Be Smart. **Keep it Simple.**

KeyHealth
MEDICAL SCHEME

MEMBER GUIDE **2021**

Disclaimer: Although every precaution has been taken to ensure the accuracy of information contained in this member guide, the official rules of the Scheme will prevail, should a dispute arise. The rules of KeyHealth are available on request or can be viewed at **www.keyhealthmedical.co.za.**

KH 01/2021

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Be Smart. **Keep it Simple.**

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01 | KeyHealth Medical Scheme

1.1 KeyHealth

KeyHealth (referred to as 'the Scheme') has a formidable footprint in the industry (more than 70 000 lives) and provides a diverse range of products designed to cater for many different medical needs – real value for money for discerning individuals and families that know what they need.

Through various amalgamations, including Pretmed, Global Health and Munimed, the Scheme boasts a proud lineage dating back to the beginning of the 20th century. KeyHealth, therefore, exemplifies longevity, dependability and stability.

KeyHealth is an open medical scheme, meaning any member of the public can join. However, the Scheme is also one of only five accredited schemes selected to operate within local government in South Africa.

1.2 Scheme rules

It is imperative for members to study and have a clear understanding of the Scheme rules in order to avoid misconceptions and prevent resultant mistakes.

Please note: This member guide is only a summary of the latest Scheme rules. A copy of the official rules is available on request or on the website at **www.keyhealthmedical.co.za.** In the event of a dispute, the latest official Scheme rules, as registered with the Council for Medical Schemes, will apply.

1.3 Limitation of expenditure

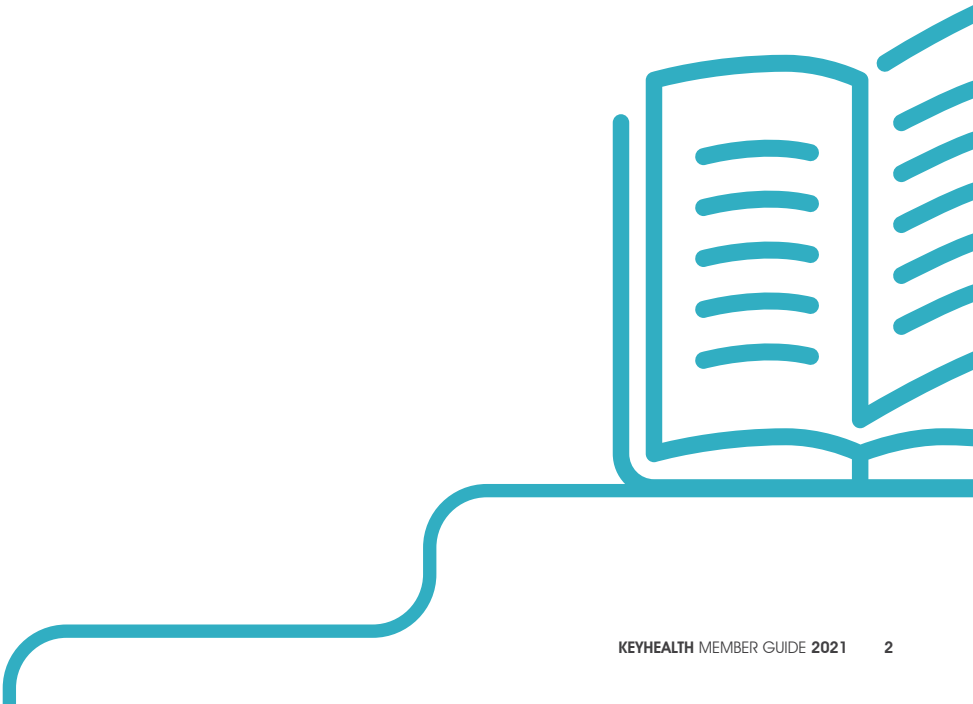
The careful use of medical services will assist in containing members' Scheme expenditure and limit future increases in membership fees to a minimum.

1.4 Exchange of benefits prohibited

Legislation prohibits the exchange of benefits between service categories, e.g. chronic medicine benefits may not be used for the payment of acute medicine claims.

1.5 The member's responsibilities

- Always comply with the prescribed treatment procedures.
- Enquire about the related costs of treatment when consulting service providers.
- Keep a record of all relevant medical documentation.
- Stay abreast of services offered by local health facilities.
- Ensure that the information reflected on statements is correct and keep statements for future reference.
- Follow up on claims that have not been paid. [A claim becomes 'stale' 4 (four) months from date of service, and payment will then be the responsibility of the member.]
- Read, take notice of and, if required, act upon all communication received from the Scheme.
- Manage benefits – new benefits received at the beginning of every benefit year are the member's healthcare 'budget' for that year; use it wisely and report abuse to the Scheme without delay.
- Do not give your membership card to anybody who is not a registered beneficiary.



02 | Glossary, abbreviations and explanations

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PM = Principal Member
AD = Adult Dependant
CD = Child Dependant
MSA = Medical Savings Account
pbpa = per beneficiary per annum (per year)
pbp2a = per beneficiary biennially (every second year)
pfpa = per family per annum (per year)
pfp2a = per family biennially (every second year)
2pfpa = two (2) (times) per family per annum (per year)

Agreed tariff:
A tariff as agreed upon between the Scheme and certain service providers.

Angiogram:
An angiogram is an X-ray examination where a special dye and camera (fluoroscopy) are employed to take pictures of the blood flow in arteries.

Beneficiary:
A Principal Member of the Scheme or a person registered as a dependant of a Principal Member.

Case management:
The application of rules, clinical protocols and medical procedures for the treatment of specific conditions.

Chronic Disease List (CDL):
A list of chronic illness conditions that are covered by the Scheme in terms of applicable legislation.

Chronic medication:
Prescribed medication continuously used for more than 3 (three) months for chronic conditions contained in the Scheme's PMB CDL (Category A, 26 conditions – all options) and/or the other conditions (Category B, 29 conditions on the Platinum option, 18 conditions on the Gold option and 3 (three) conditions on the Silver and Equilibrium options).

Conservative dentistry:
Basic dental services, such as fillings, extractions and preventative care.

Co-payment:
The portion of the amount due that a member must pay directly to the service provider involved and in accordance with the latest Scheme rules.

CT and MRI scans:
Specialised, high-definition external scanning methods for internal bodily examinations.

Day-to-day benefit:
On the Platinum, Gold, Silver, Equilibrium and Origin options – an annual, combined, non-transferable, out-of-hospital limit, which may be utilised (with due allowance for certain limitations) by any of the registered beneficiaries in respect of products and services as stated in the latest version of the different benefit structures.

Dental management:
A cost and quality Dental Management Programme provided and managed by DENIS (Dental Information Systems).

Designated Service Provider (DSP):
A healthcare provider or group of providers selected by the Scheme as the first choice to supply its members with diagnosis, treatment and health products.

Disease Risk Management (DRM) Programme:
A unique programme to assist members to help manage their chronic conditions effectively and to improve the well-being of affected members.

Easy-ER
Is an initiative that offers all beneficiaries free, direct access to a hospital's emergency room (ER) for medical treatment in emergency situations.

Emergency:
An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or intervention. If the treatment/intervention is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.

Evidence-based practice:
The conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient.

Generic medicine:
Medicine with the same active ingredients and medicinal effect as the original brand name counterpart, but usually lower in price.

Health Booster:
An additional benefit for preventive care available to beneficiaries of the Scheme at no extra cost.

ICD-10 code:
The international classification of diseases. It is used by healthcare providers to classify and code all diagnosis, symptoms and procedures.

MMAP®:
Maximum Medical Aid Price – MediKredit's MMAP® is a guideline to determine the maximum price that medical schemes will reimburse for specific pharmaceutical products.

Medical Scheme Tariff (MST):
The maximum tariff the Scheme is willing to pay for services rendered by healthcare service providers.

NAPPI code:
National Pharmaceutical Product Interface codification used for identification of ethical, surgical or consumable products, which enables electronic transfer of information throughout the healthcare delivery chain.

Oncology:
The treatment of cancer.

Optical management:
A cost and quality optical management programme provided by OptiClear.

Prosthetics/prosthesis (internal and external):
The artificial replacement of internal or external parts of the body, such as a hip or knee joint, a leg, an arm, artificial eye, heart valve, etc. Includes fixation devices and implanted devices.

PET scan:
A positron emission tomography scan – an imaging study using a very small dose of a radioactive tracer that helps to distinguish cancer from benign tissue to assist in assessing the response of cancer to therapy.

Physical trauma:
A severe bodily injury due to violence or an accident, e.g. a gunshot, stabbing, a fracture or a motor vehicle accident, causing serious and life-threatening physical injury, potentially resulting in secondary complications such as shock, respiratory failure or death. This includes penetrating, perforating and blunt force trauma.

Preferred provider:

A healthcare provider or group of providers selected by the Scheme that provides services at a specific negotiated tariff.

Platinum option:

The day-to-day benefits on the Platinum option comprise the following:

- Routine medical expenses
- Self-funding gap
- Threshold zone

- When the routine portion has been depleted, the member is responsible for the payment of day-to-day expenses, and submits proof of cash payments (copy of account and receipt) to the Scheme, as these claims accumulate to the total of the self-funding gap.
- The self-funding gap will accumulate according to MST rates. The following are excluded from the self-funding gap: co-payments, hospitalisation, dentistry, exclusions, state claims and appliances.
- Threshold zone: Once the self-funding gap has been bridged, the member will have access to further benefits.
- Over-the-counter medication is included in the self-funding gap and threshold with a sub-limit.

Reference price:

The maximum price payable by the Scheme for medication and prosthetics/prosthesis, including hearing aids, in accordance with evidence-based practice/s and cost effectiveness.

Special dependant:

Grandchildren, brothers and/or sisters of the Principal Member and/or his/her spouse/partner, if proof of care and financial dependency is provided.

Stand-in pharmacy claims:

Stand-in is dependent on the connection between the Scheme and the provider. If the communication lines are down and the transaction takes too long to process (time-out), or there is general system downtime, the claim will not be processed in real-time, but in stand-in. In stand-in, MediKredit processes the claim on behalf of the Scheme.

Switch-out pharmacy claims:

Switch-out is the term used to describe a real-time transaction between the Scheme and the provider. The benefit of switch-out is that the response the provider receives is directly from the Scheme and is basically instantaneous. It includes benefit checks; the provider will know at point-of-sale if there are any co-payments.

Tariff code:

Used for the electronic information exchange for procedures and consultation claims.

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03 | Membership

3.1 | Membership application

- KeyHealth is an open medical scheme, and membership is available to private individuals and employer groups, including local government employees.
- Legislation prohibits a person from belonging to more than one medical scheme at a time.

Supplementary documentation required when applying for membership (Principal Member and Adult/Child Dependant):

WHO	WHAT
Principal Member	• Copy of ID • Membership certificate from previous medical scheme (if applicable)
Husband/wife	• Copy of ID • Copy of marriage certificate/proof of marriage • Membership certificate from previous medical scheme (if applicable)
Child	• Copy of birth certificate or proof of birth from hospital/clinic • **Note:** Babies must be registered within 30 (thirty) days of birth
Child Dependant, up to the age of 21	• Copy of ID • Membership certificate from previous medical scheme (if applicable)
Dependant, aged 21 and over (see below)	• Copy of ID • Proof of full-time studies (if applicable) • Membership certificate from previous medical scheme (if applicable)
Continuation of membership	• Copy of ID • Letter from Principal Member requesting continuation of membership • Debit order authorisation (contributions; if applicable) • Copy of latest bank statement or affidavit of financial means
Widow(er)	• Copy of ID • Copy of death certificate • Letter from widow(er) confirming option choice • Debit order authorisation (contributions; if applicable) • Copy of latest bank statement or affidavit of financial means

WHO	WHAT
Orphan	• Copy of ID • Copy of death certificate of late parent(s) • Debit order authorisation (contributions; if applicable) • Copy of latest bank statement or affidavit of financial means • Official documents confirming continuation of membership
Disabled dependant	• Copy of ID • Detailed diagnostic description (ICD-10) from medical practitioner and/or a report from an occupational therapist
Legally adopted child	• Copy of birth certificate • Copy of final adoption order
Member's partner	• Copy of ID • Membership certificate from previous medical scheme (if applicable)
Child born before/out of wedlock	• Copy of unabridged birth certificate or proof of birth from hospital/clinic • **Note:** Babies must be registered within 30 (thirty) days of birth
Stepchild	• Copy of birth certificate • Membership certificate from previous medical scheme (if applicable)
Special dependant	• Copy of ID/birth certificate (if applicable) • Affidavit – reason for dependency

Please note: Where applicable, always complete the medical details questionnaire of the application form in full and correctly. Refer to the Scheme rules, glossary 4.3.2 for the definition of dependant/s. Dependants not registered within 30 (thirty) days will be registered from the first day of the month, following the month the application form was received.

Individuals of the Principal Member's family/household/family group qualifying for registration as dependants:

- A spouse to whom the Principal Member is married in terms of any recognised South African law or custom.
- A recognised life partner of the Principal Member, irrespective of sex.
- The Principal Member's own, foster, step- or legally adopted child.
- Brother, sister or grandchild of the Principal Member and who is dependent on the Principal Member for financial support, is regarded as a special dependant.

Please note: None of the above should be an existing beneficiary of any registered medical scheme.

Dependant, not yet 21 years old:

- A dependant, younger than 21 years, which could be the Principal Member's own (biological), foster, step- or legally adopted child, is regarded as a Child Dependant, but always keep the following in mind:

    - A disabled dependant who is permanently and totally disabled. He or she cannot engage in any substantial gainful activity because of a physical or mental condition. [Detailed diagnostic description (ICD-10) provided by a registered medical practitioner and/or a report from an occupational therapist], whatever his/her age, will be regarded as a Child Dependant.

Dependant, 21 years and older, but not yet 27 years of age:

- The dependant is regarded as a Child Dependant for the duration of the year in which he/she turns 21 years old. If official proof of full-time studies at a recognised national educational institution is provided in the following year, the dependant will continue to be regarded as a Child Dependant for the duration of the period during which such proof of studies is provided annually.
- If not a full-time student, his/her Scheme membership will default to an Adult Dependant and the contributions will be adjusted.

Dependant, 27 years and older:

- This dependant's membership will be terminated, on the last day of the month of turning 27 years old, and he/she could apply for principal membership with KeyHealth or any other registered medical scheme.

Adult Dependant (partner/spouse), not yet 27 years old:

- This dependant will pay Child Dependant contributions, provided that he/she is studying and in a committed relationship with the Principal Member.

Insurability:

- Proof of health is provided when the Principal Member completes the medical details section on the application form and signs the form (where applicable).
- According to legislation, the Scheme is entitled to request a health certificate for any applicant (Principal Member and/or dependant), where applicable.

Please note: It is important to disclose each applicant's full medical history, as this will prevent possible rejections and/or further actions because of non-disclosure.

3.2 | Underwriting

- If a Principal Member and/or dependant suffers from a specific illness, the Scheme has the right to exclude benefits for this specific condition for a period of up to 12 (twelve) months.
- Subject to the rules, the Scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 (ninety) days preceding the date of application:

    - a general waiting period of up to 3 (three) months, including PMB conditions; and
    - a condition-specific waiting period of up to 12 (twelve) months, including PMB conditions.

- The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application:

    - a condition-specific waiting period of up to 12 (twelve) months, except in respect of any treatment or diagnostic procedures covered within PMB conditions; and

    - in respect of any person contemplated, where the previous medical scheme had imposed a general or condition-specific waiting period, and such waiting period had not expired at the time of termination, a general or condition-specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.

- A child born onto the Scheme, during the period of membership, will not receive waiting periods.
- The Scheme may impose upon any person in respect of whom an application is made for

membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 (twenty-four) months, terminating less than 90 (ninety) days immediately prior to the date of application:

- a general waiting period of up to 3 (three) months, except in respect of any treatment or diagnostic procedures covered within PMB conditions.

Late joiner penalty:

- A premium loading (late joiner penalty) may be imposed on an applicant (Principal Member and/or Adult Dependant) aged 35 and over, who was not a member or dependant of one or more recognised medical scheme from a date before 1 April 2001 and without a break in coverage exceeding 90 (ninety) days since 1 April 2001. The penalty is for the duration of membership.
- This loading is calculated according to the years spent without medical scheme coverage after reaching the age of 35, with credit given for years of cover after reaching the age of 21, according to the following table:

1	to	<5 years at 5%
5	to	<15 years at 25%
15	to	<25 years at 50%
		≥25 years at 75%

Non-disclosure consequences:

- If found that false information has been submitted or that any relevant information has been omitted on an application, the Scheme may correct this in terms of its rules, which may include re-underwriting or termination of membership.

Membership in the course of the benefit year:

- When joining the Scheme in the course of a benefit year (between 1 January and 31 December), the beneficiary will receive pro rata benefits, i.e. annual maximum on benefits will be reduced according to the number of months left in the benefit year across all benefit categories.

Membership cards:

- Principal Members with one or more dependant are provided with 2 (two) membership cards.
- Principal Members without dependants are provided with 1 (one) membership card.
- A membership card, presented on request to the service provider (e.g. a general practitioner), is proof that the holder is a registered Scheme member.

- A membership card remains the property of the Scheme and must be destroyed when membership is terminated.
- A membership card may never be used by anyone other than the Principal Member or his/her registered dependants.
- Keep membership cards in a safe place.

Please note: Electronic membership cards and Easy-ER cards (if applicable) are also available on smart phones. Please see chapter 18 for more details.

The contents of a member pack:

- Welcome letter – containing member-specific information regarding the Scheme and which must be checked by the member for accuracy and completeness.
- Member guide – a booklet containing important information regarding membership and the Scheme rules.
- Membership card(s) – containing the following information and which must be checked by the member for accuracy and completeness:

    - Membership number;
    - Enrolment date;
    - Benefit date;
    - Name(s) and surname(s) of Principal Member and registered dependant(s);
    - Dependant code(s); and
    - Identity numbers of the Principal Member and registered dependant(s).

- Easy-ER brochure – this brochure contains all the information pertaining to Easy-ER, which guarantees all beneficiaries direct and free access to a hospital's emergency room (ER) facility.
- Easy-ER card(s) (if applicable) – one card for each Child Dependant. Please ensure that the information is complete and correct. To prevent fraud, safeguard the card(s) at all times.

3.3 | Membership changes

Please note: Requests submitted for option changes must be done by completing and submitting the Scheme's official option change form. This form is available on the Scheme's website at **www.keyhealthmedical.co.za** or by contacting the Client Service Centre on **0860 671 050**.

Benefit option changes:

- An option change is only allowed at the end of each benefit year, effective as from 1 January the following year.
- The request to change benefit option the following year must be submitted to the Scheme by 15 December of the previous year.

Inform the Scheme within 30 (thirty) days in the event of any of the following changes to membership details:

- Registration of new dependant(s).
- Dependant(s) no longer qualifying for membership.
- Contact details (postal address, telephone number, fax number, cell number and email address).
- Banking details (include the latest bank statement or an official letter from the bank), indicating whether the change is applicable to a claims refund or contribution deduction.

Please note: Where a spouse/partner applies to be registered as the Principal Member, a new application form must be completed.

3.4 | Retirement/death of Principal Member subsidised by employer

Retirement of Principal Member:

- A Principal Member should give at least 1 (one) month's written notice to the Scheme regarding retirement and whether membership will be continued.
- A Principal Member, who receives a subsidy from an employer, needs to confirm whether the subsidy will continue after retirement. If not, the member will be responsible for the full contribution amount.
- A Principal Member who retires may request to change benefit option, effective from the date of retirement.

Upon death of the Principal Member:

- Notify the Scheme as soon as possible of the Principal Member's death and submit a copy of the death certificate.
- Unless the Scheme is otherwise informed, the eldest dependant shall be admitted as the Principal Member. Principal Member fees shall be applicable from the first day of the month following the Principal Member's death, irrespective of age.
- Adjusted membership contributions are paid without interruption.

3.5 | Retirement/death of private individual Principal Members

Retirement of Principal Member:

- A Principal Member should give at least 1 (one) month's written notice to the Scheme regarding retirement and whether membership will be continued.
- A Principal Member, who receives a subsidy from an employer, needs to confirm whether the subsidy will continue after retirement. If not, the member will be responsible for the full contribution amount.
- A Principal Member who retires may request to change their benefit option, effective from the date of retirement.

Upon death of the Principal Member:

- Notify the Scheme as soon as possible of the Principal Member's death and submit a copy of the death certificate.
- Should the spouse/partner/child(ren) wish to continue with membership, a new application for membership form must be completed.

Retirement (continuation of membership):

- Mail notification of change to membership to:

KeyHealth Medical Scheme
PO Box 14145
Lyttelton
0140
Fax: 0860 111 390

- Notification can also be sent to **membership@keyhealthmedical.co.za**.
- No change will be implemented retrospectively.
- Please remember to state the Principal Member's full name, surname and membership number on the letter/email.

3.6 | Contributions

Date of payment:

- A Principal Member is liable for the total monthly contribution, irrespective of any subsidy received from an employer.
- Contributions are payable in arrears for local authority members and in advance for other members.
- The following payment dates are available for members paying by way of a debit order: 2nd, 7th, 26th and the last day of the month.

  - Contributions, payable in arrears, must be paid by the end of each month:
    Example: Contributions for January must be received by 31 January.
  - Contributions, payable in advance, must be paid by the 7th of each month:
    Example: Contributions for January must be received by 7 January.

Please note: Should the last day of the month fall over a weekend, the debit order will only be deducted the first working day of the new month.

Adjustment to contributions:

- If contributions are adjusted due to the registration of an additional dependant, the adjusted fees are payable as from the first day of the month of the new registration.

Please note: Benefits for such a dependant will apply from the date of membership, provided that all conditions have been met.

- If contributions are adjusted due to the registration of a newborn baby dependant, the adjusted fees are payable as from the first day of the month following the baby's date of birth.

Please note: Benefits for such a dependant will apply from the date of birth, provided that all conditions have been met.

Method of payment:

- Contribution payments can only be made into the following bank account:

Bank	**ABSA**
Name of account holder	**KeyHealth Medical Scheme**
Account number	**6 000 000 12**
Reference number	**Membership number**

- Please do **NOT** mail cash or cheques.
- The Scheme does **NOT** accept any responsibility if cash or cheques get lost in the mail.
- It is very important that members use their membership number as reference for **ALL** deposits made to/correspondence with the Scheme.
- Please fax proof of payment to **0860 111 390** or email to **proofofpayment@keyhealthmedical.co.za** for attention: Contribution Department.

3.7 | Termination of membership

Termination of a Principal Member's membership:

- On resignation of the Principal Member from an employer (where membership was a condition of service and the Principal Member did not opt to retain it).
- Upon death of the Principal Member.
- When the Scheme receives one calendar month notice of cancellation from the Principal Member/ employer.
- When a Principal Member no longer qualifies for membership in terms of any other stipulation as contained in the latest Scheme rules.
- If the Scheme finds that a Principal Member and/or dependant(s) have misused benefits. The membership will be terminated, back-dated to the inception date.

Termination of a dependant's membership:

- When the Principal Member's membership is terminated.
- When the Principal Member notifies the Scheme to terminate membership of a dependant [at least 1 (one) calendar month's written notice].

Certificate of membership:

- On termination of membership, the Scheme will issue a certificate of membership.
- If the membership was terminated by the Scheme, due to the non-disclosure of material information, no certificate of membership will be issued.

Reinstatement of membership:

- A member may apply for reinstatement of membership within 30 (thirty) days from the date of notification of termination, provided that all outstanding debts are settled. Such application must be accompanied by a Declaration of Health to determine any underwriting and is subject to approval and the discretion of the Scheme.

Be Smart. **Keep it Simple.**

04 | Prescribed Minimum Benefits (PMBs)

04 | Prescribed Minimum Benefits (PMBs)

Definition:

- PMBs are defined by the Medical Schemes Act with the aim to ensure that all medical scheme beneficiaries have access to certain minimum health benefits, regardless of the scheme benefit option they have chosen, their age or the state of their health.
- In terms of the Act, medical schemes have to cover the costs related to the diagnosis, treatment and care of:

    - all emergency medical conditions; and
    - a limited set of approximately 270 medical conditions as defined in the Diagnosis Treatment Pairs, which includes 25 chronic conditions as defined in the CDL.

- The treating doctor decides whether a condition is a PMB or not by taking into account the symptoms only
    - a diagnosis-based approach.

- Any PMB/CDL claims will first be paid from the member's applicable benefit category (day-to-day benefits), where applicable, and should this become depleted, then only will the claims be paid from the Scheme's risk benefit allocation.
- The CDL specifies the 25 chronic conditions that are covered (see below).

Please note: PMBs are not influenced by Scheme exclusions.

ICD-10 codes:

- A PMB condition can only be correctly identified by indicating the appropriate ICD-10 code.
- It is thus of the utmost importance that the correct ICD-10 codes are used in order to ensure that PMB-related services are paid from the appropriate benefits or paid at all.
- The correct ICD-10 codes must also appear on the relevant medicine prescriptions and referral notes to other healthcare service providers.

PMB CDL	
1. Addison's Disease	14. Epilepsy
2. Asthma	15. Glaucoma
3. Bipolar Mood Disorder	16. Haemophilia
4. Bronchiectasis	17. Hyperlipidaemia
5. Cardiac Failure	18. Hypertension
6. Cardiomyopathy Disease	19. Hypothyroidism
7. Chronic Renal Disease	20. Multiple Sclerosis
8. Coronary Artery Disease	21. Parkinson's Disease
9. Crohn's Disease	22. Rheumatoid Arthritis
10. Chronic Obstructive Pulmonary Disorder	23. Schizophrenia
11. Diabetes Insipidus	24. Systemic Lupus Erythematosus
12. Diabetes Mellitus Type 1 & 2	25. Ulcerative Colitis
13. Dysrhythmias	

Emergency:

- An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or intervention. If the treatment/intervention is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.
- Subject to application and approval, the Scheme will pay 100% of MST in respect of any services that are voluntarily obtained by a beneficiary from a service provider other than the DSP for a PMB condition.
- Subject to application and approval, any services in respect of PMBs that are involuntarily obtained by the beneficiary from a service provider other than the DSP, will be covered in full. (*)
- A beneficiary will be deemed to have involuntarily obtained a service from a provider other than the DSP, if:

    - the service was not available from the DSP or would not be provided without unreasonable delay;
    - immediate medical or surgical treatment for a PMB condition was required under circumstances or at locations that reasonably precluded the beneficiary from obtaining such treatment from a DSP; or
    - there was no DSP within reasonable proximity of the beneficiary's ordinary place of business or personal residence.

- Except in the case of an emergency medical condition, pre-authorisation shall be obtained by a member prior to voluntarily obtaining a service from a provider other than a DSP in terms of this paragraph to enable the Scheme to confirm that the circumstances contemplated in paragraph (*) above are applicable.

Please note: The Scheme will only fund, at cost, the involuntary use of non-DSPs for an emergency event and not continuous/future treatment.

Diagnostic tests for unconfirmed PMB diagnosis:

- Where diagnostic tests and examinations are performed but do not result in the confirmation of a PMB diagnosis (except in emergencies), such diagnostic tests or examinations are not considered to be PMB and the costs of such tests or examinations shall be subject to the limits for the various options.
- Benefits in respect of PMBs are unlimited. Benefits in respect of the CDL conditions will be covered 100% if rendered according to the prescribed therapeutic algorithm for the specific condition and treatment plans and claimed with the applicable ICD-10 codes.
- If a beneficiary knowingly declines the formulary drug and opts to use another drug, a co-payment equal to the difference between the cost of the drug and the reference price of the formulary drug will apply.
- Co-payments in respect of PMBs may not be paid out of the personal MSA.

Designated Service Providers (DSPs):

Any service falling within the Scheme Rules and rendered by the Scheme's DSP for PMB conditions will be covered in full. If a member chooses not to use a DSP, a co-payment may be applicable. Non-PMB conditions are subject to the Scheme's DSP, and subject to 100% MST. The Scheme has appointed the following DSPs:

i) Hospitalisation
   - Netcare and Life Healthcare for all options (a list of hospitals in areas where DSP hospitals are not present, is available on request).
   - Mediclinic (Western Cape).
   - Netcare – in respect of radiotherapy facilities.

ii) Specialist services
   - OneCare Specialist Network, practising within the Netcare, Life Healthcare and Mediclinic (Western Cape) hospitals. This network will be applicable to in- and out-of-hospital-related services. Details of specialists of the network may be obtained from the Pre-authorisation Department on **0860 671 060**. A list of providers are available on the Scheme's mobile app.

iii) Substance abuse
   - SANCA (A list of facilities in areas where SANCA is not present, is available on request.)

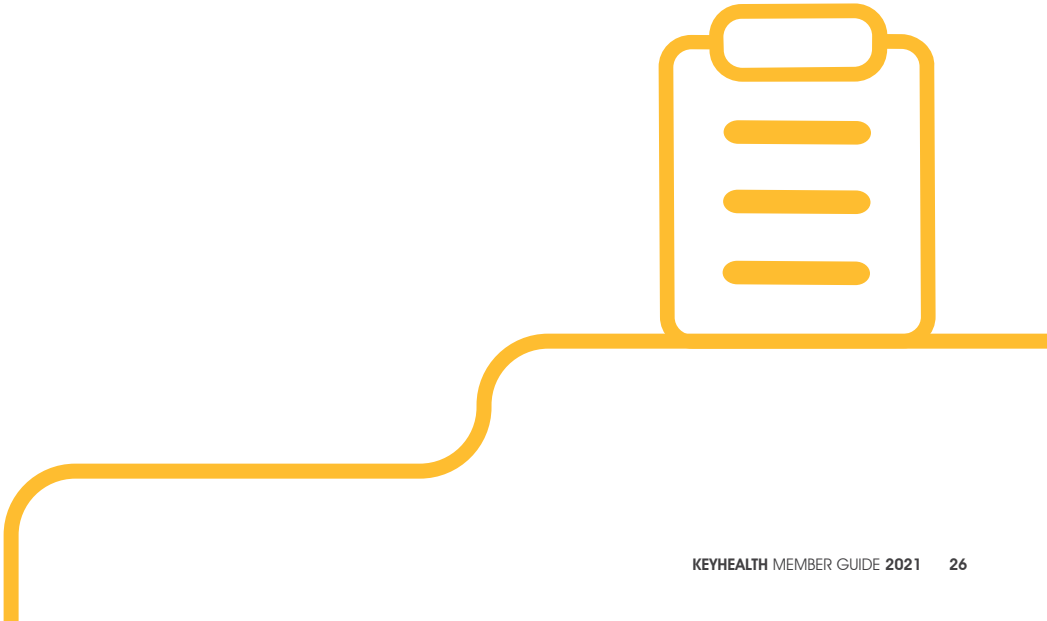
iv) Oxygen and CPAP
   - Ecomed Medical

v) Negative Pressure Wound Therapy (NPWT)

- Equity Pharma Holdings

vi) Oncology medication

- Medipost and Dis-Chem pharmacies – all options



Be Smart. **Keep it Simple.**

05 | Medication

5.1 | Prescribed acute medication

- Acute medication is once-off medication, prescribed by a medical practitioner for conditions not recognised as chronic by the Scheme. Medication, as per the Scheme's exclusion list, is excluded.
- Acute medication is subject to the application of MMAP®.

Please note: Homeopathic medicine is subject to the acute (day-to-day) benefits.

Where to obtain acute medication:

- Acute medication may be obtained from any pharmacy or from a dispensing medical practitioner.

Medication on discharge from a hospital:

- Medication provided to a beneficiary upon discharge from a hospital is limited to the following:

Platinum	R550 per admission
Gold	R550 per admission
Silver	R550 per admission
Equilibrium	R550 per admission
Origin	R550 per admission
Essence	R550 per admission

- If only a prescription for medication is received upon discharge from the hospital, the medication thus obtained will be paid from the day-to-day benefit and does not qualify as medication on discharge.

5.2 | Maximum Medical Aid Price (MMAP®)

- MMAP® is a guideline to determine the maximum price the Scheme is prepared to pay for specific medical products.
- MediKredit, a service provider of the Scheme, determines the MMAP® levels by conducting surveys in the medicine market and is responsible for the compilation and updating of MMAP®.
- Products covered in the MMAP® directive have been chosen because they have been tried, tested and approved by the Medicine Control Council. The approval is based on evaluation criteria, which determine that a product may be regarded as the pharmaceutical equivalent (also known as 'generic equivalent') of an established branded medicine. The composition and medicinal effect of generic products are thus the same but may differ in price.
- If a prescribed product is priced above the MMAP®, the beneficiary will need to pay the difference in price at the point of dispensing.
- Should the beneficiary choose to receive the MMAP® product, priced within the permitted limits, the Scheme will pay the full price of this product (excluding any possible levies that may be applicable).
- To manage benefits effectively and to affect cost savings, beneficiaries are advised to request the medical practitioner, where possible, to prescribe generic medication.

5.3 | Over-the-counter medication

- Over-the-counter medication (self-medication) is medication with a NAPPI code that can be obtained from a pharmacy without a prescription.
- These are typical cold and flu-type medicine, such as cough medicine and decongestants. These include vitamins, and Schedule 1 and 2 medication.
- The pharmacy either claims the amount due directly from the Scheme, or the beneficiary pays the pharmacy in cash and submits the claim, which should include the name, quantity, price and NAPPI code of each item of medication, and proof of payment of such account.

5.4 | Registration for chronic conditions and prescribed chronic medication

- Prescribed chronic medication is used continuously for 3 (three) months or more for conditions as contained in table 1 (Category A) and/or 2 and 3 (Category B) (see subsection 5.7).
- If a patient is diagnosed with one of the chronic conditions listed in table 1, 2 or 3, then registration of the chronic condition involved is required before access to the chronic medication benefit will be granted.
- No authorisation forms are involved, as this is a paperless process, unless there are specific test results and/or a motivation required.
- Only new condition registrations require the doctor or pharmacist to intervene.
- Chronic conditions, already registered with the Scheme, require no action at the start of the new benefit year, as existing chronic conditions will automatically remain registered.
- Authorisation for chronic medication is subject to the following:

    - The treating doctor or the pharmacist (after the initial consultation with the doctor) must register chronic conditions with MediKredit on **0800 132 345**, as detailed clinical information, including the condition's ICD-10 code and severity status, is required.
    - The doctor's prescription will then authorise the patient the right to obtain the chronic medication from a local pharmacy, a Scheme DSP pharmacy or the doctor's dispensary.
    - Certain products can only be authorised if prescribed by the appropriate specialist. These specialists must contact MediKredit on **0800 132 345** for further information.

Please note: The purpose is to improve clarity in respect of funding decisions, taking into consideration evidence-based practice, affordability and in some instances cost-effectiveness.

5.5 | The Condition Medicine List (CML)

- The CML is a Scheme-approved list of clinically appropriate medicine used for the treatment of a particular condition, therefore each condition has a CML.

- Chronic conditions are classified as PMB or non-PMB conditions.
- The CML is not a fixed list of products but is continuously being revised with regard to new products being registered, products that no longer exist, price changes, MMAP® changes, as well as changes to the product registration details for a condition.
- The CML does not contain all medication that may possibly be required to treat a patient's condition, as some medication requires a specific authorisation. This authorisation will be limited to a specific period, depending on the prescription and the motivation from the treating doctor/specialist.
- Please refer to the MediKredit section of the KeyHealth website **www.keyhealthmedical.co.za** for chronic conditions, updated products and prices, as well as possible alternatives at lower prices.
- This search facility also indicates, at a product level, whether co-payments apply.

Formulary medicine:

- According to legislated therapeutic algorithms (treatment plans), the Scheme makes use of medicine formularies (medicine lists) for chronic medication by focusing on the management of cost and ensuring accessibility and appropriate care to all beneficiaries.
- These formularies are approved lists of medication for each of the 26 chronic conditions covered by the Scheme and do not compromise the quality of healthcare the beneficiary receives.
- These medicines are included with the CML and are available to all patients with the specified condition to which no reference price applies, provided they are claimed in appropriate quantities.

Non-formulary medicine:

- Reference pricing may be applied to non-formulary medicine for both PMB CDL and non-PMB CDL conditions, in accordance with the benefit selected by the beneficiary (refer to details discussed under reference price below).

5.6 | Reference price

- Reference price is the maximum amount that the Scheme is willing to pay for medicine from a similar medicine class listed on the CML for that condition. This reference price may differ on each benefit option.
- Reference price is about patient choice. Medicine priced above the reference price may be substituted with a clinically appropriate alternative product (a generic substitute), where applicable, that is less expensive and does not incur any additional out-of-pocket costs. However, if the beneficiary chooses to remain on the existing, more expensive product when appropriate alternatives are available, a co-payment will apply.

- Reference price is reviewed once a year. This review process considers all the new medicine entries during the year, medicine discontinuations, new enhancements, clinical literature, licensed indications, price changes, generic influence, patent expiry, etc.
- Please refer to the MediKredit section of the KeyHealth website **www.keyhealthmedical.co.za** to determine the reference price of the medicine currently used. If the medicine, displayed on the screen, is above reference price, the beneficiary will then be required to pay a co-payment at the point of dispensing.
- The reference price is based on the cost of medicine from a similar drug class listed on the formulary to which no reference price applies. The beneficiary is required to pay the difference between the cost of the medicine and the reference price of the formulary medicine at the point of dispensing.

Please note: If certain medicine is still not authorised after intervention by the doctor/specialist, or the condition being treated does not fall under table 1, 2 or 3, the beneficiary can obtain the medicine from a local pharmacy or a dispensing doctor and claim it against the available day-to-day benefits, if applicable.

TABLE 1 (CATEGORY A):

PMB CDL (All options)	
1. Addison's Disease	14. Epilepsy
2. Asthma	15. Glaucoma
3. Bipolar Mood Disorder	16. Haemophilia
4. Bronchiectasis	17. Hyperlipidaemia
5. Cardiac Failure	18. Hypertension
6. Cardiomyopathy Disease	19. Hypothyroidism
7. Chronic Renal Disease	20. Hormone Replacement Therapy (HRT)(*)
8. Coronary Artery Disease	21. Multiple Sclerosis
9. Crohn's Disease	22. Parkinson's Disease
10. Chronic Obstructive Pulmonary Disorder	23. Rheumatoid Arthritis
11. Diabetes Insipidus	24. Schizophrenia
12. Diabetes Mellitus Type 1 & 2	25. Systemic Lupus Erythematosus
13. Dysrhythmias	26. Ulcerative Colitis

(*) Indicates an additional chronic condition approved by the Scheme.

5.7 | Other chronic conditions (Platinum, Gold, Silver and Equilibrium options)

TABLE 2 (CATEGORY B):

Other chronic conditions (Platinum option only)	
1. Acne	15. Iron Deficiency Anemia
2. Allergic Rhinitis	16. Major Depression(#)
3. Alzheimer's Disease	17. Menière's Disease
4. Ankylosing Spondylitis	18. Menopausal Disorder (Calcium only)(#)
5. Benign Prostatic Hypertrophy	19. Migraine
6. Clotting Disorders(#)	20. Myasthenia Gravis
7. Cystic Fibrosis	21. Osteoarthritis
8. Deep Vein Thrombosis(#)	22. Osteoporosis
9. Diverticulitis and Irritable Bowel Syndrome	23. Paraplegia, Quadriplegia(#)
10. Gastro-Esophageal Reflux Disease	24. Peripheral Vascular Disease(#)
11. Hypoparathyroidism(#)	25. Psoriasis
12. Hyperkinesis and/or ADD (Attention Deficit Disorder)	26. Rheumatic Fever
	27. Stroke(#)
13. Hyperthyroidism	28. Testosterone Deficiency
14. Interstitial Fibrosis	29. Urinary Incontinence

TABLE 3 (CATEGORY C):

Other chronic conditions (Gold option only)	
1. Acne	10. Major Depression(#)
2. Allergic Rhinitis	11. Meniere's Disease
3. Benign Prostatic Hypertrophy	12. Migraine
4. Diverticulitis and Irritable Bowel Syndrome	13. Osteoarthritis
5. Gastroesophageal Reflux Disease	14. Paraplegia, Quadriplegia(#)
6. Hypoparathyroidism(#)	15. Peripheral Vascular Disease(#)
7. Hyperkinesis (Attention Deficit Disorder)	16. Rheumatic fever
8. Hyperthyroidism	17. Testosterone deficiency
9. Iron deficiency anaemia	18. Urinary incontinence

- Chronic medication for PMB conditions indicated with (#) (only for severe life-threatening cases and motivated by the appropriate specialist), above PMB level of care, will be paid at 100% of the cost.
- 10% co-payment on chronic medication for non-PMB conditions.

Other chronic conditions (Equilibrium and Silver options only)
1. Acne
2. Hyperkinesis and/or ADD (Attention Deficit Disorder)
3. Rhinitis

- Only applicable to children up to the age of 21.

Please note: Additional co-payments may be incurred if the price of products used is higher than the reference price/MMAP®. Managed Health Care protocols apply to all conditions.

5.8 | Biological, targeted treatment and immunotherapy medication

Biological medication are substances made from a living micro-organism, plant or animal cells, and is used in the prevention, diagnosis and/or treatment of cancer and other diseases. Biological medication includes antibodies, interleukins and vaccines. Also called biologic agent and biological agent.

Targeted therapy is a cancer treatment that uses medication to target specific genes and proteins that are involved in the growth and survival of cancer cells. Targeted therapy can affect the tissue environment that helps a cancer grow and survive or it can target cells related to cancer growth, like blood vessel cells. Doctors often use targeted therapy along with chemotherapy and other treatments.

Immunotherapy is a type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection and other diseases. Some types of immunotherapy only target certain cells of the immune system. Others affect the immune system in a general way. Types of immunotherapy include cytokines, vaccines, Bacillus Calmette-Guerin (BCG) and some monoclonal antibodies, which uses the body's immune system to fight cancer.

The following protocols will be applicable to the use of biological, targeted and immunotherapy medication by beneficiaries, subject to evidence-based practice, cost-effectiveness and approval:

5.8.1 PMB (on algorithm), e.g. Multiple Sclerosis:

- Will be paid for by the Scheme on all options, subject to the compliance on optimal standard/ alternative treatment.

5.8.2 PMB (not on algorithm), e.g. Rheumatoid Arthritis, Crohn's Disease and Ulcerative Colitis:

- Platinum option only, with a 30% co-payment, subject to the compliance on optimal standard/ alternative treatment; and
- Payable from the chronic benefit and then from risk.

5.8.3 Diagnoses Treatment Pairs (DTP) conditions:

- Applicable to all options;
- The interpretation of DTP will be in accordance with the Scheme protocols, including investigation of the availability in state facilities.

5.8.4 Chronic conditions (not included in table 2 (category B)):

- Platinum option only, with a 30% co-payment;
- Annual chronic limit applies;
- If also a DTP, and the medication is eligible as per Scheme protocols.

Once the annual chronic limit has been exceeded, the provider must contact the Scheme's chronic department for DTP authorisation. Thereafter, rules and co-payments apply as per 5.8.3 above.

5.8.5 Section 21:

The Scheme only reimburses medicine/treatment that has NAPPI codes and are registered within South Africa. In the event of stock issues and where there is a need for imports, the Scheme requires the SAHPRA (Medicines Control Council) Section 21 certificate of approval.

- Platinum option only, with a 30% co-payment;
- Managed on a case-by-case basis and in accordance with the Scheme protocols;
- Clinical Committee to approve level of funding based on cost effectiveness compared to alternate registered therapy.

5.8.6 Medication used alternatively (off-label):

- Managed on a case-by-case basis and in accordance with the Scheme protocols;
- Clinical Committee to approve level of funding based on cost-effectiveness compared to alternate registered therapy;
- 30% co-payment applicable to all options.

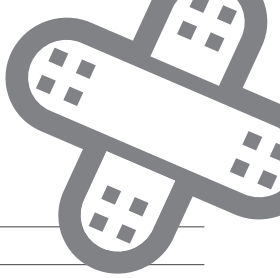
5.8.7 Oncology:

- Medication for treatment will be considered in accordance with ISIMO Health guidelines, protocols and use of DSP pharmacies (Medipost and Dis-Chem):

	Protocols	Rules
Platinum	Enhanced	No biological, targeted treatment and immunotherapy medication sublimit, unless as specified below: 30% co-payment on biological, targeted treatment and immunotherapy medication not within the protocol and sublimit of R500 000 pfpa
Gold	Enhanced	30% co-payment on biological, targeted treatment and immunotherapy medication within the protocol with a sublimit of R250 000 pfpa (no out-of-protocol benefits)
Silver	Standard	No benefit
Equilibrium	Standard	No benefit
Origin	Standard	No benefit
Essence	Standard	No benefit

Please note: Additional 20% co-payment applicable for voluntary use of non-DSP.

NOTES:



Be Smart. **Keep it Simple.**

06 | Hospitalisation and managed healthcare

6.1 | Authorisation of hospital admissions

- Before admission to hospital, the member must phone **0860 671 060** (Pre-authorisation Department) for the necessary authorisation or via the online chat facility, which is available every Monday to Friday between 08:00 and 19:00, excluding public holidays, and can be accessed from the homepage of the Scheme's website **www.keyhealthmedical.co.za**.
- Authorisation needs to be obtained within 24-hours prior to an admission, or within 2 (two) working days after an emergency admission (family members, friends or the hospital can call on behalf of the beneficiary if he/she is unable to), otherwise a penalty will be applicable. This penalty will be deducted from the member's hospital account.
- The following information must be provided when calling:

    - Membership number;
    - The full name and surname, and dependant code of the patient being hospitalised;
    - The name and practice number of the hospital to which the patient will be admitted;
    - The reason for the hospital admission:
        > Admission diagnosis or ICD-10 code;
        > If admission is for planned surgery, all relevant procedure (tariff) codes; and
        > CPT4 codes, if available.
    - The date of admission and scheduled date of the procedure;
    - The practice number of:
        > The treating doctor/specialist;
        > The referring doctor/specialist;
        > Other service providers (if applicable); alternatively,
        > The initials, surname and telephone number of both treating and referring doctor/specialist.
    - The expected length of stay in hospital.

Please note:

- Only medically appropriate claims will be covered by the Scheme and authorisation does not guarantee that all hospital and associated costs of the authorised admission will be paid.
- Benefits will be paid according to what is permitted in terms of the Scheme rules, funding guidelines and clinical protocols.
- Services must commence within 30 (thirty) days of approval and will be subject to the available benefits of the year in which the services are rendered.
- The beneficiary enjoys the particular benefits for as long as hospitalisation of the case involved has been authorised. Before and after hospitalisation, the beneficiary receives out-of-hospital benefits.

- Certain in-hospital expenses, incurred as part of a procedure/admission, may not be covered by a member's hospital benefit.
- Certain procedures done, medication and new technology used in-hospital may require separate authorisation. Members are requested to clarify this with their medical practitioner prior to admission to hospital.
- Admission to hospital, for the sole purpose of investigation/s and treatment that can be provided as an out-patient, is excluded from benefits.

- Should Members receive accounts requesting additional payments for hospitalisation, kindly contact the Client Service Centre on **0860 671 050** for verification prior to making payments.

6.2 | Authorisation of major medical services

Pre-authorisation is required for the following services:

Sub-acute facilities/stepdown: Sub-acute rehabilitation is less intense than acute or long-term rehabilitation. Patients in a sub-acute facility generally only receive one or two hours of therapy per day, and it is usually a combination of physical, occupational and speech therapy. Sub-acute care is a comprehensive and cost-effective inpatient programme for patients who have suffered an acute event as a result of an illness; injury or disease; have a determined course of treatment; and who do not require intensive diagnostic and/or invasive procedures. Transfer of skills are also provided by a multi-disciplinary team to the patient, family members or caretaker in preparation for discharge home after a hospitalisation when a patient suffered an acute event as a result of an illness, injury or disease. Patients are transferred from hospital to the sub-acute facility.

Rehabilitation (in-and-outpatient): The process of helping a person who has suffered an illness or injury to restore lost skills and to regain maximum self-sufficiency. This may be provided as inpatient rehabilitation or outpatient depending on the rehabilitation that the patient requires.

- The treating specialist will indicate if the patient will require sub-acute or rehabilitation treatment and will complete a referral letter of the specific sub-acute facility.
- The sub-acute or rehabilitation facility will evaluate the member in hospital and compile a report that will indicate the condition of the patient, needs and treatment that will be provided at the sub-acute facility and expected length of stay.

- As per The Council for Medical Schemes: All healthcare providers must submit the initial clinical assessment report to the Scheme along with a treatment plan, desired goals, and estimated duration to maximise functionality. After the patient reached the plateau the treatment focus must shift from intensive to maintenance treatment. Family members, caregivers and patients must be educated to continue with regular treatment at home to maintain functionality. Often, this approach is cost-effective and has the desired outcomes.

Authorisation process:

- Pre-authorisation is compulsory. Subject to available benefits. Not all the options have sub-acute or rehabilitation benefits available for non-PMB conditions. PMB request will be reviewed in terms of PMB entitlement and level of care requested.
- The request for sub-acute, rehabilitation and transfer of skills must be sent to **rehab@keyhealthmedical.co.za** by the sub-acute facility where they will provide the required clinical information report, FIMTM/ICF score chart and doctor's referral letter.
- Outpatient rehabilitation requests must be sent to **preauth@keyhealthmedical.co.za** and must include:

    - Quotation from the treating provider will be required for number of sessions required;
    - FIMTM/ICF score chart, rehabilitation objectives and doctor's referral letter will be required; and
    - Outpatient rehabilitation will be funded from available day-to-day benefits.

Wound care: Wound care refers to specific types of treatment for pressure sores, skin ulcers and other wounds that break the skin. This can be provided by a private nursing practitioner, hospital wound care facility or doctor.

- Subject to pre-authorisation, authorisation must be obtained before treatment starts or within 24 hours after the first consultation. Members are advised to contact the Scheme to confirm benefits.
- Subject to available benefits. Benefit options that does not have wound care benefits will be reviewed on a case-by-case basis.
- Authorisation requests must be sent to **woundcare@keyhealthmedical.co.za** and must include:

    - Detailed wound assessment and clinical information;
    - Quotation of tariff codes for wound care visits required and NAPPI codes for treatment products required;
    - Dates of planned treatment dates;
    - Detailed colour photos; and
    - If treatment needs to continue after initial authorisation dates: Wound progress reports needs to be submitted before the authorisation date expires, which will include colour photos, treatment plan with NAPPI codes, tariff codes for consultations with proposed dates.

Negative Pressure Wound Therapy (NPWT therapy): Also known as a vacuum-assisted closure, is a therapeutic technique using a suction pump, tubing and a dressing to remove excess exudate and promote healing in acute or chronic wounds.

- NPWT is not routinely funded and not considered emergency medical care.
- Subject to the use of Equity Pharma Holdings (DSP).
- Doctor's letter of motivation, comprehensive wound care assessment form, quotation and colour photos must be sent to **woundcare@keyhealthmedical.co.za**.
- For the continuation of treatment, the following must be provided; comprehensive progress report, colour photos and updated quotation, before the authorised dates expires.

Hospice: Is a type of healthcare that focuses on the palliation of a terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs, at the end of life. Hospice care prioritises comfort and quality of life by reducing pain and suffering. Hospice care provides an alternative to therapies focused on life-prolonging measures that may be arduous, likely to cause more symptoms, or are not aligned with a person's goals.

- In-or-outpatient hospice care is subject to pre-authorisation and subject to the sub-acute benefits.
- A motivation, quotation with tariff codes and number of visits, for inpatient or outpatient care, must be sent to **preauth@keyhealthmedical.co.za**.

Private nursing: Home health nurses create care plans to achieve goals based on the client's diagnosis. It provides a cost-effective alternative by providing managed home healthcare services as an alternative to long-term hospitalisation and stay in specialised care facilities. This may include home ventilation, stoma therapy, administration of intravenous medication as prescribed by a doctor and other specialised medical care to be provided as prescribed by a doctor. Home nursing will not be funded for palliative and frail care.

- Home or private nursing are subject to pre-authorisation and subject to sub-acute benefits.
- The following must be sent to **preauth@keyhealthmedical.co.za**:

  - Detailed wound assessment and clinical information.
  - Quotation with tariff codes, number of visits and NAPPI codes for any products required.
  - Dates of planned treatment/services.
  - For the continuation of treatment, the following must be provided; comprehensive progress report, motivation, treatment plan with tariff and NAPPI codes and number of visits, with proposed dates, before the authorised dates expires.

Psychiatric treatment: Psychiatry is the medical specialty devoted to the diagnosis and treatment of mental disorders. This includes consultations and psychotherapy with psychiatrists and psychologists or inpatient treatment. Industrial and educational psychologists are excluded from benefits. IQ tests, learning problems and scholastic disorders are excluded from benefits.

- Psychiatry subject to pre-authorisation, scheme rules and clinical protocols.
- Subject to available in-and-outpatient psychiatric benefits and use of DSPs.
- For outpatient treatment, the outpatient request form must be sent to **psych@keyhealthmedical.co.za**.
- For in-hospital treatment, the admitting psychiatrist must send a completed DSM IV to **psych@keyhealthmedical.co.za**.

6.3 | Designated Service Provider (DSP) hospital network

The Scheme has entered into an agreement with three of the country's biggest private hospital groups to form a DSP hospital network for members.

It is important to take note of the following aspects of the DSP hospital network:

- Beneficiaries must make use of either a Netcare or Life Healthcare hospital or Mediclinic (Western Cape), within reasonable proximity (40 (forty) kilometres) of their personal residence, subject to authorisation, for any admissions/procedures. Should a beneficiary voluntarily choose to utilise services of a non-DSP hospital, such a beneficiary will be liable for a 30% co-payment in respect of the hospital account incurred. This co-payment will be payable directly to the hospital concerned. Beneficiaries may also be required to pay an upfront cash deposit by such hospitals.
- Beneficiaries who do not have a Netcare or Life Healthcare hospital or Mediclinic (Western Cape), within reasonable proximity (40 (forty) kilometers) of their personal residence, subject to authorisation, may voluntarily utilise the service of a non-DSP hospital for any admissions/procedures, without incurring any co-payment. Information on the proximity of a DSP hospital can be obtained from the authorisation call centre by phoning **0860 671 060**. A list of all DSP hospitals will also be available on the Scheme's website **www.keyhealthmedical.co.za** and mobile app (see Section 18.3).
- Should a beneficiary involuntarily obtain services from a non-DSP hospital (e.g. in emergency situations or when transported to such facilities by emergency transport services), the Scheme will cover the cost for such services in accordance with the applicable benefit allocation and no co-payment shall apply in respect of the hospital account.
- Should a beneficiary voluntarily travel outside of his residential area to an area where there is a DSP hospital, and makes use of the non-DSP hospital, such beneficiary will be liable for a 30% co-payment in respect of the hospital account incurred.
- The DSP hospital network will not be applicable to the Scheme's Easy-ER benefit (see Section 16).

6.4 | Disease risk management programme

KeyHealth firmly subscribes to the notion that your general practitioner (GP) should ultimately manage your PMB/CDL condition. The benefit of this is that all your personal information and medical history is kept in one central place. The GP must be responsible for the following:

- Decide which tests and investigations may be required;
- Renew your chronic prescription every six months as required by law;
- Refer you to a Specialist when necessary; and
- Register you for any additional chronic conditions, which registration will result in your treatment plan being adjusted accordingly.

Being diagnosed with a chronic condition can be a life-altering event and it can dramatically affect every aspect of a member's lifestyle. But the good news is that KeyHealth, as a provider of quality medical cover, is there for members, every step of the way to help them manage their condition/s effectively.

The Scheme has introduced a unique Disease Risk Management (DRM) programme. The programme aims to ensure that members receive health information, guidance and management of their condition, while at the same time encouraging compliance to treatment prescribed by the medical practitioner.

The DRM programme enables members to manage their chronic condition more effectively and it is important to utilise the benefits for a healthy living and to minimise possible hospitalisation.

Members registered on the Essence option, need to nominate a GP, per beneficiary, for all PMB/CDL conditions.

Members registered on the Origin and Essence options, need to be referred by a GP to a Specialist for all PMB/CDL conditions – members on the Essence option must be referred by their nominated GP, and members on the Origin option by any GP of their choice.

The DRM programme includes the following conditions:

PMB CDL (All options)	
1. Addison's Disease	14. Epilepsy
2. Asthma	15. Glaucoma
3. Bipolar Mood Disorder	16. Haemophilia
4. Bronchiectasis	17. Hyperlipidaemia
5. Cardiac Failure	18. Hypertension
6. Cardiomyopathy Disease	19. Hypothyroidism
7. Chronic Renal Disease	20. Hormone Replacement Therapy (HRT)(*)
8. Coronary Artery Disease	21. Multiple Sclerosis
9. Crohn's Disease	22. Parkinson's Disease
10. Chronic Obstructive Pulmonary Disorder	23. Rheumatoid Arthritis
11. Diabetes Insipidus	24. Schizophrenia
12. Diabetes Mellitus Type 1 & 2	25. Systemic Lupus Etythematosus
13. Dysrhythmias	26. Ulcerative Colitis

6.5 | Disease/case management

The programmes below are all subject to case management.

6.5.1 Registration

- If a beneficiary does not register on an appropriate DMP, available day-to-day benefits will be applicable.

6.5.2 Oncology

- The doctor/specialist must complete a treatment plan or write a prescription for associated oncology medication to:

    - Effect registration on the programme;
    - Facilitate the evaluation and final approval of treatment; and
    - Ensure timely processing of cancer-related claims.

- Fax the treatment plan to **012 679 4469** or email to **oncology@keyhealthmedical.co.za**.
- Call **0860 671 060** for authorisation.
- The following will be covered from the oncology benefits, subject to the relevant options:

- Chemotherapy treatment at the doctor's/specialist's facility;
- Chemotherapy treatment during hospitalisation and on an outpatient basis at the hospital;
- Radiotherapy, MRI, CT and PET scans, consultations, blood tests and adjunctive treatment (in-and-out-of-hospital); and
- Refer to page 35-37 for Section 21, biological, targeted treatment, immunotherapy medication and out-of-protocol medication/treatment.

• Oncology follow-up management programme:

- Patients that received active oncology treatment will, after the treating doctor's/specialist's completion of the oncology treatment plan, still be registered on the oncology programme for follow-up visits and tests, up to a maximum of 5 (five) years, subject to pre-authorisation and benefit limits.
- Beneficiaries must register with the Scheme's oncology case manager on **0860 671 060** to manage follow-up treatments related to the original diagnosis.
- Subject to the approved follow-up care treatment plan, consultations and medication related to the original diagnosis will not be subject to the day-to-day benefits of the member, but to available oncology benefits.
- A general oncology treatment plan must be approved for patients who are in remission for longer than 5 (five) years, subject to the day-to-day benefits.

Please note: Oncology medication is subject to the use of a DSP. If the DSP is not used, a 20% co-payment will apply.

6.5.3 Transplants (solid organs, tissue and corneas) and dialysis

• Transplants and dialysis require authorisation and are subject to:

- Limits as described in the benefit structure section of this member guide;
- Case management;
- Using the Scheme's DSPs: State hospitals (transplants) and National Renal Care (dialysis);
- Haemodialysis does not need pre-approval but is subject to the use of DSP - National Renal Care.

6.5.4 HIV/AIDS

• The Scheme has contracted with LifeSense Disease Management to manage the HIV/Aids Programme.
• Registering on the HIV/Aids Programme:

- Contact LifeSense Disease Management on **0860 506 080**;
- Beneficiaries may visit the doctor of their choice for the initial examination;
- The treating doctor will complete the application form in co-operation with the beneficiary and forward the form and results of any blood test to LifeSense;

- A treatment plan, submitted by the treating doctor and based on the above information, will have to be approved by the medical advisor of LifeSense; and
- The beneficiary's doctor will be contacted by LifeSense and advised what medication options are available, taking into consideration the stage of the disease.

- Utilisation of the HIV/Aids Programme:

  - Once the beneficiary is enrolled on the programme, the treating doctor will be contacted on a regular basis by the LifeSense case manager;
  - Assistance will be provided to support and reinforce the importance of the correct utilisation of the authorised medication; and
  - The beneficiary will also be assisted with lifestyle adjustments and counselling.

Please note: Any PMB/CDL claims will first be paid from the member's applicable benefit category (day-to-day-benefits), where applicable, and should this become depleted, then only will the claims be paid from the Scheme's risk benefit allocation. Direct enquiries related to HIV/Aids claims to the Client Service Centre on **0860 671 050**.

6.6 | Maternity

- Pre-notification and pre-authorisation are essential in order to qualify for maternity benefits on Health Booster (refer to Section 14). This can be done by calling **0860 671 060**.
- Call **0860 671 060** at least 1 (one) week before a caesarean section or delivery (if possible), or within 48 hours after childbirth for authorisation about the delivery.
- Please refer to Section 15 - Smart Baby Programme.

Please note: The Scheme will cover the cost of a private ward in hospital for 3 (three) days for members on the Platinum, Gold, Silver, Equilibrium and Origin options who choose to give birth naturally.

6.7 | Medical appliances

- Medical appliances can be described as medical equipment/devices used for the treatment and cure of medical conditions.

- The medical appliance benefit includes items such as wheelchairs, orthopaedic appliances, incontinence equipment (including adult diapers) and contraceptive devices.
- No pre-authorisation is required, for in- and out-of-hospital benefits, subject to co-payments, quantity limits, reference price, duration restrictions, protocols and available benefits. The Scheme may in some instances request additional clinical information or quotations.
- Authorisation is necessary for artificial limbs and hearing aids. The replacement period is 5 (five) years.
- Authorisation is necessary for the following external medical appliances, subject to clinical protocols and registration of chronic condition(s):

  - Oxygen
  - Nebuliser
  - Glucometer
  - Blood pressure monitor
  - Pulse oximeter

- For authorisation, the medical practitioner's motivation, as well as 2 (two) quotations, must be sent to **appliances@keyhealthmedical.co.za**, or faxed to **012 679 4471** (For attention: Medical appliances).

6.8 | Prosthetics/prosthesis/internal fixations/implanted devices

- Prosthetics/prosthesis is the artificial replacement of internal or external part/s of the body, such as a hip or knee joint, a leg, an arm, a heart valve, including internal fixations, implanted devices, etc.
- Internal fixation – the stabilisation of fractured bony parts by direct fixation to one another with surgical wires, screws, pins or plates.
- Neuromodulation – a fabricated or artificial substitute that is surgically implanted permanently into the body and that does not protrude from the body and that replaces or assists a diseased or missing part of the body to restore functionality, such as deep brain stimulation, gastric electrical stimulation, intrathecal therapy, target drug delivery (pain pumps), sacral neuromodulation and spinal cord stimulation, etc. Including battery replacements. Only applicable to the Platinum option.
- Insulin pump – insulin pump therapy, also known as continuous subcutaneous insulin infusion (CSII), involves wearing a device (insulin pump) which provides a steady stream of insulin into the body. Insulin and consumables are subject to reference pricing. Including battery replacements. Only applicable to the Platinum and Gold options.

- Cochlear implant – an electrical medical device that replaces the function of the inner ear. Including battery replacements. Only applicable to the Platinum option.
- Transcatheter aortic valve implantation (TAVI) or transcatheter aortic valve replacement (TAVR) – surgical procedure that repairs the valve without removing the old, damaged valve. Instead, it wedges a replacement valve into the aortic valve's place. Only applicable to the Platinum option.
- Pre-authorisation is compulsory for all external and internal prosthetics/prosthesis/internal fixations/implanted devices by contacting **0860 671 060** and faxing at least 2 (two) quotations to **012 679 4471** (For attention: Prosthetics).
- Prosthetics/prosthesis/internal fixations/implanted devices are subject to the use of DSP, protocols, quantity limits, reference pricing, duration restrictions and available benefits.

Please note: Including replacement, adjustment and/or enhancement of current implant.

6.9 | Casualty ward or emergency room visits

All beneficiaries qualify for Easy-ER

- Access to a casualty ward or emergency room facility of a hospital, will be granted to all beneficiaries on the Scheme in terms of the Easy-ER benefit. Please refer to Section 16 for a detailed description of the Easy-ER benefit.
- If a beneficiary, subsequent to a visit to a casualty ward or emergency room, gets admitted to hospital, the costs related to the visit will be paid from the beneficiary's hospitalisation benefit. In such instances, Scheme authorisation is required immediately, or within 48 hours, or on the first working day after a weekend.

6.10 | Document-based Care (DBC)

- Documentation-Based Care (DBC) offers a holistic solution for the treatment of back and neck conditions at various facilities in South Africa, based on a scientifically proven treatment protocol. The treatment protocol was developed to reduce musculoskeletal pain and restore quality of life. The treatment protocol is applied worldwide to treat and manage back and neck conditions that often involve prolonged and severe pain.
- The programme is aimed at preventing the need for surgery and is widely used as a conservative pain and discomfort method. DBC therapists employ the DBC protocol, which uses DBC machines and treatment methods developed in Finland over 30 years ago.
- The team, consisting of doctors and physiotherapists, work alongside biokineticists, who treat patients on specialised DBC machinery. Using pain management and exercise-based methods, patients gain core strength and pain is reduced over time. This combination is very successful. Physiotherapy provides relief for pain, while biokinetics develops muscle mobility and strength that aids in pain management over the long term.
- The nature and duration of the programme depends on the severity of the pain, deconditioning of the patient and psychological profile. These are assessed with validated questionnaires and measurements – not only to define patients' needs, but also to monitor progress and document results.

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07 | Dental benefits

7.1 | DENIS contact details

- DENIS [Dental Information Systems (Pty) Ltd] manages beneficiaries' dental benefits on behalf of the Scheme, for all options except the Essence option.
- The Scheme pays benefits for dental treatment up to a specified percentage of MST. This may differ from the fees charged by dentists.
- KeyHealth's dental benefits can be viewed at **www.denis.co.za**.
- DENIS – important contact details:

Call centre telephone number	**0860 104 926**
Call centre fax number	**0866 770 336**
Email address for enquiries	**keyhealthenq@denis.co.za**
Email address for claims	**claims@denis.co.za**
Email address for DENIS authorisations	**auths@denis.co.za**
Email address for crowns	**crowns@denis.co.za**
Email address for periodontics	**perio@denis.co.za**
Email address for orthodontics and implants	**ortho@denis.co.za**

- Paper claims must be submitted to the following address:

  DENIS
  Private Bag X1
  CENTURY CITY
  7446

7.2 | General dental information

- Pre-authorisation is compulsory in order to qualify for any specialised dentistry or dental treatment.
- Contact the DENIS call centre on **0860 104 926** to obtain the necessary pre-authorisation.

Please note: All procedures and treatment, not pre-authorised, will attract a 20% co-payment. This does not apply to emergency hospital admissions.

- **Crowns, bridges and dentures**
  - A crown (cap) is an artificial restoration (hard cover) which is made to fit over a badly damaged or decayed tooth.
  - A bridge is made to replace one or more missing teeth. It is an alternative to a partial denture and usually used where there are fewer teeth to replace, or when the missing teeth are only on one side of the mouth.
  - A denture is a removable plate or frame holding one or more artificial teeth.
  - Benefits for crown, bridge work and dentures are subject to pre-authorisation, where the managed care protocols of DENIS apply.
  - All pre-authorisation requests for crown and bridge benefits must be accompanied by clinical records (treatment plans and clear X-rays of the teeth to be treated).
  - Clinical records must be faxed to DENIS on **0866 770 336** or emailed to **crowns@denis.co.za**.

- **Orthodontics (braces)**
  - Benefits for orthodontic treatment will be granted where function is impaired and are based on the DENIS managed care protocols.
  - All orthodontic treatment plans are measured against a clinical index to determine the functional severity of the case. Benefits are awarded to cases only when this severity level is met.
  - Benefits will not be granted where orthodontic treatment is required for cosmetic reasons.
  - Benefits are limited to beneficiaries between the ages of 9 and 18 years.
  - Only one beneficiary per family may commence orthodontic treatment in a calendar year, except in the case of identically aged siblings.
  - Orthodontic re-treatment is not covered.
  - Orthodontic related surgery, and the associated hospital admission, is not covered.
  - Benefits for orthodontic treatment are granted as a percentage of MST, per procedure code.
  - The applicable procedure is paid as follows:

    > A deposit when the treatment starts and the balance of the tariff over the estimated treatment period.
    > The member is responsible for paying the outstanding balance in respect of the deposit, as well as the monthly amounts for the duration of the treatment period.

- Relevant X-rays, treatment plans and clinical photographs must be faxed to DENIS on **0866 770 336** or emailed to **ortho@denis.co.za.**

- **Implants**
  - Benefit for implant treatment is only available on the Platinum option.
  - Hospital benefits are not available for dental implants.
  - Sinus lifts and bone augmentation procedures for implants are not covered.
  - Relevant X-rays and treatment plans must be faxed to DENIS on **0866 770 336** or emailed to **ortho@denis.co.za.**

- **Periodontics**
    - Periodontal benefit is only available to beneficiaries who are registered on the Perio Programme.
    - Beneficiaries must register on the Perio Programme by submitting the CPI score (supplied by the dental practitioner), together with the periodontal treatment plan, to **perio@denis.co.za** or alternatively faxing it to **0866 770 336**.
    - Further clinical records may be requested to process the application.
    - Surgical periodontics is a Scheme exclusion.

7.3 | Hospitalisation benefits

- Pre-authorisation for dental treatment in a hospital must be obtained by contacting the DENIS call centre on **0860 104 926** at least 48 hours prior to the planned treatment.
- Hospitalisation for dentistry is not automatically covered and is subject to DENIS authorisation, where the following protocols apply:

    - DSP hospital network – Netcare and Life Healthcare hospitals and Mediclinic (Western Cape).
    - General anaesthetic benefits are available for the removal of impacted teeth on all the options (except Essence), subject to DENIS managed care protocols.
    - General anaesthetic benefits are available on all options (except Origin and Essence) for Child Dependants under the age of 5 (five) years who require extensive dental treatment (multiple extractions and fillings).
    - Multiple visits to theatre are not covered.

Please note: Additional 30% co-payment if non-DSP hospital is used.

NOTES:

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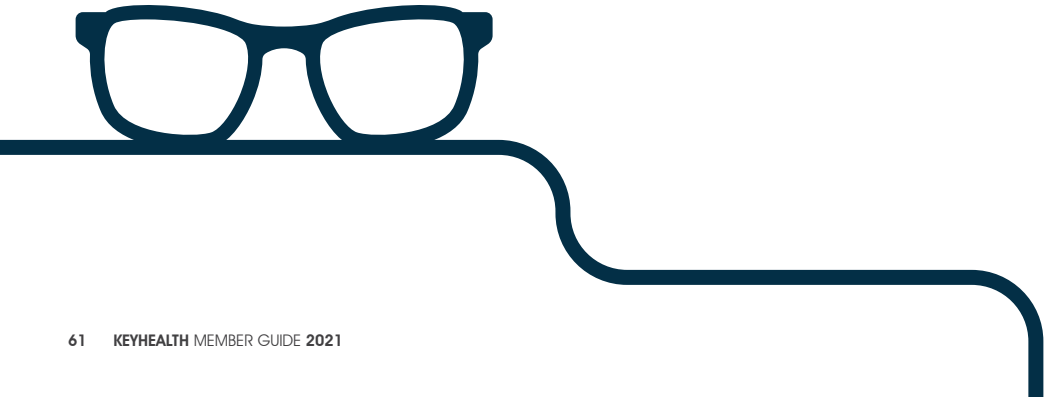
08 | Optical benefits

08 | Optical benefits

- OptiClear manages optical benefits of beneficiaries on behalf of the Scheme.
- The Scheme pays benefits for optical treatment up to 100% MST and in accordance with Scheme rules and optical protocols.
- Lenses and contact lenses must be prescribed by a registered optometrist or ophthalmologist and must be aimed at improving the patient's visual acuity.

Call centre telephone number: **011 461 6337**
Call centre fax number: **0861 100 397**



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09 | Emergency transport

09 | Emergency transport

Ambulance services

Netcare 911 provides beneficiaries with unlimited emergency service benefits, rendered in the Republic of South Africa, while managing the medical care provided to patients in the pre-hospital environment, including all associated transportation costs.

- **Emergency benefit:**
  - Emergency response to the scene of the accident is provided by road or air ambulance via the **Netcare 911** call centre by dialling **082 911** countrywide.
  - The beneficiary involved, or someone representing him/her, needs to obtain authorisation for emergency transport in order for **Netcare 911** to ensure that ambulance services are utilised appropriately, and emergency ambulance infrastructure is available to clients who require medical transportation.
  - In the event of another ambulance service provider inadvertently being used, the beneficiary, or someone representing him/her, must contact **Netcare 911** within 24 hours to obtain authorisation for the ambulance transfer.

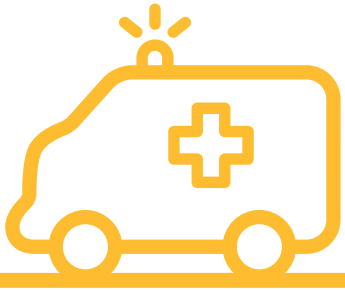
- **The following transports are covered:**
  - Primary (scene of accident/home) to hospital: emergencies only.
  - Doctor's rooms to hospital: emergencies only.
  - Hospital to hospital: subject to authorisation by the Pre-authorisation Department.
  - Hospital to stepdown/rehabilitation facility: subject to authorisation by the Pre-authorisation Department.

- **The following transports are not covered:**
  - Home to hospital: non-emergencies for booked cases.
  - Hospital to home/old age care/frail care: discharge from hospital.

- **Transfers:**
  - Authorisation for ambulance transfers must be obtained from **Netcare 911** on **082 911**.
  - Medically justified transfers to special care centres or inter-hospital transfers take place according to **Netcare 911** protocols. The Scheme provides **Netcare 911** with clinical and rule-based guidelines with regard to these transfers.

- **Additional services provided by Netcare 911:**
    - Taking care of uninjured minors;
    - Repatriation;
    - Transfers to Rape Crisis Centres of Excellence;
    - Information regarding Netcare Travel Clinics – contact **0800 223 434** (Health Online); and
    - Telephonic medical advice and information.

- **Reasons for non-payment of emergency transport-related claims:**
    - No authorisation for emergency transport was requested and obtained from **Netcare 911** within 24 hours of incident;
    - Not medically justified in terms of **Netcare 911** protocols; and
    - In case of a transfer, no authorisation was obtained from **Netcare 911**; and/or the relevant claim was received more than 4 (four) months after the service date (date on which the patient was transported).



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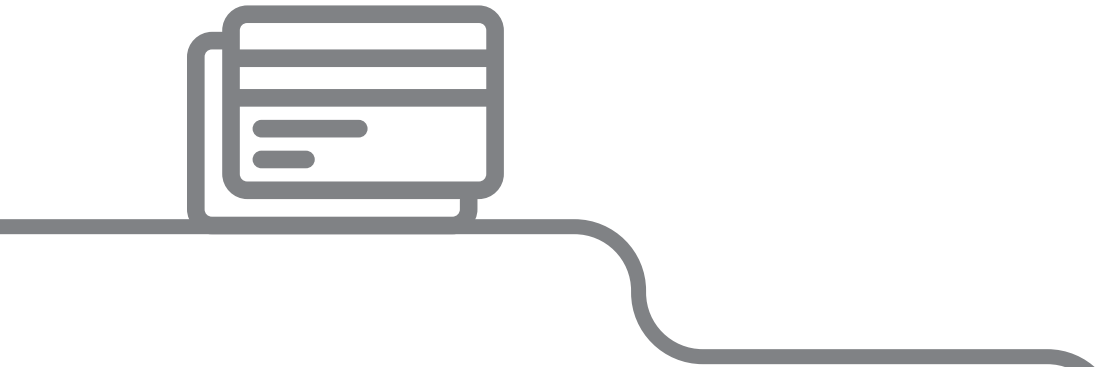
10 | Co-payments

10.1 | List of co-payments per option

Benefit		Co-payment	Explanatory notes
Platinum option			
Chronic medicine	Category B (other)	10% on non-PMB conditions	Payable directly to the service provider involved
Out-of-hospital	Pathology	20%	Payable directly to the service provider involved
Dentistry	Refer to the benefit structure summary		

Gold option			
Chronic medicine	Category B (other)	10% on non-PMB conditions	Payable directly to the service provider involved
Out-of-hospital	Pathology	30%	Payable directly to the service provider involved
Dentistry	Refer to the benefit structure summary		



Benefit		Co-payment	Explanatory notes
Silver option			
Out-of-hospital	Pathology	30%	Payable directly to the service provider involved
Dentistry	Refer to the benefit structure summary		

Equilibrium option	
Dentistry	Refer to the benefit structure summary

Origin option	
Dentistry	Refer to the benefit structure summary

Essence option	
Dentistry	Refer to the benefit structure summary

All options			
In-hospital	Hospitalisation admissions	30%	When not using DSP hospital network [Netcare, Life Healthcare and Mediclinic (Western Cape)]
Medication	Oncology medication	20%	When not using DSP pharmacies (Dis-Chem and Medipost)

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Be Smart. **Keep it Simple.**

11 | Claims

11.1 | Claims procedures

- The Scheme strives to make the claims procedure for members as user-friendly as possible.
- In most cases, claims are submitted by service providers, i.e. doctors, dentists, physiotherapists, pharmacists, etc., on behalf of the beneficiaries involved.
- The Scheme must emphasise, however, that members should check all claim entries on every claims statement to ensure that the services charged were indeed rendered to them:

    - By doing this, members will be able to notice any inaccurate claims against their benefits.
    - If there appears to be a problem on any claims statement, the member must first contact the service provider involved and enquire about the claim(s) submitted.
    - If services were indeed not rendered, contact the Scheme and point out the discrepancies, as the Scheme would like to ensure that the member only pays for services rendered.

Claims for cash payments

- If members pay cash for services covered by their benefits, they can claim back directly from the Scheme:

    - When paying cash, please remember to request a detailed account and a receipt as proof of payment.
    - Clearly mark the account submitted as 'Refund member'.

- Before submitting these claims, ensure that all accounts show the following details:

    - Member information:
        > The Principal Member's initials and surname as it appears on the latest membership card;
        > The membership number;
        > The name of the Scheme and the benefit option; and
        > The patient's first name(s) and surname, and dependant code as indicated on the latest membership card.

Please note: Ensure that the Scheme has the correct banking details for claims reimbursement.

    - Provider information:
        > The name and practice number of the service provider (doctor, hospital, pharmacy, etc.); and
        > The referring doctor and practice number, in the case of a specialist's account.

    - Services rendered:
        > The date of the service or treatment;
        > The nature and cost of each service or treatment item and the tariff code(s) [ICD-10 code(s)] involved;

> The duration of an operation (where applicable); and
> The name, quantity, price and NAPPI code of each item of medication (where applicable).

Take note: If the claim submitted does not contain all the necessary information, it will delay the process, thus delaying benefit payment.

- The Principal Member must sign and email the claim to **general@keyhealthmedical.co.za** or mail the original account and receipt to:

  KeyHealth Medical Scheme
  PO Box 14145
  Lyttelton
  0140

- Scheme reimbursement to members:
  - Any money owed to members will be paid into their bank account, provided that the Scheme has their correct banking details;
  - Payments to members are made monthly, provided that the amount payable is in excess of R50,00. If the amount payable is less than R50,00, payment will only be made once the accumulated amount reaches R50,00.

- Submission of claims:
  - Claims received by the Scheme within 4 (four) months of the date of treatment or service, will be processed according to Scheme rules;
  - If an account is not submitted within the abovementioned period, no benefits will be payable.

Please note: A receipt without the appropriate detailed account will not be considered for payment.

- Claims information supplied:
  - Processed claims will be indicated on the claims statement as follows:
    > Amounts paid by the Scheme, and to whom payment was made;
    > Refunds to members by the Scheme (if any);
    > Payments owed to the Scheme by members or any service provider (doctor, hospital, etc.); and
    > The balance of member benefits for the current benefit year.
  - Members will also receive email confirmation of claims processed (if the Scheme has the email address on its database).

Claims submitted to the Scheme by the service provider:

- Most providers of medical services and pharmacies have an electronic link to the Scheme, meaning that claims are submitted directly to the Scheme on behalf of members.
- Members are entitled to receive copies of these accounts from the service provider(s) involved.

How to submit a claim:

- **Upload claim** – Scan and upload your claim as a PDF.
- **Email claim** – Scan and email your claims to **general@keyhealthmedical.co.za**.
- **Submit via our app** – Use the app to take a photo of the claim and submit via the app.
- **Post claim** – You can submit your claim via post by sending it to: KeyHealth, PO Box 14145, Lyttelton, 0140.

Outstanding claims on resignation or death:

- Claims submitted within 4 (four) months will be considered for payment, provided the service date was prior to the date of resignation or death of the beneficiary involved.

Most common reasons for partial payment of claims:

- There may be a difference between the actual claim for the services rendered and the benefit paid by the Scheme; in other words, where the claim amount exceeds MST;
- When annual benefits are depleted; and
- Where co-payments are applicable.

Non-payment of claims:

- Services, material or medicine items are excluded from the Scheme's benefits;
- Service provider is not registered with an acknowledged professional institution;
- Allocated benefits for a specific benefit year have been depleted;
- Invalid tariff code, diagnostic or NAPPI code(s) reflected on the claim;
- Member or dependant not registered on the Scheme;
- Benefits suspended at the time of treatment/service delivery;
- No authorisation was obtained for a specific service item; or
- Claims have a service date older than 4 (four) months.

Stale claims:

- If a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform both the member and the relevant healthcare provider within 30 (thirty) days after receipt of such account, statement or claim that is erroneous or unacceptable for payment and state the reasons for such an opinion.
- After the member and the relevant healthcare provider have been informed, such member and provider must resubmit such account or statement within a period of 60 (sixty) days following the date from which it was returned for correction.
- All claims, unless otherwise arranged, must be signed and submitted to the Scheme, before the end of the 4th (fourth) month.

- For the purpose of the calculation of a benefit allocation, each month's service shall be taken into account separately, whether or not the service concerned forms part of prolonged treatment for the same illness or condition, provided that the provisions of this rule, shall not be applicable to accounts rendered by the executors of the deceased estates.

11.2 | Motor Vehicle Accident (MVA)

- In case of an MVA, and where a member and/or dependant(s) sustained injuries, requiring medical attention, take note of the following:

    - Contact the Client Service Centre on **0860 671 050** to inform the Scheme as soon as possible after the accident.
    - If a claim is instituted with the Road Accident Fund (RAF) and/or any other third party, the member concerned must provide the Scheme with a written undertaking signed by the member and/or the member's attorney involved.
    - The abovementioned document confirms the member's undertaking to reimburse the Scheme for costs defrayed relating to relevant medical expenses, in the event of the claim being favourably considered by the RAF and/or any third party.
    - On receipt of the undertaking, the Scheme will consider all relevant medical accounts for processing in accordance with the Scheme rules.
    - If a claim is not instituted at the RAF, all medical claims relating to the MVA will be considered for processing against the member's benefits and limits, and the prevailing Scheme rules.

11.3 | Injury on Duty (IOD)

- No medical claims of beneficiaries arising from an IOD are covered by the Scheme.
- All IOD claims must be submitted to the Compensation Commissioner by the employer of the beneficiary involved, without delay.
- Should it happen that claims applicable to an IOD are inadvertently paid by the Scheme, the Scheme must be informed immediately. The claims will be re-processed, and the applicable amounts will be recovered from the relevant service provider(s).

11.4 | Claims statement

- Members will be informed on a statement of all claims, activities and benefits utilised.
- Members are friendly, yet urgently, requested to carefully read every statement and to keep records for future reference, should any queries arise.
- Statements are available on the KeyHealth website and the mobi app.

11.5 | Travelling abroad

- During the overseas visit, the travelling beneficiaries will only be covered for out-of-hospital medical expenses during the first 90 (ninety) days of travel, provided that the membership is active, and the contributions are paid up to date. The member must inform the Scheme of the following in writing at least 1 (one) month in advance:

    - The full name and surname, and the dependant code of the beneficiary(ies) who will be undertaking the planned foreign visit;
    - The name(s) of the country/countries to be visited; and
    - The start and end date of the visit.

- Upon receipt of the abovementioned information, the Scheme will issue a letter to the Principal Member involved, confirming the terms and conditions of medical cover during the intended foreign visit.
- During the foreign visit, the travelling beneficiary(ies) will be liable to fund all expenses related to out-of-hospital medical treatment.
- On return, or within 4 (four) months after the date of service, the member applies to the Scheme for the reimbursement of the abovementioned claims by submitting the relevant account(s), together with the proof of payment.
- Reimbursement will be subject to the member's available day-to-day benefits and will be calculated using the foreign exchange rate applicable on the date of service and the appropriate South African tariffs for services rendered.
- No benefits available for hospitalisation, Easy-ER, medical devices/equipment, dental, optical and ambulance services.
- Any elective/planned procedure performed, outside of South Africa, will not be covered.

11.6 | Chronic medication on travelling abroad

- To qualify for additional chronic medicine (PMB/CDL medication only) for use during a foreign visit (up to a maximum of 90 (ninety) days without interruption), the Principal Member involved must inform the Scheme in writing at least 1 (one) month in advance of the following:

    - The full name and surname, and the dependant code of the beneficiary(ies) who will be undertaking the planned foreign visit;
    - The name(s) of the country(ies) to be visited;
    - The starting and end date of the visit; and
    - The name(s) of the additional chronic medicine required, and the quantities involved.

- Upon receipt of the necessary chronic information, the Scheme will issue the beneficiary, bound to travel abroad, with a letter of confirmation to be utilised by the pharmacist to release and claim for the chronic medicine involved.
- The beneficiary(ies) planning to travel abroad and who will require additional chronic medication, must then request their pharmacist to contact MediKredit at least 14 (fourteen) days prior to departure on **0800 132 345** to make the necessary arrangements.

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12 | Medical Savings Account (MSA)

12.1 | Application of MSA

Please note: In terms of legislation, a scheme member is not allowed to make any additional voluntary deposit into his/her medical savings account.

The Gold and Equilibrium options each provides for a medical savings account:

- Medical savings are allocated in advance for the full benefit year (i.e. annual medical savings). Any medical savings not being utilised during a specific benefit year will be carried over to the following benefit year.
- The member's annual medical savings balance will be utilised first for all day-to-day medical expenses. Once annual savings are depleted, day-to-day expenses will then be covered from the applicable benefits.
- After depletion of the day-to-day benefits, the available savings balance (i.e. carried forward savings) from previous years will be utilised.

Provision has been made by the Scheme for 'debt redemption' on the medical savings account. This means that any money due to the member will, after debt redemption, be refunded in the following instances:

- Change of option: Should the selected new option not make provision for a savings account.

  - Resignation (1): Should a member resign from the Scheme during the year and the member's new medical scheme does not have a savings option, the savings amount will be paid out to the member.
  - Resignation (2): Should a member resign from the Scheme during the year and the member's new medical scheme does have a savings option, the savings amount will be paid out to the new medical scheme.

Please note: Allow up to 5 (five) months for the MSA credit balance to be refunded.

In the event of the savings amount, allocated to the member, being exceeded or depleted before 31 December, the member will be liable to refund the amount due to the Scheme in the following instances:

- Change in KeyHealth option – should the new option, selected by the member, not make provision for a savings account; and
- In the event of the beneficiaries resigning from the Scheme.

The following medical expenses can also be paid from a member's medical savings account:

- Co-payments;
- Payments of amounts where the maximum benefits were exceeded;
- Payments for services excluded from benefits;
- Payment for services rendered during waiting periods; and
- Payment for services rendered in respect of underwriting exclusions.

A member's savings account may not be utilised to pay for any expenses regarding PMB and CDL conditions.

How will MSA be reflected on the member's monthly statement?

- **Opening savings balance** – This balance (on the first day of January each year) will include the previous years, carried forward savings balance.
- **Savings contribution received/reversed** – This amount will include the savings contribution paid by the member and allocated on the system in the specific month of payment, or any saving contribution reversed, e.g. backdated resignation/activation or debit order rejection.
- **Claims paid from savings/reversed** – This amount will include claims paid from the savings balance, savings refunded/recovered or transferred to another medical scheme, and/or any reversal done on claims paid from savings for the specific month.
- **Savings contributions advanced** – This amount will include all annual savings available to the member in advance, but not yet paid in by the member.

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13 | List of exclusions

13 | List of exclusions

With the exception of the Prescribed Minimum Benefits (PMBs), and unless specific provision has been made in the Scheme Rules for benefits, no benefits will be payable in respect of the following:

- Costs incurred for treatment arising out of an injury sustained by a beneficiary for which any third party is liable. The beneficiary is, however, entitled to such benefits as would have applied, provided that, on receipt of payment in respect of resultant third party claims, the Principal Member will reimburse the Scheme any payments made by the Scheme in respect of these claims.
- Services exceeding the maximum benefits to which the beneficiary is entitled to, as contained in the Scheme Rules.
- The cost of services rendered in respect of the following:

1. Persons not registered with an acknowledged professional institution that was established or registered in accordance with relevant legislation.
2. Any institution, nursing institution or similar institution, except a state hospital, that are not registered in accordance with relevant legislation.
3. Any person or institution that does not have a practice number.
4. Costs incurred for treatment arising out of an injury or disablement resulting from war, invasion or civil war, except for PMBs.
5. Accommodation or lodging fees in convalescent or old age homes, frail care facilities, institutions for the physically or the mentally handicapped, or similar institutions.
6. Accommodation and treatment in spas and resorts for health, slimming, chiropractic, homeopathic or similar purposes, and home nursing.
7. Accommodation in a private room of a hospital, except when clinically motivated by a medical practitioner and approved by the Scheme, or when giving natural birth on the Platinum, Gold, Silver, Equilibrium or Origin options.
8. The cost of holidays for recuperative purposes, whether deemed medically necessary or not.
9. Medical examinations for insurance, school camp, visa, employment or similar purposes.
10. Travelling costs incurred by beneficiaries.
11. Charges for repairs of medical appliances.
12. Medical examinations, consultations, treatment, operations and procedures relating to:

    12.1 Acupuncture;
    12.2 Bio-stress assessments;
    12.3 Colonic irrigation;
    12.4 Conservative back/neck treatment in hospital;
    12.5 Cosmetic/non-functional procedures;
    12.6 DNA testing;

12.7 Gender reassignment;
12.8 Industrial and educational psychologists;
12.9 IQ tests and learning and/or educational problems;
12.10 Music and water therapy;
12.11 Obesity and weight loss surgery (excluding benefits available on the Health Booster);
12.12 Polysomnogram and titration;
12.13 Reversal of sterilization;
12.14 Reversal of vasectomy;
12.15 Sclerotherapy of varicose veins;
12.16 Sonography and sonographer;
12.17 Therapeutic reflexology; and
12.18 VAC installation therapy, including Pico and Prevena dressings and any non-DSP Negative Pressure Wound Therapy (NPWT).

13. In respect of the PMB code 902M, infertility, the following services are excluded:

13.1 Assisted Reproductive Technology (ART) techniques, including In-Vitro Fertilisation (IVF);
13.2 Gamete Intra-Fallopian Tube Transfer (GIFT);
13.3 Zygote Intra-Fallopian Tube Transfer (ZIFT).
13.4 Intra-cytoplasmic Sperm Injection (ICSI);
13.5 Surrogacy (including the following):
13.5.1 Artificial insemination;
13.5.2 Delivery;
13.5.3 Gestational surrogacy (GS) and donor sperm (DS); and
13.5.4 Maternity benefits (day-to-day and/or Health Booster).

14. Charges for the following:

14.1 Ante- and post-natal exercise classes (excluding the benefits available on the Health Booster);
14.2 Appointments not kept;
14.3 Breast-feeding instructions;
14.4 Mother-craft; and
14.5 Telephonic consultations with medical practitioners.

15. Purchase or hire of the following equipment:

15.1 APS therapy machines or similar devices;
15.2 Bedpans;
15.3 Binders (abdominal, chest, hernia);
15.4 Breast pump/machine (except on the Smart Baby programme);

15.5 Continuous glucose monitoring system;
15.6 Commodes;
15.7 Compression pants;
15.8 Cosmetic improvement to the appearance of prosthetic/artificial limb;
15.9 CPAP machines and accessories;
15.10 Cryo cuff or similar products for compression, hot and cold therapy;
15.11 Cushions (any sort);
15.12 Elevation devices/equipment;
15.13 Foot orthotics;
15.14 Hamstring support pants;
15.15 Health shoes (any sort);
15.16 Heart Hugger/brace;
15.17 Humidifiers;
15.18 Kidney belts;
15.19 Mattresses, including Numbus mattresses;
15.20 Medic Alert bands;
15.21 Peak flow meters;
15.22 Resting splints (foot/wrist);
15.23 Restraining devices;
15.24 Sheepskin;
15.25 Special beds or chairs (any sort);
15.26 Toilet seat raiser;
15.27 Traction kit;
15.28 Waterproof sheets;
15.29 Water birth equipment purchase/rental; and
15.30 Wheelchair luxury accessories.

16. The purchase of:

16.1 Growth hormones;
16.2 Household remedies or preparations of the type advertised to the public;
16.3 Medicines that are not prescribed on a written prescription of a person authorised by relevant legislation;
16.4 Mouth protectors, gold inlays, devices and materials such as floss, toothbrushes and toothpaste;
16.5 Slimming preparations, appetite suppressants, food supplements and patent foods, including baby foods;
16.6 Soaps, shampoos and other topical applications, medicated or otherwise;
16.7 Sun-screening and tanning agents;
16.8 Supplements; and
16.9 Vitamins without a NAPPI code.

17. General optical benefit exclusions:

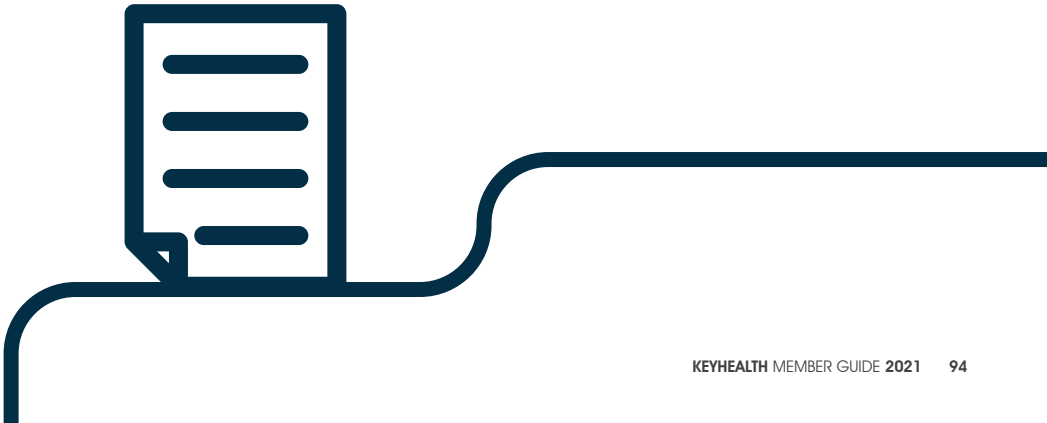
17.1 Contact lens solutions;
17.2 Lenses with a tint exceeding 35%;
17.3 Scripts less than 0.50 dioptre;
17.4 Spectacle cases;
17.5 Spectacle repairs;
17.6 Sunglasses; and
17.7 The fee associated with the fitting and adjustment of contact lenses.

General dental benefit exclusions with due regard to the PMBs:

1. Apicectomy in the hospital;
2. Appointment not kept;
3. Auto-transplantation of teeth;
4. Behaviour management;
5. Bleaching, front tooth laminate veneers and composite veneers;
6. Bone and other tissue regeneration procedures;
7. Bone augmentations;
8. Caries susceptibility and microbiological tests;
9. Clinical fee for soft base to new dentures;
10. Conservative dental treatment (fillings, extractions and root canal therapy) in the hospital for adults;
11. Cost of bone regeneration material;
12. Cost of dental materials for procedures performed under general anesthesia in-hospital;
13. Cost of gold, precious metal, semi-precious metal and platinum foil;
14. Cost of invisible retainer material;
15. Cost of mineral trioxide;
16. Cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl) and ointments;
17. Crown or crown retainers on third molars (wisdom teeth);
18. Dental bleaching and porcelain veneers;
19. Dental testimony, including dento-legal fees;
20. Dentectomies in the hospital;
21. Diagnostic dentures;
22. Electrognathographic recordings and other such electronic analyses;
23. Emergency crown that is not placed for the immediate protection in tooth injury;
24. Enamel microabrasion;
25. Fillings to restore teeth damage due to toothbrush abrasion, attrition, erosion, and/or fluorosis;
26. Fissure sealants on patients 16 (sixteen) years and older;
27. Fixed prosthodontics (crowns) used to repair teeth damaged due to bruxism (tooth grinding). toothbrush abrasion; erosion or fluorosis;
28. Fixed prosthodontics (crowns) used to restore teeth for cosmetic reasons;

29. Fixed prosthodontics (crowns) where a reasonable attempt has not been made to restore/replace the tooth conservatively;
30. Fixed prosthodontics (crowns) where the mouth is periodontally compromised;
31. Fixed prosthodontics (crowns) where the tooth has been recently restored to function;
32. Fixed prosthodontics used to repair occlusal wear;
33. Frenectomies in the hospital;
34. Full metal base to dentures;
35. Gingivectomy;
36. High-impact acrylic;
37. Hospitalisation for any dental treatment other than the removal of impacted teeth on the Origin option;
38. Hospitalisation on the Essence option;
39. Hospitalisation for surgical tooth exposure for orthodontic reasons;
40. Hospitalisation where the only reason for admission request is for a sterile facility;
41. Hospitalisation where the only reason for admission to hospital is dental fear and anxiety;
42. Implants or third molars (wisdom teeth);
43. Intramuscular or subcutaneous injection;
44. Laboratory cost of provisional and emergency crowns;
45. Laboratory costs, where the associated dental treatment is not covered;
46. Laboratory delivery fees;
47. Laboratory fabricated crowns for primary teeth.
48. Laboratory fabricated temporary crowns;
49. Metal, porcelain or resin inlays, except where such inlays form part of a bridge;
50. Multiple hospital admissions;
51. Nutritional and tobacco counselling;
52. Occlusal rehabilitation;
53. Orthodontic re-treatment;
54. Orthodontic-related surgery, and any associated hospital and laboratory costs;
55. Ozone therapy;
56. PerioChip;
57. Periodontal flap surgery and tissue grafting;
58. Polishing of restorations;
59. Pontics on second molars. Subject to managed care protocols;
60. Porcelain veneers and inlays;
61. Preventative care and evaluation;
62. Procedures that are defined as unusual circumstances and procedures that are defined as unlisted procedures;
63. Professional oral hygiene procedures in the hospital (scale, polish and fluoride treatment);
64. Professionally applied fluoride for beneficiaries younger than 5 (five) years old and 13 (thirteen) years and older;
65. Provisional crowns;
66. Provisional dentures and associated laboratory fees;

67. Pulp capping (direct and indirect);
68. Pulp tests;
69. Resin bonding for restorations charged as a separate procedure;
70. Root canal treatment on third molars (wisdom teeth) and primary teeth;
71. Sinus lifts;
72. Snoring appliances;
73. Special reports;
74. Surgery and hospitalisation associated with dental implants;
75. Three-quarter crowns (cast metal and porcelain); and
76. Treatment plan completed (currently code 8120).



Be Smart. **Keep it Simple.**

14 | Health Booster

A programme available on all options to provide beneficiaries with certain additional benefits for preventive care:

- Only the benefits stated in the benefit structure under Health Booster, and applicable to that particular benefit option, will be paid by the Scheme, up to a maximum rand value that is determined according to specific tariff codes.

Qualification:

- Members qualify automatically for Health Booster benefits according to the set criteria, however:

  - Pre-authorisation is required in order to access the maternity and weight loss benefits on Health Booster. Contact the pre-authorisation call centre on **0860 671 060** to obtain pre-authorisation. (Failing to do this will result in the service costs being deducted from day-to-day benefits);
  - When maternity-related claims are submitted by providers, these claims should specify the relevant ICD-10 code as contained in the pre-authorisation letter;
  - Verify the tariff code or maximum rand value with the call centre consultant; and
  - Inform the relevant service provider accordingly.

Screening tests:

- One of the benefits available on the Health Booster programme is the Health Assessment (HA). This assessment comprises the following screening tests:

  - Body mass index (BMI);
  - Blood sugar (finger prick test);
  - Total cholesterol (finger prick test);
  - Blood pressure (systolic and diastolic); and
  - Rapid semi-quantitative prostate specific antigen (PSA) test (finger prick).

- Principal Members and all their dependants are entitled to one Health Assessment (HA) per calendar year.
- A Health Assessment (HA) form can be obtained at any pharmacy or downloaded from **www.keyhealthmedical.co.za**.
- No authorisation is required for these screening tests.
- Results of these screening tests can be submitted by either the member or the service provider and must be faxed to **012 679 4471**.

TYPE OF TEST	WHO & HOW OFTEN
PREVENTIVE CARE	
Baby immunisation	Child Dependants aged ≤6 – as required by the Department of Health
Flu vaccination	All beneficiaries (February to June)
Tetanus diphtheria injection	All beneficiaries – as and when required
Pneumococcal vaccination (Prevenar not included)	All beneficiaries
Malaria medication	All beneficiaries – R395 once per year
HPV vaccination	Female beneficiaries aged ≤9-14 – 2 doses per lifetime
Baby growth assessments	3 baby growth assessments at a pharmacy or baby clinic for beneficiaries aged between 0-35 months, per year
Contraceptive medication – tablets/patches	Female beneficiaries aged ≥16 – R156 every 20 days (Silver, Equilibrium, Origin and Essence options only)
Contraceptive medication – injectables	Female beneficiaries aged ≥16 – R470 (Silver, Equilibrium, Origin and Essence options only)
EARLY DETECTION TESTS	
Pap smear (Pathologist)	Female beneficiaries aged ≥15 – once per year
Pap smear (including consultation and pelvic organs ultrasound; GP or Gynaecologist)	Female beneficiaries aged ≥15 – once per year
Mammogram	Female beneficiaries aged ≥40 – once per year
Prostate specific antigen (PSA) (Pathologist)	Male beneficiaries aged ≥40 – once per year
HIV/AIDS test (Pathologist)	All beneficiaries – once per year.
Health Assessment (HA): Body mass index, blood pressure measurement, cholesterol test (finger prick), blood sugar test (finger prick) PSA (finger prick)	All beneficiaries – once per year
Dental consultation including X-rays	All beneficiaries – once per year (Essence option only)
WEIGHT LOSS*	
Weight Loss Programme	For all beneficiaries when the Health Assessment BMI is ≥ 30: • 3 x dietician consultations (one per week) • 3 x additional dietician consultations (one per week, provided that a weight loss chart was received from dietician proving weight loss after first three weeks) *Pre-authorisation *Subject to the use of DSP provider(s) • One biokineticist consultation (to create a home exercise programme for the member) • 1 x follow-up consultation with biokineticist
MATERNITY*	
Antenatal visits (GP, gynaecologist or midwife) and urine test (dipstick) #	Female beneficiaries. Pre-notification of and pre-authorisation by the Scheme compulsory. 12 visits
Sonars (GP or gynaecologist) – one before the 24th week and one thereafter#	Female beneficiaries. Pre-notification of and pre-authorisation by the Scheme compulsory. 2 pregnancy scans
Short payments/co-payments for services rendered in (#) above and birthing fees	Covered to the value of R1 230 per pregnancy
Paediatrician visits	Baby registered on Scheme. 2 visits in baby's 1st year. 1 visit in baby's 2nd year
Ante-natal vitamins	Covered to the value of R2 080 per pregnancy
Ante-natal classes	Covered to the value of R2 080 for first pregnancy
*Pre-authorisation essential to access benefits, apply to disease@keyhealthmedical.co.za *Subject to the use of the Scheme's DSPs	

Be Smart. **Keep it Simple.**

15 | Smart Baby Programme

Expecting a baby is one of the most exciting and special times in any family's life. Smart Baby is there to make this experience even more special by offering great maternity benefits, support, general advice on health and wellness, and simply making the journey as enjoyable as possible for you.

More than just offering medical peace of mind for expectant mothers, Smart Baby is also KeyHealth's way of making mothers- and fathers-to-be feel special by providing them with the necessary guidance when it's needed most.

A member can register from week 12 (twelve) of the pregnancy, whereafter she will have access to the following:

- A benefit of R1 230 that will cover short payments/co-payments for services rendered during antenatal visits (GP, gynaecologist or midwife) or during pregnancy sonars (including the cost for birthing fees). This benefit can also be used for the following:

  - Breast pump
  - Thermometer
  - Nose cleaner/nasal aspirator
  - Baby monitor

- **The New Baby & Childcare Handbook** by Marina Petropulos, to assist first-time mothers during this exciting time.
- Access to the KeyHealth Smart Baby Facebook group providing valuable information and answers to questions regarding pregnancy and general childcare.
- Regular, valuable communication during the pregnancy.
- Information regarding KeyHealth's maternity benefits available to mothers and babies (e.g. antenatal visits, vitamins and classes, ultrasounds, etc.) and how to access these benefits.
- Information applicable to baby's first year (e.g. vaccinations, Easy-ER, etc.).

Members can register on the Smart Baby Programme by dialing 0860 671 060 or visit www.keyhealthmedical.co.za for more information.

Smart Baby

NOTES:

Be Smart. **Keep it Simple.**

16 | Easy-ER

When you need emergency medical treatment, the last thing you want is to get hurt twice – by admin, facility and other ER fees. These are the sort of fees which other medical schemes say they 'cover' but ultimately come from your pocket, savings or day-to-day benefits.

Easy-ER is a first-of-its-kind KeyHealth initiative that offers all KeyHealth beneficiaries, regardless of their age, free emergency medical cover without any hidden costs.

What is Easy-ER?

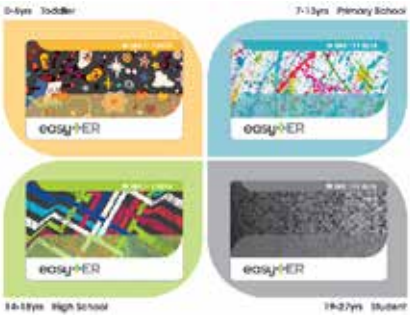
- Extended to the entire family, Easy-ER gives each beneficiary free, direct access to a hospital's emergency room (ER) for medical treatment in emergency situations. This immediate access comes without any hassles or upfront payment requirements. KeyHealth guarantees the full payment in such emergency situations.
- These emergency circumstances may include:

  - Sport injuries;
  - Playground accidents;
  - Car accidents.

Please note: To qualify, services must be rendered on the day of the incident.

The Easy-ER card for children

One of the greatest things about Easy-ER is the card for children. The reason behind the Easy-ER card is to ensure that all KeyHealth children can get immediate access to a hospital's ER facility, even if they do not have a parent with them.



Easy-ER cards have very specific design styles and these cards will certainly be something that they will want to keep with them wherever they go.

- The card contains all the details to effectively confirm the eligibility of the child. The child will gain free access to the ER facilities when presenting the Easy-ER card.
- Please see the **what you must know** section on what to do in the event that the child does not have the card with them in an emergency situation.

Benefits of Easy-ER

- No upfront payment required.
- KeyHealth guarantees payment of the full ER event – subject to the event being classified as an emergency with the diagnosis and treatment confirming the classification.
- Up until now, this payment was made from the savings/day-to-day benefit (where applicable). If a member's savings/day-to-day benefits are depleted, or their option does not include savings/day-to-day benefits (e.g. Essence option), then the amount would be payable by the member. With Easy-ER, this is no longer the case. Even if the member doesn't have normal benefits available, the full cost of the ER visit will be covered.

What you must know

- Easy-ER is available to all KeyHealth beneficiaries.
- Easy-ER guarantees free access to and treatment at any hospital's ER facility for emergency/trauma situations.
- If the beneficiary gets admitted to hospital subsequent to the ER treatment, the normal hospital benefit will apply.
- Easy-ER provides a 24-hour free call-centre for anybody to confirm eligibility of the member and/or beneficiary – **080 111 0215.**
- In the event that the beneficiary does not have the card with him/her, eligibility can be confirmed by calling the 24-hour call centre and providing the necessary membership details.
- This call line is not for hospital pre-authorisation, medical advice or any other use.
- The call centre number will be available at all ER facilities.
- In the event that the beneficiary requires emergency transport (e.g. ambulance services), the normal procedure must be followed. In such case, the Scheme's emergency transport provider, **Netcare 911**, must be called on **082 911.**

Please note: Although Easy-ER guarantees free access to ER facilities, some practices may insist on an upfront payment. In such case, the member must contact the Scheme as soon as possible on **info@keyhealthmedical.co.za** for reimbursement of this fee.

Please note: The Easy-ER benefits does not include pharmacy claims, medical appliances and follow-up visits.

Dental emergencies

- Easy-ER also covers treatment in the event of dental emergencies/accidents which are a direct result of an external blow to the mouth/face. If a tooth gets broken or is knocked out, Easy-ER will guarantee the payment of all dental treatment required to restore the damaged tooth to functional use.

  - Please note that certain limits may apply on component costs, if applicable.

- Pre-authorisation, based on the treatment plan provided by the dental practitioner, must be obtained from DENIS. Such requests must be sent to **keyhealthenq@denis.co.za**.
- In the event of a dental emergency, based on the abovementioned criteria, the beneficiary can go directly to the dental practitioner for treatment. A visit to the hospital's ER facility is therefore not a pre-requisite to qualify for Easy-ER-related dental treatment.

Emergency checklist

- It is daytime (during working hours) and you are able to, and your condition allows you to, visit your GP instead of going to an ER facility.
  (YES/NO)
- Your condition allows you to wait to see your GP, and you don't need emergency medical care immediately.
  (YES/NO)
- Your condition is a recurring condition which had previously been successfully treated by a GP.
  (YES/NO)
- The condition you are suffering from is toothache, an abscess of the tooth, or you damaged your tooth by biting or chewing.
  (YES/NO)

* *If you answer yes to any of the abovementioned questions, your condition is not classified as an emergency.*

* *If, after working hours, you are unsure whether your condition meets the Easy-ER criteria, rather choose the safer option and get ER treatment as soon as possible.*

Please note: The benefits of Easy-ER should not be abused. In instances where this benefit has been abused, KeyHealth reserves the right to recoup any monies from the Principal Member by any means possible, and to suspend the Easy-ER benefits of such a member immediately.

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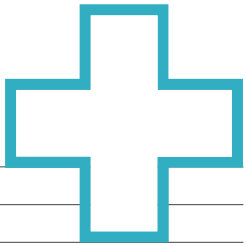

Be Smart. **Keep it Simple.**

17 | Fraud/unethical conduct

17 | Fraud/unethical conduct

- Fraud is the unlawful and intentional making of a misrepresentation which causes actual prejudice, or which is potentially prejudicial to another.
- Fraud consists of the following elements:

    - An act, that is the making of a representation;
    - A casual link between the making of the representation and the prejudice;
    - Unlawfulness;
    - Prejudice or potential prejudice;
    - Intention.

- The cost of medical fraud/unethical medical conduct in South Africa is estimated at billions of rands every year. This constitutes a huge financial loss, not only to medical schemes, but indirectly to every scheme member in the country.
- Fraud/unethical conduct is mainly committed for economic, egocentric, ideological and psychological reasons, of which the economic motive is the most common. Detection of fraud/unethical conduct is, for the most part, time consuming and costly. The Scheme is pro-active in identifying fraud by using its operational system to detect anomalies and trends, and also flags certain areas for monitoring to ensure that fraud or unethical behaviour is detected.
- KeyHealth also depends largely on its beneficiaries and suppliers to report any form of fraud/unethical conduct; whether reporting occurs openly or anonymously.
- In this regard, KeyHealth makes use of the services available from its administrator to provide a safe channel, where anonymity is guaranteed, to those who wish to report on (suspected) malpractices.
- All reported cases are then handed over to the Scheme's Internal Audit Department for the necessary investigations to be conducted. KeyHealth has a zero-tolerance policy towards fraud.
- Report any (suspected) fraud/unethical conduct at **0860 110 820** (Monday to Friday, 07:30 until 16:00, public holidays excluded), or via email at **fraud@keyhealthmedical.co.za**.

NOTES:

18 | Electronic communication

18.1 | Via the internet

www.keyhealthmedical.co.za

- KeyHealth's website is an informative, interactive gathering place for existing and prospective members, service providers, brokers and the Scheme.

Easy steps to register as an internet user:

1. Visit **www.keyhealthmedical.co.za**.
2. Click on the ***Login*** tab.
3. Click on ***Register for an account***.
4. Complete the electronic form and click on ***Submit***.
5. The following message will appear on the screen:

Your new user form has been submitted... User status is Active – Active User.

6. Click on ***OK***.
7. You can now log in by using the username and password you selected.

Forgotten password:

1. Click on the ***Login*** tab on the homepage of the KeyHealth website.
2. Click on ***Forgotten your login or password?***
3. Complete the ***Forgotten password form*** and click on ***Submit***.
4. The following message will appear on the screen:

Your forgotten password form has been submitted.

5. Click on ***OK***.
6. You will receive a new password via email.
7. Use the new password to sign in.

Online enquiries:

- The following information can be viewed when logging in with your username and password as user:

  - ***Personal details*** – This page contains all the member's personal, contact and address details.
  - ***Change my information*** – The member can update his/her language preference, personal details, beneficiaries' personal details, contact information, physical and postal addresses here.
  - ***Banking details*** – The member can view his/her banking details here.
  - ***Claims*** – All available claims submitted to the scheme can be viewed here.
  - ***Chronic conditions*** – All registered chronic conditions for the member and his/her beneficiaries can be viewed here.
  - ***Authorisations*** – The member and his/her beneficiaries' authorisation history can be viewed here.
  - ***Exclusions*** – A list of the waiting periods applicable to the member or his/her beneficiaries can be viewed here.
  - ***Benefits*** – This category includes a summary of the member's maximum, used and available benefits.
  - ***Communications and documents*** – All electronic communication sent to the member by the Scheme can be viewed here.
  - ***Statements*** – All statements related to claim payments can be viewed here.
  - ***Tax certificates*** – The tax certificate can be viewed here.

18.2 | Online chat facility

- The online chat (live support) is a web service that allows members and providers to chat with a client service consultant in real-time. This function will not replace any of the existing communication methods. It is merely an additional tool to further enhance your service experience.

- The real-time nature of the chat helps to ease the frustrations of having to phone and wait for the next available consultant, or of sending an email and having to wait for the response.

- A transcript of your conversation will be emailed to you immediately after the conversation.

- The online chat facility is available every Monday to Friday between 08:00 and 19:00, excluding public holidays, and can be accessed from the homepage of the Scheme's website **www.keyhealthmedical.co.za**.

18.3 | Mobile app

- For KeyHealth, it is all about keeping things as simple as possible for our members. This often requires a smart approach.
- The Scheme now has its own fully-fledged application (app) for mobile smart phones. It is an exciting initiative that utilises the power of technology to simplify the member experience.
- The following functionalities/valuable information is accessible to members on the app:

  - Electronic membership cards (including Easy-ER cards);
  - The ability to send copies of membership cards to providers;
  - The ability to communicate in real-time with client service consultants, using the online chat facility;
  - The ability to submit claims and other documents to the Scheme;
  - Viewing of documents (e.g. tax certificates, claims advices, etc.);
  - Interactive 'Contact us' information;
  - ER facility search;
  - DSP hospital and specialist search;
  - Information on benefits; and
  - Request travel letter.

Please note: The KeyHealth app can only be downloaded on phones operating on Android and iPhone operating systems. Each beneficiary can download the app on his/her own phone. Visit the website at **www.keyhealthmedical.co.za** for assistance on how to download the app on one of the abovementioned operating systems.

NOTES:

Be Smart. **Keep it Simple.**

19 | Important contact information

19 | Important contact information

Client Service Centre		
Email	info@keyhealthmedical.co.za	Fax: 0860 111 390
Easy-ER	**080 111 0215**	
Netcare 911	**082 911**	
Hospital pre-authorisation	**0860 671 060**	
Email	preauth@keyhealthmedical.co.za	Fax: 012 679 4471
Oncology management programme	**0860 671 060**	
Email	oncology@keyhealthmedical.co.za	Fax: 012 679 4469
DENIS (Dental) pre-authorisation	**0860 104 926**	
Email	keyhealthenq@denis.co.za	Fax: 0866 770 336
DENIS (Dental claims enquiries/Submissions)		
Email	claims@denis.co.za	
LifeSense disease management	**0860 50 60 80**	
Crisis line (Netcare 911)	**082 911**	
Chronic medication registration (to be used by providers)	**0800 132 345**	
OptiClear (Optical management)	**011 461 6337**	
		Fax: 0861 100 397
Fraud/Ethics line	**0860 110 820**	
Email	fraud@keyhealthmedical.co.za	

New business		
Email	newbusiness@keyhealthmedical.co.za	Fax: 0866 050 656

Membership	0860 671 050	
Email	membership@keyhealthmedical.co.za proofofpayment@keyhealthmedical.co.za	Fax: 0860 111 390

Claims submission (excluding DENIS claims)		
Email	general@keyhealthmedical.co.za	Fax: 0860 111 390

Broker queries	0860 671 050	
Email	info@keyhealthmedical.co.za	

Website	www.keyhealthmedical.co.za

Postal address:	KeyHealth Medical Scheme PO Box 14145 Lyttelton 0140

KeyHealth Client Service Centre business hours:

The Client Service Centre is available Mondays to Fridays between 07:30 and 18:00, and Saturdays between 08:00 and 12:00, public holidays excluded.

Walk-in offices:

Centurion
PPS Centurion Square
Cnr Gordon Hood & Heuwel Road
Centurion

Durban
Regus Business Centre
Kingsmead
11 Walnut Road
Durban

Port Elizabeth
170 Cape Road
Mill Park
Port Elizabeth

Any dispute in respect of the Scheme Rules or benefit options may be referred to the Scheme's Dispute Committee. Such submissions must be in writing and must be sent to PO Box 14145, Lyttelton, 0140. Should members not be satisfied with the Scheme's internal dispute resolution mechanisms, they can submit a complaint in this regard to the Registrar of Medical Schemes. The Registrar's contact details are:

Telephone: **0861 123 267** • Email: **complaints@medicalschemes.co.za** • Website: **www.medicalschemes.co.za**

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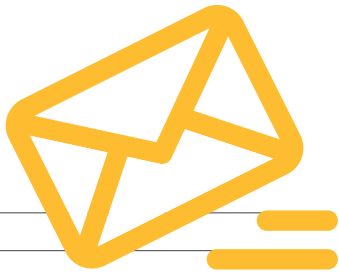

KeyHealth
MEDICAL SCHEME
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