Guide to Prescribed Minimum Benefits 2024

Who we are

SAB Medical Aid (the Scheme), registration number 1209, is a medical scheme. It is a non-profit organisation, registered with the Council for Medical Schemes and administered by 3Sixty Health (Pty) Ltd, registration number 1978/001109/07, an accredited administration and managed care service provider

What are Prescribed Minimum Benefits (PMBs)?

To protect medical scheme members, the law determines the minimum benefits that a medical scheme must offer their members no matter what plan they are on. These are called the 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:

- Any life-threatening emergency medical condition
- A defined list of 271 medical conditions
- A defined list of 27 chronic conditions (Chronic Disease List (CDL) conditions).

You can find out which conditions form part of the CDL conditions, the list of 271 conditions and their treatment pairs as well as what the definition of an emergency medical condition is on the Council for Medical Schemes' website at www.medicalschemes.co.za

All medical schemes in South Africa have to include the Prescribed Minimum Benefits in all the benefit options they offer their members. SAB Medical Aid covers more than just these minimum benefits required by law.

How do you qualify to get cover under Prescribed Minimum Benefits?

There are certain requirements you must meet to qualify for cover under Prescribed Minimum Benefits. The requirements are:

1. The condition must be on the PMB defined list of 27 CDL conditions and/or 271 defined list of medical conditions.
2. The treatment you want cover for must match the treatment defined on the published PMB list.
3. You must use Designated Service Providers (DSP), namely Healthcare Providers (doctors, pharmacies, hospitals etc.) who we have an agreement with to provide treatment or services at a contracted rate. Log on to www.sabmas.co.za and click on the **Doctor Visits** tab to search for a

Healthcare Provider or by contact us on our Customer Care Centre 0860 002 133. This does not apply in life-threatening emergencies.

Members may need to 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 in confirming the diagnosis

If the treatment you want cover for does not meet the above criteria, we will pay for claims up to the Scheme Rate, which is a set rate at which the Scheme pays Healthcare Providers.

If the Healthcare Provider charges more than this rate, you will have a co-payment which is an amount you have to pay from your own pocket.

We have preferred suppliers for suppliers of intermittent catheters, rental oxygen and other devices such as CPAP machines. Where a non-preferred supplier is used you may have a co-payment.

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 271 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.co.za for a full list of the 271 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 271 Provisions (listed 271 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** (e.g. 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 criterion 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.

You must register to get cover for PMBs

There are different types of claims for PMBs such as consultations, blood tests, other investigative tests, medicine and treatment. There are claims for conditions treated out of hospital as well as claims for hospital admissions.

If you need **medicine** on a chronic basis to treat your PMB condition, ask your Healthcare Provider to contact our Customer Contact Centre on 0860 002 133 to request pre-authorisation telephonically.

For **out-of-hospital PMBs** you must register by contacting our Customer Contact Centre on 0860 002 133. Depending on the condition, you and your doctor may be required to complete an application form. Once completed, the signed form along with any additional medical information should be submitted via email to OHPMBApplications@sabmas.co.za or by fax to 010 593 2069. The form is available to download and print from www.sabmas.co.za. Log in to the website using your username and password. Go to ***Find a document*** and click on ***Application forms***.

We will let you know the outcome of our decision by return email or fax. The decision will be based on evidence-based clinical protocols, medicine lists (formularies) and treatment guidelines. These are also in line with the defined treatments on the published PMB list.

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 the diagnosis and treatment of your condition from your Prescribed Minimum benefits, and not from your day-to-day benefits.

Any changes to approved treatment are to be submitted via the same process outlined above.

What happens if you decide not to register your condition as a PMB?

We will pay for all the consultations, blood tests, other investigative tests, medicine and treatment for the condition from your available day-to-day Benefits, subject to the 20% copayment. The 20% co-payment can be paid from available savings (Comprehensive Option) or from employer payroll deduction or debit order (self-paying members).

What happens if you get your medicine from a Healthcare Provider of your choice instead of the Scheme's Pharmacy Network?

If you are on the Essential Option, you must use our Network Pharmacy otherwise you will have a 20% co-payment on the medicine.

To find out which Network Pharmacies are available to you, go to www.sabmas.co.za under Pharmacy Network Provider or contact our Customer Contact Centre on 0860 002 133.

You need pre-authorisation for hospitalisation for PMB cover

Pre-authorisation is the approval of certain procedures and any planned **admission to a hospital**. This takes place before the procedure or when admission takes place. The preauthorisation for a hospital stay can include associated treatment or procedures performed during hospitalisation.

Whenever your doctor plans a hospital admission for you, you or your doctor must let us know 48 hours before you go to hospital by contacting our Customer Contact Centre on 0860 002 133 to get pre-authorisation.

You will be required to provide the following information:

- Your membership number
- Details of the patient (name and surname, ID number etc.)
- Reason for the procedure or hospitalisation
- The relevant diagnostic codes (ICD-10 codes), tariff codes and procedure codes – you must get these from your treating doctor.

After you have given us all the above information, we will give you an authorisation number. Please give this number to all the relevant Healthcare Providers (such as the hospital, radiologist, pathologist and the doctors) and ask them to include it when they submit claims.

Pre-authorisation does not guarantee payment of all claims

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, which your Major Medical Benefit does not cover. Certain procedures, medicine and new technologies need separate approval. Limits, clinical guidelines and policies apply to some healthcare services and procedures in hospital. It is important that you discuss this with your doctor or the hospital.

Your hospital cover is made up of the account from the hospital, namely the ward and theatre fees at the Scheme Rate. Accounts from other Healthcare Providers such as the admitting doctor, anaesthetist, radiology and pathology are separate from the hospital account and are called related accounts.

What to do if there is no available Designated Service Provider at the time of your request

There are some instances where it is not possible to use our Designated Service Providers, such as in a life-threatening emergency. In such cases, you can still have full cover by contacting our Customer Contact Centre on 0860 00 21 33 for authorisation.

Sometimes SAB Medical Aid will only pay a claim if it is a Prescribed Minimum Benefit

This happens when you have treatment linked to conditions that are excluded by your selected option, when the benefit limit is depleted or when you are in a waiting period.

This can be a general three-month waiting period or a 12-month condition-specific waiting period. If you are on the Essential Option and the yearly limit for renal dialysis is depleted, you must register for PMB cover. Contact our Customer Contact Centre on 0860 002 133 to request for an application form. The form is available to download and print from www.sabmas.co.za. Log in to the website using your username and password. Go to **Find a document** and click on ***Application forms***. Once completed, the signed form along with any additional medical information should be submitted via email to chronicqueries@sabmas.co.za.

In the above instances, we will only pay for the PMB portion of the claim i.e. the claims that 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 in which you do not have cover under Prescribed Minimum Benefits. If this is the case, you would have been informed about it when you or your dependant/s joined the medical scheme.

What happens if you need treatment that is not part of the defined PMBs?

If you need treatment that does not form part of the defined PMBs, you may send additional clinical information with a detailed explanation about why the treatment is needed. The Scheme will review the request and may approve the treatment. If we do not approve the request, you may contact us to lodge a formal appeal by following the process detailed below.

Treatment that falls outside the defined benefits, which is not approved, will be paid from your available Day-to-day Benefits according to your chosen Option. If your Option does not cover these treatments, you will have to pay for it from your own pocket.

Appeals process

To appeal against a funding decision on PMB cover, complete the Appeal form with the help of your doctor and forward the completed and signed form, along with any additional medical information, via email to OHPMBApplications@sabmas.co.za or by fax to 010 593 2069. This form can be obtained by contacting our Customer Contact Centre on 0860 002 133.

If your appeal remains unresolved, you may lodge a formal dispute by following the Scheme's internal dispute process on the SABMAS 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.co.za. Customer Care Centre: 0861 123 267 / website www.medicalschemes.co.za

Contact us

You can contact us on 0860 002 133 or visit our website at www.sabmas.co.za for more information.