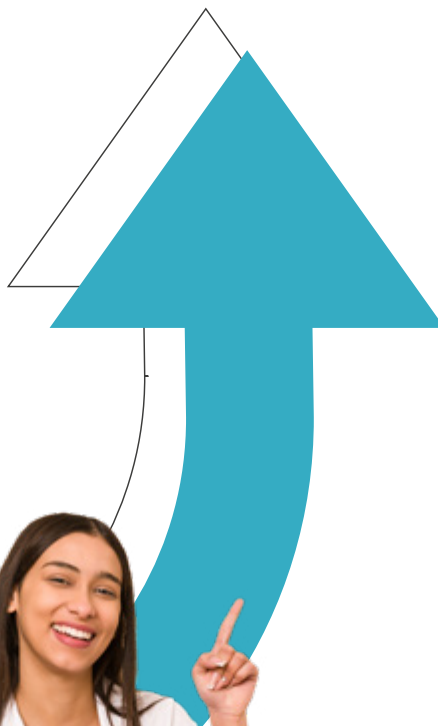




Real value speaks for itself



# MEMBER GUIDE

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\* Disclaimer: Benefits subject to approval by the Council for Medical Schemes (CMS) and although every precaution has been taken to ensure the accuracy of information contained in the benefits brochure, 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](http://www.keyhealthmedical.co.za).

# 1. KeyHealth Medical Scheme



## 1.1 KeyHealth

KeyHealth (referred to as 'the Scheme') has a formidable footprint in the industry (with about 72 500 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 4 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](http://www.keyhealthmedical.co.za). In the event of a dispute, the latest official Scheme rules, as registered with the Council for Medical Schemes, will apply.

## 1.3 Limitation of expenditure

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

## 1.4 Exchange of benefits prohibited

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

## 1.5 The member's responsibilities

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



## 2. Glossary, abbreviations and explanations



|              |                                                |
|--------------|------------------------------------------------|
| <b>PM</b>    | Principal Member                               |
| <b>AD</b>    | Adult Dependant                                |
| <b>CD</b>    | Child Dependant                                |
| <b>MSA</b>   | Medical savings account                        |
| <b>pbpa</b>  | per beneficiary per annum (per year)           |
| <b>pbp2a</b> | per beneficiary biennially (every second year) |
| <b>pbpl</b>  | per beneficiary per lifetime                   |
| <b>pfp</b>   | per family per annum (per year)                |
| <b>pfp2a</b> | per family biennially (every second year)      |
| <b>pfp5a</b> | per family every 5 years                       |
| <b>2pfp</b>  | 2 (times) per family per annum (per year)      |

## Administrator

The Administrator appointed by the Board of Trustees in terms of the Scheme rules and who has been accredited by the Council for Medical Schemes (CMS) in terms of Section 58 of the Medical Schemes Act, No 131 of 1998.

## 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.

## Annual limit

The maximum benefits to which a Principal Member and their dependants are entitled in terms of the Scheme rules and which shall be calculated annually to coincide with the financial year of the Scheme.

## Beneficiary

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

## Benefits

The benefits afforded by the Scheme to its Principal Members and their dependants in terms of Rule 17 and includes the Prescribed Minimum Benefits.

## Benefit year

The period from the 1st day of January to the 31st day of December of that year, both days included.

## Case management

A process whereby clinically indicated, appropriate and cost-effective healthcare, as an alternative to hospitalisation, or otherwise, is offered to an individual beneficiary with specific healthcare needs either by the Scheme prescribing it, or by approving an application by a Principal Member or dependant.

## Centre of Excellence

Is a team, a shared facility or an entity that provides leadership, best practices, research, support and / or training for a focus area. That provides a patient-centred focus that will include the coordination of care across multiple disciplines based on high and severe risk patient management needs, including pathology management.

## **Chronic Disease List (CDL)**

A list of chronic illness conditions that are covered by the Scheme in terms of applicable legislation.

## **Chronic medication**

Prescribed medication continuously used for more than 3 months for chronic conditions contained in the Scheme's PMB CDL (Category A, 26 conditions – all options) and / or the other conditions (Category B, 29 conditions on the Platinum option, 18 conditions on the Gold option and 4 conditions on the Silver and Equilibrium options).

## **Connected GP network**

A healthcare provider or group of providers selected by the Scheme that provides services at a specific negotiated tariff. They are digitally connected to receive home monitoring data, pathology results and a comprehensive view of the member's health record.

## **Conservative dentistry**

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

## **Co-payment**

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

## **CT and MRI scans**

Specialised, high-definition external scanning methods for internal bodily examinations.

## **Day-to-day benefit**

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

## **Dental management**

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

## **Designated Service Provider (DSP)**

A healthcare provider or group of providers selected by the Scheme as the first choice to supply its members with diagnosis, treatment and health products.

## **Disease Risk Management (DRM) Programme**

A unique programme to assist members to help manage their chronic conditions effectively and to improve the well-being of affected members.

## **Easy-ER**

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

## **Emergency**

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

## **Evidence-based practice**

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

## **Generic medicine**

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

## **Health Booster**

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

## **ICD-10 code**

The international classification of diseases. It is used by healthcare providers to classify and code all diagnoses, symptoms and procedures.

## **Immediate family**

A spouse, partner or child (biological, adopted, step or foster).

## **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 Index codification used for identification of ethical, surgical or consumable products, which enables electronic transfer of information throughout the healthcare delivery chain.

## **Oncology**

The treatment of cancer.

## **Optical management**

A cost and quality Optical Management Programme provided by Iso Leso Optics.

## **Prosthetics / prosthesis (internal and external)**

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

## **PET scan**

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

## **Physical trauma**

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

## **Preferred provider**

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

## **Platinum option**

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

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

## **Reference price**

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

## **Special dependants of the Principal Member**

Parent(s), grandchild(ren), nieces and nephews, if proof of care and financial dependency is provided.

## **Stand-in pharmacy claims**

Processing of pharmacy claims is dependent on the connection between the Scheme and the provider. If the communication lines are down and / or the transaction takes too long to process (it times out), or there is general system downtime, the claim will not be processed in real-time, but in stand-in mode. During stand-in mode, the claim(s) is processed and paid on behalf of the member. This could result in possible debt for the member if their benefits are depleted. The member will be liable for the payment of the amount.

## **Switch-out pharmacy claims**

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

## **Tariff code**

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

## **Virtual care**

Is an online healthcare consultation that allows you to visit with your healthcare provider in a convenient, affordable and accessible way without having to go to the doctor's rooms.

### 3. Membership



## 3.1 Membership application

- KeyHealth is an open medical scheme, and membership is available to private individuals and employer groups, including local government employees.
- Legislation prohibits a person from belonging to more than 1 medical scheme at a time.

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

| Beneficiary                                         | Documents required with application                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Principal Member</b>                             | <ul style="list-style-type: none"> <li>• Copy of ID</li> <li>• Member paying via debit order: Copy of a recent stamped bank statement or an official bank letter to verify the banking details</li> <li>• Company paying via debit order: Official bank letter to verify the banking details. Official company letter (on letterhead) confirming authorisation that the Scheme can debit their bank account for a member</li> <li>• If the debit order payer is not the Principal Member or a dependant: Official bank letter to verify the banking details. Account holder to sign debit order instruction (on the application form)</li> <li>• Membership certificate from previous medical scheme dated not older than 30 days or with termination date, if applicable</li> </ul> |
| <b>Minor as Principal Member</b>                    | <ul style="list-style-type: none"> <li>• Copy of ID or unabridged birth certificate</li> <li>• Affidavit from biological parent(s) and / or guardian confirming reason why minor child needs to be on their own medical scheme</li> <li>• Membership certificate from previous medical scheme dated not older than 30 days or with termination date, if applicable</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Spouse / partner</b>                             | <ul style="list-style-type: none"> <li>• Copy of ID</li> <li>• Copy of marriage certificate / proof of marriage</li> <li>• Affidavit to confirm co-habitation with partner irrespective of sex</li> <li>• Membership certificate from previous medical scheme dated not older than 30 days or with termination date, if applicable</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Second or additional spouse</b>                  | <ul style="list-style-type: none"> <li>• Copy of the customary union in terms of Customary Law or under a union recognised as a marriage in terms of any religion</li> <li>• Membership certificate from previous medical scheme dated not older than 30 days or with termination date, if applicable</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Divorced spouse</b>                              | <ul style="list-style-type: none"> <li>• Copy of the divorce settlement confirming that the Principal Member is responsible for the medical cover</li> <li>• Membership certificate from previous medical scheme dated not older than 30 days or with termination date, if applicable</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Child (biological, step-, adopted or foster)</b> | <ul style="list-style-type: none"> <li>• Copy of ID or unabridged birth certificate</li> <li>• Affidavit if the surname on the unabridged birth certificate is different from that of the Principal Member</li> <li>• Affidavit if the Principal Member's details are not on the unabridged birth certificate</li> <li>• Adopted child: Copy of adoption documentation</li> <li>• Foster child: Copy of foster placement documentation. Only qualifies up to 18 years of age</li> <li>• Stepchild: Parent of the child must be registered as dependant</li> <li>• Membership certificate from previous medical scheme dated not older than 30 days or with termination date, if applicable</li> </ul>                                                                                |

| WHO                                                     | WHAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Newborn babies                                          | <ul style="list-style-type: none"><li>Registered within 30 days of birth</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <ul style="list-style-type: none"><li>Proof of birth from the facility and / or birth certificate</li></ul>                                                                                                                                                                                                                                       |
|                                                         | <ul style="list-style-type: none"><li>Registered after 30 days of birth</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <ul style="list-style-type: none"><li>Unabridged birth certificate</li><li>Application to register a dependant form</li><li>Affidavit if the surname on the unabridged birth certificate is different from that of the Principal Member</li><li>Affidavit if the Principal Member's details are not on the unabridged birth certificate</li></ul> |
| Disabled child                                          | <ul style="list-style-type: none"><li>Copy of ID or unabridged birth certificate</li><li>Detailed diagnostic description (ICD 10) from medical practitioner and / or report from an occupational therapist</li><li>Membership certificate from previous medical scheme dated not older than 30 days or with termination date, if applicable</li></ul>                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                   |
| Child studying (between 21 and 27 years of age)         | <ul style="list-style-type: none"><li>Copy of ID or unabridged birth certificate</li><li>Proof of studies from a recognised national educational institute for the current and / or following year</li><li>Membership certificate from previous medical scheme dated not older than 30 days or with termination date, if applicable</li></ul>                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                   |
| Child not studying (between 21 and 27 years of age)     | <ul style="list-style-type: none"><li>Copy of ID or unabridged birth certificate</li><li>Affidavit from Principal Member confirming reason for financial dependency</li><li>Affidavit from adult child confirming reason for financial dependency</li><li>Proof of income (copies of the latest 3 months bank statements) from the adult child</li><li>Membership certificate from previous medical scheme dated not older than 30 days or with termination date, if applicable</li></ul>                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                   |
| SPECIAL DEPENDANTS                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                   |
| Parent                                                  | <ul style="list-style-type: none"><li>Parent(s) of Principal Member: Biological and adopted parents</li><li>Copy of ID</li><li>Affidavit from Principal Member confirming financial dependency</li><li>Affidavit from each biological parent confirming reason for financial dependency</li><li>Proof of income (copies of the latest 3 months bank statements) from each parent</li><li>Membership certificate from previous medical scheme dated not older than 30 days or with termination date, if applicable</li></ul>                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                   |
| Grandchild, niece or nephew (under the age of 21 years) | <ul style="list-style-type: none"><li>Grandchild, niece or nephew of Principal Member: Only qualifies up to 21 years of age</li><li>Copy of ID or unabridged birth certificate</li><li>Affidavit from Principal Member confirming financial dependency for grandchild, niece or nephew</li><li>Affidavit from both biological parents confirming reason for financial dependency on Principal Member</li><li>Proof of income (copies of the latest 3 months bank statements) from both biological parents</li><li>Membership certificate from previous medical scheme dated not older than 30 days or with termination date, if applicable</li></ul> |                                                                                                                                                                                                                                                                                                                                                   |

**Please note:** Where applicable, always complete the medical details questionnaire of the application form in full and correctly. Refer to the Scheme rules, glossary 4.35 for the definition of dependant(s). Newborn babies not registered within 30 days will be registered from the first day of the month, following the month in which the application form was received.

## Individuals of the Principal Member's family / household / family group who qualify 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 biological, foster, step- or legally adopted child.
- Parent(s), grandchild(ren), nieces and nephews of the Principal Member who are dependent on the Principal Member for financial support are regarded as special dependants.

**Please note:** Foster children only qualify as minors up to 18 years of age.

**Please note:** No person may be a member or dependant of more than one 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 keep the following in mind:
  - The child of a Principal Member and / or spouse / partner who, irrespective of age, suffers from a mental and / or physical disability leaving them unable to function in the private market will be regarded as a Child Dependant.

### Dependant, 21 years until 27 years of age

- The dependant is regarded as a Child Dependant for the duration of the year in which they turn 21 years old. If official proof of studies at a recognised national educational institution is provided, the dependant will continue to be regarded as a Child Dependant for the duration of the year in which such proof of studies is provided. Proof of studies is required annually.
- If not a student, their Scheme membership will default to an Adult Dependant and the contributions will be adjusted. The member must supply annual proof of financial dependency.

### Dependant, 27 years and older

- This dependant's membership will be terminated on the last day of the year in which they turn 27 years old.

### Insurability

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

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

## 3.2 Underwriting

- If a Principal Member and / or dependant suffers from a specific illness, the Scheme has the right to exclude benefits for this specific condition for a period of up to 12 months.
- Subject to the rules, the Scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 days preceding the date of application:
  - A general waiting period of up to 3 months, including PMB conditions;
  - A condition-specific waiting period of up to 12 months, including PMB conditions;

**Please note:** During the 3- and 12-month waiting periods the beneficiary will not be covered for any services, including PMBs.

- The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 months, terminating less than 90 days immediately prior to the date of application:
  - A condition-specific waiting period of up to 12 months, except in respect of any treatment or diagnostic procedures covered within PMB conditions;
  - 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;
    - \* During this period the beneficiary will not be covered for the excluded condition(s), including PMBs.
- A child born onto the Scheme, during the period of membership, will not receive waiting periods.
- The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 months, terminating less than 90 days immediately prior to the date of application:
  - A general waiting period of up to 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 90 days since 1 April 2001. The penalty is for the duration of membership.
- This loading is calculated according to the years spent without medical scheme coverage after reaching the age of 35, with credit given for years of cover after reaching the age of 21, according to the following table:

|   |    |                 |    |    |                  |
|---|----|-----------------|----|----|------------------|
| 1 | to | 4 years at 5%   | 15 | to | 24 years at 50%  |
| 5 | to | 14 years at 25% |    |    | ≥25 years at 75% |

## Non-disclosure consequences

- It is essential to declare all pre-existing conditions / illnesses / symptoms / medication use (acute and / or chronic), no matter how insignificant they may seem. The Scheme's underwriting division uses the medical information provided (on the application form) to assess the application and the associated risk(s). It is important to note that based on the medical information provided the Scheme can determine whether to impose a general waiting period of up to 3 months and / or a condition-specific waiting period of up to 12 months in terms of Section 29A of the Medical Schemes Act, No 131 of 1998.
- The Scheme may, within the first 12 months of membership, initiate a possible non-disclosure investigation for any event, even in the event of certain "emergency admissions or treatment" that may be related to a pre-existing condition(s), symptom(s) or illness that was not disclosed.
- Medical Schemes Act, No 131 of 1998, Section 29A(7) states "A medical scheme may require an applicant to provide the medical scheme with a medical report in respect of any proposed beneficiary only in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 month period ending on the date on which an application for membership was made."
- Medical Schemes Act, No 131 of 1998, Section 29(2)(e) states "A medical scheme shall not cancel or suspend a member's membership or that of any of his or her dependents, except on the grounds of non-disclosure of material information."
- If found that false information was submitted or that any relevant information was omitted on an application, the Scheme may correct this in terms of its rules, which may include suspension or termination of membership, backdated to inception.
- Subject to the requirements of the Medical Schemes Act, No 131 of 1998, failure to disclose pre-existing conditions / illnesses / symptoms / medication use (acute and / or chronic) could limit and / or exclude certain benefits or result in termination of membership, backdated to inception.

## Membership in the course of the benefit year

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

## Membership cards

- Principal Members with one or more dependant are provided with 2 membership cards.
- Principal Members without dependants are provided with 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 dependants.
- Keep membership cards in a safe place.

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

## The contents of a member pack

- Welcome letter – containing member-specific information regarding the Scheme and which must be checked by the member for accuracy and completeness.
- Membership card(s) – containing the following information and which must be checked by the member for accuracy and completeness:
  - Membership number;
  - Enrolment date;
  - Benefit date;
  - Name(s) and surname(s) of Principal Member and registered dependant(s);
  - Dependant code(s); and
  - Identity numbers of the Principal Member and registered dependant(s).
- Easy-ER card(s) (if applicable) – one card for each Child Dependant. Please ensure that the information is complete and correct. To prevent fraud, safeguard the card(s) at all times.

# 3.3 Membership changes

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

## Benefit option changes

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

## Inform the Scheme within 30 days in the event of any of the following changes to membership details

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

No changes will be implemented retrospectively. The Scheme shall not be held liable if a member's rights are prejudiced or forfeited as a result of the member neglecting to comply with the requirements of the Scheme rules.

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

## 3.4 Retirement / death of Principal Member

### Retirement of Principal Member

- A Principal Member should give at least 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.

### 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 dependent, irrespective of age, 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.
- Adjusted membership contributions are paid without interruption.

### Retirement (continuation of membership)

- Mail notification of change to membership to:

**KeyHealth Medical Scheme**  
**PO Box 14145**  
**Lytelton**  
**0140**

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

## 3.5 Contributions

### Date of payment

- A Principal Member is liable for the total monthly contribution, irrespective of any subsidy received from an employer.
- Contributions are payable in arrears for local authority members and in advance for other members, or as otherwise approved by the Scheme.
- The following payment dates are available for members paying by way of a debit order: 2nd, 26th and the last day of the month.
  - Contributions, payable in arrears, must be paid by the end of each month: Example: Contributions for January must be received by 31 January; or
  - Contributions, payable in advance, must be paid by the 7th of each month: Example: Contributions for January must be received by 7 January.
- A written confirmation of suspension will be issued to members who have not paid their contributions. Membership will be terminated if no payment is received within 90 days from the date the amount was due.

**Please note:** If you are not banking with ABSA and the last day of the month falls over a weekend, the debit order will only be deducted on the first day of the new month.

### Adjustment to contributions

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

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

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

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

### Method of payment

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

**Bank:** ABSA

**Name of account holder:** KeyHealth Medical Scheme

**Account number:** 6 000 000 12

**Reference number:** Membership number

- Please do **NOT** mail cash or cheques.
- The Scheme does **NOT** accept any responsibility if cash or cheques get lost in the mail.
- It is very important that members use their membership number as reference for **ALL** deposits made to / correspondence with the Scheme.
- Please email proof of payment to [proofofpayment@keyhealthmedical.co.za](mailto:proofofpayment@keyhealthmedical.co.za) for 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 1 calendar month notice of cancellation from the Principal Member / employer.
- When a Principal Member no longer qualifies for membership in terms of any other stipulation as contained in the latest Scheme rules.
- If the Scheme finds that a Principal Member and / or dependant(s) have misused benefits, submitted fraudulent claims, committed any fraudulent act or failed to disclose material information when applying for membership, the membership will be terminated, backdated to the inception date.

### Termination of a dependant's membership

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

### Failure to pay amounts due to the Scheme

- If, after proper notification by the Scheme, the Principal Member still fails to pay his contributions or any other debt owed to the Scheme or fails to make any payment or arrangement with the Scheme regarding payment of such debts, his membership may be terminated.
- In the event of a Principal Member who fails to pay his contributions, his membership may be terminated, backdated to the month the last full contribution was received.
- In the event of a Principal Member and / or dependant being in debt to the Scheme, such Principal Member and / or dependant can only be reinstated and / or registered once the debt is settled.
- A medical scheme may institute legal proceedings to recover outstanding contributions or backdate the termination to the last date of contributions received. This may result in reversal of claims already paid by the Scheme during the notice period. If the member had a savings account the debt may be offset before the balance is transferred to the new medical scheme or paid out to the member if he / she does not join a new benefit option with a savings account.

### Certificate of membership

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

### Reinstatement of membership

- A member may apply for reinstatement of membership within 30 days (up to the date of resignation) from the date of notification of termination, provided that all outstanding debts are settled, subject to approval and the discretion of the Scheme.
- Should a member request reinstatement of membership after the resignation date, the member needs to re-apply for membership by completing an application form, provided that all outstanding debts are settled, after which normal underwriting will apply.

## 4. Prescribed Minimum Benefits (PMBs)



## Definition

- PMBs are defined by the Medical Schemes Act, No 131 of 1998 (the 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 271 medical conditions as defined in the Diagnosis Treatment Pairs, which includes 25 chronic conditions as defined in the Chronic Disease List (CDL).
  - Diagnoses Treatment Pairs (DTPs) link a specific diagnosis to a treatment and therefore broadly indicate how each of the approximately 271 PMB conditions should be treated. The treatment and care of PMB conditions should be based on healthcare that has proven to work best, taking affordability into consideration. Should there be a disagreement about the treatment of a specific case, the standards (also called practice and protocols) in force in the public sector will be applied.
- The treating doctor decides whether a condition is a PMB or not by taking into account the symptoms only
  - A diagnosis-based approach.
- The CDL specifies the 25 chronic conditions that are covered (see below).

**Please note:** PMBs are not influenced by Scheme exclusions.

The Scheme may request confirmation of the PMB condition by requesting copies of the pathology and / or radiology reports.

## PMB identification and rules (ICD-10 codes)

- A PMB will be identified by the ICD-10 coding and supporting clinical information and documentation provided to the Scheme.
- It is thus of the utmost importance that the correct ICD-10 codes are used to ensure that PMB-related services are paid according to entitlement / level of care and / or Scheme rules and clinical protocols when claims are submitted after the PMB was confirmed.
- The correct ICD-10 codes must also appear on the relevant medicine prescriptions and referral notes to other healthcare service providers.

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

## Emergency

- An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and / or intervention. If the treatment / intervention is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.
- Subject to application and approval, the Scheme will pay 100% of MST in respect of any services that are voluntarily obtained by a beneficiary from a service provider other than the DSP or preferred provider for a PMB condition.
- Subject to application and approval, any services in respect of PMBs that are involuntarily obtained by the beneficiary from a service provider other than the DSP or preferred provider, will be covered in full. (\*)
- A beneficiary will be deemed to have involuntarily obtained a service from a provider other than the DSP or preferred provider, if:
  - The service was not available from the DSP or preferred provider or would not be provided without unreasonable delay;
  - Immediate medical or surgical treatment for a PMB condition was required under circumstances or at locations that reasonably precluded the beneficiary from obtaining such treatment from a DSP or preferred provider; or
  - There was no DSP or preferred provider within reasonable proximity of the beneficiary's ordinary place of business or personal residence.
- Except in the case of an emergency medical condition, pre-authorisation shall be obtained by a member prior to voluntarily obtaining a service from a provider other than a DSP or preferred provider in terms of this paragraph to enable the Scheme to confirm that the circumstances contemplated in paragraph (\*) above are applicable.

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

## Diagnostic tests for unconfirmed PMB diagnosis

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

## Why were PMBs introduced?

PMBs were created to serve several important purposes:

### Access to essential care

- PMBs ensure that every medical scheme member receives a minimum level of healthcare regardless of age, health status, or the specific plan to which they belong.

### Continuous healthcare coverage

- Even if a member's annual benefits are exhausted, medical schemes must continue to cover treatment for PMB conditions. This protects members from interruptions in care.

### **Financial sustainability of medical schemes**

- Promoting early and consistent treatment of PMBs helps prevent the development of condition complications that are more expensive to treat. This contributes to the long-term financial health of medical schemes.

### **Correct allocation of healthcare costs**

- Medical schemes are responsible for covering PMB treatments according to DTPs – even if the care is provided in a public hospital. This ensures that costs are funded by the appropriate party.

### **Obligations of medical scheme beneficiaries and providers on PMBs**

- A member and their dependants must educate themselves on the Scheme rules, listed medication, and treatments (formularies) for a specific condition and who the DSPs are.
- Don't bypass the Scheme rules and clinical protocols: PMBs do not exempt members or providers from following the Scheme rules and clinical protocols. Obtain pre-authorisation even in the event of a PMB, follow the Scheme rules, and make use of DSPs.
- Do not abuse PMBs: Do not contribute to fraud, wastage and abuse on PMBs. The result will be an unsustainable private healthcare system with unaffordable contribution increases.
- The "payment in full" concept is there to ensure accessibility of healthcare services for medical scheme beneficiaries if the DSP is not available; or in a bona vide emergency. It is not a reimbursement model.

### **Designated Service Providers (DSPs) and / or preferred providers – all options**

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

#### **i) Hospitalisation**

- Netcare and Life Healthcare (countrywide) and selected Mediclinics in the Western Cape, Bloemfontein and Polokwane (a list of hospitals in areas where DSP hospitals are not present, is available on request)
- Netcare – in respect of radiotherapy facilities

#### **ii) Specialist services**

- KeyHealth Specialist Network, as contracted by the Managed Care Agent. This network will be applicable to in- and out-of-hospital-related services. Details of specialists on the network may be obtained from the Pre-authorisation Department on **0860 671 060**. A list of providers is available on the Scheme's member app.

#### **iii) Substance abuse**

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

#### **iv) Oxygen and CPAP**

- Ecomed Medical

#### **v) Oncology management – ISIMO Managed Care**

#### **vi) Prosthetics / prosthesis / fixation devices (a list is available on request)**

## 5. Medication



## 5.1 Prescribed acute medication

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

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

### Where to obtain acute medication

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

### Medication on discharge from a hospital

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

|             |                    |
|-------------|--------------------|
| Platinum    | R695 per admission |
| Gold        | R695 per admission |
| Silver      | R695 per admission |
| Equilibrium | R695 per admission |
| Origin      | R695 per admission |
| Essence     | R695 per admission |

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

## 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 compiling and updating the 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 effect cost savings, beneficiaries are advised to request the medical practitioner, where possible, to prescribe generic medication.

## 5.3 Over-the-counter medication

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

**Please note:** Vitamins only qualify for payment from over-the-counter medication, even if prescribed by a provider.

## 5.4 Registration for chronic conditions and prescribed chronic medication

- Prescribed chronic medication is used continuously for 3 months or more for conditions as contained in table 1 (Category A), table 2 (Category B), table 3 (Category B) and table 4 (Category B) (see subsections 5.6 and 5.7).
- If a patient is diagnosed with one of the chronic conditions listed in table 1, 2, 3 or 4, 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.
- Medication is subject to the application of MMAP®.
- 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 to obtain the chronic medication from a local pharmacy or the doctor's dispensary; and
  - Certain products can only be authorised if prescribed by the appropriate specialist. These specialists must contact Medikredit on **0800 132 345** for further information.

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

## 5.5 The Condition Medicine List (CML)

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

### Formulary medicine

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

### Non-formulary medicine

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

## 5.6 Reference price

- Reference price is the maximum amount that the Scheme is willing to pay for medicine from a similar medicine class listed on the CML for that condition. This reference price may differ on each benefit option.
- Reference price is about patient choice. Medicine priced above the reference price may be substituted with a clinically appropriate alternative product (a generic substitute), where applicable, that is less expensive and does not incur any additional out-of-pocket costs. However, if the beneficiary chooses to remain on the existing, more expensive product when appropriate alternatives are available, a co-payment will apply.
- Reference price is reviewed once a year. This review process considers all the new medicine entries during the year, medicine discontinuations, new enhancements, clinical literature, licensed indications, price changes, generic influence, patent expiry, etc.

- Please refer to the MediKredit section of the KeyHealth website [www.keyhealthmedical.co.za](http://www.keyhealthmedical.co.za) to determine the reference price of the medicine currently used. If the medicine, displayed on the screen, is above reference price, the beneficiary will then be required to pay a co-payment at the point of dispensing.
- The reference price is based on the cost of medicine from a similar drug class listed on the formulary to which no reference price applies. The beneficiary is required to pay the difference between the cost of the medicine and the reference price of the formulary medicine at the point of dispensing.

**Please note:** If certain medicine is still not authorised after intervention by the doctor / specialist, or the condition being treated does not fall under table 1, 2, 3 or 4, the beneficiary can obtain the medicine from a local pharmacy or a dispensing doctor and claim it against the available day-to-day benefits, if applicable.

**TABLE 1 (CATEGORY A)**

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

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

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

**TABLE 2 (CATEGORY B)**

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

**TABLE 3 (CATEGORY B)**

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

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

**TABLE 4 (CATEGORY B)**

| Other chronic conditions (Silver and Equilibrium options only) |                     |
|----------------------------------------------------------------|---------------------|
| 1. Acne                                                        | 3. Rhinitis         |
| 2. Hyperkinesis and / or ADD (Attention Deficit Disorder)      | 4. Major Depression |

- Acne and Hyperkinesis and / or ADD (Attention Deficit Disorder) are only covered for children up to the age of 21 years. (If the patient is 21 years and older, the conditions will be covered as chronic on the Platinum and Gold options.)
- Allergic Rhinitis and Major Depression are covered for all ages.

## 5.8 Biological, targeted treatment, immunotherapy and high-cost medication

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

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

Immunotherapy is a type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection and other diseases.

Some types of immunotherapy only target certain cells of the immune system. Others affect the immune system in a general way. Types of immunotherapy include cytokines, vaccines, Bacillus Calmette-Guerin (BCG) and some monoclonal antibodies, which uses the body's immune system to fight cancer.

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

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

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

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

- Platinum option only, with a 30% co-payment, subject to the compliance on optimal standard / alternative treatment.
- 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 Scheme protocols, including investigation of the availability in state facilities.

### 5.8.4 Chronic conditions

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

Once the annual chronic limit has been depleted, the provider must contact the Scheme's chronic department for DTP authorisation. Co-payments may apply.

### 5.8.5 Section 21

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

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

### 5.8.6 Medication used alternatively (off-label)

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

### 5.8.7 Oncology

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

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

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

## 6. Hospitalisation and managed healthcare



## 6.1 Authorisation of hospital admissions

- Before admission to hospital, the member must phone **0860 671 060** (Pre-authorisation Department, send an email to **preauth@keyhealthmedical.co.za**) for the necessary authorisation or via the online chat facility, which is available every Monday to Friday between 08:00 and 19:00, excluding public holidays, and can be accessed from the homepage of the Scheme's website **www.keyhealthmedical.co.za**.
- Authorisation must be obtained at least 24 hours prior to an admission, or within 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 requesting authorisation:
  - Membership number;
  - The full name and surname and dependant code of the patient being hospitalised;
  - The name and practice number of the hospital to which the patient will be admitted;
  - The reason for the hospital admission:
    - > Admission diagnosis or ICD-10 code;
    - > If admission is for planned surgery, all relevant procedure (tariff) codes;
    - > CPT4 codes, if available; and
    - > For medical admissions, the following are required: symptoms, condition of the patient, vital data, radiology and / or pathology reports and proposed treatment plan.
  - 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; and
  - Documentation required:
    - > Copy of quotation for the intended prosthesis / surgical implant to be used, if applicable (refer to the Scheme's preferred provider list);
    - > Copy of all supporting documentation, e.g. radiology and pathology reports; and
    - > Copy of the injury report, if applicable (available from the hospital).

### Please note:

- Only medically appropriate claims will be covered by the Scheme and authorisation does not guarantee that all hospital and associated costs of the authorised admission will be paid.
- Benefits will be paid according to what is permitted in terms of the Scheme rules, funding guidelines and clinical protocols.
- Services must commence within 30 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.

- It remains the member's responsibility to provide the Pre-authorisation Department with the required information and to obtain authorisation.
- Certain in-hospital expenses, incurred as part of a procedure / admission, may not be covered by a member's hospital benefit.
- Certain procedures done, medication and new technology used in-hospital may require separate authorisation. Members are requested to clarify this with their medical practitioner prior to admission to hospital.
- Admission to hospital, for the sole purpose of investigation(s) and treatment that can be provided as an out-patient, is excluded from benefits.
- Where pre-authorisation was not obtained, and with due regard to the PMBs, a co-payment of R500 will be applicable for any claim which refers to an admission to a hospital in non-emergency instances, including the relevant costs of general practitioners and specialists. This co-payment will be deducted from the account of the relevant facility.
- If a procedure or treatment is undergone after a pre-authorisation number has been refused, no benefits are payable, except for PMBs.

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

## 6.2 Authorisation of major medical services

**Pre-authorisation is required for the following services:**

**Procedures done in the provider's rooms**, for example (but not limited to), to gastroscopies and / or colonoscopies, transfusion of blood and blood products, and the removal of lesions. Authorisation requests must be sent to **preauth@keyhealthmedical.co.za**.

**In-room procedures:** Platinum, Gold and Silver options only. Any GP and / or specialist rooms, provided that the provider has deemed the procedure appropriate. A list is available on request by contacting **0860 671 060** or on **www.keyhealthmedical.co.za**.

Pre-authorisation compulsory, subject to case management and Scheme protocols. When approved, the procedure(s) will be funded from the risk benefit.

The provider will be funded at the following MST:

- Platinum 200% of MST
- Gold 175% of MST
- Silver 150% of MST

**Please note:** Related accounts for in-room procedures, like the anaesthetist, pathology accounts will be funded from the Risk benefit, at 100% of MST.

**Please note:** R5 000 co-payment per hospital admission (no co-payment if done in rooms or day hospitals)

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

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

- The treating specialist will indicate if the patient will require subacute or rehabilitation treatment and will complete a referral letter of the specific subacute facility.
- The subacute or rehabilitation facility will evaluate the member in hospital and compile a report that will indicate the condition of the patient, needs and treatment that will be provided at the subacute facility and expected length of stay.
- As per The Council for Medical Schemes: All healthcare providers must submit the initial clinical assessment report to the Scheme along with a treatment plan, desired goals, and estimated duration to maximise functionality. After the patient reaches a plateau, the treatment focus must shift from intensive to maintenance treatment. Family members, caregivers and patients must be educated to continue with regular treatment at home to maintain functionality. Often, this approach is cost effective and has the desired outcomes.

**Authorisation process:**

- Pre-authorisation is compulsory. Subject to available benefits. Not all the options have subacute or rehabilitation benefits available for non-PMB conditions. A PMB request will be reviewed in terms of PMB entitlement and the level of care requested.
- The request for subacute, rehabilitation and transfer of skills must be sent to **rehab@keyhealthmedical.co.za** by the subacute facility, which will provide the required clinical information report, FIMTM / ICF score chart and doctor's referral letter.
- Outpatient rehabilitation requests must be sent to **preauth@keyhealthmedical.co.za** and must include:
  - Quotation from the treating provider for the number of sessions required;
  - FIMTM / ICF score chart, rehabilitation objectives and doctor's referral letter; and
  - Outpatient rehabilitation will be funded from available day-to-day benefits.

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

- Subject to pre-authorisation, authorisation must be obtained before treatment starts or within 24 hours after the first consultation. Members are advised to contact the Scheme to confirm benefits.
- Subject to available benefits. Benefit options that do not have wound care benefits will be reviewed on a case-by-case basis.

- Authorisation requests must be sent to **woundcare@keyhealthmedical.co.za** and must include:
  - Detailed wound assessment and clinical information;
  - Quotation of tariff codes for wound care visits required and NAPPI codes for treatment products required;
  - Dates of planned treatment dates;
  - Detailed colour photos; and
  - If treatment needs to continue after initial authorisation dates, wound progress reports are to be submitted before the authorisation date expires. The wound progress report must include colour photos, treatment plan with NAPPI codes, and tariff codes for consultations with proposed dates.

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

- NPWT is not routinely funded and not considered emergency medical care;
- Doctor's letter of motivation, comprehensive wound care assessment form, a minimum of 2 quotations and colour photos must be sent to **woundcare@keyhealthmedical.co.za.** and
- For the continuation of treatment, the following must be provided: comprehensive progress report, colour photos and an updated quotation, before the authorised dates expires.

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

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

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

- Home or private nursing are subject to pre-authorisation and subject to subacute benefits.
- The following must be sent to **preauth@keyhealthmedical.co.za:**
  - Detailed wound assessment and clinical information;
  - Quotation with tariff codes, number of visits and NAPPI codes for any products required;
  - Dates of planned treatment / services; and
  - For the continuation of treatment, the following must be provided: comprehensive progress report, motivation, treatment plan with tariff and NAPPI codes and number of visits, with proposed dates, before the authorised dates expires.

**Psychiatric treatment:** Psychiatry is the medical specialty devoted to the diagnosis and treatment of mental disorders. This includes consultations and psychotherapy with psychiatrists

and psychologists or inpatient treatment. Industrial and educational psychologists are excluded from benefits. IQ tests, learning problems and scholastic disorders are excluded from benefits.

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

**Please note:**

- Where pre-authorisation was not obtained, and with due regard to the PMBs, a co-payment of R500 will be applicable for any claim which refers to major medical services and out-of-hospital treatment (including, but not limited to, scopes in doctor's rooms, specialised radiology, wound care, appliances, Health Booster benefits, etc.), in non-emergency instances, including the relevant costs of general practitioners and specialists. This co-payment will be deducted from the account of the relevant facility and / or provider.
- If a procedure or treatment is undergone after a pre-authorisation number has been refused, no benefits are payable, except for PMBs.

## 6.3 Designated Service Provider (DSP) hospital network

The Scheme has entered into an agreement with 3 of the country's biggest private hospital groups to form a DSP hospital network for members.

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

- Beneficiaries must make use of either a Netcare or Life Healthcare hospital (countrywide) or selected Mediclinics (Western Cape, Bloemfontein and Polokwane), within reasonable proximity (40 kilometres) of their personal residence, subject to authorisation, for any admissions / procedures. Should a beneficiary voluntarily choose to utilise services of a non-DSP hospital, such a beneficiary will be liable for a 30% co-payment in respect of the hospital account incurred. This co-payment will be payable directly to the hospital concerned. Beneficiaries may also be required to pay an upfront cash deposit by such hospitals.
- Beneficiaries who do not have a Netcare or Life Healthcare hospital (countrywide) or selected Mediclinics (Western Cape, Bloemfontein and Polokwane), within reasonable proximity (40 kilometers) of their personal residence, subject to authorisation, may voluntarily utilise the service of a non-DSP hospital for any admissions / procedures, without incurring any co-payment. Information on the proximity of a DSP hospital can be obtained from the authorisation call centre by phoning **0860 671 060**. A list of all DSP hospitals will also be available on the Scheme's website **www.keyhealthmedical.co.za** and member app (see Section 18.3).

- Should a beneficiary involuntarily obtain services from a non-DSP hospital (e.g. in emergency situations or when transported to such facilities by emergency transport services), the Scheme will cover the cost for such services in accordance with the applicable benefit allocation and no co-payment shall apply in respect of the hospital account.
- Should a beneficiary voluntarily travel outside of his residential area, to an area where there is a DSP hospital, and voluntarily makes use of a non-DSP hospital, such beneficiary will be liable for a 30% co-payment in respect of the hospital account incurred.
- The DSP hospital network will not be applicable to the Scheme's Easy-ER benefit (see Section 16).

## 6.4 Disease Risk Management (DRM) Programme

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

- Decide which tests and investigations may be required;
- Renew your chronic prescription every 6 months as required by law;
- Refer you to a specialist when necessary; and
- Register you for any additional chronic conditions, which registration will result in your treatment plan being adjusted accordingly.

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

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

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

Severe and high risk members must use an allocated DSP, a connected GP or Centre of Excellence. Severe and high risk members are determined by the combination of a proprietary risk score and algorithm.

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

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

The DRM Programme includes the following conditions:

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

## 6.5 Disease / case management

The programmes below are all subject to case management.

### 6.5.1 Registration

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

### 6.5.2 Oncology

- The doctor / specialist must complete a treatment plan or write a prescription for associated oncology medication to:
  - Effect registration on the programme;
  - Facilitate the evaluation and final approval of treatment; and
  - Ensure timely processing of cancer-related claims.
- Email the treatment plan to **oncology@keyhealthmedical.co.za**.
- Call **0860 671 060** for authorisation.
- The following will be covered from the oncology benefits, subject to the relevant options:
  - Chemotherapy treatment at the doctor's / specialist's facility;
  - Chemotherapy treatment during hospitalisation and on an outpatient basis at the hospital;
  - Radiotherapy, MRI, CT and PET scans, consultations, blood tests and adjunctive treatment (in-and-out-of-hospital); and
  - Refer to pages 21-30 for Section 21, biological, targeted treatment, immunotherapy, high cost medication and out-of-protocol medication / treatment.
- Oncology follow-up management programme:
  - Patients that received active oncology treatment will, after the treating doctor's /

specialist's completion of the oncology treatment plan, still be registered on the oncology programme for follow-up visits and tests, up to a maximum of 5 years, subject to pre-authorisation and benefit limits;

- Beneficiaries must register with the Scheme's oncology case manager by sending an email to **oncology@keyhealthmedical.co.za** to manage follow-up treatments related to the original diagnosis;
  - Subject to the approved follow-up care treatment plan, consultations and medication related to the original diagnosis will not be subject to the day-to-day benefits of the member, but to available oncology benefits; and
  - A general oncology treatment plan must be approved for patients who are in remission for longer than 5 years, subject to the day-to-day benefits.
- Adjuvant treatment
    - According to the National Cancer Institute, adjuvant therapy is additional cancer treatment given after the primary treatment to lower the risk that the cancer will come back. Adjuvant therapy may include chemotherapy, radiation therapy, hormone therapy, targeted therapy, or biological therapy.

| Icon tiers       | Rules                                                                                                                                   |
|------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| <b>Enhanced</b>  | Aimed at the options with substantial oncology benefits and includes biological, targeted treatment, immunotherapy, and high-cost drugs |
| <b>Core</b>      | Aimed at the options with benefits that allow more than the PMB level of care                                                           |
| <b>Essential</b> | Aimed at the PMB level of care                                                                                                          |

Per family per rolling 12-month cycle. The benefit is available from the time of registration for treatment, regardless of the calendar year. This means that if treatment starts in August, the member is eligible for the full benefit limit from that month onward for the next 12 months.

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

### 6.5.3 Palliative care

- Palliative care refers to the holistic multi-disciplinary care of a patient and family affected by a life limiting or life-threatening illness.
- Keyhealth's palliative care offering is unique in that it acknowledges the impact of such conditions on the quality of life of those affected and aims to deliver a compassionate, patient-centric approach to uphold the dignity and wishes of our members
- Pre-authorisation is required and subject to case management and scheme protocols.

### 6.5.4 Transplants (solid organs, tissue and corneas) and dialysis

- Transplants and dialysis require authorisation and are subject to:
  - Limits as described in the benefit structure section of this member guide;

- Case management;
- Using the Scheme's DSPs; and
- Haemodialysis does not need pre-approval but is subject to the use of DSPs.

### 6.5.5 HIV / AIDS

- The Scheme has contracted with LifeSense Disease Management (LifeSense) to manage the HIV / AIDS Programme.
- Registering on the HIV / AIDS Programme:
  - Contact LifeSense on **0860 506 080**;
  - Beneficiaries may visit the doctor of their choice for the initial examination;
  - The treating doctor will complete the application form in co-operation with the beneficiary and forward the form and results of any blood test to LifeSense;
  - A treatment plan, submitted by the treating doctor and based on the above information, will have to be approved by the medical advisor of LifeSense; and
  - The beneficiary's doctor will be contacted by LifeSense and advised what medication options are available, taking into consideration the stage of the disease.
- Utilisation of the HIV / AIDS Programme:
  - Once the beneficiary is enrolled on the programme, the treating doctor will be contacted on a regular basis by the LifeSense case manager;
  - Assistance will be provided to support and reinforce the importance of the correct utilisation of the authorised medication; and
  - The beneficiary will also be assisted with lifestyle adjustments and counselling.

**Please note:** Direct enquiries related to HIV / AIDS claims to the Client Service Centre on **0860 671 050**.

### 6.5.6 Integrated care and remote monitoring

- KeyHealth has launched an innovative offering for our members with multiple chronic conditions.
- This includes a referral for home monitoring to ensure control of your chronic disease, giving your medical team a good understanding of your condition. This will also trigger assistance if values are abnormal.
- Should you be eligible for home monitoring our Integrated care team will reach out to you to ensure that you have access the required benefits.
- These services will be covered from the risk benefit and appliance benefits where applicable.
- Cardiac Monitoring Programme: Aims to educate, engage, monitor and manage members that have been identified as high risk for cardiovascular complications.

### 6.5.7 Hospital@Home

- KeyHealth has launched a hospital at home offering, whereby members can receive treatment for certain acute conditions in the comfort and privacy of their homes, while able to receive the loving support of their families.
- Part of this benefit is continuous remote vital signs monitoring, daily virtual visits, in-person visit by a clinician for the first 3 days at home, medication, pathology tests, wound care and short-term oxygen if required.

- These services will be covered from the risk benefit in the same way as an in-hospital stay would be covered.
- Some examples of conditions that may be treated at home include (but are not limited to):
  - Community-acquired pneumonia;
  - Dehydration;
  - Urinary tract infections;
  - Cellulitis;
  - Acute exacerbation of asthma;
  - Syncope / collapse;
  - Post-surgery care; and
  - DVT (blood clots).
- Speak to your GP about this innovative, patient-centered, value-based offering.
- Pre-authorisation is required and subject to case management and Scheme protocols.

### 6.5.8 Geri-care

- Elder care programme to provide support whenever required through a monthly call to the member checking on education, medical history, fall assessment, trauma assessment, and medication compliance.

## 6.6 Maternity

- Pre-notification and pre-authorisation are essential in order to qualify for maternity benefits on Health Booster (refer to Section 1.3). This can be done by calling **0860 671 060**.
- Call **0860 671 060** at least 1 week before a caesarean section or delivery (if possible), or within 48 hours after childbirth for authorisation about the delivery.
- Please refer to Section 1.4 - Smart Baby Programme.

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

## 6.7 Medical appliances

- Medical appliances can be described as medical equipment / devices used for the treatment and cure of medical conditions.
- The medical appliance benefit includes items such as wheelchairs, orthopaedic appliances, incontinence equipment (including adult diapers), contraceptive devices, and sleeves / liners (for artificial limbs).
- No pre-authorisation is required, for in- and out-of-hospital benefits, subject to co-payments, quantity limits, reference price, duration restrictions, protocols and available benefits. The Scheme may in some instances request additional clinical information or quotations.
- The replacement period for hearing aids is five (5) years.

- Authorisation is necessary for the following external medical appliances, subject to clinical protocols and registration of chronic condition(s):
  - Oxygen;
  - Nebuliser;
  - Glucometer;
  - Blood pressure monitor; and
  - Pulse oximeter.
- For authorisation, the medical practitioner's motivation, as well as 2 quotations, must be sent to **appliances@keyhealthmedical.co.za**.

## 6.8 Prosthetics / prosthesis / internal fixations / implanted devices

Prosthetics/prosthesis is the artificial replacement of internal or external part(s) of the body, such as a hip or knee joint, a leg, an arm, a heart valve, including internal fixations, implanted devices, etc.

- Internal fixation – the stabilisation of fractured bones by direct fixation to one another with surgical wires, screws, pins or plates.
- An artificial limb or eye, including refit / socket, is an artificial device that replaces a missing body part, which may be lost through trauma, disease, or a condition present at birth. A prosthesis is intended to restore the normal functions of the missing body part. The replacement period of artificial limbs and eyes is five (5) years.
- Neuromodulation – a fabricated or artificial substitute that is surgically implanted permanently into the body and that does not protrude from the body and that replaces or assists a diseased or missing part of the body to restore functionality, such as deep brain stimulation, gastric electrical stimulation, intrathecal therapy, target drug delivery (pain pumps), sacral neuromodulation and spinal cord stimulation, etc. Including battery replacements. Only applicable to the Platinum option.
- Insulin pump – insulin pump therapy, also known as continuous subcutaneous insulin infusion (CSII), involves wearing a device (insulin pump) which provides a steady stream of insulin into the body. Insulin and consumables are subject to reference pricing. Including battery replacements. Only applicable to the Platinum and Gold options.
- Cochlear implant – an electrical medical device that replaces the function of the inner ear. Including battery replacements. Only applicable to the Platinum option.
- Transcatheter aortic valve implantation (TAVI), transcatheter aortic valve replacement (TAVR), transcatheter mitral valve (TMVR) or transcatheter tricuspid valve (TTVR) – a surgical procedure that repairs the valve without removing the old, damaged valve. Instead, it wedges a replacement valve into the aortic valve's place. Only applicable to the Platinum and Gold options.
- Pre-authorisation is compulsory for all external and internal prosthetics / prostheses / internal fixations / implanted devices by contacting **0860 671 060** and sending an email to **prosthesis@keyhealthmedical.co.za** with 2 quotations.
- Prosthetics / prosthesis / internal fixations / implanted devices are subject to the use of DSP, and / or preferred providers' protocols, quantity limits, reference pricing, duration restrictions and available benefits.

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

## 6.9 Casualty ward or emergency room visits

### All beneficiaries qualify for Easy-ER

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

## 6.10 Document Based Care (DBC)

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

### Please note:

- Where pre-authorisation was not obtained, and with due regard to the PMBs, a co-payment of R500 will be applicable for any claim which refers to major medical services and out-of-hospital treatment (including, but not limited to, scopes in doctor's rooms, specialised radiology, wound care, appliances, Health Booster benefits, etc.), in non-emergency instances, including the relevant costs of general practitioners and specialists. This co-payment will be deducted from the account of the relevant facility and / or provider.
- If a procedure or treatment is undergone after a pre-authorisation number has been refused, no benefits are payable, except for PMBs.

## 7. Dental benefits



## 7.1 DENIS contact details

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

|                                                    |                                 |
|----------------------------------------------------|---------------------------------|
| Call centre telephone number                       | <b>0860 104 926</b>             |
| Call centre fax number                             | <b>0866 770 336</b>             |
| Email address for enquiries                        | <b>keyhealthenq@denis.co.za</b> |
| Email address for claims                           | <b>claims@denis.co.za</b>       |
| Email address for DENIS authorisations             | <b>auths@denis.co.za</b>        |
| Email address for DENIS In-hospital authorisations | <b>hospitalenq@denis.co.za</b>  |
| Email address for crowns                           | <b>crowns@denis.co.za</b>       |
| Email address for periodontics                     | <b>perio@denis.co.za</b>        |
| Email address for orthodontics and implants        | <b>ortho@denis.co.za</b>        |

- Paper claims must be submitted to the following address:

**DENIS**  
**Private Bag X1**  
**CENTURY CITY**  
**7446**

## 7.2 General dental information

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

**Please note:** All procedures and treatment, not pre-authorised, will attract a 20% co-payment. This does not apply to emergency hospital admissions. All dental claims subject to 100% of MST.

### Crowns, bridges and dentures

- A crown (cap) is an artificial restoration (hard cover) that is made to fit over a badly damaged or decayed tooth.
- A bridge is made to replace 1 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 1 side of the mouth.
- A denture is a removable plate or frame holding 1 or more artificial teeth.

- Benefits for crown, bridge work and dentures are subject to pre-authorisation, where the managed care protocols of DENIS apply.
- All pre-authorisation requests for crown and bridge benefits must be accompanied by clinical records (treatment plans and clear X-rays of the teeth to be treated).
- Clinical records must be emailed to **crowns@denis.co.za**.

### **Orthodontics (braces)**

- Benefits for orthodontic treatment will be granted where function is impaired and are based on the DENIS managed care protocols.
- All orthodontic treatment plans are measured against a clinical index to determine the functional severity of the case. Benefits are awarded to cases only when this severity level is met.
- Benefits will not be granted where orthodontic treatment is required for cosmetic reasons.
- Benefits are limited to beneficiaries between the ages of 9 and younger than 18 years of age.
- Only 1 beneficiary per family may commence orthodontic treatment in a calendar year, except in the case of identically aged siblings.
- Orthodontic re-treatment is not covered.
- Orthodontic-related surgery and the associated hospital admission are 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; and
  - 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 emailed to **ortho@denis.co.za**.

### **Implants**

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

### **Periodontics**

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

**Please note:** A 20% co-payment is applicable to all specialised dentistry on all options. The second crown on the Gold option will have a 30% co-payment.

## 7.3 Hospitalisation benefits

- Pre-authorisation for dental treatment in a hospital must be obtained by contacting the DENIS call centre on **0860 104 926** at least 48 hours prior to the planned treatment.
- Hospitalisation for dentistry is not automatically covered and is subject to DENIS authorisation, where the following protocols apply:
  - DSP hospital network – Netcare and Life Healthcare hospitals (countrywide) and selected Mediclinics (Western Cape, Bloemfontein and Polokwane);
  - 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 all options (except Origin and Essence) for Child Dependants under the age of 5 years who require extensive dental treatment (multiple extractions and fillings); and
  - Multiple visits to theatre are not covered.

**Please note:** A co-payment of R2 060 per hospital admission will be applicable on all options (no co-payment will apply to day hospitals). Additional 30% co-payment if non-DSP hospital is used.



## 8. Optical benefits



- Iso Leso Optics (RF) Pty Ltd 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, optical protocols and benefit confirmation.
- Lenses and contact lenses must be prescribed by a registered optometrist or ophthalmologist and must be aimed at improving the patient's visual acuity.
- Scripts less than 0.50 diopter are not covered.
- No benefits for add-ons, sunglasses (or lenses with a tint exceeding 35%), repairs, and contact lens solutions.
- All clinical / prescribed information must be submitted on all claims to ensure payment.
- Exceptions are subject to motivation and clinical approval.

#### **Platinum and Gold options**

- Combined overall benefit per beneficiary per 2-year calendar period. Including consultation, one pair of spectacles (single vision, bifocal, or base multifocal lenses and frames) and / or contact lenses (subject to MSA / day-to-day benefits / threshold).

#### **Silver, Equilibrium and Origin options**

- Consultation, pbp2a subject to Risk (separate from MSA / day-to-day benefits).
- Materials / components, combined benefit – one pair spectacles (single vision, bifocal, or base multifocal lenses, including frames) or contact lenses (subject to MSA / day-to-day benefits).

| <b>Iso Leso Optics contact details</b> |                                |
|----------------------------------------|--------------------------------|
| <b>Call centre</b>                     | 011 340 9200                   |
| <b>General</b>                         | info@isoleso.co.za             |
| <b>Queries</b>                         | queries@keyhealthoptical.co.za |
| <b>Claim submissions</b>               | claims@keyhealthoptical.co.za  |

## 9. Emergency transport



## Ambulance services

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

### Emergency benefit

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

### The following transports are covered

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

### The following transports are not covered

- Home to hospital: non-emergencies for booked cases.
- Hospital to home / old age care / frail care: discharge from hospital.

### Transfers

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

## Additional services provided by Netcare 911

- Taking care of uninjured minors.
- Repatriation (within South African borders).
- Transfers to Rape Crisis Centres of Excellence.
- Information regarding Netcare Travel Clinics – contact **0800 223 434** (Health Online).
- 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 4 months after the service date (date on which the patient was transported).



# 10. Claims



## 10.1 Claims procedures

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

**Please note:** Claims received from providers will be processed and paid in terms of the Scheme rules, provided that their annual renewal fees are paid up to date.

### 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; and
  - Clearly mark the account submitted as 'Refund member'.
- Before submitting these claims, ensure that all accounts show the following details:
  - Member information:
    - > The Principal Member's initials and surname as it appears on the latest membership card;
    - > The membership number;
    - > The name of the Scheme and the benefit option; and
    - > The patient's first name(s) and surname, and dependant code as indicated on the latest membership card.

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

- Provider information:
  - > The name and practice number of the service provider (doctor, hospital, pharmacy, etc.); and
  - > The referring doctor and practice number, in the case of a specialist's account.
- Services rendered:
  - > The date of the service or treatment;
  - > The nature and cost of each service or treatment item and the tariff code(s) [ICD-10 code(s)] involved;
  - > The duration of an operation (where applicable); and
  - > The name, quantity, price and NAPPI code of each item of medication (where applicable).

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

- The claims can be emailed to **general@keyhealthmedical.co.za** or mail the original account and receipt to:

**KeyHealth Medical Scheme**  
**PO Box 14145**  
**Lyttelton**  
**0140**

- Scheme reimbursement to members:
  - Any money owed to members will be paid into their bank account, provided that the Scheme has their correct banking details; and
  - Payments to members are made bi-weekly, provided that the amount payable is in excess of R50.00. If the amount payable is less than R50.00, payment will only be made once the accumulated amount reaches R50.00.
- Submission of claims:
  - Claims received by the Scheme within 4 months of the date of treatment or service, will be processed according to Scheme rules; and
  - If an account is not submitted within the abovementioned period, no benefits will be payable.

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

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

## **Claims submitted to the Scheme by the service provider**

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

## How to submit a claim

- **Upload claim** – Scan and upload your claim as a PDF.
- **Email claim** – Scan and email your claims to **general@keyhealthmedical.co.za**.
- **Submit via our member app** – Use the app to take a photo of the claim and submit via the app (refer to section 17.3).
- **Post claim** – You can submit your claim via post by sending it to:  
KeyHealth, PO Box 14145, Lyttelton, 0140.

## Outstanding claims on resignation or death

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

## Most common reasons for partial payment of claims

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

## Non-payment of claims

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

## Stale claims

- If a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform both the member and the relevant healthcare provider within 30 days after receipt of such account, statement or claim that is erroneous or unacceptable for payment and state the reasons for such an opinion.
- After the member and the relevant healthcare provider have been informed, such member and provider must resubmit such account or statement within a period of 60 days following the date from which it was returned for correction.
- All claims, unless otherwise arranged, must be signed and submitted to the Scheme, before the end of the 4th month.
- For the purpose of the calculation of a benefit allocation, each month's service shall be taken into account separately, whether or not the service concerned forms part of prolonged treatment for the same illness or condition, provided that the provisions of this rule, shall not be applicable to accounts rendered by the executors of the deceased estates.

## 10.2 Motor vehicle accident (MVA)

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

## 10.3 Injury on duty (IOD)

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

## 10.4 Travelling abroad

- During the overseas visit, the travelling beneficiaries will only be covered for out-of-hospital medical expenses during the first 90 days of travel, provided that the membership is active, and the contributions are paid up to date. The member must inform the Scheme of the following in writing at least 1 month in advance:
  - The full name, surname, and dependant code of the beneficiary(ies) who will be undertaking the planned foreign visit;
  - The name(s) of the country/countries to be visited; and
  - The start and end date of the visit.
- Upon receipt of the abovementioned information, the Scheme will issue a letter to the Principal Member involved, confirming the terms and conditions of medical cover during the intended foreign visit.
- During the foreign visit, the travelling beneficiary(ies) will be liable to fund all expenses related to out-of-hospital medical treatment.
- On return, or within 4 months after the date of service, the member applies to the Scheme for the reimbursement of the abovementioned claims by submitting the relevant account(s), together with the proof of payment.

- Reimbursement will be subject to the member's available day-to-day benefits and will be calculated using the foreign exchange rate applicable on the date of service and the appropriate South African tariffs for services rendered.
- No benefits available for hospitalisation, Easy-ER, medical devices/equipment, dental, optical and ambulance services.
- Any elective/planned procedure performed outside of South Africa will not be covered.

## 10.5 Chronic medication on travelling abroad

- To qualify for additional registered chronic conditions and / or medication 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 by completing the Extended Supply Form at least 1 month in advance of the following:
  - The full name, surname, and 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; and

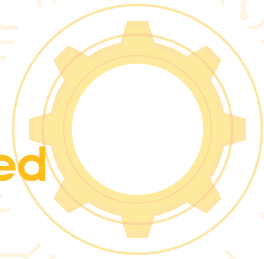
The Extended Supply Form can be obtained by contacting the Client Service Centre on **0860 671 050** or by requesting the form on the member app. Please refer to Section 17.3 for a detailed description on the mobile application.

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

## 10.6 Claims statement

- Members will be informed on a statement of all claims, activities and benefits utilised.
- Members are friendly, yet urgently, requested to carefully read every statement and to keep records for future reference, should any queries arise.
- Statements are available on the KeyHealth website and the member app.
- Please see pages 58-61 for a full breakdown of the claims statement.

# 10.7 Member statements and financial summary explained



Date

PRIVATE & CONFIDENTIAL

Statement Number: 0138

Unique number for each statement for easy reference.

|                   |             |
|-------------------|-------------|
| Principal Member  | Mr T TEST   |
| Membership Number | 3404455     |
| Group Name        | Ppsha       |
| Group Number      | 373359013   |
| Benefit Option    | Equilibrium |

Non-refundable / -transferable benefits: Out-of-hospital claims are paid from the day-to-day benefit.

## SUMMARY CLAIMS STATEMENT

| Day to Day Benefits                                              | Amount |
|------------------------------------------------------------------|--------|
| Benefits allocated                                               | 0.00   |
| Less: Claims accumulated towards your Annual Day to Day Benefits | 0.00   |
| Balance available                                                | 0.00   |

The total benefits allocated for the year.

Any claims that were processed from this benefit.

The benefits available for the remainder of the year.

Medical savings are allocated in advance for the full benefit year. This amount is used first for all out-of-hospital expenses.

## Medical Savings Account (MSA)

### Savings movement amounts

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| Opening savings balance from previous claims statement (Note 1) | -768.00 |
| Savings contributions received(+) / reversed(-)                 | 0.00    |
| Interest on savings received(+) / reversed(-)                   | 0.00    |
| Claims paid from savings(-) / reversed(+) (Note 2)              | 0.00    |
| Other savings transactions                                      | 0.00    |
| Closing savings balance                                         | -768.00 |

The amount carried over from the previous statement. This includes the previous year's savings carried over.

The monthly savings portion together with the monthly premium.

Claims paid from the savings account. This amount includes savings balances refunded / recovered or transferred to another scheme (if applicable).

Transactions that were done on the savings account.

Total savings transactions.

|                                               |         |
|-----------------------------------------------|---------|
| Plus savings contributions advanced (Note 3)  | 384.00  |
| Total savings available(+) / over utilised(-) | -384.00 |

(+) Savings that is currently available.  
(-) Amount used more than the allocated savings per year.

Note 1: This amount includes previous years' savings balances

Note 2: This amount includes savings balances refunded/recovered or transferred to another Scheme (if applicable)

Note 3: This amount includes advanced savings for contributions not yet received

# Platinum members EXPLAINED

The amount payable by the member when the routine medical expenses portion is depleted before entering the threshold zone.

| <b>Self-Funding Gap (SFG) as at this statement date</b><br><b>This section reflects the amount that you may have to personally fund.</b> |                                                           | <b>Amount</b> |
|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------|
| Annual Self Funding Gap                                                                                                                  | The total benefit allocated at the beginning of the year. | 4,090.00      |
| <b>Less:</b> Claims accumulated towards your Self funding gap (includes amount of R 0.00 accumulated this run)                           |                                                           | 4,090.00      |
| Amount that you need to personally fund                                                                                                  | Any claims that were processed from this benefit.         | 0.00          |

The amount not covered by the benefit and that the member must pay.

# Financial summary EXPLAINED

| <b>Member Financial summary information</b>           |                                                                    | <b>Amount</b> |
|-------------------------------------------------------|--------------------------------------------------------------------|---------------|
| Balance carried over from previous claims statement   |                                                                    | 0.00          |
| Other financial transactions                          |                                                                    | 0.00          |
| <b>Transactions as per detailed claims statement:</b> |                                                                    |               |
| <b>Claims</b>                                         |                                                                    |               |
| Due to member                                         | Due to the member or due by the member.                            | 0.00          |
| Due by member                                         |                                                                    | 0.00          |
| <b>Savings</b>                                        |                                                                    |               |
| Savings refunded/transferred to another Scheme        | Savings refunded / transferred to another scheme and savings used. | 0.00          |
| Savings over utilised                                 |                                                                    | 0.00          |
| Payment to member                                     | The amount the Scheme paid to the member.                          | 0.00          |
| <b>Total (due to member +/- due by member -)</b>      |                                                                    | <b>0.00</b>   |

Due to the member(+) is the amount the Scheme owes the member.  
Due by the member(-) is the amount the member owes the Scheme.

## Messages

Please remember to update your contact details with Client Services on 0860 671 050.

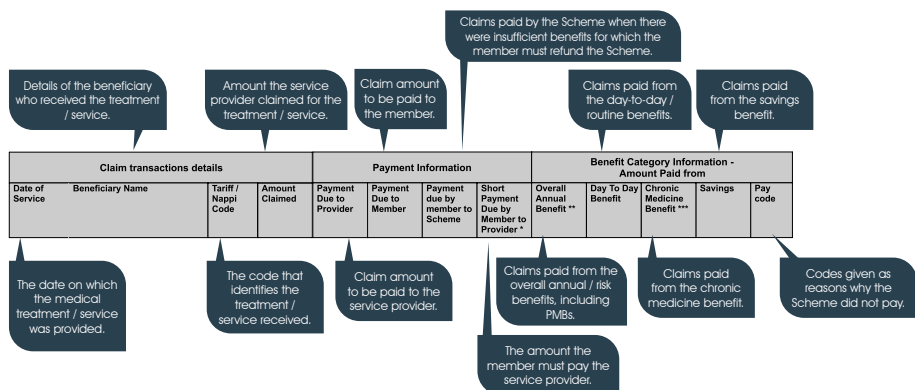
Should you require any further information, please contact the Client Service Centre on 0860 671 050 or send an email to [info@keyhealthmedical.co.za](mailto:info@keyhealthmedical.co.za). The Client Service Centre is operational Monday to Friday between 07:30 and 18:00 and Saturdays between 08:00 and 12:00, excluding public holidays.

Kind regards

*KeyHealth*  
MEDICAL SCHEME

KeyHealth Medical Scheme

## 10.8 Claims statement explained



Details of the service provider that was consulted.

|                                                                    |         |        |      |      |      |      |      |      |      |      |      |     |
|--------------------------------------------------------------------|---------|--------|------|------|------|------|------|------|------|------|------|-----|
| Provider: 000000 EXAMPLE PHARMACY, for Account Reference: 00000000 |         |        |      |      |      |      |      |      |      |      |      |     |
| 2022/00/00                                                         | 00 Name | 000000 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | X00 |
| 2022/00/00                                                         | 00 Name | 000000 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | X00 |
| 2022/00/00                                                         | 00 Name | 000000 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | X00 |
| Total for Provider: 000000 on Account Reference: 00000000          |         |        | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |     |
| Provider: 000000 DR EXAMPLE for Account Reference: XXX000          |         |        |      |      |      |      |      |      |      |      |      |     |
| 2022/00/00                                                         | 00 Name | 000000 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 000 |
| Total for Provider: 000000 on Account Reference: XXX000            |         |        | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |     |
| Grand Total                                                        |         |        | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |     |

### Explanatory Notes

\* Only applicable if member has not settled the short paid/unpaid amount to the provider

\*\* Overall Annual Benefit: Include all in Hospital Services and Category A CDL medication.

\*\*\* Chronic Medicine Benefit: This includes the Category B, 29 Chronic conditions

| **Pay code | Explanation                                          |
|------------|------------------------------------------------------|
| 420        | PMB Benefits apply                                   |
| T59        | Dispense for Choice has been checked and not applied |

Explanation of the codes given as reasons for non-payment of the claim(s).



Real value speaks for itself

# 11. Medical Savings Account (MSA)



## 11.1 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 utilised during a specific benefit year will be carried over to the following benefit year.
- The member's annual medical savings balance will be utilised first for all day-to-day medical expenses. Once annual savings are depleted, day-to-day expenses will then be covered from the applicable benefits.
- After depletion of the day-to-day benefits, the available savings balance (i.e. carried forward savings) from previous years will be utilised.

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

- Change of option: Should the selected new option not make provision for a savings account.
  - Resignation (1): Should a member resign from the Scheme during the year and the member's new medical scheme does not have a savings option, the savings amount will be paid out to the member; or
  - Resignation (2): Should a member resign from the Scheme during the year and the member's new medical scheme does have a savings option, the savings amount will be paid out to the new medical scheme.

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

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

- Change in KeyHealth option – should the new option, selected by the member, not make provision for a savings account.
- In the event of the resignation of a beneficiary 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.**

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

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



# 12. List of exclusions



With the exception of the PMBs, and unless specific provision has been made in the Scheme rules for benefits, no benefits will be payable in respect of the following:

- Costs incurred for treatment arising out of an injury sustained by a beneficiary for which any third party is liable. The beneficiary is, however, entitled to such benefits as would have applied, provided that, on receipt of payment in respect of resultant third party claims, the Principal Member will reimburse the Scheme any payments made by the Scheme in respect of these claims.
- Services exceeding the maximum benefits to which the beneficiary is entitled to, as contained in the Scheme rules.
- The cost of services rendered in respect of the following:
  1. Persons not registered with an acknowledged professional institution that was established or registered in accordance with relevant legislation.
  2. Any institution, nursing institution or similar institution, except a state hospital, that is not registered in accordance with relevant legislation.
  3. Any person or institution that does not have a practice number.
  4. Costs incurred for treatment arising out of an injury or disablement resulting from war, invasion or civil war, except for PMBs.
  5. Accommodation or lodging fees in convalescent or old age homes, frail care facilities, institutions for the physically or the mentally handicapped, or similar institutions, including home-based frail care and day-to-day care.
  6. Accommodation and treatment in spas and resorts, for health, slimming, chiropractic, homeopathic, alternative medicine or similar purposes, and home nursing.
  7. Accommodation in a private room of a hospital, except when clinically motivated by a medical practitioner and approved by the Scheme, or when giving natural birth on the Platinum, Gold, Silver, Equilibrium or Origin options.
  8. The cost of holidays for recuperative purposes, whether deemed medically necessary or not.
  9. Medical examinations for insurance, school camp, visa, employment or similar purposes.
  10. Travelling costs incurred by beneficiaries.
  11. Charges for repairs of medical appliances.
  12. Medical examinations, consultations, treatment, operations and procedures relating to:
    - 12.1 Acupuncture;
    - 12.2 Bio-stress assessments;
    - 12.3 Colonic irrigation;
    - 12.4 Conservative back / neck treatment in hospital;
    - 12.5 Cosmetic / non-functional procedures;
    - 12.6 DNA testing;
    - 12.7 Gender reassignment;
    - 12.8 Industrial and educational psychologists;
    - 12.9 IQ tests and learning and / or educational problems;
    - 12.10 Music and water therapy;
    - 12.11 Obesity and weight loss surgery (excluding benefits available on the Health Booster);
    - 12.12 Polysomnogram and titration (sleep study);
    - 12.13 Reversal of sterilisation;
    - 12.14 Reversal of vasectomy;
    - 12.15 Sclerotherapy of varicose veins;
    - 12.16 Sonography and sonographer;
    - 12.17 Therapeutic reflexology; and
    - 12.18 VAC installation therapy, including Pico and Prevena dressings.

13. In respect of the PMB code 902M, infertility, the following services are excluded:
  - 13.1 Assisted Reproductive Technology (ART) techniques, including In-Vitro Fertilisation (IVF);
  - 13.2 Gamete Intra-Fallopian Tube Transfer (GIFT);
  - 13.3 Zygote Intra-Fallopian Tube Transfer (ZIFT).
  - 13.4 Intra-cytoplasmic Sperm Injection (ICSI);
  - 13.5 Surrogacy (including the following):
    - 13.5.1 Artificial insemination;
    - 13.5.2 Delivery;
    - 13.5.3 Gestational surrogacy (GS) and donor sperm (DS); and
    - 13.5.4 Maternity benefits (day-to-day and / or Health Booster).
14. Charges for the following:
  - 14.1 Ante- and post-natal exercise classes (excluding the benefits available on the Health Booster);
  - 14.2 Appointments not kept;
  - 14.3 Breastfeeding instructions;
  - 14.4 Mothercraft; and
  - 14.5 Telephonic consultations with medical practitioners.
15. Purchase or hire of the following equipment:
  - 15.1 APS therapy machines, TENS, or similar devices;
  - 15.2 Bedpans;
  - 15.3 Binders (abdominal, chest, hernia);
  - 15.4 Breast pump / machine (except on the Smart Baby Programme);
  - 15.5 Bath transfer benches
  - 15.6 Bath and toilet railings
  - 15.7 Continuous glucose monitoring system;
  - 15.8 Commodes;
  - 15.9 Compression pants;
  - 15.10 Cosmetic improvement to the appearance of prosthetic / artificial limb;
  - 15.11 CPAP machines and accessories;
  - 15.12 Cryo cuff or similar products for compression, hot and cold therapy;
  - 15.13 Cushions (any sort);
  - 15.14 Elevation devices / equipment;
  - 15.15 Foot orthotics;
  - 15.16 Hamstring support pants;
  - 15.17 Health shoes (any sort);
  - 15.18 Heart Hugger™ / brace;
  - 15.19 Humidifiers;
  - 15.20 Kidney belts;
  - 15.21 Mattresses, including Numbus mattresses;
  - 15.22 Medic Alert bands;
  - 15.23 Peak flow meters;
  - 15.24 Resting splints (foot / wrist);
  - 15.25 Restraining devices;
  - 15.26 Sheepskin;
  - 15.27 Special beds or chairs (any sort);
  - 15.28 Toilet seat raiser;
  - 15.29 Traction kit;
  - 15.30 Waterproof sheets;
  - 15.31 Water birth equipment purchase / rental including fees for a birthing partner; and
  - 15.32 Wheelchair luxury accessories, batteries and tyres.

16. The purchase of:

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

17. General optical benefit exclusions:

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

## **General dental benefit exclusions with due regard to PMBs**

### **Oral hygiene / prevention**

- 1. Oral hygiene evaluation.
- 2. Professionally applied fluoride for beneficiaries younger than 5 and 13 years and older.
- 3. Tooth whitening.
- 4. Nutritional and tobacco counselling.
- 5. Cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl) and ointments.
- 6. Fissure sealants on patients 16 years and older.

### **Fillings / restorations**

- 7. Fillings to restore teeth damaged due to toothbrush abrasion, attrition, erosion and fluorosis.
- 8. Resin bonding for restorations and fixed restorations charged as a separate procedure to the restoration.
- 9. Polishing of restorations.
- 10. Gold foil restorations.
- 11. Ozone therapy.

### **Root canal therapy and extractions**

- 12. Root canal therapy on primary (milk) teeth.
- 13. Pulp capping (direct and indirect).
- 14. Root canal treatment on 3rd molars (wisdom teeth).

**Plastic dentures / snoring appliances / mouthguards**

15. Diagnostic dentures and associated laboratory costs.
16. Snoring appliances and associated laboratory costs.
17. The clinical fee for the addition of a soft base to new dentures is a benefit exclusion. The laboratory fee will be covered at 100% of the scheme tariff where clinical protocols apply.
18. Provisional dentures and associated laboratory costs.
19. The laboratory cost associated with mouth guards. The clinical fee will be covered at Scheme tariff where managed care protocols apply.
20. High impact acrylic (plastic and partial metal frame dentures).
21. Cost of gold, precious metal, semi-precious metal and platinum foil.
22. Laboratory delivery fees.

**Partial metal frame dentures**

23. Metal base to full dentures, including the associated laboratory costs.
24. High impact acrylic.
25. Cost of gold, precious metal, semi-precious metal and platinum foil for partial metal frame dentures.
26. Laboratory delivery fees.

**Crown and bridge**

27. Crowns or crown retainers on 3rd molars (wisdom teeth).
28. Crown and bridge procedures for cosmetic reasons and associated laboratory costs.
29. Crown and bridge procedures where there is no extensive tooth structure loss and associated laboratory costs.
30. Laboratory-fabricated temporary crowns.
31. Occlusal rehabilitations and associated laboratory costs.
32. Provisional crowns and associated laboratory costs.
33. Porcelain veneers and inlays / onlays and associated laboratory costs.
34. Emergency crowns that are not placed for the immediate protection in tooth injury and associated laboratory costs.
35. Pontics on 2nd molars. Subject to managed care protocols.
36. Cost of gold, precious metal, semi-precious metal and platinum foil.
37. Fixed prosthodontics (crowns) where the mouth is periodontally compromised.
38. Three-quarter crowns (cast metal and porcelain) and associated laboratory costs.
39. Laboratory delivery fees.

**Implants**

40. Implants on 3rd molars (wisdom teeth).
41. Laboratory delivery fees.

### **Orthodontics**

- 42. Orthodontic treatment for cosmetic reasons and associated laboratory costs.
- 43. Orthodontic treatment for individuals under the age of 9 and 18 years and older.
- 44. Orthodontic re-treatment and any related laboratory costs.
- 45. Cost of invisible retainer material.
- 46. Orthognathic (jaw correction) and other orthodontic-related surgery and any associated hospital and laboratory costs.
- 47. Laboratory delivery fees.

### **Periodontics**

- 48. Surgical periodontics which includes gingivectomies, periodontal flap surgery, tissue grafting and the hemisection of a tooth.
- 49. Perio chip placement.

### **Maxillo-facial surgery and oral pathology**

- 50. Orthognathic (jaw correction) surgery and any related hospital and associated laboratory cost.
- 51. Bone augmentations.
- 52. Bone and other tissue regeneration procedures.
- 53. Cost of bone regeneration material.
- 54. Auto transplantation of teeth.
- 55. Sinus lift procedures.

### **Hospitalisation (general anaesthetic)**

- 56. Where the only reason for admission to hospital is dental fear and anxiety.
- 57. Multiple hospital admissions.
- 58. Where the only reason for the hospital admission request is for a sterile facility.
- 59. The cost of dental materials for procedures performed under general anaesthesia.
- 60. Hospitalisation for any dental treatment other than the removal of impacted teeth on the Origin and Essence options.
- 61. Surgery and hospitalisation associated with dental implants.
- 62. The hospital and anaesthetist claims for the following procedures will not be covered when performed under general anaesthesia:
  - 62.1 Apicectomies;
  - 62.2 Dentectomies;
  - 62.3 Frenectomies;
  - 62.4 Gingivectomies;
  - 62.5 Conservative dental treatment (fillings, extractions and root canal therapy) in hospital for adults;
  - 62.6 Professional oral hygiene procedures; and
  - 62.7 Surgical tooth exposure for orthodontic reasons.

### **Additional Scheme exclusions**

- 63. Special reports.
- 64. Dental testimony including dentolegal fees.
- 65. Behaviour management.
- 66. Intramuscular or subcutaneous injection.
- 67. Procedures that are defined as unusual circumstances and procedures that are defined as unlisted procedures.
- 68. Appointment not kept.
- 69. Electrognathographic recordings, pantographic recordings and other such electronic analyses.
- 70. Caries susceptibility and microbiological tests.
- 71. Pulp tests.
- 72. Cost of Mineral Trioxide.
- 73. Enamel microabrasion.
- 74. Treatment plan completed (code 8120).





## 13. Health Booster



## A programme available on all options (except Essence option) to provide beneficiaries with certain additional benefits for preventive care

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

### Qualification

- Members qualify automatically for Health Booster benefits according to the set criteria.
  - Pre-authorisation is required in order to access the maternity and weight loss benefits (excludes the Origin option), on Health Booster. Contact the pre-authorisation call centre on **0860 671 060** to obtain pre-authorisation. (Failing to do this will result in the service costs being deducted from day-to-day benefits);
  - When maternity-related claims are submitted by providers, these claims should specify the relevant ICD-10 code as contained in the pre-authorisation letter;
  - Verify the tariff code or maximum rand value with the call centre consultant;
  - When claiming for antenatal vitamins, request the pharmacist at the dispensary to claim the antenatal vitamins electronically from the Scheme or supply the Scheme with a specified paper claim with a valid NAPPI code(s), ICD-10 code, and proof of payment for reimbursement; and
  - Inform the relevant service provider accordingly.

### Screening tests

- Health Assessment (HA) includes the following screening tests:
  - Body mass index (BMI)
  - Blood sugar (finger prick test)
  - Total cholesterol (finger prick test)
  - Blood pressure (systolic and diastolic)
  - Rapid semi-quantitative prostate specific antigen (PSA) test (finger prick)
- Digital Health Assessment (DHA) includes the following screening tests to monitor vital stats (Key Body Vitals, Heart Health, Physiological, Stress and Health Score), including:
  - Heart rate
  - Respiration rate
  - Oxygen saturation (SpO<sub>2</sub>)
  - Blood pressure
- Principal Members and all their dependants are entitled to one HA and / or DHA per calendar year.
- A HA form can be obtained at any pharmacy or downloaded from **[www.keyhealthmedical.co.za](http://www.keyhealthmedical.co.za)**.
- Members can access the DHA from the KeyHealth member app.
- 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 emailed to **[disease.management@keyhealthmedical.co.za](mailto:disease.management@keyhealthmedical.co.za)**.

| TYPE OF TEST                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | WHO & HOW OFTEN                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|
| PREVENTIVE CARE                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                            |  |
| Flu vaccination                                                                                                                                                                                            | All beneficiaries (February to June)                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                            |  |
| COVID-19 vaccination and boosters                                                                                                                                                                          | All beneficiaries                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                            |  |
| Tetanus injection                                                                                                                                                                                          | All beneficiaries – as and when required                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                            |  |
| Pneumococcal vaccination (Prevenar not included)                                                                                                                                                           | All beneficiaries                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                            |  |
| Malaria medication                                                                                                                                                                                         | All beneficiaries – R500 once per year                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |  |
| Contraceptive medication – tablets / patches                                                                                                                                                               | Female beneficiaries aged ≥ 16 – R190 every 20 days (Silver, Equilibrium and Origin options only)                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                            |  |
| Contraceptive medication – injectables                                                                                                                                                                     | Female beneficiaries aged ≥ 16 – R295 (Silver, Equilibrium and Origin options only)                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                            |  |
| EARLY DETECTION TESTS                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                            |  |
| Pap smear (pathologist)                                                                                                                                                                                    | Female beneficiaries aged ≥ 15 – once per year                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                            |  |
| Pap smear (including consultation and pelvic organs ultrasound; GP or gynaecologist)                                                                                                                       | Female beneficiaries aged ≥ 15 – once per year                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                            |  |
| Mammogram                                                                                                                                                                                                  | Female beneficiaries aged ≥ 40 – once per year                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                            |  |
| Prostate specific antigen (PSA) (pathologist)                                                                                                                                                              | Male beneficiaries aged ≥ 40 – once per year                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                            |  |
| Colon screening test for colon cancer                                                                                                                                                                      | Beneficiaries aged 50-75 years – once per year (excludes the Origin option)                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                            |  |
| HIV / AIDS test (pathologist)                                                                                                                                                                              | All beneficiaries – once per year                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                            |  |
| WEIGHT LOSS*                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                            |  |
| Weight Loss Programme (Excludes the Origin option)                                                                                                                                                         | <div>For all beneficiaries when the HA BMI is ≥ 30:</div> <ul style="list-style-type: none"><li>• 3 x dietician consultations (one per month)</li><li>• 1 x biokineticist consultation (to create a home exercise programme for the member)</li><li>• 3 x additional dietician consultations (one per month, provided that a weight loss chart was received from the dietician proving weight loss after the first 3 months)</li><li>• 1 x follow-up consultation with biokineticist</li></ul> |                                                                                                                                            |  |
| MATERNITY*                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                            |  |
| Antenatal visits (GP, gynaecologist or mid-wife) and urine test (dipstick) #                                                                                                                               | Female beneficiaries. Pre-notification of and pre-authorisation by the Scheme compulsory. 12 visits, including additional screening tests                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                            |  |
| Sonars (GP or gynaecologist) – one before the 24th week and one thereafter#                                                                                                                                | Female beneficiaries. Pre-notification of and pre-authorisation by the Scheme compulsory. 2 pregnancy scans                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                            |  |
| Short payments / co-payments for services rendered in (# above) and birthing fees                                                                                                                          | Covered to the value of R1 570 per pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                            |  |
| Antenatal vitamins                                                                                                                                                                                         | Covered to the value of R2 650 per pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                            |  |
| Antenatal classes                                                                                                                                                                                          | Covered to the value of R2 650 for first pregnancy                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                            |  |
| RSV vaccine                                                                                                                                                                                                | 1 per pregnancy from week 27 of gestation but no later than 30 days before expected date of delivery                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                            |  |
| CHILD BOOSTER BENEFITS                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                            |  |
| Child immunisation                                                                                                                                                                                         | Child Dependants aged ≤ 6 – as required by the Department of Health                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                            |  |
| HPV vaccination                                                                                                                                                                                            | Female beneficiaries aged 9-14 – 2 doses per lifetime                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                            |  |
| Specialist visits                                                                                                                                                                                          | Baby registered on Scheme<br>2 visits in baby's 1st year<br>1 visit in baby's 2nd year                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |  |
| Child growth assessments                                                                                                                                                                                   | Platinum and Gold options:<br>3 baby growth assessments per year at a pharmacy / baby clinic for beneficiaries aged 0-35 months                                                                                                                                                                                                                                                                                                                                                                | Silver, Equilibrium and Origin options:<br>3 baby growth assessments per year at a pharmacy / baby clinic for beneficiaries aged 0-7 years |  |
| Hearing screening test                                                                                                                                                                                     | Newborns aged 0-8 weeks – once (Silver, Equilibrium and Origin options only)                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                            |  |
| Eye test                                                                                                                                                                                                   | Child Dependants aged 0-7 years – once (Silver, Equilibrium and Origin options only)                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                            |  |
| *Pre-authorisation essential to access benefits, apply to <a href="mailto:disease.management@keyhealthmedical.co.za">disease.management@keyhealthmedical.co.za</a><br>*Subject to use of the Scheme's DSPs |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                            |  |



## 14. Smart Baby Programme



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

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

A member can register as soon as the pregnancy is confirmed by supplying the Scheme with the following:

- Smart Baby Registration Form, the form can be downloaded from **[www.keyhealthmedical.co.za](http://www.keyhealthmedical.co.za)**. and returned to **[smartbaby@keyhealthmedical.co.za](mailto:smartbaby@keyhealthmedical.co.za)**; and
- Copy of the ultrasound photo / report.
- After registration the mother will have access to the following:
  - A benefit of R1 570 that will cover short payments / co-payments for services rendered during antenatal visits (GP, gynaecologist or midwife) or during pregnancy sonars (including the cost of birthing fees). This benefit can also be used for the following:
    - > Breast pump;
    - > Thermometer;
    - > Nose cleaner / nasal aspirator; and
    - > Baby monitor.

**Please note:** These appliances must be obtained from a pharmacy with a valid practice number and valid nappi code.

- **The New Baby & Childcare Handbook** by Marina Petropulos, to assist first-time mothers during this exciting time.
- Regular, valuable communication during the pregnancy.
- Information regarding KeyHealth's maternity benefits available to mothers and babies (e.g. antenatal visits, vitamins and classes, ultrasounds, etc.) and how to access these benefits.
- Information applicable to baby's 1st year (e.g. vaccinations, Easy-ER, etc.).

### Additional screening tests

- Haemoglobin (Hb) level at the first antenatal visit then repeated between 28-32 weeks and 36 weeks of gestation.
- Bacteriuria at the first visit or at 12-16 weeks of gestation.
- Gestational diabetes (only for mothers who are not known to be diabetic):
  - Screened at the first antenatal visit and again at 28 weeks of gestation (if the initial screening was negative)
- Syphilis, 1 per pregnancy.
- Chlamydial infection, 1 per pregnancy.
- Hepatitis B, 1 per pregnancy
- Rh incompatibility (first pregnancy and at 24–28 weeks)

### Additional vaccine

- RSV vaccine, 1 per pregnancy from week 27 of gestation but no later than 30 days before expected date of delivery

**Members can register on the Smart Baby Programme by dialing 0860 671 060 or visit [www.keyhealthmedical.co.za](http://www.keyhealthmedical.co.za) for more information.**



## 15. Easy-ER



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

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

## What is Easy-ER?

- Extended to the entire family, Easy-ER gives each beneficiary, direct access to a hospital’s emergency room (ER) for medical treatment in emergency situations. This immediate access comes without any hassles or upfront payment requirements. KeyHealth guarantees the full payment in such emergency situations.
- These emergency circumstances may include:
  - Sport injuries;
  - Playground accidents;
  - Dental injuries (from a direct external blow to the mouth or face); and
  - Motor vehicle accidents.

**Please note:** To qualify, services must be rendered on the day of the incident. Not all visits or consultations to the casualty department will be funded from the Easy-ER benefit, as benefits are approved for *bona fide* emergencies.

## What is an 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.

## The Easy-ER card for children

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

- The Easy-ER card contains all details to effectively confirm the eligibility of the child when he or she requires emergency medical care at a hospital’s ER facility.
- Please see the **what you must know** section on what to do in the event that the child does not have the card with them in an emergency situation.

## Benefits of Easy-ER

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

## What you must know

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

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

**Please note:** The Easy-ER benefits do not include pharmacy, medical appliance claims, follow-up consultations, follow-up radiology, or pathology tests.

## Dental emergencies

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

**Please note:** Certain limits may apply on component costs, if applicable.

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

## Unsure of when to go to the ER?

- Contact Netcare 911's 24-hour Health-on-Line service on **082 911** to speak to a registered nurse about medical advice, information and your KeyHealth Easy-ER cover.
- Visit Netcare 911's website [www.netcare911.co.za](http://www.netcare911.co.za) for information on first aid, emergencies, childhood illnesses and baby / child safety.

## Emergency checklist

- It is daytime (during working hours) and you are able to, and your condition allows you to, visit your GP instead of going to an ER facility. **(YES / NO)**
  - Your condition allows you to wait to see your GP and you don't need emergency medical care immediately. **(YES / NO)**
  - Your condition is a recurring condition which had previously been successfully treated by a GP. **(YES / NO)**
  - The condition you are suffering from is toothache, an abscess of the tooth, or you damaged your tooth by biting or chewing. **(YES / NO)**
- \* If you answer yes to any of the abovementioned questions, your condition is not classified as an emergency.
- \* If, after working hours, you are unsure whether your condition meets the Easy-ER criteria, rather choose the safer option and get ER treatment as soon as possible.

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

# easy+ER



# 16. Fraud / unethical conduct



- Fraud is the unlawful and intentional making of a misrepresentation that causes actual prejudice or is potentially prejudicial to another.
- Fraud consists of the following elements:
  - An act, that is the making of a representation;
  - A causal link between the making of the representation and the prejudice;
  - Unlawfulness;
  - Prejudice or potential prejudice; and
  - Intention.
- The cost of medical fraud / unethical medical conduct in South Africa is estimated at billions of rands every year. This constitutes a huge financial loss, not only to medical schemes, but indirectly to every scheme member in the country.
- Fraud / unethical conduct is mainly committed for economic, egocentric, ideological and psychological reasons, of which the economic motive is the most common. Detection of fraud / unethical conduct is, for the most part, time consuming and costly. The Scheme is pro-active in identifying fraud by using its operational system to detect anomalies and trends, and also flags certain areas for monitoring to ensure that fraud or unethical behaviour is detected.
- KeyHealth also depends largely on its beneficiaries and suppliers to report any form of fraud / unethical conduct; whether reporting occurs openly or anonymously.
- In this regard, KeyHealth makes use of the services available from its administrator to provide a safe channel, where anonymity is guaranteed, to those who wish to report on (suspected) malpractices.
- All reported cases are then handed over to the Scheme's Internal Audit Department for the necessary investigations to be conducted. KeyHealth has a zero-tolerance policy towards fraud.
- Report any (suspected) fraud / unethical conduct at **087 023 0161** (Monday to Friday, 07:30 until 16:00, public holidays excluded), or via email at **fraud@keyhealthmedical.co.za**.

# 17. Electronic communication



## 17.1 Via the internet

**www.keyhealthmedical.co.za**

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

### Easy steps to register as an internet user

1. Visit **www.keyhealthmedical.co.za**.
2. Click on the **Login** tab.
3. Click on **Register for an account**.
4. Complete the electronic form and click on **Submit**.
5. The following message will appear on the screen:  
***Your new user form has been submitted... User status is Active – Active User.***
6. Click on **OK**.
7. You can now log in by using the username and password you selected.

### Forgotten password

1. Click on the **Login** tab on the homepage of the KeyHealth website.
2. Click on **Forgotten your login or password?**
3. Complete the **Forgotten password form** and click on **Submit**.
4. The following message will appear on the screen:  
***Your forgotten password form has been submitted.***
5. Click on **OK**.
6. You will receive a new password via email.
7. Use the new password to sign in.

### Online enquiries

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

## 17.2 Online chat facility

- The online chat (LIVE CHAT) is a web service that allows members and providers to chat with a client service consultant in real time. This function will not replace any of the existing communication methods. It is merely an additional tool to further enhance your service experience.
- The real-time nature of the chat helps to ease the frustrations of having to phone and wait for the next available consultant, or of sending an email and having to wait for the response.
- A transcript of your conversation will be emailed to you immediately after the conversation.
- The online chat facility is available on Mondays, Tuesdays and Thursdays between 07:30 and 18:00 and on Wednesdays and Fridays between 08:30 and 18:00, excluding public holidays, and can be accessed from the homepage of the Scheme's website [www.keyhealthmedical.co.za](http://www.keyhealthmedical.co.za).

## 17.3 Member app

- For KeyHealth, it is all about keeping things as simple as possible for our members. This often requires a smart approach.
- The Scheme has its own fully-fledged application (app) for mobile smart phones. It is an exciting initiative that utilises the power of technology to simplify the member experience.
- The following functionalities and information are accessible to members on the app:
  - Electronic membership cards (including Easy-ER cards);
  - Members can update their details (name / surname and contact information and submit new ID documents or supportive documents);
  - The ability to send copies of membership cards to providers;
  - Members can register newborn babies and register on the Smart Baby Programme;
  - The ability to communicate in real time with client service consultants, using the online chat facility;
  - The ability to submit claims and other documents to the Scheme;
  - Viewing of documents (e.g. tax certificates, claims advices, etc.);
  - View available benefits and track claims for the last 6 months. With this functionality, members can see the details of claims and whether there was a short payment;
  - Interactive 'Contact us' information;
  - ER facility search;
  - DSP hospital and specialist search;
  - Information on benefits;
  - Access the Digital Health Assessment (DHA);
  - Request a travel letter; and
  - In case of an emergency, members can make an immediate call to 082 911.

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



### Apple

Members with iPhones can download the new KeyHealth app [here](#). If you already have the KeyHealth app on your iPhone, just update it on the App Store to get the latest features. For a step-by-step guide on how to download the iPhone app [click here](#).



### Android

If you're an Android user, please delete the old KeyHealth app and download the new one. For new users of the KeyHealth app, you can download it [here](#). For a step-by-step guide on how to download the Android app [click here](#).



### Huawei

If you have a Huawei smartphone, please download the KeyHealth app [here](#). For a step-by-step guide on how to download the app on your Huawei device, [click here](#).

## 17.4 WhatsApp 060 976 8319

- The Scheme has its own WhatsApp channel for smart phones. It is an exciting initiative that utilises the power of technology to simplify the member experience.
- Self-service available 24/7.

### How to get started

- Save KeyHealth's WhatsApp number: 060 976 8319.
- Type and send "Hello" to initiate the chat.
- Follow the easy steps as prompted.
- Access services at any time of day!

### WhatsApp functions for members

- Access to:
  - Latest statement
  - Membership certificate
  - Tax certificate (current and previous years)
  - Membership card
- View benefits
- Upload document(s)
- Chat to a consultant: Mondays, Tuesdays and Thursdays from 08:00 to 18:00, Wednesdays and Fridays from 08:30 to 18:00, excludes weekends and public holiday

### WhatsApp functions for providers

- Claim statement(s)
- Confirmation of membership
- Chat to a consultant: Mondays, Tuesdays and Thursdays from 08:00 to 18:00, Wednesdays and Fridays from 08:30 to 18:00, excludes weekends and public holidays

# 18. Important contact information



|                                                                    |                           |
|--------------------------------------------------------------------|---------------------------|
| <b>Client Service Centre</b>                                       |                           |
| <b>Email:</b> info@keyhealthmedical.co.za                          | <b>Tel:</b> 0860 671 050  |
| <b>Broker queries</b>                                              |                           |
| <b>Email:</b> khbrokersupport@keyhealthmedical.co.za               | <b>Tel:</b> 0860 671 050  |
| <b>Hospital pre-authorisation</b>                                  |                           |
| <b>Email:</b> preauth@keyhealthmedical.co.za                       | <b>Tel:</b> 0860 671 060  |
| <b>Oncology management programme</b>                               |                           |
| <b>Email:</b> oncology@keyhealthmedical.co.za                      | <b>Tel:</b> 0860 671 060  |
| <b>Easy-ER</b> (Confirmation of child dependants)                  |                           |
| <b>Tel:</b> 080 111 0215                                           |                           |
| <b>DENIS</b> (Dental pre-authorisation)                            |                           |
| <b>Email:</b> keyhealthenq@denis.co.za                             | <b>Tel:</b> 0860 104 926  |
| <b>DENIS</b> (Dental enquiries)                                    |                           |
| <b>Email:</b> customercare@denis.co.za                             | <b>Tel:</b> 0860 104 926  |
| <b>DENIS</b> (Dental claim submissions)                            |                           |
| <b>Email:</b> claims@denis.co.za                                   | <b>Tel:</b> 0860 104 926  |
| <b>DENIS</b> (Dental orthodontic pre-authorisation)                |                           |
| <b>Email:</b> ortho@denis.co.za                                    | <b>Tel:</b> 0860 104 926  |
| <b>LifeSense Disease Management</b>                                |                           |
| <b>Email:</b> info@lifesense.co.za                                 | <b>Tel:</b> 0860 50 60 80 |
| <b>Netcare 911</b> (Crisis line and ambulance)                     |                           |
| <b>Email:</b> customer-service@netcare.co.za                       | <b>Tel:</b> 082 911       |
| <b>Disease Risk Management Programme</b>                           |                           |
| <b>Email:</b> disease.management@keyhealthmedical.co.za            | <b>Tel:</b> 0860 50 60 80 |
| <b>Chronic medication registration</b> (to be used by providers)   |                           |
| <b>Tel:</b> 0800 132 345                                           |                           |
| <b>Iso Leso Optics</b> (Optical management)                        |                           |
| <b>Email:</b> info@isoleso.co.za<br>queries@keyhealthoptical.co.za | <b>Tel:</b> 011 340 9200  |

| Fraud / Ethics line                                                                                                                                                                                 |                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| Email: <a href="mailto:fraud@keyhealthmedical.co.za">fraud@keyhealthmedical.co.za</a>                                                                                                               | Tel: 087 023 0161 |
| New business                                                                                                                                                                                        |                   |
| Email: <a href="mailto:newbusiness@keyhealthmedical.co.za">newbusiness@keyhealthmedical.co.za</a>                                                                                                   |                   |
| Membership                                                                                                                                                                                          |                   |
| Email: <a href="mailto:membership@keyhealthmedical.co.za">membership@keyhealthmedical.co.za</a><br><a href="mailto:proofofpayment@keyhealthmedical.co.za">proofofpayment@keyhealthmedical.co.za</a> | Tel: 0860 671 050 |
| Claims submission (excluding dental claims)                                                                                                                                                         |                   |
| Email: <a href="mailto:general@keyhealthmedical.co.za">general@keyhealthmedical.co.za</a>                                                                                                           |                   |
| Website                                                                                                                                                                                             |                   |
| <a href="http://www.keyhealthmedical.co.za">www.keyhealthmedical.co.za</a>                                                                                                                          |                   |
| Postal address                                                                                                                                                                                      |                   |
| KeyHealth Medical Scheme<br>PO Box 14145<br>Lyttelton<br>0140                                                                                                                                       |                   |

## KeyHealth Client Service Centre business hours

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

## Walk-in offices

**Centurion**    PPS Centurion Square  
Cnr Gordon Hood & Heuwel Roads  
Centurion

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

Telephone: **0861 123 267**  
Email: [complaints@medicalschemes.co.za](mailto:complaints@medicalschemes.co.za)  
Website: [www.medicalschemes.co.za](http://www.medicalschemes.co.za)



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