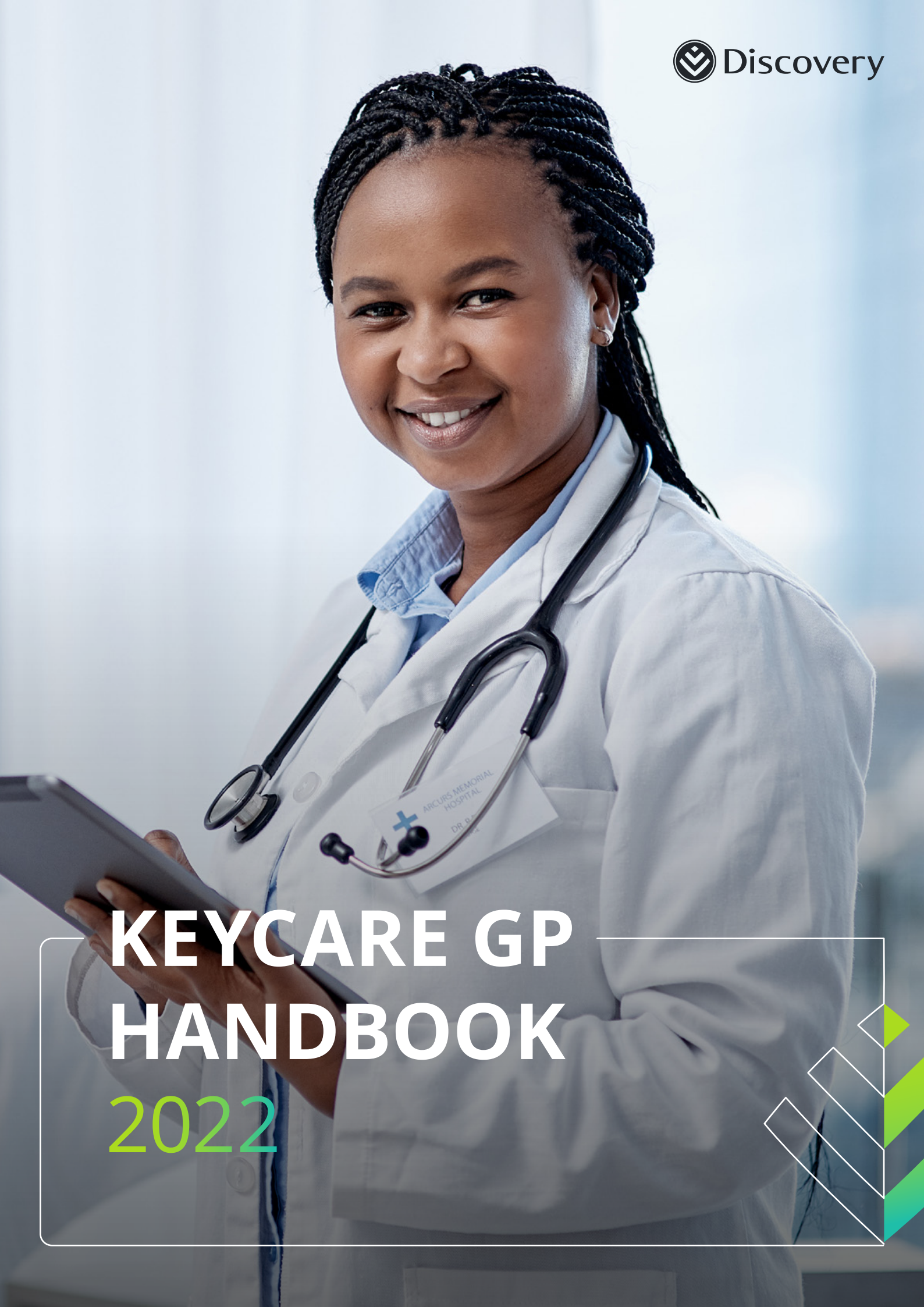


KEYCARE GP HANDBOOK

2022

Thank you for being part of the KeyCare GP Network.

Our aim is to provide more South Africans with quality private healthcare.

What's new in 2022?

This is a brief overview of changes for 2022. Please also see the Rand amount values of benefits listed in the material to show how much the patient's chosen Medical Scheme will cover for each benefit in 2022.

Nomination of primary KeyCare GP

Global data demonstrate that a strong relationship between patients and primary healthcare doctors improves both continuity and coordination of care. This is particularly important for those living with chronic or complex conditions.

In 2022, all DHMS members will be prompted to nominate a primary care doctor participating in the Discovery Health GP Network. Members on the KeyCare plans will be prompted to nominate a GP from their appropriate plan network.

This creates a consistent doctor-patient relationship and empowers general practitioners to deliver outstanding first-line healthcare.

We will communicate with all scheme members during the course of 2022 to encourage nomination of a GP. We will tell them:

- The process to follow to nominate their primary care doctor (GP)
- How to change their nominated GP, if necessary
- That this process will not impact their benefits and cover in 2022.

We will also provide GPs with easy-to-use functionality within HealthID 2.0 to assist their members to appoint them as their nominated GP.

Other changes in 2022

- The casualty visit deductible amount when visiting a KeyCare Network hospital, after acquiring a casualty authorisation will increase from R405 to R425 per casualty visit.
- From 1 January 2022 the Advanced Illness Benefit (AIB) will replace the Compassionate Care Benefit.
- Enhancements to the Allied Therapeutic and Psychology Extender Benefit from 1 January 2022.
- Enhancements to the Trauma Recovery Extender Benefit. This will be available to KeyCare Core from 1 January 2022.
- From January 2022, members on a KeyCare Core plan will have cover for additional defined intensive day-to-day care following specific traumatic events.

KeyCare Plans on schemes administered by Discovery Health

KEYCARE PLANS ON DISCOVERY HEALTH MEDICAL SCHEME

- KeyCare Plus
- KeyCare Start
- KeyCare Core

KEYCARE PLANS ON RESTRICTED SCHEMES* ADMINISTERED BY DISCOVERY HEALTH

- LA KeyPlus Plan
- TFG Health

DISCOVERY HEALTH RATE

This is a rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant healthcare services.

* For the rest of the document the above scheme's cover is the same as KeyCare Plus unless otherwise indicated.

The benefits of the KeyCare Series health plan options

	KeyCare Plus, LA KeyPlus, TFG Health	KeyCare Start	KeyCare Core
GP visits	Unlimited cover for medically appropriate GP consultations at the agreed KeyCare Rate at a member's chosen network GP. The patient will receive an SMS after the 10th consultation confirming the GP visit usage. Emergency consultations (codes 0146 and 0147) are limited to three per person per year. Telephonic consultations (code 0130) will also be covered and accumulate to the GP limit. Preauthorisation is required after a patient's 15th GP visit.	Unlimited cover for medically appropriate GP consultations at the agreed KeyCare Rate at the member's chosen network GP. Preauthorisation is required after a patient's 15th GP visit. The patient will receive an SMS after the 10th consultation confirming the GP visit usage. Emergency consultations (codes 0146 and 0147) are limited to three per person per year at their chosen GP. Members will have access to after-hours visits at their chosen GP or after-hours network provider.	This plan does not offer day-to-day medical cover.
Out-of-network GP visits	Each member has four out-of-network GP visits per year at any GP. If the patient chooses to see an out-of-network GP, then the doctor will be reimbursed at the KeyCare fee-for-service rate.	Each member has two out-of-network GP visits per year at any KeyCare network GP. If the patient chooses to see an out-of-network GP then the doctor will be reimbursed at the KeyCare fee-for-service rate.	This plan does not offer day-to-day medical cover.
Pathology tests	Basic pathology is covered subject to a specific list of blood tests, as indicated on the KeyCare pathology form, at a pathologist or medical technologist in the network.		This plan does not offer day-to-day medical cover.
Radiology tests	Basic X-rays and all ultrasounds are covered as indicated on the KeyCare radiology form, at a radiologist, ultrasonographer or radiographer in the network. KeyCare GPs with a radiology license will also be reimbursed for a specific list of X-rays.		This plan does not offer day-to-day medical cover.
Optometry	One eye test, one pair of either single vision, bifocal or multifocal lenses with a basic frame from a selected range or a set of contact lenses, every 24 months (from last claim) in the KeyCare Optometry Network.		This plan does not offer day-to-day medical cover.
Dentistry	Cover includes consultations, fillings and tooth removals in the KeyCare Dental Network. Certain rules and limits apply. In-hospital dentistry is not covered on this plan.		This plan does not offer day-to-day medical cover. In-hospital dentistry is not covered on this plan.
Acute medicine	Cover includes acute medicine subject to the KeyCare acute medicine list and only if prescribed by the member's chosen GP or dispensed by their dispensing provider.	Acute medicine is only obtainable from member's chosen KeyCare Start GP or through the member's corporate practice within their chosen regional network.	This plan does not offer day-to-day medical cover.
Medical equipment	Cover includes basic medical equipment, subject to a network provider. There is an overall annual limit of R5 400 for each family.	Medical equipment obtained out-of-hospital is not covered. Cover will only be part of an approved hospital admission within the KeyCare Start regional network.	This plan does not offer day-to-day medical cover.
Allied, therapeutic and psychology healthcare professionals	The Scheme does not cover physiotherapists, psychologists, speech therapists, audiologists, homeopaths or chiropractors from the day-to-day benefits unless it is part of an approved Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) condition where we will provide funding from the available basket of benefits.		

	KeyCare Plus, LA KeyPlus, TFG Health	KeyCare Start	KeyCare Core
Specialist visits	Specialist cover up to a limit of R4 730 for each person. The patient's primary or secondary GP must get a reference number before the consultation with the specialist. The specialist authorisation is valid for 30 days.	Each person has two specialist visits each year up to an overall limit of R2 370. The patient's chosen GP must get a reference number before the consultation with a specialist within their regional network.	Specialist cover up to a limit of R4 730 for each person.
MRI or CT scans	The Scheme pays for MRI and CT scans outside of an approved hospital admission from the Specialist Benefit, subject to a specialist authorisation.		
Full cover in the Full Cover Hospital Network, and up to 70% of the Discovery Health Rate in the Partial Cover Hospital Network.	Unlimited cover in the KeyCare Hospital Network. There is a list of procedures that are covered in the KeyCare Day Surgery Network. Cover is subject to benefit and clinical protocols. The Scheme covers in-hospital expenses up to the agreed Discovery Health Rate. The Partial Cover Hospital Network is not applicable to LA KeyPlus.	Unlimited cover in the chosen KeyCare Start Full Cover Hospital Network. There is a defined list of procedures that are covered in the KeyCare Day Surgery Network. Cover is subject to benefit and clinical protocols. The Scheme covers in-hospital expenses up to the agreed Discovery Health Rate.	Unlimited cover in the KeyCare Hospital Network. There is a list of procedures that are covered in the KeyCare Day Surgery Network. Cover is subject to benefit and clinical protocols. The Scheme covers in-hospital expenses up to the agreed Discovery Health Rate.
Renal dialysis	Patients approved for renal dialysis must use network facilities for their renal dialysis. Treatment outside of the network will attract a 20% co-payment applicable to each claim. KeyCare patients in consultation with their doctor have to complete the KeyCare chronic renal dialysis application form and send it back to us. Once reviewed, we will notify the patient and the treating doctor on the decision of the application and benefit.	Patients approved for renal dialysis must use a state facility for their renal dialysis. Treatment outside of the state network will attract a 20% co-payment applicable to each claim. KeyCare patients in consultation with their doctor have to complete the KeyCare chronic renal dialysis application form and send it back to us. Once reviewed, we will notify the patient and the treating doctor on the decision of the application and benefit.	Patients approved for renal dialysis must use network facilities for their renal dialysis. Treatment outside of the network will attract a 20% co-payment applicable to each claim. KeyCare patients in consultation with their doctor have to complete the KeyCare chronic renal dialysis application form and send it back to us. Once reviewed, we will notify the patient and the treating doctor on the decision of the application and benefit.
Chemotherapy and radiotherapy	Cover includes treatment only if it is a Prescribed Minimum Benefit (PMB) and at a network provider. Treatment outside of the network will attract a 20% co-payment.	Cover includes treatment only if it is a Prescribed Minimum Benefit (PMB) and at a state facility.	Cover includes treatment only if it is a Prescribed Minimum Benefit (PMB) and at a network provider. Treatment outside of the network will attract a 20% co-payment.
Major maxillo-facial procedures	Unlimited cover for a defined list of trauma Prescribed Minimum Benefit (PMB) procedures, subject to authorisation, in a KeyCare Network Hospital. Treatment that is not a Prescribed Minimum Benefit (PMB) will not be covered. Basic dentistry procedures will not be covered even when done as part of an in-hospital treatment.	Unlimited cover for a defined list of trauma Prescribed Minimum Benefit (PMB) procedures, subject to authorisation, in the chosen KeyCare Start Network Hospital. Treatment that is not a Prescribed Minimum Benefit (PMB) will not be covered. Basic dentistry procedures will not be covered even when done as part of an in-hospital treatment.	Unlimited cover for a defined list of trauma Prescribed Minimum Benefit (PMB) procedures, subject to authorisation, in a KeyCare Network Hospital.

	KeyCare Plus, LA KeyPlus, TFG Health	KeyCare Start	KeyCare Core
In-hospital cover for Allied, therapeutic and psychology healthcare professionals	The Scheme covers allied, therapeutic and psychology healthcare professionals up to the Discovery Health Rate, subject to approval.		
Step-down facilities	Cover includes step-down facilities at the Discovery Health Rate, subject to approval and authorisation at an accredited facility.		
Mental Health Prescribed Minimum Benefit (PMB)	21 days for admissions or up to 15 out-of-hospital consultations for each person for major affective disorders, anorexia and bulimia, and up to 12 out-of-hospital consultations for acute stress disorder accompanied by recent significant trauma. 21 days for other mental health admissions. All mental health admissions are covered in full at an in-hospital psychiatric network facility. If the patient goes elsewhere, payment will be up to 80% of the Discovery Health Rate for the hospital account.		
Alcohol and drug rehabilitation	Cover includes up to 21 days for each person at a network provider. Treatment outside of the network will attract a 20% co-payment.		
Hip and knee joint replacements (only if a Prescribed Minimum Benefit (PMB)	The Scheme only covers joint replacements if the condition is a Prescribed Minimum Benefit (PMB).		
HomeCare	Discovery HomeCare offers high quality home-based care provided by professional registered nurses for members requiring intravenous infusions, wound and post-natal care. This care is paid from the Hospital Benefit in lieu of hospitalisation. Treatment is subject to approval.		
Maternity Benefit	Members will have access to comprehensive maternity and post-birth benefits. This will be covered from the Maternity Benefit at the Discovery Health Rate and will not affect the members day-to-day benefits. The patient must activate the benefit on the Discovery website, mobile app or by obtaining a confinement authorisation. KeyCare Start patients must be referred by their chosen KeyCare Network GP to a gynaecologist within their chosen regional network. ▪ 8 x consultations with a gynaecologist, chosen GP or midwife. ▪ 1 x nuchal translucency or a non-invasive prenatal test (NIPT) screening subject to clinical entry criteria. ▪ 2 x 2D ultrasound scans – 3D and 4D scans are paid at the rate we pay for 2D scans. ▪ A defined list of pathology per pregnancy. ▪ 1 x flu vaccination during the pregnancy. ▪ Up to 5 pre- or postnatal classes or consultations up until two years after birth, with a registered nurse. ▪ 1 x lactation consultation with a registered nurse or lactation specialist. ▪ The mom also has access to postnatal care which includes: – 1 x postnatal consultation – 1 x nutritional assessment with a dietitian – 2 x mental healthcare consultations with a counselor or psychologist – 2 x consultations with a GP, paediatrician or an ENT for the baby under the age of 2 years.		
Casualty visits	Cover (subject to authorisation) in any casualty unit at one of the KeyCare Network Hospitals. The patient has to pay the first R425 towards the facility fee. Limited to one elective casualty visit per member per year, with the exception of TFG Health which remains unlimited.	Casualty visits are not covered.	Casualty visits are not covered.
Advanced Illness Benefit (AIB)	Members with advanced cancer that require palliative care have access to the Advanced Illness Benefit (AIB) which provides members with palliative care in the comfort of their home or in a hospice facility.		
Trauma Recovery Extender Benefit	Cover for additional defined intensive day-to-day care following specific trauma events.		

	KeyCare Plus, LA KeyPlus, TFG Health	KeyCare Start	KeyCare Core
Chronic Illness Benefit (CIB)	The patient's nominated KeyCare GP must prescribe the approved chronic medicine and the patient must get their medicine from an approved pharmacy for full cover.	The patient's nominated KeyCare GP must prescribe the approved chronic medicine and the patient must get their medicine from a state facility. If the patient goes elsewhere, payment will be up to 80% of the Discovery Health Rate.	The patient's nominated KeyCare GP must prescribe approved chronic medicine and the patient must get their medicine from an approved pharmacy for full cover.
Screening and Prevention Benefit	**Screening for adults:** This benefit covers certain tests like blood glucose, blood pressure, cholesterol, body mass index and HIV screening. Schemes also cover: ▪ A mammogram every 2 years. ▪ A Pap smear once every 3 years. ▪ PSA test (prostate screening) each year. Members who have been identified as 'high risk' will automatically qualify for the following additional tests: ▪ Defined diabetes and cholesterol screening tests. **Screening for children:** This benefit covers growth assessment tests, including height, weight, head circumference and health and milestone tracking.		

Specialist Benefit

Specialist visits are subject to authorisation. If a patient needs to see a maxillofacial surgeon, periodontist, ophthalmologist or a specialist for maternity care, they do not need a referral or authorisation number. This does not apply to KeyCare Start. For KeyCare Start, a specialist authorisation will be required for the initial referral for maternity care to a gynaecologist within the patient's chosen regional network.

- Each member is covered up to R4 730 on KeyCare Plus and KeyCare Core plans.
- KeyCare Start members are covered for 2 specialist visits up to an annual limit of up to R2 370 per person.

PATIENTS NEED TO BE REFERRED TO A SPECIALIST BY THEIR CHOSEN GP. PATIENTS ON KEYCARE CORE PLANS CAN BE REFERRED BY ANY GP.

01
FOR URGENT SPECIALIST REFERRALS

This is applicable if a patient needs to see the specialist for their medical condition within 48 hours after seeing the GP.

Obtain an urgent specialist authorisation from the GP contact centre by calling **0860 44 55 66**. Authorisation will be given if the case meets the requirements for an urgent referral.

02
NON-URGENT SPECIALIST REFERRAL

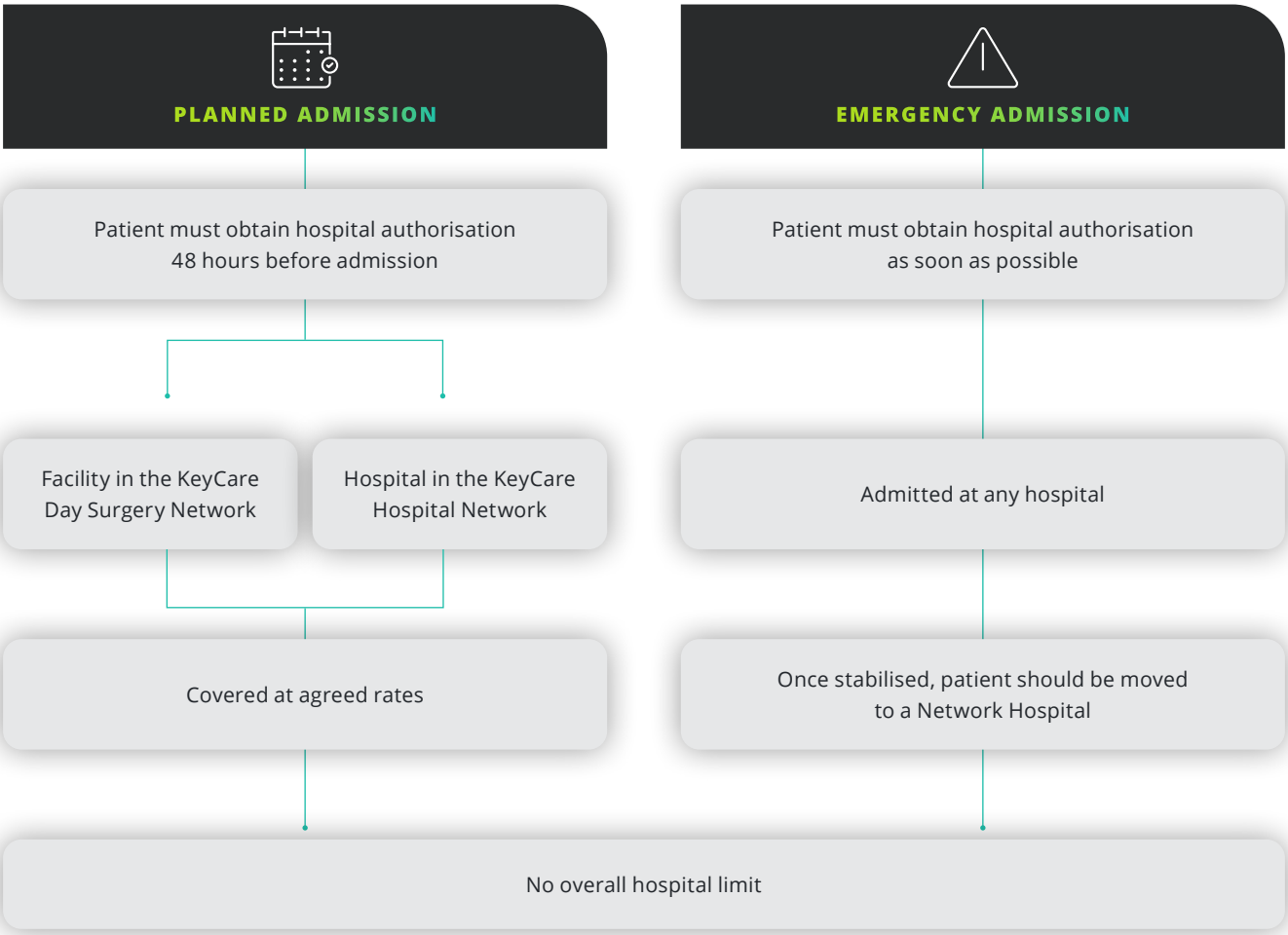
This is applicable if a patient needs to see the specialist for their medical condition but not within 48 hours after seeing the GP.

- KeyCare and KeyCare Start GPs that make use of HeathID can submit GP to specialist referral requests through HealthID or they can complete a GP to specialist referral form.
- The completed form must be emailed to **keycareauth@discovery.co.za** for review.
- Please attach any test results or motivations.
- Discovery Health will review the request.
- A notification will be sent to the patient or GP within two working days of request receipt.

Hospital Benefit

KeyCare Core and KeyCare Plus

- **For GP admissions:** The GP must be the member's primary GP, have admitting rights at a KeyCare network hospital and be the treating provider in hospital. The member's secondary GP will not be able to admit the member. The treating GP may refer the patient to a specialist in the event that they are unable to admit the patient.
- **For specialist admissions**: Hospital authorisations will be granted within 30 days of an approved specialist authorisation.
- Planned admissions are only covered in the KeyCare Hospital Network or in a state hospital.
- Preauthorisation is required from us before admission.
- When a member goes to casualty, the casualty officer needs to obtain a casualty authorisation.
- Emergency admissions are covered in any private or state hospital.
- The Scheme covers the first R180 of the patient's medicine to take home after discharge, only if it is included in the hospital account.

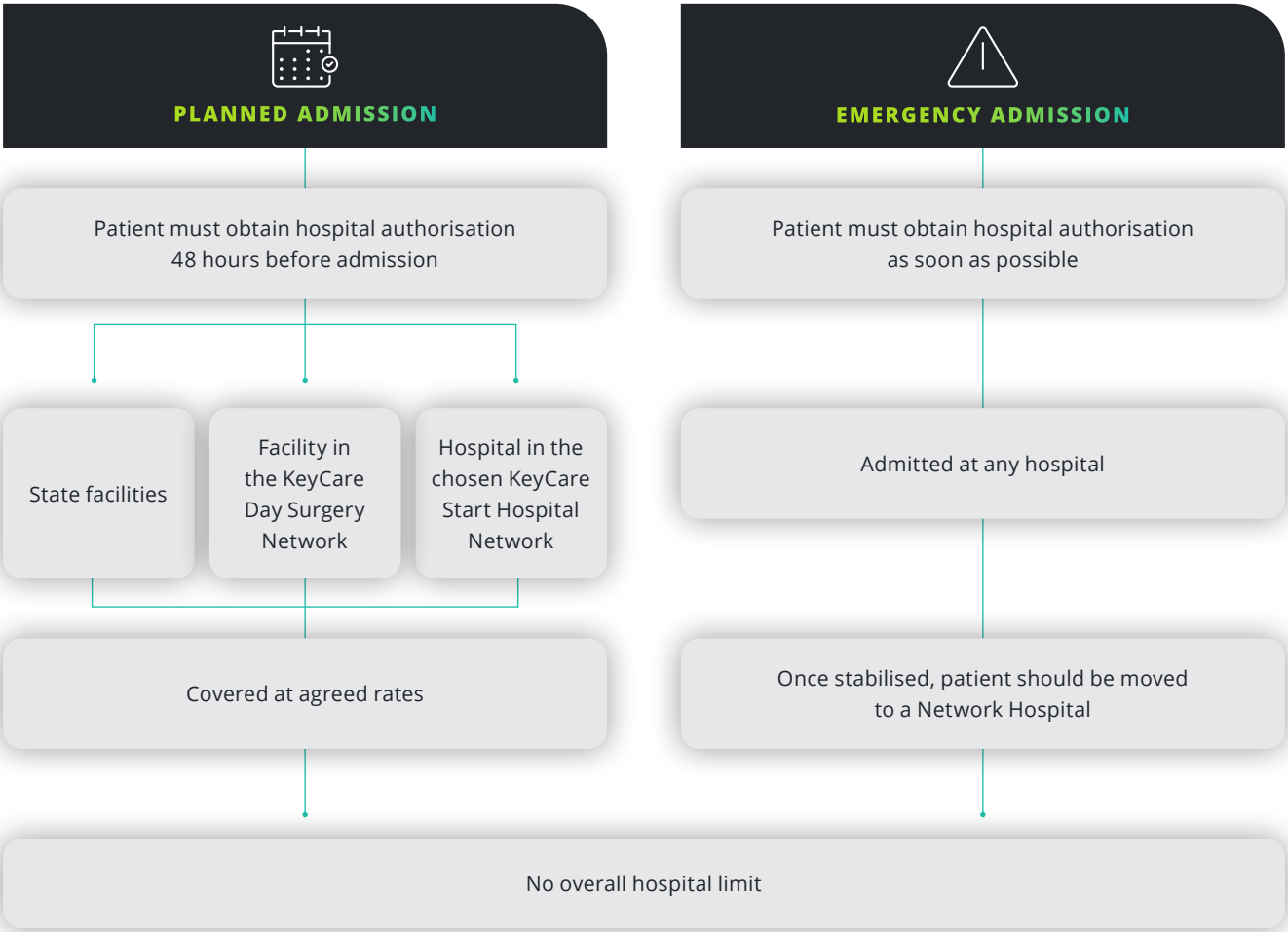


KeyCare Start Plan

For GP admissions: The GP must be the member's chosen GP, have admitting rights at the members KeyCare Hospital Network within their nominated regional network and be the treating doctor in hospital. The GP may refer the patient to a specialist in the event that they are unable to admit the patient.

For specialist admissions: Hospital authorisations will be granted within 30 days of an approved specialist authorisation.

- Planned admissions are only covered in the chosen KeyCare Start Hospital Network based on the member's chosen GP and regional selection or in a state hospital.
- Preauthorisation is required from us before admission.
- Emergency admissions are covered in any private or state hospital.
- The Scheme covers the first R190 of the patient's medicine to take home after discharge, only if it is included in the hospital account.



Procedures Covered In Our Day Surgery Network

Certain planned procedures will only be covered in our Day Surgery Network

The list of day surgery procedures and the Day Surgery Network list can change at any time. Please refer to the latest list available on the Healthcare Professional Zone before any planned admissions.

To find the latest list:

Log in to the **Healthcare Professional Zone > Tools > Forms and formularies > Day Surgery Network list**

A clinical exceptions process applies to all cases with complex presentations and those procedures that may require an extended length of stay. The member will be transferred to an appropriate facility where required.

Phone for authorisation 48 hours before admission

Admission must take place in a in a KeyCare day clinic or KeyCare day-rate hospital

Payment at agreed rates

For patients on KeyCare Start plan, the Scheme will pay for planned day procedures in the KeyCare Day Surgery Network within the members chosen regional network.

Exclusions

Treatments and procedures not covered on the KeyCare Series

In addition to the general Scheme exclusions that apply to all plans, the KeyCare Series does not cover the following, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits (PMB):

- Hospital admissions related to, amongst others:
  - Dentistry
  - Nail disorders
  - Skin disorders including benign growths and lipomas
  - Investigations and diagnostic work-up
  - Functional nasal surgery
  - Elective caesarean section, except if medically necessary
  - Surgery for oesophageal reflux and hiatus hernia
  - Back and neck treatment or surgery
  - Knee and shoulder surgery
  - Arthroscopies
  - Joint replacements, including but not limited to hips, knees, shoulders and elbows
  - Cochlear implants, auditory brain implants and internal nerve stimulators – this includes procedures, devices and processors
  - Healthcare services that should be done out of hospital and for which an admission to hospital is not necessary.
- Endoscopic procedures with the exception of:
  - where scope is part of approved surgical procedure
  - Prescribed Minimum Benefit (PMB) conditions
  - Children under the age of 12
  - High risk patients
- Correction of hallux valgus/Bunion and Tailor's bunion/bunionette
- Removal of varicose veins
- Refractive eye surgery
- Non-cancerous breast conditions
- Healthcare services outside South Africa.

The Scheme also does not cover the cost of treatment for any complications or the direct and indirect expenses that relate to any of these excluded conditions and treatments.

The Scheme does not pay for healthcare services related to the following, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits (PMB)

General Scheme Exclusions

GENERAL EXCLUSION LIST INCLUDES

- Cosmetic procedures and treatments
- Otoplasty for bat ears, port-wine stains and blepharoplasty (eyelid surgery)
- Breast reductions or enlargements and gynaecomastia
- Obesity
- Frail care
- Infertility
- Alcohol, drug or solvent abuse
- Wilful and material violation of the law
- Wilful participation in war, terrorist activity, riot, civil commotion, rebellion or uprising
- Injuries sustained or healthcare services arising during travel to or in a country at war
- Experimental, unproven or unregistered treatments or practices
- Search and rescue
- Any costs for which a third party is legally responsible.

The Scheme also does not cover the complications or the direct or indirect expenses that arise from any of the exclusions listed above, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits (PMB).

For a full list of exclusions, please visit **www.discovery.co.za.**

WAITING PERIODS

If waiting periods apply because the patient has never belonged to a medical scheme or has had a break in medical scheme membership of more than 90 days before joining a medical scheme, the patient will not have access to Prescribed Minimum Benefits (PMB) during their waiting periods. This includes cover for emergency admissions. If the patient has had a break in cover of less than 90 days before joining a medical scheme, they may have access to Prescribed Minimum Benefits (PMB) during their waiting period.

Emergency benefits

EMERGENCY HOSPITAL ADMISSIONS

If a KeyCare member needs to go to hospital in an emergency, they can go to the closest hospital. They will then be moved to the nearest KeyCare network hospital as soon as they are stable enough to do so.

AMBULANCE BENEFITS AND EMERGENCY SERVICES

KeyCare members have cover for ambulance or helicopter transport in a medical emergency. KeyCare members have access to Discovery 911, a service that provides highly trained paramedics in response vehicles, and people who will help with all aspects of an emergency. The emergency number is **0860 999 911**.

CASUALTY BENEFIT FOR THE KEYCARE PLUS PLAN

On KeyCare Plus, members are covered in any network casualty unit at one of the KeyCare network hospitals. Your patients will have to pay the first R425 of the consultation and cover is subject to authorisation, limited to one elective casualty visit per member per year, with the exception of TFG Health which is unlimited.

If your patients use a casualty unit outside of the KeyCare Casualty Network, they will have to pay the difference between what the Scheme pays and what is charged. The rest of the account will be covered as per the KeyCare day-to-day benefits.

Any specialist visits in casualty will be paid from the Specialist Benefit limit of R4 730 for each person each year.

Any medical equipment supplied during the casualty visit will be paid from the medical equipment benefit limit of R5 400 for each family a year, if the item is on the mobility formulary and obtained from a mobility network provider. KeyCare Start does not cover mobility devices except where it forms part of an approved hospital admission.

Members on the KeyCare Start and KeyCare Core plans do not have access to the Casualty Benefit. On KeyCare Start, members have access to after-hours care at their chosen KeyCare Start GP or network provider. To view the most up-to-date KeyCare Casualty Hospital list, please **click here.**

Prescribed Minimum Benefits

PRESCRIBED MINIMUM BENEFIT (PMB) CONDITIONS

In terms of the Medical Schemes Act of 1998 (Act No. 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 diagnostic treatment pairs
- 27 Chronic Disease List (CDL) conditions.

To access Prescribed Minimum Benefits (PMB), there are rules that apply:

- The patient's medical condition must qualify for cover and be on the list of defined Prescribed Minimum Benefit (PMB) conditions.
- The treatment needed must match the treatments in the defined benefits on the Prescribed Minimum Benefit (PMB) list.
- The patient must use designated service providers (DSPs) in our network for full cover unless there is no DSP available on the member's plan. This does not apply in emergencies. However even in these cases, where appropriate and according to the rules of the Scheme, the patient may be transferred to a hospital or other service providers in our network, once the patient's condition has stabilised.

If the patient's treatment doesn't meet the above criteria, payment of up to 80% of the Discovery Health Rate will apply. The patient will be responsible for the difference between what the Scheme pays and the actual cost of the treatment.

WHAT IS AN EMERGENCY

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 or the patient for additional information to confirm the emergency.


Your patients' health
is everything.

Chronic Illness Benefit

The Chronic Illness Benefit covers the diagnosis, chronic medicine and ongoing management for 27 chronic onditions according to the Prescribed Minimum Benefits (PMB). Cover for chronic illness medicine is subject to meeting benefit entry criteria and approval by the Scheme.

Patients have access to a list of chronic conditions and full cover for chronic medicine on the KeyCare medicine list, subject to the approval of the Chronic Illness Benefit application.

AUTHORISATION PROCESS FOR A CHRONIC CONDITION

To access the Chronic Illness Benefit, patients must first apply.

Please help the patient with the following:

- Check the chronic conditions list to see if the Scheme covers the condition.
- Download the Chronic Illness Benefit application form from the **Healthcare Professional Zone > Tools > Forms and formularies.**
- Use the medicine list to complete the form and email, or post it back to us.
- Keep a copy of the completed form for your records.
- The Scheme will review the application and inform the patient if they have asked us to do so, whether they have approved it or not within three to five working days.
- You can submit the chronic application through HealthID, provided the patient has provided you consent.
- If the patient needs new or additional medicine to treat their approved chronic condition, you can call us on **0860 44 55 66**.

DESIGNATED SERVICE PROVIDER FOR CHRONIC MEDICINES

- Patients on the KeyCare Plus and Keycare Core plans must get their approved chronic medicine from one of our network pharmacies or from their nominated dispensing KeyCare GP.
- Patients on the KeyCare Start plan need to get their approved medicine from a state facility. If patients get their medicine from anywhere else, they will have a 20% co-payment on their medicine.

If you prescribe chronic medicine that is not on our medicine list, we will pay up to the Reference Price, which is up to the lowest cost medicine of the same kind on the medicine list for the condition.

CONSULTATIONS AND TESTS FOR AN APPROVED CHRONIC CONDITION

GP visits

- Members will have four GP visits per year.
- Members need to nominate a GP in the Keycare GP Network as their primary care provider for the management of their chronic conditions.
- We will pay claims for consultations and procedures from the member's nominated GP up to the agreed rate.
- Members registered for a chronic condition will be prompted to nominate a primary care network doctor appropriate to their chosen health plan. This nomination process will not impact their benefits and cover for 2022. We will share communication during the course of 2022 to explain:
  - The process to follow to nominate a primary care doctor (GP).
  - How to change a nominated GP, if necessary.

Specialist visits

- For selected chronic conditions, patients approved for chronic benefits are entitled to specialist visits, subject to Discovery Health Medical Scheme's Prescribed Minimum Benefit (PMB) treatment baskets.

Blood tests and X-rays

- For selected chronic conditions, patients approved for chronic benefits are entitled to blood tests and X-rays, subject to the Scheme's Prescribed Minimum Benefit (PMB) treatment baskets.

MEDICINE FORMULARIES

Formularies may be updated during the year. For the latest version of these documents, please log in to the **Healthcare Professional Zone > Tools > Forms and formularies.** You can log into HealthID for an updated list of formulary medicine.

CHRONIC DISEASE LIST (CDL) CONDITIONS

Addison's disease, asthma, bipolar disorder, bronchiectasis, cardiac failure, cardiomyopathy, chronic obstructive pulmonary disease (COPD), chronic renal disease, coronary artery disease, Crohn's disease, diabetes insipidus, diabetes type 1, diabetes type 2, dysrhythmia, epilepsy, glaucoma, haemophilia, HIV, hyperlipidaemia, hypertension, hypothyroidism, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, schizophrenia, systemic lupus erythematosus, ulcerative colitis.

Suite of patient management programmes

DIABETES CARE

Our Diabetes Care Programme, together with a Premier Plus GP, will help patients actively manage their diabetes. The Diabetes Care Programme is based on clinical and lifestyle guidelines. The programme gives patients access to various tools to monitor and manage their condition and to ensure they have access to high-quality coordinated care.

Patients, together with their nominated GP can track progress on a personalised dashboard displaying their unique diabetes management score. The programme also unlocks cover for valuable healthcare services from healthcare providers like dietitians and biokineticists.

Any Discovery Health Medical Scheme member registered on the Chronic Illness Benefit for diabetes can join the Diabetes Care Programme.

MENTAL HEALTH CARE PROGRAMME

If the patient meets the Scheme's clinical entry criteria they will have access to defined cover for the management of episodes of major depression.

Enrollment on the programme unlocks cover for prescribed medicine, up to three consultations with their enrolling Premier Plus GP, referral to a psychiatrist and psychotherapy consultations.

MEMBER CARE PROGRAMME

The Member Care Programme is designed for patients who typically suffer from multiple chronic conditions. The programme aims to provide high quality, planned, person-centred care and chronic condition management. The aim is to improve the quality, continuity and efficiency of care by:

- Collaborating with relevant healthcare professionals
- Helping your patients to be better informed to manage their condition(s)
- Assisting your patients with navigating their available Scheme benefits.

These benefits are intended to optimise the patient's out of hospital care and to ensure they are well managed. If patients who are invited to participate choose not to participate in the programme, they will be responsible for a 20% co-payment on all non-Prescribed Minimum Benefit (PMB) hospital admissions (including related accounts) thereafter.

COVER FOR MATERNITY AND EARLY CHILDHOOD

These healthcare services for maternity and early childhood are covered from the Maternity Benefit at the Discovery Health Rate. This cover does not affect the member's day-to-day benefits and depends on the plan they choose. Benefits will be activated when the member's pregnancy profile is created on the Discovery app, on our website **www.discovery.co.za**, when the member preauthorises their delivery or when they register their baby onto the Scheme.

DISCOVERY HIV CARE PROGRAMME

Patients living with HIV and AIDS must register on the Discovery HIV Care Programme by calling the Discovery Care team on **0860 99 88 77**.

For members who are registered on the HIV Care Programme, Discovery Health Medical Scheme pays for four GP consultations for GPs in the Premier Plus HIV Network and one specialist consultation per person each year for the management of HIV.

HIV MEDICINES

Patients who test positive for HIV have cover for antiretroviral medicines that are on our HIV medicine list (formulary). This includes:

- Treatment for prevention of mother-to-child transmission.
- Treatment of sexually transmitted infections and HIV-related (or AIDS-defining) infections.
- We will fund supportive medicine for patient's whose conditions meet our requirements for cover (clinical entry criteria). Our case managers will coordinate HIV medicine applications and monitor the member's use of antiretroviral treatment to ensure the treatment is effective.
  - For preventive treatment in the case of sexual assault, mother-to-child transmission, trauma or injury on duty, any HIV waiting periods do not apply to preventive medicine. Cover is subject to national treatment guidelines and benefit confirmation. Members do not need to register on the HIV Care Programme for this preventive treatment.

We pay for nutritional feeds for babies born to HIV-positive mothers from the date of birth and up to six months. We approve the first month upfront, however, the infant needs to be registered on the member's health policy in order to qualify for the remaining five months. These are paid according to the HIV nutritional and mother to child prevention medicine list (formulary). This formulary can be found on the **Discovery website > Medical aid > Manage your health plan > Find important documents and certificates**.

DESIGNATED SERVICE PROVIDER (DSP) FOR HIV MEDICINES

Patients registered on the Discovery HIV Care Programme must use a pharmacy that is in the HIV designated service provider (DSP) Pharmacy Network or a state facility for KeyCare Start patients or the patient's nominated dispensing GP for their approved HIV ARV medicine and HIV supportive medicines. For more information, members can visit the **Discovery website > Medical aid > Manage your health plan > Find important documents and certificates**.

If a patient uses a non-designated service provider (DSP), the patient will be liable for a 20% co-payment.

Cover for HIV

Out-of-hospital	KeyCare Plus and KeyCare Start Plans	KeyCare Core Plan
GP consultations	Four consultations per person each year if enrolled on the Discovery HIV Care Programme (for GPs in the Premier Plus HIV Network).	
Specialist consultations	The Scheme covers one specialist visit (this will not be paid from the Specialist Benefit limit and patients do not have to get authorisation).	
HIV prophylaxis* Sexual assault, mother-to child transmission, trauma or workman's compensation	Cover is subject to national treatment guidelines and benefit confirmation. Members do not need to register on the HIV Care Programme for this preventive treatment.	
Antiretrovirals, HIV supportive and prophylactic treatment eg TB*	Unlimited but subject to the HIV antiretroviral and HIV supportive formularies and Discovery Health protocols. KeyCare Start members must receive their medicine from a state facility.	
Prescribed medicine (other than antiretrovirals and HIV supportive)	Only available through the patient's chosen GP, subject to the KeyCare acute and/or chronic medicine lists. KeyCare Start members must receive their medicine from a state facility.	Not covered.
HIV monitoring blood tests	The following HIV monitioring blood tests are covered for each patient each year if enrolled on the Discovery HIV Care Programme: ■ CD4 count four times a year ■ ALT three times a year ■ Fasting lipogram once a year ■ Urea and electrolytes with creatinine twice a year ■ Viral load four times a year ■ FBC four times a year ■ Liver function test once a year ■ Fasting glucose test once a year.	

* Patients must call the Discovery Care team on **0860 99 88 77** to access HIV prophylactic treatment.

Cover for Cancer

Patients diagnosed with cancer must register on the Oncology Programme. If they need cancer treatment, their cancer specialist should send us the treatment plan for approval before starting with the treatment. The treating doctor must also send a copy of the patient's laboratory results confirming the diagnosis.

Patients can call us on **0860 99 88 77** or doctors can call us on **0860 44 55 66**.

Cover includes all approved cancer-related healthcare services up to 100% of the agreed rate at a KeyCare ICON provider. Patients on KeyCare Plans only have access to oncology treatment if it is a Prescribed Minimum Benefit (PMB).

CANCER-TREATING GPS

The primary or secondary chosen GP who is part of the KeyCare GP Network.

KeyCare Start Plan

On the KeyCare Start plan, the Scheme covers cancer treatment and related costs at agreed rates, if it is a Prescribed Minimum Benefit (PMB), in a state facility only.

KeyCare Plus and KeyCare Core Plans

CANCER TREATMENT

Patients must access their cancer care from a network group (KeyCare ICON) of oncologists. Treatment must be in line with agreed protocols and subject to treatment at a KeyCare oncology provider.

Patients have cover for approved chemotherapy, radiotherapy and other treatment prescribed by their cancer specialist at the agreed rates. Schemes also cover pathology and radiology. This treatment must be in line with agreed protocols and subject to treatment at a KeyCare ICON provider.

SURGERY FOR CANCER

The Scheme pays the medical expenses incurred during an approved hospital admission from the Hospital Benefit and not the Oncology Benefit. Patients must use a hospital in the KeyCare Hospital Network and a specialist participating in:

- a KeyCare Specialist Network or
- any cancer specialist in the KeyCare ICON network or
- any specialist practising in a state hospital who is contracted with us.

MEDICINE FOR CANCER

All approved cancer-related treatment must be obtained from the designated service provider (DSP) to avoid a 20% co-payment. We will also pay for medicine prescribed during active treatment to treat symptoms resulting from the cancer treatment. We cover approved medicine in full up to the Scheme rate if the medicine is on the supportive formulary. Medicine not listed on the formulary will be covered up to the Reference Price. Your patient will be liable for a co–payment.

For information please visit **www.discovery.co.za**.

BONE MARROW DONOR SEARCHES AND TRANSPLANTATION

Patients on the KeyCare Plus and KeyCare Core Plans have access to local bone marrow donor searches once their transplant procedure and treatment has been approved.

PET-CT SCANS

Cover includes PET-CT scans, subject to certain terms and conditions, at a KeyCare PET network provider. Patients need to authorise PET-CT scans with us before having them done. The patient's condition determines how many PET-CT scans will be covered. PET scans will be covered in full at our Prescribed Minimum Benefit (PMB) PET networks.

WIGS

On all KeyCare Plans, patients need to pay the cost for wigs themselves.

ADVANCED ILLNESS BENEFIT

Through the Advanced Illness Benefit (AIB), Discovery Health Medical Scheme aims to ensure that their members with advanced stages of cancer have access to comprehensive palliative care that offers quality care in the comfort of their own home, with minimum disruption to their normal routine and family life.

Palliative care is provided by trained doctors, nurses or care workers in partnership with the Hospice Palliative Care Association of South Africa. Enrolled patients have access to this service through the Advanced Illness Benefit.

To register, please complete the Advanced Illness Benefit application form and email it to AIB@discovery.co.za.

The AIB application form is available on our website the **Discovery website > Medical aid > Manage your health plan > Find important documents and certificates**. Upon successful registration, patients will gain access to a comprehensive basket of care.

Radiology

OUT-OF-HOSPITAL RADIOLOGY (FOR KEYCARE PLUS AND KEYCARE START PLANS)

- KeyCare GPs that make use of HeathID can submit radiology requests through HealthID.
- Patients must read the liability form to acknowledge that they are aware that any tests not covered are for their own account.
- The patient has to go to a radiology network to have their tests done, except for in the case of a casualty event for KeyCare Plus members.

IN-HOSPITAL RADIOLOGY (ALL KEYCARE PLANS)

- Radiology will be covered as part of an approved hospital event. These claims will be covered at 100% of the Discovery Health Rate.
- The radiology network does not apply.

GP RADIOLOGY CODES

Cover includes the following X-rays performed by a KeyCare GP with a radiology licence.

Medical code	Description	Medical code	Description
3305	Finger, toe.	6504	Radius and ulna
3321	Per region, eg cervical, sacral, lumbar coccygeal, one region thoractic.	6505	Elbow
3331	Pelvis (sacro-iliac or hip joints only to be added where an extra set of views is required).	6506	Humerus
3445	Chest (item 3601 included).	6507	Shoulder
3449	Ribs.	6508	Acromio-clavicular joint
3477	Control films of the abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram etc).	6509	Clavicle
3479	Acute abdomen or equivalent studies.	6510	Scapula
3615*	Routine obstetric ultrasound at 10 to 20 weeks gestational age, preferable at 10 to 14 weeks gestational age to include nuchal translucency assessment.	6512	Ankle
3617*	Routine obstetric ultrasound at 20 to 24 weeks, to include detailed anatomical assessment.	6513	Calcaneus
3629	High definition (small parts) scan: Thyroid, breast lump, scrotum, etc.	6514	Tibia and fibula
6500	Hand.	6515	Knee
6501	Wrist (specify region).	6517	Femur
6503	Scaphoid.	6518	Hip

* *Can be performed by a GP without a radiology licence (up to a maximum of two scans a person each year).*

KeyCare Hospital Networks

Your patients must go to a hospital in the KeyCare Hospital Network for planned admissions on the KeyCare Plus and KeyCare Core plans. For full cover hospitals, we cover your patients in full at the rate agreed with the hospital in accordance with their health plan benefits. For KeyCare Partial Cover hospitals, we pay up to a maximum of 70% of the hospital account. Your patient must pay the balance of the hospital account. If the admission is a Prescribed Minimum Benefit (PMB), we will pay 80% of the Discovery Health Rate. If members do not use one of these hospitals for a planned admission, they will need to pay these claims.

To view the most up-to-date KeyCare Hospital Network list, please **click here**. If members do not use one of these hospitals for a planned admission, they will need to pay these claims.

KeyCare Casualty Hospitals

On KeyCare Plus, members are covered in any network casualty unit at one of the KeyCare network hospitals. Your patients will have to pay the first R425 of the consultation and cover is subject to authorisation, limited to one elective casualty visit per member per year, with the exception of TFG Health which is unlimited. If your patients use a casualty unit outside of the KeyCare Casualty Network, they will have to pay the difference between what the Scheme pays and what is charged.

On KeyCare Start members have access to after-hours care at their chosen KeyCare Start GP or network provider.
To view the most up-to-date KeyCare Casualty Hospital list, please **click here**.

The hospital network lists can change at any time. Please go to www.discovery.co.za to see the latest list before any planned admissions.

KeyCare Start Hospital Network

We cover your patients on the KeyCare Start plan in full at the agreed rate in their chosen KeyCare Start Network Hospital. If your patients do not use their chosen hospital for a planned admission, they will need to pay these claims.

Based on the chosen KeyCare Start GP your patients will have access to a KeyCare Start Network Hospital in their region.

The KeyCare Start Hospital Network lists can change at any time. To view the most up-to-date list, please **click here**.

KeyCare Day Surgery Network 2022

If your patients on the KeyCare Core and KeyCare Plus plans do not use one of the hospitals in the KeyCare Day Surgery Network for a planned day surgery admission, they will need to pay these claims. If your patients on a KeyCare Start plan do not use one of the hospitals in the KeyCare Start Day Surgey Network for a planned day surgery admission, they will need to pay these claims.

The Day Surgery Network lists can change at any time. To view the most up-to-date KeyCare Day Surgery Network list, please **click here**.

ICD-10 CODING

The representation of clinical information in the form of ICD-10 diagnosis codes is a valuable way to collect important data that facilitates analysis of disease burden and appropriate benefit management.

ICD-10 is a structured coding schema from the World Health Organisation (adopted as the standard for use in South Africa). The accurate use of these codes brings uniformity to clinical interactions between providers of healthcare and funders. It also removes inconsistencies and ambiguities often experienced in written text. Wherever possible, the use of valid ICD-10 codes on the referral form is therefore encouraged to assist in streamlining the efficiencies of this interaction.

The hospital network lists can change at any time. Please go to www.discovery.co.za to see the latest list before any planned admissions.

Contact us

GP CONTACT CENTRE (BOTH GENERAL AND CLAIMS-RELATED QUERIES)

Email | healthpartnerinfo@discovery.co.za

Telephone | 0860 44 55 66

Health professional | +27 83 123 55 66

CHRONIC ILLNESS BENEFIT APPLICATIONS

Email | CIB_APP_FORMS@discovery.co.za

Telephone | 0860 99 88 77

Health professional | +27 83 123 88 77

PRESCRIBED MINIMUM BENEFIT APPLICATIONS

Email | PMB_APP_FORMS@discovery.co.za

Telephone | 0860 99 88 77

Health professional | +27 83 123 88 77

HIV AND AIDS DISEASE MANAGEMENT PROGRAMME TEAM

Email | HIV_Diseasemanagement@discovery.co.za

Telephone | 0860 99 88 77

PATIENT CONTACT CENTRE

Get help on our website

Telephone | 0860 99 88 77 or +27 83 123 88 77

HOSPITAL PREAUTHORISATIONS TEAM

Telephone | 0860 99 88 77

AMBULANCE AND EMERGENCY

Telephone | 0860 999 911

MOBILITY PROVIDER NETWORK

MEDOP | 011 827 5893/4/5

CE Mobility | 011 210 6347/011 210 6300

Chairman Industries | 011 624 1222

PATIENT LISTS OR FORMULARIES

www.discovery.co.za > Medical Aid > Manage your health plan > Find important documents and certificates

INTERNATIONAL CALLERS

Dial **+27 11 529 2888** and speak to our switchboard who will direct your call accordingly.

Contact centre 0860 99 88 77 PO Box 784262, Sandton, 2146 www.discovery.co.za

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