Discovery
Health Medical Scheme

INTERNATIONAL TRAVEL BENEFIT AND COVER FOR TREATMENT RECEIVED ABROAD

DISCOVERY HEALTH MEDICAL SCHEME
2023

Overview

This document summarises the cover you may have access to if medical care or treatment is received abroad. The cover comprises of:

- International Travel Benefit; and
- Cover for non-emergency claims (elective treatment) and claims for treatment received abroad outside what is covered by the International Travel Benefit.

International Travel Benefit for emergencies

The International Travel Benefit is available on the Executive, Comprehensive, Priority, Saver, Smart and Core plans. The benefit is not available on the KeyCare plans. The International Travel Benefit covers costs associated with a relevant health service obtained outside of South Africa for a condition or health event that occurs as a result of an accident or emergency. If you will be visiting multiple countries, you do not need to request multiple letters confirming your cover while abroad. You will only need one letter for Schengen countries and one letter for non-Schengen countries.

Cover for non-emergency claims

For all plans except the KeyCare plans, you have cover at the equivalent local costs for non-emergency treatment (elective treatment) and treatment received abroad outside of the 90-day travel period as long as:

- The treatment is routinely available in South Africa from a registered member of the medical profession; and
- It would normally be covered by your plan according to the Scheme Rules.

If the treatment meets the above criteria, you will need to pay for these medical expenses upfront. You can then submit all the claims to us on your return to South Africa. The Scheme will reimburse you into the South African bank account that we already have on record.

About some of the terms we use in this document

There may be some terms we refer to in the document that you may not be familiar with. Here are the meanings of these terms.

TERMINOLOGY	DESCRIPTION
Above Threshold Benefit (ATB)	**Available on the Executive, Comprehensive and Priority plans** Once the day-to-day claims you have sent to us add up to the Annual Threshold, we pay the rest of your day-to-day claims from the Above Threshold Benefit (ATB), at the Discovery Health Rate (DHR) or a portion of it. The Executive and Comprehensive plans have an unlimited Above Threshold Benefit (ATB), and the Priority plans have a limited ATB.
Annual Threshold	**Available on the Executive, Comprehensive and Priority plans** We set the Annual Threshold amount at the beginning of each year. The number and type of dependants (spouse, adult or child) on your plan will determine the amount. The Annual Threshold is an amount that your claims need to add up to before we pay your day-to-day claims from the Above Threshold Benefit (ATB).
Co-payment	This is an amount that you need to pay towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service or if the amount the service provider charges is higher than the rate we cover. If the co-payment amount is higher than the amount charged for the healthcare service, you will have to pay for the cost of the healthcare service.
Cover	Cover refers to the benefits you have access to and how we pay for these healthcare services such as consultations, medicine and hospitals, on your health plan.
Day-to-day benefits	These are the available funds allocated to the Medical Savings Account (MSA) and Above Threshold Benefit (ATB), where applicable. Depending on the plan you choose, you may have

TERMINOLOGY	DESCRIPTION
	cover for a defined set of day-to-day benefits. The level of day-to-day benefits depends on the plan you choose.
Emergency medical condition	An emergency medical condition, also referred to as an emergency, is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical and surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy. An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency.
Global Fee	A global fee is a single amount that we calculate based on the average claims experience in South Africa subject to your specific plan. Clinical protocols and policies apply, and this means that we will only pay medically appropriate claims. Cover will also be subject to the rules of the Scheme and funding policies.
Medical Savings Account (MSA)	**Available on the Executive, Comprehensive, Priority and Saver plans** The Medical Savings Account (MSA) is an amount that gets allocated to you at the beginning of each year or when you join the Scheme. You pay this amount back in equal portions as part of your monthly contribution. We pay your day-to-day medical expenses such as GP and specialist consultations, acute medicine, radiology and pathology from the available funds allocated to your MSA. You can choose to have your claims paid from the MSA either at the Discovery Health Rate, or at cost. Any unused funds will carry over to the next year. Should you leave the Scheme or change your plan during the year and have used more of the funds than what you have contributed, you will need to pay the difference to us.
Medical Services Organisation International (MSOI)	MSOI is Discovery Health's appointed service provider for facilitation and case management of international claims.
Member	The reference to member in this document also includes dependants, where applicable.
Pre-existing conditions	A condition for which medical advice, diagnosis, care, or treatment was recommended or received at any time during the 30-day period immediately preceding the date of departure from South Africa. This includes any acute or chronic conditions, and complications and/or any other treatment that may be required as a consequence thereof.
Routinely available medical treatment	This is a treatment that is capable of being provided in South Africa in that the know-how, skill, expertise, device and/or equipment required for the treatment prevails or exists. This scenario describes an instance where a suitable clinically appropriate or cost-effective alternative treatment is capable of being provided to satisfactorily treat the member.
Waiting period	A waiting period can be general (up to 3 months) or condition-specific (up to 12 months) and means that the member has to wait for a set time before he or she can claim from their chosen plan's cover.

The International Travel Benefit

You have emergency cover while travelling outside the Republic of South Africa (RSA) for 90 days from departure

The International Travel Benefit covers you for emergency medical costs outside the borders of the Republic of South Africa for 90 days from your date of departure from South Africa. The cover ends on your return home or after 90 days from your date of departure from South Africa, whichever happens first.

We cover your emergency medical costs up to a limit for each journey

Cover for authorised emergency medical costs is limited to US $1million for each person per journey for members on the Executive Plan, and R5 million for each person per journey for members on Comprehensive, Priority, Saver, Smart and Core Plans. This benefit is not available on the KeyCare Series.

The following criteria is important to note:

- You must be a member of the Scheme in good standing (contributions are up to date) at the time of the claim.
- Healthcare services related to a condition-specific waiting period are not covered by the International Travel Benefit and you must not be in a three-month general waiting period.
- You must receive treatment from a qualified and registered healthcare professional.
- Direct payment to overseas healthcare professionals is arranged by Medical Services Organisation International (MSOI)
- If you elect not to contact MSOI for assistance and agree to pay the claim upfront, you will have to settle the claim directly with the service provider and then claim back from the Scheme. At the time of claiming, the Scheme will validate the membership and check for pre-existing conditions before reimbursing you.
- Clinical protocols and policies apply, and this means that we only pay medically appropriate claims. Cover will also be subject to the rules of the Scheme and funding policies.

The Scheme will reimburse these claims up to 100% of the cost for in-and-out of hospital treatment and where such treatment is paid in a foreign currency, the cost will be paid at an exchange rate for such currency as set by the bank at which the Scheme has its account.

You also have cover at equivalent local costs for non-emergency treatment or treatment received outside of the 90 days, as long as the treatment is readily and routinely available in South Africa and it would normally be covered by your plan according to the Scheme Rules. You can read more about this in the *non-emergency claims* section of this document.

Cover for treatment related to pre-existing conditions

If the claim relates to a pre-existing medical condition, then the Scheme will reimburse you at the global fee equivalent to what the Scheme would have paid in South Africa in accordance with your chosen plan. A global fee is a single amount that we calculate based on the average claims experience in South Africa subject to your specific plan.

The cover available in terms of this benefit is subject to Rules of the Scheme, and includes payment for:

- The usual, reasonable and medically necessary medical, surgical, relevant dental and/or other treatment as may be provided in-hospital as authorised by a medical professional as a result of an accident or any emergency
- Emergency transport and evacuation to the nearest appropriate facility
- The additional cost necessary for your return to South Africa to receive further treatment, as determined by the Scheme
- In the case of air travel, the International Travel Benefit covers:
    - The cost of changing the return flight date only and/or if required, a change to the grade of the flight booking upon review by the Scheme but excludes any cost of return if you are not in possession of a valid flight ticket.
    - Entails the cost of any medical or non-medical escort as approved by the Scheme where medically necessary.

If you are travelling for more than 90 days, you may choose to arrange additional travel insurance for medical cover through your travel agent before leaving South Africa. Additional information on travel during the COVID-19 Pandemic can be found on www.discovery.co.za > Medical Aid > Benefits and Cover > Covid-19 Benefits > Resource documents.

In the case of air travel:

- If the medical condition necessitates emergency transport and evacuation to the nearest appropriate facility and you are fit to travel, MSOI will arrange this.
- If you are fit to travel and can return to South Africa but choose not to, the Scheme will not pay the costs of transport, evacuation or repatriation at a later stage. All medical expenses incurred after this date will be paid according to the South African global fee equivalent for your chosen health plan.

- If your medical condition needs hospitalisation and you are unable to return to South Africa, your cover may be extended for such period as is reasonably necessary to enable you to return to South Africa, up to a maximum of 90 days from the date of admission to hospital.

While in a country covered under the Africa Evacuation Benefit, you also have cover for emergency medical evacuations (transport) from that country to South Africa, subject to authorisation from MSO International Limited, registration number 01338V a division of Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider. For more information about the Africa Evacuation Benefit, please visit our website www.discovery.co.za > Medical Aid > Manage your health plan > Find important documents and certificates > Request a letter for visa purposes.

Emergency hospital expenses

You need to notify Medical Services Organisation International (MSOI) as soon as possible after your emergency

If you need emergency hospitalisation while travelling overseas, notify MSOI as soon as possible after the emergency on + 27 11 529 6900. If you need assistance in contacting MSOI, you can also contact the international operator of the country you are visiting and request to be connected to MSOI on reverse call charges. Once connected, MSOI will validate your membership. Before MSOI authorises the admission and issue a payment guarantee, they will also identify whether the current funding request relates to a medical or surgical condition that existed previously.

Out-of-hospital emergency treatment

You need to pay the first US $150 or €100 (European countries) in respect of emergency out-of-hospital treatment within 90 days of departure, per person per journey. The balance will be covered by the Scheme. Your Medical Savings Account (MSA) and other day-to-day benefits will not be used for emergency out-of-hospital treatment covered by the International Travel Benefit. The co-payment applies to each person, per journey and not to each claim. If you are travelling in a country with a different currency, your claim will be converted to US dollars or Euros, whichever is the most appropriate, to calculate what you are responsible for, and what we need to pay.

Dental treatment under certain circumstances

The International Travel Benefit will only cover you for emergency dental treatment on sound teeth relating to temporary caps and/or fillings for teeth that have broken, re-cementing of crowns and bridges, and root canal treatment for pain control. Your plan may cover you for other dentistry from your available day-to-day benefits, as long as you haven't reached any limits that may apply.

How to claim for out-of-hospital emergency medical expenses

You can choose between these options:

- Pay upfront for out-of-hospital emergency medical expenses, and claim back from the Scheme on your return, or;
- If the total cost of your out-of-hospital emergency claims is more than €100 (European Countries) or US $150 for each person, you can call Medical Services Organisation International (MSOI) while you are still overseas. MSOI will provide you with approval if the claim is related to a medical emergency and will contact your healthcare professionals overseas to make sure they are paid directly.

Cover for non-emergency claims and claims for treatment received abroad not covered by the International Travel Benefit

List of healthcare services covered at the equivalent local cost

In certain situations, the Scheme will reimburse you at the global fee equivalent to what the Scheme would have paid in South Africa in accordance with your chosen plan. A global fee is a single amount and equivalent local cost that we calculate based on the average claims experience in South Africa subject to your specific plan.

The following services may be covered in accordance with your chosen health plan benefits at the global fee and subject to benefit limits, where applicable:

- Pregnancy or childbirth when travelling contrary to medical advice, or should medical emergencies arise after the 24th week of pregnancy. If the baby is born outside South Africa, they will not be covered by the Scheme until you register them on the Scheme.
- Situations where the health status of you or your dependants prior to departure from South Africa could foreseeably give rise to any medical claim.
- Situations where you or your dependants are travelling contrary to medical advice, or with the intention of obtaining medical treatment, or where a terminal prognosis has been given.
- Renal dialysis or chemotherapy as well as healthcare services relating thereto.
- Any emergency treatment for pre-existing conditions of acute or chronic nature, and complications and/or any other treatment that may be required as a consequence thereof, for which treatment or medical advice was received at any time during the 30-day period immediately preceding the date of departure from South Africa.
- Healthcare services in respect of cancer diagnosed and/or treated within the 12-month period immediately before the date of departure from South Africa.
- Healthcare services in respect of organ failure diagnosed and/or treated within the 12-month period immediately before the date of departure from South Africa.
- Any non-emergency planned or elective treatment.
- In circumstances where you and/or your dependant uses a relevant health service and where the health service is causally related to or caused by the same condition that resulted in the accident or emergency for which the Scheme has requested you or your dependant to return to South Africa for further treatment. This applies if you or your dependant fails or refuses to return even after the medical professional who is treating you whilst you are abroad, approved your return.
- Dentistry, except those stated as covered above.
- Optical treatment, including but not limited to refractive surgery, the cost of spectacles and the cost of lenses (contact and/or insertion in spectacles).
- Any claims related to treatment received abroad outside of the 90-day travel period.

Prescribed Minimum Benefits regulations do not apply beyond the borders of South Africa.

How to submit claims you have already paid

You need to send us the following:
A copy of the International Travel Benefit (ITB) claim form, completed in full and including the following documentation:

- Proof of travel dates in the form of air ticket stubs or passport stamps
- A detailed invoice/account in English
- If the original invoice/account is in another language, please provide the original invoice/account and a translated version of the account
- The Invoice needs to include the following details: Patient name and surname, the diagnosis, provider details, date of service, treatment description and cost of the treatment
- Proof of payment for all attached claims in English
- Confirmation of the diagnosis in a form of a doctor's report/letter in English

The International travel benefit claim form must be completed in full and emailed to Claims@discovery.co.za along with the supporting documentation. When sending us overseas medical claims, please keep copies for your own records. You can access the form at www.discovery.co.za > Medical Aid > Manage your health plan > Find important documents and certificates.

Treatment we do not cover

Exclusions

While travelling, the following will not be covered:

- Healthcare services while you are in a waiting period for pre-existing conditions and any healthcare services while you are in a three-month general waiting period.

- Healthcare services related to any General Scheme Exclusion (GSE) which includes search and/or rescue operations or for any travel to and in a country at war. The list of countries may change from time to time. You can access the list at www.discovery.co.za > Medical Aid > Benefits and Cover to familiarise yourself with the full list of exclusions before travelling abroad.
- Any healthcare services, if you are on a KeyCare plan.

Contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66
Go to www.discovery.co.za to Get Help or ask a question on WhatsApp. Save this number 0860 756 756 on your phone and say "Hi" to start chatting with us 24/7.
PO Box 784262, Sandton, 2146. 1 Discovery Place, Sandton, 2196.

Complaints process

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

1 STEP 1 – TO TAKE YOUR QUERY FURTHER:

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

2 STEP 2 – TO CONTACT THE PRINCIPAL OFFICER:

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

3 STEP 3 – TO LODGE A DISPUTE:

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

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

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