



KEYCARE SPECIALIST
Handbook 2022





Thank you for being part of the KeyCare Specialist Network.

Our aim is to provide more South Africans with quality 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 (scheme) will cover for each benefit 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.
- As from 1 January 2022 the Advanced Illness Benefit (AIB) will replace the Compassionate Care Benefit.
- There are enhancements to the Allied Therapeutic and Psychology Extender Benefit from 1 January 2022.
- As from 1 January 2022, the Trauma Recovery Extender Benefit will be available to KeyCare Core members.

KeyCare plans on schemes administered by Discovery Health

KEYCARE PLANS ON DISCOVERY HEALTH MEDICAL SCHEME

- KeyCare Core
- KeyCare Plus
- KeyCare Start
- KeyCare Start Regional

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 Core	KeyCare Plus, LA KeyPlus, TFG Health	KeyCare Start	KeyCare Start Regional
GP visits	This plan does not offer day-to-day medical cover.	<p>Unlimited cover for medically appropriate GP consultations at the agreed KeyCare Rate at the member's chosen network GP.</p> <p>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.</p> <p>Emergency consultations (codes 0146 and 0147) are limited to three per person per year.</p>	<p>Unlimited cover for medically appropriate GP consultations at the agreed KeyCare Rate at the member's chosen network GP.</p> <p>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.</p> <p>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.</p>	<p>Unlimited cover for medically appropriate GP consultations at the agreed KeyCare Rate at the member's chosen network GP.</p> <p>Emergency consultations (codes 0146 and 0147) are limited to two per person per year. After hours code 0148 is unlimited if treatment is accessed via the Online Practice or the member's chosen GP.</p>
Out-of-network GP visits	This plan does not offer day-to-day medical cover.	Each person 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 person 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.	
Pathology tests	This plan does not offer day-to-day medical cover.	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.		
Radiology tests	This plan does not offer day-to-day medical cover.	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.		
Optometry	This plan does not offer day-to-day medical cover.	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.	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.	
Dentistry	This plan does not offer day-to-day medical cover.	Cover includes consultations, fillings and tooth removals in the KeyCare Dental Network. Certain rules and limits apply.		

	KeyCare Core	KeyCare Plus, LA KeyPlus, TFG Health	KeyCare Start	KeyCare Start Regional
Acute medicine	This plan does not offer day-to-day medical cover.	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. Specialists may refer patients to any pharmacy.	Acute medicine is only obtainable from member's chosen KeyCare Start Regional network pharmacy, scripted by the Online Practice GP or through the member's corporate practice within their chosen regional network. Specialists may refer patients to any pharmacy
Medical equipment	This plan does not offer day-to-day medical cover.	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.	
Allied, therapeutic and psychology healthcare professionals	The Scheme does not cover physiotherapists, psychologists, speech therapists, audiologists, homeopaths or chiropractors from 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.			
Specialist visits	Specialist cover up to a limit of R4 730 for each person. The specialist authorisation is valid for 30days.	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 annual limit of R2 370. The patient's chosen GP must get a reference number before the consultation with a specialist within their regional network.	
MRI or CT scans	The Scheme pays for MRI and CT scans outside of an approved hospital admission from the Specialist Benefit, subject to the specialist authorisation.			
Overall hospital 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.	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. On KeyCare Start, there is no cover provided in the Partial Cover Hospital Network. Specialists may only admit patients in their chosen KeyCare Start Hospital.	Unlimited cover in the chosen KeyCare Start Regional 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. On KeyCare Start Regional, there is no cover provided in the Partial Cover Hospital Network. Specialists may only admit patients in their chosen KeyCare Start Regional Hospital.
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.			

	KeyCare Core	KeyCare Plus, LA KeyPlus, TFG Health	KeyCare Start	KeyCare Start Regional
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.	
Major maxillofacial procedures	Unlimited cover for a defined list of trauma Prescribed Minimum Benefit (PMB) procedures, subject to authorisation, in a KeyCare Network Hospital.	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 the chosen KeyCare Start Regional 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.
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.			

	KeyCare Core	KeyCare Plus, LA KeyPlus, TFG Health	KeyCare Start	KeyCare Start Regional
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 as part of an approved hospital authorisation. Treatment is subject to approval.			
Maternity Benefit	<p>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 member's day-to-day benefits. The patient must activate the benefit on the Discovery website, mobile app or by obtaining a confinement authorisation. KeyCare Start Regional patients must be referred by their chosen KeyCare Start or KeyCare Start Regional GP a gynaecologist within their chosen regional network.</p> <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> - 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	Casualty visits are not covered.	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. This plan remains unlimited.	Casualty visits are not covered.	
Advanced Illness Benefit (AIB)	Members with advanced illness 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, subject to approval.			
Trauma Recovery Extender Benefit	Cover for additional defined intensive day-to-day care following specific trauma events.			
Screening and Prevention Benefit	<p>Screening for adults: This benefit covers certain tests like blood glucose, blood pressure, cholesterol, body mass index and HIV screening. The Scheme also covers:</p> <ul style="list-style-type: none"> ▪ A mammogram every 2 years. ▪ A Pap smear once every 3 years. ▪ PSA test (prostate screening) each year. <p>Members who have been identified as 'high risk' will automatically qualify for the following additional tests:</p> <ul style="list-style-type: none"> ▪ Defined diabetes and cholesterol screening tests. <p>Screening for children: This benefit covers growth assessment tests, including height, weight, head circumference and health and milestone tracking.</p>			

Specialist benefit

The following specialist benefits are covered on the KeyCare plans once Discovery Health has authorised the consultation.

BENEFIT ON THE KEYCARE PLUS, TFG HEALTH, LA KEYPLUS, KEYCARE CORE PLANS AND KEYCARE START REGIONAL

Specialist visits* covered subject to review and authorisation and the Specialist Benefit limit of R4 730 for each member each year. For KeyCare Plus, TFG Health and LA KeyPlus, the members chosen primary or secondary GP must obtain a reference number before a consultation with a specialist in the KeyCare Specialist Network. Members on the KeyCare Core Plan can be referred by any GP.

KEYCARE START AND KEYCARE START REGIONAL

KeyCare Start members are covered for 2 specialist visits up to an annual limit of up to R2 370 per person. The patient's chosen GP must obtain a reference number before the consultation with a specialist within their regional network.

PATHOLOGY

Subject to the Specialist Benefit limit provided that the specialist authorisation was obtained. Formulary not applicable for pathology requested by a specialist.

RADIOLOGY

Radiology (including MRI and CT scans if requested by a specialist) subject to the Specialist Benefit limit provided that the specialist authorisation was obtained. Formulary not applicable for radiology requested by the specialist, however, patients should use our network of radiologists, ultrasonographers or radiographers.

* If a patient is treated by a provider participating in the KeyCare Specialist Network, there will be no shortfall in payment for the patient subject to the Specialist Benefit limit and benefit rules. Members may have a co-payment when using providers who are not part of the KeyCare Specialist Network.

THE SPECIALIST BENEFIT DOES NOT COVER THE FOLLOWING

- Allied, therapeutic and psychology healthcare professionals and alternative healthcare providers, for example psychologists, physiotherapists and homeopaths.
- Any treatment relating to a waiting period or if the membership is not active.
- Non-COVID-19-related vaccines.
- Any specialist visits not authorised by Discovery Health.

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 members on a KeyCare Start Plan. For KeyCare Start, a specialist authorisation is required for visits to a maxillofacial surgeon, periodontist, ophthalmologist as well as for an initial referral for maternity care to a gynaecologist within the patient's chosen regional network.

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

IF A SPECIALIST NEEDS TO REFER THE PATIENT TO ANOTHER SPECIALIST:

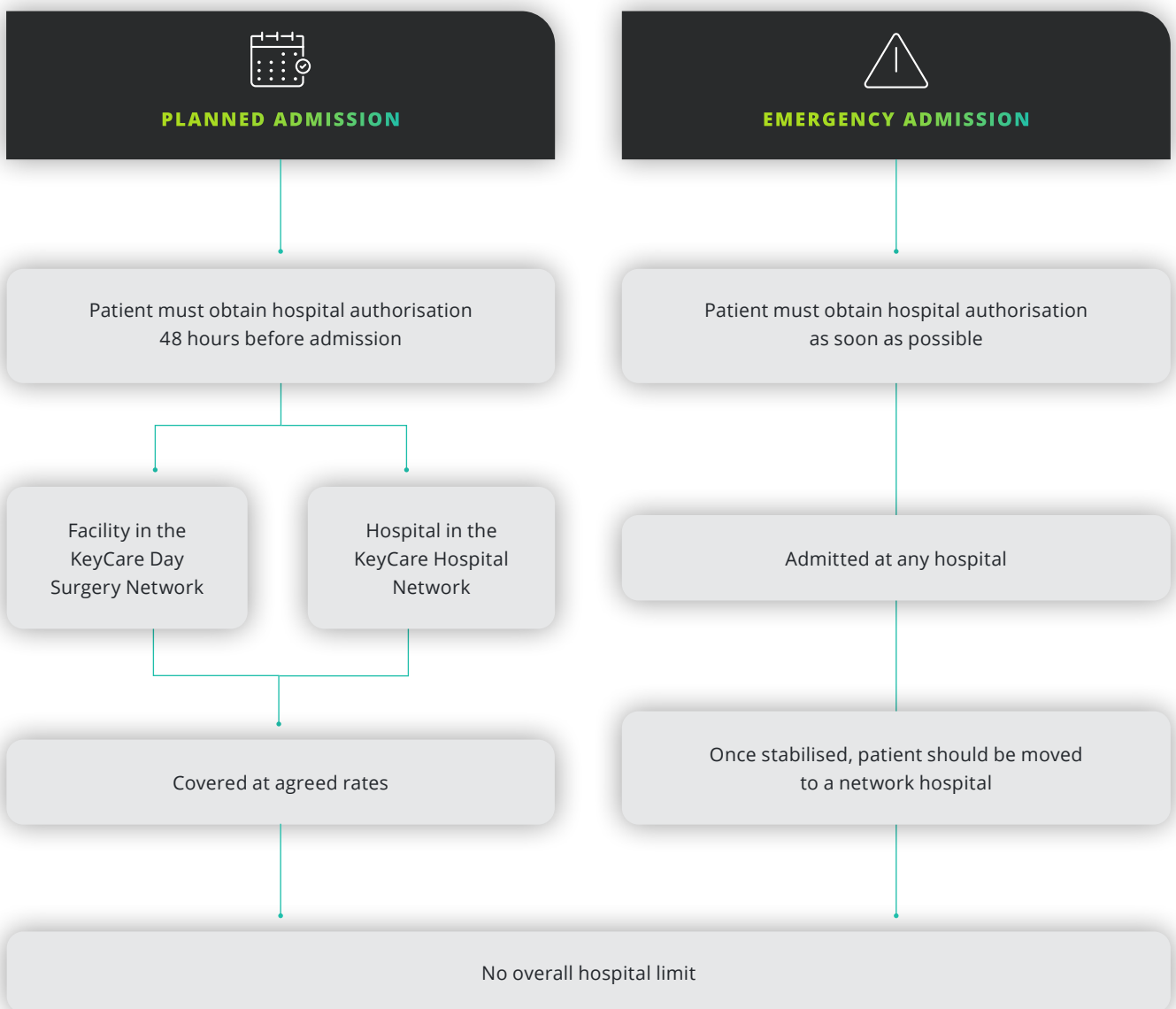
- Complete the KeyCare specialist to specialist referral form or
- Phone our contact centre at **0860 44 55 66** for an urgent referral.



Hospital benefit

KEYCARE CORE AND KEYCARE PLUS PLANS

- **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. Funding will not be available if the member's secondary GP admits the member into hospital. 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 R190 of the patient's medicine to take home after discharge, only if it is included in the hospital account.

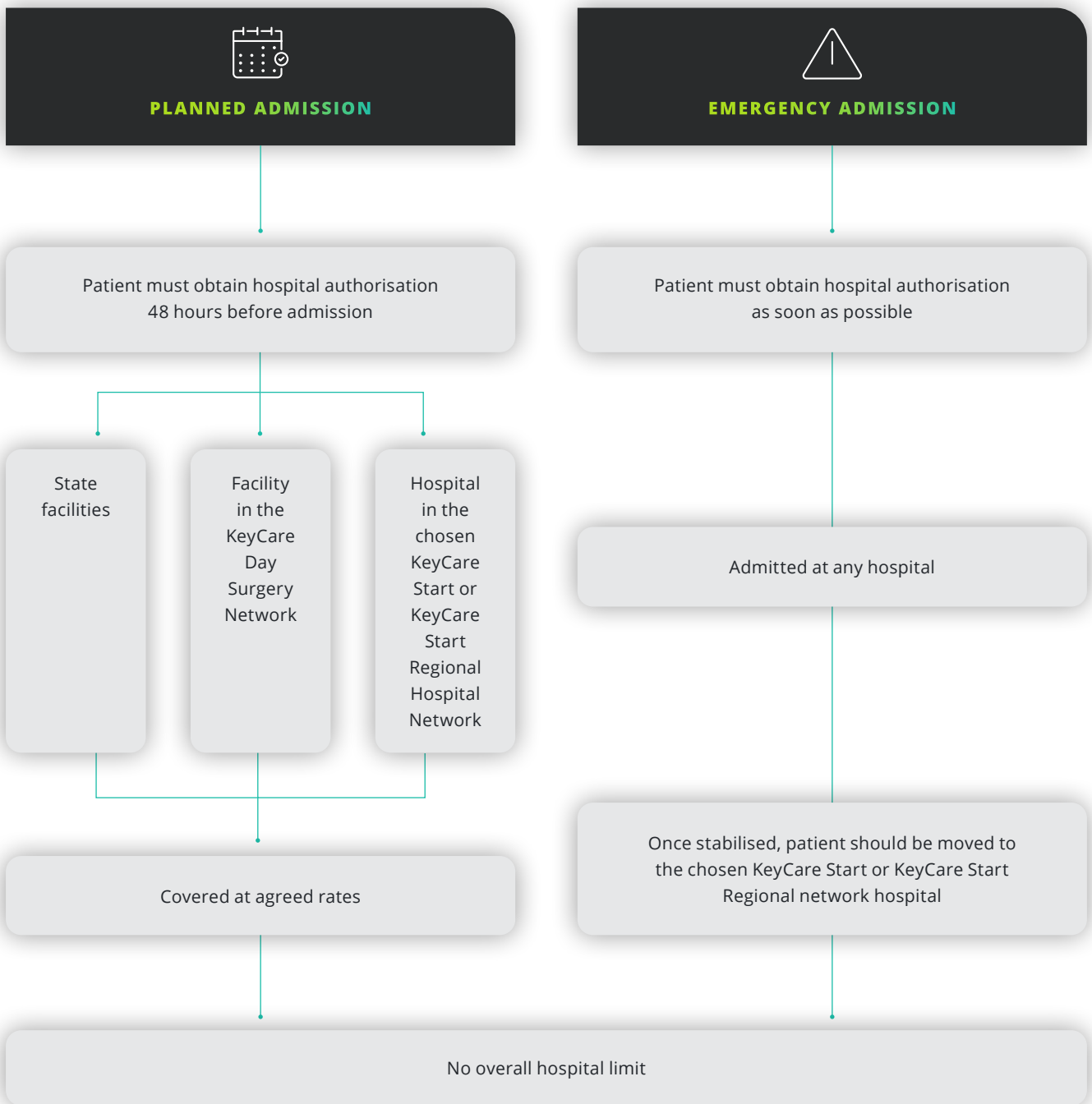


KEYCARE START PLAN

For GP admissions: The GP must be the member's chosen GP, have admitting rights at the member's 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 KeyCare Start and KeyCare Start Regional Network Hospital based on the member's chosen GP and regional network 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 KeyCare 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 KeyCare day clinic or a KeyCare day-rate hospital

Payment at agreed rates

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

Exclusions

In addition to the general exclusions that apply to all plans, the KeyCare plans do 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
 - Arthroscopies
 - Knee and shoulder surgery
 - 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, processors and hearing aids)
 - Healthcare services that should be done out of hospital and for which an admission to hospital is not necessary.
 - Endoscopic procedures
- 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 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 the 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 waiting periods.

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, or KeyCare Start Regional members have access to after-hours care at their chosen KeyCare Start or KeyCare Start Regional GP or network provider.



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 part of the defined list of 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 applicable to 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 conditions 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.

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.

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 consent.
- If the patient needs new or additional medicine to treat their approved chronic condition, you can call us on **0860 44 55 66**.

CONSULTATIONS AND TESTS FOR AN APPROVED CHRONIC CONDITION

- 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.
- 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.
- 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.

DESIGNATED SERVICE PROVIDER FOR CHRONIC MEDICINES

- Patients on the KeyCare Plus and Keycare Core plans need to get their approved chronic medicine from one of our network pharmacies to avoid a 20% co-payment or from their 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 to pay 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. Patients on the KeyCare Regional plan need to get their approved chronic medicine from their allocated regional pharmacy. If patients get their chronic medicine from anywhere else, they will have to pay a 20% co-payment.



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 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, and up to three consultations with their enrolling Premier Plus GP, referral to a psychiatrist consultation 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 specific 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 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 their plan. Benefits will be activated when your pregnancy profile is created in the Discovery app, on our website www.discovery.co.za, when the delivery is preauthorised or when the baby is registered 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.

Members must nominate a GP in the KeyCare GP Network to manage their chronic condition. To get full cover for GP consultations and referred healthcare services, such as radiology and pathology, the member must visit their nominated GP. If the member visits a GP, or is referred to healthcare services by any doctor other than their nominated GP, a 20% co-payment will apply. Members can change their nominated GP once a year.

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 patients 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 or KeyCare Start Regional 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 and KeyCare Start Regional members must receive their medicine from a state facility.	Not covered.
HIV monitoring blood tests	<p>The following HIV monitoring blood tests are covered for each patient each year if enrolled on the Discovery HIV Care Programme:</p> <ul style="list-style-type: none"> ■ 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** and 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 and KeyCare Start Regional 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. The Scheme also pays for approved medicine prescribed during active treatment to treat symptoms resulting from cancer treatment. All approved medicines are covered in full up to the Scheme rate if the medicine is on the supportive formulary. Medicines not listed on the formulary will be covered up to the Reference Price and 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.

COLORECTAL CANCER (CRC) PROGRAMME

The CRC programme aims at providing CRC patients with good quality of care, based on the principles of centres of excellence and supported by bidirectional electronic information sharing; which enables monitoring and evaluation to guide decision making on the improvement of care.

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 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 HealthID can submit radiology requests through HealthID.
- 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.

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 for 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. This is limited to one elective casualty visit per member per year, with the exception of TFG Health Plan as this remains 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 and KeyCare Start Regional, 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 and KeyCare Start Regional Hospital Network

We cover your patients on the KeyCare Start and KeyCare Start Regional Plan in full at the agreed rate in their chosen KeyCare Start and KeyCare Start Regional 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 and KeyCare Start Regional Network Hospital in their region.

To view the most up-to-date KeyCare Start Network Hospital list, please **[click here](#)**.

KeyCare Start Regional Hospital Network

We cover your patients on the KeyCare Start Regional Plan in full at the agreed rate in their chosen KeyCare Start Regional 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 Regional GP your patients will have access to a KeyCare Start Regional Network Hospital in their region.

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 Day Surgery Network 2022

If your patients on 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 or KeyCare Start Regional Plan do not use one of the hospitals in the KeyCare Start or KeyCare Start Regional Day Surgery 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

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 44 55 66

Health professional | +27 83 123 88 77

PRESCRIBED MINIMUM BENEFIT APPLICATIONS

Email | PMB_APP_FORMS@discovery.co.za

Telephone | 0860 44 55 66

Health professional | +27 83 123 88 77

HIV AND AIDS DISEASE MANAGEMENT PROGRAMME TEAM

Email | HIV_Diseasemanagement@discovery.co.za

Telephone | 0860 44 55 66

PATIENT CONTACT CENTRE

Email | healthinfo@discovery.co.za

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

HOSPITAL PREAUTHORISATIONS TEAM

Telephone | 0860 44 55 66

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.



www.discovery.co.za



Contact centre 0860 99 88 77



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