Taken from CMS Member education on PMBs

Prescribed Minimum Benefits (PMBs)

In terms of the Medical Schemes Act, medical schemes have to cover the costs related to the diagnosis, treatment and care of:
• any emergency medical condition;
• a limited set of ±270 medical conditions; and
• 25 chronic conditions.

This is known as Prescribed Minimum Benefits (PMBs) and you are entitled to these benefits regardless of the medical scheme option you have selected. PMBs, where indicated, include medicine.

Taken from CMS Circular 29 June 2009

Medical schemes have a legal obligation to provide cover for prescribed minimum benefit (PMB) conditions in all their options.

Your savings account
Regulation 10(6) of the Medical Schemes Act 131 of 1998 is clear: the funds in a member's medical savings account shall not be used to pay for costs of a prescribed minimum benefit (PMB).

Prescribed minimum benefits
Prescribed minimum benefits (PMBs) are described in Section 29(1)(o) and Regulation 7 of the Medical Schemes Act 131 of 1998.
All medical schemes must pay in full for the PMB conditions of all their members, regardless of the benefit option to which they belong.
In terms of PMBs, schemes must cover all costs to diagnose, treat, and care for:

1. the ±270 Diagnosis and Treatment Pairs (DTPs);
2. 2 the 25 chronic conditions on the Chronic Diseases List (CDL); and
3. any emergency medical condition.

Your benefit option
Subject to the provisions of Regulation 8(1) of the Medical Schemes Act 131 of 1998, any and every benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, for the diagnosis, treatment and care costs of prescribed minimum benefit (PMB) conditions.