

ALLIANCE-MIDMED MEDICAL SCHEME

PREScribed MINIMUM BENEFITS (PMBs)

ANNEXURE D

(With effect from 1 January 2017)

(Unless otherwise stated below)

1. Definitions

1.1 “Prescribed minimum benefits”, the benefits contemplated in Section 29(1)(o) of the Act and consist of the provision of the diagnosis, treatment and care costs of:-

1.1.1 the diagnosis and treatment pairs listed in Annexure A of the Regulations, subject to any limitations specified therein; and

1.1.2 any emergency medical condition.

1.2 “Prescribed minimum benefit condition”, a condition contemplated in the diagnosis and treatment pairs listed in Annexure A of the Regulations or any emergency medical condition.

1.3 “Any emergency medical condition”, the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or 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.

2. Designation of service providers

2.1 The Scheme designates the Alliance-Midmed Network for the delivery of prescribed minimum benefits to its beneficiaries.

2.2 The Alliance-Midmed Network shall for the purposes of this Annexure be referred to as “designated service providers”.

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3. Prescribed minimum benefits obtained from designated service providers

The Scheme will pay 100% of the cost in respect of diagnosis, treatment and care of prescribed minimum benefit conditions if those services are obtained from a designated service provider.

4. Prescribed minimum benefits voluntarily obtained from other providers

If a beneficiary voluntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the benefit payable in respect of such service is subject to:

4.1 In the case of hospitalisation, such benefit limitations as are normally applicable.

4.2 In the case of all other providers, a co-payment equal to the difference between the actual cost incurred and the cost that would have been incurred had the designated service provider been used.

5. Prescribed minimum benefits involuntarily obtained from other providers

5.1 If a beneficiary involuntarily obtained diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the medical scheme will pay 100% of the cost in relation to those prescribed minimum benefit conditions.

5.2 For the purposes of paragraph 5.2.1, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider if:-

5.2.1 The service was not available from the designated service provider or would not be provided without unreasonable delay;

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- 5.2.2 Immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtained such treatment from a designated service provider; or
- 5.2.3 There was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.
- 5.3 Except in the case of an emergency medical condition, pre-authorisation shall be obtained by a member prior to involuntarily obtaining a service from a provider other than a designated service provider in terms of this paragraph, to enable the Scheme to confirm that the circumstances contemplated in paragraph 5.2.2 are applicable.

6. Medication

- 6.1 Where a prescribed minimum benefit includes medication, the Scheme will pay 100% of the cost of that medication if that medication is obtained from a designated service provider or is involuntarily obtained from a provider other than a designated service provider, *and*
- 6.1.1 the medication is included on the applicable formulary in use by the Scheme; and
- 6.1.2 the formulary does not include a drug that is clinically appropriate and effective for the treatment of that prescribed minimum benefit condition.
- 6.2 Where a prescribed minimum benefit includes medication and that medication is voluntarily obtained from a provider other than a designated service provider, a co-payment equal to the difference between the cost of the drug and the reference price of the formulary drug will apply.

7. Prescribed minimum benefits obtained from a public hospital

Notwithstanding anything to the contrary contained in these Rules, the Scheme will pay 100% of the costs for prescribed minimum benefits obtained in a public hospital, without limitation.

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8. Diagnostic tests for an unconfirmed PMB diagnosis

Where diagnostic tests and examinations are performed but do not results in confirmation of a PMB diagnosis, except for an emergency medical condition, such diagnostic tests or examinations are not generally considered to be a PMB.

9. Co-payments

Co-payments in respect of the costs for PMBs may not be paid out of medical savings accounts.

10. Chronic conditions

The Scheme covers the full costs for services rendered in respect of the prescribed minimum benefits which includes the diagnosis, medical management, medication and care to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specific conditions, published by the Minister by notice in the Government Gazette

10.1 Chronic conditions included in the Chronic Disease List

DIAGNOSIS	
Addison's disease	Asthma
Bipolar mood disorder	Bronchiectasis
Cardiac failure	Cardiomyopathy disease
Chronic renal disease	Coronary artery disease
Chronic obstructive pulmonary disorder	Crohn's disease
Diabetes insipidus	Diabetes mellitus type 1 & 2
Dysrhythmias	Epilepsy
Glaucoma	Haemophilia
HIV/AIDS	Hyperlipidaemia
Hypertension	Hypothyroidism
Multiple sclerosis	Parkinson's disease
Rheumatoid arthritis	Schizophrenia
Systematic lupus erythematosus	Ulcerative colitis

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