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.
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1.1 KEYHEALTH

KeyHealth (referred to as ‘the Scheme’) has a formidable footprint in the industry (more than 85 000 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’ four (4) 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.
Glossary, Abbreviations & Explanations
### GLOSSARY, ABBREVIATIONS & EXPLANATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PM</td>
<td>Principal Member</td>
</tr>
<tr>
<td>AD</td>
<td>Adult Dependant</td>
</tr>
<tr>
<td>CD</td>
<td>Child Dependant</td>
</tr>
<tr>
<td>MSA</td>
<td>Medical Savings Account</td>
</tr>
<tr>
<td>pbpa</td>
<td>per beneficiary per annum (per year)</td>
</tr>
<tr>
<td>pbp2a</td>
<td>per beneficiary biennially (every second year)</td>
</tr>
<tr>
<td>pfpa</td>
<td>per family per annum (per year)</td>
</tr>
<tr>
<td>pfp2a</td>
<td>per family biennially (every second year)</td>
</tr>
<tr>
<td>2pfpa</td>
<td>two (2) (times) per family per annum (per year)</td>
</tr>
</tbody>
</table>

**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 three (3) 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 – Platinum option only).
Conservative dentistry:
• Basic dental services, such as fillings, extractions and oral hygiene.

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 and Equilibrium 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 preferred provider(s) to supply its Members with diagnosis, treatment and health products at specific negotiated tariffs.

Disease Risk Management (DRM) Program:
• A unique program 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 the children of KeyHealth Members 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.

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.

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 unique medication identification.

Oncology:
- The treatment of cancer.

Optical management:
- A cost and quality Optical Management Programme provided by Opticlear.

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.

Platinum Option:
- The day-to-day benefits on the Platinum option comprise of 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.
- 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.

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.
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):

<table>
<thead>
<tr>
<th>WHO</th>
<th>WHAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Member</td>
<td>• Copy of ID.</td>
</tr>
<tr>
<td></td>
<td>• Membership certificate from previous medical scheme (if applicable).</td>
</tr>
<tr>
<td>Husband/Wife</td>
<td>• Copy of ID.</td>
</tr>
<tr>
<td></td>
<td>• Copy of marriage certificate / proof of marriage.</td>
</tr>
<tr>
<td></td>
<td>• Membership certificate from previous medical scheme (if applicable).</td>
</tr>
<tr>
<td>Biological baby</td>
<td>• Copy of birth certificate or proof of birth from hospital/clinic.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Note: babies must be registered within 90 days of birth.</strong></td>
</tr>
<tr>
<td>Child Dependant; up to the age of 21</td>
<td>• Copy of ID.</td>
</tr>
<tr>
<td></td>
<td>• Membership certificate from previous medical scheme (if applicable).</td>
</tr>
<tr>
<td>Dependant; aged 21 and over (see below)</td>
<td>• Copy of ID.</td>
</tr>
<tr>
<td></td>
<td>• Proof of full-time studies (if applicable).</td>
</tr>
<tr>
<td></td>
<td>• Membership certificate from previous medical scheme (if applicable).</td>
</tr>
<tr>
<td>Continuation of membership</td>
<td>• Copy of ID.</td>
</tr>
<tr>
<td></td>
<td>• Letter from Principal Member requesting continuation of Membership.</td>
</tr>
<tr>
<td></td>
<td>• Debit order authorisation (contributions; if applicable).</td>
</tr>
<tr>
<td></td>
<td>• Copy of latest bank statement or affidavit of financial means.</td>
</tr>
<tr>
<td>Widow(er)</td>
<td>• Copy of ID.</td>
</tr>
<tr>
<td></td>
<td>• Copy of death certificate.</td>
</tr>
<tr>
<td></td>
<td>• Letter from widow(er) confirming option choice.</td>
</tr>
<tr>
<td></td>
<td>• Debit order authorisation (contributions; if applicable).</td>
</tr>
<tr>
<td></td>
<td>• Copy of latest bank statement or affidavit of financial means.</td>
</tr>
<tr>
<td>WHO</td>
<td>WHAT</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Orphan</td>
<td>• Copy of ID.</td>
</tr>
<tr>
<td></td>
<td>• Copy of death certificate of late parent(s).</td>
</tr>
<tr>
<td></td>
<td>• Debit order authorisation (contributions; if applicable).</td>
</tr>
<tr>
<td></td>
<td>• Copy of latest bank statement or affidavit of financial means.</td>
</tr>
<tr>
<td></td>
<td>• Official documents confirming continuation of membership.</td>
</tr>
<tr>
<td>Disabled Dependant</td>
<td>• Copy of ID.</td>
</tr>
<tr>
<td></td>
<td>• Detailed diagnostic description (ICD10) from Medical Practitioner.</td>
</tr>
<tr>
<td>Legally adopted child</td>
<td>• Copy of birth certificate.</td>
</tr>
<tr>
<td></td>
<td>• Copy of final adoption order.</td>
</tr>
<tr>
<td>Member’s Partner</td>
<td>• Copy of ID.</td>
</tr>
<tr>
<td></td>
<td>• Membership certificate from previous medical scheme (if applicable)</td>
</tr>
<tr>
<td>Child born before/out of wedlock (if surname differs)</td>
<td>• Copy of birth certificate or proof of birth from hospital/clinic.</td>
</tr>
<tr>
<td></td>
<td>• Note: babies must be registered within 90 days of birth.</td>
</tr>
<tr>
<td>Stepchild</td>
<td>• Copy of birth certificate.</td>
</tr>
<tr>
<td></td>
<td>• Membership certificate from previous medical scheme (if applicable)</td>
</tr>
<tr>
<td>Special Dependant</td>
<td>• Copy of ID/birth certificate (if applicable).</td>
</tr>
<tr>
<td></td>
<td>• Official Scheme documentation confirming dependency (available on Scheme’s website).</td>
</tr>
</tbody>
</table>

**Please note:** Where applicable, always complete the Medical Details section of the application form in full and correctly.
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 [Detailed diagnostic description (ICD10) provided by a registered Medical Practitioner], 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 if official proof of full-time studies at a recognized national educational institution is provided (annually).
- If not a full time student, his/her Scheme membership will be terminated and he/she could apply for principal membership with KeyHealth or any other registered medical scheme.

Dependant; 27 years and older:

- This Dependant’s membership will be terminated and he/she could apply for principal membership with KeyHealth or any other registered medical scheme.

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 twelve (12) 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 ninety (90) days preceding the date of application:
  - a General Waiting Period of up to three (3) months, including PMB conditions; and
  - a Condition-specific Waiting Period of up to twelve (12) 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 twenty-four (24) months, terminating less than ninety (90) days immediately prior to the date of application:
  - a Condition-specific Waiting Period of up to twelve (12) 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.

- 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 twenty-four (24) months, terminating less than ninety (90) days immediately prior to the date of application:
  - a General Waiting Period of up to three (3) 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 three (3) consecutive months since 1 April 2001.
• 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:

<table>
<thead>
<tr>
<th>Years</th>
<th>Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to &lt;5</td>
<td>&lt;5 years at 5%</td>
</tr>
<tr>
<td>5 to &lt;15</td>
<td>&lt;15 years at 25%</td>
</tr>
<tr>
<td>15 to &lt;25</td>
<td>&lt;25 years at 50%</td>
</tr>
<tr>
<td>≥25</td>
<td>≥25 years at 75%</td>
</tr>
</tbody>
</table>

Non-disclosure consequences:
• If found that false information has been submitted or that any relevant information has deliberately 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 01 Jan. and 31 Dec.), 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 two (2) membership cards.
• Principal Members without Dependants are provided with one (1) 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 Dependents.
• Keep membership cards in a safe place.

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.
• Member 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);
  - Identity numbers of the Principal Member and registered Dependant(s).

• Easy-ER brochure (If applicable) - this brochure contains all the information pertaining to Easy-ER which guarantees all Child Dependents 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.

• Other documentation: Netcare 911 sticker.

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.

A Member joining the Scheme has the right to change benefit option within the first three (3) months:
• The change will be effective from the date of joining, with backdated correction of membership fees and claims submitted.

Normal 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 thirty (30) 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 e-mail address).
- Banking details (include the latest bank statement or an official letter from the bank), indicating whether the change is applicable to claims refund or contribution deduction.

3.4 | RETIREMENT / DEATH OF PRINCIPAL MEMBER

Principal Member subsidised by employer:

- A Principal Member should give at least one (1) 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.
- The membership number remains unchanged when the Spouse/Partner becomes the Principal Member, and new card(s) will be issued.
- Adjusted membership contributions are paid without interruption.
- In all other instances a new membership number and new card(s) will be issued.
Retirement (continuation of membership):

- Mail notification of change to Membership at:

  KeyHealth Medical Scheme  
P.O. Box 14145  
Lyttelton 0140  
Fax: 0860 111 390

- No change will be implemented retrospectively.
- Please remember to state the Principal Member’s full name, surname and membership number on the letter/fax.

3.5 | CONTRIBUTIONS

Date of payment:

- Contributions are payable in arrears for Local Authority members and in advance for all other Members.

  - 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.

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:

<table>
<thead>
<tr>
<th>Bank</th>
<th>ABSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Account Holder</td>
<td>KeyHealth Medical Scheme</td>
</tr>
<tr>
<td>Account Number</td>
<td>6 000 000 12</td>
</tr>
<tr>
<td>Reference Number</td>
<td>Membership Number</td>
</tr>
</tbody>
</table>

- 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, attention: Contribution Department.

3.6 | 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’s 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.

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.
Certificate of membership:
• On termination of membership, the Scheme will furnish a certificate of membership.

Re-instatement of membership:
• A Member may apply for re-instatement of membership within thirty (30) 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.
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 Chronic Disease List.
• The treating Doctor decides whether a condition is a PMB or not by taking into account the symptoms only – a diagnosis-based approach.
• Out-of-hospital PMB/CDL claims will first be paid from the Member’s applicable benefit category, where applicable, and should this become depleted, then only will the claims be paid as PMB.
• The Chronic Disease List (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.
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 which 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 which 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 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 which 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 voluntary 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.

---

**PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL)**

| 1. Addison’s Disease     | 14. Epilepsy    |
| 2. Asthma             | 15. Glaucoma |
| 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 |
| 12. Diabetes Mellitus Type 1 & 2 | 25. Ulcerative Colitis |
| 13. Dysrhythmias       |           |

---
Diagnostic tests for unconfirmed PMB diagnosis:

- Where diagnostic tests and examinations are performed but do not result in the confirmation of a PMB diagnosis, 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 Medical Savings Account.

DSPs for PMBs: Any service falling within the PMBs and rendered by the Scheme’s Designated Service Provider (DSP) will be covered in full. If a Member chooses not to use a DSP, a co-payment may be applicable. The Scheme has appointed the following DSPs:

i) Hospitalisation
   - The National Hospital Network (NHN).
   - The State Hospitals (Gauteng, Free State and Western Cape) as the DSP for organ transplants and any major medical services which fall within PMBs. In the absence of any formal agreement, any other hospital will be regarded as a DSP.

ii) Specialist Services
   - OneCare Specialist Network. This network will be applicable to in-and out-of-hospital, PMB related services. Details of Specialists on the network may be obtained from the Pre-Authorisation Call Centre on 0860 671 060. A full list will also be available for Members post-logon at www.keyhealthmedical.co.za.

iii) Substance abuse
    - SANCA

iv) Oxygen and CPAP
    - Ecomed Medical

v) Wound care
    - Equity Pharma Holdings

vi) Gastroscopy and/or Colonoscopy
    - Netcare, LifeHealth, NHN, Clinix and Mediclinic Hospitals
• 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® (Maximum Medical Aid Price).

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:

<table>
<thead>
<tr>
<th>PLATINUM</th>
<th>R440 per admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOLD</td>
<td>R385 per admission</td>
</tr>
<tr>
<td>SILVER</td>
<td>R190 per admission</td>
</tr>
<tr>
<td>EQUILIBRIUM</td>
<td>R385 per admission</td>
</tr>
<tr>
<td>ESSENCE</td>
<td>R315 per admission</td>
</tr>
</tbody>
</table>

• 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.
- For over-the-counter benefits on all options, see the Benefit Structure in chapter 3 of this Member Guide.
- 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 three (3) months or more for conditions as contained in Table 1 (Category A) and/or Table 2 (Category B) (see subsection 5.7).
- If a patient is diagnosed with one of the chronic conditions listed in Table 1 or Table 2, 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.

5.5 | THE CONDITION MEDICINE LIST (CML)

- The CML (Condition Medicine List) is a Scheme approved list of clinical appropriate medicine used for the treatment of a particular condition, i.e. 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 MediKredit on the KeyHealth website on 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 Condition Medicine List 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 MediKredit on the Key-Health website at 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 or 2, 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):**

| Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) (All Options) |
|---|---|
| 1. Addison’s Disease | 14. Epilepsy |
| 2. Asthma | 15. Glaucoma |
| 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 |
| 12. Diabetes Mellitus Type 1 & 2 | 25. Systemic Lupus Erythematosus |

(*) Indicates an additional chronic condition approved by the Scheme.
5.7 | OTHER CHRONIC CONDITIONS (PLATINUM OPTION)

TABLE 2 (CATEGORY B):

<table>
<thead>
<tr>
<th>OTHER CHRONIC CONDITIONS (PLATINUM OPTION ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acne</td>
</tr>
<tr>
<td>2. Allergic rhinitis</td>
</tr>
<tr>
<td>3. Alzheimer’s disease</td>
</tr>
<tr>
<td>4. Ankylosing spondylitis</td>
</tr>
<tr>
<td>5. Benign prostatic hypertrophy</td>
</tr>
<tr>
<td>6. Clotting disorders(#)</td>
</tr>
<tr>
<td>7. Cystic fibrosis</td>
</tr>
<tr>
<td>8. Deep vein thrombosis(#)</td>
</tr>
<tr>
<td>9. Diverticulitis and Irritable bowel syndrome</td>
</tr>
<tr>
<td>10. Gastro-esophageal reflux disease</td>
</tr>
<tr>
<td>11. Hypoparathyroidism(#)</td>
</tr>
<tr>
<td>12. Hyperkinesis (ADD - Attention Deficit Disorder)</td>
</tr>
<tr>
<td>13. Hyperthyroidism</td>
</tr>
<tr>
<td>14. Interstitial fibrosis</td>
</tr>
<tr>
<td>15. Iron deficiency anemia</td>
</tr>
<tr>
<td>16. Major depression(#)</td>
</tr>
<tr>
<td>17. Meniere’s disease</td>
</tr>
<tr>
<td>18. Menopausal disorder (Calcium only)(#)</td>
</tr>
<tr>
<td>19. Migraine</td>
</tr>
<tr>
<td>20. Myasthenia gravis</td>
</tr>
<tr>
<td>21. Osteoarthritis</td>
</tr>
<tr>
<td>22. Osteoporosis</td>
</tr>
<tr>
<td>23. Paraplegia, quadriplegia(#)</td>
</tr>
<tr>
<td>24. Peripheral vascular disease(#)</td>
</tr>
<tr>
<td>25. Psoriasis</td>
</tr>
<tr>
<td>26. Rheumatic fever</td>
</tr>
<tr>
<td>27. Stroke(#)</td>
</tr>
<tr>
<td>28. Testosterone deficiency</td>
</tr>
<tr>
<td>29. Urinary incontinence</td>
</tr>
</tbody>
</table>

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

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.
The following protocols will be applicable to the use of biological medication by Beneficiaries:

5.8.1 | PMB (on Algorithm), e.g. multiple sclerosis:
- Will be paid for by the Scheme on all options;
- No co-payment will be applicable if obtained from a Scheme DSP;
- When the medication is obtained from a non-DSP, the following co-payments will apply:
  - 10% co-payment on the Platinum option;
  - 15% co-payment on the Gold option;
  - 30% co-payment on the Silver, Equilibrium and Essence options.

5.8.2 | PMB (not on Algorithm), e.g. rheumatoid arthritis, Crohn’s disease and ulcerative colitis:
- Applicable to the Platinum option only;
- 10% co-payment when medication is obtained from a non-DSP;
- 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 Performance Health (PH) protocols, including investigation of the availability in State facilities;
- When the medication is obtained from a non-DSP, the following co-payments will apply:
  - 10% co-payment on the Platinum option.
  - 15% co-payment on the Gold option;
  - 30% co-payment on the Silver, Equilibrium and Essence options;

5.8.4 | Chronic Conditions:
- Platinum option only;
- 10% co-payment applicable when using a non-DSP;
- 10% co-payment not applicable to PMB conditions;
- Annual chronic limit applies;
- If also a DTP and the medication is eligible as per PH protocols:
Once the annual chronic limit has been exceeded, the provider must contact MediKredit for DTP authorisation. Thereafter, rules and co-payments apply as per 5.8.3 above.

### 5.8.5 | Section 21 and Medication Used Alternatively (off-label):

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

### 5.8.6 | Oncology:

- Medication for treatment will be considered in accordance with the South African Oncology Consortium (SAOC) guidelines and protocols:
  - Tier 3 – 30% co-payment.  
    Platinum option only.
  - Tier 2 (State facilities) – no co-payment.  
    All options.
  - Tier 2 (not in State facilities)  
    Platinum option – no co-payment.  
    Other options - co-payment.
  - Tier 1  
    All options - no co-payment.
Agreements have been reached with pharmacies throughout South Africa for the supply of medication to KeyHealth Beneficiaries at reduced rates.

The list below shows only the nationwide DSP pharmacies.

For a comprehensive list, visit www.keyhealthmedical.co.za or contact the KeyHealth Client Service Centre on 0860 671 050.

### Chronic medicine obtained from a non-DSP pharmacy:

The Scheme will pay 100% up to the reference price for chronic medication, and the following co-payments will apply:

<table>
<thead>
<tr>
<th>PLATINUM</th>
<th>10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOLD</td>
<td>15%</td>
</tr>
<tr>
<td>SILVER</td>
<td>30%</td>
</tr>
<tr>
<td>EQUILIBRIUM</td>
<td>30%</td>
</tr>
<tr>
<td>ESSENCE</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Please note:** HIV/Aids medicine must be obtained from Medipost Pharmacy. Should Members choose to obtain this medicine from any other pharmacy; the Scheme will not be responsible for the payment thereof.
5.10 CHRONIC MEDICATION ON TRAVELLING ABROAD

- To qualify for additional chronic medicine for use during a foreign visit (up to a maximum of 90 days without interruption), the Principal Member involved must inform the Scheme in writing at least one (1) 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;
  - 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 fourteen (14) days prior to departure on 0800 132 345 to make the necessary arrangements.
Before admission to hospital, the Member must phone 0860 671 060 (Authorisation Call Centre) for the necessary authorisation. Members and providers can also logon to the Scheme’s website (www.keyhealthmedical.co.za) to obtain online authorisation.

Authorisation needs to be obtained within 24 hours prior to an admission, or within two (2) 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 diagnoses or ICD-10 code;
  > If admission is for planned surgery, all relevant procedure (tariff) codes;
  > 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 associated costs of the authorised procedure 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 thirty (30) 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 planned procedure 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.

• 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 | DISEASE RISK MANAGEMENT PROGRAM

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 condition/s effectively.

The Scheme has therefore introduced a unique Disease Risk Management (DRM) program, specifically designed to improve the well-being of affected Members.

The first phase of the DRM program includes all cardiac conditions:
• Cardiac Failure
• Cardiomyopathy
• Chronic Renal Failure
• Dysrhythmias
• Hyperlipidaemia
• Hypertension
• Coronary Artery Disease / Ischemic Heart Disease

By taking part in this program, Members are taking the first step to a healthy and fulfilling lifestyle, at no extra cost.
The DRM program enables Members to manage their chronic condition more effectively through a personalised treatment plan. This treatment plan will be customised for each member, specifying the specific tests and/or consultations relevant to his/her condition for which he/she has benefits. The treatment plan will also include regular consultations with the relevant healthcare providers to ensure that the medication being used is still effective as well as to preventatively ensure that no further complications, related to the chronic condition concerned, develop.

Each Member participating in the program will be assigned a Disease Manager who will:

- Assist with reminders to go for procedures and consultations;
- Provide advice and guidance regarding preventative care;
- Assist with medicine management;
- Provide clinical screening on results of tests;
- Provide guidance regarding a healthier lifestyle;
- Regularly monitor the Member’s progress.

A booklet, designed to help Members choose cost effective medicine for the specific treatment of a particular condition, will also be provided. The list of medication is approved by the Council for Medical Schemes, complies with legislation and is generally accepted by the medical industry.

A typical example of a treatment plan will include the following:
A description of the various types of disciplines and their respective codes will form part of the treatment plan, e.g. discipline 14 is a General Practitioner.

Members will receive regular communication regarding their chronic condition, as well as reminders to visit certain service providers as precautionary measures. Visits to these providers play a very important role in the management of the condition.

6.3 | DISEASE / CASE MANAGEMENT

The programmes below are all subject to case management.

6.3.1 | Registration

- If a Beneficiary does not register on an appropriate Disease Management Programme, available day-to-day benefits will be applicable.

6.3.2 | Oncology

- The Doctor/Specialist must complete a South African Oncology Consortium (SAOC) treatment plan or write a prescription for associated oncology medication to:
  - Effect registration on the programme;
  - Facilitate the evaluation and final approval of treatment;
  - Ensure timely processing of cancer related claims.
- Fax the treatment plan to 012 679 4469.
- Call 0860 671 060 for specific authorisation in respect of:
  - 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 and blood tests.
- 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 program 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.
  - Approved 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.
6.3.3 | Organ transplants and dialysis

- Organ 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 (organ transplants) and National Renal Care (dialysis).

6.3.4 | HIV/AIDS

- The Scheme has contracted with LifeSense Disease Management to manage the HIV/AIDS Program.
- Registering on the HIV/AIDS Program:

  - 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;
  - The Beneficiary’s Doctor will be contacted by LifeSense and advised what medication options are available, taking in consideration the stage of the disease.

- Utilisation of the HIV/AIDS Program:

  - Once the Beneficiary is enrolled on the program, 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;
  - The Beneficiary will also be assisted with lifestyle adjustments and counselling.

Direct enquiries related to HIV/AIDS claims to the Client Service Centre on 0860 671 050.
6.4 | MATERNITY

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

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

6.5 | MEDICAL APPLIANCES

- Medical appliances can be described as medical equipment used for the treatment and cure of medical conditions.
- The medical appliance benefit includes items such as wheelchairs, orthopaedic appliances, incontinence equipment (including nappies for adults) and contraceptive devices.
- Authorisation is necessary for the following external medical appliances:
  - Oxygen
  - CPAP
  - Insulin Pump
  - Nebuliser

For authorisation, fax the Medical Practitioner’s motivation as well as a quotation to 012 679 4471 (attention: Medical Appliances). All other appliances do not require pre-authorisation, but will be subject to protocols, quantity limits, pricing and available benefits. Please refer to Chapter 13 for a list of appliances that are excluded from benefits by the Scheme.
6.6 | PROSTHETICS

- Prosthesis (an artificial body part) is an artificial replacement of an internal or external part of the body, such as a hip or knee joint, a leg, an arm, a heart valve etc.
- Pre-authorisation is compulsory for all external and internal prosthesis by contacting 0860 671 060, and faxing a quotation to 012 679 4471 (attention: Prosthetics).
- Prosthetics are subject to protocols, quantity limits, pricing and available benefits.

6.7 | ENDOSCOPIC PROCEDURES

- The Scheme has entered into an DSP arrangement with the following hospital groups in respect of gastroscopy and/or colonoscopy procedures:
  - Netcare
  - Lifehealth
  - NHN
  - Clinix
  - Mediclinic

- Members will not have a co-payment for gastroscopy and/or colonoscopy procedures done at any of the above mentioned hospitals.
6.8 | CASUALTY WARD OR EMERGENCY ROOM VISITS

The Adult Beneficiary’s choice

- Adult Beneficiaries have access to the services of the casualty ward or emergency room facilities of a hospital. All costs related to such visits (including the consultation, facility fee, any procedure performed, etc.) will be paid from the Adult Beneficiary’s MSA and/or day-to-day benefits.

- If an Adult Beneficiary’s MSA and/or day-to-day benefits have been exhausted, and the visit to the casualty ward or emergency room is classified as a PMB condition, the Scheme will cover the costs related to such a visit in full.

- If, subsequent to a visit to a casualty ward or emergency room, the Adult Beneficiary gets admitted to hospital, the costs related to the visit will be paid from the Adult Beneficiary’s hospitalisation benefit. In such instances Scheme authorisation is required immediately or within 48 hours/on the first working day after a weekend.

Child Dependents

- Access for Child Dependents to a casualty ward or emergency room facility of a hospital, will be granted in terms of Easy-ER. Please refer to Chapter 16 for a detailed description of Easy-ER.
07 | DENTAL BENEFITS
7.1 | DENIS CONTACT DETAILS

- DENIS [Dental Information Systems (Pty) Ltd] manages Beneficiaries’ dental benefits on behalf of the Scheme.
- 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 |
| E-mail address for enquiries  | keyhealthenq@denis.co.za |
| E-mail address for claims    | claims@denis.co.za |
| E-mail address for DENIS authorisations | auths@denis.co.za |
| E-mail address for crowns    | crowns@denis.co.za |
| E-mail address for periodontics | perio@denis.co.za |
| E-mail 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 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 and Bridges:**

- 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.
- Benefits for crown and bridge work 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 e-mailed 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 younger than 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.
- Orthognathic (jaw correction) and other 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 e-mailed 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 e-mailed 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 CPITN 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:

  - General anaesthetic benefits are available for the removal of impacted teeth on all the options; subject to DENIS managed care protocols.
  - General anaesthetic benefits are available on the Platinum and Gold options for Child Dependents under the age of five (5) years who require extensive dental treatment (multiple extractions and fillings).
  - Multiple visits to theatre are not covered.

Please Note: A co-payment of R1 150 per hospital admission will be applicable on all options.
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.
- Opticlear important contact details:

  Call Centre telephone number: 0861 678 427
  Call Centre fax number: 0861 100 397
09 | EMERGENCY TRANSPORT
EMERGENCY TRANSPORT

AMBULANCE SERVICES

Netcare 911 provides Beneficiaries with unlimited emergency service benefits 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.

• Transfers:
  - Authorisation for ambulance transfers must be obtained from Netcare 911 on 082 911.
  - Medically justified transfers to special care centers 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 Centers of Excellence;
  - Information regarding Netcare Travel Clinics, contact 0800 223 434 (Health on Line);
  - 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;
  - In case of a transfer, no authorisation was obtained from Netcare 911; and/or
  - The relevant claim was received more than four (4) months after the service date (date on which the patient was transported).
NOTES:
## CO-PAYMENTS ON SPECIFIC ENDOSCOPIC PROCEDURES (IN-HOSPITAL / PER SCOPE):

### Platinum/Gold:

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>CO-PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy and/or Gastroscopy</td>
<td>If using a non-DSP, a co-payment will apply if the claim is in excess of the negotiated DSP rate. The Scheme’s DSPs for these procedures are Netcare, LifeHealth, NHN, Clinix and MediClinic Hospitals.</td>
</tr>
</tbody>
</table>

- Pre-authorisation compulsory.

### Silver/Equilibrium/Essence:

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>CO-PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy and/or Gastroscopy</td>
<td>If using a non-DSP, a co-payment will apply if the claim is in excess of the negotiated DSP rate. The Scheme’s DSPs for these procedures are Netcare, LifeHealth, NHN, Clinix and MediClinic Hospitals.</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>R1 700</td>
</tr>
<tr>
<td>Sigmoidoscopy</td>
<td>R1 700</td>
</tr>
<tr>
<td>Hysteroscopy</td>
<td>R2 300</td>
</tr>
<tr>
<td>Arthroscopy</td>
<td>R2 300</td>
</tr>
<tr>
<td>Laparoscopy (diagnostic)</td>
<td>R2 900</td>
</tr>
</tbody>
</table>
### LIST OF CO-PAYMENTS PER OPTION:

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>CO-PAYMENT</th>
<th>EXPLANATORY NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PLATINUM OPTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-hospital Internal/external</td>
<td>20%</td>
<td>Upon exceeding the R59 000 pfpa limit</td>
</tr>
<tr>
<td>External prosthesis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In- or out-of-hospital MRI and</td>
<td>R1 150 per scan</td>
<td>Payable directly to the service provider involved</td>
</tr>
<tr>
<td>CT scans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-hospital Endoscopic</td>
<td>See 10.1 above</td>
<td>Payable directly to the hospital involved</td>
</tr>
<tr>
<td>procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic medicine Category A</td>
<td>10%</td>
<td>When using a non-DSP pharmacy</td>
</tr>
<tr>
<td>(CDL)</td>
<td></td>
<td>Payable directly to the service provider involved</td>
</tr>
<tr>
<td>Chronic medicine Category B</td>
<td>10%</td>
<td>When not using a DSP pharmacy</td>
</tr>
<tr>
<td>(other)</td>
<td></td>
<td>Payable directly to the service provider involved</td>
</tr>
<tr>
<td>Chronic medicine Category B</td>
<td>10%</td>
<td>When not using a DSP pharmacy</td>
</tr>
<tr>
<td>(other)</td>
<td></td>
<td>Payable directly to the service provider involved</td>
</tr>
<tr>
<td>Out-of-hospital Pathology</td>
<td>20%</td>
<td>Payable directly to the service provider involved</td>
</tr>
<tr>
<td>Out-of-hospital Threshold</td>
<td>10%</td>
<td>All day-to-day services within threshold</td>
</tr>
<tr>
<td>Dentistry</td>
<td>Refer to the benefit structure</td>
<td></td>
</tr>
<tr>
<td>summary</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GOLD OPTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In- or out-of-hospital MRI and</td>
<td>R1 150 per scan</td>
<td>Payable directly to the service provider involved</td>
</tr>
<tr>
<td>CT scans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-hospital Endoscopic</td>
<td>See 10.1 above</td>
<td>Payable directly to the hospital involved</td>
</tr>
<tr>
<td>procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic medicine Category A</td>
<td>15%</td>
<td>When not using a DSP pharmacy</td>
</tr>
<tr>
<td>(CDL)</td>
<td></td>
<td>Payable directly to the service provider involved</td>
</tr>
<tr>
<td>Chronic medicine Pathology</td>
<td>30%</td>
<td>Payable directly to the service provider involved</td>
</tr>
<tr>
<td>Dentistry</td>
<td>Refer to the benefit structure</td>
<td></td>
</tr>
<tr>
<td>summary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT</td>
<td>CO-PAYMENT</td>
<td>EXPLANATORY NOTES</td>
</tr>
<tr>
<td>----------------------------</td>
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<td>--------------------------------------------------------</td>
</tr>
<tr>
<td><strong>SILVER OPTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In- or out-of-hospital</td>
<td>MRI and CT scans</td>
<td>R1 150 per scan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Payable directly to the service provider involved</td>
</tr>
<tr>
<td>In-hospital</td>
<td>Endoscopic procedures</td>
<td>See 10.1 above</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Payable directly to the hospital involved</td>
</tr>
<tr>
<td>Chronic medicine</td>
<td>Category A (CDL)</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>When not using a DSP pharmacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Payable directly to the service provider involved</td>
</tr>
<tr>
<td>Out-of-hospital</td>
<td>Pathology</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Payable directly to the service provider involved</td>
</tr>
<tr>
<td>Dentistry</td>
<td>Refer to the benefit structure summary</td>
<td></td>
</tr>
<tr>
<td><strong>EQUILIBRIUM OPTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In- or out-of-hospital</td>
<td>MRI and CT scans</td>
<td>R1 150 per scan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Payable directly to the service provider involved</td>
</tr>
<tr>
<td>In-hospital</td>
<td>Endoscopic procedures</td>
<td>See 10.1 above</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Payable directly to the hospital involved</td>
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<tr>
<td>Chronic medicine</td>
<td>Category A (CDL)</td>
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<tr>
<td></td>
<td></td>
<td>When not using a DSP pharmacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Payable directly to the service provider involved</td>
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<tr>
<td>Dentistry</td>
<td>Refer to the benefit structure summary</td>
<td></td>
</tr>
<tr>
<td><strong>ESSENCE OPTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In- or out-of-hospital</td>
<td>MRI and CT scans</td>
<td>R1 150 per scan</td>
</tr>
<tr>
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<td>Dentistry</td>
<td>Refer to the benefit structure summary</td>
<td></td>
</tr>
</tbody>
</table>
NOTES:
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, and 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 appear on the latest membership card;
    > The membership number;
    > The name of the Scheme and the benefit option;
    > 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.);
    > 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);
  > 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 mail the *original* account and receipt to:
  
  KeyHealth Medical Scheme
  
  P.O. 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 four (4) months of the date of treatment or service, will be processed according to Scheme Rules;
  - If an account is not submitted within the above mentioned 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.);
    > The balance of Member benefits for the current benefit year.
- Members will also receive e-mail confirmation of claims processed (if the Scheme has the e-mail 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.

**Outstanding claims on resignation or death:**
- Claims submitted within four (4) 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 exhausted;
- 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 exhausted;
- 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;
- Claims have a service date older than four (4) months.
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 provides the Scheme with a written undertaking signed by the Member and/or the Member’s attorney involved.
  - The above mentioned 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 reprocessed 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.
11.5 TRAVELLING ABROAD

- To qualify for the reimbursement of medical claim expenses incurred by a Beneficiary during the first ninety (90) days of travelling abroad, the Principal Member involved must inform the Scheme of the following in writing at least one (1) 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;
  - The starting and end date of the visit.

Please note: The Scheme may exercise sole discretion if informed within a shorter period of time.

- Upon receipt of the above mentioned 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 for all expenses regarding out-of-hospital medical treatment.
- On return, or within four (4) months after the date of service, the Member applies to the Scheme for the reimbursement of the above mentioned claims by submitting the relevant account(s), together with the proof of payment.
- Reimbursement will be subject to the Member’s available 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.
- Any elective/planned procedure performed outside of South Africa, will not be covered.
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. When annual savings are exhausted, day-to-day expenses will then be covered from the applicable benefits.
  - After exhausting 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 five (5) months for the medical savings account credit balance to be refunded.
• In the event of the savings amount allocated to the Member being exceeded/exhausted 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;
  - In the event of the Member 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;
  - 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.

12.2 | INTEREST ON MSA ACCOUNTS

• As from, 1 January 2012, monthly interest is calculated on a Member’s available savings balance.
• Interest is calculated on a Member’s available savings balance on the same day as when the month-end statement run takes place, e.g. interest for October 2013 will be calculated on 26 October 2013.
• Medical savings balances and/or movements is communicated to all Members on a monthly basis. The Scheme provides this information on each Member’s monthly claims statement (please see below).
• How does the calculation of interest affect a Member’s medical savings account balance?

• The interest rate used for calculation purposes is received from the Scheme’s banking institution (ABSA), based on the actual interest rate on the day of the calculation.
• Interest is only calculated on savings contributions received (paid by the Member as part of his/her contributions) and not on the annual advanced savings balance.
• The Member receives his/her annual medical savings in advance; meaning that he/she has the year’s total savings amount available as from the first day of January of each year. This also means that a Member might use his/her total savings allocation for the year before he/she actually has paid any savings contribution amount for that year. In such cases, no interest will however be calculated on the debit savings balance, and a Member will not be charged interest on any overspent savings balance.

• How will the interest on an 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 year’s carried forward savings balance.

• Savings contribution received/reversed – This amount will include the saving 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.

• Interest on savings received/reversed – This amount will include interest received or reversed from the previous month.

• 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.
NOTES:
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 by the following:
  - Persons not registered with an acknowledged professional institution which was established or registered in accordance with relevant legislation;
  - Any institution, nursing institution or similar institution, except a State Hospital, which are not registered in accordance with relevant legislation;
  - Costs incurred for treatment arising out of an injury or disablement resulting from war, invasion or civil war, except for PMBs;
  - Any expenses incurred by a Beneficiary who has been duly certified as mentally unsound;
  - Injuries resulting from occupational sport, speed contests and speed trials, except for PMBs;
  - Attempted suicide, wilfully self-inflicted injuries or sickness conditions/costs incurred in respect of treatment associated with drug abuse or overdosing, including Alkogen treatment, except for PMBs;
  - Accommodation or lodging fees in convalescent or old age homes, frail care facilities, institutions for the physically or the mentally handicapped or similar institutions;
  - Accommodation and treatment in spas and resorts for health, slimming, chiropractic, homeopathic or similar purposes and home nursing;
  - Accommodation in a private room of a hospital, except when prescribed by a Medical Practitioner and approved by the Scheme or when giving natural birth on the Gold, Silver and Equilibrium Options.
  - The cost of holidays for recuperative purposes, whether deemed medically necessary or not;
  - Medical examinations for insurance, school camp, visa, employment or similar purposes;
  - Travelling costs incurred by Beneficiaries;
  - Medical examinations, consultations, treatment, operations and procedures relating to:
> Acupuncture;
> Bio-stress assessments;
> Colonic irrigation;
> Cosmetic purposes;
> DNA testing;
> EBCT – Computed Tomography Coronary and Heart;
> Gastroplasty;
> IQ tests and learning problems;
> Obesity (excluding benefits available on the Health Booster);
> Reversal of sterilization;
> Reversal of vasectomy;
> Sclerotherapy of varicose veins.

- In respect of the PMB code 902M, Infertility, the following services are excluded:

  > Assisted Reproductive Technology (ART) techniques, including In Vitro Fertilisation (IVF);
  > Gamete Intra-Fallopian Tube Transfer (GIFT);
  > Intra-cytoplasmic Sperm Injection (ICSI);
  > Zygote Intra-Fallopian Tube Transfer (ZIFT).

- Charges for the following:

  > Ante- and post-natal exercise classes;
  > Appointments not kept;
  > Breast-feeding instructions;
  > Mother-craft;
  > Telephonic consultations with Medical Practitioners;
  > Water-births.

- Purchase or hire of the following equipment:

  > APS therapy machines or similar devices;
  > Bedpans;
  > Binders (abdominal, chest, hernia);
  > Blood-pressure monitors;
  > Commodes;
  > Cushions (any sort);
  > Foot orthotics;
> Health shoes, e.g. Green Cross;
> Humidifiers;
> Kidney belts;
> Mattresses, including Numbis mattresses;
> Medic Alert bands;
> Peak flow meters;
> Restraining devices;
> Sheepskin;
> Special beds or chairs;
> Waterbeds;
> Waterproof sheets.

- The purchase of:

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

- General optical benefit exclusions:

> Contact lens solutions;
> Lenses with a tint exceeding 35%;
> Scripts less than 0.50 dioptre;
> Spectacle cases;
> Spectacle repairs;
> Sunglasses;
> The fee associated with the fitting and adjustment of contact lenses;
> Charges for repairs of medical appliances (for the maintenance of hearing aids, see the Benefit Structure).
General dental benefit exclusions with due regard to the PMBs:

- Apisectomies in the hospital;
- Appointment not kept;
- Auto-transplantation of teeth;
- Behaviour management;
- Bleaching, front tooth laminate veneers and composite veneers;
- Bone and other tissue regeneration procedures;
- Bone augmentations;
- Caries susceptibility and microbiological tests;
- Closure of an oral-antral opening (currently code 8909) when claimed during the same visit with impacted teeth (currently codes 8941, 8943 and 8945);
- Conservative dental treatment (fillings, extractions and root canal therapy) in the hospital for adults;
- Cost of bone regeneration material;
- Cost of dental materials for procedures performed under general anesthesia in-hospital;
- Cost of gold, precious metal, semi-precious metal and platinum foil;
- Cost of invisible retainer material;
- Cost of Mineral Trioxide;
- Cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl) and ointments;
- Crown or crown retainers on third molars (wisdom teeth);
- Dental bleaching and porcelain veneers;
- Dental testimony including dento-legal fees;
- Dentectomies in the hospital;
- Diagnostic dentures;
- Dolder bars and associated abutments on implants (including the laboratory cost);
- Electrognathographic recordings and other such electronic analyses;
- Emergency crown that is not placed for the immediate protection in tooth injury;
- Enamel microabrasion;
- Fillings to restore teeth damage due to toothbrush abrasion, attrition, erosion, and/or fluorosis;
- Fissure sealants on patients older than 16 years;
- Fixed prosthodontics (crowns) used to repair teeth damaged due to bruxism (tooth grinding);
  toothbrush abrasion; erosion or fluorosis;
- Fixed prosthodontics (crowns) used to restore teeth for cosmetic reasons;
- Fixed prosthodontics (crowns) where a reasonable attempt has not been made to restore/replace the tooth conservatively;
- Fixed prosthodontics (crowns) where the mouth is periodontal compromised;
- Fixed prosthodontics (crowns) where the tooth has been recently restored to function;
- Fixed prosthodontics used to repair acclusal wear;
- Frenectomies in the hospital;
• Full mouth rehabilitation;
• Gingivectomy;
• High-impact acrylic;
• Hospitalisation for any dental treatment other than the removal of impacted teeth on the Essence, Equilibrium and Silver options;
• Hospitalisation for surgical tooth exposure for orthodontic reasons;
• Hospitalisation where the only reason for admission request is for a sterile facility;
• Hospitalisation where the only reason for admission to hospital is dental fear and anxiety;
• Implants or third molars (wisdom teeth);
• Intramuscular or subcutaneous injection;
• Laboratory cost associated with mouth guards (including material cost);
• Laboratory cost of provisional and emergency crowns;
• Laboratory costs, where the associated dental treatment is not covered;
• Laboratory delivery fees;
• Laboratory fabricated crowns on primary teeth;
• Lingual orthodontics;
• Full metal base to dentures;
• Metal, porcelain or resin inlays, except where such inlays form part of a bridge;
• Multiple hospital admissions;
• Nutritional and tobacco counselling;
• Oral hygiene instruction and evaluation;
• Orthodontic re-treatment;
• Orthognathic (jaw correction) and other orthodontic surgery and the related hospital cost;
• Ozone therapy;
• Perio Chip;
• Periodontal flap surgery and tissue grafting;
• Polishing of restorations;
• Pontics on second molars;
• Porcelain or resin inlays, except where the inlay forms part of a bridge;
• Procedures that are defined as unusual circumstances and procedures that are defined as unlisted procedures;
• Professional oral hygiene procedures in the hospital (scale, polishing and fluoride treatment);
• Professionally applied fluoride for Beneficiaries thirteen (13) years and older;
• Provisional crowns;
• Provisional dentures;
• Pulp capping (direct and indirect);
• Pulp tests;
• Resin bonding for restorations charged as a separate procedure;
• Root canal treatment on third molars (wisdom teeth) and primary teeth;
• Sinus lifts;
• Snoring appliances;
• Soft base to new dentures;
• Special reports;
• Surgery and hospitalisation associated with dental implants;
• Three-quarter crowns (cast metal and porcelain);
• Treatment plan completed (currently code 8120).
A program available on all options to provide Beneficiaries with certain additional benefits for preventative 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 which 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 benefits on Health Booster. Contact the Client Service Centre on 0860 671 050 and 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 ICD10 code as contained in the pre-authorisation letter;
  - Verify the tariff code or maximum rand value with the Call Centre Consultant;
  - Inform the relevant service provider accordingly.

Screening tests:
- One of the benefits available on the Health Booster program is the Health Assessment. 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);
  - Prostate Phlebotomy for PSA;
    - Rapid Semi-Quantitative Prostate Specific Antigen (PSA) test (finger prick).

- Principal Members and their Adult Dependents are entitled to one Health Assessment per calendar year and must have the screening tests done at a KeyHealth DSP pharmacy.

- A Health Assessment (HA) form can be obtained at any KeyHealth DSP pharmacy or downloaded from KeyHealth’s website at 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.
<table>
<thead>
<tr>
<th>TYPE</th>
<th>WHO &amp; HOW OFTEN?</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVENTIVE CARE</td>
<td></td>
</tr>
<tr>
<td>Baby immunisation</td>
<td>Child Dependents aged ≤6 – as required by the Department of Health.</td>
</tr>
<tr>
<td>Flu vaccination</td>
<td>All Beneficiaries.</td>
</tr>
<tr>
<td>Tetanus diphtheria injection</td>
<td>All Beneficiaries – as and when required.</td>
</tr>
<tr>
<td>Pneumococcal vaccination</td>
<td>All Beneficiaries.</td>
</tr>
<tr>
<td>EARLY DETECTION TESTS</td>
<td></td>
</tr>
<tr>
<td>Pap smear (Pathologist)</td>
<td>Female Beneficiaries aged ≥15 – once per year.</td>
</tr>
<tr>
<td>Pap smear (consultation; GP or Gynaecologist)</td>
<td>Female Beneficiaries aged ≥15 – once per year.</td>
</tr>
<tr>
<td>Mammogram</td>
<td>Female Beneficiaries aged ≥40 – once per year.</td>
</tr>
<tr>
<td>Prostate specific antigen (Pathologist)</td>
<td>Male Beneficiaries aged ≥40 – once per year.</td>
</tr>
<tr>
<td>HIV/AIDS test (Pathologist)</td>
<td>Beneficiaries aged ≥15 – once per year.</td>
</tr>
<tr>
<td>Health Assessment (HA)</td>
<td>Adult Beneficiaries – once per year.</td>
</tr>
<tr>
<td>Body mass index, Blood pressure measurement, Cholesterol test (finger prick), Blood sugar test (finger prick) Phlebotomy for PSA test</td>
<td></td>
</tr>
<tr>
<td>WEIGHT LOSS</td>
<td></td>
</tr>
<tr>
<td>Weight Loss Program</td>
<td>For all Beneficiaries when the Health Assements BMI is ≥ 35:</td>
</tr>
<tr>
<td></td>
<td>• 3 x Dietician consultations (one per week),</td>
</tr>
<tr>
<td></td>
<td>• 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),</td>
</tr>
<tr>
<td></td>
<td>• One biokineticist consultation (to create a home exercise programme for the Member),</td>
</tr>
<tr>
<td></td>
<td>• 1 x Follow-up consultation with biokineticist.</td>
</tr>
<tr>
<td>MATERNITY*</td>
<td></td>
</tr>
<tr>
<td>Antenatal visits (GP or Gynaecologist) &amp; urine test (dipstick)</td>
<td>Female Beneficiaries. Pre-notification of and pre-authorisation by the Scheme compulsory. Twelve (12) visits.</td>
</tr>
<tr>
<td>Scans (one before the 24th week and one thereafter)</td>
<td>Female Beneficiaries. Pre-notification of and pre-authorisation by the Scheme compulsory. Two (2) pregnancy scans.</td>
</tr>
<tr>
<td>Paediatrician visits</td>
<td>Baby registered on Scheme. Two (2) visits in baby’s 1st year.</td>
</tr>
</tbody>
</table>

*Pre-authorisation essential to access benefits
Be Smart. Keep it Simple.
Expecting a baby is one of the most exciting and special times in a family’s life. Smart Baby is there to make this experience even more special - from general advice on health and wellness to just plain fun!

The Smart Baby program is designed to assist parents through this experience. Smart Baby is more than just medical peace of mind for expectant mothers; it is one way the Scheme can offer Members support and guidance when they need it most.

A Member can register from the 12th week of pregnancy, where after she will receive great discount vouchers (e.g. Huggies nappies, car child seats, strollers, camp cots, maternity clothing etc.) with her welcome letter. After delivery of the baby, the Member will receive a Smart Baby gift bag filled to the brim with different goodies for mom and baby. The Member will also receive a weekly e-mail at the different stages of pregnancy; what to expect; nutrition; common ailments; preparing for birth. DAD also receives e-mails twice a month just to ensure he is kept well informed with the progress of the pregnancy. A consultant will contact the Member involved every trimester to make sure she and her baby are making healthy progress.

For the convenience of pregnant Members, a 24-hour medical advice line, assisting Members in English, Zulu, Xhosa Tswana and Afrikaans and a website have been made available, both of which are handled by trained professionals.

Members can register on the Smart Baby program by dialling 011 704 0792 or they may send an e-mail to info@babyhealth.co.za with any enquiries or concerns they may have.
Our children are the future. On a far more intimate level, children are capable of evoking an emotion in parents that nobody or nothing else can. Although these emotions cannot always be explained, they are based on a natural instinct that all parents can relate to.

In fact, it’s this very instinct that inspired KeyHealth to launch Easy-ER.

By ensuring that children have direct, free access to medical treatment in emergency situations, Easy-ER is the Scheme’s way of providing Members with the necessary peace of mind.

What is Easy-ER?

• Easy-ER is a KeyHealth initiative that offers the children of KeyHealth members free, direct access to a hospital’s Emergency Room (ER) for medical treatment in emergency situations. This immediate access comes without any hassles or up-front payment requirements.

• These emergency circumstances may include:
  - Sport injuries;
  - Playground accidents;
  - Car accidents;
  - Sudden illness that requires immediate ER care;
  - And many other trauma situations/events.

The Card

Easy-ER cards have very specific design styles to represent each child’s life stage:
• Children entering a new life stage during the course of the year will only receive a new card at the start of the next year.

• 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 Triage System definition criteria (see TRIAGE section).

• 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 exhausted, or their option does not include savings/day-to-day benefits (e.g. Essence) then the amount will 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 registered child dependents up to the age of 27.

• Easy-ER guarantees free access to and treatment at any hospital ER facility for emergency/trauma situations.

• If a child gets admitted to hospital, subsequent to the ER treatment, the normal hospital benefit will apply.

• Easy-ER provides a 24-hour free call-centre to confirm eligibility of the Member and/or child.

• The parent, hospital, ER, teacher, caregiver or even the child can call the call-centre on 080 111 0215.
• In the event that the child does not have the card with him or 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 uses.

• The call-centre number will be available at all ER facilities.

• In the event that the child requires emergency transport (e.g. ambulance services) the normal procedure must be followed. In cases like this the Scheme’s emergency transport provider, Netcare 911, must be called on 082 911.

• Parents do not need to be present. By presenting the card, or confirming eligibility through the call-centre, the child will gain access to the ER facilities without any payment requirements.

Please Note: Although Easy-ER guarantees free access to ER facilities, some practices may insist on an upfront payment. In such an event the member must contact the Scheme as soon as possible on comments@keymed.co.za for a reimbursement of this fee.

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 is broken or 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 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 case of a dental emergency, based on the above mentioned criteria, the child 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.

Triage System
• All ER facilities use a specific system to manage the treatment and flow of patients. This system is called Triage, and it uses colour codes to categorize the priority of patients’ treatments based on the severity of their condition.
For a Green classification only normal benefits will apply. The child will still gain access to the ER facilities but because Green is not defined as an emergency situation, payment will be made from the normal savings/day-to-day benefits (where applicable).

For Yellow, Orange and Red, Easy-ER ensures direct access to the ER facilities, no questions asked, and KeyHealth will cover the full ER cost.

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)

- You are familiar with the Triage system, and you are aware that your condition is classified as “Green” (see TRIAGE section).
  
  (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 when this benefit has been abused, KeyHealth reserves the right to recoup any monies from the Principle Member by any means possible, and to suspend the Easy-ER benefits of such a Member immediately.
FRAUD / UNETHICAL CONDUCT
The cost of medical fraud / unethical medical conduct in South Africa is estimated at billions of rand 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.

In view of this, KeyHealth depends largely upon 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 in order to conduct the necessary investigations.

Report any (suspected) fraud / unethical conduct at 0860 110 820 (Monday to Friday, 07:30 until 16:00, public holidays excluded), or via e-mail at fraud@keyhealthmedical.co.za.
NOTES:

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18.1 | VIA THE INTERNET

www.keyhealthmedical.co.za

- KeyHealth’s website on the worldwide web is an informative, interactive gathering place for Members, Service Providers, Brokers and the Scheme.

Easy steps to register as an internet user:
- Access the KeyHealth website on www.keyhealthmedical.co.za.
- In the ‘Online Services’ field, click on ‘Register’.
- Click on ‘Register now’ under the ‘Member registration’ heading.
- Please choose the relevant registering option:
  - ‘Option 1: Register online’
  - ‘Option 2: Call the contact centre’
  - ‘Option 3: Activation request’

- When choosing Option 1:
  - Enter the relevant KeyHealth member number and click on ‘Validate’.
  - Complete the following fields: surname, first name, ID number and e-mail address.

Take note: If any of the completed fields do not correspond with the information on the Scheme’s system, registration will be unsuccessful.

- The password is sent to the Member via e-mail/sms.

- The following message appears on the screen:
  ‘Thank you for registering for web access.
  Your new password has been sent via e-mail/sms – once you have received it, you may log in immediately.’

- Click on ‘Log in’.

- The user is requested to change his/her password. Do this by entering the relevant member number and the old and new password.

- The following message appears on the screen:
  ‘Thank you - your password was successfully changed’.

- Click on ‘continue’.

- Log in by using the new password.
Forgotten Password:
• In the ‘Online Services’ field, click on ‘Forgot Password’.
• In the ‘Login’ field, type in the username.
• Select ‘Member’.
• Click on ‘Submit’. The new password is received via e-mail/SMS.
• The user is requested to change his/her password. Do this by entering the member number and the old and new password.
• The following message appears on the screen:
  ‘Thank you - your password was successfully changed’.
• Click on ‘continue’.
• The Member can now log in using the new password.

Online enquiries:
• Members can view their claims history and personal information by completing their username and password in the ‘Online Services’ field.
• The ‘Summary’ information page is displayed once logged in.
• The following information can be viewed:

  - ‘Summary’ – a summary of the member’s personal details as well as a list of the last 5 claims, 6 statements and 6 contributions.
  - ‘Details’ – this page contains all of the Member’s personal, contact, Scheme, address, employment and banking details.
  - ‘Claims’ – all available claims submitted.
  - ‘Benefits’ – this category includes a summary of the Member’s maximum, used and available benefits.
  - ‘Statements’ - all available claims statements.
  - ‘Contributions’ – a view of the Member’s contribution history.
  - ‘Waiting periods’ – a list of the waiting periods applicable to dependants.
  - ‘Correspondence’ – the previous correspondence between the Member and the Scheme.
  - ‘Enquiry’ – a summary of the Member’s enquiries.
  - ‘Providers’ – a facility where the Member can search for a provider.
  - ‘Cases’ - the Member’s authorisation history.
  - ‘Health Info’ – detailed information on chronic conditions, lifestyle conditions and clinical reference.
  - ‘GRP and medicine search’ – to search for product information by using the product name.
18.2 | VIA E-MAIL (WEBMAIL)

- Webmail is an e-mail based interface enabling Members to access their Scheme information, without having to phone the Client Service Centre.
- The Member can activate a webmail by e-mailing the Scheme at webmail@keyhealthmedical.co.za; no details are required in the subject field or the body of the mail.
- The e-mail address of the Member will be authenticated against the e-mail address loaded onto the system.
- If the Member’s e-mail address is not registered onto the system or if there is more than one Member using the same e-mail address, the user will receive a response, informing him/her that the Scheme is unable to authenticate this e-mail address and is therefore unable to generate the webmail.
- If the Member’s e-mail address is authenticated, the system will e-mail a complete ‘package’ of information. This package includes:
  - Membership details;
  - Case History;
  - Claims History
  - Benefits;
  - Contributions.

18.3 | VIA SMS

- Members have access to useful information 24 hours a day by sending an SMS to 32899.
- The different options are as follows:
  - Send an SMS with the letter B as the message - receive an SMS with the Member’s current benefits available.
  - Send an SMS with the letter C as the message - receive an e-mail with the Member’s latest claims.
  - Send an SMS with the letter D as the message - receive an SMS with the Member’s current membership details.
  - Send an SMS with the letters IC and the relevant ICD-10 code as the message - receive an SMS with the ICD-10 code description details.
- The Member should receive a reply within minutes, provided his/her current mobile number is available on the Scheme’s administrative system.
- Contact the Client Service Centre on 0860 671 050 to update personal details (Mondays to Fridays between 07:30 and 18:00, and Saturdays between 08:00 and 12:00, public holidays excluded).
18.4 | ONLINE CHAT FACILITY

- Online Chat (Live Support) is a web service that allows Members and Providers to communicate with or chat to a Client Service Consultant in real time.

- The real-time nature of the chat experience can help ease user frustration by not having to phone the Client Service Call Centre and to wait for the next available Consultant, and unlike e-mail support, it is a medium for more immediate responses as Members will be able to communicate with a Consultant in real time.

- As soon as the conversation is terminated, the Member will receive a transcript of the chat conversation via e-mail.

- The Online Chat function will not replace any of the current communication methods used by the Scheme. It is merely an additional communication method implemented to further enhance the Members’ KeyHealth service experience.

- The Online Chat facility is available every Monday to Friday between 08:00 and 16:00, excluding public holidays, and can be accessed from the home page of the Scheme’s website (www.keyhealthmedical.co.za).
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Service Centre</td>
<td>0860 671 050</td>
</tr>
<tr>
<td></td>
<td>e-mail <a href="mailto:info@keyhealthmedical.co.za">info@keyhealthmedical.co.za</a></td>
</tr>
<tr>
<td></td>
<td>Fax: 0860 111 390</td>
</tr>
<tr>
<td>Easy-ER</td>
<td>080 111 0215</td>
</tr>
<tr>
<td>Netcare 911</td>
<td>082 911</td>
</tr>
<tr>
<td>Hospital pre-authorisation</td>
<td>0860 671 060</td>
</tr>
<tr>
<td></td>
<td>e-mail <a href="mailto:Preauth@keyhealthmedical.co.za">Preauth@keyhealthmedical.co.za</a></td>
</tr>
<tr>
<td></td>
<td>Fax: 012 679 4471</td>
</tr>
<tr>
<td>Oncology management programme</td>
<td>0860 671 060</td>
</tr>
<tr>
<td></td>
<td>e-mail <a href="mailto:oncology@keyhealthmedical.co.za">oncology@keyhealthmedical.co.za</a></td>
</tr>
<tr>
<td></td>
<td>Fax: 012 679 4469</td>
</tr>
<tr>
<td>DENIS (Dental) pre-authorisation</td>
<td>0860 104 926</td>
</tr>
<tr>
<td></td>
<td>e-mail <a href="mailto:keyhealthenq@denis.co.za">keyhealthenq@denis.co.za</a></td>
</tr>
<tr>
<td></td>
<td>Fax: 0866 770 336</td>
</tr>
<tr>
<td>DENIS (Dental claims enquiries / Submissions)</td>
<td>e-mail <a href="mailto:claims@denis.co.za">claims@denis.co.za</a></td>
</tr>
<tr>
<td>LifeSense disease management</td>
<td>0860 50 60 80</td>
</tr>
<tr>
<td>Crisis line (Netcare 911)</td>
<td>082 911</td>
</tr>
<tr>
<td>Chronic medication registration (to be used by providers)</td>
<td>0800 132 345</td>
</tr>
<tr>
<td>Optical management</td>
<td>0861 678 427</td>
</tr>
<tr>
<td></td>
<td>Fax: 0861 100 397</td>
</tr>
<tr>
<td>Fraud/Ethics line</td>
<td>0860 110 820</td>
</tr>
<tr>
<td></td>
<td>e-mail <a href="mailto:fraud@keyhealthmedical.co.za">fraud@keyhealthmedical.co.za</a></td>
</tr>
<tr>
<td>New Business</td>
<td>0860 873 628</td>
</tr>
</tbody>
</table>
e-mail  newbusiness@keyhealthmedical.co.za  Fax: 0866 050 656

Membership  0860 671 050

e-mail  membership@keyhealthmedical.co.za

Billing  billing@keyhealthmedical.co.za  Fax: 0860 111 390

Claims submission (Excluding DENIS claims)
e-mail  general@keyhealthmedical.co.za  Fax: 0860 111 390

Broker queries  0860 873 628

e-mail  brokersupport@keyhealthmedical.co.za

Website  www.keyhealthmedical.co.za

Postal address:  KeyHealth Medical Scheme
P.O. 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  Block D
Corporate Park 66
Cnr. Lenchen Avenue and Von Willich Street
Die Hoewes
Centurion

Durban  2nd floor
Momentum House
Cnr. Florence Nzama Street (previously Prince Alfred Street) and
Bram Fisher Road (previously Ordnance Road)
Old Fort
Durban

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  •  E-mail: complaints@medicalschemes.com  •  Website: www.medicalschemes.com