Discovery
Health Medical Scheme

FREQUENTLY ASKED QUESTIONS

DISCOVERY HEALTH MEDICAL SCHEME

HEALTH LAUNCH 2024 | CONTRIBUTION INCREASE, BENEFIT AND PRODUCT UPDATES

CONTRIBUTIONS

Technical questions relating to the contribution increase strategy

1. What factors informed Discovery Health Medical Scheme (DHMS) weighted average increase of 7.5% for 2024?

The DHMS contribution increase for 2024 has been set with consideration of the following three principles:

1. Risk contributions must increase with medical inflation
2. Risk contribution increases need to allow for variable plan-level utilisation experience
3. Gross contribution increases must maintain affordability in growing and most popular plan ranges

Risk contributions must increase with medical inflation

In 2024, healthcare claims paid by the Scheme are expected to increase in line with medical inflation, and the Scheme would need to increase contributions accordingly, to ensure that contributions received continue to match claims paid.

Medical inflation in any year is informed by:

- Tariff inflation which is the increase in the cost of healthcare services linked to the Consumer Price Index (CPI)
- Demand-side utilisation which is driven by an increase in the disease burden or demand for healthcare services from the members of Discovery Health Medical Scheme
- Supply-side utilisation changes as a result of increases in the supply of healthcare services

The demand-side utilisation is impacted by the following unique factors experienced in 2023:

- Increased levels of adverse selection as a result of the challenging economic climate that members are facing. Typically, during periods of high inflation and high interest rates the Scheme experiences a higher level of selection, with new lives claiming more on average and withdrawing lives claiming less than average when compared to other periods.
- The ongoing cost of COVID-19, related to the testing, treatment and hospitalisation for COVID-19, is expected to continue and needs to be accounted for in the anticipated medical inflation for 2024. In 2019, the Scheme did not have any COVID-19 claims. 2023 is the first year since the pandemic began that the Scheme is able to estimate what the expected ongoing cost of COVID-19 is that needs to be budgeted for. Once these COVID-19 costs have been included in the budget, the costs are expected to increase with medical inflation in the future, similarly to all other healthcare services paid by the scheme,

Risk contribution increases need to allow for variable plan-level utilisation experience

Utilisation experience has varied across different benefit options on DHMS in 2023. As a result, projected medical inflation is different for 2024, depending on the plan.

Risk contribution increases need to account for the plan-specific medical inflation. On 1 January 2024, risk contributions will increase by:

- 12.9% on the Executive plan and Coastal plans
- 11.9% on Classic Comprehensive
- 10.9% on KeyCare Plus
- 9.9% for all other KeyCare plans (excluding KeyCare Plus), Priority, Core and Saver plans (excluding Coastal)
- 8.9% for Smart plans (excluding Essential Dynamic Smart and Classic Smart Comprehensive)

Gross contribution increases must maintain affordability in growing plan ranges

Economic pressures from rising interest rates, stagnant growth and high levels of consumer price inflation have placed substantial financial strain on affordability for members in 2024.

After careful consideration of the current economic climate, DHMS aims to optimise affordability for its member by reducing the Medical Savings Account (MSA) contributions on the Saver series in 2024. As a proportion of total contributions, the MSA allocation will reduce from:

- 25% to 20% for Classic Saver and Classic Delta Saver
- 20% to 15% for Coastal Saver
- 15% to 10% for Essential Saver and Essential Delta Saver

After accounting for the reduction in MSA allocations for the Saver series, on 1 January 2024, gross contributions (total contributions including the contribution to the MSA) will increase by:

- 12.9% on the Executive plan and Coastal Core
- 11.9% on Classic Comprehensive
- 10.9% on KeyCare Plus
- 9.9% for all other KeyCare plans (excluding KeyCare Plus), Priority and Core
- 8.9% on Smart plans (excluding Essential Dynamic Smart and Classic Smart Comprehensive)
- 6.3% on Coastal Saver
- 3.8% on Essential Saver and Essential Delta Saver
- 3.0% on Classic Saver and Classic Delta Saver

Essential Dynamic Smart will have no increase for 2024 and Classic Smart Comprehensive will have an 11.9% risk contribution increase as well as the addition of a 15% MSA which impacts total contributions by 32%.

39% of Discovery Health Medical Scheme members will experience a gross contribution increase of under 5% in 2024 with a total of 73% of members experiencing a gross contribution increase under 10%.

2. Why is the contribution increase in 2024 different across different DHMS plan series?

The differentiated increase across plans takes into account the higher demand-side inflation experienced across the Executive, Comprehensive, Coastal and KeyCare Plus plans. The rate of change in the average age and the chronic ratio on these plans are higher than other plans on DHMS, which results in higher levels of utilisation on these plans in 2023.

As a result, projected medical inflation is varied for different benefit options for 2024 and the 2024 contribution increase needs to match the varying levels of medical inflation.

3. Why is the risk contribution increase and the gross contribution increase different for the Saver series?

The Scheme is required to increase risk contributions in-line with medical inflation. For the Saver series, medical inflation for 2024 is expected to be 9.9% and therefore risk contributions for the Saver series need to increase by 9.9%.

In an attempt to support the affordability for members, particularly in the growing and popular Saver series, MSA allocations have been reduced.

As a result, total contributions increase by lower than 9.9%. Practically, the effect on a principal member contribution is as follows:

- For Classic Saver, risk contributions increase from R3 045 to R3 347 (an increase of 9.9%). The contribution to the MSA decreases from R1 015 to R835. The total contribution increases from R4 060 to R4 182 (an increase of 3.0%)
- For Classic Delta Saver, risk contributions increase from R2 433 to R2 674 (an increase of 9.9%). The contribution to the MSA decreases from R811 to R668. The total contribution increases from R3 244 to R3 342 (an increase of 3.0%)
- For Coastal Saver, risk contributions increase from R2 577 to R2 911 (an increase of 12.9%). The contribution to the MSA decreases from R643 to R512. The total contribution increases from R3 220 to R3 423 (an increase of 6.3%)
- For Essential Saver, risk contributions increase from R2 744 to R3 017 (an increase of 9.9%). The contribution to the MSA decreases from R483 to R334. The total contribution increases from R3 227 to R3 351 (an increase of 3.8%)
- For Essential Delta Saver, risk contributions increase from R2 189 to R2 407 (an increase of 9.9%). The contribution to the MSA decreases from R385 to R266. The total contribution increases from R2 574 to R2 673 (an increase of 3.8%)

BENEFIT CHANGES

Technical questions relating to changes to the DHMS Comprehensive series

1. Which plans will be available on the DHMS Comprehensive series in 2024?

The Comprehensive plan range is being realigned in 2024 in order to simplify the fragmented Comprehensive series, to provide plans with the appropriate level of healthcare cover to meet the needs of members at the appropriate price. In 2023, 87% of Comprehensive lives are on the Classic Comprehensive plan with only 13% on other Comprehensive plans.

The Comprehensive plan range will be consolidated into two options, Classic Comprehensive and Classic Smart Comprehensive. This enables a competitive plan with the extensive day-to-day cover that the Comprehensive series is known for, as well as a more affordable price point, in the extensive day-to-day range, with the Classic Smart Comprehensive plan.

2. What will happen to members who currently belong to Classic Delta Comprehensive, Essential Comprehensive or Essential Delta Comprehensive?

Members who are currently on Essential Comprehensive, Classic Delta Comprehensive or Essential Delta Comprehensive will be defaulted to one of the two Comprehensive plans on 1 January 2024 unless they choose an alternative plan before 1 January 2024.

Default strategy

- The default strategy aims to preserve benefits as appropriate, based on the following criteria:
- Members who have claimed from the Oncology Benefit or the SMTB during 2023 or are registered for an illness on the ADL will be defaulted to the Classic Comprehensive option for 2024.
- Members who have not claimed from these benefits and are not registered for an illness on the ADL and have used the Smart network will be defaulted to the Classic Smart Comprehensive option for 2024.
- All other members will be defaulted to the Classic Comprehensive option for 2024.
- All defaults will be effective 1 January 2024.
- Members who are defaulted to Classic Comprehensive or Classic Smart Comprehensive on 1 January 2024 will have the opportunity to change their plan until 31 March 2024, including the option to upgrade their plan choice.

Member communication

- Members will be informed of the change during early November 2023.
- Members will be informed that they have until 31 December 2023 to choose a different plan on Discovery Health Medical Scheme in consultation with their appointed broker.

Adviser support

- Adviser reports with a list of impacted clients have been distributed, including details of the associated employer for each client.

3. What enhancements have been made to the Classic Smart Comprehensive plan?

In 2024, the Classic Smart Comprehensive plan has been enhanced in order to retain a more affordable price point in the Comprehensive series.

Addition of a 15% Medical Savings Account (MSA)

In 2024, an MSA (at 15% of total contribution) will be included on the Classic Smart Comprehensive plan to enhance the day-to-day offering. The MSA offers members more choice and flexibility in respect of their day-to-day healthcare expenses. The addition of the MSA impacts total contributions by 32% and affects 400 DHMS policies that are currently on the plan.

Unlimited Smart GP visits

The Classic Smart Comprehensive plan will retain the Smart GP benefit with unlimited GP consultations, at a GP in the Smart network, with a R65 co-payment. The MSA can be used to fund the co-payment to ensure a seamless experience at point of service.

Introduction of a fair usage limit on the Above Threshold Benefit (ATB)

To align with the changes to the Classic Comprehensive plan, a limit on the ATB will be introduced. The limit in 2024 will be:

- R30 000 for the principal member
- R30 000 for each spouse or adult dependant
- R7 500 for each child (maximum of three children considered when calculating the ATB)

Reduction of the child dependant contribution rate
The child dependant contribution rate on Classic Smart Comprehensive will be reduced by 17.9% to align with the child dependant contributions on the Classic Comprehensive plan.

All the above enhancements will be effective on 1 January 2024.

4. What changes have been made to the Classic Comprehensive plan?

Fair usage limit on the Above Threshold Benefit (ATB) introduced on Classic Comprehensive
A fair usage limit on the ATB is being introduced in order to maintain the value of Classic Comprehensive and effectively manage wasteful healthcare expenditure. The limit in 2024 will be:

- R35 000 for the principal member
- R35 000 for each spouse or adult dependant
- R8 500 for each child (maximum of three children considered when calculating the ATB)
- 97% of Comprehensive policies will be unaffected by this fair usage limit.

50% co-payment for a defined list of oncology drugs on the Oncology Innovation Benefit
Claims for oncology drugs specified on a defined list as part of the Oncology Innovation Benefit will have a co-payment of 50% applied for Classic Comprehensive members. All other drugs that form part of the Oncology Innovation Benefit but fall outside of the defined list will maintain a 25% co-payment.

99.5% of Comprehensive policies will be unaffected by this co-payment increase.

5. How will members who are currently claiming for the Oncology Innovation Benefit be impacted by the increased co-payment?

Members who are accessing one of the drugs on the defined list in 2023 as part of their current approved treatment plan will be grandfathered. The approved treatment plan will be unaffected into 2024.

The new funding rule for these drugs will only apply for new treatment plans approved from 1 January 2024.

6. What changes have been made to the Executive plan?

No changes have been made to the Executive plan. The ATB on the Executive plan will remain unlimited in 2024. The Oncology Innovation Benefit will also not be impacted by the increased co-payment and all drugs on the Oncology Innovation Benefit will remain at a 25% co-payment for Executive members.

Technical questions relating to changes to the DHMS Saver series

1. How will the Medical Savings Account (MSA) allocations on DHMS be impacted in 2024?

MSA allocations for the Executive, Comprehensive and Priority plans will remain unchanged for 2024. The MSA will increase in-line with the risk contribution increases:

- The MSA on the Executive plan will increase by 12.9%
- The MSA on the Classic Comprehensive plan will increase by 11.9%
- The MSA on the Priority plans will increase by 9.9%

The MSA allocations for the Saver series will be reduced in 2024. As a proportion of total contributions, the MSA allocation will reduce from:

- 25% to 20% for Classic Saver and Classic Delta Saver
- 20% to 15% for Coastal Saver
- 15% to 10% for Essential Saver and Essential Delta Saver

2. How are members impacted by the reduction in MSA allocations?

Members will be in a net neutral or positive position after the MSA reduction. An illustrative example of the impact can be seen with the following two case studies:

a. For members who are currently claiming more than the annual MSA:

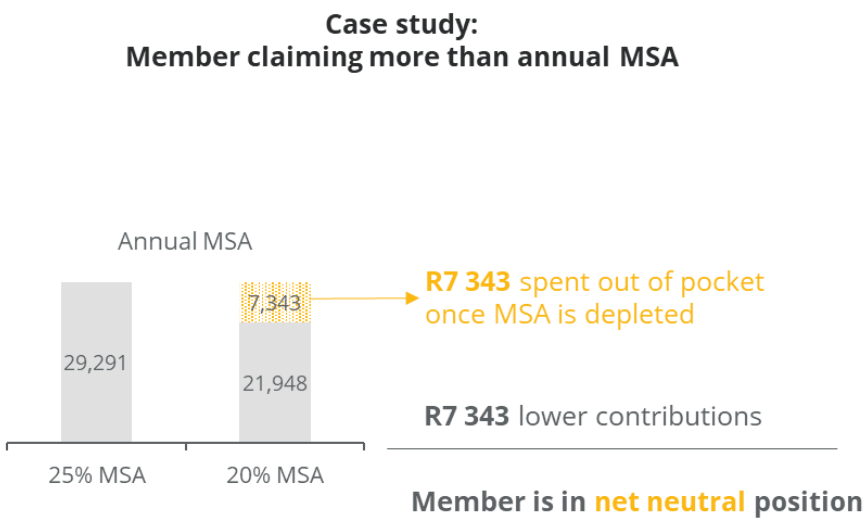
SCENARIO 1: RETAINING THE MSA AT 25%

- If the MSA allocation was retained at 25% for Classic Saver, the annual MSA for a family (one principal member, one spouse and one child) would be R29 921.
- This policy claims a total of R29 921 for their day-to-day expenses and therefore uses their full allocation of MSA of R29 921.
- The annual contributions for this policy amount to R117 215 (R9 768 x 12).

SCENARIO 2: REDUCING THE MSA TO 20%

- The new MSA allocation at 20% for Classic Saver results in an annual MSA for a family (one principal member, one spouse and one child) of R21 948.
- This policy claims a total of R29 921 for their day-to-day expenses. With the lower MSA, the family will pay R7 343 out of pocket for the healthcare services that are now not covered by the MSA.
- The annual contributions for this policy amount to R109 884 (R9 157 x 12). This is R7 343 lower than the total contributions for scenario 1 (R117 215 – R109 884 = R7 343).

This family pays R7 343 out of pocket as a result of the reduction in MSA, but they save R7 343 in total contributions as a result of the lower contribution increase. Members who claim more than the current annual MSA will be in a net neutral position.



b. For members who are currently claiming less than the annual MSA:

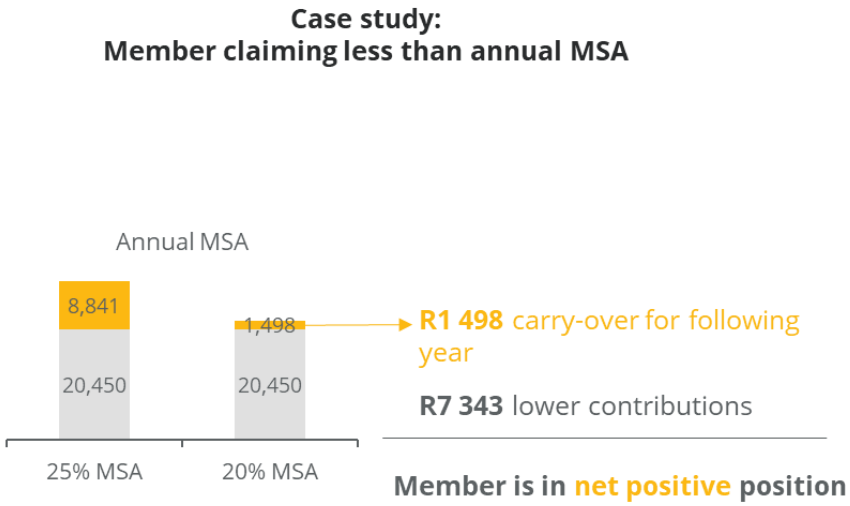
Scenario 1: retaining the MSA at 25%

- If the MSA allocation was retained at 25% for Classic Saver, the annual MSA for a family (one principal member, one spouse and one child) would be R29 921.
- This policy claims a total of R20 450 for their day-to-day expenses and therefore would carry-over additional MSA of R8 841 to the following year.
- The annual contributions for this policy amount to R117 215 (R9 768 x 12).

Scenario 2: reducing the MSA to 20%

- The new MSA allocation at 20% for Classic Saver results in an annual MSA for a family (one principal member, one spouse and one child) of R21 948.
- This policy claims a total of R20 450 for their day-to-day expenses. With the lower MSA, the family will still have left over savings but at a lower amount of R1 498 to carry-over to the following year.
- The annual contributions for this policy amount to R109 884 (R9 157 x 12). This is R7 343 lower than the total contributions for scenario 1 (R117 215 – R109 884 = R7 343).

This family has a lower carry-over in MSA as a result of the reduction in MSA, but they save R7 343 in total contributions as a result of the lower contribution increase. Members who claim less than the annual MSA will be in a net positive position due to the lower contribution increase.



3. Is the reduction in the MSA allocation temporary?

The reduction in MSA is not temporary. In order to increase the MSA allocation in future, a contribution increase above medical inflation would be required which would negatively impact the affordability constraints of members. The MSA allocations will remain at these levels for the foreseeable future.

Technical questions relating to nomination of a primary care GP to manage PMB chronic conditions

1. Why is it necessary for a member to nominate a single/primary GP to manage all PMB chronic conditions?

Primary care GPs manage the day-to-day healthcare needs of members. A patient's primary care GP will establish their health history, conduct screening and prevention tests, coordinate specialist referrals where necessary, and make recommendations to improve health and wellness. This continuum and coordination of care is particularly important for the effective management of complex health conditions.

Both internal and international research show clear evidence that an established relationship with a single primary care GP improves the long-term health outcomes of members managing chronic conditions. These efficiencies arise through the provision of an efficient and consistent access point to the healthcare system, with better management and coordination of care. According to a recent World Health Organisation report, patients have a preference to see a single provider for coordinated care and place greater value on seeing a provider they know and trust. Patients who saw the same doctor recorded 13% fewer hospital admissions and 27% fewer visits to the emergency department, substantially improving the quality of care for members with complex healthcare needs.

Based on the significant opportunity to improve health outcomes, from 2024, all members registered for Prescribed Minimum Benefit (PMB) chronic conditions will be required to nominate a primary care network GP for the management of their chronic illnesses.

2. Do all DHMS members need to nominate a primary care GP?

All members registered for PMB chronic conditions, with the exception of those on the Executive plan, will need to nominate a primary care GP to access full cover for consultations associated with their chronic condition.

3. What will happen if a member does not nominate a GP or visits any GP other than their nominated GP?

Should a member with a registered chronic condition opt not to nominate a primary care network GP, or should a member voluntarily choose to consult a GP other than their nominated network GP, the Scheme will cover the GP consultation at 80% of the Discovery Health Rate from 1 January 2024. No co-payment will be required in the event of an emergency or involuntary use of a non-designated service provider. Members who have nominated a primary care GP will have access to one GP consultation at a network GP who is not their nominated GP, without any co-payment.
Members receive full cover for GP consultations for their chronic conditions at their nominated primary care network GP.

4. What benefits will be subject to a 20% co-payment if the nominated primary care GP is not consulted?

The 20% co-payment will only apply to consultations relating to the management of the member's chronic condition.
Cover for prescribed chronic medicine, chronic illnesses managed by specialists, or consultations relating to acute conditions, will not be impacted by a member visiting a non-nominated primary care GP and will continue to be covered subject to the member's chosen plan.

5. Does the nomination of a primary GP need to take place for both Chronic Disease List (CDL) and Additional Disease List (ADL) conditions?

Members are required to nominate a primary GP for the treatment of Chronic Disease List and OH DTP-PMB chronic conditions. While no co-payment will be incurred for consultations and referred services for non-PMB ADL conditions with GPs outside of the Discovery GP network, members are strongly encouraged to use the same GP to treat and manage all their chronic conditions.

6. Will members be allowed to nominate any primary care GP to manage their PMB chronic conditions?

Affected members will need to nominate a GP participating in the Discovery Health GP Network or nominated Network GP, depending on the member's chosen health plan, for full cover to treat all PMB chronic conditions. Members will be able to nominate a non-network GP however, a 20% co-payment will be applied to consultations relating to the management of the member's chronic condition.
KeyCare members must use their nominated KeyCare network GP and members on the Smart plans must make use of a Smart network GP.

7. How does the Premier Plus GP Network and the Discovery Health GP Network differ for management of all chronic conditions?

A Premier Plus GP remains the point of contact for enrolment on the Chronic Illness Benefit Programme. All Premier Plus GPs form part of the Discovery Health GP network, enabling members to be both enrolled and treated by their Premier Plus GP. In order to ensure members have access to efficient and consistent management of their chronic conditions, it was necessary to expand this network beyond Premier Plus GPs to participating GPs on the Discovery GP network. Members therefore have access to a wider selection of network GPs to manage their chronic conditions.

Members who currently have their chronic condition managed via a specialist as the care coordinator, will not be impacted and can continue to access their specialist benefits and chronic basket of care via the managing specialist, subject to benefit and plan limits.

8. How does a member nominate a primary care GP?

Members will be able to nominate a primary care GP on the new Discovery app or on the Discovery website:

- Members that have visited a network GP before will simply be asked to confirm the nomination of their GP.
- Members that have not visited a network GP before will be able to search for a GP in their area and are then able to nominate their primary care GP.

Members are also able to nominate their GP through the Discovery call centre or their chosen network GP.
As part of the Scheme's year-end communication, impacted members will be receiving additional information regarding the process to nominate and change their nominated primary GP.

9. Can different beneficiaries on the same health policy nominate a different primary GP to treat their individual chronic conditions?

Yes.

10. Can a member select a medical practice or group instead of one primary GP for the treatment of their PMB chronic conditions?

Yes, provided the medical practice is part of the network.

11. Will a member be able to change their nominated doctor?

Yes, a member will have the option to change their nominated GP three times per year.

12. How will a member's cover be affected if they are travelling and cannot access their primary GP?

Members who have nominated a GP will be allowed one GP consultation at a GP who is not their nominated GP. For full cover members must ensure this visit is still to a network GP. KeyCare members who have not nominated a KeyCare Primary GP will be part of the KeyCare out-of-area clinic visit.

Technical questions relating to the introduction of the home-based hospital network

1. Why is there a drive towards hospital-level care being provided in a home-setting?

Home-based hospital care is a global trend that is improving efficiency, convenience and quality of hospital-level care that can be delivered in a patient's home.

In 2021, Discovery launched Discovery Hospital at Home to provide patients with home-based hospital care for conditions that can safely and effectively be treated while the patient remains in the comfort of their home. The experience to date has shown that hospital-level care can be delivered safely in a home-setting for a range of clinically appropriate conditions, with similar or superior outcomes compared to traditional in-hospital care.

Based on the success of home-based hospital care globally and in South Africa, Discovery Health Medical Scheme will introduce the Home-based Hospital Network in 2024 as a designated service provider for a limited number of low acuity conditions on the KeyCare, Smart and Delta plans. This network includes Discovery Hospital at Home, Mediclinic at Home and Quro Medical.

2. Who is eligible for treatment in the Home-based Hospital Network?

All eligible DHMS members have access to Hospital@Home. Members on KeyCare, Smart and Delta plans who meet the condition and patient eligibility criteria, will need to be admitted to the Home-based Hospital Network instead of being admitted to a hospital.

Patients eligible for treatment

Members need to meet the following criteria to be eligible for home-based care:

- Be an adult member (18 years or older)
- Need hospital-level care that can be given in a general ward
- Live within 30 kilometres of a hospital with an emergency room (casualty unit)
- Live in Cape Town, Durban, Pietermaritzburg, Johannesburg or Pretoria
- Have enough family support to be safe at home (cannot live alone)
- Have running water within the home
- Have electricity within the home

Conditions eligible for treatment

A member can only be admitted into the Home-base Hospital Network if they require an admission for one of the following low-acuity (non-life threatening) conditions:

- Pneumonia
- Diabetes
- Chronic obstructive pulmonary disease
- Deep vein thrombosis

- Asthma
- Cellulitis
- Stable heart failure
- Urinary tract infection

Patients meeting the above eligibility criteria will not be eligible for home-based treatment if their condition meets any of the exclusion criteria or condition specific criteria. For example, if a member is pregnant or needs critical care, they cannot be treated at home.

For more details on the eligibility criteria and exclusion list, **click here**.

3. How is a patient's home deemed suitable for home-based hospital care?

There are upfront social criteria questions to screen for suitability of the patient's home before admission. When the admission is approved, the suitability is subject to ongoing assessment performed by the nurse at each visit (including water supply interruption and food insecurity). If at any point the nurse is concerned that the home is not suitable, they can make a recommendation to the doctor to transfer the patient to hospital.

4. How does a member get admitted into a network facility in the Home-based Hospital Network?

If the patient meets all of the above eligibility criteria, they can be admitted into the Home-based Hospital Network through presenting at casualty or the doctor's rooms (GP or specialist), as well as following early discharge from hospital.
Treating providers will be notified by Discovery through HealthID and pre-authorisation that a patient is eligible for treatment in the Home-based Hospital Network. As home-based care becomes more familiar to treating providers (through engagement and training sessions hosted by Discovery), the treating doctor will become responsible for referral into the Home-based Hospital Network.
At the time of pre-authorisation, treating doctors will be able to choose which network facility their patient will be admitted into, including Discovery Hospital at Home, Mediclinic at Home or Quro Medical

5. What happens if eligible members or treating doctors opt out of home-based hospital care?

From 1 January 2024, for those on KeyCare, Smart and Delta plans where home-based hospital care is the DSP, should the patient and admitting doctor opt-out of home-based care where the eligibility criteria has been met, a deductible of R5,000 will apply.

Given that home-based hospital care is still a relatively new concept for most members, DHMS will be lenient in applying the deductible initially in cases where members and doctors are certain that they would prefer treatment in-hospital. Home-based care has been proven to improve both patient experience and clinical outcomes, and thus DHMS will be strongly encouraging members to use home-based care when they are eligible.

6. Is there a difference in funding for home-based hospital care compared to traditional hospital admissions?

Funding for services provided in the Home-based Hospital Network will be the same as for traditional hospital admissions. All services offered within the Home-based Hospital Network fund from the member's Hospital Benefit on all DHMS plans where there is a valid pre-authorisation in lieu of hospitalisation. The pre-authorisation unlocks risk-based funding for approved devices and healthcare services for members who meet the clinical and benefit criteria.

7. How are patients treated for their condition from their home?

Care coordination and home set-up:
Within two to four hours of admission, a home monitoring kit is delivered to the patient, which includes:

- A wearable monitoring device
- Blood pressure cuff and pulse oximeter
- UPS backup for charging devices
- A smartphone with a dual sim and preloaded data.

The assigned nurse assists the patient with setting up the monitoring devices and conducts an assessment of the patient.

Live monitoring, clinical services, and consultations

- The patient's condition is monitored 24/7, through a secure dashboard, by their treating healthcare provider, their dedicated nurse and a team of clinicians in the ER Consulting clinical command centre.
- Blood samples are taken to track how the patient is responding to treatment and the patient's treating doctor receives a notification when the results are shared from the lab.
- The patient receives daily visits from their treating nurse and conducts daily online consultations with their physician to track their progress.

Discharge:

If the patient is responding well to treatment and is well enough, the patient is discharged from home-based care. The nurse will assist with delivery of take-home medicine and discharge planning services.

8. How is the Home-based Hospital Network equipped to deal with power disruptions due to loadshedding?

The home-based hospital facilities are adequately equipped to deal with loadshedding through:

- Wearable devices that have a battery life of 18 - 20 hours, with a 90-minute fast charge. Both patients and their care team will get alert notifications when the battery is running low to ensure batteries are kept fully charged.
- Smartphone with two sim cards that allow patients to roam across multiple networks if the signal is unstable during loadshedding.
- Portable UPS power backup, that is supplied for the duration of the admission, allows for monitoring devices to be charged when the battery is low.
- If the patient's data sync is erratic, they can be assigned extra nurse visits to ensure patient stability.

9. Who is liable if the home monitoring kit is damaged or stolen?

If the home monitoring kit is damaged or stolen, the member will not be held liable for the cost of or replacing the kit.

Technical questions relating to changes to the KeyCare Series

1. What changes have been made to the KeyCare series in 2024?

KeyCare GP Benefit:

Following global best practices and in line with the Scheme's commitment to improving quality of care through better care coordination, all KeyCare members will be required to nominate a single primary care GP for 2024. In alignment with the Scheme's care coordination strategy, the following changes will be implemented across the KeyCare series from 1 January 2024:

- Primary GP nomination: KeyCare Plus members will no longer have cover for secondary GP consultations, with all day-to-day healthcare needs being addressed and coordinated by one nominated primary GP.
- Out-of-network consultations: Out-of-network GP consultations for KeyCare Plus, KeyCare Start and KeyCare Start Regional members will be replaced with one annual consultation with a network nurse or healthcare provider at a network pharmacy clinic. Members will be referred for a virtual consultation with a GP or an in-person consultation where needed.

Exclusion list:

The following procedures have been added to the KeyCare series exclusion list:

- Tonsillectomies
- Myringotomies
- Adenoidectomies

Cover will be provided for these procedures in the case of emergencies or Prescribed Minimum Benefit treatment.

KeyCare Hospital Network:

For the purpose of maintaining the highest quality of care, ensuring efficient healthcare delivery and delivering value for members, the following changes have been made to the KeyCare Hospital Network:

Changing from partial cover to full cover network status

- Gauteng: Zuid-Afrikaans Hospital
- KZN: Lenmed Shifa Hospital and Midlands Medical Centre

Changing from full cover network to no network status

Province	Hospital changed	Nearest hospital
Gauteng	Mediclinic Muelmed	Mediclinic Medforum (1km)
Western Cape	Netcare Kuilsriver Hospital	Mediclinic Louis Leopoldt (7km)
Western Cape	Netcare Christiaan Barnard Hospital	Netcare UCT Medical Centre (6km) Rondebosch Medical Centre (10km)

Changing from partial cover network to no network status

Province	Hospital changed	Nearest hospital
Gauteng	Louis Pasteur Hospital	Mediclinic Medforum (300m)
Gauteng	Arwyp Medical Centre	Life the Glynnwood Hospital (19km)

Changing from full cover network to cardiac referral network status only

- KZN: Netcare St Anne's Hospital - nearest hospital is Midlands Medical Centre (1.5km)

2. What options are available for a KeyCare member if they are unable to access their Primary GP?

KeyCare members will be able to change their nominated GP up to three times per year, depending on the member's chosen KeyCare plan. This change will only be effective from the start of the next month.

If a member is unable to change their nominated GP to take effect before needing to see a GP, they can use their out-of-network consultation at a network pharmacy clinic, with referral to a GP if needed.

In cases where the chosen GP is away for a prolonged period (due to illness or being on leave) and there is no reasonable alternative available, a member can apply for the claim to be paid as an exception (without using the out-of-network consultation).

3. Which pharmacies can be used for the KeyCare out-of-network consultation?

KeyCare members can visit an Unjani Clinic or Netclinic, with over 200 clinics located across South Africa.

4. Have there been any other changes to the KeyCare Hospital Network?

There are no other changes to the KeyCare Hospital Network other than those mentioned above. However, a Home-based Hospital Network has been introduced for KeyCare members that meet certain condition and patient eligibility criteria. The intention of this network is to deliver quality, convenient hospital-level care from the comfort of a member's home, when clinically appropriate. For more details on the Home-based Hospital Network, please see the details on **page 9.**
Technical questions relating to changes to chronic illness benefit, specialised medicine and technology benefit, oncology medicine, chronic drug amounts and formularies

5. What are the changes?

- Annual formulary changes and Chronic Drug Amount (CDA) updates will be applied.
- Generic reference pricing will be introduced for Chronic Disease List medicine, where a generic alternative exists.
- Medicine on the formulary list will be funded in full.
- Non-formulary medicine will be funded up to the Discovery Health Rate (DHR) or Generic Reference Price, whichever is applicable subject to the CDA according to the chosen plan type.
- A Therapeutic Reference Price will be introduced on all of the Specialised Medicine and Technology Benefit for biologic therapies.
- From April 2024, generic reference pricing for chemotherapy and supportive oncology medicine will be introduced for all new treatment plan approvals from 2024 onwards, where a generic alternative exists. Oncology approved medicine will be paid up to the maximum of the DHR or Generic Reference Price, whichever is applicable, and subject to the Oncology Threshold.
- These changes will be communicated directly to affected members.

6. How does that impact **members** currently utilising the chronic illness benefit for their medication requirements?

Members will have until the end of 2023 to make changes to their treatment to avoid or reduce co-payments that may result from changes to the formulary and chronic drug amount. Members registering for the chronic illness benefit for the first time in 2024 will have to make use of the new formulary in order to avoid co-payments on their medication.

Technical questions relating to benefit limits, thresholds, co-payments and deductibles

Will all benefit limits increase from 1 January 2024?

- Co-payments and deductibles will be increased by 5.9%, in line with expected consumer price inflation.
- Thresholds for the Above Threshold Benefit on Executive, Comprehensive and Priority options will be increased in line with plan-specific contribution increases.
- Spinal prosthesis limits will be updated per plan, where a non-network supplier is used.
- KeyCare income bands will remain unchanged in 2024.
- On 1 January 2024, all benefit limits will increase by 5.9%, with the following exceptions:
    - Specialised Medicine and Technology Benefit
    - International Travel Benefit
    - Oncology Benefit Thresholds
    - Overseas Treatment Benefit
    - Surgical and appliance items including hip, knee and shoulder joint prosthesis, and external medical appliances.

FREQUENTLY ASKED QUESTIONS

DISCOVERY HEALTH

HEALTH LAUNCH 2024 | BENEFIT AND PRODUCT UPDATES

NEW DISCOVERY HEALTH APP

Technical questions relating to the new Discovery Health app

1. How do members access the new Discovery Health app?

The new Discovery Health app can be access via the below link:
Discovery Health App - Discovery

When logged in to their profile on the current Discovery app or on the website, members will receive a push notification with a link to the new Discovery Health app.

There will also be links to the new Discovery Health app permanently in the current Discovery Corporate app and Discovery Bank app.

2. Who has access to the Discovery Health app?

All members of Discovery Health Medical Scheme and users of any Discovery Health products will have access to the platform.

3. On what devices does the new Discovery Health app run?

The app runs on all devices, including Apple and Android, phones, tablets and laptops.

4. Can the app be downloaded from the Apple or Android app store?

It is a web-based platform, and therefore can be accessed via a web page rather than through an app download. However, for members who prefer a traditional downloadable version, this will be available in the Apple and Android app stores.

5. What are the features of a web-based app?

A web-based app does not require any downloads, and therefore requires less data than a traditional app. The operating updates are also faster, allowing Discovery Health to innovate and constantly improve the app at a faster rate.

6. Does the new Discovery Health app replace the existing Discovery corporate app?

Yes, push notifications will appear on the current Discovery app to move members over to the new platform. Health information will no longer be available on the current app from the end of Q1 2024, however a link will exist to direct members to the new platform.

7. What happens to Connected Care?

The services provided on Connected Care will be migrated to the Discovery Health app. This will be communicated to members as part of year-end communication. The power of the new Discovery Health app is that all programmes and services are now available to members from a single point.

8. Can members access their other Discovery products from the Health app?

Yes, the Discovery Health app offers seamless integration with the other Discovery Health products. These include other health products such as Gap, Flexicare and Trauma cover, as well as other products in the Discovery ecosystem including Bank, Insure and Invest.

Technical questions relating to 'Speak to a doctor now'

1. Where can members access the 'Speak to a doctor now' benefit?

Members can access the panel of dedicated doctors by selecting the 'Speak to a doctor now' option on the 'Get care' tab of the new Discovery Health app.

2. How long does it take to speak to a doctor?

It takes on average only 90 seconds before a member will be able to speak to a doctor for their urgent care needs. The maximum time to connect to a doctor will be no more than 5 minutes.

3. Is the 'Speak to a doctor now' feature the same as emergency care?

No, 'Speak to a doctor now' is for the treatment of non-emergency conditions which typically require medical attention within the next 24 hours.

4. Is the consultation risk funded?

Yes, for all truly urgent care consultations, the consultation will be risk funded.

- DHMS members on all plans, with the except of KeyCare which has different limits, will receive four (4) risk-funded consultation per family per year.
- All KeyCare members will receive one (1) risk-funded consultation per family per year.
- Members on **KeyCare Start Regional** must access urgent care through their existing virtual care pathway (KeyCare Online Practice).

5. Can medicine be ordered for online delivery or does it need to be collected?

Both. Members will be able to order medicine online for delivery, or for in-person collection.

6. What is the consultation fee for non-urgent care?

For all consultations deemed to be non-urgent care, members will be charged R250.

Technical questions relating to Virtual Physical Therapy

1. Where can members access Virtual Physical Therapy?

Virtual Physical Therapy is provided by Discovery Health's partners, Genie Health. Members gain seamless access to the Genie Health platform via the My Health tab on the new Discovery Health app.

2. Is Virtual Physical Therapy a replacement for in-person sessions with healthcare providers?

No, Virtual Physical Therapy is a complementary service to in-person treatments, aimed at enhancing a member's recovery journey through monitoring and support during self-managed rehabilitation.

3. Are members able to have a virtual consultation on Virtual Physical Therapy?

Yes, members can complete a virtual consultation with a healthcare provider on the Genie Health network.

4. Beyond the virtual link to providers, how does Virtual Physical Therapy support recovery?

Through advanced AI technology, the platform monitors how patients complete their rehabilitation exercises in order to provide guidance on the correct form, thereby enhancing patient recovery.

5. Who can access Virtual Physical Therapy?

All DHMS members 18-years and older have access to Virtual Physical Therapy, via the Discovery Health app.

6. How is Virtual Physical Therapy funded?

This benefit is funded through available day-to-day benefits. Indicative pricing provided in the below table:

Service	Rates
Initial assessments and exercise programme (30 min)	R375
Follow-up session	R200
Weekly virtual therapy programme and monitoring	R275 per week
Monthly virtual therapy programme and monitoring	R1,100 per month

Technical questions relating to the mental wellbeing assessment

1. Who can take the mental wellbeing assessment?

All DHMS members can take the mental wellbeing assessment at any time.

2. Where can the mental wellbeing assessment be accessed?

The mental wellbeing assessment can be accessed via the My Health tab on the Discovery Health app.

3. For which mental health condition does the assessment unlock risk-funded support?

The mental wellbeing assessment unlocks risk-funded support for members at risk of developing or not yet diagnosed with depression. Depression is the most prevalent mental health condition worldwide and in South Africa, with one-in-every-four South Africans suffering from probable depression since 2019.

4. Once the assessment has been completed, how do members access support?

Members with low risk of developing depression can retake the assessment at any time. Members with higher levels of depression risk, will be proactively contacted for diagnosis and referral to relevant mental health support:

- Members identified to have moderate to severe symptoms of depression, will receive a risk-funded virtual consultation with a GP or psychologist.
- Members identified to have severe symptoms of depression will receive access to a proactive risk-funded coaching session with a suitably trained healthcare professional as well as a virtual or face-to-face consultation with a GP or psychologist.

5. Is there a limit to how many times a member can complete the mental wellbeing assessment?

No, members can retake the assessment at any time.

Technical questions relating to digital therapeutics for mental health

1. What are digital therapeutics?

Digital therapeutics (DTx) is a category of evidence-based interventions which use clinically validated software designed to prevent, manage or treat a broad range of diseases and disorders.
DTx is being integrated into healthcare systems to complement more traditional treatments, leveraging AI-driven technology and virtual engagement with trained professionals to provide high levels of personalisation, remote monitoring, real-time adjustment to programmes and instantaneous feedback and interaction for patients.

2. What makes digital therapeutics different to wellness apps?

Wellness apps are widespread and provide behavioural support, while in contrast digital therapeutics are a medically prescribed form of treatment, which is clinically validated and uses advanced software to provide personalised and adjustable treatment plans.

3. What is internet-based cognitive behavioural therapy (iCBT)?

Internet-based Cognitive Behavioural Therapy (iCBT) is a type of digital therapeutic which provides online treatment for mental health conditions. iCBT helps people overcome negative thought patterns in order to break down specific problems and improve the way they feel – providing regular and practical ways of improving their state of mind such as interactive tools and virtual engagement with trained therapists.

Delivered through digital channels it allows members to benefit from support in whichever environment they feel most safe and comfortable, through a scalable and cost-effective form of treatment.

4. Where do DHMS members access iCBT?

All members who are medically referred can access iCBT through the 'My Health' tab on the Discovery Health app, from which they will be seamlessly linked to the SIlvercloud platform. Silvercloud is an established global provider of digital therapeutics.

5. Do members have to be on the Mental Health Care Programme to access this benefit?

This benefit is risk-funded for all members on the Mental Health Care Programme, Mental Health Relapse Programme and OHPMB Basket of care. The platform is importantly also available to any other DHMS member not on these programmes, who is diagnosed and referred by a GP or psychologist.

6. How is this benefit funded for members not on the Mental Health Care Programme?

For members who are not on the Mental Health Care Programme but are referred by a GP or psychologist, funding is paid out of available day-to-day benefits. The cost of 12-months access to the Silvercloud platform is R1,850.

Technical questions relating to Personal Health Pathways

1. Who will Personal Health Pathways be available to?

Initially Personal Health Pathways will be available as part of existing disease management programmes in the first quarter of 2024. Towards the second half of 2024, the personal health pathways and gamification platform will then become available to all DHMS members.

2. Where will members be able to access Personal Health Pathways?

Individualised personal health pathways will appear on the Discovery Health app, for members to closely view and track their next best health actions and rewards achieved.

3. What makes Personal Health Pathways unique?

Discovery Health is in the fortunate position of having access to a large clinical and behavioural data set which, when combined with science-based clinical expertise and advanced machine learning and data science capability, can provide hyper-personalised health guidance to members.

ENHANCED FLEXICARE OFFERING

Technical questions relating to Flexicare

1. Is the pre-existing Flexicare offering still available?

Yes, the Flexicare offering which has been available for the last two years to employer groups and individuals, will retain the same benefit structure and be referred to as Flexicare Plus going forward.

2. What is the premium increase for Flexicare in 2024?

Standard Flexicare premiums will increase by 8.5% from 1 January 2024. Employer-specific increase are dependent on group size and experience and will be communicated to individual employer groups in October 2023.

3. How is the enhanced nurse-led, digitally enabled primary care clinic offering different to Flexicare Plus?

Flexicare and Flexicare Plus have the same benefit design, with the following differences:

- **Benefits:** Optometry, dentistry and chronic medication are covered on Flexicare Plus only. However, Flexicare members do have cover for HIV treatment, counselling and education including antiretroviral medicine, multivitamins and supportive medicine, blood tests, X-rays and post-exposure prophylaxis medicine.
- **Healthcare referral pathways:** Flexicare Plus members access healthcare through their network GP, either in-person or online. Flexicare members access healthcare by visiting
    - a network nurse-led clinic, with the functionality to virtually consult with a GP where necessary.
    - or consulting virtually with a GP through an online clinic consultation.

4. Which nurse-led clinics can Flexicare members visit in 2024?

Unjani and Netclinic are the new Flexicare network partners, providing access to over 200 nurse-led clinics with the ability to connect to a GP virtually, while Intercare will be supporting the online clinic consultations pathway. Further expansion of the network is planned in 2024.