MALCOR
MEDICAL AID SCHEME
Administered by Discovery Health

Guide to Prescribed Minimum Benefits

2015

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No matter what medical scheme or plan a member decides on, there are some common benefits that apply to all members on all plans.

This document tells members how the Malcor Medical Aid Scheme covers each of its members 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 members may not be familiar with. Members can find the meaning of these terms in the table below.

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	The Malcor Medical Aid Scheme ("the Scheme") pays service providers at a set rate, the Scheme Rate. If the service providers charge higher fees than this rate, the member will have to pay the outstanding amount from his or her pocket.
Waiting period	A waiting period can be general or condition-specific and means that a member may have to wait for a set time before he or she can benefit from his or her chosen plan's cover.
Diagnostic Treatment Pairs – Prescribed Minimum Benefit (DTP PMB)	Links a specific diagnosis to a treatment and broadly indicates treatment of PMB condition
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.

Understanding the Prescribed Minimum Benefits

PMBs are guided by a set list of medical conditions as defined in the Medical Schemes Act of 1998.

In terms of 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, and
- 27 chronic conditions.

These conditions and their treatments are PMBs.

All medical schemes in South Africa have to include PMBs in the health plans they offer to their members. There are, however, certain requirements that a member must meet before he or she can benefit from PMBs.

The three requirements are:

1. The condition must be part of the list of defined PMB conditions.
2. The treatment needed must match the treatments in the defined benefits.
3. Members must use the scheme's designated service providers (DSP).

The Malcor Medical Aid Scheme offers far greater benefits

All Malcor Medical Aid Scheme plans cover more than just the minimum benefits required by law. Some plans cost more but offer more comprehensive benefits while others have lower contributions with fewer benefits.

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

This happens when a member is in a waiting period or when a member has treatments linked to conditions that are excluded by their plan. In all of the above mentioned instances, members can still have cover in full, provided the three requirements as described above, set out by PMB regulations are met.

More about meeting PMB requirements

The medical condition must be part of the list of defined conditions for PMBs

Members may need to send the Scheme the results of their medical tests and investigations that confirm the diagnosis of the condition. This will allow us to identify whether the member's condition qualifies for the treatment. The member's treating doctor needs to provide the relevant documents to help us confirm 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 PMB list. These defined benefits are supported by thoroughly-researched evidence, based on clinical protocols, medicine lists (formularies) and treatment guidelines.

The 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 choose to approve the treatment. If we decline the appeal, 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 lessening our members' day-to-day benefits. We will inform our members of their entitlement to PMBs when their condition and treatment has been approved.

How we cover medicine for the 27 chronic conditions

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

If a medicine that is not on the medicine list is claimed the member may have these claims paid from the acute medicine benefit subject to available benefits.

Using the designated healthcare service providers (DSP)

All medical schemes must ensure that their members do not experience shortfalls when their members make use of DSPs. Members of the Scheme need to use doctors, specialists or other healthcare providers with who we have an agreement, so they do not experience a shortfall.

Members can use the MaPS Advisor on www.malcormedicalaid.co.za or call us on 0860 100 698 to find healthcare service providers with whom we have an agreement.

There are some cases where it is not necessary to meet these requirements, but a member will still have full cover. An example of this is in a life-threatening emergency.

Cover for In-hospital PMB claims

In Hospital PMB claims for non-designated healthcare service providers will be funded in full and the members will not experience any shortfall.

How the Scheme manages PMB claims

There are different types of claims for PMBs, such as claims for hospital admissions, chronic conditions and other conditions treated out of hospital. In most cases, we automatically recognise that the member claiming for these medical services is entitled to cover under the PMBs.

There are, however, times when a member needs to apply for cover under the PMBs. Once the member's healthcare professional confirms the diagnosis as a PMB condition, the member can apply for cover for these claims to be funded from risk benefits without using their day-to-day cover.

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 that 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.

Instances where members do not have PMB cover

There are certain instances where the member is not covered for PMB treatment. This can happen when a person joins a medical scheme for the first time, with no medical scheme membership before that.

This can also happen if someone joins a medical scheme more than 90 days after leaving his or her previous medical scheme. In both these cases, the medical scheme would impose a waiting period, during this time these members will not have access to PMB treatment, no matter what medical conditions they might have.

How to apply for PMB cover

If a member wants to apply for out-of-hospital PMB cover or cover for their chronic condition, he or she needs to:

1. Download and print an "Application for out-of-hospital management of a PMB condition" or "The Chronic Illness Benefit Application" form, available on www.malcormedicalaid.co.za. Members can also call 0860 100 698 to request any of the above forms.
2. Complete the application form with the assistance of his or her healthcare professional
3. Send the completed, signed application form, along with any additional medical information, by email to PMB_APP_FORMS@discovery.co.za or by fax 011 539 2780.

Once we receive the application form and it meets the PMB requirements, we will automatically pay the associated investigations, treatment and consultations for that condition from risk benefits. If a member wants to apply for in-hospital PMB cover, he or she must call us on 0860 100 698 to request authorisation.