ANGLOVAAL GROUP MEDICAL SCHEME

Administered by Discovery Health

Guide to Prescribed Minimum Benefits 2020

Who we are

The Anglovaal Group Medical Scheme (referred to as 'the Scheme'), registration number 1571, is the medical scheme that you are a member of. This 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 1997/013 480/07). We take care of the administration of your membership for the Scheme.

Contact us

You can call us on **0860 100 693** or visit www.avgms.co.za for more information.

Overview

No matter what medical scheme or plan you decide on, there are some common benefits that apply to all members on all plans. This document tells you how the 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 you may not be familiar with. We give you the meaning of these terms:

Terminology	Description
Prescribed Minimum Benefits (PMB)	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 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 the member has to wait for a set time before they can benefit from their chosen plan's cover
Chronic Drug Amount (CDA)	The CDA is a maximum monthly amount we pay up to for a medicine class. This applies to medicine that is not listed on the medicine list (formulary). The Chronic Drug Amount includes VAT and the dispensing fee.
Diagnostic Treatment Pairs Prescribed Minimum Benefit	Links a specific diagnosis to a treatment and broadly indicates how each of the PMB conditions should be treated.

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.
Reference Pricing	Non-formulary medication that falls in the same medicine category and generic group as the formulary medication. Funds up to a Reference Price.

Understanding the Prescribed Minimum Benefits

What are PMBs?

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:

- A life-threatening emergency medical condition;
- A defined list of 270 diagnoses;
- A defined list of 27 chronic conditions (Chronic Disease List conditions).

Please refer to the Council for Medical Schemes website at www.medicalschemes.com for a full list of the diagnoses and chronic conditions.

All medical schemes in South Africa have to include the PMBs in the health plans they offer to their members.

How does the Scheme pay claims for PMBs and non-PMB benefits?

We pay for PMBs in full from the Risk Benefits if you receive treatment from a designated service provider (DSP). Treatment received from a non-DSP may be subject to a co-payment if the healthcare provider charges more than what we pay. We pay for benefits not included in the PMBs from your day-to-day benefits, according to the rules and benefits of your chosen health plan.

Requirements you must meet to benefit from PMBs

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

- The condition must qualify for cover and be on the list of defined PMB conditions
- The treatment needed must match the treatments in the published defined benefits on the PMB list
- You must use the Scheme's designated service providers. This does not apply in life threatening emergencies. However even in these cases, where appropriate and according to the rules of the Scheme, you may be transferred to a designated service provider hospital or facility.

If the treatment does not meet the above criteria, we will pay the claims up to the Scheme Rate, which is a set rate at which the Scheme pays service providers. If the service provider charges above this rate, you will have to pay the outstanding amount from your pocket. This amount you have to pay is called a co-payment.

Kindly note:

- PMB regulations and their accompanying provisions do not apply to healthcare services obtained outside the borders of South Africa.
- PMB-related claims for services obtained outside the borders of South Africa shall be treated as normal (non-PMB) claims, subject to the relevant Scheme Rate and any other limitations applicable to normal (non-PMB) claims within the borders of South Africa.

The Scheme offer benefits richer than that of the PMBs

The Scheme covers more than just the minimum benefits required by law.

Sometimes the Scheme will only pay a claim as a PMB

This happens when you are in a waiting period or when you have treatments linked to conditions that are excluded by your plan. This can be a general three-month waiting period or a 12-month condition-specific waiting period. But you can still have cover in full, if you meet the requirements stipulated by the PMB regulations.

There may be times when you do not have cover under PMBs
There are some circumstances where you do not have cover for the 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.

You and your dependants must register to get cover for PMBs and Chronic Disease List conditions

How to register your chronic or PMB conditions to get cover from the Risk Benefit?

There are different types of PMB claims such as claims for In Hospital admissions, Out of Hospital PMB's (OHPMBs), PMB CDL conditions, Oncology and HIV.

If you want to apply for out-of-hospital PMBs or cover for a chronic condition on the Chronic Disease List, you must get a PMB or a Chronic Illness Benefit Application form:

- Both forms are available to download and print from www.avgms.co.za;
- Log on to the website using your username and password. Go to "Find a document" and click on the application forms;
- You can also call 0860 100 693 to request any of the above forms.

We will also let you know about the outcome of the application. We will send you a letter confirming your cover for that condition.

If your application meets the requirements to benefit from PMBs, we will automatically pay the associated approved blood tests and other investigative tests, treatment, medicine and consultations for that condition from the Risk Benefits (not from your day-to-day benefits).

More information on Out of Hospital PMB's (OHPMBs) and PMB CDL conditions is available on www.avgms.co.za under Medical Aid > Find a document.

If you want to apply for in-hospital PMB cover, you must call us on 0860 100 693 to request an authorisation.
In an emergency a member must go directly to a hospital and notify the scheme as soon as possible of their admission. In cases of emergency, members are covered at cost for the first 24hrs or until stable.

Why it is important to register your PMB or chronic conditions?

The Scheme pays for specific healthcare services related to each of your approved conditions. These services include treatment, medicine, consultations, blood tests and other investigative tests. We pay for the services without affecting your day-to-day benefits because we pay it from your Risk Benefits.

We will pay for treatment or medicine that falls outside the defined benefits and that is not approved, from your available day-to-day benefits. If the Scheme does not cover this treatment, you will have to pay the claims.

There are times when you need to apply for cover under the PMBs. Once your healthcare professional confirms the diagnosis as a PMB condition, you can apply to us for payment of the claims from your Risk Benefits without using your day-to-day benefits. Once the treatment is approved we will automatically recognise that the medical services you are claiming for fall under the PMB.

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 chronic medicine.

Where you must send the completed registration form

You can send the completed PMB application form:

- By fax to: **011 539 2780**
- By email to: PMB_APP_FORMS@discovery.co.za
- By post to: Anglovaal Group Medical Scheme, PMB Department, PO Box 652509, Benmore, 2010.

You can send the completed chronic application form:

- By fax to: **011 539 7000**
- By email to: CIB_APP_FORMS@discovery.co.za
- By post to: Anglovaal Group Medical Scheme, CIB Department, PO Box 652509, Benmore, 2010.

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

We will inform you of our decision by fax or email (as you have indicated on you application form).

The treatment needed must match the treatments in the published defined benefits on the PMB list as is. 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.

About what happens if you need treatment that falls outside of the defined benefits?

The Scheme is only required to cover the defined benefits. If treatment that falls outside the defined benefits is not approved, it will be paid from your 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.

If you need treatment that falls outside of the defined benefits and you send additional clinical information with a detailed explanation of why the treatment is needed, the Scheme will review it and may choose to approve the treatment. If we decline the request, you may contact us to lodge a formal dispute by following the dispute process detailed on the website at www.avgms.co.za.

We cover approved medicine on our medicine list (formulary) in full

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

If we approve a medicine that is not on the medicine list, we will pay it up to a set monthly rand amount called the Chronic Drug Amount (CDA) or up to a Reference Price. You may have a co-payment if the cost of the medicine is greater than the CDA or Reference Price.

This is unless the medicine is a substitute for one that has been ineffective or has caused an adverse reaction. In that case you and your doctor can appeal the funding decision. If the appeal is successful there will be no co-payment.

To appeal for PMB cover or cover for chronic medicine/treatment:

- Download and print a "PMB Appeal Form" or "The Chronic Illness Benefit Appeal form", available on www.avgms.co.za. Members can also call **0860 100 693** to request any of the above forms;
- Complete the appeal form with the assistance of your healthcare professional.
- Send the completed, signed appeal form, along with any additional medical information, by email to PMB_APP_FORMS@discovery.co.za or by fax **011 539 2780** or by email to CIB_APP_FORMS@discovery.co.za or by fax to **011 539 7000;**

If we approve the requested medicine/treatment on appeal, we will automatically pay from your Risk Benefits. If the appeal is unsuccessful the member can lodge a formal dispute by following the Scheme's internal disputes process on the website.

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About who must register to receive chronic medicine for their PMB or chronic conditions

The main member and all dependants with PMB or chronic conditions must register. Each individual must register their specific conditions. You only have to register once for a chronic condition. If your medicine or other treatment changes, your doctor can just let us know about the changes.

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

About what happens if there is a change in your approved medicine

For chronic conditions, the treating doctor or dispensing pharmacist can make changes to medicines telephonically by calling **0860 100 693**. You can also fax an updated prescription to **011 539 7000** or email it to CIB_APP_FORMS@discovery.co.za.

For PMB conditions, the treating doctor or dispensing pharmacist can make changes to medicines by sending the updated prescription by fax to **011 539 2780** or email it to PMB_APP_FORMS@discovery.co.za.

What are designated service providers (DSPs) and how to find them?

A DSP is a healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have a payment arrangement with. According to this arrangement, they will provide treatment or services at a contracted rate. This will make sure that you do not have any co-payments when you use their services. You can use the MaPS Advisor on www.avgms.co.za or call us on **0860 100 693** to find a healthcare service provider we have a DSP payment arrangement with.

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

There are some cases where it is not necessary to use designated service providers, but you will still have full cover. An example of this is in a life-threatening emergency.

In cases where there are no services or beds available within the designated service provider when you or one of your dependants needs treatment, you must contact us on **0860 100 693** and we will intervene and make arrangements for an appropriate facility or healthcare provider to accommodate you.

About what happens if you get your medicine from a provider of your choice instead of the Scheme's DSPs

All medical schemes must make sure their members do not experience co-payments when they use designated service providers. You must use doctors, specialists and other healthcare providers who we have a DSP payment arrangement with, so that you do not experience a co-payment.

If you do not use healthcare providers who we have a DSP payment arrangement with, you will have to pay part of the treatment costs yourself. This amount you have to pay is called 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. In an emergency a member must go directly to a hospital and notify the scheme as

soon as possible of their admission. In cases of emergency, members are covered at cost for the first 24hrs or until stable.

Go to www.avgms.co.za for the latest copy of the treatment guidelines or contact us on **0860 99 88 77** and we will send you a copy.

Oncology

Depending on your health plan, once you are registered on the Oncology Programme, the Scheme covers your approved cancer treatment over a 12-month cycle up to the Discovery Health Rate, in accordance with your plan benefits. For non-malignant PMB conditions, please follow the OHPMB process outlined previously. For more information please visit the website www.avgms.co.za

HIV

When you register for our HIV Care Programme to manage your condition, you are covered for the care you need. For more information please visit the website (www.avgms.co.za) for information.

Complaints process

You may lodge a complaint or query with Anglovaal Group Medical Scheme directly on **0860 100 693** or address a complaint in writing directly to the Principal Officer. Should your complaint remain unresolved, you may lodge a formal dispute by following Anglovaal Group Medical 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.com. Customer Care Centre: **0861123 267**/website www.medicalschemes.com.