Guide to Prescribed Minimum Benefits – 2020

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is the medical scheme that you are a member of. This is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

Contact us

For further information, call us on 0860 103 933 or visit us at www.lahealth.co.za

This document tells you how LA Health covers a list of conditions called Prescribed Minimum Benefits (PMBs).

About 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. We give you the meaning 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.
Shortfalls	LA Health pays service providers at a set rate, the LA Health Rate. If you service providers charge higher fees than this rate, you will have to pay the shortfall amount from your pocket.
Waiting period	A waiting period can be general or condition-specific and means you have to wait for a set time before you can claim from your chosen benefit option's cover.
Chronic Drug Amount (CDA)	The CDA is a maximum monthly amount we pay up to for a medicine class for a specific condition. 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 (DTPPMB)	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 or negotiated rate.
Reference Price	Non-formulary medication that falls in the same medicine category and generic group as the formulary medication are paid up to a Reference Price.

Understanding the Prescribed Minimum Benefit

What are Prescribed Minimum Benefits (PMBs)?

They are a set of minimum benefits that medical schemes must give to all their members – according to the law [Medical Schemes Act of 1998 (Act number 131 of 1998)]. The cover it gives includes the diagnosis, treatment and cost of ongoing care for:

01 | Any life threatening emergency

02 | A defined set of 270 diagnoses

03 | 27 chronic conditions.

All medical schemes in South Africa have to include the Prescribed Minimum Benefits in the benefit options they offer to their members.

How does LA Health pay claims for PMBs and non-PMB benefits?

We cover PMBs in full from the Scheme Risk Benefits provided you receive treatment from a designated service provider (DSP). Treatment received from a non-DSP may be subject to a co-payment if the provider charges more than we pay. Out of hospital non-PMB benefits are paid from your day-to-day benefits, in accordance with your chosen benefit option.

Requirements you must meet to benefit from PMBs

There are certain requirements before you can benefit from the Prescribed Minimum Benefits. The requirements are:

1. The condition must be on the list of defined PMB conditions.
2. The treatment needed must match the treatments in the defined benefits on the PMB list.
3. You must use the Scheme's DSPs unless there is no DSP close to your home or usual workplace.

What are Designated Service Providers (DSPs)?

A designated service provider (DSP) is a healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have an agreement with. According to this agreement they will give you treatment or services at a contracted or negotiated rate. This is to make sure you do not have any co-payments when you use their services. For a full list of our DSPs, go to www.lahealth.co.za

This does not normally apply in emergencies. However even in these cases, where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service providers in our network, once your condition has stabilised should you want to avoid copayments. If your treatment doesn't meet the above criteria, we will pay according to your Option's benefits.

Kindly note

- PMB regulations and their accompanying provisions do not apply to healthcare services obtained outside the borders of South Africa.
- PMB-related claims for services obtained outside the borders of South Africa shall be paid as normal (non-PMB) claims, subject to the relevant Scheme Rate and any other limitations applicable to normal (non-PMB) claims within the borders of South Africa.

What are co-payments

LA Health pays service providers at a set rate – the LA Health Rate. If the service provider charges above this rate, you will have to pay the shortfall amount from your pocket. This amount you have to pay is called a co-payment.

You and your dependants must register to get cover for PMBs and Chronic Disease List (CDL) conditions

How to register your chronic or PMB conditions to get cover from your Risk Benefits

There are different types of PMB claims such as claims for In-Hospital admissions, Out of Hospital PMB's (OHPMBs), PMB CDL conditions, Oncology and HIV.

To apply for out-of-hospital Prescribed Minimum Benefits, or cover for a Chronic Disease List condition, you must use a Prescribed Minimum Benefit or a Chronic Illness Benefit Application form:

- Both forms are available to download and print from www.lahealth.co.za. Log in to the website using your username and password. Go to "Find a document" and click on "application forms".
- You can also call 0860 103 933 to request any of the above forms.

Once we receive the application form, and it meets the Prescribed Minimum Benefit requirements, the Scheme will pay for associated, approved investigations, treatment and consultations for that condition from the Scheme Risk Benefits (not from your Medical Savings Account, if applicable). We will also let you know about the outcome of the application.

More information on Out of Hospital PMB's (OHPMBs) and PMB CDL conditions is available on www.lahealth.co.za under Medical Aid > Find a document.

If you want to apply for in-hospital Prescribed Minimum Benefit cover, you must call us on 0860 103 933 to request authorisation.

In an emergency you must go directly to a hospital and notify the Scheme as soon as possible of the admission. In cases of emergency, the Scheme will pay at cost for the first 24hrs, or until the patient's condition is stable.

Why it is important for you and your dependents to register your PMB or chronic conditions

LA Health pays for specific healthcare services related to each of your approved conditions. These services include consultations, blood tests and other investigative tests. The Scheme pays for the services so your day-to-day benefits are not affected.

Treatment that falls outside the defined PMB benefits, that is not approved, will be paid from your available benefits according to your chosen benefit option. If your benefit option does not cover these expenses, you will have to pay the claims.

There are times when you need to apply for cover under the Prescribed Minimum Benefits. Once your healthcare professional confirms the diagnosis as a Prescribed Minimum Benefit condition, you can apply for the Scheme to pay the claims from your Risk Benefits without using your day-to-day cover. Once approved, we will automatically recognise that the medical services you are claiming for falls under the Prescribed Minimum Benefits.

Who must register to receive chronic medicine for their PMB or chronic conditions

Every person who registered on your membership, and who has been diagnosed with a PMB or chronic illness condition, must register. Each person must register their specific conditions.

When your condition is diagnosed, you only have to register once for a chronic condition. If your medicine or other treatment changes, your healthcare professional can just let us know about the changes. If you are diagnosed with another chronic or PMB condition, you have to register for the new condition before we will cover the treatment and consultations from your Risk Benefits and not from your day-to-day benefits.

Who must complete and sign the registration form when applying for chronic medicine

You, or any of your dependants with a PMB or chronic illness condition, can complete the application form with the help of the treating healthcare professional.

Additional documents needed to support the application

You may need to send LA Health the results of the medical tests and investigations that confirm the diagnosis of the condition. This will help us to identify that your condition qualifies for the treatment.

We need additional clinical information from your doctor if you request funding of any treatment that falls outside the standard treatment for the condition. If treatment that falls outside the defined benefits is not approved, it will be paid from your available day-to-day benefits according to your chosen benefit option. If your benefit option does not cover these expenses, you will be responsible to pay the claims.

Where you must send the completed form

You can send the completed **PMB application form**:

- By fax to: 011 539 2780
- By email to: PMB_APP_FORMS@discovery.co.za
- By post to: LA Health Medical Scheme, PMB Department, PO Box 652509, Benmore, 2010.

You can send the completed **chronic application form**:

- By fax to: 011 539 7000
- By email to: CIB_APP_FORMS@discovery.co.za
- By post to: LA Health Medical Scheme, CIB Department, PO Box 652509, Benmore, 2010.

We will let you know if we approve your application and what you must do next

We will inform you of your entitlement to PMBs when your condition and treatment has been approved.

We will do this by fax or email (as you indicated on your application form).

There are standard treatments, procedures, investigations and consultations for each condition on the PMB list. These defined benefits are supported by thoroughly researched evidence, based on clinical protocols, medicine lists (formularies) and treatment guidelines.

What happens if there is a change in your treatment

Your treating healthcare professional can call 0860 44 55 66 to register changes to your medicine for an approved condition. You only need to complete an application form when applying for a new PMB or chronic condition.

What happens if a healthcare professional prescribes other medicine to treat the condition in the middle of the month

The treating healthcare professional or dispensing pharmacist can make changes to medicine for chronic illness conditions telephonically. You can also send an updated prescription by fax to 011 539 7000 or email it to CIB_APP_FORMS@discovery.co.za

For PMB conditions, the treating healthcare professional or dispensing pharmacist can make changes to medicine by sending the updated prescription by fax to 011 539 2780 or email it to PMB_APP_FORMS@discovery.co.za

What happens if you get your medicine from a provider of your choice, instead of the Scheme's DSP

When you use doctors, specialists or other healthcare providers who are the Scheme's DSPs, you do not experience a co-payment.

If you do not use a healthcare provider who is one of the Scheme's DSPs, and your provider charges more than the LA Health Rate, you will have to pay part of the treatment costs yourself. Contact us for the latest copy of the treatment guidelines or go to www.lahealth.co.za

What is a waiting period

A waiting period can be general or condition-specific, and means you have to wait for a set time before you can claim from your chosen benefit option's cover.

What happens when you use medicine that is not on the formulary list for your particular benefit option

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

If we approve a medicine that is not on the medicine list, we will pay it up to a Chronic Drug Amount (CDA) or up to a Reference Price for that condition. You may have a co-payment if the medicine you use to treat the condition, cost more than the Chronic Drug Amount or Reference Price.

If the medicine that is not on the Scheme's list is a substitute for one that has been ineffective or has caused an adverse reaction, you and your doctor can appeal, and if the appeal is successful there will be no co-payment.

What happens when you need treatment that is not on the list

The Scheme is only required to cover the treatments, procedures, investigations and consultations that is given for each specific condition on the list. If you need treatment that is not on the list and you send additional clinical information that thoroughly explains why you need the treatment, the Scheme will review it, and may choose to approve the treatment. You have a right to appeal our decision, but will have to fully motivate such appeal.

Our list of designated service providers

You can Find a healthcare professional who is on the Scheme's list of DSPs at www.lahealth.co.za or call us on 0860 103 933 for assistance.

What to do if a DSP is not available at the time of your request

There are some cases where it is not necessary to use DSPs, but you will still have full cover, for instance:

- in a life-threatening emergency, or
- In cases where there are no services or beds available from the DSP when you, or one of your dependants needs treatment. In these cases, you must contact us on 0860 103 933. We will intervene and make arrangements for an appropriate facility or healthcare provider to accommodate you.

LA Health Medical Scheme offers benefits that are far richer than that of the Prescribed Minimum Benefits

All the LA Health benefit options cover more than just the minimum benefits required by law. Some benefit options cost more, but offer more comprehensive benefits, while others have lower contributions with lesser benefits.

Sometimes LA Health will only pay approved Prescribed Minimum Benefit claims

This happens when you are in a waiting period or when you have treatments linked to conditions that are excluded by your benefit option. But you can still have cover in full, if you meet the requirements stipulated by the Prescribed Minimum Benefit regulations.

Instances where you do not have cover for Prescribed Minimum Benefits

Sometimes you do not have cover for the Prescribed Minimum Benefits. This can happen when you join the Scheme with no previous medical scheme membership.

It can also happen when you join the Scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme would impose a waiting period, during which you and your dependants will not have access to the Prescribed Minimum Benefits, no matter what conditions you might have.

Oncology

Depending on your benefit option, once you are registered on the Oncology Programme, the Scheme covers your approved cancer treatment over a 12-month cycle up to the Scheme Rate, in accordance with your benefits.

For non-malignant PMB conditions, please follow the OHPMB process outlined elsewhere in this documents. For more information please visit the website, www.lahealth.co.za

HIV

When you register on the Scheme's HIV Care Programme to manage your condition, you are covered for the care you need. For more information please visit the website, www.lahealth.co.za, for information.

Complaints process

You may lodge a complaint or query with LA Health Medical Scheme directly, on 0860 103 933. If after having escalated the query or complaint to a Team Leader or Manager at the Scheme's administrator, you are not satisfied, you may address a complaint in writing to the Principal Officer at the Scheme's registered address.

Should your complaint remain unresolved, even after input from the Principal Officer and the Board of Trustees, you may lodge a formal dispute by following the LA Health Medical Scheme internal disputes process.

You may, as a last resort, approach the Council for Medical Schemes for assistance. Their contact details are as follows:

Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 / 0861 123 267 / complaints@medicalschemes.com / www.medicalschemes.com