



UNIVERSITY OF KWAZULU-NATAL
MEDICAL SCHEME

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Health



Guide to Prescribed Minimum Benefits

2015



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

This document tells you how University of KwaZulu-Natal Medical Scheme covers our members for a list of conditions called Prescribed Minimum Benefits (PMBs).

Understanding some of the terms we use in this document

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

Terminology	Description
Prescribed Minimum Benefits (PMBs)	A set of minimum benefits that, by law, must be provided to all medical scheme members. The cover it gives includes the diagnosis, treatment and cost of ongoing care for a list of conditions.
Shortfall	University of KwaZulu-Natal Medical Scheme pays service providers at a set rate, known as the Scheme Rate. If the service providers charge higher fees than this rate, the member will have to pay the outstanding amount from his or her pocket.
Waiting period	A waiting period can be general or condition-specific and means that the member has to wait for a set time before he or she can benefit from his or her chosen plan's cover.
Chronic Drug Amount (CDA)	The CDA is a maximum monthly amount we pay up to for a medicine class. This applies to medicine that is not listed on the medicine list (formulary). The Chronic Drug Amount includes VAT and the dispensing fee.
Diagnostic Treatment Pairs Prescribed Minimum Benefit (DTP PMB)	Links a specific diagnosis to a treatment and broadly indicates how each of the PMB conditions should be treated.
Designated Service Provider	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.



Understanding the Prescribed Minimum Benefits

The Prescribed Minimum Benefits are guided by a set list of medical conditions as defined in the Medical Schemes Act of 1998.

In terms of 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 270 diagnoses and
- 27 chronic conditions.

These conditions and their treatments are known as the Prescribed Minimum Benefits (PMB).

All medical schemes in South Africa have to include the Prescribed Minimum Benefits in the health plans they offer to their members. There are, however, certain requirements that a member must meet before he or she can benefit from the Prescribed Minimum Benefits.

The three requirements are:

1. The condition must be part of the list of defined PMB conditions.
2. The treatment needed must match the treatments in the defined benefits.
3. Members must use the scheme's designated healthcare service providers.

All life threatening emergency medical conditions, 270 illnesses and 27 chronic conditions qualify for Prescribed Minimum Benefits as defined by the Medical Schemes Act of 1998

University of KwaZulu-Natal Medical Scheme plans offer benefits far greater than that of the Prescribed Minimum Benefits

All University of KwaZulu-Natal Medical Scheme plans cover more than just the minimum benefits required by law.

There are a few instances when University of KwaZulu-Natal Medical Scheme will only pay a claim as a Prescribed Minimum Benefit

This happens when a member is in a waiting period or when a member has treatments linked to conditions that are excluded by their plan. University of KwaZulu-Natal Medical Scheme also pays day-to-day claims automatically if you have day-to-day benefits available.

In all of the above mentioned instances, you could still have cover in full, provided the three requirements as described above, set out by the Prescribed Minimum Benefit regulations are met.



More about meeting the Prescribed Minimum Benefit requirements

The medical condition must be part of the list of defined conditions for Prescribed Minimum Benefits

Medical Scheme members may need to send University of KwaZulu-Natal Medical Scheme the results of their medical tests and investigations that confirm the diagnosis of the condition. This will allow University of KwaZulu-Natal Medical Scheme to identify whether the member's condition qualifies for the treatment. The member's treating doctor needs to provide the relevant documentation to assist University of KwaZulu-Natal Medical Scheme 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 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.

The medical scheme is only required to provide cover for the treatments, procedures, investigations and consultations that is given for each specific condition on the list. If a member needs treatment that is not on the list and sends a clinical motivation that thoroughly explains why the treatment is needed, the scheme will review it and may choose to approve the treatment if necessary. If the appeal is declined the member may contact us to lodge a formal dispute.

University of KwaZulu-Natal Medical Scheme pays for specific healthcare services related to each of our members' approved conditions, such as consultations, blood tests and other investigative tests, without lessening our members' day-to-day benefits. We will inform our members of their entitlement to Prescribed Minimum Benefits when their condition and treatment has been approved.

How we cover medicine for the 27 chronic conditions

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

If a medicine that is not on the medicine list is approved, we will pay it up to a Chronic Drug Amount (CDA). The member may have a co-payment if the cost of the medicine is greater than the Chronic Drug Amount.

The Chronic Drug Amount does not apply to the UKZN KeyPlus Plan.



Using the designated healthcare service providers

All medical schemes must ensure that their members do not experience shortfalls when their members make use of designated service providers. Members of University of KwaZulu-Natal Medical Scheme need to use doctors, specialists or other healthcare providers who we have an agreement with, so that they do not experience a shortfall.

Members can use MaPS Advisor on www.discovery.co.za or call us on 0860 11 33 22 to find healthcare service providers who we have an agreement with.

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

How University of KwaZulu-Natal Medical Scheme manages claims under Prescribed Minimum Benefits

There are different types of claims for Prescribed Minimum Benefits (PMB), such as claims for hospital admissions, chronic conditions and other conditions treated out of hospital, listed under the Prescribed Minimum Benefits.

In most cases, we automatically recognise that the member claiming for these medical services is entitled to cover under the Prescribed Minimum Benefits.

There are, however, times when a member needs to apply for cover under the Prescribed Minimum Benefits. Once the member's healthcare professional confirms the diagnosis as a PMB condition, the member can apply for cover for claims to be funded from risk benefits without using their day-to-day cover.

We require additional clinical information from the member's healthcare professional for requests for funding of any treatment that falls outside the standard treatment for the condition. If a treatment that falls outside the defined benefits and is not approved, it will be paid for from the available benefits according to the member's chosen health plan. If the member's health plan does not cover these expenses, the member will be responsible to pay the unpaid claims.

Instances where members do not have cover under Prescribed Minimum Benefits

There are some circumstances where members do not have cover for the Prescribed Minimum Benefits by their medical scheme. This can happen when a person joins a medical scheme for the first time, with no medical scheme membership before that.

This can also happen if someone joins a medical scheme more than 90 days after leaving his or her previous medical scheme. In both these cases, the medical scheme would impose a waiting period, during this time; members will not have access to the Prescribed Minimum Benefits, no matter what conditions they might have.



How to apply for Prescribed Minimum Benefit cover

If a member wants to apply for out-of-hospital Prescribed Minimum Benefits or cover for their chronic condition, he or she needs to:

1. Download and print an **“Application for out-of-hospital management of a Prescribed Minimum Benefit condition”** or **“The Chronic Illness Benefit Application”** form, available on www.discovery.co.za. Members can also call 0860 11 33 22 to request any of the above forms.
2. Complete the application form with the assistance of his or her healthcare professional.
3. Send the completed, signed application form, along with any additional medical information, by email or fax.

Once we receive the application form and it meets the Prescribed Minimum Benefits requirements, we will automatically pay the associated investigations, treatment and consultations for that condition.

If a member wants to apply for in-hospital PMB cover, he or she can call us on 0860 113 322 to request authorisation.