

2020 KEYCARE PLANS

Healthcare for your life



WELCOME TO

DISCOVERY HEALTH MEDICAL SCHEME

Discovery Health Medical Scheme provides health plans that are as unique as you are. Seamless, personalised, connected health cover to protect you and those that you care for most, at every stage of your life.

Read this guide to understand how your chosen health plan works including:

- What to do when you need to go to a doctor or to a hospital
- The preventative screening, medical conditions and treatments that we cover
- The payment rules for medicine and other treatments
- Which benefits you need to apply for and if there are any limits for certain benefits
- The medical conditions and treatments that we do not cover
- Tips for you to conveniently manage and access all the information for your chosen health plan using the Discovery app and website



The benefits explained in this brochure are provided by Discovery Health Medical Scheme, registration number 1125, administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider. This brochure is only a summary of the key benefits and features of Discovery Health Medical Scheme plans, awaiting formal approval from the Council for Medical Schemes. In all instances, Discovery Health Medical Scheme Rules prevail. Please consult the Scheme Rules on www.discovery.co.za. When reference is made in this brochure to “we” in the context of benefits, members, payments or cover, this refers to Discovery Health Medical Scheme. We are continuously improving our communication to you. The latest version of this guide as well as detailed benefit information is available on www.discovery.co.za.

KEY TERMS

ABOUT SOME OF THE TERMS WE USE IN THIS DOCUMENT

C CHRONIC ILLNESS BENEFIT (CIB)

The Chronic Illness Benefit (CIB) covers you for a defined list of chronic conditions. You need to apply to have your medicine and treatment covered for your chronic condition.

CO-PAYMENT

This is an amount that you need to pay towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service or if the amount the service provider charges is higher than the rate we cover.

COVER

Cover refers to the benefits you have access to and how we pay for these healthcare services such as consultations, medicine and hospitals, on your health plan.

D DAY-TO-DAY BENEFITS

You have cover for a defined set of day-to-day medical expenses such as medically appropriate GP consultations, blood tests, X-rays or medicine in our KeyCare networks.

DEDUCTIBLE

Depending on the plan you choose, this is an upfront amount that you must pay to the hospital for specific treatments/procedures.

DESIGNATED SERVICE PROVIDER (DSP)

A healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have an agreement with to provide treatment or services at a contracted rate. Visit www.discovery.co.za or click on Find a provider on the Discovery app to view the full list of DSPs.

DISCOVERY HEALTH RATE (DHR)

This is a rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services. This rate may vary depending on the plan you choose.

DISCOVERY HEALTH RATE FOR MEDICINE

This is the rate we pay for medicine. It is the Single Exit Price of medicine plus the relevant dispensing fee.

DISCOVERY HOME CARE

Discovery Home Care is an additional service that offers you quality home-based care in the comfort of your home for healthcare services like IV infusions, wound care, post-natal care and advanced illness care.

E EMERGENCY MEDICAL CONDITION

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 for additional information to confirm the emergency.

F FIND A HEALTHCARE PROVIDER

Find a healthcare provider is a medical and provider search tool which is available on the Discovery app or website www.discovery.co.za.





H HEALTHID

HealthID is an online digital platform that gives your doctor fast, up-to-date access to your health information. Once you have given consent, your doctor can use HealthID to access your medical history, make referrals to other healthcare professionals and check your relevant test results.

M MEDICINE LIST (FORMULARY)

A list of medicine we cover in full for the treatment of approved chronic condition(s). This list is also known as a formulary.

N NETWORKS

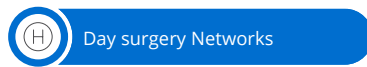
You may need to make use of specific hospitals, pharmacies, doctors or specialists in a network. We have payment arrangements with these providers to ensure you get access to quality care at an affordable cost. By using network providers, you can avoid having to pay additional costs and co-payments yourself.



You have chosen a plan with a hospital network, make sure you use a hospital in that network to get full cover.



You have full cover for GPs and specialists in our networks who we have payment arrangements with.



Full cover for a defined list of procedures in our day surgery network.



Use a pharmacy in our network to enjoy full cover and avoid co-payments when claiming for chronic medicine on the prescribed medicine list.

P PAYMENT ARRANGEMENTS

The Scheme has payment arrangements with various healthcare professionals and providers to ensure that you can get full cover with no co-payments.

PREMIER PLUS GP

A Premier Plus GP is a network GP who has contracted with us to provide you with coordinated care for your defined chronic conditions.

PRESCRIBED MINIMUM BENEFITS (PMB)

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:

- An emergency medical condition
- A defined list of 270 diagnoses
- A defined list of 27 chronic conditions.

To access Prescribed Minimum Benefits, there are rules defined by the Council for Medical Schemes (CMS) that apply:

- Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit conditions
- The treatment needed must match the treatments in the defined benefits
- You must use Designated Service Providers (DSPs) in our network. This does not apply in emergencies. Where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service providers in our network, once your condition has stabilised. If you do not use a DSP we will pay up to 80% of the Discovery Health Rate (DHR). You will be responsible for the difference between what we pay and the actual cost of your treatment.

If your treatment doesn't meet the above criteria, we will pay according to your plan benefits.

R RELATED ACCOUNTS

Any account other than the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology.

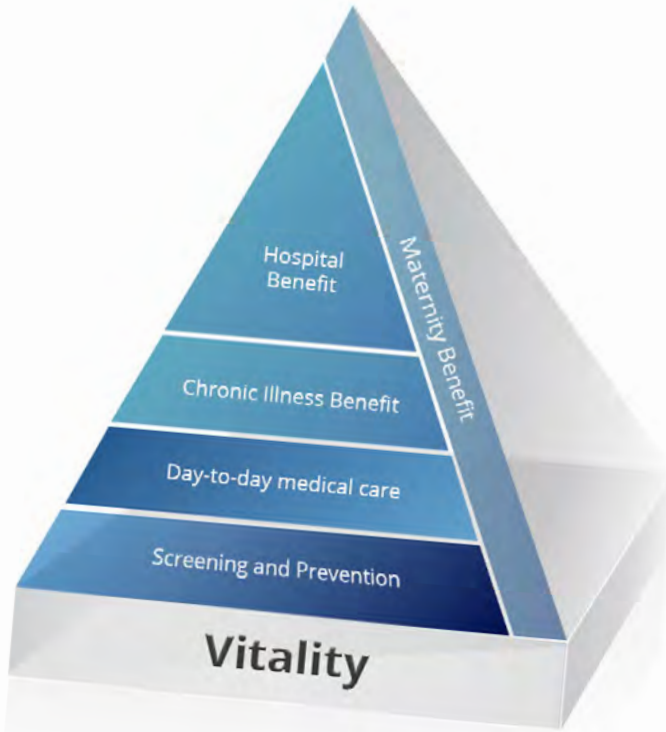


KEYCARE PLANS

There are three KeyCare plan options:
KeyCare Plus | KeyCare Core | KeyCare Start



KEY FEATURES



UNLIMITED COVER FOR HOSPITAL ADMISSIONS

Unlimited hospital cover in our KeyCare hospital networks.

FULL COVER IN HOSPITAL FOR SPECIALISTS

Guaranteed full cover in hospital for specialists on the KeyCare network, and up to 100% of the Discovery Health Rate (DHR) for other healthcare professionals.

DAY-TO-DAY COVER

Unlimited cover for medically appropriate GP consultations, blood tests, X-rays or medicine in our KeyCare networks on the KeyCare Plus and KeyCare Start plans.

FULL COVER FOR CHRONIC MEDICINES

Essential cover for chronic medicine on the KeyCare medicine list for all Chronic Disease List (CDL) conditions when you use a Designated Service Provider (DSP). Cover depends on the plan you choose.

EXTENSIVE COVER FOR PREGNANCY

You get comprehensive benefits for maternity and early childhood that cover certain healthcare services before and after birth.

SCREENING AND PREVENTION

Screening and prevention benefits that cover vital tests to detect early warning signs of serious illness.

The benefits on the different KeyCare plans

*The three plan options have differences in benefits, as shown in the table.
All other benefits not mentioned in the table are the same across all plan options.*

	Plus	Core	Start
Day-to-day cover	Day-to-day cover at your chosen KeyCare GP. Medicine from our medicine list is covered in at a network pharmacy Specialists are covered up to R4 400 per person per year, if you are referred by your KeyCare Network GP	Specialists are covered up to R4 400 per person per year. This plan does not offer any additional day-to-day cover	Primary care is covered at your chosen KeyCare Start GP Medicine from our medicine list is covered in full if you use a network pharmacy Two specialist visits up to R2 200 per person per year, if you are referred by your KeyCare Start Network GP
Non-emergency casualty visits	Cover for one casualty visit per person per year in any casualty unit at a hospital in the KeyCare network. Unlimited for emergencies You pay the first R390 of the consultation. You must get approval before your visit	Not covered	We cover after-hours care at your chosen KeyCare Start GP or network provider
Chronic medicine prescriptions	Your approved chronic medication must be dispensed by your KeyCare GP, or you must get your approved chronic medicine from a pharmacy in the network	Any KeyCare Network GP can prescribe your approved chronic medicine and you must get your approved chronic medicine from a pharmacy in the network	Your chronic medicine is covered in a state facility
Cancer	We cover your treatment if it is a Prescribed Minimum Benefit (PMB). You must use a network provider		Your treatment is covered in a state facility
Chronic Dialysis	You must use a network provider once you are registered, or you can go to a state facility. If you go elsewhere we will pay 80% of the Discovery Health Rate (DHR)		You are covered at a provider in a state facility
Full Cover Hospital Network	We pay up to the Discovery Health Rate (100%)		We pay the Discovery Health Rate (DHR) at your chosen KeyCare Start Network Hospital
Partial Cover Hospital Network	We pay up to 70% of the hospital account and you must pay the balance of the account. If the admission is a Prescribed Minimum Benefit (PMB), we will pay 80% of the Discovery Health Rate (DHR)		No cover for non-emergency admissions
Defined list of procedures in a day surgery network	Covered in the KeyCare Day Surgery Network		Covered in the KeyCare Start Day Surgery Network



What is a medical emergency?

An emergency medical condition, also referred to as an emergency, is the sudden and unexpected onset of a health condition that requires immediate medical and surgical treatment. Failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy.

An emergency does not necessarily require a hospital admission. We may ask you or your treating provider for additional information to confirm the emergency.

What we pay for

We pay for all of the following medical services that you may receive in an emergency:

- the ambulance (or other medical transport)
- the account from the hospital
- the accounts from the doctor who admitted you to the hospital
- the anaesthetist
- any other healthcare provider that we approve.



Emergency cover

Emergencies are covered in full. If you have an emergency, you can go straight to hospital. If you need medically equipped transport, like an ambulance call:

0860 999 911

Emergency Assist



Click on Emergency Assist on your Discovery app

Prescribed Minimum Benefits (PMB)

Prescribed Minimum Benefit (PMB) conditions in terms of the Medical Schemes Act 131 of 1998 and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- An emergency medical condition
- A defined list of 270 diagnoses
- A defined list of 27 chronic conditions.

To access Prescribed Minimum Benefits, there are rules defined by the Council for Medical Schemes (CMS) that apply:

- Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit conditions
- The treatment needed must match the treatments in the defined benefits
- You must use Designated Service Providers (DSPs) in our network.

This does not apply in emergencies. Where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service providers in our network once your condition has stabilised. If your treatment doesn't meet the above criteria, we will pay up to 80% of the Discovery Health Rate (DHR). You will need to pay the difference between what we pay and the actual cost of your treatment.



You have access to essential screening and prevention benefits

We cover various screening tests at our wellness providers.

This benefit pays for certain tests that can detect early warning signs of serious illnesses. We cover various screening tests at our wellness providers, for example, blood glucose, cholesterol, HIV, Pap smears, mammograms and prostate screenings.

SCREENING FOR KIDS

This benefit covers growth assessment tests, including height, weight, head circumference and health and milestone tracking at any one of our wellness providers.

SCREENING FOR ADULTS

This benefit covers certain tests such as blood glucose, blood pressure, cholesterol, body mass index and HIV screening at one of our wellness providers. We also cover a mammogram every two years, a Pap smear once every three years, a PSA test (prostate screening) each year and bowel cancer screening tests every two years for members between 45 and 75 years.

HOW WE PAY

These tests are paid from the Screening and Prevention Benefit. Consultations that do not form part of PMBs will be paid from your available day-to-day benefits where applicable.



View a list of our wellness providers on our website www.discovery.co.za

ADDITIONAL TESTS

Clinical entry criteria apply to these tests:

- Defined diabetes and cholesterol screening tests
- Breast MRI or mammogram and once-off BRCA testing for breast screening
- Colonoscopy for bowel cancer screening
- Pap smear for cervical screening.

Seasonal flu vaccine for members who are:

- Pregnant
- 65 years or older
- Registered for certain chronic conditions.

Visit www.discovery.co.za to view the detailed Screening and Prevention benefit guide.

Your day-to-day cover

You have access to the following day-to-day cover on KeyCare Plus and KeyCare Start plans. On KeyCare Start your chosen KeyCare Start GP must refer you and you must use providers in your chosen KeyCare Start network.

Day-to-day cover	What we pay
GP visits	You have unlimited cover for medically appropriate GP consultations. When joining, you must choose a GP from the KeyCare or KeyCare Start GP network, depending on the plan you choose. You must go to your chosen GP for us to cover your consultations, including some minor procedures. Preauthorisation is required after your 15th GP visit.
Blood, urine and other fluid and tissue tests	We pay for a list of blood, urine and other fluid and tissue tests from a network provider. Your chosen GP must ask for these tests by filling in a KeyCare pathology form.
Day-to-day medicine	We pay for medicine from our medicine list if they are prescribed and/or dispensed by your chosen KeyCare Network GP or chosen KeyCare Start network GP, depending on the plan you choose.
Basic X-rays	We pay for a list of basic X-rays at a network provider. Your chosen GP must ask for the X-rays to be done.
Out-of-network GP visits	On KeyCare Plus, if you need to see a doctor and your chosen GP is not available, each person on your plan can go to any GP for an out-of-network visit. On KeyCare Start you can go to any KeyCare Network GP for an out-of-network visit. Out-of-network GP visits are limited to four visits per person on KeyCare Plus and two per person on KeyCare Start each year, covered up to the DHR, depending on the plan you choose. We will cover the GP visit, selected blood tests and X-rays, and medicine on our medicine list.
Eye care	We cover one eye test for each person, but you must go to an optometrist in the KeyCare Optometry Networks. The optometrist will have a specific range of glasses which you can choose from. You can get a set of contact lenses instead of glasses if you choose to. You can get new glasses or contact lenses every 24 months.
Dentistry	We cover consultations, fillings and tooth removals at a dentist in our dentist network. Certain rules and limits may apply.
Casualty visits	On KeyCare Plus you have cover for one casualty visit per person per year at any casualty unit at a hospital in the KeyCare network. You must pay the first R390. On KeyCare Start you can go to your chosen KeyCare Start GP or network provider for after-hours care.
Medical equipment	On KeyCare Plus, we cover wheelchairs, wheelchair batteries and cushions, transfer boards and mobile ramps, commodes, long-leg calipers, crutches and walkers on the medical equipment list, if you get them from a network provider. There is an overall limit of R5 400 for each family.
Specialist Benefit	Specialist cover up to R4 400 on KeyCare Plus and KeyCare Core, and up to two visits up to R2 200 on KeyCare Start per person per year. Your chosen GP must refer you to a specialist and you need a reference number from us before your consultation with the specialist. On KeyCare Plus, if you need to see a maxillo-facial surgeon, periodontist, ophthalmologist or a specialist for maternity care, you do not need a referral from your GP or a reference number from us. Out-of-hospital MRI and CT scans are paid up to the Specialist Benefit limit. Cover depends on the plan you choose.
Other types of healthcare	We do not cover other types of healthcare professionals, such as physiotherapists, psychologists, speech therapists, audiologists, homeopaths or chiropractors.





You get cover for healthcare services related to your pregnancy and treatment for the first two years of your baby's life. This applies for each pregnancy and for each child from birth until they are two years old.

HOW TO GET THE BENEFIT

You can activate the benefit in any of these ways:

- Create your pregnancy profile in the Discovery app or on our website at www.discovery.co.za
- When you register your baby as a dependant on the Scheme.



Activate your pregnancy profile on the Discovery app

You have cover for maternity and early childhood

DURING PREGNANCY



AFTER YOU GIVE BIRTH



Antenatal consultations

We pay for up to eight consultations with your gynaecologist, GP or midwife.

Ultrasound scans and screenings during pregnancy

You are covered for up to two 2D ultrasound scans, including one nuchal translucency test. 3D and 4D scans are paid up to the rate we pay for 2D scans. You are also covered for one chromosome test or Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria.

Flu vaccinations

We pay for one flu vaccination during your pregnancy.

Pre- and postnatal care

We pay for a maximum of five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth. We pay for one breastfeeding consultation with a registered nurse or a breastfeeding specialist.

To activate these benefits on KeyCare Start your chosen GP must refer you.

Visit www.discovery.co.za to view the detailed Maternity Benefit guide.

Blood tests

We pay for a defined list of blood tests for each pregnancy.

GP and specialists to help you after birth

Your baby under the age of two years is covered for two visits to a GP, paediatrician or an ear, nose and throat specialist.

Other healthcare services

You also have access to postnatal care, which includes a postnatal consultation within six-weeks post-birth, a nutritional assessment with a dietitian and two mental healthcare consultations with a counsellor or psychologist.



You have cover for treatment of ongoing medical conditions (chronic conditions)

WHAT IS THE BENEFIT

The Chronic Illness Benefit (CIB) covers you for a defined list of chronic conditions on the Chronic Disease List (CDL).

WHAT WE COVER

Prescribed Minimum Benefit (PMB) conditions

You have access to treatment for a list of medical conditions under the Prescribed Minimum Benefits (PMBs). The PMBs cover the 27 chronic conditions on the Chronic Disease List (CDL).

Our plans offer benefits that are richer than PMBs. To access PMBs, certain rules apply.

HOW WE PAY FOR MEDICINE

We pay for medicine up to a maximum of the Discovery Health Rate (DHR). The DHR for medicine is the price of the medicine and the fee for dispensing it.

Visit www.discovery.co.za to view the detailed Chronic Illness Benefit guide.

WHERE TO GET YOUR MEDICINE

You need to get your approved chronic medicine that is on the KeyCare medicine list from one of our network pharmacies or from your chosen KeyCare GP (if he or she dispenses medicine). If you get your medicine from anywhere else, you will have to pay 20% of the Discovery Health Rate (DHR) for medicines. For medicine not on our list, we cover you up to the cost of the lowest formulary listed drug.

On KeyCare Start, you must use a state facility.

HOW TO GET THE BENEFIT

You must apply for the Chronic Illness Benefit. Your doctor must complete the form online or send it to us for approval.

MEDICINE TRACKER

You can set up reminders and prompts to assist you with taking your medicine on time and as prescribed. Your approved chronic medicines will automatically be displayed, and you will then be prompted to take your medicine and confirm when each dose is taken.



CHRONIC BENEFITS



CHRONIC DISEASE LIST (CDL) CONDITIONS

Chronic conditions covered
on KeyCare plans

- A** Addison's disease, asthma
- B** Bipolar mood disorder, bronchiectasis
- C** Cardiac failure, cardiomyopathy, chronic obstructive pulmonary disease, chronic renal disease, coronary artery disease, Crohn's disease
- D** Diabetes insipidus, diabetes Type 1, diabetes Type 2, dysrhythmia
- E** Epilepsy
- G** Glaucoma
- H** Haemophilia, HIV, hyperlipidaemia, hypertension, hypothyroidism
- M** Multiple sclerosis
- P** Parkinson's disease
- R** Rheumatoid arthritis
- S** Schizophrenia, systemic lupus erythematosus
- U** Ulcerative colitis



Member Care Programme – for members with one or more chronic conditions

If you are diagnosed with one or more chronic conditions, you might qualify for our Member Care Programme. We will contact you to confirm if you do qualify. The programme offers organised care to help you to manage your conditions and to get the best quality healthcare.

If you are registered and take part in the programme, we will pay in full for your treatment.

If you choose not to take part, we will cover the hospital and related accounts up to 80% of the Discovery Health Rate (DHR).

If you need chronic dialysis

Once you are registered, we will allocate you to a network provider or you can go to a state facility. If you go elsewhere, we will pay up to 80% of the Discovery Health Rate (DHR).

On KeyCare Start you have cover at a provider in a state facility.



TRACK YOUR HEALTH

You can get personalised health goals that help you to manage your weight, nutrition and exercise. If you are at risk of developing or you are diagnosed with cardiovascular disease or diabetes, we will give you goals tailored to your circumstances. You can track your progress on the Discovery app and we will reward you for meeting your goals.



Click on Track your Health on the Discovery app to activate the programme

Condition-specific care programmes for diabetes, mental health, HIV and heart conditions

We cover condition-specific care programmes that help you to manage diabetes, mental health, HIV or heart-related medical conditions. You have to be registered on these condition-specific care programmes to unlock additional benefits and services. You and your Premier Plus GP can track progress on a personalised dashboard to identify the next steps to optimally manage your condition and stay healthy over time.



MENTAL HEALTH PROGRAMME

If you meet the Scheme's clinical entry criteria you have access to defined cover for the management of episodes of major depression. Enrolment on the programme unlocks cover for prescribed medicine, and additional GP consultations to allow for effective evaluation, tracking and monitoring of treatment.



DIABETES CARE PROGRAMME

If you are registered on the Chronic Illness Benefit for diabetes, you can join the Diabetes Care programme. The programme unlocks cover for additional consultations with dietitians and biokineticists. You also have access to a nurse educator to help you with the day-to-day management of your condition. You have to see a Premier Plus GP to avoid a 20% co-payment.



HIV CARE PROGRAMME

If you are registered on the HIV programme, you are covered for the care you need, which includes additional cover for social workers. You can be assured of confidentiality at all times. You have to see a Premier Plus GP to avoid a 20% co-payment. You need to get your medicine from a Designated Service Provider (DSP) to avoid a 20% co-payment.



CARDIO CARE PROGRAMME

If you are registered on the Chronic Illness Benefit for hypertension, hyperlipidaemia and ischaemic heart disease you have access to a defined basket of care and an annual cardiovascular assessment, if referred by your Premier Plus GP and enrolled on the Cardio Care programme.



You have comprehensive cover for cancer

PRESCRIBED MINIMUM BENEFITS (PMB)

Cancer treatment that is a Prescribed Minimum Benefit (PMB), is always covered in full. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount we will continue to cover your PMB cancer treatment in full. On the KeyCare plans we cover cancer treatment in our network, or in a state facility if you are on KeyCare Start. If you choose to use any other provider, we will only cover up to 80% of the DHR.

ADVANCED ILLNESS BENEFIT

Members with cancer have access to a comprehensive palliative care programme. This programme offers unlimited cover for approved care at home.

ONCOLOGY BENEFIT

If you are diagnosed with cancer and once we have approved your cancer treatment, you are covered by the Oncology Care Programme. We cover your approved cancer treatment over a 12-month cycle.

All cancer-related healthcare services are covered up to 100% of the Discovery Health Rate (DHR). You might have a co-payment if you do not use the Designated Service Provider (DSP) or if your healthcare professional charges above this rate. On the KeyCare plans we cover cancer treatment in our network, or in a state facility if you are on KeyCare Start.

If you choose to use any other provider, we will only cover up to 80% of the DHR.

You need to get your approved oncology medicine on our medicine list from a Designated Service Provider (DSP) to avoid a 20% co-payment. Speak to your treating doctor to confirm that they are using our DSPs for your medicine and treatment received in rooms or at a treatment facility.

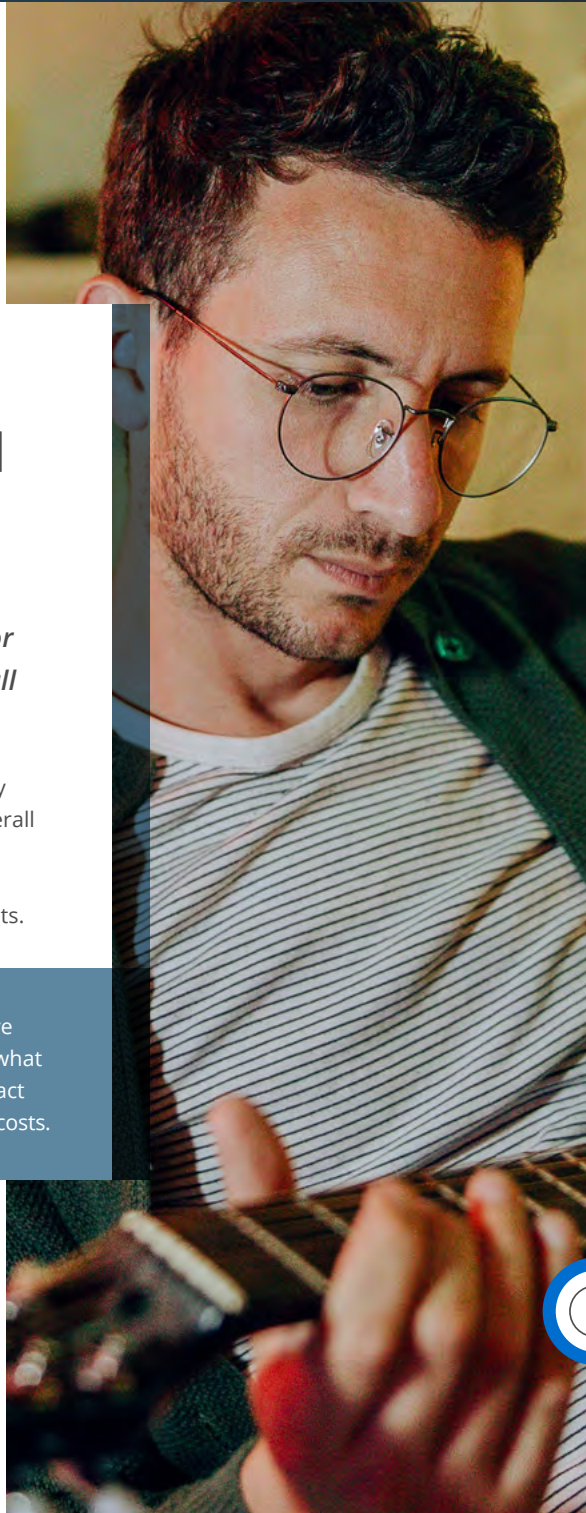
Visit www.discovery.co.za to view the detailed Oncology Benefit guide.

If you need to be admitted to hospital

The KeyCare plans offer cover for hospital stays. There is no overall limit for the hospital benefit.

If you have to go to hospital, we will pay your hospital expenses. There is no overall hospital limit for the year on any of the plans. However, there are limits to how much you can claim for some treatments.

Contact us in good time before you have to go to hospital. We will let you know what you are covered for. If you do not contact us before you go, we might not pay the costs.



WHAT IS THE BENEFIT?

This benefit pays the costs when you are admitted into hospital.

WHAT WE COVER

Unlimited cover in private hospitals approved by the Scheme, subject to the KeyCare network requirements.

You have cover for planned stays in our KeyCare hospital networks.

HOW TO GET THE BENEFIT

Get your confirmation first

Contact us to confirm your hospital stay before you are admitted (this is known as preauthorisation).

Where to go

You have cover for planned admissions in a defined network. For planned admissions at hospitals outside these KeyCare networks, you either have to pay the full amount or a portion of the hospital account.

View the KeyCare hospital networks on our website, www.discovery.co.za.

What we pay

We pay for planned hospital stays from your Hospital Benefit. We pay for services related to your hospital stay, including all healthcare professionals, services, medicines authorised by the Scheme for your hospital stay. If you use doctors, specialists and other healthcare professionals that we have an agreement with, we will pay for these services in full. We pay up to the Discovery Health Rate (DHR) for other healthcare professionals.

You can avoid co-payments by:

- Going to a hospital in the network of hospitals for your plan
- Using healthcare professionals that we have a payment arrangement with.



View hospitals in the KeyCare Hospital Networks using Find a healthcare provider on the Discovery app

Find a healthcare provider is brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

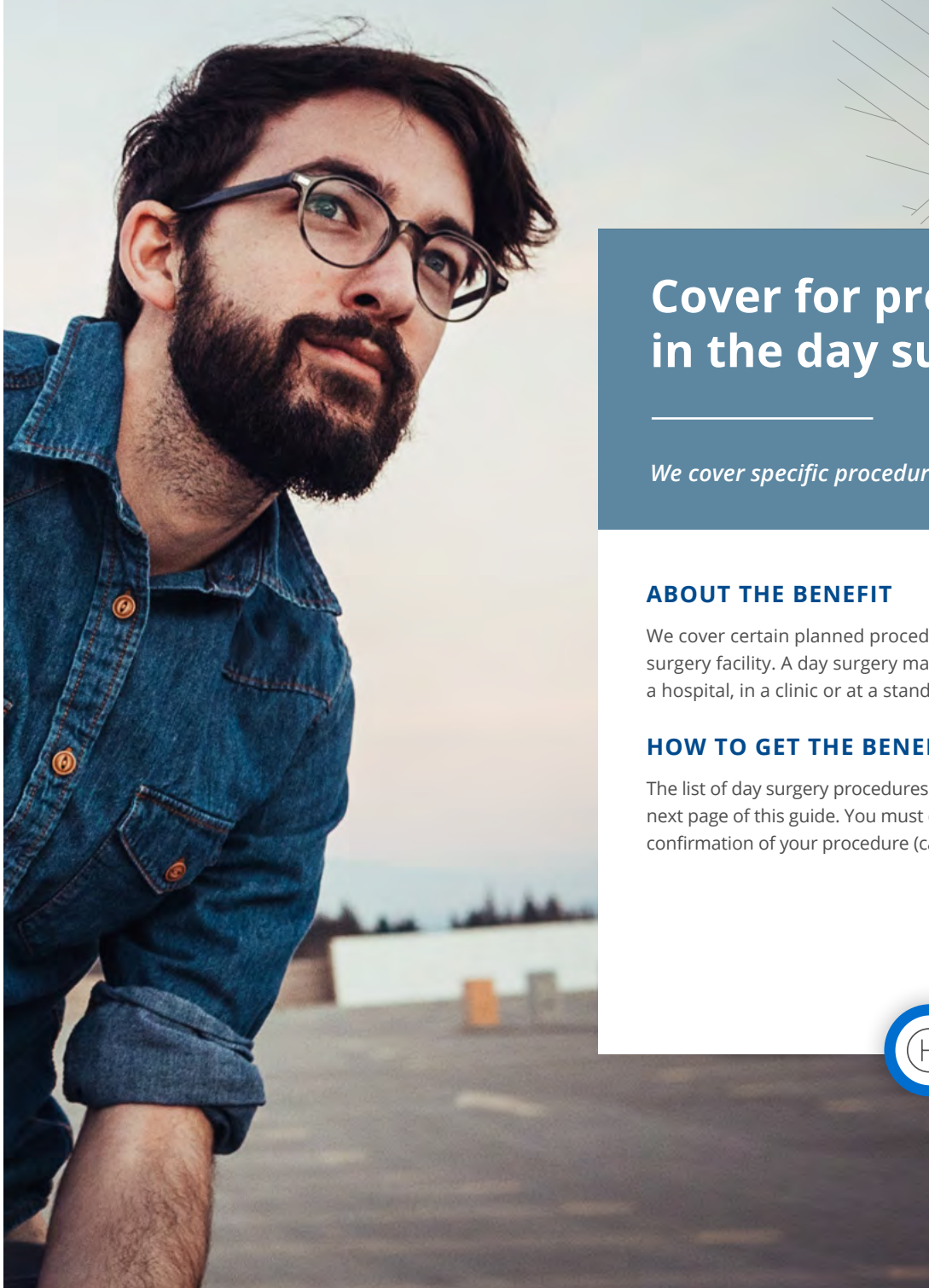


Your hospital cover

The KeyCare Plans offer unlimited hospital cover.

The table below shows how we pay for your approved hospital admissions:

	Plus	Core	Start
Full Cover Hospital Network	We pay up to the Discovery Health Rate (100%)		Covered in full at your chosen KeyCare Start Network Hospital
	If you do not use your chosen hospital in the networks, you will have to pay all the costs. This does not apply in an emergency		
Partial Cover Hospital Network	We pay up to 70% of the hospital account and you must pay the balance of the account. If the admission is a Prescribed Minimum Benefit, we will pay 80% of the Discovery Health Rate (DHR)		No cover for non-emergency admissions
Defined list of procedures in a day surgery network	Covered in the KeyCare Day Surgery Network		Covered in the KeyCare Start Day Surgery Network
Non-network hospitals	We will not pay the hospital and related accounts if you are admitted to a non-network hospital for a planned procedure. If the admission is a Prescribed Minimum Benefit (PMB), we will pay 80% of the Discovery Health Rate (DHR)		
Specialists and healthcare professionals in our network	Full cover		Full cover at a contracted provider in your KeyCare Start Network Hospital.
Specialists and healthcare professionals not in our network	The Discovery Health Rate (DHR). If they charge more, you must pay the balance of the account		We will pay the Discovery Health Rate (DHR) for providers at your KeyCare Start hospital who we do not have a payment arrangement with, you must pay the balance of the account
X-rays and blood tests (radiology and pathology)	The Discovery Health Rate (DHR)		The Discovery Health Rate (DHR)
Cover for scopes (gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy)	Prescribed Minimum Benefit (PMB) cover in the KeyCare Day Surgery Network. Authorised scopes done in the doctor's rooms will be covered from your Hospital Benefit		Prescribed Minimum Benefit (PMB) cover in the KeyCare Start Day Surgery Network. Authorised scopes done in the doctor's rooms will be covered from your Hospital Benefit
Alcohol and drug rehabilitation	We pay for 21 days of rehabilitation per person per year. Three days per approved admission per person for detoxification.		
Mental health	21 days for admissions or up to 15 out-of-hospital consultations per 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. Three days per approved admission for attempted suicide. 21 days for other mental health admissions. All mental health admissions are covered in full at a network facility. If you go elsewhere, we will pay up to 80% of the Discovery Health Rate (DHR) for the hospital account.		



Cover for procedures in the day surgery network

We cover specific procedures that can be performed in a day surgery network facility.

ABOUT THE BENEFIT

We cover certain planned procedures in a day surgery facility. A day surgery may be inside a hospital, in a clinic or at a standalone facility.

HOW TO GET THE BENEFIT

The list of day surgery procedures are set out on the next page of this guide. You must contact us to get confirmation of your procedure (called preauthorisation).

How we pay

We pay these services from your Hospital Benefit. We pay for services related to your hospital stay, including all healthcare professionals, services, medicines authorised by the Scheme up to the Discovery Health Rate (DHR).

If you use doctors, specialists and other healthcare professionals that we have a payment arrangement with, we will pay for these services in full.

WHEN YOU HAVE TO PAY

If you go to a facility that is not in your plan’s day surgery network, you will have to pay the full account.

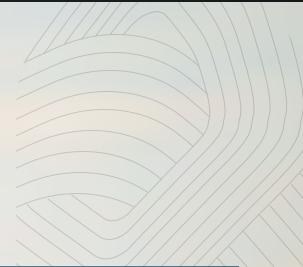
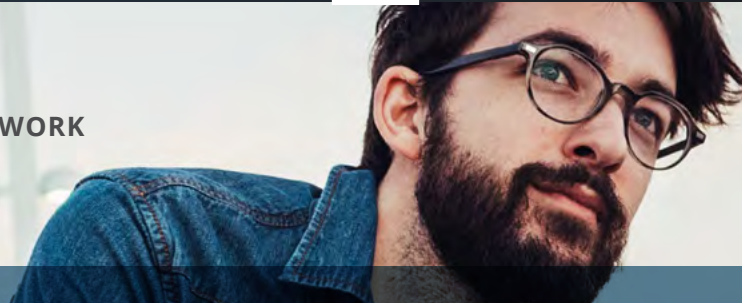


View all day surgery network facilities using Find a healthcare provider on the Discovery app.



LIST OF PROCEDURES COVERED IN THE DAY SURGERY NETWORK

The following is a list of procedures that we cover in a day surgery.



B Biopsies

- Skin*, subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes

Breast Procedures

- Mastectomy for gynaecomastia
- Lumpectomy* (fibroadenoma)

E Ear, nose and throat Procedures

- Tonsillectomy and/or adenoidectomy
- Repair nasal turbinates*, nasal septum*
- Simple procedures for nose bleed (extensive cautery)
- Sinus lavage*
- Scopes (nasal endoscopy*, laryngoscopy)
- Middle ear procedures (tympanoplasty, mastoidectomy, myringoplasty, myringotomy and/or grommets)

Eye Procedures

- Cataract surgery
- Corneal transplant*
- Treatment of glaucoma
- Other eye procedures (removal of foreign body, conjunctival surgery (repair laceration, pterygium), glaucoma surgery, probing & repair of tear ducts, vitrectomy, retinal surgery, eyelid surgery, strabismus repair)

G Ganglionectomy

Gastrointestinal

- Gastrointestinal scopes (oesophagoscopy, gastroscopy, colonoscopy, sigmoidoscopy, proctoscopy, anoscopy)*
- Anorectal procedures (treatment of haemorrhoids, fissure, fistula)

Gynaecological Procedures

- Diagnostic Dilatation and Curettage
- Endometrial ablation
- Diagnostic Hysteroscopy
- Colposcopy with LLETZ
- Examination under anaesthesia

O Orthopaedic Procedures

- Arthroscopy, arthrotomy (shoulder, elbow, knee, ankle, hand, wrist, foot, temporomandibular joint), arthrodesis (hand, wrist, foot)*
- Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty*)
- Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy). Subject to individual case review
- Repair bunion or toe deformity*
- Treatment of simple closed fractures and/or dislocations, removal of pins and plates. Subject to individual case review

R Removal of foreign body

- Subcutaneous tissue, muscle, external auditory canal under general anaesthesia

S Simple superficial lymphadenectomy

Skin Procedures

- Debridement
- Removal of lesions* (dependent on site and diameter)
- Simple repair of superficial wounds

U Urological

- Cystoscopy
- Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocoele, vasectomy)

Some of these procedures are not covered on KeyCare plans. These are noted by an asterisk * in the list above.



Extra benefits on your plan

You get the following extra benefits to enhance your cover.



HOME CARE BENEFIT



Discovery Home Care is a service that offers you quality care in the comfort of your own home when recommended by your doctor as an alternative to a hospital stay. Services include postnatal care, end-of-life care, IV infusions (drips) and wound care. These services are paid from the Hospital Benefit, subject to approval.

Discovery Home Care is the Designated Service Provider (DSP) for administration of defined intravenous infusions. Avoid a 20% co-payment by using Discovery Home Care for these infusions.



COMPASSIONATE CARE BENEFIT

The Compassionate Care Benefit gives you access to holistic home-based end-of-life care up to R48 200 per person in their lifetime, for care not related to cancer.

INTERNATIONAL SECOND OPINION SERVICES



Through your specialist, you have access to second opinion services from Cleveland Clinic for life-threatening and life-changing conditions. We cover 50% for the cost of the second opinion service.



CLAIMS RELATED TO TRAUMATIC EVENTS

The Trauma Recovery Extender Benefit extends your cover for out-of-hospital claims related to certain traumatic events. Claims are paid from the Trauma Recovery Extender Benefit for the rest of the year in which the trauma occurred, as well as the year after the event occurred. You need to apply for this benefit. The benefit does not apply to KeyCare Core plan.



Your contributions

KeyCare income bands	Main member	Adult	Child*
KeyCare Plus			
13 801+	R2 450	R2 450	R656
8 551 – 13 800	R1 659	R1 659	R468
0 – 8 550	R1 207	R1 207	R439
KeyCare Core			
13 801+	R1 809	R1 809	R410
8 551 – 13 800	R1 183	R1 183	R292
0 – 8 550	R949	R949	R245
KeyCare Start			
13 801+	R2 394	R2 394	R650
9 151 – 13 800	R1 538	R1 538	R601
0 – 9150	R914	R914	R550

* We count a maximum of three children when we calculate your monthly contributions. For any additional children, cover is free.

** Income verification will be conducted for the lower income bands. Income is considered as: the higher of the main member's or registered spouse or partner's earnings, commission and rewards from employment; interest from investments; income from leasing of assets or property; distributions received from a trust, pension and/or provident fund; receipt of any financial assistance in terms of any statutory social assistance programme.





EXCLUSIVE ACCESS TO VALUE-ADDED OFFERS

Our members have exclusive access to value-added offers outside of the Discovery Health Medical Scheme benefits and rules. Go to www.discovery.co.za to access these value-added offers.



SAVINGS ON PERSONAL AND FAMILY CARE ITEMS

You can sign up for Healthy Care to get savings on a vast range of personal and family care products at any Clicks or Dis-Chem. Healthy Care items include a list of baby care, dental care, eye care, foot care, sun care and hand care products, as well as first aid and emergency items and over-the-counter medicine.



SAVINGS ON STEM CELL BANKING

You get access to an exclusive offer with Netcells that gives expectant parents the opportunity to cryogenically store their newborn baby's umbilical cord blood and tissue stem cells for potential future medical use, at a discounted rate.



ACCESS TO VITALITY TO GET HEALTHIER

You have the opportunity to join the world's leading science-based wellness programme, Vitality, which rewards you for getting healthier. Not only is a healthy lifestyle more enjoyable, it is clinically proven that Vitality members live healthier, longer lives.

Vitality is not part of Discovery Health Medical Scheme. Vitality is a separate wellness product, sold and administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07, an authorised financial services provider. Healthy Care is brought to you by Discovery Vitality (Pty) Ltd, registration number 1997/007736/07, an authorised financial services provider. Netcells is brought to you by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

If you have a complaint

Discovery Health Medical Scheme is committed to providing you with the highest standard of service and your feedback is important to us. The following channels are available for your complaints.

PLEASE GO THROUGH THESE STEPS IF YOU HAVE A COMPLAINT:

01 | To take your query further

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

02 | To contact the Principal Officer

If you are still not satisfied with the resolution of your complaint after following the process in Step 1 you are able to escalate your complaint to the Principal Officer of the Discovery Health Medical Scheme. You may lodge a query or complaint with Discovery Health Medical Scheme by completing the online form on www.discovery.co.za or by e-mailing principalofficer@discovery.co.za.

03 | To lodge a dispute

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

04 | To contact the Council for Medical Schemes

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

