BMW Employees Medical Aid Society

Administered by Discovery Health

Guide to Prescribed Minimum Benefits – 2019

Who we are

The BMW Employees Medical Aid Society (referred to as 'BEMAS'), registration number 1526. 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 BEMAS.

Overview

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

This document tells you how BEMAS covers each of you for 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.
Shortfall	BEMAS pays service providers at a set rate, the Society Rate. If the service providers charge higher fees than this rate, you will have to pay the outstanding amount from your pocket.
Waiting period	A waiting period can be general or condition-specific and means that you have to wait for a set time before they can benefit from your 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 (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 rate.
Reference Price	Non-formulary medication that falls in the same medicine category and generic group as the formulary medication. Funds up to a Reference Price.

Understanding the Prescribed Minimum Benefits

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:

- Any life-threatening emergency medical condition
- A defined set of 270 diagnoses
- 27 chronic conditions.

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

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 rate. This will make sure that you do not have any co-payments when you use their services. For a full list of our DSPs, go to www.bemas.co.za > Find a healthcare professional.

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

We cover PMBs in full from your Risk Benefits provided that 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 fund. Non-PMB benefits are funded from your day-to-day benefits.

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 designated service providers unless there is no designated service provider close to your home or usual workplace.

If the treatment does not meet the above criteria, we will pay the claims up to the Society Rate, which is a set rate at which BEMAS pays service providers. If the service provider charges above this rate, you will have to pay the outstanding amount from your pocket. This amount you have to pay is called a co-payment.

BEMAS offers benefits far richer than that of the Prescribed Minimum Benefits

BEMAS covers more than just the minimum benefits required by law.

Sometimes BEMAS will only pay a claim as a Prescribed Minimum Benefit
This happens when you are in a waiting period or when you have treatments linked to conditions that are excluded. 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 under Prescribed Minimum Benefits
There are some circumstances where you do not have cover for the Prescribed Minimum Benefits. This can happen when you join a medical scheme for the first time, with no medical scheme membership before that.

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

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

How to register your chronic or PMB conditions to get cover from your Risk Benefits
If you want to apply for out-of-hospital Prescribed Minimum Benefits or cover for a chronic condition, you must get a Prescribed Minimum Benefit or a Chronic Illness Benefit Application form:

- Both forms are available to download and print from www.bemas.co.za
- Log in to the website using your username and password. Go to “Find a document” and click on the application forms.
- You can also call 0860 002 107 to request any of the above forms.

Once we receive the application form, and it meets the Prescribed Minimum Benefit requirements, we will automatically pay the associated approved investigations, treatment and consultations for that condition from your Risk Benefits (not from your day-to-day benefits). We will also let you know about the outcome of the application.

If you want to apply for in-hospital Prescribed Minimum Benefit cover, you must call us on 0860 002 107 to request authorisation.

We have explained what PMBs are, but what are Chronic Disease List conditions?
They are a list of chronic conditions covered on all plans as defined in the Prescribed Minimum Benefit legislation.

Why it is important for you and your dependants to register your PMB or chronic conditions?
BEMAS pays for specific healthcare services related to each of your approved conditions. These services include consultations, blood tests and other investigative tests. We pay for the services without lessening your day-to-day benefits because we pay it from your Risk Benefits.

Treatment that falls outside the defined benefits and is not approved, will be paid from your available day-to-day benefits. If BEMAS does not cover these expenses, you will have to pay the claims.

There are different types of claims for Prescribed Minimum Benefits. There are claims for hospital admissions, chronic conditions and other conditions treated out-of-hospital.

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 us to pay the claims from your Risk Benefits without using your day-to-day cover. Once the treatment is approved we will automatically recognise that the medical services you are claiming for falls under the Prescribed Minimum Benefits.

What happens when your condition is not registered as a PMB or chronic condition?
We will pay all the consultations, blood tests, other investigative tests, medicine and other treatment for the PMB or chronic condition from your day-to-day benefits.

Who must register to receive chronic medicine for their PMB or chronic conditions?
The main member and all dependants with PMB or chronic conditions must register their specific conditions. You only have to register once for a chronic condition. If your medicine or other treatment changes, your doctor can just let us know about the changes.

If you get another 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 your dependant with the PMB or chronic condition, can complete the application form with the help of the treating doctor.

Additional documents needed to support the application

You may need to send BEMAS 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. If BEMAS does not cover these expenses, you will be responsible to pay the claims.

Where you must send the completed registration 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: BMW Employees Medical Aid Society, 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: BMW Employees Medical Aid Society, 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 Prescribed Minimum Benefits when your condition and treatment has been approved. We will do this by fax or email (as you indicated on you application form).

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.

What happens if there is a change in your treatment?

Your treating doctor can call 0860 002 107 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.

How to get your medicine from the appropriate designated service provider

We include this information in the decision letter that we send when we approve your application.

What happens if your doctor changes your or your dependant's medicine in the middle of the month?

For chronic conditions the treating doctor or dispensing pharmacist can make changes to medicine 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 doctor 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 medical scheme's designated service provider?

All medical schemes must make sure that their members do not experience co-payments when they use designated service providers. You must use doctors, specialists or other healthcare providers who we have a designated service provider payment arrangement with, so that you do not experience a co-payment. If you do not use healthcare providers who we have a payment arrangement with, 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.bemas.co.za

What are co-payments?

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

What is a waiting period?

A waiting period can be general or condition-specific and means that you have to wait for a set time before you can claim for cover.

What happens when you use medicine that is not on the medicine list?

We pay medicine on the medicine list (formulary) up to the Society Rate for medicine. There will be no co-payment for medicine selected from the medicine list.
If we approve a medicine for a condition that is not on the medicine list, we will pay it up to a Chronic Drug Amount (CDA) or a Reference Price. You may have a co-payment if the cost of the medicine is greater than the
Chronic Drug Amount or Reference Price. This is unless the medicine is a substitute for one that has been ineffective or has caused an adverse reaction. In that case 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?

BEMAS is only required to cover the treatments, procedures, investigations and consultations that are 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, BEMAS will review it and may choose to approve the treatment. If we decline the appeal, you may contact us to lodge a formal dispute.

Can you get benefits for more than one month's supply of medicine?
You can get more than a month's supply of approved chronic medicine in when you are travelling outside the borders of South Africa. Members can complete an Extended Supply of Medicine form that you can find on www.bemas.co.za

Our list of designated service providers
You can Find a healthcare professional on www.bemas.co.za or call us on 0860 002 107 to find a healthcare service provider we have a designated service provider payment arrangement with.

What we will cover if you do not use the designated service provider or baskets of care
We pay for treatment and services up to the Society Rate. If you do not use a designated service provider, you may have co-payments for services and treatment you receive.

What to do if there is no available designated service provider at the time of your request
There are some cases where it is not necessary to use designated service providers, but you will still have full cover. An example of this is in a life-threatening emergency.

In cases where there are no services or beds available within the designated service provider when you or one of your dependants needs treatment, you must contact us on 0860 002 107 and we will intervene and make arrangements for an appropriate facility or healthcare provider to accommodate you.

Changes on the medicine list
Because there are regular changes to our medicine list (formulary), we only inform affected members of the changes. For example, we will only communicate changes in the formulary for hypertension medicine to patients who will be affected by the change.

Get preauthorisation for hospitalisation and other procedures

What is preauthorisation and what does it mean?
Preauthorisation is the approval of certain procedures and any planned admission to a hospital before the procedure or admission takes place. It includes associated treatment or procedures performed during hospitalisation.

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

Whenever your doctor plans a hospital admission for you, you must let us know 48 hours before you go to hospital.

Please note: if you don't preauthorise your admission, we will only pay 70% of the costs we would normally cover.

You will get full cover only if you us a network hospital. Please find out if the hospital you plan to use, is part of the network.

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) at the rate agreed with the hospital
- Cover for the accounts from your treating healthcare professionals (such as the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology) are separate from the hospital account and are called related accounts.

Remember: Limits, clinical guidelines and policies apply to some healthcare services and procedures in hospital.

There are some expenses you may incur while you are in hospital that we don't cover. Certain procedures, medicine or new technologies need separate approval. Please discuss this with your doctor or the hospital.

Find out more about our clinical rules and policies for cover by contacting us on 0860 002 107 or log in to our website to view "what we cover".

Benefits that require preauthorisation

You need to get preauthorisation from us for:

- Hospitalisation
- Day-clinic admissions
- Special procedures (like a scopes, MRI and CT scans).

Who you must contact

Call us on 0860 002 107 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 it when they submit a claim.

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

We will ask for the following information when you request preauthorisation:

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

What happens once you are admitted to hospital

We only pay medically appropriate claims. Your cover is subject to BEMAS Rules, funding guidelines and clinical rules. 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 doctor or the hospital.

Contact us

You can call us on 0860 002 107, or visit the website on www.bemas.co.za for more information.

Complaints process

You may lodge a complaint or query with BMW Employee Medical Aid Society directly on 0860 002 107 or address a complaint in writing directly to the Principal Officer. Should your complaint remain unresolved, you may lodge a formal dispute by following BMW Employees Medical Aid Society's 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.com. Customer Care Centre: 0861 123 267/website www.medicalschemes.com