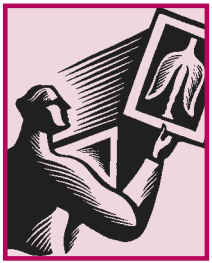
Council for Medical Schemes



MEDICAL SCHEME MEMBERS

Prescribed Minimum Benefits

10 Things

no one tells you about PMBs

Minimum benefits are always part of the deal

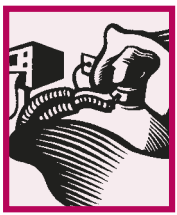
In terms of the Medical Schemes Act, medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- any emergency medical condition;
- a limited set of ±270 medical conditions; and
- 25 chronic conditions.

This is known as Prescribed Minimum Benefits (PMBs) and you are entitled to these benefits regardless of the medical scheme option you have selected. PMBs, where indicated, include medicine.

Exclusions are excluded

Medical schemes often have a list of conditions – such as cosmetic surgery – for which they will not pay, or circumstances – such as examinations for insurance purposes – under which a member has no cover. These exclusions, however, do not apply to PMB conditions. If you contract septicaemia after cosmetic surgery, for example, your scheme has to provide healthcare cover for septicaemia because it is a PMB. PMBs are concerned about the diagnosis; it doesn't matter how you got the condition.



The DSP and me

A Designated Service Provider (DSP) is a healthcare provider (doctor, pharmacist, hospital, etc) that is your medical scheme's first choice when your PMB condition needs attention. State facilities can be designated as a DSP only where services are reasonably available and accessible.

When you choose not to use the DSP, you may have to pay a portion of the claim (a co-payment).

Your medical scheme has to ensure that it is easy for you to get to the DSP. If there is no DSP reasonably close to your work or home, then you can visit any provider and the scheme has to pay.

When you suffer an emergency condition, or are involved in an accident, you may go to the nearest healthcare facility for treatment, even if it is not a DSP.

Are co-payments okay?

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Yes, co-payments are okay IF you decide of your own free will not to use your scheme's DSP. The co-payment will either be the difference between the actual cost and what the scheme would have paid if you had used its DSP, or the percentage co-payment as registered in the scheme's rules.

However, co-payments are not okay IF you have followed the rules and used your scheme's DSP. Remember that your savings account cannot be used for PMB co-payments.

SOS!

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Emergencies do not usually allow for careful planning, especially when lives are at stake. The treatment of emergencies is also a Prescribed Minimum Benefit, which means your scheme has to pay for the appropriate treatment.

When you end up in the emergency room and the doctors suspect that you are suffering from a PMB condition, your medical scheme has to approve the treatment. Once your life is no longer in danger, the diagnosis of your condition will have to be confirmed so that the medical scheme knows exactly what it paid for.

Beat the chronic blues

Twenty-five chronic conditions are covered by PMBs and you need to know that:

- Your scheme can demand that you obtain pre-authorisation or join a benefit management programme before your cover comes into effect.
- Your scheme may decide for which medicines it will pay for each chronic condition, as long as they are at least on par with the published treatment standards.
- Chronic medicine limits can still be set, but if you exhaust your limit, your scheme will have to continue paying for appropriate chronic medication you obtain from its DSP for a PMB condition.

Protocols, formularies and other big words

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Medical schemes often put rules in place that state which treatments and medicines they will cover and which not. These are so-called protocols and formularies that schemes use to manage members' use of benefits and reduce the schemes' risk.

Fortunately, scheme rules also have to adhere to legislation. The minimum standards for treatment of all PMB conditions have been published in the Government Gazette, and are known as treatment algorithms. Your scheme may decide for which medicines it will pay for your condition, but the treatment may not be below the published standards.

Toe the line

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Don't bypass the system: if your scheme wants you to use a GP to refer you to a specialist, then do so. If it has a DSP, then make use of the scheme's DSP as far as possible.
If it has informed you of a formulary, then stick with your scheme's listed drug for your medication unless it is clinically proven to be ineffective or to cause an adverse reaction.

Be a good consumer: ask questions and follow the complaints process if you are not treated fairly.

What if there's a medication meltdown?

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If the medication on your medical scheme's list (or formulary) really does not agree with you or is not effective, you can put your case to the scheme and ask for alternative treatment. You will need your doctor to provide the necessary proof to back up your request. If your appeal succeeds, the scheme will pay in full for the alternative medicine.

Just remember that personal preference is not grounds for appeal. If your scheme pays for generic medicine and you prefer the brandname, you might face a co-payment.

The CMS can help

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PMBs can be a rather complicated subject and your medical scheme might not be able to answer all your questions. Do not despair. The Council for Medical Schemes (CMS) was established to supervise medical schemes in South Africa. In this role, its first priority is to protect the rights of consumers and to ensure that they are treated fairly.

Therefore, if you have a problem with your medical scheme, contact us in any of the following ways:

Tel: 012 431-0500 / 0861 123 267

E-mail: support@medicalschemes.com

COUNCIL FOR MEDICAL SCHEMES

FOR MORE INFORMATION

Tel: 012 431-0500 / 0861 123 267

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