

GUIDE TO PRESCRIBED MINIMUM BENEFITS FOR IN-HOSPITAL TREATMENT

MEDIPOS MEDICAL SCHEME 2026

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.

MEDiPOS Medical Scheme ensures comprehensive cover, based on the member's chosen benefit option. Some options cost more and offer more comprehensive cover, while others have lower contributions with fewer benefits. Irrespective of this, all our options cover more than just the minimum benefits required by law. Always consult your Benefit Guide to see how you are covered.

This document tells you how the Scheme covers the PMBs for in hospital treatment. Please refer to the PMB guide on www.medipos.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 the document that you may not be familiar with. Here are the meanings of these terms.

TERMINOLOGY	DESCRIPTION
Comprehensive cover	<p>This cover includes benefits that go beyond the essential health care services and Prescribed Minimum Benefits, as prescribed by the Medical Schemes Act. Comprehensive cover offers extra cover and supplementary benefits to compliment basic cover. You have the flexibility to choose your benefit option and service providers. Whether it's full cover or outside of full cover, we give you the freedom to decide what suits your needs. Our cover is in line with- or goes beyond defined clinical best practices. This makes sure that you get treatment that is expected and clinically appropriate.</p> <p>We may review these principles from time to time, to stay current with changes in the health care landscape. While comprehensive cover remains subject to the Scheme's treatment guidelines, protocols, and designated service providers. We still prioritise managed care to ensure the best outcomes for your health.</p>
Shortfall	<p>This is an amount that you need to pay towards a healthcare service. The amount payable can vary based on the type of covered health care service, place of service or, if the amount the service provider charges is higher than the rate we cover. If the shortfall amount is higher than the amount charged for the health care service, you will have to pay for the cost of the health care service.</p>
Day-to-day benefits	<p>These are the available funds allocated to the Personal Medical Savings Account (PMSA). Depending on the</p>

TERMINOLOGY	DESCRIPTION
	Option you choose, you may have cover for a defined set of day to day benefits. The level of day to day benefits depend on the Option you choose.
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).
Member	The reference to member in this document also includes dependants, where applicable.
Emergency medical condition	<p>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. 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 could place the person's life in serious jeopardy.</p> <p>An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency.</p>
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 health care 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 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).

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 PMBs in the options they offer to their members.

Requirements you must meet to benefit from 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.

Important to note

- PMB regulations and their accompanying provisions do not apply to health care 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 benefit option. This is depending on the relevant Medical 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 PMB cover

This happens when you have a waiting period or when you have treatments linked to conditions that we do not cover on your benefit 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 PMBs, regardless of the conditions you may have. We will communicate with you at the time of applying for membership, if waiting periods apply.

How we pay for In-Hospital PMBs

Option A and Option B

We pay for confirmed PMBs at 100% of cost in relation to the PMB conditions, depending on the PMB regulations.

Option B Classic and Option C

We pay for confirmed PMBs at cost in relation to the PMB conditions, depending on the PMB regulations for admissions at a hospital on the MEDiPOS Hospital Network.

We pay for confirmed PMBs at 80% of the Medical Scheme Rate in relation to the PMB conditions, depending on the PMB regulations for admissions at a hospital not on the MEDiPOS Hospital Network. You will be liable for the balance of the account.

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

We pay for benefits not included in the PMBs from your appropriate and available major medical expenses benefits and/or day-to-day benefits, according to the rules of your chosen benefit option.

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 when going to hospital. Whenever your doctor plans to take you to hospital, you must let us know at least 3 working days before you go to the hospital or day clinic.

You also need specific preauthorisation for Magnetic Resonance Imaging (MRI), 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 as soon as possible within 24 hours of your admission.

Contact us for preauthorisation

Call us on 0860 100 078 to get pre-authorization. We will give you an authorisation number. Please give the authorisation number to the relevant health care 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-authorization:

- 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 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, you will be liable for a R2 640 shortfall on the hospital account.

Preauthorisation 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
- Cover for the accounts from your treating health care providers, such as the admitting doctor, anaesthetist and any approved health care expenses like radiology or pathology. These 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 major medical expenses benefits do not cover, for example certain procedures, medicines 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 care criteria may apply to some healthcare services and procedures in hospital. Find out more about these by contacting us on 0860 100 078 or visit www.medipos.co.za for more information on how you will be covered.

Working to care for and protect you

Our goal is to provide support for you in the times when you need it most.

How to contact us

Tel (members): 0860 100 078, Tel (health providers): 0860 100 078

Go to www.medipos.co.za to Get Help

PO Box 652509, Benmore 2010

What to do if you have a complaint

01 | TO TAKE YOUR QUERY FURTHER:

If you have already contacted MEDiPOS and feel that your query has still not been resolved, please complete our online complaints form on www.medipos.co.za. We would also love to hear from you if we have exceeded your expectations.

02 | TO CONTACT THE PRINCIPAL OFFICER:

If you are still not satisfied with the resolution of your complaint after following the process above, you are able to escalate your complaint to the Principal Officer of the Scheme. You may lodge a query or complaint by completing the online form on www.medipos.co.za or by emailing enquiries@medipos.co.za.

03 | TO LODGE A DISPUTE:

If you have received a final decision from the Scheme and want to challenge it, you may lodge a formal dispute. You can find more information of the Scheme's dispute process on the [website](#).

04 | TO CONTACT THE COUNCIL FOR MEDICAL SCHEMES:

MEDiPOS Medical Scheme is regulated by the Council for Medical Schemes. You may contact the Council at any stage of the complaints process, but we encourage you to first follow the steps above before contacting the Council. Contact details for the Council for Medical Schemes: Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion 0157 | complaints@medicalschemes.co.za | 0861 123 267 | www.medicalschemes.co.za.

Your privacy is important to us

We hold your privacy in the highest regard. Our unwavering commitment to protecting your personal information and ensuring the security and confidentiality of your data is clearly outlined in our Privacy Statement. You can view our latest version on www.medipos.co.za.