ANNEXURE D.1
PRESCRIBED MINIMUM BENEFITS (PMBs)

1.1 Definitions

1.1.1 'Prescribed Minimum Benefits'

The benefits contemplated in section 29(1)(o) of the Medical Schemes Act (Act 131 of 1998) (the Act) and consist of the provision of the diagnosis, treatment and care costs of –

(a) the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations to the Act, subject to any limitations specified therein; and

(b) any emergency medical condition.

1.1.2 'Prescribed minimum benefit condition'

A condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations to the Act or any emergency medical condition.

1.1.3 'Emergency medical condition'

Means 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 could result in serious impairment to bodily functions or serious dysfunction of bodily organ or part, or would place the person's life in serious jeopardy.

1.1.4 'Designated service provider'

"Means a health care provider or group of providers selected by the medical scheme as the preferred provider or providers to provide to its members' diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions."

1.2 Interventions shall be deemed hospital-based where they require:

1.2.1 An overnight stay in hospital;

1.2.2 The use of an operating theatre together with the administration of a general or regional anesthetic;

1.2.3 The application of other diagnostic or surgical procedures that carry a significant risk of death, and consequently require on-site resuscitation and/or surgical facilities;

1.2.4 The use of equipment, medications or medical professionals not generally found outside of hospitals; or

1.2.5 Where the treatment component of a category in Annexure A of the Regulations in terms of the Medical Schemes Act is stated in general terms.

1.3 Medical management or surgical management as stipulated in published guidelines:

1.3.1 '…should be interpreted as referring to prevailing Public hospital-based medical or surgical diagnostic and treatment practice for the specified condition. Where significant differences exist between Public and Private sector practices, the interpretation of the Prescribed Minimum Benefits should follow the predominant Public Hospital practice, as outlined in the relevant provincial or national public hospital clinical protocols, where these exist. Where clinical protocols do not exist, disputes will be settled by consultation with provincial health authorities to ascertain prevailing practice.'

The following interventions shall however be excluded from the generic medical/surgical management categories unless otherwise specified:

1.3.1.1 Tumor chemotherapy

1.3.1.2 Tumor radiotherapy

1.3.1.3 Bone marrow transplantation / rescue

1.3.1.4 Mechanical ventilation

1.3.1.5 Hyperbaric oxygen therapy

1.3.1.6 Organ transplant

1.3.1.7 Treatments, drugs or devices not yet registered by the relevant authority in the Republic of South Africa

1.4 As per the provisions of Regulation 8(4) which allows for medical schemes to employ appropriate managed health care interventions, benefits in respect of PMB shall be subject to the following:

1.4.2.1 Pre-authorization;

1.4.2.2 Authorization for emergency medical conditions within 24 (twenty-four) hours or the first working day thereafter;

1.4.2.3 Designated service providers (where applicable);

1.4.2.4 Bestmed treatment protocols; and

1.4.2.5 Formularies.

1.5 The following principles apply for the reimbursement of medicine:

1.5.1 Where medicines have generic alternatives registered with the Medicines Control Council (MCC) of South Africa, the Scheme will reimburse those medicines up to the generic reference price for that active ingredient (MRP price);

1.5.2 Benefit amount of medicine will be calculated at Single Exit Price (SEP), taking in account 1 above plus professional fee as determined by the Scheme plus VAT, where applicable; and

1.5.3 Designated service providers (DSP) may apply with possible penalty (co-payment) for the voluntary use of a non-DSP.

1.6 Designated Service Providers

Bestmed, in terms of the provisions of the Medical Schemes Act and the Regulations thereof, designates State facilities, where contracts are in place, for the delivery of Prescribed Minimum Benefits (PMBs), where these benefits are reasonably available and can be assured: providing that a formal contract is submitted to the CMS as determined. The Scheme may further designate a specific preferred provider or a group of providers to provide diagnosis, treatment and care in respect of one or more PMB conditions. A full list of the Scheme's contracted designated service providers (DSPs) is available from the Scheme's website or can be provided through the Scheme's Client Service channels, on request. In the case of hospital admission and network providers the member must first obtain pre-authorisation, except in the case of an Emergency medical condition as defined in the Medical Schemes Act No 131 of 1998, where authorisation must be obtained within 24 (twenty-four) hours or on the first working day thereafter.

1.7 Chronic Disease List treatment algorithms

Bestmed will fund in accordance with the published legislative treatment algorithms for registered conditions on the Chronic Disease List. The Beneficiaries' treating physician must apply in writing to register any and all conditions listed on the Chronic Disease List at Bestmed's medicine department, before these benefits can be applied. Refer to the section on medicine benefits.

1.8 Prescribed minimum benefits voluntarily obtained from other providers in respect of hospitalisation

If a Beneficiary voluntarily obtains diagnosis, treatment and care in respect of hospitalisation and other PMB related treatment or consultations from a provider other than a designated service provider (DSP), the benefit payable in respect of such a service is subject to a co-payment equal to the difference between the actual cost incurred and the Scheme tariff or contracted DSP rate, whichever is less.

1.9 Prescribed minimum benefits involuntarily obtained from other providers

If a Beneficiary involuntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider (DSP), Bestmed will fund the services in relation to those prescribed minimum benefit conditions, subject to the limitations specified within published legislation and guidelines of governing bodies, provided that:

1.9.1 The service was not available from the designated service provider (DSP) or would not be provided without unreasonable delay;

1.9.2 Immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or

1.9.3 There was no designated service provider (DSP) within reasonable proximity to the Beneficiary's ordinary place of business or personal residence.

Except in the case of an Emergency medical condition, pre-authorisation must be obtained by a member prior to involuntarily obtaining a service from a provider other than a designated service provider (DSP) in terms of this paragraph, to enable the Scheme to confirm that the circumstances are applicable for the use of a provider other than the designated service provider (DSP). In the case of an emergency medical condition, the member must obtain the authorisation within 24 (twenty-four) hours of the incident or on the next working day.

1.10 Prescribed minimum benefits obtained from a public hospital

Notwithstanding anything to the contrary contained in these rules, prescribed minimum benefits obtained in a public hospital, subject to the published treatment pairs and algorithms will be funded as determined by the Scheme, i.e. in full or at UPFS rates.

1.11 Diagnostic tests for an unconfirmed PMB condition

Where diagnostic tests and examinations are performed but do not result in confirmation of a PMB diagnosis, except for an Emergency medical condition, such diagnostic tests or examinations are considered not to be a PMB.

1.12 Co-Payments

Co- payments in respect of the costs for PMBs may not be paid out of Member's Personal Medical Savings Accounts, where applicable in terms of the Benefit option the Member is registered on.

Co-payments in respect of the costs for PMBs may be applied for the voluntary use of a non-designated service provider.