sasolmed

Guide to Prescribed Minimum Benefits for In Hospital Treatment 2024

Who we are

Sasolmed, registration number 1234, 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 1997/013480/07). We take care of the administration of your membership for the Scheme.

Overview

In terms of the Medical Schemes Act No. 131 of 1998, Prescribed Minimum Benefits (PMBs) are a set of defined benefits that all registered medical schemes in South Africa are obliged to provide for all their members. All members have access to these benefits, irrespective of their chosen benefit option. PMBs ensure that all medical scheme members have access to continuous care to improve their health.

Sasolmed benefit options are structured in such a way that the member's chosen Option provides comprehensive cover. The Comprehensive Network Option costs more but offers more comprehensive networks, while the other has lower contributions with more restrictive networks. Irrespective of this, both our network options cover more than just the minimum benefits required by law. Always consult your Benefit Guide to see how you are covered.

This document explains how the Scheme covers PMBs for in hospital treatment. Please refer to the PMB guide on sasolmed.co.za for more details about PMBs and how they are covered.

About some of the terms we use in this document

TERMINOLOGY	DESCRIPTION
Pre-authorisation	The process whereby a member applies for approval for a procedure or treatment from Sasolmed; this may include the submission of quotations.
Benefit year	The period for which benefits and contributions apply – in this case 1 January to 31 December, if you join Sasolmed during a benefit year, you are only entitled to a pro-rata portion of the benefits and limits for that year, i.e., in proportion to the number of months of membership.
Direct co-payment	This is an amount that you need to pay towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service or if the amount the healthcare provider charges is higher than the tariff we cover. If the direct co-payment amount is higher than the amount charged for the healthcare service, the cost of the healthcare service will be for your own cost.
Out of Hospital Risk Benefits	These are the available funds allocated to you for out-of-hospital healthcare services. Depending on the network option you choose, you will have cover for a defined set of out-of-hospital benefits.

Designated Service Provider (DSP)	A healthcare provider (for example GP, specialist, allied healthcare provider, pharmacist, or hospital) who we have an agreement with to provide treatment or services at a contracted tariff.
Scheme Tariff	This is a tariff we pay for healthcare services from hospitals, pharmacies, healthcare providers and other providers of relevant healthcare services.
Medicine Price	This is the tariff at which Sasolmed will pay for medicine. It is the Single Exit Price of medicine plus the relevant dispensing fee.
ICD-10 code	A clinical code that describes diseases, signs, and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO).
Beneficiary	A member and/or dependant registered with Sasolmed.
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 healthcare provider, anaesthetist and any approved healthcare expenses like radiology or pathology.

What is a Prescribed Minimum Benefit (PMB)?

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

- Any life-threatening emergency medical condition
- A defined set of 271 diagnostic treatment pairs
- 27 chronic conditions

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

Requirements you must meet to benefit from PMBs:

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

- The condition must qualify for cover and be on the list of defined PMB conditions; and
- The treatment needed must match the treatments in the defined benefits on the PMB list.

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 treated in accordance with your chosen etwork option, subject to the relevant Scheme Tariff and any other limitations applicable to your benefits within the borders of South Africa.

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

This happens when you have a waiting period or when you have treatments linked to conditions that are excluded by your Network option. This can be a three-month general waiting period or a 12-month condition-specific waiting period. Depending on the category of waiting periods, you may still qualify for cover from the PMBs.

There are 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. Also, if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme could impose waiting periods, during which you and your dependants will not have access to the PMBs, regardless of the conditions you may have. For newborns, the waiting periods will apply where not registered on the membership within 30 days of birth. We will communicate with you at the time of applying for membership, if waiting periods apply.

How we pay for In Hospital PMBs

We pay for confirmed PMBs in full if you receive treatment from a Designated Service Provider (DSP) i.e. for pathology Sasolmed has DSPs namely Ampath, Lancet, Pathcare and Vermaak and Partners. Where we have an agreement in place, we will pay 100% of the contracted rate which is what the healthcare provider will charge. Where we do not have agreements in place, we will pay at cost.

There are some instances when you will still have full cover if you use a healthcare provider who we do not have a payment arrangement with:

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

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

We pay for benefits not included in the PMBs from your appropriate and available hospital benefit and/or your out of hospital benefits, according to the Rules of your chosen network option.

Find healthcare providers

You can access the MaPS tool on our website to find a healthcare provider near you.

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 healthcare provider plans a hospital or day-clinic admission for you, you must let us know at least 48 hours before you go to the hospital or day-clinic.

You also need specific pre-authorisation for Magnetic Resonance Imaging (MRI) and Computed Tomography (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 Scheme within 48 hours of your admission.

Contact us for pre-authorisation

Call us on **0860 002 134** 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 your 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, and other relevant information),
- Date and time of the admission,
- Practice number for the hospital or day clinic, and admitting healthcare provider,
- Reason for the procedure or hospitalisation, and
- Diagnostic codes (ICD-10 codes), tariff codes and procedure codes (you must get these from your treating healthcare provider).

Pre-authorisation does not guarantee payment of all claims.

Your hospital cover

Your hospital cover includes:

- Cover for the account from the hospital which includes the ward and theatre fees; and
- Cover for the accounts from your treating healthcare provider such as the admitting specialist, anaesthetist and any approved healthcare expenses like radiology or pathology, which are separate from the hospital account.

There are some expenses you may have in hospital as part of a planned admission that your hospital benefit does not cover, for example certain procedures, medicine, and new technologies, which may need separate approval. It is important that you discuss this with your healthcare provider. Please take note that benefit limits, Scheme rules, treatment guidelines and managed healthcare criteria may apply to some healthcare services and procedures in hospital.

Find out more about these by contacting us on **0860 002 134** or visit sasolmed.co.za for more information on how you will be covered.

Complaints process

You may lodge a complaint or query with Sasolmed directly on **0860 002 134** or send an email to enquiries@sasolmed.co.za. If the query or complaint remains unresolved, you may address a complaint in writing to the Principal Officer. Please be sure to include the reference number obtained through the process with the Administrator.

Should your complaint still not be resolved to your satisfaction, you may lodge a formal dispute by following the Scheme's internal disputes process, as explained on the website at sasolmed.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

Contact us

You can find other important information on our website at sasolmed.co.za or contact us on **0860 002 134**.