MALCOR
MEDICAL AID SCHEME
Administered by Discovery Health

Guide to In-Hospital Prescribed Minimum Benefits – 2024

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.

Malcor Medical Aid Scheme plans are structured in such a way that the member's chosen plan type 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 Guide to see how you are covered.

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

TERMINOLOGY	DESCRIPTION
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 pocket.
Day-to-day benefits	These are the available funds allocated to the Out-of-hospital Overall annual limit. Depending on the plan you choose, you may have cover for a defined set of day-to-day benefits. The level of day-to-day benefits depends on the plan you choose.
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.malcormedicalaid.co.za to view the full list of DSPs.
Scheme Rate	This is the rate that Malcor Medical Aid Scheme sets for paying claims from healthcare professionals.
At Cost	Fees charged by a provider that are more than the Scheme Rate.
Overall Annual Limit (OAL)	A specific amount allocated and defined by either an individual member or per family unit. The OAL is the maximum amount that may be claimed by either member or the family unit. Different sub-limits apply in respect of major medical expenses.
Member	The reference to member in this document also includes dependants, where applicable.
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

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	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.
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.

How we cover In-Hospital claims

We pay for confirmed PMBs 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.

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

Using the 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 healthcare providers who we have a payment agreement with so that they do not experience co-payments.

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.

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, no matter what conditions you might 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. But you might have cover in full, if you meet the requirements stipulated by the PMB regulations.

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Get preauthorisation for hospitalisation 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 hospitalisation. 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 as soon as possible of your admission. In cases of emergency, you are covered at cost for the first 24hrs or until stable.

Contact us for preauthorisation

Call us on 0860 100 698 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, 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).

Please note: If you don't preauthorise 48 hours before your admission, we will not cover your admission. For emergencies, members have 72 hours after admission, to obtain authorisation.

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 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.

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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.

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 100 698. 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 health plan. 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 100 698 or visit www.malcormedicalaid.co.za.

PMB status	Service provider type	Hospital	Healthcare professional
Emergency	Designated service provider	• Hospital account is paid at the contracted rate	• Related accounts are paid in full at the agreed rate
	Not a designated service provider	• Hospital account is paid in full at cost	• Related accounts are paid in full at cost
Elective	Designated service provider	• Hospital account is paid at the contracted rate	• Related accounts are paid in full at the agreed rate
	Not a designated service provider	• Hospital account is paid up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The co-payment, which you will be liable for, 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 co-payment, which you are liable for, is equal to the amount that the provider charges above the Scheme Rate.
Plan A and Plan B have an unlimited Overall Annual limit. **Plan C has an Overall Annual limit of R1 000 000 per family per annum. In-hospital PMB claims received for Plan C will accumulate to the Overall Annual Limit and pay through this limit should it be reached.**			

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Contact us

You can call us on 0860 100 698 or visit www.malcormedicalaid.co.za.

Complaints process

You may lodge a complaint or query with Malcor Medical Aid Scheme directly on 0860 100 698 or address a complaint in writing directly to the Principal Officer. Should your complaint remain unresolved, you may lodge a formal dispute by following Malcor Medical Aid Scheme'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.co.za. Customer Care Centre: 0861 123 267 / Website www.medicalschemes.co.za