Guide to Prescribed Minimum Benefits for in-hospital treatment

2024

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Overview

In terms of the Medical Schemes Act No. 131 of 1998, Prescribed Minimum Benefits (PMB) are a set of defined benefits that all registered medical schemes in South Africa are obliged to provide for all their members. All members have access to these benefits, irrespective of their chosen plan type. PMB's ensure that all medical scheme members have access to continuous care to improve their health.

TFG Medical Aid Scheme plans are structured in such a way, that the member's chosen benefit plan provides comprehensive cover. Some plans cost more, but offer more comprehensive cover, while others have lower contributions with fewer benefits. Irrespective of this, all our plans cover more than just the minimum benefits required by law. Always consult your benefit plan Guide to see how you are covered.

This document tells you how the Scheme covers the PMBs, specifically for in-hospital treatment. Please refer to the Prescribe Minimum Benefit guide on www.tfgmedicalaidscheme.co.za for more details about PMBs and how they are covered.

TERMINOLOGY	DESCRIPTION
Deductible	A specific payment for which you will be personally liable. The amount and/or percentage applied is as specified in the Scheme Rules.
Scheme Rate (SR)	This is the rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services. The Scheme Rate is a rate that we negotiate with service providers. In some instances, cover is at 80% of Scheme Rate and in other instances at 100% of the Scheme

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TERMINOLOGY	DESCRIPTION
	Rate. If your doctor charges more than the Scheme Rate , we will pay claims up to the Scheme Rate. Please consult the 'Rate' column, in the benefit tables provided in this benefit guide, for the appropriate benefit to know when claims are paid at 100% of Scheme Rate and when at 80% of Scheme Rate.
At Cost	Fees charged by a provider that may be more than the Scheme Rate.
Designated service provider (DSP)	A healthcare provider (doctor, specialist, pharmacist or hospital) who we have an agreement with to provide treatment, or services, at a contracted rate. Visit www.tfgmedicalaidscheme.co.za or click on 'Find a Provider' on the Discovery app to view the full list of DSPs.
Member	The reference to member in this document also includes dependants, where applicable.
Prescribed Minimum Benefits (PMBs)	In terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its Regulations, all medical schemes must cover the costs related to the diagnosis, treatment, and care of: • An emergency medical condition • A defined list of 271 diagnoses • A defined list of 27 chronic conditions. To access Prescribed Minimum Benefits, there are rules, defined by the Council for Medical Schemes (CMS), that apply: • Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit conditions • In order to ensure that your PMB related claims are funded in full, once you've reached your benefit limit you will need to use Designated Service Providers (DSPs) in the Hospital Networks and In-Hospital GP Network. This does not apply in life-threatening emergencies, however, even in these cases, where appropriate, and according to the Rules of the Scheme, you may be transferred to a DSP or Network Service Provider, otherwise you will have to pay a deductible. If your treatment doesn't meet the above criteria, we will pay according to your plan benefits.

TERMINOLOGY	DESCRIPTION	TERMINOLOGY
Hospital Networks and In-Hospital GP Network	TFG Health benefit plan	TFG Health Plus benefit plan
	If you are registered on the **TFG Health benefit plan**, you have chosen a benefit plan with a hospital network and need to make sure you use a hospital in that network to get full cover. The **TFG Health benefit plan** makes use of the KeyCare Hospital Network. An In-Hospital GP Network was established, in addition to the pharmacy Designated Service Providers ("DSP") on this benefit plan, which is a defined list of GPs and specialists authorised by us to provide in-hospital services to members as part of the doctor networks servicing members in hospital on the **TFG Health benefit plan**.	If you are registered on the **TFG Health Plus benefit plan**, you have chosen a benefit plan with contracted Designated Service Providers ("DSP") at agreed and contracted Scheme Rates. Members registered on this benefit plan also have access to the KeyCare Hospital Network and In-Hospital GP Network **to obtain services for PMB at full cover**. This means no deductible can be applied where the admitting service provider is on the Scheme's DSP or In-Hospital GP/Specialist Network and services are obtained from a hospital in the KeyCare Hospital Network.
Emergency medical condition	An emergency medical condition is the sudden and, at the time, unexpected onset of a health condition, that requires immediate medical and surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions, or serious dysfunction of a bodily organ, or part, or would place the person's life in serious jeopardy. An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency. **In cases of emergency, you are covered at cost for the first 24 hours or until you are stabilised. If you need further hospital treatment, you may be moved to a network hospital. If you choose, if so required, to remain at a non-network hospital, depending on your chosen benefit plan, you will be responsible to pay a portion of the hospital account, if registered on the TFG Health Plus benefit plan or not be covered for funding outside of the network arrangement, if registered on the TFG Health benefit plan.**	
Related accounts	Any account, other than the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology.	

Using the designated service providers and/or Network service providers

All medical schemes must ensure that their members do not experience shortfalls when using their DSPs or Network service providers. Members of the Scheme should use healthcare providers, who we have a payment agreement with, so that they do not experience co-payments.
Some examples of DSPs you might have when admitted to hospital are:

- Specialists
- GPs
- Psychologists
- Social workers

You can use www.tfgmedicalaidscheme.co.za or call us on 0860 123 077 to find healthcare service providers who we have an agreement with for your specific plan type.

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. **In cases of emergency, you are covered at cost for the first 24 hours or until you are stabilised.**

How your claims will be funded in hospital

Prescribed Minimum Benefit status	Service provider type	Hospital	Healthcare professional
Emergency, for the duration of the emergency medical condition **(TFG Health and TFG Health Plus)**	Designated service provider/Network provider	• Hospital account is paid at in full at cost/the Scheme Rate	• Related accounts are paid in full at cost/the Scheme Rate
	Not a designated service provider/non-network provider	• Hospital account is paid in full at cost	• Related accounts are paid in full at cost
Elective/Voluntarily use **(TFG Health)**	Designated service provider/Network provider	• Hospital account is paid at the Scheme Rate	• If your primary admitting Dr is a DSP, related accounts are paid at 100% at the Scheme Rate for the providers who are DSPs and at cost for those providers with whom we do not have agreements. No deductibles are applied if DSP or Network providers are used.
	Not a designated service provider/non-network provider	• Hospital account is paid up to a maximum of 80% of the Scheme Rate for voluntary use of a non-	• Related accounts are paid up to a maximum of 80% of the Scheme Rate for voluntary use of a non-DSP. The deductible is

		DSP. The deductible is equal to the amount that the provider charges above the Scheme Rate.	equal to the amount that the provider charges above the Scheme Rate. There may be deductibles applied if non-DSP or non-network providers are used
Elective/Voluntarily use (TFG Health Plus)	Designated service provider/Network provider	• Hospital account is paid at the Scheme Rate	• If your primary admitting Dr is a DSP, related accounts are paid at 100% at the Scheme Rate for the providers who are DSPs and at cost for those providers with whom we do not have agreements. No deductibles are applied if DSP or Network providers are used.
	Not a designated service provider/non-network provider	• Hospital account is paid up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The deductible is equal to the amount that the provider charges above the Scheme Rate.	• Related accounts are paid up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The deductible is equal to the amount that the provider charges above the Scheme Rate. There may be deductibles applied if non-DSP or non-network providers are used

There are some circumstances where you do not have cover for PMBs

This can happen when you join a medical scheme for the first time, with no medical scheme membership before that. It can also happen if you join a medical 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 PMBs, irrespective of pre-existing conditions you may have. We will communicate with you at the time of applying for membership if waiting periods apply.

There are a few instances when the Scheme will only pay a claim as a PMB

This happens when you have a waiting period or when you have treatments linked to conditions that are excluded by your plan. This can be a three-month general waiting period or a 12-month condition-specific waiting period. Yet, you may have cover in full if you meet the requirements stipulated by the PMB regulations. If your membership was activated without waiting periods, you have cover for these conditions from day one.

Get preauthorisation for admission and other procedures

What preauthorisation is and what it means

Preauthorisation is the approval of certain procedures, and any planned admission to a hospital before the procedure or planned admission takes place. It includes associated treatment, or procedures, performed during admission. Whenever your doctor plans a hospital, or day-clinic admission for you, **you must let us know at least 48 hours before you go to the hospital or day-clinic.**

You also need specific preauthorisation for MRI and CT scans, radio-isotope studies, and for certain endoscopic procedures, whether done in hospital or not.

In an emergency you must go directly to a hospital and notify the Scheme you must apply for authorization on the next available working day if the emergency event occurs after hours or over the weekend and at least within 24 hours after such an emergency admission or treatment have been initiated. **In cases of emergency, you are covered at cost for the first 24 hours or until you are stabilised.**

Contact us for preauthorisation

Call us on 0860 123 077 to get preauthorisation. We will give you an authorisation number. Please give the authorisation number to the relevant healthcare provider and ask them to include this when they submit their claims.

Please make sure you understand what is included in the authorisation and how we will pay your claims.

We will ask for the following information when you request preauthorisation

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

Please note: *If you don't preauthorise your admission, benefits are payable subject to a R2 000 deductible, if registered on the TFG Health Plus benefit option. You will only be covered in full if you use a Designated Service Provider. You can find a healthcare professional on www.tfgmedicalaidscheme.co.za or call us on 0860 123 077 to find a healthcare service provider we have a designated service provider payment arrangement with.*

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Preauthorisation does not guarantee payment of all claims

Your hospital cover is made up of:

Cover for the account from the hospital (the ward and theatre fees) are paid at the Scheme Rate, and cover for the accounts from your treating healthcare professionals (such as the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology), which are separate from the hospital account and are called related accounts.

There are some expenses you may have in hospital as part of a planned admission that your Hospital Benefit does not cover. Certain procedures, medicine and new technologies need separate approval. It is important that you discuss this with your healthcare professional.

How we pay your in-hospital PMB claims

We pay for confirmed PMBs in full from the risk benefit if you receive treatment from a DSP. Treatment received from a non-DSP may be subject to a co-payment if the healthcare provider charges more than what we pay.

In order for some claims to qualify for cover as a PMB, supporting documents may be requested confirming your PMB diagnosis. Examples of such claims include MRI scans and endoscopic procedures.

There is a network of hospitals where you will receive full cover if your condition is a PMB. If your condition is a PMB, and you are admitted into a DSP hospital and your admitting doctor is a DSP provider, we will fund all related accounts (where the provider does not have agreements with us) at cost. All related accounts for healthcare providers that do have agreements with us will be funded at the agreed Scheme Rates.

In cases where there are no services or beds available within the DSP, when you, or one of your dependants needs treatment, you must contact us on 0860 123 077. We will intervene and make arrangements for an appropriate facility or healthcare provider to accommodate you.

We pay for benefits, not included in PMBs, according to the rules and benefits of your chosen benefit plan. There are some in-hospital expenses you may have as part of a planned admission that your Hospital Benefit does not cover. An example of this would be certain procedures, medicine and new technologies need separate approval. It is important that you discuss this with your healthcare professional. Remember: Benefit limits, Scheme rules, treatment guidelines and managed care criteria may apply to some healthcare services and procedures in hospital. Find out more about these by contacting us on 0860 123 077 or visit www.tfgmedicalaidscheme.co.za

For a comprehensive list of the TFGMAS Hospital Network (relevant to TFG Health benefit plan) or you are on the TFG Health Plus benefit plan and need PMB treatment in the PMB Hospital Network, visit www.tfgmedicalaidscheme.co.za and navigate to “Find a Document” > “Information Guides” > TFGMAS Hospital Network.

Contact us

You can call us on 0860 123 077 or visit www.tfgmedicalaidscheme.co.za for more information.

Complaints process

You may lodge a complaint or query with TFG Medical Aid Scheme directly on 0860 123 077 or address a complaint in writing to the Principal Officer at the Scheme’s registered address. Should your complaint remain unresolved, you may lodge a formal dispute by following the TFG Medical Aid Scheme internal disputes process.

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 / www.medicalschemes.co.za