

Guide to Prescribed Minimum Benefits – 2026

Who we are

MEDiPOS Medical Scheme (referred to as ‘the Scheme’), registration number 1548, 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 on behalf of the Scheme.

Overview

There are some common benefits that apply to all members regardless of your benefit option.

This document tells you how MEDiPOS covers members for a list of conditions called Prescribed Minimum Benefit (PMB) conditions.

About some of the terms we use in this document

There are a number of terms we refer to, that you may not be familiar with. Please see the meaning of these terms below:

Terminology	Description
Prescribed Minimum Benefits (PMBs)	A set of minimum benefits that, by law, must be provided to all members. This cover includes the diagnosis, treatment and cost of ongoing care for a list of conditions.
Shortfall	MEDiPOS pays service providers at a set rate, called the Medical Scheme Rate. If service providers charge more this rate, you will have to pay the outstanding amount or shortfall, from your pocket.
Waiting period	A waiting period can be general or condition-specific and means that you have to wait for a set time before you can benefit or claim from your chosen option.
Diagnostic Treatment Pairs Prescribed Minimum Benefit (DTPMB)	These link a specific diagnosis to a treatment and broadly indicate how each PMB condition should be treated.
Designated Service Provider (DSP)	A general practitioner with whom we have an agreement to provide treatment or services at a contracted rate.

Understanding the PMBs

What are PMBs?

PMBs are guided by a list of medical conditions as defined in the Medical Schemes Act 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:

- Any life-threatening emergency medical condition
- A defined set of 271 diagnoses and related treatment
- 27 chronic conditions (Chronic Disease List (CDL) 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.

Requirements you must meet to benefit from PMBs

All medical schemes in South Africa have to include the PMBs in the benefit options they offer to their members, however, there are certain requirements before you can benefit from PMBs:

- Your condition must qualify for cover and be on the list of defined PMB conditions.
- Your treatment must match the treatments in the defined benefits on the PMB list.
- You must use the Scheme's DSPs for full cover when consulting a general practitioner (GP).

If you do not use a DSP, we will pay up to 80% of the Medical Scheme Rate for treatment received from a general practitioner (GP). You will be responsible for the difference between what we pay and the cost of your treatment. This does not apply in emergencies. If your treatment doesn't meet the above criteria, we will pay the treatment according to rules of your benefit option.

Claims for services received outside of the borders of South Africa will be covered in accordance with the rules of your chosen benefit option.

Your medical condition must be part of the list of defined conditions for PMBs

You should send the Scheme the results of your medical tests and investigations that confirm the diagnosis of the condition. This will allow us to identify whether your condition qualifies for the treatment. Your treating provider needs to send the relevant documentation to assist us in confirming the diagnosis.

Your treatment must match the treatments included in the defined benefits

There are standard treatments, procedures, investigations and consultations for each PMB condition on the 271 diagnostic treatment (DT) PMB list. These defined benefits are supported by thoroughly researched, evidence based clinical protocols, medicine lists (formularies) and treatment guidelines.

An example of a PMB provision

Below is an example of a PMB condition and the treatment that qualifies for this cover:

Provision	Provision description	Treatment	ICD-10 code
236K	Iron deficiency; vitamin and other nutritional deficiencies – life-threatening	Medical management	D50.8- Other iron deficiency anaemias

- The PMB Provision is 236K. This is one of the listed 271 Provisions (listed conditions) as published in the Medical Schemes Act and Regulations.
- In this example the Provision Description lists "Iron deficiency; vitamin and other nutritional deficiencies - life-threatening". The provision states that the condition should be life-threatening. For this provision, if the diagnosis is not a life-threatening episode, the condition does not qualify for PMB funding.
- The treatment covered as a PMB for this provision includes medical management. For example, medicine, doctor consultations, investigations, etc.

- In addition to the above information, the Council for Medical Schemes (CMS) also provides ICD-10 codes (e.g. D50.8) that fall within the 236K Provision, shown in the last column in the above table. The ICD-10 codes are an industry guide as to which conditions may qualify for PMB cover, subject to their still meeting the Provision Description and treatment criteria.

For this example, to qualify for the out-of-hospital PMB (OHPMB) funding, you or your healthcare provider may apply for medical management of life-threatening iron deficiency, vitamin and other nutritional deficiencies. These criteria stated in the provision description need to be met to qualify for OHPMB funding related to the outlined treatment.

Any application for treatment that is not listed in the “treatment” provision for a condition, cannot be considered as a PMB as it does not form part of the prescribed treatment that forms part of PMB level of care. Speak to your healthcare provider to ensure that all criteria for treatment are met before applying for PMB cover.

How we pay claims for PMBs and non-PMBs

We pay for confirmed PMBs in full if you receive treatment from a DSP when consulting a general practitioner (GP). Treatment received from a non-DSP may be subject to a co-payment if the healthcare provider charges more than the amount we pay. For healthcare providers other than GP’s, we will pay for treatment at the Medical Scheme Rate.

We have preferred suppliers for intermittent catheters, oxygen rental, and other devices such as CPAP machines. Where a non-preferred supplier is used, you may have a co-payment.

We pay for benefits not included in the PMBs from the appropriate benefits available, according to the rules of your chosen option. Visit www.medipos.co.za or call us on 0860 100 078 to find a participating DSP healthcare provider.

There may be times when you do not have cover under PMBs

This can happen when you join a medical scheme for the first time, with no previous medical scheme cover. Or if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme will impose a waiting period, during which you and your dependants will not have access to the PMBs, regardless of the conditions you may have. We will communicate if any waiting periods apply to you or your dependants this at the time of your applying for your membership.

There are a few instances when the Scheme will only pay a claim as a PMB

This happens when you have a waiting period or when you have treatments linked to conditions that are excluded by your option. This can be a three-month general waiting period or a 12-month condition-specific waiting period. You may have full cover, if you meet the requirements stipulated by the PMB regulations.

You and your dependants must register to get cover for PMB and Chronic Disease List (CDL) conditions

How to register your chronic or PMB conditions to get cover from your major medical expenses benefit

There are different types of PMBs. These include cover for in-hospital admissions, conditions covered under the Chronic Disease List, out-of-hospital management of PMB conditions, and treatment of PMB conditions such as HIV and oncology.

To apply for out-of-hospital PMBs or cover for a CDL condition, you must complete the **Prescribed Minimum Benefit**, or a **Chronic Medicine Benefit** application form.

- Up to date forms are always available on www.medipos.co.za
- You can also call 0860 100 078 to request the above forms.

For more information on the PMB chronic conditions, HIV or oncology and how to register, please refer to the relevant benefit guides on www.medipos.co.za

To confirm your in-hospital cover for PMB conditions, call us on 0860 100 078 and request authorisation. We will then tell you about your cover.

Why it is important to register your PMB or chronic conditions

We pay for specific healthcare services related to each of your approved conditions. These services include approved treatment, medicine, consultations, blood tests and other defined investigative tests. We pay for these services from your PMBs, which will not affect your day-to-day benefits.

We will pay for treatment or medicines that fall outside the defined benefits and that are not approved, from your available day-to-day benefits, according to your chosen benefit option. If your option does not cover these expenses, you will have to pay these claims.

Who must complete and sign the registration form when applying for PMB cover or chronic condition cover

The person with the PMB or chronic condition must complete the relevant application form with the help of their treating healthcare provider. The main member must complete and sign the form if the patient is a minor.

Each person with PMB or chronic conditions must register their specific conditions separately. You only have to register once for a chronic condition. If your medicine or other treatment changes, your doctor can let us know about these.

For new conditions, you will have to register each new condition before we will cover the treatment and consultations from your PMBs and not from your day-to-day benefits.

Additional documents needed to support the application

You must send the Scheme the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying. This will help us identify that your condition qualifies for PMB cover.

Where to send the completed registration form

Send the completed **PMB application form** to pmb.app.forms@medipos.co.za

Send the completed **chronic medicine application form** to cib.app.forms@medipos.co.za

We will let you know if we approve your application for PMB cover and what you must do next

We will let you know the outcome of your application and will send you a letter confirming your cover for the condition, via email. If your application meets the requirements for cover from PMBs, we will automatically pay for the associated approved blood tests and other defined investigative tests, treatment, medicine and consultations for the diagnosis and treatment of your condition. These costs will be covered from your PMBs, and not from your day-to-day benefits.

What happens if you need treatment that falls outside of the defined benefits

Your treatment must match the treatments in the published defined benefits on the PMB list as there are standard treatments, procedures, investigations, and consultations for each condition on the PMB list. These defined benefits are supported by thoroughly researched evidence, based on clinical protocols, medicine lists (formularies) and treatment guidelines.

If you need treatment that falls outside of the defined benefits, you and your healthcare provider can send us additional clinical information with a detailed explanation of the treatment that is needed, for review. If the treatment is not approved as a PMB, it can be paid from your available day-to-day benefits, according to your chosen option. If your option does not cover these expenses, you will have to pay the costs of these claims.

1. Download the **Request for additional cover for out-of-hospital PMB conditions** form or **Request for additional cover for Chronic Disease List (CDL) conditions registered on the Chronic Medicine Benefit** form. Up to date forms are always available on www.medipos.co.za. You can also call **0860 100 078** to request any of the above forms.
2. Complete the form with the assistance of your healthcare provider.
3. Send the completed, signed form, along with any additional medical information, to pmb.app.forms@medipos.co.za or cib.app.forms@medipos.co.za

For more information on your cover for chronic or PMB medicine please login to www.medipos.co.za.

What happens if there is a change in your approved medicine

For chronic conditions, your treating provider or dispensing pharmacist can make changes to your medicine by emailing cib.app.forms@medipos.co.za.

For other PMB conditions, the treating doctor or dispensing pharmacist can only make changes to medicine by sending the updated prescription pmb.app.forms@medipos.co.za.

Cover for Cancer

Depending on your chosen benefit option, once you are registered on the Oncology Programme, the

Scheme covers your approved cancer treatment over a 12-month cycle up to the Medical Scheme Rate, in accordance with your benefit option.

PMB cancer treatment is always covered in full, from your oncology benefit if prescribed by your cancer specialist within the ICON Network. If you use a cancer specialist who is not in the ICON Network, the Scheme will pay 75% of the MSR and you need to pay the balance.

All approved PMB cancer treatment costs add up to the oncology limit for your option. If your treatment costs more than the cover amount, we will continue to cover your PMB cancer treatment in full.

For more information on your cover for cancer, please login to www.medipos.co.za.

Cover for HIV

When you register for our HIVCare Programme to manage your condition, you are covered for the care you need, which includes counselling and approval for doctor and specialist consultations, pathology blood tests, x-rays and treatment medicines. You can be assured of confidentiality at all times.

For more information on your cover for HIV please login to www.medipos.co.za.

Cover for PMB admissions

You must pre-authorise all hospital admissions. When you call us for pre-authorisation, we will tell you how you are covered.

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

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.

For more information on your in-hospital PMB cover please login to www.medipos.co.za

Contact us

You can call us on **0860 100 078** or login to www.medipos.co.za for more information.

Complaint process

You may lodge a complaint or query with MEDiPOS Medical Scheme directly at **0860 100 078** or send an email to enquiries@medipos.co.za.

If your query or complaint is not resolved to your satisfaction, address a complaint in writing to the Principal Officer at the Scheme's registered address. Please be sure to include the reference number obtained through your direct contact with the Scheme.

Should your complaint remain unresolved, you may lodge a formal dispute by following the MEDiPOS Medical Scheme internal disputes process, which is explained on the website at www.medipos.co.za.

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 via email at complaints@medicalschemes.co.za. Contact centre: 0861 123 267 / website www.medicalschemes.co.za.