Be Smart. **Keep it Simple.**

BENEFITS BROCHURE 2019
SILVER

KeyHealth
MEDICAL SCHEME

SILVER OPTION

MAJOR MEDICAL BENEFITS	MST(≤)	BENEFIT	EXPLANATORY NOTES / BENEFIT SUMMARY
HOSPITALISATION			Unlimited. Pre-authorisation compulsory.
Varicose vein surgery, facet joint injections, hysterectomy, rhizotomy, reflux surgery, back and neck surgery (incl. spinal fusion), joint replacement.			PMB entitlement only for varicose vein surgery and reflux surgery. The other procedures will be covered at 100% of Agreed Tariff.
Private hospitals			Unlimited, up to 100% of Agreed Tariff, subject to use of DSP hospital (Netcare or Life Healthcare). (30% co-payment at non-DSP hospital).
State hospitals			Unlimited, up to 100% of Agreed Tariff.
Specialist and anaesthetist services	100%		Unlimited, subject to use of DSP provider.
Medicine on discharge	100%	R500	Per admission.
Maternity	100%		Private ward for 3 days for natural birth.
MAJOR MEDICAL OCCURRENCES			
SUB-ACUTE FACILITIES & WOUND CARE Hospice, private nursing, rehabilitation, step-down facilities and wound care.	100%	R28 000	Pre-authorisation compulsory and subject to Case Management and Scheme Protocols. Pfpa. Wound care is included in this benefit, up to an amount of R9 000. Combined in- and out-of-hospital benefit.
TRANSPLANTS (Solid organs, tissue and corneas) Hospitalisation, harvesting and drugs for immuno-suppressive therapy.	100%		Pre-authorisation compulsory and subject to Case Management. PMB entitlement in DSP hospitals only.
DIALYSIS	100%		Pre-authorisation compulsory and subject to Case Management and Scheme Protocols. PMB entitlement only.
ONCOLOGY	100%	R165 000	Pfpa. Pre-authorisation compulsory and subject to Case Management and Scheme Protocols.
RADIOLOGY	100%		Pre-authorisation: specialised radiology, including MRI, CT and PET scans. Hospitalisation not covered if radiology is for investigative purposes only. (Day-to-day benefits will then apply.)
MRI and CT scans		R15 500	Pfpa. R1 560 co-payment per scan (in- or out-of-hospital), excluding confirmed PMBs.
X-rays			Unlimited.
PET scans			No benefit.
PATHOLOGY	100%		Unlimited.

OUT-OF-HOSPITAL BENEFITS	MST(≤)	BENEFIT	EXPLANATORY NOTES / BENEFIT SUMMARY
DAY-TO-DAY BENEFITS			
ROUTINE MEDICAL EXPENSES General practitioner and specialist consultations, radiology (incl. Nucleur Medicine Study and bone density scans). Prescribed and over-the-counter medicine. Optical and auxiliary services, e.g. physiotherapy, occupational therapy, contraceptive pills and biokinetics. (This is a family benefit which means that one member of the family can use the total benefit allocation.)	100%		Principal member: R7 245 p.a. Adult dependant: R5 265 p.a. Child dependant: R1 460 p.a. **Additional general practitioner consultations (3pfpa) after depletion of available day-to-day benefit for Child Dependant/s up to the age of 21.**
Over-the-counter medicine	100%	R1 560	Pfpa sublimit. Subject to day-to-day benefit.
Over-the-counter reading glasses		R120	Pbpa. 1 pair per year. Subject to the over-the-counter medicine sublimit.
PATHOLOGY	70%		Subject to day-to-day benefit. (Co-payment payable directly to the relevant service provider.)
OPTICAL SERVICES	100%	R1 470	Pbp2a total optical benefit. Subject to day-to-day benefit and Optical Management. Benefit confirmation compulsory.
Frames		R490	Per frame, 1 frame pbp2a. Subject to overall optical benefit.
Lenses			1 pair single vision lenses pbp2a. Subject to overall optical benefit.
Eye test			1 test pbp2a. Subject to overall optical benefit.
Contact lenses		R655	Pbpa. Subject to overall optical benefit.
Refractive surgery			No benefit.
DENTISTRY			
CONSERVATIVE DENTISTRY			DENIS protocols, Scheme Rules and Managed Care interventions apply. Exclusions apply in accordance with Scheme Rules.
Consultations	100%		2 check-ups pbpa.
X-rays: Intra-oral	100%		
X-rays: Extra-oral	100%		1 pbp3a.
Oral hygiene	100%		2 scale and polish treatments pbpa.
Fillings	100%		1 per tooth per 365 days. A treatment plan and X-rays may be required for multiple fillings. Re-treatment of a tooth subject to clinical protocols.
Tooth extractions and root canal treatment	100%		Root canal therapy on primary (milk) teeth, wisdom teeth (3rd molars), as well as direct/indirect pulp capping procedures, are excluded.
Plastic dentures	100%		1 set (upper and lower jaw) pbp4a. DENIS pre-authorisation compulsory.
SPECIALISED DENTISTRY			No benefit.
Orthodontics (non-cosmetic treatment only)	80%		DENIS pre-authorisation compulsory. Subject to Denis protocols, Managed Care interventions and Scheme Rules. Exclusions apply in terms of Scheme Rules.

DENTISTRY			
Maxillo-facial and oral surgery	100%		Subject to DENIS protocols, Managed Care interventions and Scheme Rules. Exclusions apply in accordance with Scheme Rules.
Surgery in dental chair	100%		DENIS pre-authorisation not required. Temporo-Mandibular Joint (TMJ) therapy limited to non-surgical intervention / treatment. Claims for oral pathology procedures (cysts, biopsies and tumour removals) only covered if supported by a laboratory report confirming diagnosis.
Surgery in-hospital (general anesthesia)	100%		DENIS pre-authorisation compulsory. (See Hospitalisation below.)
Hospitalisation and anesthetics			Subject to DENIS protocols, Managed Care interventions and Scheme Rules. Exclusions apply in accordance with Scheme Rules.
Hospitalisation (general anesthesia)	100%		R1 560 co-payment per hospital admission. DENIS pre-authorisation compulsory. Removal of impacted teeth and for children under the age of 5 years for extensive dental treatment.
Laughing gas in dental rooms	100%		DENIS pre-authorisation not required.
IV conscious sedation in dental rooms	100%		DENIS pre-authorisation compulsory. Limited to extensive dental treatment.

PAY ALL DENTAL CO-PAYMENTS DIRECTLY TO THE RELEVANT SERVICE PROVIDER

CHRONIC BENEFITS	MST(≤)	BENEFIT	EXPLANATORY NOTES / BENEFIT SUMMARY
CHRONIC MEDICATION			
Category **A** (CDL)	100%		Unlimited – subject to reference pricing and protocols. Registration on Chronic Disease Programme compulsory.
Category **B** (other)	90%		Additional 3 non-PMB/CDL conditions (Acne/ADHD or ADD/Rhinitis) for children up to the age of 21. (Co-payment payable directly to the service provider involved.)

SUPPLEMENTARY BENEFITS	MST(≤)	BENEFIT	EXPLANATORY NOTES / BENEFIT SUMMARY
PSYCHIATRIC TREATMENT	100%	R18 700	Pfpa. Pre-authorisation compulsory and subject to Case Management. In-hospital benefit only. Out-of-hospital: PMB entitlement.
BLOOD TRANSFUSION	100%		Unlimited. Pre-authorisation compulsory.
PROSTHETICS / PROSTHESIS (Internal, external, fixation devices and implanted devices)	100%	R6 000	Pfpa. Pre-authorisation compulsory and subject to Case Management, reference pricing, DSP and Scheme Protocols.
DOCUMENT BASED CARE (DBC) (Back and neck)	100%		Conservative back and neck treatment in lieu of surgery. Pre-authorisation compulsory and subject to Case Management and Scheme Protocols at approved DBC facilities.
HIV/AIDS	100%		Unlimited. Chronic Disease Programme, managed by Lifesense, applicable.
AMBULANCE SERVICES	100%		DSP – NETCARE 911. Unlimited, subject to use of DSP and protocols. (20% co-payment at non-DSP service provider.)
MEDICAL APPLIANCES			
Wheelchairs, orthopaedic appliances and incontinence equipment (incl. contraceptive devices).	100%	R7 100	Pfpa. Combined in- and out-of-hospital benefit, subject to quantities and protocols. No pre-authorisation required.
Oxygen/nebulizer/glucometer			Pre-authorisation compulsory and subject to protocols.
Hearing aids and maintenance (batteries included)			Subject to medical appliances benefit.
ENDOSCOPIC PROCEDURES (SCOPES)	100%		
Colonoscopy and/or gastroscopy			Pre-authorisation compulsory. No co-payment if done in DSP hospital, out-of-hospital and in the case of PMB conditions.
All other endoscopic procedures			Pre-authorisation compulsory. No co-payment if done in DSP hospital, out-of-hospital and in the case of PMB conditions.

MONTHLY CONTRIBUTION			
	Principal Member	Adult Dependant	Child Dependant
Monthly contribution	R3 474	R1 869	R724

***Members only pay for a maximum of 3 Child Dependants.**

HEALTH BOOSTER

The Health Booster provides additional benefits to Members at no extra cost. It is aimed at preventive treatment and therefore also gives access to free screening tests.

Only those benefits stated in the Benefit Structure under Health Booster will be paid by the Scheme, up to a maximum rand value which is determined according to specific tariff codes.

QUALIFICATION:
Members qualify automatically for Health Booster benefits according to the set criteria.

- However, pre-authorisation is required in order to access the Maternity benefits on Health Booster. Contact the Client Service Centre on **0860 671 050** to obtain authorisation. (Failing to do this will result in the service costs being deducted from day-to-day benefits.)
- Verify the tariff code or maximum rand value with the Call Centre consultant.
- Inform the service provider involved accordingly.

SCREENING TESTS:
One of the benefits available on the Health Booster programme is the Health Assessment. This assessment comprises the following screening tests:

- Body Mass Index (BMI)
- Blood sugar (finger prick test)
- Cholesterol (finger prick test)
- Blood pressure (systolic and diastolic)
- Prostate Phlebotomy for PSA test

Principal members and their Adult dependants will be entitled to one Health Assessment per calendar year and can have the screening tests done at any pharmacy.

A Health Assessment (HA) form can be obtained at any pharmacy or downloaded from **www.keyhealthmedical.co.za.**

No authorisation is required for these screening tests.

Results can be submitted by either the Member or the service provider and must be faxed to **0860 111 390**.

TYPE OF TEST	WHO & HOW OFTEN
PREVENTIVE CARE	
Baby immunisation	Child dependants aged ≤6 – as required by the Department of Health.
Flu vaccination	All beneficiaries.
Tetanus diphtheria injection	All beneficiaries – as and when required.
Pneumococcal vaccination	All beneficiaries.
Malaria medication	All beneficiaries – R360 once per year.
HPV vaccination	Female beneficiaries aged ≤9-14 – 2 doses per lifetime.
Baby growth assessments	3 baby growth assessments at a pharmacy/baby clinic for beneficiaries aged between 0 – 35 months – per year.
EARLY DETECTION TESTS	
Pap smear (Pathologist)	Female beneficiaries aged ≥15 – once per year.
Pap smear (including consultation and pelvic organs ultrasound; GP or Gynaecologist)	Female beneficiaries aged ≥15 – once per year.
Mammogram	Female beneficiaries aged ≥40 – once per year.
Prostate specific antigen (PSA) (Pathologist)	Male beneficiaries aged ≥40 – once per year.
HIV/AIDS test (Pathologist)	Beneficiaries aged ≥15 – once per year.
Health Assessment (HA): Body mass index, Blood pressure measurement, Cholesterol test (finger prick), Blood sugar test (finger prick) PSA (finger prick)	Adult beneficiaries – once per year.
WEIGHT LOSS*	
Weight Loss Programme	For all beneficiaries when the Health Assessment BMI is ≥ 30: • 3 x dietician consultations (one per week). • 3 x additional dietician consultations (one per week, provided that a weight loss chart was received from dietician proving weight loss after first three weeks). • One biokineticist consultation (to create a home exercise programme for the member). • 1 x follow-up consultation with biokineticist.
MATERNITY*	
Antenatal visits (GP, Gynaecologist or midwife) & urine test (dipstick)	Female beneficiaries. Pre-notification of and pre-authorisation by the Scheme compulsory. 12 visits.
Ultrasounds (GP or Gynaecologist) – one before the 24th week and one thereafter#	Female beneficiaries. Pre-notification of and pre-authorisation by the Scheme compulsory. 2 pregnancy scans.
Short payments/co-payments for services rendered in (#) above and birthing fees	Covered to the value of R1 120 per pregnancy.
Paediatrician visits	Baby registered on Scheme. 2 visits in baby's 1st year.
Ante-natal vitamins	Covered to the value of R1 890 per pregnancy.
Ante-natal classes	Covered to the value of R1 890 for first pregnancy.
*Pre-authorisation essential to access benefits	

GLOSSARY

Agreed Tariff	A tariff agreed to from time to time between the Scheme and service providers, e.g. hospital groups.
Chronic Disease List (CDL)	A list of chronic illness conditions that are covered in terms of legislation.
Day-to-day benefit	A combined out-of-hospital limit which may be used by any beneficiary in respect of general practitioners, specialists, radiology, optical, pathology, prescribed medicine and auxiliary services, and which may include a sub-limit for self-medication.
DENIS (Dental Information Systems)	A service provider contracted by the Scheme to manage dental benefits on behalf of the Scheme according to protocols.
Designated Service Provider (DSP)	A provider that renders healthcare services to members at an agreed tariff and has to be used to qualify for certain benefits.
Emergency	An emergency medical condition means the sudden and unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.
Health Booster	An additional benefit for preventive health care.
Medical Scheme Tariff (MST)	Also referred to as KeyHealth tariff. A set of tariffs the Scheme pays for services rendered by service providers.
Optical Management	A cost and quality Optical Management programme provided by Opticlear.
Phlebotomy	The process of making an incision in a vein when collecting blood.
Physical Trauma	A severe bodily injury due to violence or an accident, e.g. gunshot, knife wound, fracture or motor vehicle accident. Serious and life-threatening physical injury, potentially resulting in secondary complications such as shock, respiratory failure and death. This includes penetrating, perforating and blunt force trauma.
OTC	Over-the-counter (medicine or glasses)
MSA	Medical Savings Account
Medicine on discharge	Medicine given to members upon discharge from a hospital. Does not include medicine obtained from a script received upon discharge.
pbpa	per beneficiary per annum (per year)
pbp2a	per beneficiary biennially [every 2 (second) year(s)]
pfpa	per family per annum (per year)
pfp2a	per family biennially [every 2 (second) year(s)]
2pfpa	2 per family per annum (per year)