Out of Hospital Prescribed Minimum Benefit 2020

Who we are

The BMW Employees Medical Aid Society (referred to as 'BEMAS'), registration number 1526, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to '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

This document provides information about your Prescribed Minimum Benefits (PMBs). It tells you how the Scheme covers each of its members for a list of conditions called OHPMB.

No matter what medical scheme or plan you decide on, PMBs apply to all members on all plans.

All our plans cover more than just the minimum benefits required by law. Always consult your Health Plan Guide to see how you are covered.

About some of the terms we use in this document

You might come across some terms in the document that you may not be familiar with. Here are the terms with their meaning:

TERMINOLOGY	DESCRIPTION
Day-to-day benefits	These are the available funds allocated to the Medical Savings Account and Above Threshold Benefit, where applicable.
Scheme rate	This is a rate set by us. We pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services at this rate.
Medicine rate	This is the rate at which the Scheme will pay for medicine. It is the Single Exit Price of medicine plus the relevant dispensing fee.
Co-payment	We pay service providers at a set scheme rate. If the accounts are higher than this rate, you will have to pay the outstanding amount from your own pocket.
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 benefit from your chosen plan's cover.
Designated service provider (DSP)	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. Visit www.bemas.co.za to view the full list of DSPs.

Formulary	Approved Medicine list. If members make use of medicine on the list it will be paid in full up to the medication rate. Medication not on the formulary is subject to a co-payment.
Reference Price	Non-formulary medicine that falls in the same medicine category and generic group as the formulary medicine is paid up to a Reference Price.
Emergency medical condition	An emergency medical condition, also referred to as an emergency, 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.

What is a PMB?

PMB's are a guided by a set list of medical conditions defined in the Medical Schemes Act of 1998

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 set of 270 diagnoses
- 27 chronic conditions (Chronic Disease List conditions).

Please refer to the Council for Medical Schemes website (www.medicalschemes.com) for a full list of the 270 diagnostic treatment pairs.

All Medical schemes in South Africa have to include the PMB's in the plans they offer to their members.

Requirements you must meet to benefit from PMB's

There are certain requirements that need to be met before you can benefit from PMB's:

- The Condition Must qualify for cover and be on the list of defined PMB conditions
- The treatment must match the treatments in the defined benefits on the PMB list.
- You must use the scheme's DSP's for full cover unless there is no DSP applicable to your plan.

If you do not use a DSP, we will pay up to 80% of the scheme rate. You will be responsible for the difference between what we pay and the actual cost of your treatment.

This does not 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 co-payments.

If your treatment doesn't meet the above criteria, we will pay according to your plan benefits.

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 condition on the 270 OH DTPMB list. These defined benefits are supported by thoroughly researched, evidence based clinical protocols; medicine lists (formularies) and treatment guidelines.

Below is an example of a PMB provision as listed in Annexure A of the Medical Schemes Act and the treatment that qualifies for PMB cover:

Provision	Provision Description	Treatment	ICD-10 code
6F	Hernia with obstruction and /or gangrene; uncomplicated hernias under age 18	Repair: bowel resection	K42.1- Umbilical hernia with gangrene

Based on the above example:

- The PMB provision is 6F i.e. one of the listed 270 Provisions in the Medical Schemes Act
- The Provision description includes' Hernia with obstruction and /or gangrene; uncomplicated hernias under age 18
- The treatment that may be covered as a PMB is Repair: bowel resection
- An example of a ICD-10 code that falls within the 6F Provision is 'Umbilical hernia with gangrene' (K42.1)

In order to qualify for PMB funding, the member and provider must apply for Repair: bowel resection. This is performed in a hospital setting and classified as surgical management. All categories stipulated in the PMB provision have to be met in order to qualify for PMB funding. The ICD-10 code alone cannot be considered in isolation. In the above example, Hernias will be covered for members over the age of 18 if it is obstructed and/or has gangrene. Uncomplicated hernia will only be covered for members younger than 18 years of age.

Furthermore, out of hospital medical management (e.g. medication, doctor consultations and investigations) for the condition does not fall under the scope of the PMB provision, and will therefore not be considered as a PMB.

The medical scheme is only required to provide cover for the treatments, procedures, investigations and consultations that is given for each specific condition on the list. If a member needs treatment that is not

on the list and sends additional clinical information that thoroughly explains why the treatment is needed, the scheme will review it and may approve the treatment. If the appeal is declined, the member may contact us to lodge a formal dispute.

The scheme pays for specific healthcare services related to each of our members' approved conditions such as consultations, blood tests and other investigative tests without affecting members' day-to-day benefits. We will inform members of their entitlement to PMB when their condition has been approved.

Using designated healthcare service providers

All medical schemes must ensure that their members do not experience shortfalls when their members make use of designated service providers. Members of the scheme should use doctors, specialist or other healthcare providers who we have an agreement with so that they do not experience a shortfall.

Members can use Maps advisor on www.bemas.co.za or call us on 0860 002 107 to find healthcare service providers who we have an agreement with for your specific plan type.

There are some cases where it is necessary to meet these requirements but you will still have full cover. An example of this is in a life-threatening emergency.

How the scheme manages claims under PMB

Once the member's healthcare professional confirms the diagnosis as a PMB condition, the member can apply for cover for claims to be funded from risk benefits without using their day-to-day cover.

If you have been recently diagnosed with and approved for an OHPMB condition, costs relating to the diagnosis of the condition can be paid from PMB risk benefits if you were an active and valid member of the scheme when the diagnosis of your condition was made. Call us on 0860 002 107 or email Service@discovery.co.za for us to review your claims.

We require additional clinical information from the member's healthcare professional for requests for funding of any treatment that falls outside the standard treatment for the condition. If a treatment falls outside the defined benefits and is not approved, it will be paid for from the available benefits according to the member's chosen health plan. If the member's health plan does not cover these expenses, the member will be responsible to pay the unpaid claims.

Getting the most out of your benefits

Register for your OHPMB condition

To apply for OHPMB's you must complete an *Out of Hospital PMB* application form.

- Up to date forms are always available on www.bemas.co.za under Medical Aid > Find a document
- You can also call 0860 002 107 to request a form.

Who must complete and sign the registration form when applying for PMB

The individual with the PMB condition must complete the application form with the help of their treating doctor. The main member must complete and sign the form if the patient is a minor.

Additional documents needed to support the application
You may need to send the scheme the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying for cover. This will help us to identify that your condition qualifies for the treatment.

Where to send the completed registration form
You must send the completed OHPMB 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

We will let you know the outcome of your PMB application

We will inform you of our decision by fax or email (as you have indicated on your application form). The treatment needed must match the treatments in the published defined benefits on the PMB list as there are standard treatments, procedures, investigations and medicine lists (formularies) for each condition on the PMB list. These defined benefits are supported by thoroughly researched evidence, based on clinical protocols, and treatment guidelines.

We are required to cover defined benefits. If your request meets the defined PMB benefits, we will automatically pay the associated approved blood tests and other defined investigative tests, treatments, medicine and consultations for that condition from the risk benefits (not from your day to day benefits).

What happens if you need treatment that falls outside the defined benefits.

If you need treatment that falls outside of the defined benefits or you require additional benefits, you may submit a PMB appeal application. Additional clinical information with a detailed explanation of why the treatment is needed must be submitted to the scheme for review.

If your application is not approved, it will be paid from available day to day benefits according to your chosen health plan. If your health plan does not cover these expenses, you will be responsible to pay the claims.

To Submit a PMB appeal form:
Download and print an "OHPMB Appeal form"

- Complete the form with the assistance of your doctor/healthcare professional
- Send the completed, signed form, along with any additional medical information, by email to
- PMB_APP_FORMS@discovery.co.za or by fax 011 539 2780

If we approve the requested medicine/treatment on appeal, we will automatically pay from the risk benefits. If the appeal is unsuccessful and you remain unsatisfied you can lodge a formal dispute by following the scheme's internal disputes process on www.bemas.co.za .

What happens if there is a change in your medication

The treating doctor or dispensing pharmacist can only make changes to medicine by sending the updated prescription by fax to 011 539 2780 or emailing it to PMB_APP_FORMS@discovery.co.za

How we pay your claims

We pay for confirmed PMB's in full from the risk benefits 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 the scheme rate.

If approved medication is not on the formulary list, we will pay up to a reference price where the non-formulary medicine falls within the same medicine category and generic group as the formulary medicine. You may have a co-payment if the cost of medication is higher than the reference price.

Once your PMB benefits have been depleted, claims will fund from available plan benefits where applicable.

We pay for benefits not included in the PMB's from your appropriate and available day-to-day benefits, according to the rules and benefits of your chosen health plan.

Complaints process

You may lodge a complaint or query with BEMAS 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 BEMAS' 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