

**ANNEXURE D****PRESCRIBED MINIMUM BENEFITS (PMBS)****Definitions****"Prescribed minimum benefits"**

the benefits contemplated in section 29(1)(o) of the Act and consist of the provision of the diagnosis, treatment and care costs of -

- (a) the Diagnosis and Treatment Pairs (DTPs) listed in Annexure A of the regulations, subject to any limitations specified therein; and
- (b) any emergency medical condition.

**"Prescribed minimum benefit condition"**

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

**"ICD-10 Code"**

Service providers must quote an accurate ICD 10 code on each PMB claim submitted to the Scheme to ensure that the claim is paid against the correct benefit category.

**1. Designation of service providers**

The medical scheme designates the following service providers for the delivery of prescribed minimum benefits to its beneficiaries, subject to provisions made in paragraph 4:

- a) Preferred Provider Network Hospitals
- b) State Hospital facilities
- c) Centre for Diabetes and Endocrinology for all diabetes related care.

The above service providers shall for the purpose of this Appendix be referred to as "designated service providers".

**2. Prescribed minimum benefits obtained from designated service providers**

100% of the cost in respect of diagnosis, treatment and care costs of prescribed minimum benefit conditions if those services are obtained from designated service providers.

**3. Prescribed minimum benefits voluntarily obtained from other providers**

If a beneficiary voluntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the benefit payable in respect of such service is subject to such benefit limitations as are normally applicable in terms of the Scheme's benefit structure and rules.

**4. Prescribed minimum benefits involuntarily obtained from other providers.**

- a. 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, the medical scheme will pay 100% of cost in relation to those prescribed minimum benefit conditions.
- b. For the purposes of paragraph a, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if -
  - (a) the service was not available from the designated service provider or would not be provided without unreasonable delay;
  - (b) 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
  - (c) there was no designated service provider within reasonable proximity to the beneficiary's place of business or personal residence.
- c. Except in the case of an emergency medical condition, preauthorisation shall be obtained by a member prior to involuntarily obtaining a service from a provider other than a designated service provider in terms of this paragraph, to enable the Scheme to confirm that the circumstances contemplated in paragraph b are applicable.

**5. Medication**

- (a) Where a prescribed minimum benefit includes medication, the Scheme will pay 100% of the cost of that medication, subject to Maximum Medical Aid Pricing (MMAP), if that medication is obtained from a designated service provider or is involuntarily obtained from a provider other than a designated service provider.
- (b) Where a prescribed minimum benefit includes medication, benefit limitations normally applicable in terms of the Scheme's benefit structure and rules will apply if that medication is voluntarily obtained from a provider other than a designated service provider.

**6. Diagnostic tests for an unconfirmed PMB diagnosis.**

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

**7. Chronic Conditions**

The Scheme covers the full cost for services rendered in respect of the prescribed minimum benefits, which includes the diagnosis, medical management and medication to the extent that it is provided for in terms of the therapeutic algorithm as prescribed for the specified chronic conditions, and where the Scheme's Designated Service Provider is used and/or a drug formulary has been approved. Members, suffering from one of the 25 PMB DTP and CDL chronic conditions, have to apply for registration on the relevant Managed Care Programme.

<b>DIAGNOSIS</b>	
Addison's disease	Asthma
Bipolar mood disorder	Bronchiectasis
Cardiac Failure	Cardiomyopathy disease
Chronic renal dialysis	Coronary artery disease
Chronic obstructive pulmonary disorder	Crohn's disease
Diabetes insipidus	Diabetes mellitus type 1 & 2
Dysrhythmias	Epilepsy
Glaucoma	Haemophilia
Hyperlipidaemia	Hypertension
Hypothyroidism	Multiple sclerosis
Parkinson's disease	Rheumatoid arthritis
Schizophrenia	Systemic lupus erythematosus
Ulcerative colitis	

The HIV/AIDS benefit provided will be in accordance with the National Antiretroviral Treatment Guidelines and the algorithms specified within the prescribed minimum benefits for the treatment and management of HIV/AIDS.