



UNIVERSITY OF KWAZULU-NATAL  
MEDICAL SCHEME

Administered by  
 **Discovery**  
Health



*Member Brochure*  
— 2015 —

# University of KwaZulu-Natal Medical Scheme



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# WELCOME TO THE UNIVERSITY OF KWAZULU-NATAL MEDICAL SCHEME\*

The UKZN Medical Scheme believes in giving you the power to manage your health by offering access to a wellness programme and excellent cover for your healthcare expenses. The Scheme gives you the tools to improve your health, wellbeing and peace of mind when you need it most.

The UKZN Medical Scheme provides benefits to all employees of the University of KwaZulu-Natal and their immediate family members. 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 mandates given by the Scheme's Board of Trustees.

## 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.

### Discovery 911

**In a medical emergency, you can call Discovery 911 on 0860 999 911 at any time of the day or night.**

Highly qualified emergency personnel from ER24 provide the Discovery 911 service. If you need a helicopter or ambulance, they will send one to you. This emergency medical transport is covered by your Major Risk 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, Discovery 911 will determine the most appropriate way to transport you
  - Transfers between hospitals, subject to authorisation and the Scheme's rules
  - Escorted return of minors
- 24-hour access to "Ask the doctor/nurse" health line
- 24-hour crisis counselling service

### 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 Major Risk Benefit, if you 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 if you are on the Standard Plan. Some casualty wards charge a facility fee, which we do not cover.

On the KeyPlus Plan you can go to any casualty unit at one of the KeyPlus Network Hospitals. You have to pay a portion of the casualty account if you are not admitted to hospital from casualty. The treatment you get will be paid from your day-to-day benefits, according to our list of medicines and other services.

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

## Cover for trauma on KeyPlus

The Trauma Recovery Extender Benefit covers out-of-hospital medical expenses for certain traumatic events. The benefit pays certain day-to-day medical care costs of the traumatic event, in the year it happened and in the following benefit year.

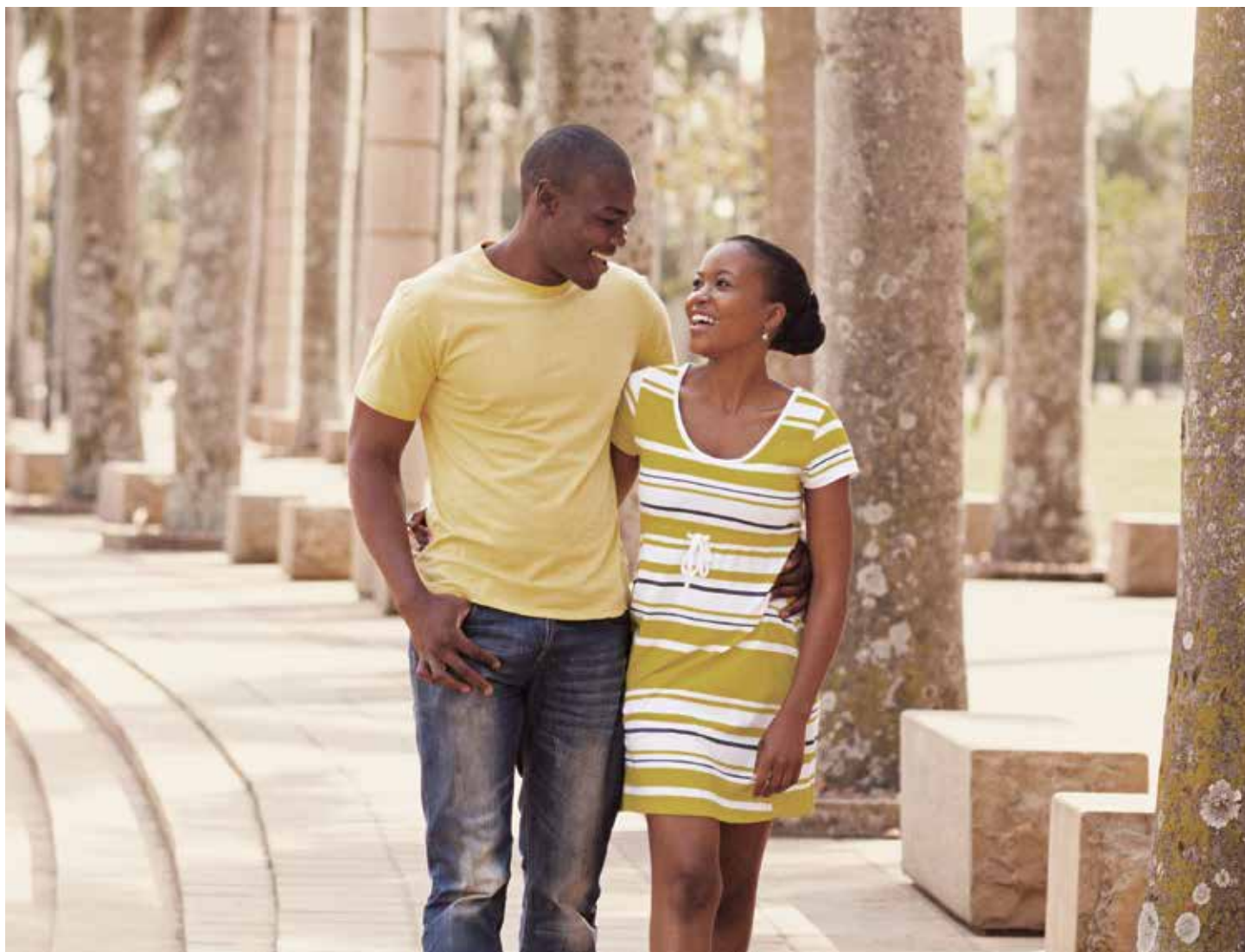
Members must meet the clinical entry criteria to access cover on the Trauma Recovery Extender Benefit.

Conditions covered after a traumatic incident:

- Paraplegia, quadriplegia, tetraplegia and hemiplegia
- Conditions resulting from a near-drowning, a severe anaphylactic reaction, poisoning or crime-related injuries
- Severe burns
- Certain external and internal head injuries
- Loss of limb or part thereof, as a result of trauma.

Please note that these benefits are limited.

Please read your Benefit Schedule to see these limits.



The brochure is a summary of the UKZN Medical Scheme 2015 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](http://www.discovery.co.za)

# 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 operation 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 Major Risk 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 have to use hospitals on the UKZN Medical Scheme Hospital Network and members on the KeyPlus Plan have to go to hospitals on the KeyPlus 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.

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

The Scheme will only transfer members to another hospital when the required medical treatment is not available from the non-network hospital to which the member was admitted. The Scheme has no intention of moving 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 to receive ongoing treatment.

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

You may also access the latest information by logging on to [www.discovery.co.za](http://www.discovery.co.za)

|  |   |  |
|--|---|--|
| <b>KwaZulu-Natal</b> <ul style="list-style-type: none"><li>Life Chatsmed Garden Hospital</li><li>Pietermaritzburg Medi-Clinic</li><li>Life Westville Hospital</li><li>Ethekwini Hospital and Heart Centre</li><li>Life Entabeni Hospital</li><li>Midlands Medical Centre</li><li>The Bay Hospital</li><li>Howick Medi-Clinic</li></ul> | <b>Gauteng</b> <ul style="list-style-type: none"><li>Morningside Medi-Clinic</li><li>Arwyp Medical Centre</li><li>Life Bedford Gardens Hospital</li><li>Midvaal Private Hospital</li><li>Life Roseacres Clinic</li><li>Louis Pasteur Hospital</li><li>Life Suikerbosrand Clinic</li><li>Clinix Private Hospital – Lesedi</li><li>Life Fourways Hospital</li><li>Emfuleni Medi-Clinic</li><li>Life Wilgeheuwel Hospital</li><li>Legae Private Hospital</li></ul> | <ul style="list-style-type: none"><li>Life Robinson Private Hospital</li><li>The Donald Gordon Medical Centre</li><li>Life Carstenhof Clinic</li><li>Clinix Private Hospital – Sebokeng</li><li>Life Little Company of Mary</li><li>Sandton Surgical Centre</li><li>Clinton Clinic</li><li>Genesis Clinic (Saxonworld)</li><li>Bougainville Private Hospital</li></ul> |
| <b>Free State</b> <ul style="list-style-type: none"><li>Universitas Private Hospital</li><li>Bloemfontein Eye Centre</li><li>Life Rosepark Hospital</li></ul>  |   |  |
| <b>Western Cape</b> <ul style="list-style-type: none"><li>Life Vincent Palotti Hospital</li><li>Cape Town Medi-Clinic</li><li>Panorama Medi-Clinic</li></ul>   | <ul style="list-style-type: none"><li>Mitchells Plain Medical Centre</li><li>Gatesville Medical Centre</li><li>Vergelegen Medi-Clinic</li></ul>   | <ul style="list-style-type: none"><li>New Merchantile Hospital</li><li>Delta Life HealthCare Hospital</li></ul>  |



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### **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 R3 600 per event, 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**

Discovery 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 the 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 at the time of confirming benefits. It will assist the agent 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.

### **KeyPlus Plan Hospital Network**

On the KeyPlus Plan we cover you in any hospital in the KeyPlus Hospital Network\*. If you don't go to a KeyPlus Network Hospital for a planned admission, you will have to pay the claims yourself.

The KeyPlus hospitals are: **Midland Medical Centre, The Bay Hospital, and Life Entabeni Hospital.**

### **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. If it is an emergency, you or a family member if you are unable, must let us know that you have been admitted to hospital as soon as you can, within 48 hours after the admission.

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.

If you do not preauthorise your admission or let us know of an emergency on the KeyPlus Plan, you will not be covered.

### **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
- Mandeni Medical Services Palm Day Clinic
- Pinetown Medicross Theatre
- Malvern Medical & Dental Centre
- Pinetown Clinic (Pty) Ltd
- Shelly Beach Day Clinic

There are several facilities in other regions. You may access the latest information by logging on to **[www.discovery.co.za](http://www.discovery.co.za)**

### Day-surgery network facilities for the KeyPlus Plan

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

#### KwaZulu-Natal

|   |  |
|---|--|
| <ul style="list-style-type: none"><li>• Kokstad Private Hospital</li><li>• McCord Hospital</li><li>• Isipingo Clinic</li><li>• Empangeni Garden Clinic (Pty) Ltd</li><li>• Victoria Hospital Limited</li><li>• Midlands Medical Centre</li><li>• Mount Edgecombe Hospital</li><li>• Entabeni Hospital</li><li>• St Anne's Hospital</li><li>• Kingsway Hospital</li><li>• Chatsmed Garden Hospital</li></ul> | <ul style="list-style-type: none"><li>• City Hospital Ltd</li><li>• Nu-Shifa Hospital</li><li>• The Bay Hospital</li><li>• The Crompton Hospital</li><li>• Newcastle Private Hospital</li><li>• Hibiscus Hospital</li><li>• Shelly Beach Day Clinic</li><li>• Bluff Medical and Dental Centre</li><li>• Malvern Medical and Dental Centre</li><li>• Pinetown Medicross Theatre</li></ul> |
|---|--|

There are several facilities in other regions. You may access the latest information by logging on to [www.discovery.co.za](http://www.discovery.co.za)

### On the KeyPlus Plan, the procedures listed below will only be covered in our network of day-case facilities

|  |   |
|--|---|
| <ul style="list-style-type: none"><li>• Arthrocentesis</li><li>• Adenoidectomy</li><li>• Cautery of vulva warts</li><li>• Circumcision</li><li>• Colonoscopy</li><li>• Cystourethroscopy</li><li>• Diagnostic D &amp; C</li><li>• Gastroscopy</li><li>• Hysteroscopy</li><li>• Myringotomy</li></ul> | <ul style="list-style-type: none"><li>• Myringotomy with intubation (grommets)</li><li>• Proctoscopy</li><li>• Prostate biopsy</li><li>• Removal of pins and plates</li><li>• Sigmoidoscopy</li><li>• Simple abdominal hernia repair</li><li>• Simple nasal procedures for nose bleeding (nasal plugging and nasal cautery)</li><li>• Tonsillectomy</li><li>• Treatment of Bartholin's, cyst/abscess</li><li>• Vasectomy</li><li>• Vulva biopsy/cone biopsy</li></ul> |
|--|---|

## Prescribed Minimum Benefits

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 an applicable benefit.

In most cases the UKZN Medical Scheme Plans offer benefits that are far greater than the Prescribed Minimum Benefits (PMBs).

By law, we are not allowed to use your available Medical Savings Account to pay any PMB, if you have a Medical Savings Account.

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 Services Providers (DSPs), co-payments may apply.

## Designated Service Providers

**When you use the services of a Designated Service Provider, all claims, including Prescribed Minimum Benefits, are paid in full. This means you will not have to make out-of-pocket payments at these providers.**

These are specific providers of healthcare services, for example general practitioners 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                              | Standard Plan | KeyPlus Plan |
|--------------------------------------|---------------|--------------|
| UKZN Medical Scheme Hospital Network | ✓             | ✗            |
| KeyCare Hospital Network             | ✗             | ✓            |
| The Specialist Network               | ✓             | ✓            |
| The GP Network                       | ✓             | ✗            |
| The KeyCare GP Network               | ✗             | ✓            |
| SANCA, Nishtara and Ramot            | ✓             | ✗            |
| National Renal Care                  | ✓             | ✗            |
| Fresenius                            | ✗             | ✓            |
| Pharmacy Network                     | ✓             | ✓            |
| VitalAire                            | ✓             | ✓            |
| Optipharm                            | ✓             | ✓            |

#### If you do not use the services of the Designated Service Provider, what will happen?

The Designated Service Providers (DSPs) are the only service providers you may use for certain services, as shown in this booklet and your Benefit Schedule. If you do not use these services 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.

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

- UKZN Medical Scheme Hospital Network, State or public health system (all related services)
- Any general practitioner on the Discovery GP Network for the Standard Plan and any GP in the KeyCare GP Network for the KeyPlus 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 on the Discovery Specialist Network for the Standard Plan and Specialists in the KeyCare Network for the KeyPlus 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
- 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 DSP, you will get 100% cover up to the relevant Oncology Benefit limit. If you don't use a DSP, 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 and the KeyPlus Plans.

To find a specialist in this network, use MaPS (Medical and Provider Search) on [www.discovery.co.za](http://www.discovery.co.za).

## Preferred providers

The Scheme uses the services of several preferred providers:

### Centre for Diabetes and Endocrinology (CDE) (only available on the Standard Plan)

This is an optional benefit, available to members who meet the benefit entry criteria of the programme, who are registered on the Scheme's Chronic Illness Benefit for diabetes. The Centre for Diabetes and Endocrinology provides the following services:

- Ongoing education and information about diabetes
- One podiatrist's visit a year
- One optometrist's visit a year
- Access to the services of a specialised dietitian
- Access to the services of a GP who specialises in diabetes care
- Continuous medical care and advice
- Active managed care during hospitalisation.

The programme is aimed at controlling the disease to improve quality of life. We recommend registration if you have been diagnosed with diabetes.

Members may get more information about these providers on [www.discovery.co.za](http://www.discovery.co.za) or call 0860 11 33 22 for assistance.

Limits, clinical guidelines and policies apply to some healthcare services and procedures. Please check the benefit tables in the benefit schedule for more information.



## The Chronic Illness Benefit

The Chronic Illness benefit covers approved medicine for a list of 27 Prescribed Minimum Benefit conditions (including HIV and AIDS) called the Chronic Disease List conditions. We will pay your approved chronic medicine in full 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 amount (Chronic Drug Amount) 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 medicines up to the one monthly Chronic Drug amount for that medicine category.

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

You can get a copy of the latest application form on the website at [www.discovery.co.za](http://www.discovery.co.za) or call 0860 11 33 22 to get one.

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

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

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.

# THE CHRONIC ILLNESS BENEFIT

## Chronic Disease List (CDL) Prescribed Minimum Benefit (PMB) conditions

- |  |  |   |  |
|--|--|---|--|
| <ul style="list-style-type: none"><li>• Addison's disease</li><li>• Asthma</li><li>• Bipolar mood disorder</li><li>• Bronchiectasis</li><li>• Cardiac failure</li><li>• Cardiomyopathy</li><li>• Chronic obstructive pulmonary disease</li></ul> | <ul style="list-style-type: none"><li>• Chronic renal disease</li><li>• Coronary artery disease</li><li>• Crohn's disease</li><li>• Diabetes insipidus</li><li>• Diabetes mellitus type 1</li><li>• Diabetes mellitus type 2</li><li>• Dysrhythmia</li></ul> | <ul style="list-style-type: none"><li>• Epilepsy</li><li>• Glaucoma</li><li>• Haemophilia</li><li>• HIV and AIDS</li><li>• Hyperlipidaemia</li><li>• Hypertension</li></ul> | <ul style="list-style-type: none"><li>• Hypothyroidism</li><li>• Multiple sclerosis</li><li>• Parkinson's disease</li><li>• Rheumatoid arthritis</li><li>• Schizophrenia</li><li>• Systemic lupus erythematosus</li><li>• Ulcerative colitis</li></ul> |
|--|--|---|--|

For us to cover your medicine from the Chronic Illness Benefit, your condition must be on our list of chronic conditions and you need to meet the benefit entry criteria for cover of the condition.

We do not cover all medicine from the Chronic Illness Benefit. If we do not approve a medicine for cover from the Chronic Illness Benefit, it may be paid from the Medical Savings Account.

You also have cover for other life threatening or degenerative conditions that are listed on the Scheme's Additional Disease List (ADL) (only available on the Standard Plan), 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 pay for the medicine from your available day-to-day benefits.

## Additional Chronic conditions covered on the Scheme's Additional Disease List on the Standard Plan only. Non-PMB chronic conditions on the Scheme's Additional Disease List (ADL)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"><li>• Attention deficit disorder (hyperactivity)</li><li>• Anterior horn cell disorders</li><li>• Chronic anxiety disorders</li><li>• Chronic dyspepsia</li><li>• Chronic rhinitis</li><li>• Chronic sinusitis</li></ul> | <ul style="list-style-type: none"><li>• Chronic vertigo</li><li>• Collagen disease</li><li>• Dementia</li><li>• Depression</li><li>• Eczema</li><li>• Gout</li></ul> | <ul style="list-style-type: none"><li>• Neurogenic bladder</li><li>• Osteoarthritis</li><li>• Psoriasis</li><li>• Recurrent cystitis</li><li>• Spastic colon</li><li>• Vascular headaches</li></ul> |
|--|--|---|

There is no medicine list (formulary) for these conditions. We pay approved medicines for these conditions up to the monthly Chronic Drug Amount.

## Diagnosis, treatment and care for Prescribed Minimum Benefit conditions

The UKZN Medical Scheme will pay for the treatment, ongoing management and care of Prescribed Minimum Benefit conditions, according to the legal requirements concerning PMBs. The benefits available for each of the Prescribed Minimum Benefit Chronic Disease List conditions are contained in a basket of care. Included in these baskets of care are tests and consultations (relating to GPs and specialists) which we cover during the year for both the diagnosis and ongoing management of each condition. Each basket of care also includes procedure codes for pathology and radiology claims if the condition is approved by the Chronic Illness Benefit.

On approval of your Prescribed Minimum Benefit chronic condition, a selection of codes will be loaded for the condition for each registered member or dependant.

### Payment for the diagnosis and medical management of Prescribed Minimum Benefit Chronic Disease List conditions

If your condition is approved, you do not have to pay for the diagnosis and medical management costs provided in the baskets of care. These costs are paid according to the rules of the Scheme from your Major Risk Benefit. Unless approved with further motivation by your doctor, we will pay benefits exceeding those provided for in the baskets of care from your day-to-day benefits.

The Scheme will pay in full (that is, without any co-payments or deductibles such as levies) for the diagnosis, treatment and care of Prescribed Minimum Benefit conditions, provided your treating doctor is a Designated Service Provider in the network and he or she includes the correct ICD-10 code on their account. If the correct code is not included, your claim will be treated as an ordinary day-to-day or out-of-hospital claim, and will be paid from your applicable day-to-day benefits.

# MANAGED CARE PROGRAMMES

## The Oncology Programme

### What UKZN Medical Scheme does for members who are diagnosed with cancer

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

We pay 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.

On the Standard Plan, the Scheme will pay your approved cancer treatment in full over a 12-month cycle, starting on the date you register on the programme up to the Oncology limit, per case for non-PMB 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.

On the KeyPlus Plan, all authorised cancer treatment, including chemo- and radiotherapy, will be covered if provided by a KeyCare Network Oncologist. The benefit is subject to PMBs and strict benefit criteria.

When you use our 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 treatment. If you don't, you will have to make a co-payment (pay for some of the cost yourself).

### Stem cell transplants

On KeyPlus, stem cell transplants will only be covered from your Major Risk Benefit if obtained from a state hospital or the Scheme's Designated Service Provider, subject to Prescribed Minimum Benefit requirements and benefit protocols.

On the Standard Plan it is covered as a Prescribed Minimum Benefit only. Subject to Prescribed Minimum Benefit requirements and benefit protocols.

## The HIVCare Programme

The HIVCare 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 approval for 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 PMB. 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 DSP.

# GENERAL BENEFIT POOL

The General Benefit Pool will pay for certain healthcare costs up to a specific annual limit, at 100% of the Scheme Rate. This benefit is only available on the Standard Plan.

This benefit pays claims for:

|   |   |   |
|---|---|---|
| <ul style="list-style-type: none"><li>• Basic dentistry</li><li>• GPs and specialists</li></ul> | <ul style="list-style-type: none"><li>• Mental health</li><li>• Basic optometry</li></ul> | <ul style="list-style-type: none"><li>• Out-patient services</li><li>• Paramedical services</li></ul> |
|---|---|---|

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

|  |
|--|
| <ul style="list-style-type: none"><li>• Private nursing</li><li>• X-rays, radiology and pathology.</li></ul> |
|--|



# DAILY MEDICAL EXPENSES

## How the Medical Savings Account works

### Please note, this is only available on the Standard Plan

The Medical Savings Account pays for your visits to the doctor, medicine from the pharmacy or 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 we carry it over to the next year.

If you resign from UKZN Medical Scheme and have funds left in your Medical Savings Account, we 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 KeyPlus Plan does not have a Medical Savings Account for day-to-day medical expenses.

### How daily medical expenses are covered on the KeyPlus Plan

#### Basic x-rays

We pay for a list of basic x-rays at a network provider. Your chosen GP must ask for the x-rays to be done. Go to [www.discovery.co.za](http://www.discovery.co.za) for the list of radiology facilities in our network or call us on 0860 11 33 22.

#### Blood, urine and other fluid and tissue tests

We pay for a list of blood, urine and other fluid and tissue tests. Your chosen GP must ask for these tests by filling in a pathology form.

#### Medicine to treat conditions that don't last long

We pay for medicines on our medicine list if they are prescribed or dispensed by your chosen KeyCare network GP.

#### You get one out-of-network GP visit

If you need to see a doctor and your chosen GP in our network is not available, each person on your membership can go to any GP once. We will cover the GP visit, with selected blood tests and x-rays and medicines on our medicine list. We pay for this up to the Discovery Health medicine rate, and you have to pay for anything over this amount.

#### Cover for dentistry

We cover consultations, fillings and tooth removal at a dentist in our dentist network.

#### Cover for eye care

We cover one eye test for each person but you must go to an eye doctor in our network. The eye doctor will have a specific range of glasses that you can choose from. You can get a set of contact lenses instead of glasses if you choose to. You can get new glasses or contact lenses every 24 months.

#### Trauma Recovery Extender Benefit

We will cover specific out-of-hospital claims for your recovery after certain traumatic events. We will cover you for the rest of the year in which the trauma took place, and in the year after your trauma.

#### How we cover medical equipment

We cover wheelchairs, wheelchair batteries and cushions, transfer boards and mobile ramps, commodes, long-leg calipers, crutches and walkers on the medical equipment list, if you get them from a network provider. There is an overall limit of R4 700 for each family on the KeyPlus Plan and subject to available funds in your Medical Savings Account on the Standard Plan.

#### Cover for other types of healthcare professionals

We do not cover other types of healthcare professionals, like physiotherapists, psychologists, speech therapists, audiologists, homeopaths or chiropractors from your day-to-day benefits.

Day-to-day benefits include healthcare cover in situations that normally happen outside of the hospital and are not life-threatening.

#### Cover for GP visits

When joining the KeyPlus Plan, you must choose a GP from the KeyCare GP network. You must go to your chosen GP for us to cover your consultations and some minor procedures.



# WHAT THE SCHEME DOES NOT COVER

The 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
- The treatment of infertility
- 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, including injuries due to negligence, illegal acts or to failure to carry out the instructions of a medical practitioner
- Medicines not included in a prescription from a medical practitioner, except with the assistance of a professional pharmacist
- Medicines not registered with the Medicines Control Council and new medicines
- 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 medicines 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 Ultra base, Cream E45 and sunscreens
  - Anti-addiction and anti-habit agents
  - Anabolic steroids
  - Multivitamin preparations and vitamin combinations
  - Contact lens preparations
  - Cosmetic preparations, medicated or otherwise including hydroquinine products
  - Prenatal and infant vitamins and vitamin/mineral supplements
  - Geriatric vitamins/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 donations 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
- All costs for Prescribed Minimum Benefit services provided outside of the borders of South Africa.

## Additional exclusions that apply to the KeyPlus Plan

In addition to the general exclusions that are listed on the previous pages, the KeyPlus Plan does not cover the following, except if the Prescribed Minimum Benefits say they do:

1. Hospital admissions related to:

- dentistry
- skin disorders
- investigations and diagnostic work-up
- functional nasal surgery
- elective caesarean section, except if medically necessary
- surgery for oesophageal reflux and hiatus hernia
- back and neck treatment or surgery
- joint replacements, including but not limited to hips, knees, shoulders and elbows
- cochlear implants, auditory brain implants and internal nerve stimulators – this includes procedures, devices and processors
- healthcare services that should be done out of hospital and for which admission to hospital is not necessary.
- bunionectomy
- arthroscopy
- removal of varicose veins

2. Brachytherapy for prostate cancer

3. Refractive eye surgery

4. Non-cancerous breast conditions.

We also do not cover the complications or the direct or indirect expenses that arise from any of the exclusions listed in this section.



# TOOLS TO HELP YOU

## A quick guide to help you with:

### Adding a dependant

You may register your spouse or partner on the UKZN Medical Scheme, as long as they are not a beneficiary, a member or a registered dependant of a member 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, who are full-time students and financially dependent on you. We need annual proof of registration at a recognised learning institution
- Your children over the age of 21, who are unemployed and financially dependent on you. We need annual proof of dependency.
- Your children who are 21 years of age or older, who suffer from a mental or physical disability and who are financially dependent on you, will continue to be recognised as your child dependants.

You may register other members of your immediate family, for whom you are liable for family care and support, as long as such person is 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 the relevant affidavit as proof of legal liability 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.

#### Please make sure the application form is fully completed and that the following information for the new dependant is on it:

- Full names
- Date of birth and identity number
- Relationship to you (spouse, common-law spouse, child, step-child, legally adopted child, adult dependant)
- Gender (male or female)
- The date on which the new dependant will be joining 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 please 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 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 periods 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.

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

- 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.

## **What to do before you go to hospital**

### **Preauthorisation**

Before you go to hospital for a planned procedure, remember to get authorisation first. Here are the steps:

- 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 or in the KeyPlus network
- Preauthorise your hospital admission. Do this by calling us on 0860 111 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 are on the Standard Plan and 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. If you are a KeyPlus member, we will not make any payments if your in-hospital treatment is not preauthorised. 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](http://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.

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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 the supply of 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 in respect of the medicine.

There are various 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 the Scheme.

#### **What happens after you send your claim**

Once we receive your claim, we scan it and capture it on our system. We then assess the claim and make sure all the information on the claim matches the information we have on record for the patient. The turnaround time for processing claims is 72 hours – from the time we receive a claim to the time we process it. It is then either approved for payment or declined. Once we have made the payment, you will receive your claims statement, detailing all the claims payments.

#### **How to check on the status of your claim**

To see the status of your claim, you can check your claim statement or use the Claims Tracker tool on our website at [www.discovery.co.za](http://www.discovery.co.za). You can also get your details on your cellphone: go to the WAP site, [www.discoveryinfo.mobi](http://www.discoveryinfo.mobi) on your cell phone or SMS "Claim" to 31DIS (31347).

If we have your email address, you will receive a claims payment notification that will give you all the information about the latest claims we have processed for you – how they were assessed against your available benefits, how they were paid and what the latest balances are – MSA or others. Please log in to **[www.discovery.co.za](http://www.discovery.co.za)** and make sure your information is updated.

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

Normally the 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.

# QUICK A TO Z

## Benefit entry criteria

For certain illnesses, *benefit entry criteria* determine what we cover.

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

## Co-payment

An amount you have to pay towards a healthcare service. If your doctor is not one of the Scheme's network providers and charges above the Scheme Rate, you will have to pay the difference to that doctor. We call this a *co-payment*.

## Deductible

If you are on the Standard Plan, 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, we pay the provider directly and in full. On the Standard Plan, we pay participating specialists at the Premier rate for claims. We also pay participating general practitioners at the GP rate for all consultations. This means you will not have to pay any of these providers extra from your own pocket. If you are a KeyPlus member, we will pay it in full if you use the services of a KeyCare GP in the network or a KeyCare Specialist that works in one of the KeyCare Network Hospitals.

## Discovery 911/ER24

You have access to **Discovery 911**, a service that provides highly trained paramedics from ER24 in response vehicles who will help you with all aspects of a medical emergency. You can call Discovery 911 on **0860 999 911** for emergency help.

## Exclusions

There are certain expenses that are not covered by the 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 Coding

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 the Scheme without the ICD-10 codes may result in claims payments being made from the incorrect benefit, such as your General Benefit Pool (GBP) benefits or your Medical Savings Account (MSA), 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 0-2 and generic or non-generic medicine, whether prescribed or not, is also known as over-the-counter medicine and we only pay for these on the Standard Plan. If you buy medicine over the counter, on the advice of a pharmacist, and you want to claim for these from the 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.

We 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. Good examples of this are 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 the specific condition. It is based on scientific evidence and research.

#### Pro-rated benefits

If you join the Scheme partway through the year, we calculate your benefits and limits 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 we pay your medical claims. The UKZN Medical Scheme Rate is based on specific rates we negotiate with healthcare professionals. Unless we state 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 will have to pay the doctor.

## Contact us

#### Ambulance and other emergency services

Discovery 911: 0860 999 911

#### To register on the HIVCare Programme

HIVCare Programme: 0860 11 33 22

#### Send your claims

Email: [claims@discovery.co.za](mailto:claims@discovery.co.za)

Fax: 0860 329 252

Hand-drop the claims into 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

Email: [preauthorisations@discovery.co.za](mailto:preauthorisations@discovery.co.za)

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](mailto:service@discovery.co.za)

Website: [www.discovery.co.za](http://www.discovery.co.za)

Call: 0860 11 33 22

#### Walk-in centres:

##### Cape Town

Knowledge Park, Heron Crescent, Century City

##### Johannesburg

16 Fredman Drive, Sandton

##### Durban

41 Umvubu Park Place, Riverhouse Valley Business Estate, off Nandi Drive

##### Centurion

Corner of Oak and Tegel Avenues, Highveld Techno Park

##### Port Elizabeth

BPO Building, Zone 4 -IDZ, Coega

#### Anonymous fraud tips

Fraud Hotline: 0800 004 500

Email: [forensics@discovery.co.za](mailto:forensics@discovery.co.za)

Website: [www.fraudline.co.za](http://www.fraudline.co.za)

#### Other services

Internet queries: 0860 100 696

#### Principal Officer

Philippa Hempson

Email: [philippa.hempson@gmail.com](mailto:philippa.hempson@gmail.com)

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

## NOTES

This image shows a single sheet of white paper with horizontal green ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.





UNIVERSITY OF KWAZULU-NATAL  
MEDICAL SCHEME

Discovery Health | 41 Invubupark Place, Durban | 0860 11 33 22 | [www.discovery.co.za](http://www.discovery.co.za)

University of KwaZulu-Natal Medical Scheme, registration number 1520. Administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07. An authorised financial services provider.