ANNEXURE G

PRESCRIBED MINIMUM BENEFITS (PMB'S)

1. Definitions

"Prescribed Minimum Benefits"

the benefits contemplated in section 29(1)(o) of the Act, and consisting of the provision, diagnosis, treatment and care costs of –

a. the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations, subject to any limitations specified in Annexure A; and

b. any Emergency Medical Condition.

"Prescribed Minimum Benefit Condition"

a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations or any Emergency Medical Condition.

2. Designated Service Providers

The Fund selects Netcare 911 as it's Designated Service Provider for Ambulance Services, subject to review from time to time.

The Fund selects the Momentum Health Solutions Pharmacy Network as it's Designated Service Provider for chronic medicine benefits.

The Fund selects all contracted private hospitals and the Momentum Health Solutions (formerly known as CareCross) Network as its Designated Service Provider for all other services.

If a relevant PMB service is not available via the chosen Designated Service Provider, an alternative provider may be used with prior approval from the Managed Health Care Organisation or the Fund.

The Fund may, from time to time, contract with a speciality service provider with the aim to assist in managing the health conditions of members.

3. Care Plans

Members are entitled to PMB benefits for diseases on the Chronic Diseases List (CDL) and all other PMB conditions from a Designated Service Provider at the Agreed Tariff subject to an authorised Momentum Health Solutions Risk Management Care Plan. By providing these Care Plans to the treating practitioners, beneficiaries can ensure that their treatment stays within the clinical protocols prescribed by the Plans and prevent treatment being undertaken that will not be covered under the Insured Benefits.

4. Prescribed Minimum Benefits obtained from Designated Service Providers

The Fund shall pay 100% of the cost of diagnosis, treatment and care of the PMB conditions provided that such services are obtained from the Designated Service Provider, subject to the Fund's clinical protocols.

5. Prescribed Minimum Benefits voluntarily obtained from other providers

a. If a Beneficiary voluntarily obtains diagnosis, treatment and care in respect of a PMB condition from a provider other than the Designated Service Provider, the benefit payable in respect of such service will be subject to the Fund's clinical protocols and a co-payment equal to the difference between the actual cost incurred and the cost that would have been incurred had the Designated Service Provider been used will be levied on the member.

b. Except in the case of an Emergency Medical Condition, pre-authorisation shall be obtained by a Beneficiary prior to voluntarily obtaining a service from a provider other than the Designated Service Provider in terms of this paragraph.

6. Prescribed Minimum Benefits involuntarily obtained from other Providers

a. If a Beneficiary involuntarily obtains diagnosis, treatment and/or care in respect of a PMB condition from a provider other than the Designated Service Provider, the Fund will pay 100% of the cost in relation to such PMB conditions subject to the Fund's clinical protocols.

b. For the purpose of this paragraph, a Beneficiary will be deemed to have involuntarily obtained a service from a provider other than the Designated Service Provider, if –

I. The service was not available from the Designated Service Provider, or could not be provided by the Designated Service Provider without unreasonable delay;

II. Immediate medical or surgical treatment for a PMB condition was required under circumstances, or at locations, which reasonably precluded the Beneficiary from obtaining such treatment from the Designated Service Provider; or

III. There was no Designated Service Provider within reasonable proximity of the Beneficiary's ordinary place of business or personal residence.

c. Except in the case of an Emergency Medical Condition, pre-authorisation shall be obtained by a Beneficiary prior to involuntarily obtaining a service from a provider other than the Designated Service Provider in terms of this paragraph.

7. Medication

a. Where the treatment of a PMB condition includes medication, the Fund will pay 100% of the cost of such medication if such medication is obtained from the Designated Service Provider, or is involuntarily obtained from a provider other than the Designated Service Provider, *and*

I. the medication is included on the applicable formulary in use by the Fund;

or

II. the formulary does not include a drug that is clinically appropriate and effective for the treatment of that PMB condition; and

III. pre-authorisation is obtained from the Managed Health Care Organisation.

a. Where the treatment of a PMB condition includes medication and that medication is voluntarily obtained from a provider other than the Designated Service Provider, a co-payment equal to the difference between the cost of the drug and the reference price of the formulary drug will be levied on the Member.

If the Managed Health Care Organisation formulary includes a drug that is clinically appropriate and effective for the treatment of a PMB condition suffered by a Beneficiary and that Beneficiary knowingly declines the formulary drug and opts to use another drug instead, a co-payment equal to the difference between the cost of the drug and the reference price of the formulary drug will be levied on the Member at the point of service.

8. Prescribed Minimum Benefits obtained from a public hospital

Notwithstanding anything to the contrary contained in these rules, the Fund shall pay 100% of the costs of the treatment of PMB conditions obtained in a public hospital, without limitation.

9. Diagnostic tests for an unconfirmed Prescribed Minimum Benefit diagnosis

Where diagnostic tests and examinations are performed but do not result in confirmation of a PMB diagnosis, except in the case of an Emergency Medical Condition, such diagnostic tests or examinations will not considered to be a PMB.

10. Co-payments in respect of Prescribed Minimum Benefits

Where co-payments in respect of the costs for PMB's are applied, the Member must pay such co-payments at the point of delivery of such services.

11. Chronic conditions

All Options cover the full cost for services rendered in respect of PMB chronic conditions including diagnosis, medical management (as specified in the Care Plan) and medication to the extent that such services are provided in terms of a therapeutic algorithm as prescribed for the specified PMB chronic conditions, published by the Minister by notice in the Gazette.

Details of the Chronic Medication Programme can be found in Annexure F.