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Guide to Out-of-Hospital Prescribed Minimum Benefits 2024

Who we are

Sasolmed (referred to as 'the Scheme'), registration number 1234, 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). Discovery takes care of the administration of your membership for the Scheme.

Overview

This document gives you information about the Prescribed Minimum Benefits (PMBs). It explains your cover for PMB related healthcare. We also give you information on how we cover healthcare providers consultations, laboratory tests and x-rays.

We deal with each case with complete confidentiality

Our healthcare team respects your right to privacy and will always deal with any clinical-related query or case with complete confidentiality.

About some of the terms we use

Here is a list of some of the terms that you may not be familiar with, along with their meanings:

Terminology	Description
Co-payment	Sasolmed pays service providers at the set Scheme Tariff. If the service providers charge more than the Scheme Tariff, the outstanding amount will be for your own cost.
Designated Service Provider (DSP)	A healthcare provider or group of providers designated by the Scheme to provide services to our members for the diagnosis, treatment and care of medical conditions.
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.
Formulary	Also known as a chronic disease medicine list, is a list of cost-effective, evidence-based medicines that the Scheme funds for certain conditions.
ICD-Code	A clinical code that describes diseases, signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO).
Payment arrangement	We have payment arrangements in place with specific healthcare providers to pay them in full at a higher tariff.

Prescribed Minimum Benefits (PMB)	In terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its Regulations, all medical schemes have to 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 PMBs 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 PMB conditions • The treatment needed must match the treatments in the defined treatment basket • You must use DSP where applicable. 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. If you do not use a DSP, we will pay up to the Scheme Tariff. The difference between what we pay and the actual cost of your treatment will be for your own cost. If your treatment doesn't meet the above criteria, we will pay according to your network option.
Procedure or treatment code	Procedure or treatment codes are a sub-type of medical classification used to identify specific surgical, medical, or diagnostic interventions.
Scheme Tariff	This is a tariff we pay for healthcare services from hospitals, pharmacies, healthcare providers and other providers of relevant health services.

You have access to clinically sound and cost-effective treatment

Sasolmed's coverage policies are developed using a rigorous, evidence-based decision-making process, consisting of a clinical and financial filter. The clinical filter uses evidence-based literature, the opinions of local and international leaders, and current treatment guidelines to ensure that the healthcare service is safe, ethical, clinically appropriate and cost-effective. Sasolmed reserves the right to review this when needed.

What is a Prescribed Minimum Benefit (PMB)?

Prescribed Minimum Benefits (PMBs) are guided by a list of medical conditions as defined in the Medical Schemes Act of 1998

According to the Medical Schemes Act 131 of 1998 and its Regulations, all medical schemes must cover the costs related to the diagnosis, treatment, and care of:

1. Any life-threatening emergency medical condition
2. A defined set of 271 diagnostic treatment pairs
3. 27 chronic conditions (Chronic Disease List (CDL) conditions), including HIV.

Please refer to the Council for Medical Schemes website www.medicalschemes.co.za for a full list of the 271 diagnostic treatment pairs. All medical schemes in South Africa must include the PMBs in the plans they offer to their members.

Requirements you must meet to benefit from Prescribed Minimum Benefits (PMBs)

There are certain requirements before you can benefit from PMBs. The requirements are:

1. The condition must qualify for cover and 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 (DSPs) for full cover unless there is no DSP applicable to your Network Option.

If you do not use a GP on the network DSP 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 Scheme Rules, you may be transferred to a hospital or other service providers in our network once your condition has stabilised, to avoid co-payments. If your treatment doesn't meet the above criteria, we will pay according to your Option benefits.

Claims for services received outside of the borders of South Africa will be covered in accordance with your chosen Option benefits and rules. For more information on cover while travelling, please refer to the guide on the cover for treatment received abroad, available on our website sasolmed.co.za.

The medical condition must be part of the list of defined conditions for Prescribed Minimum Benefits (PMBs)

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

The treatment needed must match the treatments included in the defined benefits

There are standard treatments, procedures, investigations, and consultations for each PMB condition on the 271 diagnostic treatment (DT) PMB list. These defined benefits are supported by thoroughly researched, evidence based clinical protocols, medicine lists (formularies) and treatment guidelines.

Please refer to the Council for Medical Schemes website www.medicalschemes.co.za for a full list of the 271 diagnostic treatment pairs.

An example of a Prescribed Minimum Benefit (PMB) provision

Below is an example of a PMB condition and the treatment that qualifies for PMB cover:

PROVISION	PROVISION DESCRIPTION	TREATMENT	ICD-10 CODE
236K	Iron deficiency; vitamin and other nutritional deficiencies - life-threatening	Medical management	D50.8- Other iron deficiency anaemias

- The PMB Provision is 236K. This is one of the listed 271 Provisions (listed 271 conditions) as published in the Medical Schemes Act and Regulations.
- In this example the Provision Description lists “Iron deficiency; vitamin and other nutritional deficiencies - life threatening”. The provision states that the condition should be life threatening. For this provision, if the diagnosis is not a life-threatening episode, the condition does not qualify for PMB funding.
- The Treatment covered as a PMB for this provision includes medical management for example medicine, healthcare provider consultations investigations etc.
- In addition to the above information, the Council for Medical Schemes (CMS) also provides ICD-10 codes (e.g., D50.8) that fall within the 236K Provision, as per the last column in the above table. The ICD-10 codes (diagnosis codes) are an industry guide as to which conditions may qualify for PMB cover, subject to them still meeting the Provision Description and treatment criteria.

Any treatment that is not listed in the “treatment” provision for a condition, cannot be considered as PMB as it does not form part of the prescribed treatment that forms part of PMB level of care. Speak to your healthcare provider to ensure that all criteria for treatment are met before applying for PMB cover.

How we pay claims for Prescribed Minimum Benefits (PMBs) and non-Prescribed Minimum Benefits (non-PMB)

We pay for confirmed PMBs in full if you receive treatment from a DSP and/or preferred supplier. Treatment received from a non-designated service provider (non-DSP) or medical items from a supplier who is not a preferred supplier may be subject to a co-payment if the healthcare provider or supplier charges more than the amount we pay.

We have preferred suppliers for external medical items such as CPAP machines or rental oxygen. Where a non-preferred supplier is used you may have a co-payment. To view the External Medical Items Benefit guide visit sasolmed.co.za

We pay for benefits not included in the PMBs from your appropriate and available plan benefits, according to the rules of your chosen health plan. Visit sasolmed.co.za or click on Find a healthcare provider using your app or call us on 0860 002 134 to find a participating DSP.

There are some circumstances where you do not have cover for Prescribed Minimum Benefits (PMBs)

This can happen when you join a medical scheme for the first time, with no previous medical scheme membership. Also, if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme may impose a waiting period, during which you and your dependants will not have access to the PMBs, regardless of the conditions you may have. We will communicate with you at the time of applying for your membership if any waiting periods apply to you or your dependants.

There are a few instances when the Scheme will only pay a claim as a Prescribed Minimum Benefit (PMB)

This happens when you have a waiting period or when you have treatments linked to conditions that are excluded by your Network Option. This can be a three-month general waiting period or a 12-month condition-specific waiting period. Depending on the category of waiting periods, you may still qualify for cover from the PMBs.

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

How to register your chronic conditions

There are different types of PMBs. These include PMB cover for in-hospital admissions, conditions covered under the Chronic Disease List (CDL), the out-of-hospital management of PMB conditions, and treatment of PMB conditions such as HIV and oncology.

To apply for out-of-hospital Prescribed Minimum Benefits (OHPMBs) or cover for a Chronic Disease List (CDL) condition, you must complete the Prescribed Minimum Benefit or a Chronic Illness Benefit application form.

- Up to date forms are always available on sasolmed.co.za.
- You can also call **0860 002 134** to request any of the above forms.

For more information on the PMB Chronic Disease List (CDL) conditions, HIV or Oncology and how to register please refer to the relevant benefit guides available on sasolmed.co.za

To confirm your in-hospital cover for PMB conditions, you can call us on 0860 002 134 and request an authorisation. We will then confirm your cover.

Why it is important to register your chronic condition

We will pay for treatment or medicines that fall outside the defined benefits and that are not approved, from your available day-to-day benefits, according to your chosen Network Option. If your Network Option does not cover these expenses, these claims will be for your own pocket.

Who must complete and sign the registration form when applying for chronic condition cover?

The person with the chronic condition must complete the relevant application form with the help of their treating healthcare provider. The main member must complete and sign the form if the patient is a minor.

Each person with chronic condition(s) must register their specific condition(s) separately. You only have to register once for a chronic condition. If your medicine or other treatment changes, your healthcare provider can let us know about these changes.

For new conditions, you will have to register each new condition before we will cover the treatment and consultations from your PMBs and not from your day-to-day benefits.

Additional documents needed to support your application

You must send the Scheme the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying. This will help us to identify whether your condition qualifies as a PMB. Remember to keep a copy of the completed form for your records.

Where to send the completed application form(s) You must send the completed Prescribed Minimum Benefit (PMB) application form to PMB.appeal@sasolmed.co.za.

You must send the completed Chronic Illness Benefit (CIB) application form to chronic@sasolmed.co.za.

We will let you know if we approve your application for chronic condition cover and what you must do next

We will let you know about the outcome of your application and will send you a letter confirming your cover for the condition, using your preferred method of communication. If your application meets the requirements for cover from PMBs, we will automatically pay the associated approved blood tests and other defined

investigative tests, treatment, medicine and consultations for the diagnosis and treatment of your condition from your PMBs, and not from your day-to-day benefits.

The treatment needed must match the treatments in the published defined benefits on the PMB list as 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 you need treatment that falls outside of the defined benefits

If you need treatment that falls outside of the defined benefits you and your healthcare provider can send additional clinical information with a detailed explanation of the treatment that is needed and we will review it. If this treatment is not approved as PMB, it can be paid from your available day-to-day benefits, according to your chosen Network Option. If your Network Option does not cover these expenses, these claims will be for your own cost.

You can follow the easy steps below to apply for additional cover Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB):

1. Download the request for additional cover for Request for additional cover for PMB CDL conditions registered on CIB. Up to date forms are always available on sasolmed.co.za . You can also call **0860 002 134** to request any of the above forms.
2. Complete the form with the assistance of your healthcare provider.
3. Send the completed, signed form, along with any additional medical information, by email to PMB.appeal@sasolmed.co.za or chronic@sasolmed.co.za.

If we approve the request for additional medicine or treatment, we will automatically pay these from either approved benefit. If the application for additional cover is unsuccessful and you are not satisfied with the outcome you may also lodge a formal dispute by following the Scheme's disputes process.

For more information on your cover for Chronic or PMB medicine please visit our website sasolmed.co.za.

What happens if there is a change in your approved medicine

For chronic conditions, your treating healthcare provider or dispensing pharmacist can make changes to your medicine telephonically by calling **0860 002 134** or by emailing the updated prescription to chronic@sasolmed.co.za.

For other PMB conditions, the treating healthcare provider or dispensing pharmacist can only make changes to medicine by sending the updated prescription via email to PMB.appeal@sasolmed.co.za.

If you get your medicine or treatment from a provider of your choice who is not part of the Scheme's designated service providers (DSPs)

You must use GP's, specialists and other healthcare providers, including pharmacies, who we have a payment arrangement with, to avoid a co-payment. This does not apply in the event of an emergency or where the use of a non-DSP is involuntary or when no DSP is available. If you use a healthcare provider who we do not have a payment arrangement with, part of the treatment may be for your cost.

In an emergency, you can go directly to hospital and notify the scheme as soon as possible of your admission. In the case of an emergency, you are covered in full for the first 24 hours or until you are stable enough to be transferred.

Go to sasolmed.co.za or click on Find a healthcare provider using your Sasolmed app or call us on **0860 002 134** to find a participating designated service provider (DSP).

Get the most out of your benefits

Elective admissions for PMB conditions and procedures are covered in full if you choose to use a DSP hospital and DSP treating healthcare provider. Where your primary treating healthcare provider is a DSP, reimbursement will be made in full without any co-payment for any required anaesthetic services you may need during your admission.

The below conditions need to be met for full cover for these providers:

- You are being admitted for a procedure for a PMB condition
- Your chosen hospital or day facility is on the PMB network for your Network Option
- Your primary treating healthcare provider is on the PMB network for your Network Option.

If all the above conditions are met your hospital, healthcare provider and anaesthetist accounts will be covered in full.

Nominate a GP for the management of your PMB chronic conditions

If you are approved for a chronic PMB condition, you must nominate a General Practitioner (GP) in the Sasolmed GP network for your plan to be your primary care healthcare provider for the management of your chronic conditions. Where a GP has not been nominated for the treatment of a chronic condition you may incur a co-payment.

You can nominate your primary care healthcare provider in three simple steps:

- Log in to the Sasolmed app or website
- Navigate to nominate your primary care healthcare provider
- Follow the prompts in the Care Portal and select your primary care healthcare provider and their associated practice.

You can access your Care portal on the Sasolmed app or website to update your nominated GP should you need to do so.

What to do if there is no available designated service provider (DSP) at the time of your request

There are some instances when you will still have full cover if you use a healthcare provider who we do not have a DSP arrangement with. An example of this is in an emergency, cases when the use of non-DSP is involuntary or when there is no DSP available.

In cases where there are no services or beds available at a DSP when you or one of your dependants need treatment, you can contact us on 0860 002 134 and we will make arrangements for an appropriate facility or healthcare provider to accommodate you.

Cover for Cancer

Depending on your chosen Network 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 Tariff, in accordance with your Network Option benefits.

Cancer treatment that is a PMB is always covered in full. All PMB treatment costs add up to the oncology cover amount for your Network Option. If your treatment costs more than the cover amount, we will continue to cover your PMB cancer treatment in full.

For more information on your cover for cancer please visit our website sasolmed.co.za

Cover for HIV

When your Premier Plus GP enrols you on the HIV Care Programme to manage your condition, you are covered for the care you need, which includes additional cover for social workers. You can always be assured of confidentiality.

For more information on your cover for HIV please visit our website sasolmed.co.za

Cover for COVID-19

The WHO Global Outbreak Benefit provides cover for global disease outbreaks recognised by the World Health Organization (WHO) such as COVID-19. This benefit offers cover for the vaccine administration, out-of-hospital management and appropriate supportive treatment related to the management of acute COVID-19 and long COVID. Please visit our website sasolmed.co.za under Medical Aid > Benefits and cover > COVID-19 Benefits for more information.

Cover for Prescribed Minimum Benefit (PMB) admissions

You must preauthorise all hospital admissions. When you call us to preauthorise your admission, we will tell you how you are covered. You must use DSPs in our network. This does not apply in emergencies. 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. If you do not use a DSP we will pay up to 80% of the Scheme Tariff for the admission.

In instances where a co-payment or deductible is applicable to the admission, additional information such as a scan or scope report will be required. If the PMB condition is confirmed no co-payments or deductibles will be applicable.

For more information on your in-hospital PMB cover please visit our website sasolmed.co.za.

Your healthcare provider can apply for additional cover

If clinically appropriate, you can request additional cover if your condition requires this through an appeals process.

Complaints process

You may lodge a complaint or query with Sasolmed directly on **0860 002 134** or send an email to enquiries@sasolmed.co.za. If the query or complaint remains unresolved, you may address a complaint in writing to the Principal Officer. Please be sure to include the reference number obtained through the process with the Administrator.

Should your complaint still not be resolved to your satisfaction, you may lodge a formal dispute by following the Scheme's internal disputes process, as explained on the website at sasolmed.co.za

You may, as a last resort, approach the Council for Medical Schemes for assistance: 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.co.za / www.medicalschemes.co.za

Contact us

You can find other important information on our website at sasolmed.co.za or contact us on **0860 002 134**.