UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

UKZN MEDICAL SCHEME
Administered by Discovery Health

University of KwaZulu-Natal Medical Scheme

BENEFIT BROCHURE

2022

CONTENTS

WELCOME TO THE UNIVERSITY OF KWAZULU-NATAL MEDICAL SCHEME*

UKZN Medical Scheme believes in giving you the power to manage your health by offering access to excellent cover for your healthcare expenses and a wellness programme.

The Scheme gives you the tools to improve your health, wellbeing and peace of mind when you need it most.

UKZN Medical Scheme provides benefits to employees of the University of KwaZulu-Natal and their immediate family members registered on the Scheme. The Scheme is registered with the Council for Medical Schemes and operates according to the Medical Schemes Act, No 131 of 1998 and its regulations.

A Board of Trustees consisting of 10 members governs the Scheme. Members elect five of these Trustees and the Council of the University of KwaZulu-Natal, the participating employer, appoints the remaining five. The Trustees are appointed to ensure the financial soundness of the Scheme and to protect the members' interests.

The Board of Trustees appoints the Principal Officer on an executive level. Discovery Health (Pty) Ltd is the Scheme's administrator, appointed by the Board of Trustees. They provide administration and managed-care services to the Scheme, according to the Scheme Rules and instructions given by the Scheme's Board of Trustees.

* University of KwaZulu-Natal Medical Scheme will be referred to as UKZN Medical Scheme in the rest of the brochure.

MEDICAL EMERGENCIES

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

A stroke, cardiac arrest, fractured hip or even an emergency appendicitis or serious eye injury are regarded as emergencies, even if the patient is fully conscious. It is impossible to give a definitive list of all possible conditions that may be considered as an emergency medical condition. Only an attending doctor can determine whether a condition is an emergency or not. He or she must then submit the account under the correct emergency codes.

ER24

Highly qualified emergency personnel from ER24 provide emergency medical services. If you need a helicopter or ambulance, they will send one to you. The Scheme covers emergency medical transport from your Hospital Benefit, whether you are admitted to hospital or not.

The following services are available:

- Unlimited 24-hour medical assistance (ambulance services)
  - Transport by road or by air, ER24 will determine the most appropriate way to transport you
  - Transfers between hospitals, subject to preauthorisation and the Scheme Rules
  - Escorted return of minors.

Full **emergency** cover

There are times when you may not have access to cover on your plan, for example, when you have run out of benefits, reached a benefit limit or are in a waiting period. Even then, you will still be covered for a life-threatening emergency if it is on the list of Prescribed Minimum Benefit conditions. This means the Scheme will pay for your hospital expenses until your condition is stable.

Cover for going to **casualty**

If you go to casualty or the emergency room, and are admitted to hospital from there, we will cover the costs of the casualty visit from your Hospital Benefit, if you or a family member or friend phone us for authorisation within 48 hours of being admitted.

If you go to casualty or the emergency room but you are not admitted to hospital, we will pay the casualty visit's cost from your General Benefit Pool or your day-to-day benefits. Some casualty wards charge a facility fee, which we do not cover.

In a medical emergency

In a medical emergency, you can call ER24 on 084 124 at any time of the day or night. This number also gives you access to a:

- 24-hour 'Ask the doctor/nurse' health line
- 24-hour crisis counselling service.

The brochure is a summary of the UKZN Medical Scheme 2022 benefits pending approval from the Council for Medical Schemes. A copy of the Scheme Rules can be downloaded from the Scheme website www.discovery.co.za

This brochure gives you a brief outline of the benefits the UKZN Medical Scheme offers. This does not replace the Scheme Rules. The Registered Scheme Rules are legally binding and always take precedence.

HOSPITAL BENEFIT

How the **hospital benefit** works

This Benefit covers expenses incurred while you are in hospital, if we have confirmed cover for your admission. Examples of such expenses are theatre and ward fees, X-rays, blood tests and medicine given to you while you are in hospital.

When you need an o**peration or hospital treatment**

For planned hospital stays, you have to call us for preauthorisation at least 48 hours before going to hospital. UKZN Medical Scheme covers you for planned hospitalisation. We pay your hospital accounts at the rate we agreed with the hospital.

The Hospital Benefit covers theatre and ward fees, X-rays, blood tests and the medicine you have to take while you are in hospital, if you have preauthorised your admission.

Network hospitals

To get full cover, members on the Standard Plan must use hospitals in the UKZN Medical Scheme Hospital Network. Please note that this only applies to planned procedures. In emergency situations you will always be treated at the nearest hospital. In some cases, you may be transferred to a network hospital when you are in a stable condition and when your treating doctor deems it appropriate to move you to a network hospital.

Moving patients from a non-network hospital to one that is in the network

The Scheme will not move a patient who has been admitted to a non-network hospital to any other hospital,except for sound medical reasons.

Moving a member from a non-network hospital to one that is in the network, other than in the above situation, would normally only be done with the consent of the member and the treating doctor. The member will have to be out of danger but likely to remain hospitalised for a lengthy period for monitoring purposes, or receive ongoing treatment.

UKZN Medical Scheme Hospital Network **for members on the Standard Plan**

KwaZulu-Natal

- Ethekwini Hospital and Heart Centre*
- Hillcrest Private Hospital*
- Lenmed Howick Hospital
- Life Chatsmed Garden Hospital
- Life Entabeni Hospital*
- Life Westville Hospital
- Midlands Medical Centre
- Netcare Kingsway
- Netcare The Bay Hospital
- Pietermartizburg Mediclinic*.

Free State

- Horizon Eye Centre
- Life Rosepark Hospital*
- Universitas Private Hospital.

Western Cape

- Cape Town Mediclinic
- Delta Life HealthCare Hospital
- Life Mercantile Hospital
- Life Vincent Pallotti Hospital*
- Melomed Gatesville Medical Centre*
- Melomed Mitchells Plain Medical Centre
- Panorama Mediclinic*
- Vergelegen Mediclinic*.

Gauteng

- Arwyp Medical Centre*
- Clinix Lesedi Private Hospital
- Clinix Sebokeng Private Hospital
- Clinton Medical Clinic
- Emfuleni Mediclinic
- Genesis Clinic (Saxonwold)

- Legae Mediclinic
- Life Bedford Gardens Hospital*
- Life Carstenhof Clinic
- Life Fourways Hospital*
- Life Groenkloof (Little Company of Mary)*
- Life Robinson Private Hospital
- Life Roseacres Clinic
- Life Suikerbosrand Clinic
- Life Wilgeheuwel Hospital*
- Louis Pasteur Private Hospital
- Midvaal Private Hospital
- Morningside Mediclinic
- Netcare Bougainville Private Hospital
- Life Sandton Surgical Centre
- Wits University Donald Gordon Medical Centre*.

*Spinal Hospital Network: A 20% co-payment will apply if you have your spinal surgery done at a non-spinal network hospital.

When you will have to pay a deductible

When you go to a non-network hospital for a planned procedure, you have to pay a deductible of R4 600 for the admission, regardless of the length of your stay.

When the preauthorisation consultant confirms the benefits, they will also tell the patient and the hospital about the deductible; you will need to pay the deductible to the hospital.

The deductible is only charged when necessary

The Scheme has mapped members' geographic location by means of GPS and identified all members living more than 50 kilometres from the nearest network hospital. When you call UKZN Medical Scheme, the authorisations consultant will verify whether the hospital is 'out-of-area' for you and confirm that no co-payment will be loaded when your benefits are confirmed. It will assist the consultant if you can indicate that you live far from a network hospital, because in areas such as George, Stanger and East London, as well as in various inland areas, there are no network hospitals.

Preauthorisation (confirmation of benefits)

If you are going to hospital for a planned procedure, you must phone us on **0860 11 33 22** to confirm benefits before being admitted. In emergencies, you or a family member must let us know within 48 hours after the admission to gain authorisation.

On the Standard Plan, if you do not preauthorise your admission, or neglect to let us know in an emergency, your claims will only be paid at 70% of the Scheme Rate and you will therefore be responsible for 30% of the total hospital costs.

Day-surgery network facility for the Standard Plan

On the Standard Plan, certain procedures will only be covered in our network of day-case facilities listed below.

KwaZulu-Natal

- Bluff Medical and Dental Centre
- Malvern Medical and Dental Centre
- Mandeni Medical Services Palm Day Clinic
- Pinetown Clinic (Pty) Ltd
- Pinetown Medicross Day Theatre
- Shelly Beach Day Clinic
- Pietermaritzburg Eye Hospital.

There are several facilities in other regions. You can access the latest information by logging in to **www.discovery.co.za Find a healthcare professional.**

Prescribed Minimum Benefits **(PMBs)**

By law, all medical schemes in South Africa must cover a minimum set of medical treatments for certain conditions. This is even true when scheme exclusions apply or when we have applied waiting periods in certain circumstances, or when you have reached a limit for the applicable benefit.

In most cases the UKZN Medical Scheme Standard Plan offers benefits that are far greater than the Prescribed Minimum Benefits.

By law, we are not allowed to use your available Medical Savings Account to pay for any Prescribed Minimum Benefits.

We will pay for Prescribed Minimum Benefits only if treatment is provided by or at one of the Scheme's designated service providers, except in emergencies, unless otherwise indicated. If you don't use the Scheme's designated service providers, co-payments may apply.

Designated service providers (DSPs)

When you use the services of a designated service provider, all claims, including those for Prescribed Minimum Benefits, are paid in full. This means you will not have to make out-of-pocket payments to these providers.

These are specific providers of healthcare services, for example GPs and specialists, who have agreed to provide services according to certain agreed rates. The Scheme pays these providers directly.

Here is a list of the Scheme's designated service providers for the diagnosis, treatment and care (which may include medicine) of Prescribed Minimum Benefit illnesses and injuries.

Network	Service
Any pharmacy participating within the HIV ARV network	HIV or AIDS related medicine
Discovery GP network	
Discovery Health Premier Plus GP network	For HIV, Diabetes, Mental Health and Cardio Care
Fresenius	Renal dialysis and other care related to renal treatment
National Renal Care	Renal dialysis and other care related to renal treatment
Physiotherapist Network	
Psychologist and registered counsellors Network	
SANCA, Nishtara and Ramot	Alcohol and drug rehabilitation
Specialist Network	
UKZN Medical Scheme Hospital Network	
VitalAire	Oxygen

What will happen if you do not use designated service providers?

Your cover depends on whether or not you choose to use the designated service providers selected by the Scheme. Prescribed Minimum Benefits are paid in full when making use of a designated service provider and Scheme limits will not apply. If you do not use designated service providers for your Prescribed Minimum Benefit treatment, the Scheme may apply co-payments, or you may have to pay deductibles.

You will not have to pay a co-payment or deductible if you have to obtain the services from a provider other than a designated service provider, when:

- It is an emergency, for hospital admissions.
- The service is not available from the designated service provider or will not be provided without unreasonable delay.
- There is no designated service provider within a reasonable distance from your place of business or residence.

We will add more designated service providers and networks to this list as they become available.

You may also access the latest information by logging in to **www.discovery.co.za > Find a healthcare professional.**

The Scheme's designated service providers for the diagnosis, treatment and care of Prescribed Minimum Benefit conditions (which may include medicine) are:

- UKZN Medical Scheme Hospital Network, state or public health system (all related services).
- Any GP in the Discovery GP Network for the Standard Plan. If you use these providers, you will not have to pay any co-payments, as claims will be paid at the Scheme Rate.
- Any specialist in the Discovery Specialist Network for the Standard Plan. If you use the services of these providers for in- or out-of-hospital care, you will not have to make co-payments, as the provider will only charge at the Scheme Rate. UKZN Medical Scheme will pay these claims in full.
- Your chosen Discovery Health Premier Plus GP in the Discovery GP Network for HIV, Diabetes, Mental Health and Cardio Care, and nurses contracted to the Scheme to deliver home-based care in lieu of hospitalisation.
- Other service providers, as selected by the Scheme from time to time.
- Centres of Excellence as Discovery Health, the Scheme's Managed Care provider, may determine from time to time for:
  - PET scans – if you use a designated service provider, you will get 100% cover up to the relevant Oncology Programme limit. If you don't use a designated service provider, you will have to make a co-payment.

- Stem cell transplants, where these treatments relate to oncology treatment. Members have to register on the Scheme's Oncology Programme to have access to the benefit. Treatment will be covered in full if one of the Scheme's Centres of Excellence is used.

- The applicable hospital network for all planned PMBs for the Standard Plan.

To find a specialist in this network, log in to **www.discovery.co.za > Find a healthcare professional.**

Clinical Maintenance Organisation (CMO)

Diabetes-cardiometabolic population health management

This benefit is available to members who meet the benefit entry criteria of the programme, and are register on the Scheme's Chronic Illness Benefit for diabetes type 1 or type 2 and related cardiometabolic conditions.

The objective of the programme is to ensure improved diabetes outcomes through:

- Strong care coordination
- Adherence to evidence-based clinical pathways
- Lifestyle modification

This will be achieved through a range of fully integrated specialised diabetes management assets such as virtual consultation platforms, diabetes-specific coaching and navigation, diabetes specific condition management, patient and provider interface using a digital health platform, remote monitoring and screening.

The programme includes:

- Endocrinologists consults
- GP consultations
- Diabetic nurse educator
- Dietician consultation
- Coach
- Pathway navigator
- Related pathology
- Foot screening
- Eye screening
- Digital platform
- Condition management
- Biokineticists
- Patient dashboard

Your GP in the Discovery Health Premier Plus GP network can enroll you on the Diabetes Care Programme. You must see a network GP to avoid a 20% co-payment on their consultations for diabetes and/or any cardiovascular disease (hypertension, hyperlipidaemia or ischaemic heart disease). Members can find a doctor on the network by logging in to www.discovery.co.za > Find a healthcare professional or call 0860 11 33 22.

Limits, clinical guidelines and policies apply to some healthcare services and procedures. Please check the benefit tables included in this benefit brochure.

THE CHRONIC ILLNESS BENEFIT

If your Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) condition is approved by the Chronic Illness Benefit, the Scheme will cover certain procedures, tests and consultations for the diagnosis and ongoing management of the condition in line with Prescribed Minimum Benefits.

All members qualify for chronic medication for the 26 conditions on the Chronic Disease List (CDL), subject to benefit entry criteria, that the Medical Schemes Act (No 131 of 1998), as amended from time to time, defines as Prescribed Minimum Benefits.

You must apply for chronic cover by completing a *Chronic Illness Benefit* application form with your doctor and submitting it for review.

For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria you need to meet.

If necessary, you or your doctor may have to give additional information or copies of certain documents to the Scheme to finalise your application.

You can get a copy of the latest Chronic Illness Benefit application form by logging in to www.discovery.co.za > Find a document or call 0860 11 33 22 to get one.

Cover for medicine for approved prescribed minimum benefit (PMB) Chronic disease list (CDL) conditions

We will pay your approved chronic medicine in full, up to the Scheme Rate, if it is on our medicine list (formulary). If your approved chronic medicine is not on our medicine list, we will pay your chronic medicine up to a set monthly Chronic Drug Amount (CDA) for each medicine category. You will be responsible to pay any shortfall yourself.

If you use a combination of medicine in the same medicine category, where one is on the medicine list and the other is not, we will pay for the medicine up to one monthly Chronic Drug Amount for that medicine category.

You need to let us know when your treatment plan changes

You do not have to complete a new Chronic Illness Benefit application form when your treating doctor changes your medicine during the management of your approved chronic condition, however, you do need to let us know when your doctor makes these changes to your treatment so that we can update your chronic authorisation. You can email the prescription for changes to your treatment plan for an approved chronic condition to CIB_APP_FORMS@discovery.co.za. Alternatively, your doctor can submit changes to your treatment plan through HealthID, provided that you have given consent to do so. If you do not let us know about changes to your treatment plan, we may not pay your claims from the correct benefit.

Should you be diagnosed with a new chronic condition, a new Chronic Illness Benefit application form would need to be completed.

To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete, when they refer you to the pathologists and/or radiologists for tests. This will enable the pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit to ensure that we pay your claims from the correct benefit.

Please refer to the website for more information on what is covered and the benefit and how it is covered.

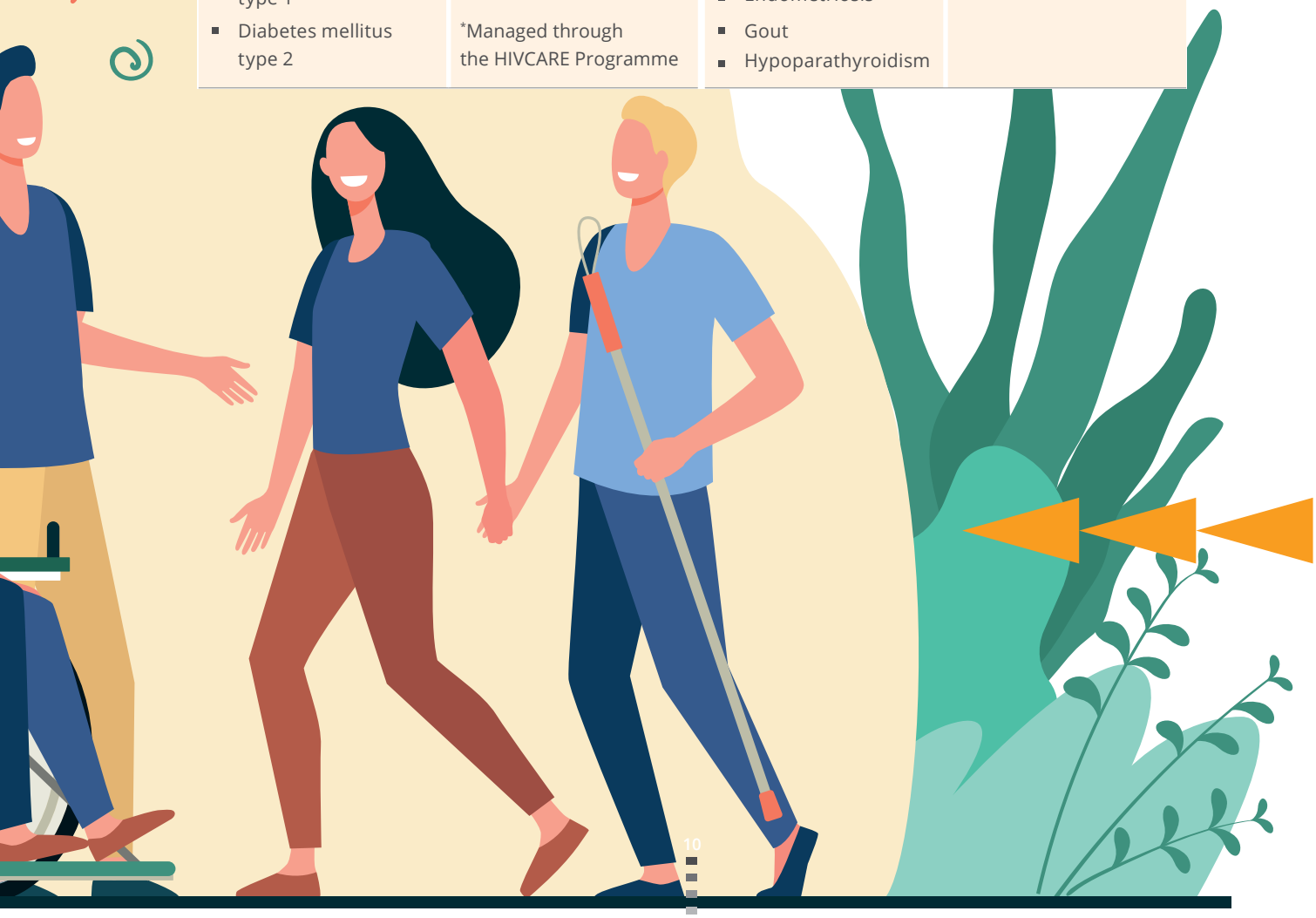
Remember

If you leave out any information or do not provide the medical test results or documents needed with the application, cover will start only from the date we get the outstanding documents or information.

Medicine for the treatment of a condition that does not meet the benefit entry criteria, and has not been approved, will not be covered from the Chronic Illness Benefit but may be paid from your Medical Savings Account.

You also have cover for other conditions that are listed on the Scheme's Additional Disease List (ADL), as defined by the Scheme. These conditions are selected according to clinical and actuarial rules. This means that although your doctor may define a condition as chronic, it may not meet the rules for cover from this benefit. In that case, you will be able to obtain the medicine from your available Medical Savings Account.

Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions		Non-Prescribed Minimum Benefits chronic conditions on the Scheme's Additional Disease List (ADL) conditions	
▪ Addison's disease ▪ Asthma ▪ Bipolar mood disorder ▪ Bronchiectasis ▪ Cardiac failure ▪ Cardiomyopathy ▪ Chronic obstructive pulmonary disease ▪ Chronic renal disease ▪ Coronary artery disease ▪ Crohn's disease ▪ Diabetes insipidus ▪ Diabetes mellitus type 1 ▪ Diabetes mellitus type 2	▪ Dysrhythmia ▪ Epilepsy ▪ Glaucoma ▪ Haemophilia ▪ HIV and AIDS* ▪ Hyperlipidaemia ▪ Hypertension ▪ Hypothyroidism ▪ Multiple sclerosis ▪ Parkinson's disease ▪ Rheumatoid arthritis ▪ Schizophrenia ▪ Systemic lupus erythematosus ▪ Ulcerative colitis *Managed through the HIVCARE Programme	▪ Attention deficit hyperactivity disorder ▪ Anterior horn cell disorders ▪ Chronic anxiety disorders ▪ Chronic dyspepsia ▪ Chronic rhinitis ▪ Chronic sinusitis ▪ Chronic vertigo ▪ Collagen disease ▪ Dementia ▪ Depression ▪ Eczema ▪ Endometriosis ▪ Gout ▪ Hypoparathyroidism	▪ Osteoarthritis ▪ Peripheral vascular disease ▪ Prostatic hypertrophy ▪ Psoriasis ▪ Recurrent cystitis ▪ Spastic colon ▪ Vascular headaches.



CLEVELAND CLINIC'S MYCONSULT® PROGRAMME

UKZN Medical Scheme is committed to delivering the best medical care to our members. We recognise that South African specialists offer exceptional quality of care through their high levels of expertise and knowledge.

Our experience tells us that there are times when a specialist may want to collaborate with other experts in a certain field of medicine, especially when their patients are facing life-threatening and life-changing conditions, particularly when this involves new forms of treatment. In some cases, a patient may ask their specialist to assist them in obtaining a second opinion for these conditions and for those that affect the quality of their life. To make this possible, we have collaborated with Cleveland Clinic, an international medical centre in the United States, which is recognised worldwide as a leader in healthcare.

The Scheme offers members the opportunity to obtain an online second opinion from a Cleveland Clinic physician specialist. Members will be reimbursed 50% of the payment made to Cleveland Clinic from their Risk Benefit.

Cleveland Clinic is a non-profit, multi-speciality academic and medical centre. The clinic integrates clinical and hospital care with research and education, which achieves optimal outcomes in the treatment of rare and complex conditions. They are recognised as leaders in providing second opinions especially in cases where there is limited expertise.

Benefits

Cleveland Clinic MyConsult® offers online medical second opinions for more than 1 200 diagnoses. These diagnoses include conditions that affect a person's quality of life and/or life-threatening conditions, including inborn errors of metabolism like Pompe disease, nephroblastoma, and unusual conditions in children like insulinoma.

The 15 most requested diagnoses in the MyConsult® programme are:

- Coronary artery disease
- Atrial fibrillation
- Prostate cancer
- Aortic stenosis
- Mitral regurgitation
- Lumbar disc herniation
- Kidney tumour
- Lumbar canal stenosis
- Breast cancer (medical management review)
- Degenerative disc disease
- Spinal stenosis with degenerative spondylolisthesis
- Cardiomyopathy
- Aortic regurgitation
- Congestive heart failure
- Lung cancer.

The MyConsult® online second opinion service is not for treatment related to scheme exclusions.

The MyConsult® service is for when a member faces a life-threatening diagnosis or one that affects quality of life. The second opinion provides confirmation of the diagnosis and treatment recommendations. It does not include the actual treatment related to any of the conditions and treatment that is excluded from cover on UKZN Medical Scheme.

HEALTH@HOME BENEFIT

Health@Home comprise of several sub-programmes providing members access to a full spectrum of quality healthcare across all levels of acuity, from home. Health@Home brings together both new and existing benefits and service offerings thereby offering our members an end-to-end, integrated at-home care experience.

Connected Care for Acute Care

According to the National Institute for Health and Care Excellence (NICE), there is increasing evidence to support the treatment of some acute medical illnesses in a patient's own home, or a care home, after a clinical assessment where it is safe to do so with an appropriate care model in place.

The Connected Care for Acute Care benefit provides qualifying members (based on specific clinical entry criteria) who require inpatient acute hospital treatment with care in their homes, either in lieu of hospitalisation, after early discharge or as a continuation of care after discharge.

Care delivery within Connected Care for Acute Care will be facilitated by a dedicated care team, which will include doctors and nurses who will provide clinical support and monitoring of the member's condition.

Continuation of care after discharge (Readmission prevention)

Hospital readmissions are increasing worldwide and equally noticeable within our Scheme. Internationally up to 20% of patients admitted have a readmission within 30 days and mainly occurs within the 1st week of being discharged.

Whilst efforts have been concentrated on preparing patients for good discharge during their admission, there is still gains to be made from focusing on managing patients considered high risk for a readmission within the immediate acute stages following a discharge. This benefit is aimed to achieve improvements in readmission rates based on international literature showing that a 27% reduction in readmissions can occur with a home health initiative. When integrated into the continuum of care, home health ensures that patients discharged from acute care, do not suffer a relapse or deterioration that may require readmission to hospital.

This benefit has 3 components:

- Homecare (1 physical visit, 3 virtual consults, and a care coordination aspect)
- A doctor follow-up consultation
- A medicine reconciliation done at the point of discharge by the treating doctor

These components will occur intensely within the first 10-14 days of the patient leaving the hospital.

The benefit is targeted at only those considered high risk for a readmission, as such a predictive model, built for this purpose, will identify those considered highest risks for a readmission for benefit eligibility.

HOMECARE NURSING BENEFIT

Home nursing refers to the care and support that is provided at home in the time of need by a skilled, registered provider or professional nurse, until the patient or family can perform the required healthcare tasks themselves.

The American Medical Association and Council on Scientific Affairs define home care as 'the provision of equipment and services to the patient in the home for the purpose of restoring and maintaining his or her maximal level of comfort, function and health'.

In the report 'Building the evidence of the nursing and midwifery contribution to health' by the World Health Organization, several studies identified the positive impact that home-based nursing has on reducing the number of hospital admissions. Another finding is that home-based nursing assists in preventing disability.

The various fields of medical care delivered in the patient's own home, as opposed to institutional care in nursing homes, include:

- Preventative care
- Diagnostic investigations
- Therapeutic care
- Rehabilitation
- Long-term care.

The aim is to bridge the gap between hospitalisation and the patient's home, and to offer:

- Continuity of care
- A shorter hospital stay
- A reduced risk of unplanned re-admission into hospital.

The rationale for home-based nursing is supported by the National Department of Health in the context of limited resources for healthcare, or for reasons that relate to:

- A shortage of hospital beds.
- Not enough medical, nursing and allied professionals.
- Limited resources for treatment and medicine.
- Increasing demands for curable conditions on existing institutional care.
- The high cost of ongoing institutional care.

Who will benefit from home nursing?

Home nursing provides care for patients who need extended care, not necessarily in hospital, that can be administered in their own home setting.

Patients that may benefit from home care or nursing, include:

- A patient who has complex or skilled needs and placement of a nurse in the home is done to meet the skilled needs of the member only, not the convenience of the family caregiver.
- A medically stable patient, according to the attending doctor's report or information.
- A patient with no co-morbidities that would impact their medical status, eg uncontrolled hypertension.
- A patient that needs less than 15 hours of therapy a week.

The goal is to make the patient's family as independent as possible and to wean them from nursing care as the patient's medical condition improves. Expectations about regression of nursing hours and eventual termination of these services should be conveyed to the patient (member) or family before the home service starts.

Provider information

Home nursing can be provided by:

- The doctor (practice number 14 and 15)
- Registered nursing agencies (practice number 80)
- Registered nurse (practice number 88)
- Staff nurse (enrolled nurse)
- Enrolled nursing assistant.

Provider eligibility criteria

- The home nurse should have a valid, registered practice number and be registered with the South African Nursing Council (SANC).
- Registered nurses working for a nursing agency or a registered nurse with their own Board of Healthcare Funders (BHF) practice number can render services.
- A registered nurse with their own BHF practice number cannot bill for services rendered if they were working for a nursing agency at the time the service was rendered.

Home nursing includes:

- Ventilator management and weaning off ventilator
- Tracheotomy care
- Wound care including dressings and irrigation
- Pain management
- Administration of IV medicine instead of hospitalisation
- Phototherapy
- Compassionate care
- Stoma therapy
- Maternity care, eg home deliveries
- Renal dialysis
- General care
- Bed bathing mobilisation (getting patients out of bed)
- Washing the hair and cleaning the mouth
- Pressure parts care.

TRAUMA RECOVERY EXTENDER BENEFIT

Certain traumatic events can result in extremely high costs after members leave hospital.

The Trauma Recovery Extender Benefit (TREB) covers **certain** out-of-hospital costs related to the member's registered condition that would previously have been funded from the member's Medical Savings Account or their own pocket. **Certain** out-of-hospital claims related to the member's registered condition will be paid from this Benefit without affecting the Medical Savings Account and General Benefit Pool for the calendar year. There are certain sub-limits which apply, some of which are pro-rated to the date you joined the Scheme if applicable.

Benefits

The benefit pays for the day-to-day healthcare expenses related to the traumatic event in the year it happened, and in the year after it happened. The benefit will only cover claims that are related to the original diagnosis following the traumatic event for the member who is registered for the benefit.

To qualify for cover, you must be a member of the Scheme in the year that the traumatic event occurs. The Trauma Recovery Extender Benefit extends you cover for the following traumatic incidents: crimerelated injuries, conditions resulting from a near drowning, poisoning and severe anaphylactic (allergic) reaction if the trauma results in one of the following conditions:

- Paraplegia
- Quadriplegia
- Severe burns
- External and internal head injuries.

Limits

UKZN Medical Scheme pays 100% of the Scheme Rate for all medical expenses normally paid for under the General Benefit Pool or Medical Savings Account, excluding cover for optometry, dentistry and over-the-counter medicine.

Unlimited for benefits such as GP and specialist consultations, radiology and pathology and other auxiliary treatment related to the event.

The following limits apply per beneficiary

Mental health	21 days
Prescribed medicine – each year	
	R15 850
+	R18 800
+ +	R22 200
+ + +	R26 950
External medical appliances	R31 600
Hearing aids	R16 150
Prosthetic limbs	R93 550 (no further access to the External Items limit)

Allied and therapeutic healthcare services including: acousticians, biokineticists, chiropractors, dieticians, homeopaths, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrics, registered counsellors, social workers, speech and hearing therapists limited to:

	R8 100
+	R12 150
+ +	R15 150
+ + +	R18 250

BENEFIT PLATFORM

Savings Account

- Carry-over Medical Savings Account funds are saved here
- This account earns interest
- May be used to fund shortfalls during the Self-payment Gap or for any other expenses not covered.

Prevention Benefit

- Covers vaccinations for high-risk individuals and children
- Seasonal flu vaccines
- Childhood vaccines for children up to six years
- Human papillomavirus (HPV) vaccine
- Pneumococcal vaccine.

Screening Benefit

- Screening test consisting of:
  - Blood sugar
  - Blood pressure
  - Cholesterol
  - Body mass index (BMI).

  You must use a pharmacy in the Wellness Network of Pharmacies.
- Additional screening tests:
  - Mammograms – One test every two years
  - Pap smears – One test every three years
  - Prostate Specific Antigen (PSA)
  - HIV.

This benefit provides one Mammogram per beneficiary every two years and one Pap smear and Prostate Specific Antigen (PSA) Testing per beneficiary every three years.

Chronic Illness Benefit

- Provides cover for medicine for conditions where ongoing medicine is required.
- No other medical scheme in the country offers a chronic medicine benefit as rich and easy to access.
- Includes a list of 26 conditions known as the Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions and 21 Additional Disease List (ADL) conditions determined by and covered by UKZN Medical Scheme.
- You have to apply by sending us a *Chronic Illness Benefit* application form.
- Your doctor needs to complete the form.
- We will tell you whether we have approved your cover.
- If approved, you can claim from this benefit.

Medical Savings Account

- Access to the full yearly amount in your Medical Savings Account at the beginning of the year, while the member pays the contribution monthly
- Pro-rated if you join mid-year
- If you have spent all of your Medical Savings Account and you withdraw from UKZN Medical Scheme mid-year, you will have to pay back the amount in your Medical Savings Account for the months that you have not yet paid through your monthly contributions
- Fixed portion of your contribution: 17.3% for 2022
- You earn interest on positive accrued funds
- What you don't use, is carried forward to the following year.

Extended Major Medical Expenses

- Unlimited cover
- Day-to-day cover
- Network providers only
- Includes:
  - GP consultation fees
  - Prescribed medicine from the preferred list of day-to-day medicine
  - Blood tests
  - Maternity consultations and 2D scans.

Major Medical Expenses Benefit (in-hospital)

- Extensive private hospital cover
- You must get preauthorisation for hospitalisation, except in an emergency
- If you do not have your admission for a planned procedure authorised, a non-notification penalty of 30% up to a maximum of R1 550 is applied for the total admission
- Pre-authorise at least 48 hours in advance.

Oncology Benefit

- Extensive oncology cover
- Access to the latest technology and treatment
- Coverage of radiotherapy and chemotherapy
- Coverage of scans and related treatment
- Supportive therapy included.

MANAGED CARE PROGRAMMES

The Oncology Programme

A special cancer care programme called the Oncology Programme is available to help members who are diagnosed with cancer. The Scheme works with the patient and the doctor to make sure that the treatment is affordable and works as it should.

The Scheme pays most claims for treating cancer from the Oncology Benefit, and some claims from the day-to-day benefit.

To register, please call 0860 11 33 22.

The Scheme pays your approved cancer treatment over a 12-month cycle, starting on the date you register on the Programme up to the Oncology limit, per case for non-Prescribed Minimum Benefit treatment. Once the limit is exhausted in the 12 months, further unlimited cover will be provided for PMB treatment only, payable at the Scheme Rate.

When you use designated service providers, oncology treatment that is part of the Prescribed Minimum Benefit is always covered in full, with no co-payment. Please call us to register on the Oncology Programme.

PET scans

You must use a designated service provider and get authorisation for your scans. The Scheme will fund 100% for this benefit if a DSP is used. If you don't use a DSP, claims related to the PET scan will accumulate towards your annual limit of R309 000 per beneficiary for Oncology. You will have to make a co-payment (pay for some of the cost yourself).

Stem cell transplants

Covered as a Prescribed Minimum Benefit only. Subject to Prescribed Minimum Benefit requirements and Scheme Rules.

The HIV*Care* Programme

The HIV*Care* Programme offers unlimited cover for patients living with HIV or AIDS-related diseases. This fully inclusive Programme makes sure patients get personal and confidential service, which includes counselling and approved antiretroviral medicine.

To register for this programme, call 0860 11 33 22.

HIV-positive patients or those with AIDS, need to register on the programme and make use of the Scheme's designated service providers to receive unlimited benefits. We pay the claims at the rate charged. Whether you do or do not register on the programme, all related costs (including those for hospitalisation) will be paid up to the Scheme Rate from risk as a Prescribed Minimum Benefit. If you register, but do not make use of the designated service providers, you will have to pay any co-payments that are charged.

We cover medicine to prevent HIV

If you need medicine to prevent HIV infection because of occupational or traumatic exposure to HIV or sexual assault, call us immediately on **0860 11 33 22,** because the treatment must start as soon as possible.

We also cover medicine to prevent mother-to-child transmission. You must get your medicine for the ongoing treatment of HIV or AIDS from Optipharm, the Scheme's designated service provider.

Please note that for HIV or Aids related illnesses, the Scheme will pay 100% of the costs, provided DSPs are used.

CardioCare Programme

Our CardioCare programme is available to members over the age of 18. Members who are registered on the Chronic Illness Benefit with hypertension and/or ischemic heart disease (interchangeably termed coronary artery disease) and/or hyperlipaedemia are eligible to enroll. Additional benefits include an extended consultation with a Discovery Health Premier Plus GP.

Mental Health Care Programme

The Mental Health Care Programme is designed to offer our Members diagnosed with acute or episodic major depression the optimal care from the best Service Providers in a coordinated network, to ensure the best outcomes and quality of life. To access the programme, you need to be diagnosed with acute or episodic Major depression. A GP in the Premier Plus GP network or a psychologist in the Mental Health Care Programme Network can do the assessment to confirm the diagnosis and enroll you onto the programme. The Programme, which will be active for 6 months from the date of enrollment, will give your healthcare provider access to tools to monitor and manage your condition and to ensure you have access to high-quality coordinated care. By Joining the Mental Health Care Programme, you will have access to a basket of care including limited GP consultations, psychotherapy and certain first line anti-depressant therapy.

Mental Health Relapse Prevention Programme

The Depression Relapse Prevention Programme seeks to reduce the risk of chronicity of major depression and to prevent multiple admissions to hospital for depression related illnesses. A Risk Intelligence prediction tool will be used to identify members who are at risk of being admitted to hospital for a depression related illness and at risk of a relapse thereafter. Once identified, these members will be referred to the Member Care Programme for the enrolment to the Relapse Prevention Programme giving them access to the relapse prevention basked of care.

Spinal Care Programme

Our Spinal Care Programme aims at changing the hospicentric approach to the management of back pain, to that of conservative care at primary care level where appropriate. This programme provides members who suffer from severe back pain with access to conservative care out-of-hospital and/or or spinal surgery when needed.

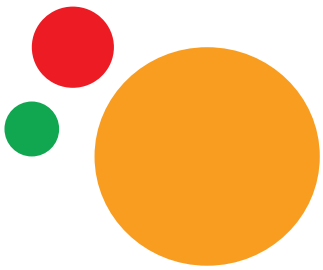
If spinal surgery is the only option to manage your back pain, the surgery must be performed at a facility in our Spinal Hospital Network. A 20% co-payment will apply to the hospital account in the event that you do not use a hospital in our network.

Diabetes Care Programme

The Diabetes Care Programme is designed to offer optimal care from the best service providers in a coordinated network, ensuring the best outcomes and quality of life for our members.

To access the programme, you need to be registered on the Chronic Illness Benefit with either type 1 or type 2 Diabetes. A GP in the Premier Plus GP network can enroll you onto the programme. The programme gives you and your Premier Plus GP access to various tools to monitor and manage your condition.

In addition to the standard treatment basket of procedures and consultations available to members registered on the Chronic Illness Benefit with Diabetes, members who join the Diabetes Care Programme will have access to an additional dietician and one biokineticist consultation per year. Refer to page 8 for more detail on this benefit.



GENERAL BENEFIT POOL

The General Benefit Pool provides cover for certain healthcare costs up to a specific annual limit, at 100% of the Scheme Rate.

This benefit pays claims for

- Basic dentistry
- GPs and specialists
- Mental health
- Basic optometry
- Out-patient services
- Paramedical services
- Private nursing
- X-rays, radiology and pathology.

It includes audiology tests, dietitians, occupational therapy, orthoptics, podiatry, speech therapy, biokinetics, chiropody, physiotherapy, etc (for any registered practice).

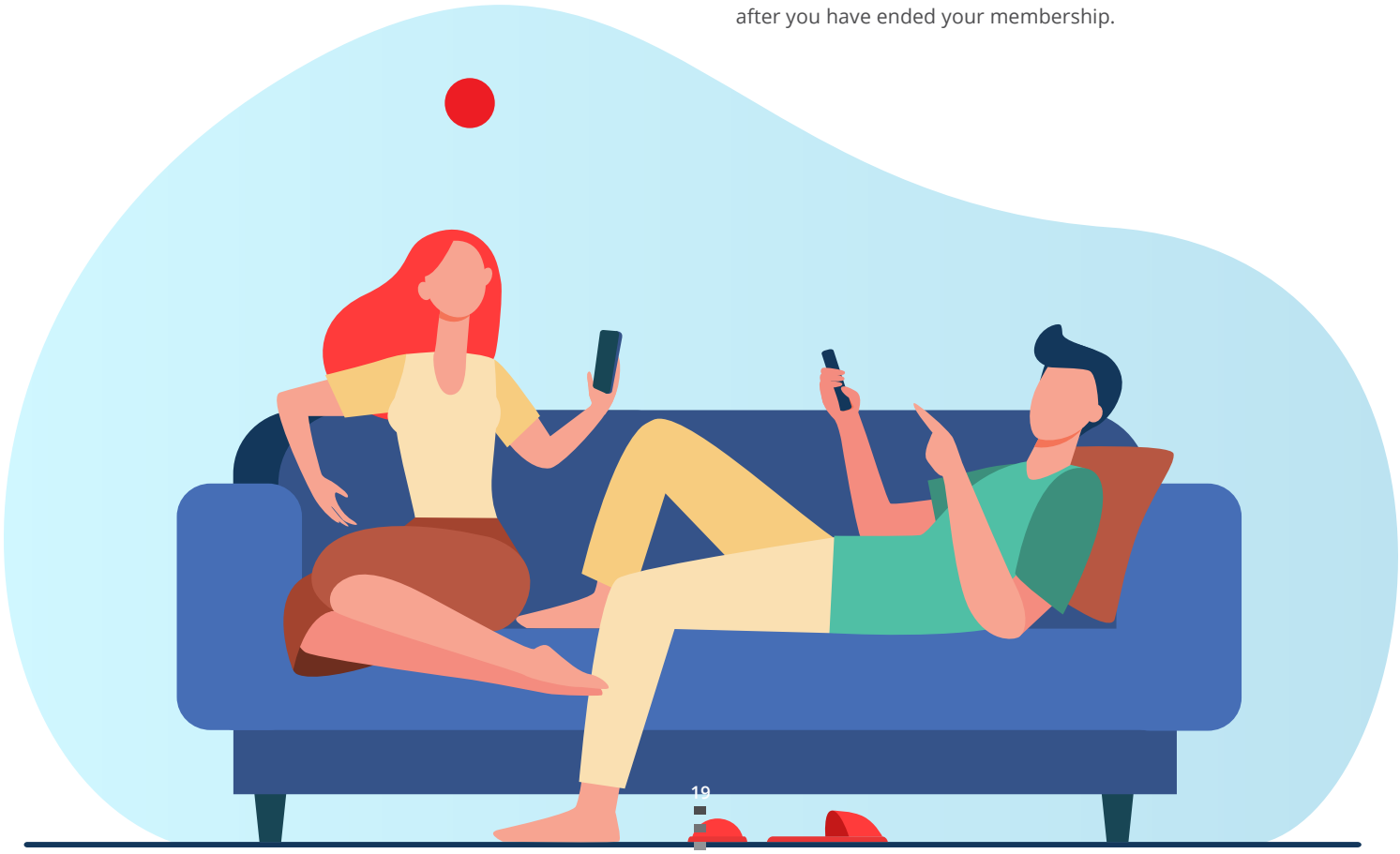
DAILY MEDICAL EXPENSES

How your Medical Savings Account works

The Medical Savings Account pays for your visits to the doctor at the Scheme rate, once the applicable limit in your General Benefit Pool (GBP) has been depleted. The Medical Savings Account pays for your medicine from the pharmacy and other daily medical expenses. If you do not use all the funds in your Medical Savings Account during the year, you earn interest on the amount and the balance at the end of the year is carried over to the next year.

If you resign from UKZN Medical Scheme and have funds left in your Medical Savings Account, the Scheme will transfer the money to your new medical scheme (if it has a Medical Savings Account on the option you choose) or refund the money after four months.

The Scheme pays refunds from the Medical Savings Account after four months according to the rules set out in the Medical Schemes Act to accommodate claims submitted for four months after you have ended your membership.



WHAT UKZN MEDICAL SCHEME DOES NOT COVER

UKZN Medical Scheme will not cover claims in connection with any of the following, except as described in the Prescribed Minimum Benefits:

- Obesity
- Cosmetic procedures (including but not limited to, breast augmentation, breast reduction, blepharoplasty, abdominoplasty, rhinoplasty and bat-ear correction)
- Wilfully self-inflicted injuries
- Injuries arising from hang-gliding, professional sport, parachuting, speed contests, speed trials and other activities that involve an unacceptable risk of injury
- Any sickness or condition such as injuries due to negligence, illegal acts or failure to carry out the instructions of a medical practitioner
- Medicine not included in a prescription from a medical practitioner, except with the assistance of a professional pharmacist
- Medicine not registered with the Medicines Control Council and new medicine
- All costs for services provided by an unregistered provider or at an unregistered healthcare facility
- Any purchase of:
  - Contraceptive preparations and devices
  - Slimming preparations used to treat or prevent obesity
  - Patent medicine and propriety preparations
  - Food and nutritional supplements including all baby food and milk supplements
  - Diagnostic agents and appliances, unless approved by the Scheme
  - Bandages and dressings
  - Aphrodisiacs
  - Soaps, shampoos and other topical applications
  - Cosmetic preparations, medicated or otherwise, including Ultrabase cream, E45 and sunscreens
  - Anti-addiction and anti-habit agents
  - Anabolic steroids
  - Multivitamin preparations and vitamin combinations
  - Cosmetic preparations, medicated or otherwise, including hydroquinine products
  - Prenatal and infant vitamins and vitamin or mineral supplements
  - Geriatric vitamins or mineral supplements
  - Single vitamin preparations
  - Immunoglobulins
  - Tonics.
- Charges for appointments which a member or dependant of a member fails to keep
- The use of precious metal in dentures
- Organ donation to any person other than to a member or dependant of a member
- Optical devices that are not regarded as clinically essential by the South African Optometric Association
- Treatment for erectile dysfunction and loss of libido
- Gender re-alignment for personal reasons and not directly caused by or related to illness, accident or disease
- Photodynamic therapy
- Hyperbaric oxygen therapy except for anaerobic life-threatening infections and Prescribed Minimum Benefit conditions
- Autopsies
- Orthodontic treatment for members over the age of 21 years, as well as lingual orthodontics and labial frenectomies
- All costs in excess of the Scheme Rate or any negotiated rate between the Scheme and a designated service provider, for a specific benefit

TOOLS TO HELP YOU

A quick guide to help you

Adding a dependant

You may register your spouse or partner on the UKZN Medical Scheme, as long as they are not a member or a beneficiary or a registered dependant of another medical scheme. If you are married to more than one spouse under customary marriage, additional partners will be regarded by the Scheme as adult dependants. To avoid waiting periods, registration must take place within 30 days of the marriage.

You may also register:

- Your newborn baby. You must register the baby within 30 days of the date of birth. Contributions are payable from the 1st of the month after the baby was born.
- Your children under the age of 21 years, as well as adopted or foster children. You must have a duty to support these adopted or foster children and they may not be members or registered dependants of a member of another medical scheme.
- Your children over the age of 21 years, may remain on the Scheme until the age of 30. You will not be asked to submit eligibility documents once your child turns 21. Please note that once your child turns 21, the adult rate premium will apply.
- Once your child dependent turns 30, they will only be allowed to remain on the Scheme in two instances:
    1. In the event of disability-medical reports supporting this would need to be submitted to the Scheme.
    2. If the dependent is financially dependant on the Principal member in terms of the definition in the Scheme rules (currently earning less than twice the state pension amount).

You may register other members of your immediate family, for whom you are responsible, as long as they are not a beneficiary of another medical scheme. For adult dependants other than your spouse or partner, you are required to complete the additional adult dependant application form with a relevant affidavit as proof of legal responsibility for care and support. These applications will be considered at the discretion of the Board of Trustees.

If you want to add a dependant to your existing membership, you have to complete an Additional Dependant application form. Please attach a copy of the additional dependant's identity document to the application form. You must first send the completed and signed form to your employer for approval. Retired members who will be responsible for paying the dependant contribution from their own pocket must submit the form directly to the Scheme.

Please make sure you complete the application form in full and that the following information for the new dependant is on it:

- Full name
- Date of birth and identity number
- Relationship to you (spouse, common-law spouse, child, stepchild, legally adopted child, adult dependant)
- Gender (male or female)
- The date on which the new dependant will join the Scheme – always on the first day of a month.

Also send us copies of these documents with the form:

- Copy of marriage certificate for adding a spouse. If you are not legally married to your partner, you must complete the partnership declaration and submit it with your application form
- Birth certificate or adoption papers for adding a child dependant.

Late-joiner penalties

Under certain circumstances and in terms of the Medical Schemes Act, the Scheme may impose a late-joiner penalty on the membership of a new member or dependant.

Waiting periods

Upon admission to the Scheme, your membership or those of your dependants, may be subject to certain waiting periods before you or they become eligible for benefits. These waiting periods will be applied in terms of the Medical Schemes Act (1998) and its amendments. These are:

- A general waiting period of up to three months for all services
- A condition-specific waiting period of up to 12 months
- Any unexpired waiting periods imposed by a former medical scheme.

Please note: No waiting period will apply for a Prescribed Minimum Benefit condition, except for a member or dependant who was without medical cover for a period of at least 90 days before applying to become a member of the Scheme.

Non-employee members and their dependants may continue their membership of the Scheme:

- No waiting period applies if you join the Scheme within 90 days of leaving your previous medical Scheme, proof of your previous medical cover will be required.
- When retiring from active employment.
- If ceasing employment is approved on the grounds of ill health, early retirement or permanent disability.
- When a spouse (who is the principal member) dies, the widowed spouse and qualifying dependants may continue membership of the Scheme without any new restrictions, limitations or waiting periods for up to a maximum of R1 475 00.

What to do before you go to hospital

Preauthorisation

Before you go to hospital for a planned procedure, remember to get authorisation first:

- Visit your doctor. He or she will decide if it is necessary for you to be admitted to hospital.
- Find out which doctor is going to admit you to hospital. Sometimes, your own doctor will refer you to another doctor or specialist.
- Choose the hospital to which you want to be admitted, but remember that not all procedures are done in all hospitals. Your doctor can give you advice on this. Remember, you must use a hospital in the UKZN Medical Scheme Hospital Network.
- Preauthorise your hospital admission. Do this by calling us on 0860 11 33 22 at least 48 hours before you go to hospital. We will give you information that is relevant to how we will pay for your hospital stay. If you do not confirm your admission, we will only pay 70% of the costs we would normally cover, and you will have to make a co-payment of up to a maximum of R1 550. Also remember that certain procedures can only be done in a facility in the day care network.

Registering for our online services

- Make sure we have your email address on our system.
- Go to **www.discovery.co.za.**
- Click on 'Register'.
- Complete the registration process.
- Once you are registered, you will have electronic access to your benefit information.
- If you need help to register, please call us on **0860 100 696.**

Submitting claims

When sending claims to the Scheme, please make sure you do the following:

- Check your personal file with your doctor to make sure all your details are up to date.
- Check all your details against your membership card, especially your membership number.
- Ask your doctor if he or she charges the Scheme Rate or a higher rate and negotiate with him or her to charge the Scheme Rate.
- If your doctor sends the claim to the Scheme electronically, you do not have to send us a copy.
- If you send your claim to the Scheme, please send the original copy with your correct membership number.
- Send us a detailed claim and not just a receipt. We need the details so we can process your claim.
- Make sure your membership number, doctor's details and practice number are clearly visible on the claim.

By law, each claim must contain the following information:

- The surname and initials of the member
- The surname, first name and other initials of the patient
- The name of the medical scheme
- The membership number of the member
- The practice code, group practice and individual provider registration number issued by the registering authorities for providers, if applicable. In the case of a group practice, the name of the practitioner who provided the service must also be given
- The relevant diagnostic and other item codes that relate to the healthcare service
- The date on which each relevant healthcare service was provided
- The nature and cost of each relevant healthcare service rendered, including supplying medicine to the member concerned or to a dependant of that member and the name, quantity and dosage of and net amount payable by the member for the medicine.

There are a number of ways of sending claims to the Scheme for processing:

- Send your claim by email to **claims@discovery.co.za**
- Fax it to **0860 329 252**
- Drop your claim off at Discovery Health's offices or in any other Discovery Health claims box. You can find these boxes at Virgin Active or Planet Fitness gyms, Dis-Chem pharmacies and most private hospitals
- Post your claim to **PO Box 652509, Benmore 2010** or **Postnet Suite 116, Private Bag X19, Milnerton 7435**.

What happens after you send your claim

Once the claim is received it is captured for processing. The claim is assessed to make sure all of the information on the claim matches the information on record for the patient. It is then either approved for payment or declined. The turnaround time for processing claims is 72 hours from the time the claim is received to the time it is processed. Once the payment is made, you will receive your claims statement, detailing all the claims paid.

How to check on the status of your claim

To see the status of your claim, you can check your claims statement or use the Claims Tracker tool on our website at **www.discovery.co.za**

If we have your email address, you will receive a claims payment notification that will give you all the information about the latest claims processed for you – how they were assessed against your available benefits, how they were paid and what the latest Medical Savings Account or other balances are. Please log in to **www.discovery.co.za** and make sure your information is up to date.

Manage the process when a third party is legally responsible for expenses

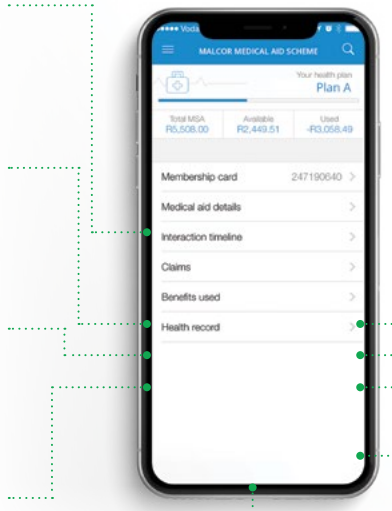
Normally UKZN Medical Scheme will not cover any costs for expenses related to, or incurred as a result of the involvement of a third party that is legally responsible, unless these costs are seen as Prescribed Minimum Benefits, or unless the Board decides otherwise. These may, for instance, be costs related to injuries sustained when you are at work or when you are involved in a motor vehicle accident.

You are, however, entitled to such benefits as would otherwise have applied, if you give the Scheme a written undertaking as soon as possible after the incident, that:

- On receipt of any payment from the third party, arising from any claim for medical expenses, you will immediately reimburse the Scheme for costs incurred by the Scheme on your behalf for these expenses.
- You will pursue such a claim for the recovery of any benefit paid by the Scheme and keep the Scheme informed of progress.
- You will carry all costs arising from the pursuit of any claim or action against such a third party, unless otherwise agreed to in writing by the Scheme.

YOUR HEALTH PLAN AT YOUR FINGERTIPS

The Discovery smartphone app puts you fully in touch with your health plan no matter where you are. If your mobile device is with you, so is your plan.



Electronic membership card

View your electronic membership card with your membership number and tap on the emergency medical numbers on your card to call for emergency assistance.

Submit and track your claims

Submit claims by taking a photo of your claim using your smartphone camera and submit. You can also view a detailed history of your claims history.

Track your day-to-day medical spend and benefits

Access important benefit information about your specific plan. You can also keep track of your available benefits.

Access your health records

View a full medical record of all doctor visits, health metrics, past medicine, hospital visits and dates of X-rays or blood tests. It is all stored in an organised timeline that is easy and convenient to use.

Find a healthcare provider

Find your closest healthcare provider who we have a payment arrangement with such as pharmacies and hospitals, specialists or GPs and be covered in full.

Request a document

Need a copy of your membership certificate, latest tax certificate or other important medical scheme documents? Request it on our app and it will be emailed directly to you.

Access the procedure library

View information on hospital procedures in our comprehensive series of medical procedure guides. You can also view a list of your approved planned hospital admissions.

Update your emergency details

Update your blood type, allergies and emergency contact information.

Give consent to your doctor accessing your medical records

Give consent to your doctor to get access to your medical records on HealthID. This information will help your doctor understand your medical history and assist you during a consultation.

Managing your health plan online is now more convenient than ever. Everything from simply checking your benefits is now even easier than picking up the phone.

A website that responds to your device

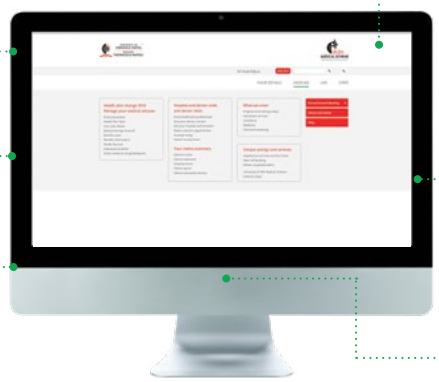
Our website has been designed to work on a variety of different digital devices – your computer, your tablet and your cellphone. No matter what size the screen, the information will always be customised to your particular device making it easy to read.

Keeping track of your benefits

You can keep track of your available benefits online. You can access all important benefit information about your plan.

Ordering medicine

You can order medicine from MedXpress to be delivered to your preferred address. You can do this by taking a photo of your new script and submitting it. You can also re-order an existing repeat script.



Keeping track of your claims

We have securely stored information about your claims. You can submit your claim online, view your claims statement, do a claims search if you are looking for a specific claim, see a summary of your hospital claims and even view your claims transaction history.

Accessing important documents

We have securely stored documents so that they are available when you need them most. Whether you are looking for your tax certificate, membership certificate or simply looking for an application form, we have them all stored on our website.

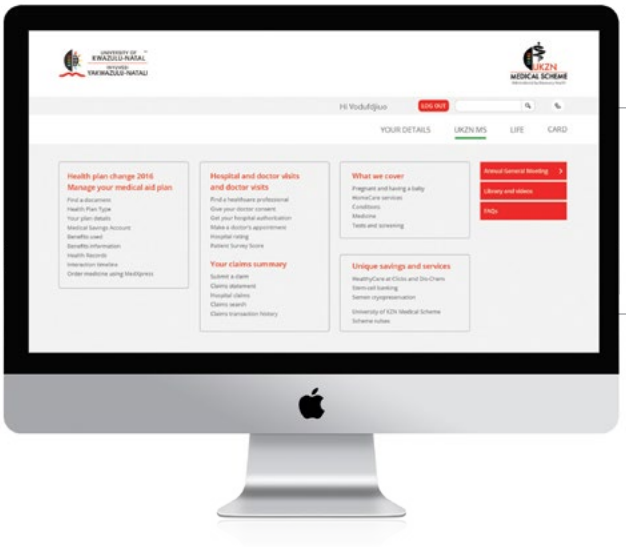
Finding a healthcare professional

You can use our Medical and Provider Search tool to find a healthcare professional. You can also find one who we cover in full so that you don't have a co-payment on your consultation. You can even filter your search by speciality and area and the results will be tailored to your requirements.

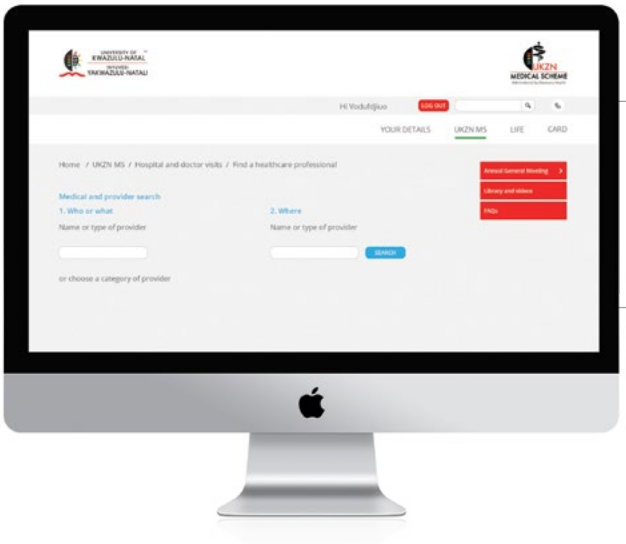
www.discovery.co.za

FIND A HEALTHCARE PROFESSIONAL

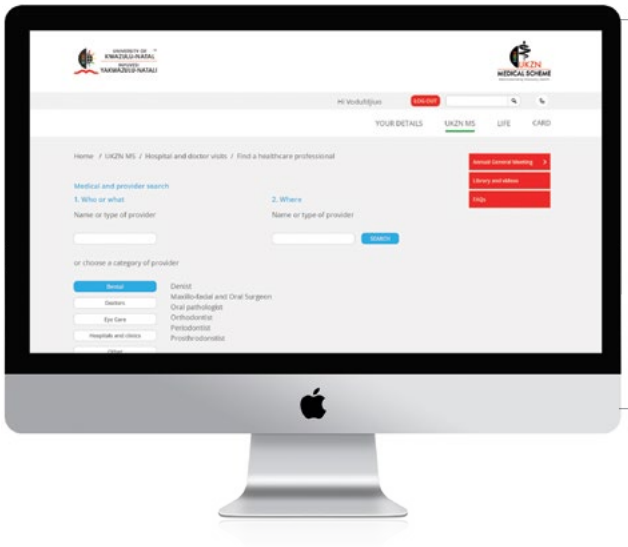
Go to www.discovery.co.za and log in with your username and password.



If you are looking for the nearest doctor or hospital, click on the 'UKZN MS' tab. Look under 'Hospital and doctor visits' and click on 'Find a healthcare professional'.



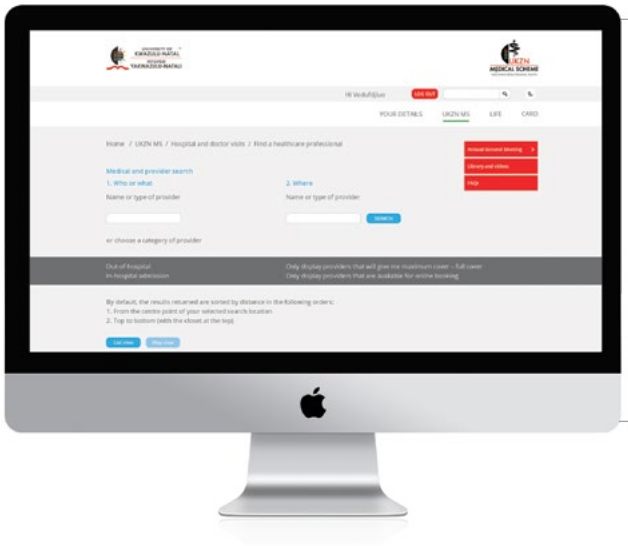
The page will open the Find a healthcare professional tool.



There are two sections:

1. Provider (‘1. Who or what’)
2. Location (‘2. Where’)

In the Provider section you have to choose the category of provider you are looking for. If you are looking for a doctor, you will have to indicate what type of healthcare provider (doctor) you need, for example, ‘Psychiatrist’.



After you’ve chosen the type of advisor, fill in the location under ‘2. Where’ (province, city or suburb), for example **Doctors > Psychiatrist > Western Cape > Cape Town > Observatory,** and click on ‘Search’. You will be able to see a list of all the available network psychiatrists in your area. The doctor’s details include the practice name, practice number, physical address and even GPS coordinates.

QUICK A TO Z

Benefit entry criteria

For certain illnesses, benefit entry criteria determine what is covered.

This means that we need certain details from the member and the doctor before payment can be made for medical expenses.

Co-payment

An amount you have to pay towards a healthcare service. If your doctor is not one of UKZN Medical Scheme's network providers and charges above the Scheme Rate, you will have to pay the difference to that doctor. This is called a co-payment. In the event that you use a service provider who is not on the Scheme's network of providers, the Scheme will refund you for the services and you will need to pay the service provider.

Deductible

This is the amount you will have to pay when you go to a non-network hospital for a planned procedure. A deductible may not be paid from your Medical Savings Account.

Designated service provider

A designated service provider is a doctor, specialist or other healthcare provider with whom the Scheme has an agreement about payment and rates.

When you use the services of a designated service provider, the provider is paid directly and in full. Participating specialists are paid at the Premier rate for claims. Participating GP's are paid at the GP rate for all consultations. This means you will not have to pay any of these providers from your own pocket.

ER24

You have access to **ER24**, a service that provides highly trained paramedics in response vehicles who will help you with all aspects of a medical emergency. You can call **ER24** on **084 124** for emergency help.

Exclusions

There are certain expenses that are not covered by UKZN Medical Scheme. These are called exclusions.

Formulary

A formulary is an approved restricted list of medicine considered to be clinically appropriate and effective for the treatment of a disease or illness.

Cover for treating Prescribed Minimum Benefit conditions is unlimited, subject to a fixed formulary.

ICD-10 codes

The ICD-10 is an international coding system that provides detailed descriptions of known diseases, injuries and procedures by transforming verbal descriptions into numbers. It is compulsory for all healthcare service providers in South Africa to include ICD-10 diagnostic codes on their accounts. Service provider claims submitted to UKZN Medical Scheme without the ICD-10 codes may result in claims not being paid for or being paid from the incorrect benefit, such as your General Benefit Pool or your Medical Savings Account, instead of being paid as a Prescribed Minimum Benefit.

Medical emergency

A medical emergency is a condition that develops very fast or an accident for which you need immediate medical treatment or an operation. In a medical emergency, your life could be in danger if you are not treated, or you could lose a limb or organ.

Network hospitals

Members can use specific hospitals to avoid a deductible for planned procedures. UKZN Medical Scheme has made special arrangements with these hospitals to make sure that you get good, affordable healthcare.

In an emergency, you can go to the nearest hospital, and may then be transferred to a network hospital once you are in a stable condition.

Over-the-counter medicine

Schedule 0 to 2 medicine, whether prescribed or not, is also known as over-the-counter medicine and the Scheme pays for these. If you buy medicine over the counter, on the advice of a pharmacist, and you want to claim for these from UKZN Medical Scheme, please make sure:

- You get the medicine from a registered healthcare provider with a valid practice number
- The claim displays a valid ICD-10 and a medicine dispensing code.

The Scheme will only pay for medicine bought over the counter if you have available funds in your Medical Savings Account, and up to the applicable limit.

Preauthorisation

You must let us know if you plan to be admitted to hospital. Please phone us on 0860 11 33 22 for preauthorisation, so that we can check your membership and help you make sure about your benefits. If you do not preauthorise your benefits, you might have to pay a co-payment.

There are some procedures or treatments your doctor could do in his or her rooms for which you also have to get preauthorisation. Preauthorisation examples are for procedures such as endoscopies and scans.

If you are admitted to hospital in an emergency, you must let us know about it as soon as possible so that we can authorise payment of your medical expenses.

We make use of certain clinical policies when we decide whether to approve hospital admissions. The clinical policy gives us guidance about what is expected to happen when someone is treated for a specific condition. It is based on scientific evidence and research.

Pro-rated benefits

If you join the Scheme partway through the year, your benefits and limits are calculated according to the number of months left in the calendar year.

Related accounts

This type of account is separate from the hospital account for a member who is admitted to hospital. Related accounts include the accounts from doctors or other healthcare professionals, like that of the anaesthetist, or for pathology or radiology tests when you are treated in hospital.

Risk Benefit

The Risk Benefit covers your expenses for serious illness and high-cost care while you are in hospital.

Scheme Rate

This is the rate at which the Scheme pays your medical claims. The Scheme Rate is based on specific rates negotiated with healthcare professionals. Unless it is stated differently in this brochure, claims are paid at 100% of the Scheme Rate.

If your doctor charges more than the Scheme Rate, we will pay the claim to you at the Scheme Rate and you are responsible to pay the doctor.

YOUR 2022 BENEFITS

Core benefits

- Benefits are subject to preauthorisation and the overall annual limit for all non-Prescribed Minimum Benefits (PMBs).
- Prescribed Minimum Benefits will be paid according to the regulations.
- Benefits are subject to the use of the services of the Scheme's designated service providers (DSPs). If you use the services of the Scheme's designated service providers, your claim will be covered in full. If you voluntarily use the services of a non-designated service provider, your claim will be paid at the Scheme Rate only. You may have to pay part of the cost yourself (co-payment) if the service provider charges more than what the Scheme will pay.

● Indicates the designated service provider.

Benefit		Limit
Overall annual limit	For all in-hospital services, including actual hospital and hospital-related costs	R890 000 for each member a year.
Ambulance services	● ER24	Unlimited, subject to authorisation and the use of the Scheme's DSP emergency response services, ER24. If not authorised, member may be responsible for the cost of transport.
Alcohol and drug rehabilitation	PMBs only ● SANCA ● Ramot Treatment Centre for Addiction Nishtara Alcohol and Drug Centre	100% of the Scheme Rate, subject to the use of DSPs. 21 days in hospital for a person each year. Treatment for detoxification limited to three days for a person each year.
Allied healthcare services	In-hospital consultations, visits, procedures and treatment provided by for example, physiotherapists and biokineticists	100% of the Scheme Rate or cost, whichever is lower.
Alternatives to hospitalisation	Step-down nursing facilities and rehabilitation centres	100% of the Scheme Rate Subject to the Scheme's Treatment guidelines and Managed Health Care criteria and the use of DSP
Blood transfusions and blood products	–	100% of the Scheme Rate or cost, whichever is lower, limited to R65 400 for a person each year for any non-PMB treatment.
Diagnosis, consultations and care for conditions on the Chronic Disease List (CDL)	–	100% of the cost if rendered by a DSP. Voluntary use of non-DSP providers paid up to the Scheme Rate only. Subject to benefit entry criteria and protocols. Certain limits may apply. ● Premier A and B Specialist Network ● GP Network ● Your chosen Discovery Health Premier Plus GP for HIV, Diabetes, Mental Health and Cardio Care.

This brochure is a summary of the UKZN Medical Scheme 2022 benefits, pending approval from the Council for Medical Schemes. Full details can be found in the Scheme Rules.

Benefit		Limit
Endoscopic procedures	In-hospital gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	100% of the Scheme Rate or cost, whichever is lower, to a maximum of R2 700 covered from General Benefit Pool (Out-of-Hospital Benefit). Remainder of the hospital account covered by the Scheme from the Risk Benefit, subject to DSP. • University of KwaZulu-Natal Medical Scheme Hospital Network.
HIV or AIDS-related illnesses	Subject to PMBs	Unlimited from the Scheme's DSP, subject to PMBs. Paid at 100% of cost.
HIV prophylaxis (occupational or traumatic exposure to HIV, sexual assault or mother-to-child transmission)	–	Paid from the Hospital Benefit with no overall limit.
HIV or AIDS-related medicine	• Any pharmacy participating within the HIV ARV network	Unlimited from the Scheme's DSP, subject to PMBs.
Hospital	Accommodation, theatre fees, materials, and prescribed medicine for duration of hospitalisation	100% of Scheme Rate. Subject to the use of the UKZN Medical Scheme Hospital Network. If a DSP hospital is not used, a deductible of R4 950 applies per event, regardless of length of stay. If treatment is not preauthorised, a deductible of 30% of the cost of the hospitalisation is payable by the member. • University of KwaZulu-Natal Medical Scheme Hospital Network.
Infertility treatment	–	Unlimited cover for PMBs only.
Influenza Immunisation Benefit	For high-risk members in the following categories: Members older than 65 years. Members who are registered for the following Chronic Illness Benefit conditions: 1 | Chronic obstructive pulmonary disease (COPD) 2 | Asthma 3 | HIV or AIDS 4 | Diabetes 5 | Chronic renal failure	100% of the Scheme Rate. Paid once a year from risk benefits.
Internal prostheses	–	100% of the Scheme Rate or cost, whichever is lower. Subject to authorisation and the use of the Scheme's DSP. Limited to R59 450 for a prosthesis for each admission if the prosthesis is not supplied by the Scheme's network of preferred providers. This benefit includes cover for prostheses for hips, knees, shoulder replacements and spinal devices. Unlimited if obtained from the Scheme's DSPs.
Cochlear implant	–	Limited to R254 000 per prosthesis per annum.
Major maxillo-facial procedures	Certain severe infections, jaw-joint replacements, cancer, certain trauma-related surgery, cleft lip and palate repairs	150% of the Scheme Rate or cost, whichever is lower. Unlimited, subject to PMBs and use of DSPs. A deductible of R4 950 irrespective of length of stay, applies per case, even in a day case for voluntary use of Non Network Hospitals, except in emergencies

Benefit		Limit
Medicine for the Chronic Disease List (CDL) conditions	Subject to PMBs ● Any dispensing provider or pharmacy	Approved medicine on the medicine list (formulary) will be funded in full up to the Scheme Rate. Approved medicine not on the medicine list will be funded up to the monthly Chronic Drug Amount (CDA). Members who are registered for diabetes may access benefits through the Discovery Clinical Maintenance Organisation (CMO) who is responsible for managing the health of the Scheme's diabetes-cardiometabolic population.
Medicine for additional chronic conditions listed by the Scheme	–	Approved medicine will be funded up to the Scheme rate Limited to R8 825 for a person per year.
Mental and emotional disorders	Subject to PMBs	Subject to the use of the Scheme's DSPs. 21 days for a person each year in hospital (15 days outpatient visits). Subject to benefit entry criteria and protocols ● University of KwaZulu-Natal Medical Scheme Hospital Network ● DPA Specialist Network.
Non-surgical procedures and tests	–	100% of the cost subject to DSP or up to 150% of the Scheme Rate. ● University of KwaZulu-Natal Medical Scheme Hospital Network.
Oncology	All relevant oncology treatment, including chemotherapy and radiotherapy Stem cell transplants	All oncology-related care is paid at the Scheme Rate to a limit of R334 000 for a condition in a 12-month cycle, subject to PMBs. Subject to authorisation, benefit entry criteria and protocols. 100% of the Scheme Rate, subject to preauthorisation, the oncology limit and PMBs.
Organ transplants	Harvesting and transplantation, post-operative anti-rejection treatment and medicine. Subject to PMBs	100% of the Scheme Rate or cost, whichever is lower. Limited to R277 000 for a person each year. Medicine for immunosuppressive therapy subject to authorisation and DSP.
Oxygen	● VitalAire	Covered in full at the Scheme's DSP. If the DSP is not used, then only paid up to the Scheme Rate.
Pathology	–	100% of the Scheme Rate or cost, whichever is lower.
PET scans	PET scans are only paid as part of oncology-related care	100% of the Scheme Rate, subject to PMBs, the use of the Scheme's DSP and subject to the oncology limit. If the DSP is not used, all claims related to the PET Scan will accumulate to the R334 000 oncology treatment limit.
Radiology	–	100% of the Scheme Rate or cost, whichever is lower.
Renal dialysis	Dialysis and other care related to renal treatment and educational care includes authorised related medicine	100% of cost if obtained from the Scheme's DSP. If services are not obtained from the DSP, the Scheme will pay claims up to the DSP rate only. ● National Renal Care.
Screening and Prevention Benefit	**Screening benefit** ● Pharmacy in the Wellness Network of Pharmacies ■ Blood sugar test ■ Blood pressure test ■ Cholesterol test ■ Body mass index (BMI) ■ Faecal occult blood testing (FOBT), Faecal immunochemical testing (FIT)	100% of the Scheme Rate. Limited to two tests per beneficiary per annum, paid for an individual or basket of these tests. Payable from the Hospital Benefit only if one of the Scheme's DSPs is used. One FOBT or FIT for members between 45 – 75 every two years.
	Prevention benefit ■ One mammogram ■ One Pap smear ■ One prostrate-specific antigen (PSA) test ■ HIV blood tests (rapid, ELISA, and western blot)	100% of the lower cost or the Scheme Rate. This benefit provides one Mammogram per beneficiary every two years and one Pap smear and Prostate Specific Antigen (PSA) Testing per beneficiary every three years.

Benefit		Limit
Specialists and GPs	In-hospital consultations, visits, surgical and non-surgical procedures and treatment	150% of the Scheme Rate, subject to the use of DSPs. Voluntary use of non-DSP providers for PMBs and other services: paid up to the Scheme Rate only. ● Premier A and B Provider Network ● GP Network Subject to PMBs.
Specialised radiology	MRI and CT scans	First 30% of the scan up to a maximum of R3 150 paid from the General Benefit Pool (GBP). Remainder of account covered from the Hospital Benefit, limited to R30 800 for a person each year, subject to PMBs and the use of a DSP.
Statutory Prescribed Minimum Benefits	–	Unlimited and paid according to regulations, irrespective of any overall limits. DSP and co-payments apply, as indicated.
Take-home medicine	Medicine that you take home when discharged from hospital	Up to 100% of Scheme Rate for medicine when claimed under the hospital account.
Terminal Care and Advanced Illness Benefit	Hospice and other approved facilities, excluding frail care	100% of the Scheme Rate or cost, whichever is lower.
Trauma Recovery Extender Benefit (TREB)	Benefits for specific day-to-day care after one of the following traumatic incidents: crime-related injuries, conditions resulting from a near-drowning, poisoning and severe anaphylactic (allergic) reaction, if the trauma results in one of the following conditions: ■ Paraplegia ■ Quadriplegia ■ Severe burns ■ External and internal head injuries	100% of the Scheme Rate for all medical expenses normally paid for under the GBP or MSA, excluding cover for optometry, dentistry and over-the-counter medicine. Unlimited for benefits such as consultations with GPs and specialists, radiology and pathology, and other auxiliary treatment related to the event. The following limits apply for each beneficiary: Mental health – 21 days Prescribed medicine – each year: M = R15 850; M + 1 = R18 800; M + 2 = R22 200; M + 3 or more = R26 950 External medical appliances – R31 600 Hearing aids – R16 150 Prosthetic limbs – R93 550 (no further access to the External Items limit). Allied and therapeutic healthcare services including: acousticians, biokineticists, chiropractors, dieticians, homeopaths, nursing providers, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrics, registered counsellors, social workers, speech and hearing therapists limited to: M = R8 100; M + 1 = R12 150; M + 2 = R15 150; M + 3 or more = R18 250 ● Physiotherapist Network ● Psychologists and registered counsellor Network
Vaccination benefit	Benefits for children up to the age of six. The following vaccines are covered: ■ Oral polio vaccine ■ Tuberculosis vaccine ■ Hepatitis B vaccine ■ Rotavirus vaccine ■ Diphtheria, tetanus, acellular pertussis/inactivated polio vaccine/haemophilus influenzae type b and hepatitis B vaccine ■ Pneumococcal conjugated vaccine ■ Measles ■ Pneumococcal conjugated vaccine ■ Chickenpox ■ Measles, mumps and rubella vaccine ■ Hepatitis A vaccine	100% of the Scheme Rate.

Day-to-day benefits

- Day-to-day benefits on the Standard Plan are paid from the General Benefit Pool (GBP) or the member's Medical Savings Account (MSA) according to specific benefit descriptions in the tables below.
- Subject to the use of the services of the Scheme's designated service provider (DSP).
  - Indicates the designated service provider.

Benefit		Limit
	General Benefit Pool limits **M = R9 010** **M + 1 = R10 970** **M + 2+ = R11 640**	
Allied and alternative healthcare professionals	Includes treatment by biokineticists, home nursing, occupational, physio, speech and hearing therapists, acousticians, homeopaths, dietitians, psychometricians, social workers, podiatrists, chiropractors and psychologists	Subject to the applicable GBP limits, thereafter from available MSA. Up to 100% of the Scheme Rate. Physiotherapist Network Psychologist and registered counsellors Network
Basic dentistry	–	100% of the Scheme Rate. Subject to the applicable GBP limits, thereafter from available MSA. Surgery subject to preauthorisation and using a DSP. Includes minor oral surgery and other oral procedures performed by dental practitioners, plastic dentures and the applicable dental technicians' and therapists' fees.
Orthodontics	–	100% of the Scheme Rate. Subject to applicable GBP limits, thereafter from available MSA. Treatment costs for orthodontic treatment for those over the age of 21, as well as lingual orthodontics and labial frenectomies are not covered by the Scheme.
GPs and specialists	Consultations, visits, surgical and non-surgical procedures and treatment	100% of the cost, subject to the use of DSPs. Subject to the applicable GBP limits, thereafter from available MSA. For the voluntary use of non-DSP providers for PMB and other services, paid up to the Scheme Rate only. Premier A and B Specialist Network GP Network Discovery Health Premier Plus GP for HIV, Diabetes, Mental Health and Cardio Care.
Maternity benefit	Antenatal consultations and selected blood tests	100% of the Scheme Rate. Limited to treatment by DSP GPs and specialists and paid from GBP or MSA, subject to PMBs.
Medicine	Prescribed and acute medicine Scheme's Pharmacy Network	Subject to available funds in the MSA. 100% of the cost at DSPs, or up to 100% of the Scheme Rate for medicine purchased at a non-DSP. Once the annual MSA has been depleted, claims for acute medicine will be paid from the General Benefit Pool, if benefits are still available, up to a limit of R2 280 per beneficiary with a family limit of R4 555
Mental health	Includes psychiatry, psychology and social work except for PMBs	100% of the Scheme Rate. Subject the use of a DSP specialist for psychiatry. Subject to a limit of R3 310 for a member, thereafter payable from GBP and MSA. Psychologists and registered counsellor Network

Benefit		Limit
Optical (basic)	–	100% of the Scheme Rate limited to available benefits in the member's MSA and GBP for specialised lenses, spectacles, contact lenses and refractive eye surgery. Please contact our call centre on 0860 11 33 22 for enquiries about how your optical treatment will be paid.
Casualty outpatient benefit	–	100% of the Scheme Rate. Limited to available funds in the GBP and thereafter from available MSA and available benefits.
Endoscopic procedures (out-of-hospital)	–	100% of the Scheme Rate. First R2 700 of the account covered from GBP. Remainder of account covered from the Hospital Benefit, subject to applicable limits and PMBs.
External medical items	–	Limited to MSA and subject to PMBs and GBP.
Specialised radiology	MRI or CT scans	100% of the Scheme Rate. First 30% up to a maximum of R3 150 covered from the GBP. Remainder paid from the Hospital Benefit, subject to the joint in- and out-of-hospital limit of R30 800 for specialised radiology for a person each year. Subject to PMBs.
X-rays, radiology and pathology	–	Subject to the applicable GBP limits, thereafter from available MSA. Up to 100% of the Scheme Rate.

Medical Savings Account (MSA)

- Certain day-to-day benefits on the Standard Plan are only paid from the Medical Savings Account whilst others will first pay from the available Medical Savings Account and once depleted will pay from the General Benefit Pool (GBP).
- Refer to the specific benefit descriptions in the tables below.
- Subject to the use of the services of the Scheme's
  - Indicated designated service provider (DSP).

Benefit		Limit
Limits stated for a person each year.		M = R8 148 A = R6 096 C = R2 172
Acute medicine GPs and specialists	–	Subject to the applicable MSA limits. Paid up to 100% of the Scheme Rate for medicine.
Advanced dentistry	Advanced dentistry, osseo-integrated implants and orthognatic surgery, including the cost of hospitalisation. This benefit also includes benefits for inlays, crowns, bridges, mounted study models, metal-based partial dentures, treatment by a periodontist or prosthodontist, and the cost of any related dental technician fees	Subject to the applicable MSA limits. Paid up to 100% of Scheme Rate.
Alternative healthcare services	Including acupuncture, aromatherapy, ayurveda, homeopathy, iridology, naturopathy, osteopathy and reflexology	Subject to the applicable MSA limits. Paid up to 100% of Scheme Rate.
Casualty outpatient benefit	For medicine prescribed during a visit	Covered from available funds in your MSA. Facility fees not covered. University of KwaZulu-Natal Medical Scheme Hospital Network.
External medical items	–	Subject to the applicable MSA and GBP limits. Paid up to 100% of Scheme Rate.
Optical	Multi-focal, hardened or darkened lenses, frames, readers, refractive eye surgery (excluding hospital costs where applicable)	Subject to the applicable MSA and GBP limits. Paid up to 100% of Scheme Rate.
Prescribed medicine	Pharmacy Advised Therapy (PAT), including Schedule 0, 1 and 2 medicine even if prescribed	Limited to R315 for a script, and further subject to applicable MSA limit. Up to 100% of the Scheme Rate for medicine.
WHO Global Outbreak Benefit	Basket of out of hospital management and approporiate supportive treatment of global World Health Organization recognised disease outbreaks	Up to a maximum of 100% of the Scheme rate for services within the basket of care. Subject to the Scheme's preferred provider, protocols and clinical entry criteria

Contributions

	Member	Adult dependant	Child dependant
Scheme contribution	R3 234	R2 423	R865
Medical savings contribution	R679	R508	R181
Total monthly contribution	R3 913	R2 931	R1 046

Note: Contributions are stated for a month

This brochure is a summary of the benefits and features of UKZN Medical Scheme, pending formal approval from the Council for Medical Schemes.

Please note that this brochure does not replace the Scheme Rules. The registered Scheme Rules are legally binding and always take precedence.

CONTACT US

Ambulance and other emergency services

ER24: 084 124

To register on the HIVCare Programme

HIV*Care* Programme: 0860 11 33 22

Send your claims

Email: claims@discovery.co.za

Fax: 0860 329 252

Hand deliver the claims to any Discovery claims box

Post: PO Box 652509, Benmore 2010 or

Postnet Suite 116, Private Bag X19, Milnerton 7435

Confirm benefits for in-hospital treatment

Call: 0860 11 33 22

Register for chronic or oncology care

Chronic Illness Benefit: 0860 11 33 22

Oncology Programme: 0860 11 33 22

General queries

Email: service@discovery.co.za

Website: www.discovery.co.za

Call: 0860 11 33 22

Fraud tips

If you even slightly suspect someone of committing fraud, report all information directly to the Discovery fraud hotline:

forensics@discovery.co.za

Or you may remain anonymous if you prefer:

Toll-free number: 0800 004 500

SMS 43477 and include the description of the alleged fraud

Toll-free fax: 0800 00 77 88
Email: discovery@tip-offs.com

Post: Freepost DN298, Umhlanga Rocks 4320

Other services

Website queries: 0860 100 696

Principal Officer

Philippa Hempson

Email: PO-Ukznms@ukzn.ac.za

This brochure is a summary of the benefits and features of UKZN Medical Scheme, pending formal approval from the Council for Medical Schemes.

THE COUNCIL FOR MEDICAL SCHEMES

For you, for health, for life.

What?

The Council for Medical Schemes (CMS) is a statutory body established in terms of the Medical Schemes Act 131 of 1998 to provide regulatory oversight to the medical scheme industry. The CMS' vision is to promote vibrant and affordable healthcare cover for all.

Why?

It is our mission to regulate the medical schemes industry in a fair and transparent manner.

- We protect the public, informing them about their rights, obligations and other matters, in respect of medical schemes;
- We ensure that complaints raised by members of the public are handled appropriately and speedily;
- We ensure that all entities conducting the business of medical schemes, and other regulated entities, comply with the Medical Schemes Act;
- We ensure the improved management and governance of medical schemes;
- We advise the Minister of Health of appropriate regulatory and policy interventions that will assist in attaining national health policy objectives; and
- We collaborate with other entities in executing our regulatory mandate.

Who?

The CMS governs the medical schemes industry and therefore your complaint should be related to your medical scheme. Any beneficiary or any person who is aggrieved with the conduct of a medical scheme can submit a complaint.

It is however very important to note that a prospective complainant should always first seek to resolve complaints through the complaints mechanisms in place at the respective medical scheme before approaching the CMS for assistance.

You can contact your scheme by phone or if not satisfied with the outcome, in writing to the Principal Officer of the scheme, giving her/him full details of your complaint. If you are not satisfied with the response from your Principal Officer, you can ask the matter to be referred to the Disputes Committee of your scheme.

If you are not satisfied with the decision of the Disputes Committee, you can appeal against the decision within 3 months of the date of the decision to the CMS. The appeal should be in the form of an affidavit directed to the CMS. We are for you.

When?

When you need us! The CMS protects and informs the public about their medical scheme rights and obligations, ensuring that complaints raised are handled appropriately and speedily. We are for health.

How?

Complaints against your medical scheme can be submitted by letter, fax, email or in person at our Offices from Mondays to Fridays (08:00-17:00).The complaint form is available from **www.medicalschemes.com**

Your complaints should be in writing, detailing the following: Full names, membership number, benefit option, contact details and full details of the complaint with any documents or information that substantiate the complaint.

The CMS' Customer Care Centre and Complaints Adjudication Unit also provides telephonic advice and personal consultations, when necessary.

Our aim is to provide a transparent, equitable, accessible, expeditious, as well as a reasonable and procedurally fair dispute resolution process. The CMS will send a written acknowledgement of a complaint within three working days of its receipt, providing the name, reference number and contact details of the person who will be dealing with a complaint.

This information has been obtained from the website for the Council for Medical Schemes. You may visit the site at www.medicalschemes.com.

In terms of Section 47 of the Medical Schemes Act 131 of 1998, a written complaint received in relation to any matter provided for in this Act will be referred to the medical scheme. The medical scheme is obliged to provide a written response to the CMS within 30 days.

The CMS shall within four days of receiving the complaint from the scheme or its administrator, analyse the complaint and refer the complaint to the relevant medical scheme for comments.

You can contact the CMS

Customer Care Centre

0861 123 267
0861 123 CMS

Reception

Tel: 012 431 0500
Fax: 012 430 7644

General enquiries

Email enquiries: information@medicalschemes.com
www.medicalschemes.com

Complaints

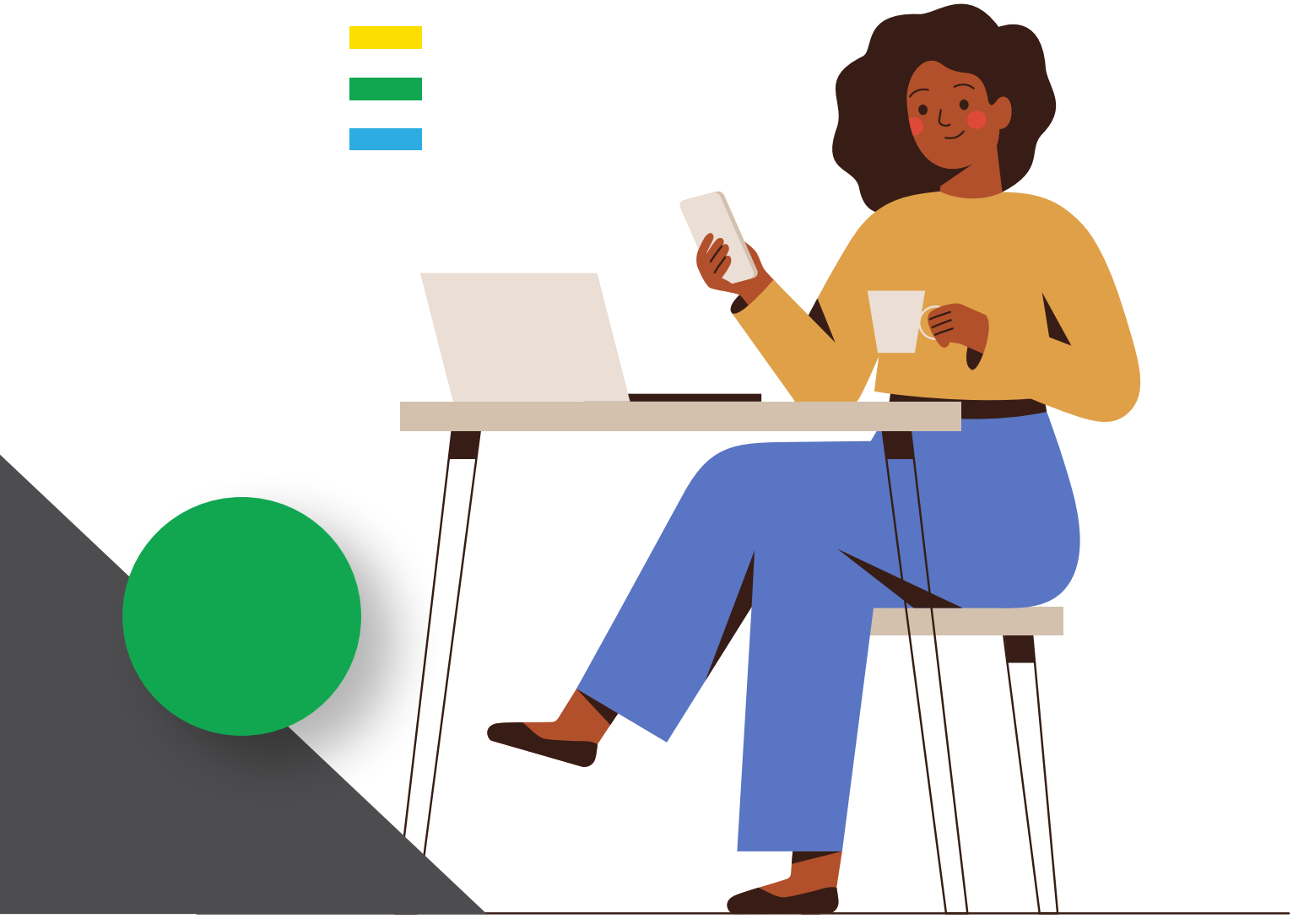
Fax: (086) 673 2466
Email: complaints@medicalschemes.com

Postal address

Private Bag X34
Hatfield
0028

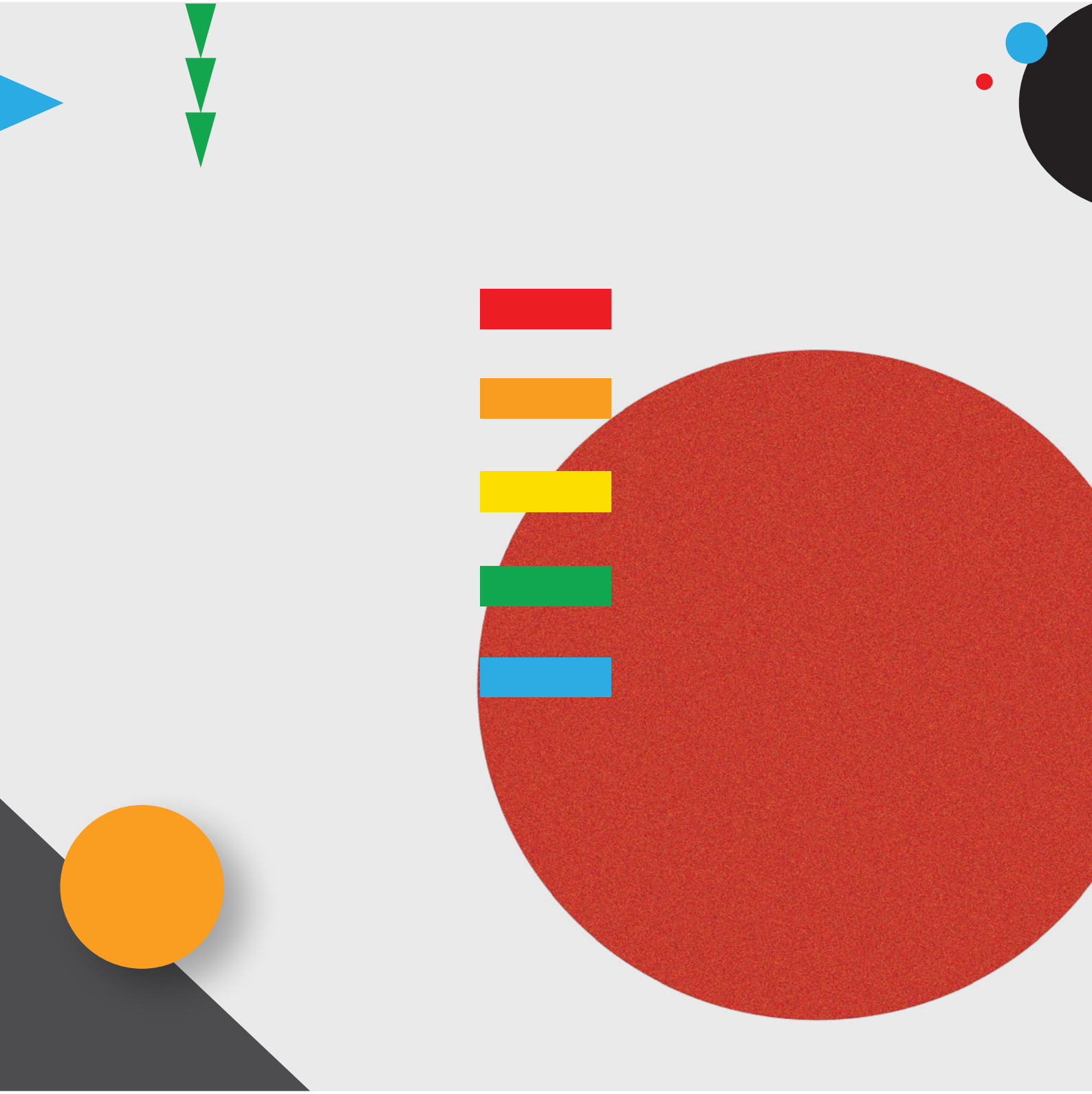
Physical address

Block A, Eco Glades 2 Office Park
420 Witch-Hazel Avenue
Eco Park, Centurion
0157



UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

UKZN MEDICAL SCHEME
Administered by Discovery Health



Call Centre 0860 11 33 22 | service@discovery.co.za | www.discovery.co.za

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