ENGEN | Medical Benefit Fund

Administered by Discovery Health

Guide to Prescribed Minimum Benefits 2021

Who we are

Engen Medical Benefit Fund (referred to as 'the Fund'), registration number 1572, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider. Discovery Health (Pty) Ltd is responsible for the administration of your membership on behalf of the Fund.

About this document

This document tells you about the Prescribed Minimum Benefits and your benefits.

What are Prescribed Minimum Benefits (PMBs)?

PMBs are guided by a list of medical conditions as defined in the Medical Schemes Act of 1998 According to the Medical Schemes Act and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

1 | Any life-threatening emergency medical condition
2 | A defined set of 270 diagnoses
3 | 27 chronic conditions (Chronic Disease List conditions).

Please refer to the Council for Medical Schemes website, www.medicalschemes.com, for a full list of the 270 diagnostic treatment pairs. All medical schemes in South Africa have to include the Prescribed Minimum Benefits in the plans they offer to their members.

How do you qualify for benefits under Prescribed Minimum Benefits?

There are certain requirements before you can access Prescribed Minimum Benefits. 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 Fund's Designated Service Providers (DSPs) for full cover unless there is no DSP applicable to your plan.

If you do not use the services of a DSP, we will pay claims for PMBs up to 80% of the Fund Rate. You will be responsible to pay the shortfall difference between what we pay and the actual cost of your treatment.

This does not apply in emergencies. However, even in those cases, where appropriate and according to Fund 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 benefits.

Claims for services received outside of the borders of South Africa will be covered in accordance with the Fund 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 www.engenmed.co.za and click on Find documents.*

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

You must send the results of their medical tests and investigations that confirm the diagnosis of the condition to the Fund. This will allow us to identify that the condition qualifies for the treatment. Your treating doctor needs to provide the relevant documentation to assist us in confirming the diagnosis.

The treatment needed must match the treatments included in the PMB

There are standard treatments, procedures, investigations and consultations for each PMB condition on the 270 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.com, for a full list of the 270 diagnostic treatment pairs.

An example of a 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 270 Provisions (listed 270 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", meaning 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, doctor's consultations, investigations etc.
- In addition to the above information, the Council for Medical Schemes also provides **ICD 10 codes** (eg. D50.8) for the specific **Provision,** as per the last column in the above table. The ICD 10 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.

For this example, in order to qualify for the out-of-hospital PMB (OHPMB) funding, you or your healthcare professional may apply for medical management of life-threatening iron deficiency; vitamin and other nutritional deficiencies. The criteria stated in the **Provision description** need to be met to qualify for OHPMB funding related to the treatment, as outlined.

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

How we pay claims for PMBs and non-PMBs

We pay for confirmed PMBs in full if you receive treatment from a Designated Service Provider (DSP). PMB treatment received willingly from a provider who is not a DSP, may be subject to a co-payment. If the healthcare provider charges more than the amount we pay, you will also have to pay that difference.

We have preferred suppliers for suppliers of intermittent catheters, rental oxygen and other devices such as CPAP machines. Where a preferred supplier is not used, you may have a co-payment.

We pay for benefits that are not included in the PMBs from your appropriate and available benefits, according to the Fund Rules. Visit www.engenmed.co.za or call us on 0800 001 615 to find a participating DSP healthcare provider.

There may be times when you do not have cover under Prescribed Minimum Benefits

This can happen when you join a medical scheme for the first time, with no previous medical scheme membership, or if you join another scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Fund will 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 will apply to you or your dependants.

Circumstances under which only PMB benefits apply

This happens when you have a waiting period, or when you have treatments linked to conditions that are excluded by your benefits. 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.

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

How to register your chronic or PMB conditions to get cover from the Fund's risk benefits?

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

To apply for out-of-hospital PMBs 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 www.engenmed.co.za under Medical Aid > Find a document.
- You can also call 0860 001 615 to request any of the above forms.

For more information on the PMB Chronic Disease List conditions, HIV or Oncology and how to register, please refer to the relevant benefit guides available on www.engenmed.co.za under Medical Aid > Find a document.

To confirm your in-hospital cover for PMB conditions, you can call us on 0860 001 615 and request an authorisation. We will then tell you about your benefits.

Why it is important to register your PMB or chronic condition

We pay for specific healthcare services related to each of your approved conditions. These services include approved treatment, medicine, consultations, blood tests and other defined investigative tests. If your condition is a PMB condition, we pay for these services from the PMB, which will not affect your day-to-day benefits.

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. If you do not have benefits to cover these expenses, you will have to pay the claims from your own pocket.

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

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

Each person with a PMB or chronic condition must register their specific conditions separately.

You only have to register once for a chronic condition. If your medicine or other treatment changes, your doctor can let us know about these changes.

You will have to register each new condition before we will cover the treatment and consultations from your Prescribed Minimum Benefits and not from your day-to-day benefits.

Additional documents needed to support your application

You must send the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying for to the Fund. This will help us to identify that your condition qualifies for PMB benefits.

Where you must send the completed application form(s) to

You must send the completed **PMB application form** using either of the following methods:

1 | Fax to: 011 539 2780

2 | Email to: PMB_APP_FORMS@engenmed.co.za

You must send the completed **Chronic Illness Benefit application form** using either of the following methods:

3 | Fax to: 011 539 7000
4 | Email to: CIB_APP_FORMS@engenmed.co.za

We will let you know if we approve your application for PMB or 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 as Prescribed Minimum benefits, and not from your day-to-day benefits.

The treatment needed must match the published, defined 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 professional 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 Prescribed Minimum Benefit, it can be paid from your available day-to-day benefits. If you do not have benefits to cover these expenses, you will have to pay the costs of these claims from your own pocket

To appeal against the funding decision on PMB cover or cover for chronic medicine/treatment:

1 | Download the OHPMB *Appeal Form* or *Chronic Illness Benefit Appeal form*. Up to date forms are always available on www.engenmed.co.za under Medical Aid > Find a document. You can also call 0800 001 615 to request any of the above forms.
2 | Complete the form with the assistance of your doctor/healthcare professional.
3 | Send the completed, signed form, along with any additional medical information, by email to PMB_APP_FORMS@engenmed.co.za or by fax 011 539 2780 or by email to CIB_APP_FORMS@engenmed.co.za or by fax 011 539 7000

If we approve the requested medicine/treatment on appeal, we will automatically pay these from either the PMB or Chronic Illness Benefit, whichever is applicable. If the appeal is unsuccessful and you are not satisfied with the outcome, you may also lodge a formal dispute by following the Fund's disputes process on www.engenmed.co.za.

For more information on your cover for the CDL chronic conditions and PMB medicine, please visit our website www.engenmed.co.za and click on Find documents.

What happens if there is a change in your approved medicine

For approved chronic conditions, your treating doctor or dispensing pharmacist can make changes to your medicine telephonically by calling 0800 001 615, or by faxing an updated prescription to 011 539 7000, or by emailing it to CIB_APP_FORMS@engenmed.co.za

For other PMB conditions, the treating doctor or dispensing pharmacist can only make changes to medicine by sending the updated prescription by fax to 011 539 2780, or emailing it to PMB_APP_FORMS@engenmed.co.za

If you get your medicine or treatment from a provider of your choice instead of the Fund's Designated Service Providers

The Fund has entered into payment arrangements with doctors, specialists and other healthcare providers, including pharmacies. To receive full cover, you must make use of the services of these Designated Service Providers (DSPs).

This does not apply in the event of an emergency or where the use of the services of a non-DSP provider is involuntary, or when no DSP is available. If you choose to use the services of a healthcare provider who we do not have a payment arrangement with, you may have to pay a co-payment and any amount that provider charges above the Fund Rate.

In an emergency, you can go directly to hospital and notify the Fund as soon as possible of the admission. In the case of an emergency, members you have full cover for the first 24hrs in-hospital, or until your condition is stable enough for you to be transferred.

Go to www.engenmed.co.za and click on Find a healthcare provider, or call us on 0860 001 615 to find the nearest Designated Services Provider to treat your condition.

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 a 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 001 615 and we will make arrangements for an appropriate facility or healthcare provider to accommodate you.

Cover for Cancer

Once you are registered on the Oncology Programme, the Fund covers your approved cancer treatment over a 12-month cycle up to the Fund Rate, in accordance with your benefits.

Cancer treatment that is a Prescribed Minimum Benefit (PMB), is always covered in full. All PMB treatment costs add up to the Oncology threshold. If your treatment costs more than that threshold we will continue to cover your PMB cancer treatment in full.

For more information on your cover for cancer please visit our website www.engenmed.co.za and click on Find document.

Other Prescribed Minimum Benefit (PMB) conditions

For other PMB conditions, you can apply for out-of-hospital PMB, as outlined above.

For more information please visit our website www.engenmed.co.za and click on Find Document.

Cover for HIV

When you register on the HIV Care Programme, you are covered for the care you need, which includes additional cover for social workers. You can be assured of confidentiality at all times.

For more information on your cover for HIV please visit our website www.engenmed.co.za and select Find a document.

Cover for PMB hospital admissions

You must pre-authorise all hospital admissions. When you call us to pre-authorise we will tell you how you are covered.

For full PMB cover, you must use Designated Service Provider (DSP) Hospitals in our network. If you choose not to go to a DSP Hospital, we will pay your claims up to 80% of the Fund Rate. You will be responsible for the co-payment and any amounts the provider may be charging above the Fund Rate.

This does not apply in emergencies.

Where appropriate and according to the Rules of the Fund, you may be transferred to a hospital or other service providers in our network once your condition has stabilized.

For more information on your in-hospital PMB cover please visit our website www.engenmed.co.za and click on Find a document.

Contact us

You can contact the Fund on 0800 001 615 or visit our website at www.engenmed.co.za for more information.

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Complaints process

You may lodge a complaint or query with the Fund directly on 0800 001 615 or by emailing service@engenmed.co.za.

If you are not satisfied with how your query was resolved, please send a complaint in writing to the Principal Officer at the Fund's registered address.

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