2019

DISCOVERY HEALTH MEDICAL SCHEME

GUIDE TO PRESCRIBED MINIMUM BENEFITS

Overview

All registered medical schemes in South Africa need to cover Prescribed Minimum Benefits on all the plans they offer to their members.

Discovery Health Medical Scheme (The Scheme) plans are structured in such a way so as to maximise cover no matter which plan members choose. Some plans cost more but offer more comprehensive benefits while others have lower contributions with fewer benefits. Regardless of this, all our plans cover more than just the minimum benefits required by law. Always consult your Health Plan Guide to see how you are covered.

This document tells you how the Scheme covers the Prescribed Minimum Benefits.

TERMINOLOGY	DESCRIPTION
Co-payment	We pay service providers at a set Discovery Health Rate. If the accounts are higher than this rate, you will have to pay the outstanding amount from your pocket.
Chronic Drug Amount (CDA)	Discovery Health Medical Scheme pays up to a monthly amount for a chronic medicine class subject to the member's plan type. This applies to chronic medicine that is not listed on the formulary or medicine list. The Chronic Drug Amount does not apply to the Smart and KeyCare plans, on these plans the cost of the lowest formulary listed drug will apply.
Chronic Disease List (CDL)	A defined list of chronic conditions we cover according to the Prescribed Minimum Benefits.
Day-to-day benefits	These are the available funds allocated to the Medical Savings Account and Above Threshold Benefit, where applicable.
Designated service provider (DSP)	A healthcare provider (for example doctor, specialist, pharmacist or hospital) who we have an agreement with to provide treatment or services at a contracted rate. Visit www.discovery.co.za or click on **Find a provider** on the Discovery app to view the full list of DSPs.
Discovery Health Rate	This is a rate set by us. We pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services at this rate.
Discovery Health Rate for Medicine	This is the rate at which Discovery Health Medical Scheme will pay for medicine. It is the Single Exit Price of medicine plus the relevant dispensing fee.
Member	The reference to member in this document also includes dependants, where applicable.
Prescribed Minimum Benefits (PMBs)	In terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of: ▪ An emergency medical condition ▪ A defined list of 270 diagnoses ▪ A defined list of 27 chronic conditions. To access Prescribed Minimum Benefits, there are rules that apply: ▪ Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit conditions ▪ The treatment needed must match the treatments in the defined benefits ▪ You must use designated service providers (DSPs) in our network. This does not apply in emergencies. However even in these cases, where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service providers in our network, once your condition has stabilised. If you do not use a DSP we will pay up to 80% of the Discovery Health Rate (DHR). You will be responsible for the difference between what we pay and the actual cost of your treatment. If your treatment doesn't meet the above criteria, we will pay according to your plan benefits.

TERMINOLOGY	DESCRIPTION
Emergency medical condition	An emergency medical condition, also referred to as an emergency, is the sudden and, at the time unexpected onset of a health condition that requires immediate medical and surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy. An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency.
Related accounts	Any account other than the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology.
Reference Price	Non-formulary medicine that falls in the same medicine category and generic group as the formulary medicine is paid up to a Reference Price.

How we pay claims for PMBs and non-PMB benefits

We pay for confirmed PMBs in full from the risk benefits if you receive treatment from a DSP. Visit www.discovery.co.za or click on **Find a provider** on the Discovery app or call us on 0860 99 88 77 to find a healthcare service provider we have a DSP payment arrangement with. Treatment received from a non-DSP may be subject to a co-payment if the healthcare provider charges more than what we pay.

We pay for benefits not included in the PMBs from your appropriate and available risk and day-to-day benefits, according to the rules and benefits of your chosen health plan.

There are some circumstances where you do not have cover for PMBs

This can happen when you join a medical scheme for the first time, with no medical scheme membership before that. It can also happen if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme would impose a waiting period, during which you and your dependants will not have access to the PMBs, no matter what conditions you might have. We will communicate with you at the time of applying for membership if waiting periods apply.

You and your dependants must register to get cover for PMBs and Chronic Disease List conditions

How to register your chronic or PMB conditions to get cover from the risk benefits

There are different types of claims for PMBs. There are claims for hospital admissions, Chronic Disease List conditions and other conditions treated out of hospital.

To apply for out-of-hospital PMBs or cover for a Chronic Disease List condition, you must complete a *Prescribed Minimum Benefit* or a *Chronic Illness Benefit a*pplication form.

- Up to date forms are always available on www.discovery.co.za under Medical Aid > Find a document.
- You can also call 0860 99 88 77 to request any of the above forms.

We will let you know about the outcome of the application. We will send you a letter confirming your cover for the condition. If your application meets the requirements to benefit from PMBs, we will automatically pay the associated approved blood tests and other defined investigative tests, treatment, medicine and consultations for that condition from the risk benefits (not from your available day-to-day benefits).

To apply for in-hospital PMB cover, you must call us on 0860 99 88 77 to request an authorisation.

Why it is important to register your PMB or chronic conditions

We pay for specific healthcare services related to each of your approved conditions. These services include approved treatment, medicine, consultations, blood tests and other defined investigative tests. We pay for the services without affecting your day-to-day benefits because we pay it from your risk benefits.

We will pay for treatment or medicines that falls outside the defined benefits and that are not approved, from your available day-to-day benefits according to your chosen health plan. If your health plan does not cover these expenses, you will have to pay the claims.

When you do not register your condition as a PMB or chronic condition

If you do not register your condition, we will pay all the consultations, blood tests, other investigative tests, medicine and treatment for the PMB or chronic condition from your available day-to-day benefits.

Who must complete and sign the registration form when applying for PMB or chronic condition cover

The individual with the PMB or chronic condition, must complete the application form with the help of their treating doctor. The main member must complete and sign the form if the patient is a minor.

The main member and each of the dependants with PMB or chronic conditions must register their specific conditions separately.

You only have to register once for a chronic condition. If your medicine or other treatment changes, your doctor can just let us know about the changes.

For new conditions, you have to register for each new condition before we will cover the treatment and consultations from the risk benefits and not from your day-to-day benefits.

Additional documents needed to support the application

You must send the Scheme the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying for cover. This will help us to identify that your condition qualifies for the chronic medicine.

Where you must send the completed registration form

You must send the completed **PMB application form**:

- By fax to: 011 539 2780
- By email to: PMB_APP_FORMS@discovery.co.za
- By post to: Discovery Health, PMB Department, PO Box 652919, Benmore, 2010.

You must send the completed **Chronic Illness Benefit application form**:

- By fax to: 011 539 7000
- By email to: CIB_APP_FORMS@discovery.co.za
- By post to: Discovery Health, CIB Department, PO Box 652919, Benmore, 2010.

We will let you know if we approve your application for PMB or chronic condition cover and what you must do next

We will inform you of our decision by fax or email (as you have indicated on your application form). The treatment needed must match the treatments in the published defined benefits on the PMB list as there are standard treatments, procedures, investigations

and consultations for each condition on the PMB list. These defined benefits are supported by thoroughly researched evidence, based on clinical protocols, medicine lists (formularies) and treatment guidelines.

What happens if you need treatment that falls outside of the defined benefits

We are required to cover defined benefits. If you need treatment that falls outside of the defined benefits and you send additional clinical information with a detailed explanation of why the treatment is needed, the Scheme will review it. If treatment that falls outside the defined benefits is not approved, it will be paid from your available day-to-day benefits according to your chosen health plan. If your health plan does not cover these expenses, you will be responsible to pay the claims.

We cover approved medicine on our medicine list (formulary) in full

We pay medicine on the medicine list (formulary) up to the Discovery Health Rate for medicine. There will be no co-payment for medicine selected from the medicine list (formulary). The most up to date medicine list (formulary) is always available on www.discovery.co.za under Medical Aid > Find a document.

If we approve a medicine that is not on the medicine list (formulary), we will pay it up to a set monthly rand amount called the Chronic Drug Amount or up to a Reference Price or the cost of the lowest medicine list (formulary) listed drug on the Smart and KeyCare plans.

***Please note**: The Chronic Drug Amount (CDA) only applies to chronic conditions and does not apply to Smart and KeyCare plans. On these plans, the lowest medicine list (formulary) drug will apply. Medicine on KeyCare Start is covered in a state facility.*

You may have a co-payment if the cost of the medicine is greater than the Chronic Drug Amount or the cost of the lowest medicine list (formulary) listed drug.

If the medicine is a substitute for one that has been ineffective or has caused an adverse reaction you and your doctor can appeal the funding decision. If the appeal is successful there will be no co-payment.

To appeal against the funding decision on PMB cover or cover for chronic medicine/treatment:

1 | Download and print a "*PMB Appeal Form*" or "*Chronic Illness Benefit Appeal form*". Up to date forms are always available on www.discovery.co.za under Medical Aid > Find a document. You can also call 0860 99 88 77 to request any of the above forms.
2 | Complete the form with the assistance of your doctor/healthcare professional.
3 | Send the completed, signed form, along with any additional medical information, by email to PMB_APP_FORMS@discovery.co.za or by fax 011 539 2780 or by email to CIB_APP_FORMS@discovery.co.za by fax to: 011 539 7000
If we approve the requested medicine/treatment on appeal, we will automatically pay from the risk benefits. If the appeal is unsuccessful you can lodge a formal dispute by following the Scheme's internal disputes process on www.discovery.co.za

Where to get your medicine

The below plans need to use a designated service provider (DSP) to avoid a 20% co-payment for medicine:

Priority, Saver, Core and Delta plans	Smart plans	KeyCare plans
MedXpress or MedXpress Network Pharmacies	MedXpress, Clicks or Dis-Chem (MedXpress Network Pharmacies	**KeyCare Plus and KeyCare Core plans** You must use a network pharmacy or your chosen GP

	do not apply for Smart plan members)	**KeyCare Start** You must use a state facility

We will tell you if we make changes to the medicine list and it affects you

Because there are regular changes to our medicine list (formulary), we only inform those members who will be affected by the changes. For example, we will only inform members who are registered for high blood pressure about changes to high blood pressure medicines on the medicine list (formulary).

When you need to get more than one month's supply of medicine

You can get more than one month's, or up to and no longer than six months' supply of approved chronic medicine if you are travelling outside the borders of South Africa. You need to fill in an Extended Supply of Medicine form. Up to date forms are always available on www.discovery.co.za under Medical Aid > Find a document. Send the form to us using the details provided on the form. We will review your request and inform you if we have approved it.

What happens if there is a change in your approved medicine

For chronic conditions, your treating doctor or dispensing pharmacist can make changes to your medicine telephonically by calling 0860 99 88 66 or by faxing an updated prescription to 011 539 7000 or emailing it to CIB_APP_FORMS@discovery.co.za

For PMB conditions, the treating doctor or dispensing pharmacist can only make changes to medicine by sending the updated prescription by fax to 011 539 2780 or emailing it to PMB_APP_FORMS@discovery.co.za

If you get your medicine or treatment from a provider of your choice instead of the Scheme's DSPs

You must use doctors, specialists and other healthcare providers who we have a DSP payment arrangement with, so that you do not experience a co-payment. This does not apply in the event of an emergency or where the use of a non-DSP is involuntary or when no DSP is available.

If you do not use healthcare providers who we have a DSP payment arrangement with, you will have to pay part of the treatment costs yourself.

Go to www.discovery.co.za for the latest copy of the treatment guidelines or contact us on 0860 99 88 77 and we will send you a copy.

What to do if there is no available DSP at the time of your request

There are some instances when you will still have full cover if you use a non-DSP. An example of this is in an emergency, cases when the use of a non-DSP is involuntary or when there is no DSP available.

In cases where there are no services or beds available within the DSP when you or one of your dependants needs treatment, you must contact us on 0860 99 88 77 and we will intervene and make arrangements for an appropriate facility or healthcare provider to accommodate you.

Get preauthorisation for hospitalisation and other procedures

What preauthorisation is and what it means

Preauthorisation is the approval of certain procedures and any planned admission to a hospital before the procedure or planned admission takes place. It includes associated treatment or procedures performed during hospitalisation. Whenever your doctor plans a hospital or day-clinic admission for you, you must let us know at least 48 hours before you go to the hospital or day-clinic.

You also need specific preauthorisation for MRI and CT scans, radio-isotope studies, and for certain endoscopic procedures, whether done in hospital or not.

Who you must contact for preauthorisation

Call us on 0860 99 88 77 to get preauthorisation. We will give you an authorisation number. Please give the authorisation number to the relevant healthcare provider and ask them to include it when they submit their claim.

Please make sure you understand what is included in the authorisation and how we will pay the claims.

We will ask for the following information when you request preauthorisation

- Your membership number
- Details of the patient (name and surname, ID number, and more)
- Reason for the procedure or hospitalisation
- Diagnostic codes (ICD-10 codes), tariff codes and procedure codes (you must get these from your treating doctor).

Please note: *If you don't preauthorise your admission, we will only pay 70% of the costs we would normally cover, unless it is an emergency, if the use of a non-DSP is involuntary or when there is no DSP is available. On certain plans you will only be covered in full if you use a network hospital. Please find out if the hospital you plan to use, is part of the network applicable to your health plan. Visit www.discovery.co.za or click on* ***Find a provider*** *on the Discovery app to find a network hospital applicable to your health plan.*

Preauthorisation does not guarantee payment of all claims

Your hospital cover is made up of:

- Cover for the account from the hospital (the ward and theatre fees) at the DHR, and
- Cover for the accounts from your treating healthcare professionals (such as the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology), which are separate from the hospital account and are called related accounts.

There are some expenses you may have in hospital as part of a planned admission that your Hospital Benefit does not cover

Certain procedures, medicine and new technologies need separate approval. It is important that you discuss this with your healthcare professional.

Remember: Benefit limits, Scheme rules, treatment guidelines and managed care criteria may apply to some healthcare services and procedures in hospital. Find out more about these by contacting us on 0860 99 88 77 or visit www.discovery.co.za **to view "what we cover".**

Contact us

Tel (Members): 0860 99 88 77, Tel (Health partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za, 1 Discovery Place, Sandton, 2196.

Complaints process

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

1 STEP1 – TO TAKE YOUR QUERY FURTHER:

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

2 STEP 2 – TO CONTACT THE PRINCIPAL OFFICER:

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

3 STEP 3 – TO LODGE A DISPUTE:

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

4 STEP 4 – TO CONTACT THE COUNCIL FOR MEDICAL SCHEMES:

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