ENGEN | Medical Benefit Fund

Administered by Discovery Health

Guide to Prescribed Minimum Benefits

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 (PMB)

PMB 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 must cover the costs related to the diagnosis, treatment, and care of:

1 | Any life-threatening emergency medical condition
2 | A defined set of 271 diagnoses
3 | 27 chronic illness conditions (Chronic Disease List conditions), including HIV.

Please refer to the Council for Medical Schemes website, www.medicalschemes.co.za, for a full list of the 271 diagnostic treatment pairs.

How do you qualify for benefits under PMB

There are certain requirements before you can access PMB. 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 (DSP) for full cover.

If you do not use the services of a DSP, we will pay PMB claims up to the Fund Rate. You will be responsible to pay the shortfall, which is the 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 the Fund's rules, you may be transferred to a hospital or other service provider in our Network once your condition has stabilised.

If your treatment doesn't meet the above PMB 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 benefits and Rules that apply for claims incurred in South Africa. 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 a document.*

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

You must send the results of your medical tests and investigations, that confirm the diagnosis of the condition, to the Fund. This will allow us to identify whether the condition qualifies for cover as a PMB condition. Your treating doctor needs to provide the relevant information to assist us in confirming the benefits.

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 271 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.co.za, for a full list of the 271 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 271 Provisions (listed 271 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, to qualify for the out-of-hospital PMB 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 out-of-hospital PMB funding related to the treatment, as outlined.

Treatment that is not listed in the PMB "treatment" provision for a condition, does not form part of the prescribed PMB level of care, and will be covered as per the Rules of the Fund. Speak to your healthcare professional to ensure that all criteria for treatment are met, before applying for PMB cover.

How we pay claims for PMB and non-PMB treatment and care

We pay for confirmed PMB treatment or care 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 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 PMB 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 for the first time, with no previous medical scheme membership, or if you join the Fund 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 PMB cover, regardless of the conditions you may have.

We communicate with you at the time of applying for your membership, to confirm if any waiting periods will apply to you or your dependants.

Circumstances under which only PMB 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.

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You and your dependents must register to get cover for PMB 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 PMB. These include:
- PMB cover for in-hospital admissions,
- chronic illness 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 PMB or Chronic Disease List (CDL) cover, 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 0800 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 a PMB condition, you can call us on 0800 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 these services from the Risk Benefits, which will not affect your day-to-day benefits.

We will pay for non-PMB treatment or medicine 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 illness cover

The patient 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. You must register every PMB or chronic condition 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 as PMB 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, which you are applying to register for, to the Fund. This will help us to identify whether your condition qualifies for PMB benefits.

You must send the completed **PMB application form** to:
1 | Fax to 011 539 2780, or
2 | Email to PMB_APP_FORMS@engenmed.co.za

You must send the completed **Chronic Illness Benefit application form** to:
3 | Fax to 011 539 7000, or
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 tell you 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, via email. If your application meets the requirements for cover from PMB, 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 PMB, 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 PMB, 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 those claims from your own pocket.

You can follow the below easy steps to apply for additional cover for out-of-hospital Prescribed Minimum Benefit (PMB) conditions or for Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB):

1 | Download the "Request for additional cover for out-of-hospital Prescribed Minimum Benefit conditions" form or "Request for additional cover for Prescribed Minimum Benefit Chronic Disease List condition" 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 the relevant address:

For PMB applications: PMB_APP_FORMS@engenmed.co.za or by fax 011 539 2780;

For Chronic Illness applications: CIB_APP_FORMS@engenmed.co.za or by fax 011 539 7000

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 a document*.

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 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 (DSP).

This does not apply in the event of an emergency, when the use of the services of a non-DSP provider is involuntary, or when no DSP is available. If you willingly 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, you have full cover for the first 24 hours 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 0800 001 615 to find the nearest DSP to treat your condition.

Get the most out of your benefits

Elective admissions for Prescribed Minimum Benefit (PMB) conditions and procedures are covered in full if you choose to use a designated service provider (DSP) hospital and designated service provider (DSP) treating doctors. Where your primary treating doctor is a designated service provider (DSP), reimbursement will be made in full without any co-payment for any required anaesthetic services you may need during your admission.

The below conditions need to be met for full cover for these providers:

- You are being admitted for a procedure for a Prescribed Minimum Benefit (PMB) condition.
- Your chosen hospital or day facility is on the Prescribed Minimum Benefit (PMB) network.
- Your primary treating doctor is on the Prescribed Minimum Benefit (PMB) network.

If all the above conditions are met your hospital, doctor and anaesthetist accounts will be covered in full.

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 0800 001 615 and we will arrange 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 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 a 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 COVID-19

The WHO Global Outbreak Benefit provides cover for global disease outbreaks recognised by the World Health Organization (WHO), such as COVID-19. This benefit offers cover for the vaccine, out-of-hospital management, and appropriate supportive treatment in the event of you contracting COVID-19. 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 go to a DSP Hospital in our Network. If your care is planned, and 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 stabilised.

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.

Queries and complaints process

You may lodge a query or complaint 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, if you are still not satisfied with how your query or compliant was resolved, follow the Fund's internal disputes process. You may read more about this process on www.engenmed.co.za.

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