Guide to In-hospital Prescribed Minimum Benefits Treatment - 2025

Who we are

The Anglovaal Group Medical Scheme (referred to as 'the Scheme'), registration number 1571, is the medical scheme that you are a member of. This 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, 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 plan. PMBs ensure that all medical scheme members have access to continuous care to improve their health.

The Anglovaal Group Medical Scheme is structured in such a way that the member's plan provides comprehensive cover. Our plan covers more than just the minimum benefits required by law. Always consult your Health Plan Guide to see how you are covered.

This document tells you how the Scheme covers PMBs specifically for In-hospital treatment. Please refer to the PMB guide on www.avgms.co.za for more details about PMBs and how they are covered.

About some of the terms we use in this document

There may be some terms we refer to in this document that you may not be familiar with. Here are the meanings of these terms.

Terminology	Description
Member	The reference to member in this document also includes dependants, where applicable.
Scheme Rate	This is a rate set by us. This is a rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health service.
At Cost	Fees charged by a provider that are more than the Scheme Rate.
Co-payment	This is an amount that you need to pay towards a healthcare service if a service provider charges above our scheme rate. The amount can vary by the type of covered healthcare service, place of service and age of the patient.
Day-to-day benefits	These are the available funds allocated to the Medical Savings Account (MSA).

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.avgms.co.za to view the full list of designated service providers (DSPs).
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.

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 271 diagnostic treatment pairs.
3 | 27 chronic 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. All medical schemes in South Africa have to include the PMBs in the plans they offer to their members.

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

There are certain requirements before you can benefit from PMBs. 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 Scheme's DSPs for full cover unless there is no DSP applicable to your chosen health plan.

If you do not use a DSP we will pay up to 100% of the Scheme 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 these cases, where appropriate and according to Scheme 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 health plan 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 shall be treated as in accordance with your chosen health plan benefits, subject to the relevant Scheme Rate and any other limitations applicable to your benefits within the borders of South Africa.

There are a few instances where you will only have Prescribed Minimum Benefit (PMB) cover

This happens when you have a waiting period or when you have treatments linked to conditions that are excluded by your plan. This can be a 3-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.

There are some circumstances where you do not have cover for Prescribed Minimum Benefits (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 a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme would impose a waiting period, during which you and your dependants will not have access to the PMBs, no matter what conditions you might have. We will communicate with you at the time of applying for membership if waiting periods apply.

How we cover In-Hospital Prescribed Minimum Benefits (PMBs)

In-Hospital we pay for confirmed PMBs in full from the risk benefits if you receive treatment from a DSP. Treatment received from a non-DSP may be subject to a co-payment, if the healthcare provider charges more than what we pay.

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:

- 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 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 0860 99 88 77. 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 Hospital Benefit and/or day-to-day benefits, according to the rules of your chosen health plan.

Using the designated healthcare service providers

All medical schemes must ensure that their members do not experience shortfalls when their DSPs are used. Members of the Scheme should use doctors, specialists or other healthcare providers who we have a payment agreement with so that they do not experience co-payments.

You can find a healthcare provider on www.avgms.co.za or call us on 0860 100 693 to find healthcare service providers who we have an agreement with us for your plan.

There are some cases where it is not necessary to meet these requirements, but you will still have full cover. An example of this is in a life-threatening emergency.

Get preauthorisation for hospitalisation and other procedures

What preauthorisation is and what it means

Preauthorisation 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 at least 48 hours before you go to the hospital or day-clinic.

You also need specific preauthorisation for Magnetic Resonance Imaging (MRI) and Computed Tomography (CT), 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 as soon as possible of your admission. In cases of emergency, you are covered in full for the first 24 hours or until you are stable enough to be transferred.

PMB status	Service provider type	Hospital	Healthcare professional
Emergency	Designated service provider	▪ Hospital account is paid at the contracted 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
Elective	Designated service provider	▪ Hospital account is paid at the contracted rate	▪ Related accounts are paid in full at the agreed rate

	Not a designated service provider	▪ Hospital account is paid up to a maximum of 100% of the Scheme 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 Scheme Rate.	▪ Related accounts are paid up to a maximum of 100% of the Scheme 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 Scheme Rate

Contact us for preauthorisation

Call us on 0860 100 693 to get preauthorisation. 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 preauthorisation

- Your membership number
- Details of the patient (name and surname, ID number, and more)
- Date and time of the admission
- Practice number for the hospital or day clinic, and admitting doctor
- 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 preauthorise your admission, we will only pay 70% of the costs we would normally cover, on the hospital and related accounts."*

Preauthorisation does not guarantee payment of all claims

Your hospital cover is made up of:

- Cover for the account from the hospital (the ward and theatre fees) at the Scheme Rate.
- 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.

Contact us

You can call us on 0860 100 693 or visit www.avgms.co.za for more information.

ANGLOVAAL GROUP MEDICAL SCHEME

Administered by Discovery Health

Complaints process

You may lodge a complaint or query with Anglovaal Group Medical Scheme directly on 0860 100 693 or address a complaint in writing directly to the Principal Officer. Should your complaint remain unresolved, you may lodge a formal dispute by following Anglovaal Group Medical Scheme's internal disputes process.

Members, who wish to approach the Council for Medical Schemes for assistance, may do so in writing to: Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 or email complaints@medicalschemes.co.za. Customer Care Centre: 0861 123 267/website www.medicalschemes.co.za