ENGEN | Medical Benefit Fund

Administered by Discovery Health

Guide to Prescribed Minimum Benefits for In-Hospital Treatment 2022

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 and is responsible for the administration of your membership on behalf of the Fund.

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 must provide to all their members. All Engen Medical Benefit Fund members have access to these benefits.

Engen Medical Benefit Fund's benefits provide comprehensive cover, more than just the prescribed minimum benefits required by law. You can read about your benefits in the Benefit Guide.

This document tells you how the Fund covers Prescribed Minimum Benefits (PMB), specifically for In-hospital treatment. Please refer to the Prescribed Minimum Benefit guide on www.engenmed.co.za for more details.

To help you understand, we explain some of the terminology we are using in this document:

TERMINOLOGY	DESCRIPTION
Co-payment	This is an amount that you will have to pay from your own pocket towards a health care service. The amount can vary by the type of covered healthcare service, place of service, your age or the difference between what the Fund pays and what the service provider charges. If the co-payment amount is higher than the amount charged for the healthcare service, you will have to pay for the cost of the healthcare service.
Day-to-day benefits	These are the available funds allocated to the Medical Savings Account (MSA) and your Primary Care benefits.
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.engenmed.co.za to view the full list of DSPs.
Fund Rate	This is a rate set by us. We pay in full for healthcare services when the provider charges at the Fund Rate.
ICD-10 code	A clinical code that describes diseases and signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO).
Member	When we refer to "member" in this document, it can also be in reference to your dependants that are registered on your membership.

TERMINOLOGY	DESCRIPTION
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 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.

What is a Prescribed Minimum Benefit (PMB)?

Prescribed Minimum Benefits (PMBs) are guided by a list of medical conditions as defined in the Medical Schemes Act 131 of 1998.

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:

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

Please refer to the Council for Medical Schemes website www.medicalschemes.co.za for a full list of the 270 diagnostic treatment pairs.

Requirements you must meet to benefit from Prescribed Minimum Benefits (PMBs)

There are certain requirements you must meet before you can benefit from Prescribed Minimum Benefits (PMBs). The requirements are:

1 | The condition must qualify for cover and be on the list of defined Prescribed Minimum Benefit (PMB) conditions.
2 | The treatment needed must match the treatments in the defined benefits on the Prescribed Minimum Benefit (PMB) list.
3 | You must use the Fund's designated service providers (DSPs) for full cover unless no provider has been designated for the specific service.

If you do not use a DSP we will pay up to 100% of the Fund Rate. You will be responsible for 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 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 claims according to your available benefits.

Important to 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 will be paid according to your available benefits, subject to Fund Rate and the applicable limits that would normally apply for claims in respect of healthcare services obtained within the borders of South Africa.

There are a few instances where you will only have PMB cover

If you have recently joined the Fund and a three-month general waiting period or a 12-month condition-specific waiting period was placed, or when you have treatments linked to conditions that are excluded by the Fund, the Fund will not pay your claims. But you might have cover in full, if you meet the requirements stipulated by the PMB regulations

There are also 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 more than 90 days after leaving your previous medical scheme. In both these cases, the Fund would impose a waiting period, during which you and your dependants will not have access to the PMB treatment or care regardless of the conditions you may have. We will tell you if any waiting periods will apply when we are finalising your membership application.

How we cover In-Hospital PMB claims

For confirmed PMB, the Fund will cover the hospital account at 100% of the negotiated rate from the Fund Risk benefits and related accounts in full at the agreed rate if you receive treatment at a DSP hospital from a DSP. If you don't make use of the services of the Fund's DSPs you may be subject to co-payments if the healthcare provider charges more than what the Fund pays.

There are some instances when you will still have full cover if you use a healthcare provider who we do not have a designated service provider (DSP) arrangement with:

- The in hospital event was an emergency.
- The use of a non-DSP was involuntary.
- There is no DSP available at the time of the event.

We may require additional supporting documents to confirm cover and fund claims as a PMB. Documents may be requested confirming your PMB diagnosis, for example Magnetic Resonance Imaging (MRI) scans and endoscopic procedure reports.

In cases where there are no services or beds available at a DSP when you or one of your dependants needs treatment, you must contact us on 0800 001 615. We will intervene and make arrangements for an appropriate facility or healthcare provider to accommodate you.

We pay for benefits not included in the PMBs from your appropriate and available Risk and/or day-to-day benefits, according to the rules of the Fund.

Using the services of DSPs

To ensure you will not experience shortfalls, you should use the services of DSPs. These are providers with whom the Fund has payment agreements. If you use their services, you will not have to make any co-payments.
In an emergency, you can go directly to hospital and notify the Fund of your admission as soon as possible. In the case of an emergency, you are covered in full for the first 24 hours or until you are stable enough to be transferred.

Some examples of DSP for in hospital care are:

- KeyCare Specialists and Specialists who charge at the Premier A or B rates
- KeyCare GPs and GPs in the Discovery GP network
- KeyCare hospitals

You can find healthcare service providers who we have an agreement with on www.engenmed.co.za or you can call us on **0800 001 615** to find out about these providers.

How we will pay your claims when you are in hospital

Prescribed Minimum Benefit status	Service provider type	Hospital	Healthcare professional
Emergency	Designated service provider	• Hospital account is paid at the negotiated 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
Planned treatment	Designated service provider	• Hospital account is paid at the negotiated rate	• If your primary admitting Dr is a DSP Specialist or GP, related accounts are paid in full at the agreed rate for the providers who are DSPs and at cost for those providers with whom we do not have agreements
	Not a designated service provider	• Hospital account is paid up to a maximum of 100% of the Fund 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 Fund Rate.	• Related accounts are paid up to a maximum of 100% of the Fund 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 Fund Rate
Once you have authorised your stay in hospital, the Fund provides comprehensive cover without an overall annual limit.			

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Get pre-authorisation for hospitalisation and other procedures

What pre-authorisation is and what it means

Pre-authorisation 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 before you go to the hospital or day-clinic.

You also need specific pre-authorisation 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 Fund 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 pre-authorisation

Call us on **0800 001 615** to get pre-authorisation. 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 pre-authorisation

- Your membership number
- Details of the patient (name and surname, ID number, etc.)
- 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 pre-authorise your admission, you will have to pay the first R1000 of the costs of the service obtained. We call this a deductible.*

*You will only be covered in full if you use the services of a Designated Service Provider. You can find your nearest DSP on www.engenmed.co.za or call us on **0800 001 615** for the information about our contracted providers.*

Pre-authorisation does not guarantee full payment of all claims

Your hospital cover

Your hospital cover includes cover for the account from the hospital (the ward and theatre fees), 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.

There are some expenses you may have in hospital as part of a planned admission that the Fund does not cover.

Certain procedures, medicine and new technologies need separate approval.

It is important that you discuss this with your healthcare professional. Please take note that benefit limits, Fund 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 0800 001 615 or visit www.engenmed.co.za for more information on how you will be covered.

Contact us

You can call us on **0800 001 615** or visit www.engenmed.co.za for more information.

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.

If your complaint or query is not resolved to your satisfaction, you may ask the Board of Trustees to review the responses received. And if that is not successful, you may declare a dispute that will be heard by an independent Disputes Committee of the Fund.

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.