chronic Disease List condition, you must get a *Prescribed Minimum Benefit* or a *Chronic Illness Benefit a*pplication form.

- Both forms are available to download and print from www.discovery.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 0860 99 88 77 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 blood tests and other investigative tests, treatment, medicine and consultations for that condition from the risk benefits (not from your available day-to-day benefits).

If you want to apply for in-hospital Prescribed Minimum Benefit cover, you must call us on 0860 99 88 77 to request an authorisation.

Why it is important to register your PMB or chronic conditions

The Scheme pays for specific healthcare services related to each of your approved conditions. These services include treatment, medicine, consultations, blood tests and other investigative tests. We pay for the services without affecting your day-to-day benefits because we pay it from your risk benefits.

We will pay for treatment or medicine that falls outside the defined benefits and that is 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 the claims.

There are times when you need to apply for cover under the Prescribed Minimum Benefits. Once your healthcare professional confirms the diagnosis as a Prescribed Minimum Benefit condition, you can apply to us for payment of the claims from risk benefits without using your available day-to-day benefits. Once approved, we will automatically recognise that the medical services you are claiming for fall under the Prescribed Minimum Benefits.

When you do not register your condition as a PMB or chronic condition

We will pay all the consultations, blood tests, other investigative tests, medicine and treatment for the PMB or chronic condition from your available day-to-day benefits.

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

The individual with the PMB or chronic 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 or chronic conditions must register. Each individual must register their specific conditions.
You only have to register once for a chronic condition. If your medicine or other treatment 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 treatment and consultations from the risk benefits and not from your day-to-day benefits.

Additional documents needed to support the application

You may need to send the Scheme the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying for cover. This will help us to identify that your condition qualifies for the chronic medicine.

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_FORMS@discovery.co.za
- By post to: Discovery Health, PMB Department, PO Box 652919, Benmore, 2010.

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

- By fax to: 011 539 7000
- By email to: CIB_APP_FORMS@discovery.co.za
- By 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 inform you of our decision by fax or email (as you have indicated on your application form). 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 Prescribed

Minimum Benefit list. These defined benefits are supported by thoroughly researched evidence, based on clinical protocols, medicine lists (formularies) and treatment guidelines.

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

The Scheme is only required to cover defined benefits. If treatment that falls outside the defined benefits is not approved, it will 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 be responsible to pay the claims.

If you need treatment that falls outside of the defined benefits and you send additional clinical information with a detailed explanation of why the treatment is needed, the Scheme will review it and may choose to approve the treatment. If we decline the request, you may contact us to lodge a formal dispute by following the dispute process detailed on the website at www.discovery.co.za

We cover approved medicine on our medicine list (formulary) in full

We pay medicine on the medicine list (formulary) up to the Discovery Health Rate for medicines. There will be no co-payment for medicine selected from the medicine list.

If we approve a medicine that is not on the medicine list, we will pay it up to a set monthly rand amount called the Chronic Drug Amount (CDA). You may have a co-payment if the cost of the medicine is greater than the Chronic Drug Amount.

This is unless the medicine is a substitute for one that has been ineffective or has caused an adverse reaction. In that case you and your doctor can appeal the funding decision. If the appeal is successful there will be no co-payment.

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

1. Download and print a “PMB Appeal Form” or “The Chronic Illness Benefit Appeal form”, available on www.discovery.co.za. Members can also call 0860 99 88 77 to request any of the above forms
2. Complete the appeal form with the assistance of your healthcare professional
    - Send the completed, signed appeal 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 by fax to: 011 539 7000
3. If we approve the requested medicine/treatment on appeal, we will automatically pay from risk benefits. If the appeal is unsuccessful the member can lodge a formal dispute by following Discovery Health Medical Scheme’s internal disputes process on the Discovery website.

***Please note**: The Chronic Drug Amount (CDA) does not apply to the Smart Plan and KeyCare plans.*

We will tell you if we make changes to the medicine list and it affects you

Because there are regular changes to our medicine list, we only inform those members who will be affected by the changes. For example, we will only inform members who are registered for high blood pressure about changes to high blood pressure medicines on the medicine list.

When you need to get more than one month's supply of medicine

You can get more than one month's supply of approved chronic medicine if you are travelling outside the borders of South Africa. You need to fill in an *Extended Supply of Medicine form.* Log on to the website using your username and password. Go to *Find a document* and click on *Application forms.* Send the form to us using the details provided on the form. The Scheme will review your request and tell you if they have approved it.

About what happens if there is a change in your approved medicine

For chronic conditions, the treating doctor or dispensing pharmacist can make changes to medicines telephonically by calling 0860 99 88 66. You can also fax an updated prescription to 011 539 7000 or email it to CIB_APP_FORMS@discovery.co.za

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

About what happens if you get your medicine from a provider of your choice instead of the Scheme's designated service providers (DSPs)

All medical schemes must make sure their members do not experience co-payments when they use designated service providers. A designated service provider (DSP) is a healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have a payment arrangement with. You must use doctors, specialists and other healthcare providers who we have a DSP payment arrangement with, so that you do not experience a co-payment.

If you do not use healthcare providers who we have a DSP payment arrangement with, you will have to pay part of the treatment costs yourself. This amount you have to pay is called a co-payment.

Go to www.discovery.co.za for the latest copy of the treatment guidelines or contact us on 0860 99 88 77 and we will send you a copy.

What to do if there is no available designated service provider at the time of your request

There are some cases where it is not necessary to use designated service providers, but you will still have full cover. An example of this is in a life-threatening emergency.

In cases where there are no services or beds available within the designated service provider when you or one of your dependants needs treatment, you must contact us on 0860 99 88 77 and we will intervene and make arrangements for an appropriate facility or healthcare provider to accommodate you.

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 admission takes place. It includes associated treatment or procedures performed during hospitalisation.

You also need specific preauthorisation for MRI and CT scans, radio-isotope studies, and for certain endoscopic procedures, whether during hospitalisation or not.

Whenever your doctor plans a hospital admission for you, you must let us know 48 hours before you go to hospital.

Benefits that require preauthorisation

You need to get preauthorisation from us for:

- Hospitalisation
- Day-clinic admissions
- Special procedures (like a scopes, MRI and CT scans).

Who you must contact for preauthorisation

Call us on 0860 99 88 77 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 it when they submit their claim.

You can also log in to www.discovery.co.za and use HospitalXpress to plan and preauthorise most admissions and also read the important information that tells you how we will pay for your hospital stay.

Please make sure you understand what is included in the authorisation and how we will pay the 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 more)
- 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, we will only pay 70% of the costs we would normally cover. Certain plans give full cover only if you use a network hospital. Please find out if the hospital you plan to use, is part of the network applicable to your health plan.

Preauthorisation 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 Discovery Health 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.

Remember: Limits, clinical guidelines and policies apply to some healthcare services and procedures in hospital.

There are some expenses you may incur while you are in hospital that we don't cover. Also, certain procedures, medicines or new technologies need separate approval. Please discuss this with your doctor or the hospital.

Find out more about our clinical rules and policies for cover by contacting us on 0860 99 88 77 or log in to our website to view "what we cover".

What happens once you are admitted to hospital

Your cover is subject to the Scheme rules, funding guidelines and clinical rules. There are some expenses you may have in hospital as part of a planned admission that your Hospital Benefit does not cover. Certain procedures, medicines and new technologies need separate approval. It is important that you discuss this with your doctor or the hospital.

Contact us

You can call us on 0860 99 88 77 or visit www.discovery.co.za for more information.

Complaints process

You may lodge a complaint or query with Discovery Health Medical Scheme by completing an online complaints form on www.discovery.co.za or address a complaint in writing directly to the Principal Officer. Should your complaint remain unresolved, you may lodge a formal dispute by following Discovery Health Medical Scheme's internal disputes process on the Discovery website. 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 email complaints@medicalschemes.com. Customer Care Centre: 0861 123 267 / website www.medicalschemes.com