

PHARMACY NETWORK HANDBOOK

DISCOVERY HEALTH
2026





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Overview

The challenge facing medical schemes

Rising healthcare costs place severe pressure on healthcare systems and governments globally. In South Africa, medical schemes rely on the surpluses generated by healthy scheme members to fund the cost of treatment for unhealthy scheme members. These cross-subsidies must be managed and balanced carefully to make sure that all medical scheme members enjoy cover when they need it most, and medical scheme contributions remain affordable.

The current medical scheme regulatory environment is based on open enrolment and community rating, which means that medical schemes must accept all applicants regardless of age and health status. South Africa is unique in that medical scheme membership is voluntary. This results in adverse selection where people join a medical scheme when they believe they will need it, or they join lower-cost options and 'buy up' to more comprehensive options when they get sick.

Medicine inflation together with demographic trends (such as an ageing insured population and a rapidly increasing chronic, cancer and lifestyle disease burden) drive increased demand for healthcare services. For Discovery Health as an administrator of medical schemes, managing these cost drivers is important to maintain the balance between quality, access and affordability of healthcare. This requires rigorous efforts and collaboration between all stakeholders.

With this in mind, we continually develop initiatives to manage medicine costs to make sure that medicine remains affordable for our members and the schemes we administer, and to ensure the sustainability of the healthcare industry. Performance Based Remuneration (PBR) and MedXpress (including MedXpress network pharmacies) are two such initiatives.

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
Chronic Illness Benefit (CIB) claim	The Chronic Illness Benefit (CIB) covers members for a defined list of chronic conditions. Discovery Health Medical Scheme covers claims for treatment, including medicine for conditions on the Chronic Disease List (CDL) according to the Prescribed Minimum Benefit (PMB) treatment algorithms for all plans. It excludes claims paid from other benefits, such as oncology, although these conditions are chronic illnesses.
Chronic formulary (medicine list)	A list of medicines covered in full in line with the Council for Medical Schemes' Prescribed Minimum Benefit (PMB) treatment guidelines relating to the CDL for the treatment of approved chronic conditions. Different formularies apply to the different Discovery Health Medical Scheme plans: <ul style="list-style-type: none"> • Comprehensive formulary for Executive and Comprehensive plans • Core formulary for Core, Priority and Saver plans • KeyCare formulary for KeyCare plans Chronic Illness Benefit medicine formulary
Performance Based Remuneration (PBR) formulary	A subset of preferentially priced, generic medicine that is on the chronic formulary. Performance Based Remuneration (PBR) rewards providers for compliance with the best-priced formulary generics. It integrates inflationary dispensing fee income with optimised performance.
PBR formulary item	The trade name of the formulary-listed medicine which includes the product name, strength, and dosage formulation where listed on the formulary. The formulary item is linked to the approved CIB condition. PBR formulary items attract the higher PBR dispensing fee.
PBR benchmark item	Any generic equivalent with the same active ingredient, strength, dosage formulation and the same clinical indication as the formulary product where the unit single exit price (SEP) is equal to or lower than the benchmark unit price. These are flagged along with formulary items for easy identification when dispensing. Benchmark items attract the higher PBR dispensing fee.
Benchmark price	The selected unit price published in the PBR formulary and benchmark document, to which the SEP of all generic equivalent items on the formulary is compared. Generic equivalents are



TERMINOLOGY	DESCRIPTION
	required to be lower or equal to the PBR benchmark unit price. The latest list is available on our website on the Pharmacy communiqués page.
Non-benchmark item	Any generic equivalent to a formulary product with the same active ingredients, strength and dosage formulation and the same clinical indication as the formulary medicine, where the unit SEP exceeds the formulary benchmark unit price. Non-benchmark items attract the lower PBR dispensing fee.
Non-formulary items	<p>Products that treat the same chronic conditions (listed on the PMB CDL) as the formulary item and are paid from Chronic Illness Benefits (CIBs) but have different active ingredients (molecules) to the formulary medicine.</p> <p>The monthly Chronic Drug Amount (CDA) applies to these therapeutic equivalents. Members will have a co-payment where the price of their prescribed non-formulary item exceeds the monthly CDA applied per medicine class and plan type. This group of therapeutic equivalents can be divided into two groups:</p> <ul style="list-style-type: none"> • If no generically substitutable items are available, the standard dispensing fee will apply as these items are excluded from PBR. • If generically substitutable items are available, the lowest-priced generic equivalents will continue to attract the standard Discovery Health dispensing fee, as these are excluded from PBR. Higher-priced items attract the lower PBR dispensing fee.
Chronic formulary compliance	A pharmacy's performance is measured as a percentage of formulary items and formulary benchmark price compliant items dispensed out of all the generically substitutable claims paid from chronic benefits for applicable plans. For MedXpress designated service provider (DSP) network participation, we measure and report performance monthly by looking at chronic medicine claims for all Discovery Health Medical Scheme plans (excluding KeyCare) paid over a rolling six-month period.
Generic equivalent	Medicine that is registered with the South African Health Products Regulatory Authority based on bioequivalence, safety, efficacy and quality. Generic equivalents contain the same active ingredient with the same strength and the same formulation as the original brand product. The recommendation to use best-priced generics is a safe and affordable recommendation aimed to assist consumers.
Discovery Health medicine rate (DHMR)	DHMR is the Single Exit Price (SEP) for the claimed quantity of a product + the contracted dispensing fee, both inclusive of VAT.
Chronic Drug Amount (CDA)	The Chronic Drug Amount is the maximum monthly amount that we pay up to for a medicine class, inclusive of VAT and dispensing fee as per plan type. The CDA applies to non-formulary medicines inclusive of non-formulary generic equivalents of the formulary listed brands, and non-formulary therapeutic equivalents. CDA does not apply to Oncology Benefits.
Generic Reference Pricing (GRP)	The Generic Reference Pricing (GRP) is the unit SEP (incl. VAT) reference price that we pay up to for non-formulary genericised molecules within each generic category (same molecule, strength and formulation) as per plan type. We pay up to the lesser of GRP or CDA or DHMR or the claimed amount. This only applies to Chronic Illness Benefits.
Therapeutic Reference Pricing (TRP)	This is maximum monthly amount that we pay up to for a medicine class, inclusive of VAT and dispensing fee as per plan type. We pay up to the lesser of the TRP or DHMR or the claimed amount.
Compliance with the HIV antiretroviral (ARV) formulary	The percentage of ARV formulary items and ARV benchmark items that were dispensed out of all generically substitutable ARV claims paid from HIV benefits for the various schemes as communicated on the monthly report. We measure and report performance monthly by looking at ARV claims paid over a rolling six-month period.
Oncology preferred product list compliance	The percentage of oncology supportive preferred products and their benchmark items that were dispensed out of all generically substitutable claims paid from oncology benefits for members of Discovery Health Medical Scheme. We measure and report performance monthly by looking at oncology claims paid over a rolling six-month period.



TERMINOLOGY	DESCRIPTION
Performance Based Remuneration (PBR)	<p>A voluntary programme designed to provide additional payment to pharmacists for adhering to Discovery Health Medical Scheme formularies. PBR only applies to claims paid from the CIB.</p> <p>CIB claims must be preauthorised according to the PMB treatment guidelines for conditions on the CDL, taking PBR exclusions into consideration.</p> <p>PBR exclusions are claims paid from:</p> <ul style="list-style-type: none">• KeyCare and Delta plans• Benefit pools other than those for chronic medicine claims, such as oncology, HIV and acute benefits• Non-SEP claims – surgical, unregistered and schedule 0 items• MedXpress direct orders and courier pharmacies.
Compliance with the oncology preferred product list	<p>The percentage of oncology support preferred products and their benchmark items that were dispensed out of all generically substitutable claims paid from oncology benefits for members of Discovery Health Medical Scheme. We measure and report performance monthly by looking back at oncology claims paid over a rolling six-month period.</p>



Discovery Health pharmacy networks and services

The Medical Schemes Act governs our professional practice and allows for the use of DSPs to make sure that quality healthcare is accessible and affordable for members of medical schemes in South Africa.

MedXpress Pharmacy Network

To give retail and community pharmacies equal opportunities, we created the MedXpress Pharmacy Network. MedXpress network pharmacies are the DSPs for all approved, chronic medicine for Discovery Health Medical Scheme members on the Delta, Priority, Saver and Core plans.

This means that members on these plans must use a MedXpress network pharmacy to avoid a 20% co-payment on their approved chronic medicine. Pharmacies can participate in the network by meeting MedXpress formulary compliance criteria.

This means that the pharmacy will not attract a 20% non-DSP co-payment on chronic medicines for members who use MedXpress as their DSP. Only contracted Discovery Health network pharmacies charging the agreed Discovery Health tariffs and who meet the MedXpress formulary-compliance criteria are eligible to participate in the MedXpress Pharmacy Network. Pharmacy contracts that charge rates over and above the agreed Discovery Health Rate will be terminated.

How members benefit from using network pharmacies

MedXpress benefits members by reducing co-payments and benefits the schemes through additional savings, which result from a high generic substitution rate. If a Discovery Health Medical Scheme member chooses to use a pharmacy outside of the MedXpress Pharmacy Network, they may be liable for a 20% co-payment on their chronic medicine. If a Discovery Health Medical Scheme member chooses to use a pharmacy outside of the HIV Pharmacy Network, they may be liable for a 20% co-payment on their non-formulary ARV medicine. The amount charged for such a co-payment in these circumstances is set out in Regulation 8(2) of the Medical Schemes Act.

Pharmacy participation in the MedXpress Pharmacy Network

Participation in the MedXpress Pharmacy Network is open to all contracted network pharmacies that meet the participation criteria. The participation criteria are based on pharmacies' compliance with Discovery Health Medical Scheme's formulary. We monitor and report back monthly to pharmacies on their formulary compliance. We review pharmacies' performance on a four-monthly basis for network participation. Pharmacies without a signed and valid contract for the standard network rate with us cannot participate in the MedXpress Pharmacy Network.

To be eligible for inclusion in the MedXpress Pharmacy Network, pharmacies must comply with the Discovery Health CIB formulary and oncology preferred formulary. The formulary adheres to legal requirements as set out in the PMB legislation and treatment algorithms for specific conditions on the CDL.

Discovery MedXpress and MedXpress network pharmacies will remain the DSPs for Core, Priority, Saver, Smart and Delta plans.

BENEFIT	MEDXPRESS DSP NETWORK PARTICIPATION CRITERIA
Chronic Illness Benefit	We require a minimum compliance with the chronic medicine formulary over a rolling six-month period of $\geq 77\%$ (measuring HIV and oncology separately).
Oncology Benefit	In addition to the above, where there have been more than 180 claims over a six-month period, we require compliance of $\geq 90\%$ with the oncology preferred product list.

Please refer to the terminology table on page 2 for a better understanding of how we measure chronic formulary compliance and oncology compliance. These definitions are also included in your monthly report.



How we support you in reaching formulary compliance for participation in Discovery Health DSP networks

- We measure your compliance with the Chronic, Oncology and ARV formularies and your claims volumes monthly and send this report to the email address that we have on system for your practice. Please make sure we have your pharmacy's correct email address. If your email address has changed, please send your new contact details along with your Board of Healthcare Funders (BHF) number and pharmacy name to Provider_administration@discovery.co.za.
- We arrange with numerous software vendors to flag formulary items for easy identification on pharmacy screens while dispensing. Please ask your software vendor to activate this functionality if you do not already use it. [Chronic Illness Benefit medicine formulary](#)
- We publish the latest updated Discovery Health formulary (which includes Chronic, Oncology and HIV items) on our website on the [Pharmacy communiqués](#) page to assist you with stock management and ordering.

Creating a stable pharmacy network

It is important for us to ensure the stability of the MedXpress Pharmacy Network and the HIV Pharmacy Network so that our members can avoid out-of-network co-payments on their medicines. Therefore, we measure compliance over the past six months.

If your pharmacy has fewer than 30 oncology claims per month (or 180 claims over a rolling six-month period), we won't consider the compliance rate with the oncology preferred medicine list and you won't be affected by the small claims volume.

Our DSP network review process

We review MedXpress network pharmacies and HIV network pharmacies for inclusion and ongoing participation in the network on a four-monthly basis.

- Inclusion: Once a practice meets the participation criteria, the practice is automatically enrolled in the network for the next four months. The practice will need to maintain formulary compliance to remain in the network. The practice will receive notice of inclusion in the monthly compliance report.
- Termination: Participating pharmacies that do not meet the criteria during review, as measured over the previous six months, will be removed from the network for the next four-month cycle. We will email the practice with notification of termination. The pharmacy will then attract a 20% non-DSP co-payment until they meet the entry criteria during future reviews. We will also inform members that the pharmacy is no longer a participating network pharmacy.

How we pay for formulary medicines at DSP and non-DSP pharmacies

Please note:	MedXpress DSP pharmacies	Non-DSP pharmacies
Formulary item	Pay up to 100% of DHMR (which is the SEP price + agreed dispensing fee)	Pay up to 80% of DHMR with 20% non-DSP copayment
Non-Formulary item	Pay up to the lesser of CDA /GRP as per plan type.	Pay up to the lesser of 80% of CDA /GRP as per plan type with 20% non-DSP copayment.

HIV Pharmacy Network

Discovery Health network pharmacies are eligible to participate in the HIV Pharmacy Network if they meet the criteria of ARV formulary compliance. Any contracted qualifying pharmacy will automatically be included in the HIV Pharmacy Network when meeting or exceeding the compliance criteria for the HIV ARV formulary.

Pharmacies without a signed and valid Discovery Health Standard Pharmacy Network Agreement with us cannot participate in the HIV Pharmacy Network. The [Discovery Health DSP & Standard Pharmacy Network agreement](#) is on our website.



BENEFIT	HIV DSP NETWORK PARTICIPATION CRITERIA
HIV Benefit	We require a minimum compliance with the HIV ARV formulary over a rolling six-month period of ≥95% for participation and a minimum of 90% to retain participation.

Please note:

- **ARV formulary items** will always be paid in full up to the Discovery Health medicine rate (DHMS) regardless of whether at a HIV DSP or a non-DSP pharmacy.
- **Non-formulary ARV items**, the following applies at a:
 - **Non-DSP** pharmacy: Paid at 80% Chronic Drug Amount (CDA) /Therapeutic Reference Price (TRP) as per plan type.
 - **DSP** Pharmacy: Paid at Chronic Drug Amount (CDA)/Therapeutic Reference Price (TRP) as per plan type.

Please note:	HIV ARV DSP pharmacies	Non-DSP pharmacies
Formulary item	Pay up to 100% of DHMR (which is the SEP price + agreed dispensing fee)	Pay up to 100% of DHMR (which is the SEP price + agreed dispensing fee)
Non-Formulary item	Paid at Chronic Drug Amount (CDA)/Therapeutic Reference Price (TRP) as per plan type.	Paid at 80% Chronic Drug Amount (CDA) /Therapeutic Reference Price (TRP) as per plan type with 20% Non-DSP copayment)

The HIV Pharmacy Network will be the DSP for all Discovery Health Medical Scheme plans, except KeyCare Start. The HIV Pharmacy Network will also be the DSP for the following schemes administered by Discovery Health:

- LA KeyPlus
- MultiChoice Medical Aid Scheme
- Remedi Standard Option
- TFG Medical Aid Scheme
- Tsogo Sun Group Medical Scheme
- University of KwaZulu-Natal Medical Scheme

Please refer to the terminology table on page 2 for a better understanding of how we measure ARV formulary compliance. These definitions are also included in your monthly report.

Please refer to page 6 to understand how we support pharmacies to reach formulary compliance.

Performance Based Remuneration (PBR)

What is the objective of PBR?

PBR is an incentive designed to provide an additional dispensing fee to pharmacists for adhering to the Scheme’s chronic medicine formulary. The PBR model aims to create additional remuneration for pharmacies through improved prescription price efficiency.

Pharmacies without a signed and valid Standard Pharmacy Network Agreement with us cannot participate in the PBR network.

PBR model

The model, currently offered only by Discovery Health Medical Scheme, ensures an increase in revenue for pharmacists, lower out-of-pocket expenses for medical scheme members and the ongoing sustainability of the Scheme. The benefits of the PBR model are that it:

- Attracts a much higher PBR dispensing fee for formulary items and their generic replacement equivalents within the formulary price benchmark (benchmark items)
- Attracts a higher PBR dispensing fee penalty for non-preferentially priced generic medicines (non-benchmark items)
- Excludes medicines where the pharmacist cannot substitute with preferentially priced generic alternatives as these are not available



- Allows for the highest percentage income incentive to be paid for dispensing the lowest-priced item.
- This allows the retrospectively PBR dispensing fee to be re-applied to the best-priced formulary equivalent generic medicine in the medicine class.
- Has a 100% PBR compliance target which is easier to interpret and to communicate.

How does PBR work?

The model only applies to generically substitutable medicine claims paid from the CIB, subject to specific inclusion and exclusion criteria. The PBR model allows for a differential dispensing fee to be retrospectively applied once the PBR qualifying participation criteria has been met. This comprises a differential PBR dispensing fee for:

Formulary molecules:

- A higher PBR dispensing fee applies to PBR claim lines based on formulary listed items and benchmark items (generic equivalent replacement items within benchmark pricing per plan type).
- A lower PBR dispensing fee applies to PBR claim lines where the generic replacement items fall outside benchmark pricing (non-benchmark items).

Methodology:

We use a reference price which is based on the best-priced generic formulary item in the medicine class (generic grouper).

The SEP of each CIB claim in these generic groupers is retrospectively recalculated using the reference price and the quantity claimed.

The PBR higher and lower dispensing fees are then applied to this adjusted SEP as applicable:

- Formulary and benchmark items: Dispensing fee amount = Higher dispensing fee (based on Ref price × Quantity)
- Non-benchmark items: Dispensing fee amount = Lower dispensing fee (based on Ref price × Quantity)

For the value, please see the formulary document which is published on our website on the [Pharmacy communiqués](#) page.

Non-formulary molecules:

- The lower PBR dispensing fee applies to CIB claim lines (SEP) that are not listed on the formulary.

Methodology:

- The best-priced generic of the non-formulary item is exempt from the lower PBR dispensing fee, which means the standard dispensing fee will continue to apply
- Other generic non-formulary molecules: Dispensing fee amount = Lower dispensing fee (based on SEP × Quantity)

Standard Discovery Health dispensing fee

This is the contracted dispensing fee structure that applies during the dispensing and claims process. Independent pharmacies have a choice to participate in one of two Discovery Health standard DSP networks, attracting the specified standard dispensing fees for all medicines (whether paid from chronic or acute benefit payment pools).

Community network	36.32% capped at R59.92 (including 15% VAT)
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To be eligible for the PBR network the independent pharmacy must be a contracted Discovery Health Standard DSP Network pharmacy in either the Community Network or the Corporate Network (applying corporate rates on pharmacy choice). PBR does not apply to courier pharmacies, corporate retail or hospital pharmacies.

What are the new PBR differential dispensing fees?

Rate (including VAT)	Community pharmacies
Higher PBR fee	58% capped at R113.80
Lower PBR fee	27.23% capped at R40.85
Standard Discovery Health Rate	36.32% capped at R59.92



Compliance measures for PBR

PBR compliance is measured and communicated to pharmacies monthly.

- PBR compliance means the pharmacy's performance measured as a percentage of PBR formulary and benchmark items dispensed out of all generically substitutable chronic medicine claims paid for the report period, taking into consideration the PBR exclusion rules.
- Benchmark items are generic equivalents of listed formulary items which fall within the same price bands as formulary products. These items are flagged along with formulary items for easy identification on dispensing screens. These items fall within the benchmark unit price as published in the latest PBR formulary and benchmark document, which is sent out early December of every year to all pharmacies and is then kept on the Discovery website on the [Pharmacy communiqués](#) page.

What is the PBR threshold?

The pharmacy is protected by a threshold which acts as a safety net and makes sure that the pharmacy will never earn lower dispensing fees than it did before joining the network. The threshold is one of two points where the PBR differential dispensing fee starts.

CRITERIA
For PBR dispensing fees to apply, pharmacies need to reach or exceed either of the two qualifying criteria (thresholds):
Value-based threshold Qualification by claims value when reaching or exceeding 65%, calculated as follows: <ul style="list-style-type: none">• Determine the total value of PBR formulary items and their generic replacement equivalents in month one = R100,000• Total value spent on formulary generic substitutable medicines in month one = R64,300• Total value spent on items within the formulary price benchmark in month one = R700• Formulary compliance (value) = 65%
Volume-based threshold Qualification by claims volume when reaching or exceeding 70%, calculated as follows: <ul style="list-style-type: none">• Determine the total claims volume of PBR formulary items and their generic replacement equivalents in month one = 1,000 claims• Total formulary claims dispensed during month one = 630• Total items within the formulary price benchmark dispensed in month one = 140• Formulary compliance (volume) = 77%

Which claims are excluded from PBR?

Claims listed below do not qualify for PBR and continue to be paid at the appropriate chosen standard network rates. These are represented by:

- KeyCare and Delta plan options
- Non-SEP items including unregistered medicine, schedule 0 medicines and surgical consumable items
- Medicine not paid as pre-approved CIB conditions, i.e. medicine that is paid from other benefits, such as HIV, Oncology, Acute, Special Medicine and Technology Benefit (SMTB) and over-the-counter benefits
- Pharmacies that are not contracted by Discovery Health
- Medicine orders facilitated by Discovery MedXpress
- Medicine dispensed by courier pharmacies.

How to participate in the PBR network

PBR participation is based on a willing provider network with a termination period of one calendar month. If not already participating, your pharmacy needs to submit two signed contracts for the following:

- [Discovery Health DSP & Standard Pharmacy Network agreement](#)
- This agreement also contains the PBR agreement for independently owned community pharmacies
- To apply, you will need to sign the latest [Discovery Health DSP & Standard Pharmacy Network agreement](#) and email it to us at Provider_administration@discovery.co.za.



You can also request a copy of the agreement by emailing us at HealthPartnerInfo@discovery.co.za or calling us on 0860 44 55 66. Once you have submitted a signed agreement, you will receive email confirmation of your participation in the network.

Meeting the compliance criteria

Dispensing formulary items is the best option. Dispensing formulary items will increase both PBR compliance and additional PBR dispensing fees while also increasing MedXpress DSP compliance.

If you need more support to meet the compliance criteria, please email Provider_administration@discovery.co.za to ask for a top-ranking item report. This report identifies the top-ranking formulary items that improve your pharmacy's compliance as well as the top-ranking substitutable non-formulary items that lower your pharmacy's compliance.

Do I need to amend my pharmacy's rate setting?

No amendments to scheme submission codes or the standard network rates according to the Discovery Health Standard Pharmacy Network Agreement are required for PBR. The current rates and codes remain unchanged as the adjustments will be applied retrospectively per report.

Once your pharmacy opts in for PBR, the differential PBR dispensing fee will automatically apply once your pharmacy qualifies and meets the PBR compliance criteria. Additional fees are calculated and paid retrospectively.

The PBR criteria act as a safety net to make sure that your pharmacy will never be financially worse off with the lower PBR differential dispensing fee. Therefore, with PBR, you have a chance to earn more than you are currently earning on the standard network fee, without any risk.

How does payment of additional PBR dispensing fees work?

- Payment takes place quarterly, and the cycle dates are displayed in your monthly report.
- We apply the PBR differential dispensing fee structure retrospectively to all the chronic claim lines paid from the CIB in the PBR line level report that covers the three-month report period starting in the month when the pharmacy has qualified by meeting or exceeding the PBR criteria. The difference in the standard and newly applied PBR differential fee is calculated.
- If you want to verify the additional PBR dispensing fee paid on chronic claim lines paid from the CIB, please email us at Provider_administration@discovery.co.za and provide your pharmacy name and practice number to request the payment report on PBR line level. The report contains all the affected CIB claim lines where the differential PBR dispensing fee has been re-applied as well as the settlement amount.
- The additional PBR amount due to you will be paid at the end of the payment cycle for the preceding three months.
- Look out for your payments on your statement which will show as 'PBR additional fees', paid in a lump sum with the rest of the payments that may be due.

What happens if your pharmacy falls below the PBR qualifying participation criteria again?

If your pharmacy subsequently falls below the PBR criteria, you will no longer qualify for the PBR differential dispensing fee, nor will you receive the payment report on PBR line level for payment due. Your pharmacy will revert to the standard network dispensing fee according to your signed Discovery Health Standard Pharmacy Network Agreement.

How do you identify the PBR formulary and benchmark items when dispensing?

We have worked with the pharmacy system vendors to highlight the PBR formulary and benchmark items on your pharmacy screens so that these items are easily identifiable at the time of dispensing. All you need to do is to enrol by sending us a signed contract and send a copy of the signed PBR agreement to your vendor to ask them to highlight these items for you.

Technical questions and frequently asked questions

What is the difference between MedXpress and PBR and how do we measure it?

To illustrate the difference between the ways we measure PBR compliance and MedXpress compliance, we use the avocado analogy.

PBR financial model - If an avocado pear represents last month's medicine claims ...

1. Last month's claims

Cutting off other claims than chronic - DHMS

2. Chronic Illness Benefit claims

Generic equivalents

Pip: Formulary (brand) items
Membrane: Equivalents ≤ BMK price
Flesh: Equivalents > BMK price
Skin: Non-formulary molecules divided into items where:
 (i) generic equivalents are available
 (ii) generic equivalents are not available - excluded

3. Exclusions

Only Chronic Illness Benefit claims

Excluding claims:

- KeyCare & Delta
- Oncology & HIV
- Non-SEP items
- Courier

4. Example

PMB CDL condition: Hypercholesterolemia
Formulary: atorvastatin & simvastatin

- Formulary: atorvastatin (10, 20 & 40 mg)
- Benchmark (BMK) R1.05 per SEP unit
- Benchmark (BMK) only applies for chronic

Trade name	Unit price
A Adco-atorvastatin 10mg	R1.05
B Alipto, Cholmin	R1.03, R1.05
C Lipitor	R14.66
D Crestor	Non-formulary

5. How PBR compliance is measured

Cross-subsidisation makes PBR affordable

PBR applies to all generically substitutable CIB claims:

A: Formulary item ↑PBR fee on Ref price
 B: Equivalents ≤ BMK price ↑PBR fee on Ref price
 C: Equivalents > BMK price ↓PBR fee on Ref price
 D: Non-formulary (i)
 - More expensive generics ↓PBR fee on SEP
 - Best priced generics =Std fee on SEP

$$\% \text{ Compliance} = \frac{A+B}{A+B+C} \times 100\%$$

6. Threshold & dispensing fees

- PBR payment starts at Threshold, either
 Value of dispensed lines: $\frac{A+B}{A+B+C} \% \geq 65\%$
- Volume of dispensed lines: $\geq 70\%$

Independent fees

1. Std fee = 36.32% cap R59.32
2. ↑PBR fee = 58% cap R113.80
3. ↓PBR fee = 27.23% cap R40.85

The retrospectively, re-applied PBR variable dispensing fee is based on the reference price of the best priced formulary generic equivalent in the medicine class for CIB claims.

DSPs: If an avocado pear represents last month's medicine claims ...

1. Last month's claims

Cutting off other claims than chronic

2. Chronic Illness Benefit claims

Generic equivalents

Pip: Formulary (brand) items
Membrane: Equivalents ≤ BMK price
Flesh: Equivalents > BMK price
Skin: Non-formulary items divided into items where:
 (i) generic equivalents are available
 (ii) generic equivalents are not available.

3. Formulary molecule claims

- Looking back on past 6 months' claims
- Measure compliance on *generally substitutable* items only.
- Measure following separately:
 - Chronic Illness benefit (Chronic claims)
 - Oncology benefit claims (support)
 - HIV ARV benefit claims

4. Example

ARV formulary

Emtricitabine, tenofovir disoproxil and efavirenz

- No benchmark applicable to ARV formulary
- Benchmark applies for ARVs and oncology.

Trade name	Unit price
A Trenvir /Rizene	R8.18 / R7.93 /R8.18
B Benchmark (BMK)	Atenef at R7.93
C Atripla /Trivenz, etc	R23.85 / R10.21, etc.
D Not applicable	

5. How compliance is measured

Only generically substitutable claims

1. Chronic formulary compliance
 $\% \text{ Compliance} = \frac{A+B}{A+B+C} \times 100\%$
2. Oncology support list compliance
 $\% \text{ Compliance} = \frac{A+B}{A+B+C} \times 100\%$
3. HIV ARV and oncology compliance
 $\% \text{ Compliance} = \frac{A+B}{A+B+C} \times 100\%$

} MedXpress DSP
} HIV DSP

6. DSP qualifying criteria

1. MedXpress DSP network compliance:
 - **Chronic claims**
 Chronic compliance = 77% and
oncology support claims >180/6mths
 - **Oncology claims**
 Oncology support item compliance = 90%
2. HIV DSP network compliance
 - **HIV claims**
 ARV formulary compliance =95%

How does a change in chronic formulary influence PBR?

Discovery Health Medical Scheme reviews the CDL formulary and Chronic Drug Amounts (CDAs) twice a year. This is done to make sure that the way medicine is paid for through the CIB accurately reflects preferentially priced, accessible medicine as well as relevant new medicine in this dynamic market.



Any newly added formulary items will immediately improve the pharmacy's compliance figures from the implementation date onward. However, this is not due to the pharmacy's performance, but to the change in formulary. The opposite is also true – any formulary deletions may immediately lower a pharmacy's compliance figures.

To moderate this impact, we monitor and measure the effect of the formulary change over the three months directly after the update. During this period, we run compliance reports against both the old and new formulary to quantify the portion of the pharmacy's increased or decreased compliance rate that is due to the change in formulary. Taking the effect into consideration, we may adjust the qualifying participation criteria.

How does Discovery Health currently pay from chronic benefits?

The Discovery Health Medical Scheme CIB formulary covers the medicine requirement for PMB treatment algorithms for specific conditions on the CDL and is published on our website: [Chronic Illness Benefit medicine formulary](#)

For all plans (except KeyCare where the formulary is NAPPI specific) we pay for non-formulary items (which include generic and therapeutic items that fall within the same medicine class as treatment for the same condition) up to the monthly CDA. Whenever the monthly CDA for the condition for the month is exceeded, the member will have a co-payment.

When you see 'Prescribed Minimum Benefits', it has been paid from chronic benefits. When you see '479 Non-formulary item', please substitute. Please note that 'Prescribed Minimum Benefits' means that although this is not a formulary item for the patient's specific condition, the item has been paid for from chronic benefits because of a special clinical appeal authorisation.

What is the difference between a formulary item and a benchmark item?

Regardless of price increases, we continue to cover **formulary items in full** as published on our website when approved for an authorised chronic condition. The CDA does not apply to formulary items.

When the pharmacy has met the compliance criteria, formulary items always attract the higher dispensing fee for PBR participating pharmacies regardless of price increases. Please note that the Excel version of the Discovery Health PBR formulary with the benchmark pricing is published on our website on the [Pharmacy communiqués](#) page.

PBR benchmark items are not on the formulary. These are generic equivalents of formulary items that fall at or below the PBR benchmark unit price at any given time. SEP increases, however, may cause these items to fall outside the PBR benchmark unit price, at which point the lower dispensing fee applies as soon as the price has been updated. Both PBR formulary and benchmark items will be highlighted on the pharmacy screen for easy identification while dispensing. The CDA applies to formulary items. Therefore, although the item may count as a benchmark item when dispensed, the CDA may attract a co-payment for the member.

What happens if the price of the formulary item has increased, and the unit price is now higher than the PBR benchmark unit price?

The formulary list of items is published on our website on the [Pharmacy communiqués](#) page. Regardless of price increases, we cover formulary items in full when authorised. When the pharmacy meets the compliance criteria, these authorised items attract the higher dispensing fee for PBR participating pharmacies even though the SEP unit price may be higher than the PBR benchmark unit price after the increase.

What about non-formulary items, for example rosuvastatin for hypercholesterolemia?

We pay for non-formulary items (which include generic and therapeutic items that fall within the same medicine class as treatment for the same condition) up to the monthly CDA depending on your client's plan type. Whenever the monthly CDA is exceeded, the member will have a co-payment.

Dispensing non-formulary items may influence your compliance rate negatively where:

- The molecule is on the formulary (such as atorvastatin and simvastatin), but the SEP unit price of the particular generic product exceeds the PBR benchmark unit price
- The ingredient or molecule is not on the formulary (such as rosuvastatin).



For PBR, Discovery Health does not expect the pharmacy to achieve a 100% compliance rate. We understand that certain members and certain healthcare professionals may choose non-formulary items that do not comply and may attract the lower dispensing fee. The PBR dispensing fee is paid in addition to the existing standard network dispensing fee, while the criteria act as a safety net to make sure that your pharmacy is never worse off as a result of your client's choices.

While prescriber preferences may vary from time to time and compromise adherence to the medicine list, this is adequately compensated for in the PBR model by lower compliance criteria. Please note that – depending on the availability of preferentially priced generics – there may not always be a generic replacement item on the PBR medicine list.

What happens if I dispense a more expensive item that exceeds the PBR benchmark unit price, but sacrifice part of the dispensing fee to fall within the PBR benchmark unit price?

Dispensing a non-formulary item and charging less so that the unit price falls within the PBR benchmark unit price will not affect your compliance positively as the compliance report is drawn on NAPPI codes and the SEP value that we have on our file.

Therapeutic replacements where there are no generic items available for substitution

PBR is about cost-efficient generic substitution. Once the pharmacy has met the compliance criteria, the lower dispensing fee applies for non-formulary items. The higher dispensing fee applies only to formulary items that either are on the formulary list or fall below the PBR benchmark unit price.

However, whenever your client is not satisfied with a co-payment and the prescribed ingredient is not listed on the formulary (for products such as Crestor or Eltroxin), choosing the best-priced generic will avoid the lower PBR dispensing fee.

You will receive the higher dispensing fee when you dispense a formulary item or one that falls below the PBR benchmark unit price.

It is important to note that it always has to be in the best interest of the patient and, therefore, it will always remain the decision of the pharmacist, patient and treating healthcare professional whether to make a (therapeutic) substitution or not. Discovery Health will in no way interfere with this decision.

We do not expect the pharmacy to achieve a 100% compliance rate. We understand that certain patients and healthcare professionals will choose not to fully comply. It is important to understand that:

- While prescriber preferences may compromise formulary compliance from time to time, this is adequately compensated for by lower compliance criteria
- We continue to promote access to affordable medicine and, therefore, affordable pricing remains a key consideration in inclusion of the CIB formulary. Depending on the availability of preferentially priced generics, there may not always be a generic replacement item on the formulary.

What are the principles that Discovery Health considers for substitution and formulary inclusion?

- Affordable pricing remains a key consideration in medicine benefit design. We continue to promote access to affordable medicine.
- Discovery Health Medical Scheme's chronic formulary benefits are compliant with the Council for Medical Scheme's treatment algorithms for CDL PMBs.
- Medicines registered with the Medicines Control Council (MCC) are treated as compliant with registration requirements of safety, efficacy and quality until deemed otherwise by the MCC.
- Items not suitable for generic substitution will be strictly aligned with guidance from the MCC as applicable to all in South Africa.
- We will consider clinical guidance from external independent clinical consultants in conjunction with prevailing regulations and legislation pertaining to medicine in SA.

What if I offer generic replacement items but the patient or doctor does not agree to a generic replacement?

You need to dispense the item on the prescription according to the patient or doctor's decision and you will be paid the lower fee. You always have to adhere to legislation. While prescriber preferences may compromise formulary compliance from time to time, this is adequately compensated for by lower compliance criteria. We do not expect 100% PBR compliance.

Why do certain items not attract a co-payment for the member, yet they attract the lower dispensing fee?

We pay up to the monthly CDA for non-formulary medicines for each medicine class and condition each month. For example, we cover a few atorvastatin and simvastatin products on the formulary. If the products for hypercholesterolemia (even rosuvastatin)



fall within the CDA, your client will have no co-payment. The patient needs to pay the balance when the monthly amount for hypercholesterolemia is exceeded.

The CDA, however, has no bearing on the PBR benchmark unit price, which determines whether the pharmacy will earn the:

- Lower dispensing fee, such as when a non-formulary item is dispensed (e.g. rosuvastatin) or the SEP unit price of the dispensed atorvastatin 20 mg item exceeds the PBR benchmark unit price of atorvastatin 20 mg for the plan (such as R1.14 per unit for both the Core formulary and the Comprehensive formulary)
- Higher dispensing fee for an atorvastatin 20 mg item on the formulary (such as Adco atorvastatin 20 mg, Aspavor 20 mg, Atorvastatin Unicorn 20 mg and Lestavor 20 mg) or for any other product where the SEP unit price of the dispensed atorvastatin item falls within the PBR benchmark unit price of R1.14 for both the particular plans.

What happens when a formulary item is dispensed, but it has not been authorised for funding from the CIB?

PMBs only apply to medicine where the treatment has been preauthorised and payment has been made from the chronic benefit. PMB regulations allow for the use of formularies for specific PMB conditions on the CDL according to the PMB algorithms. This means that treatment is approved for funding on the CIB according to:

- Medical scheme plan type (the formulary for the Core plans differs from the formulary for the Executive Plan)
- Condition according to CDL
- Formulary item
- When the medical scheme member qualifies according to certain clinical entry criteria.

Claims paid from other benefits, such as but not limited to oncology, HIV and acute benefits, fall outside PBR. These claims will continue to be paid according to the chosen network dispensing fees.

You also need to keep in mind that an item that forms part of a treatment guideline for a particular condition (such as bisoprolol for congestive heart failure) may not form part of the treatment guidelines of another condition (such as bisoprolol for hypertension), in which case it may not be authorised for a patient for hypertension.

When an item has not been clinically authorised for a member with a condition, the item is funded from the day-to-day benefits (Medical Savings Account). The standard network dispensing fee is paid, even if the item is on the formulary for that condition or for a different condition. When an item has been clinically preauthorised for a patient with a condition, the item is funded from the CIB and the claim qualifies for PBR dispensing fees even though it may have been authorised for a different condition. For example, while bisoprolol is normally only authorised for congestive heart failure, it is authorised for some patients for hypertension on a clinical appeal authorisation.

PBR only applies to claims of pre-approved chronic medicine paid from the CIB. You also need to keep in mind that there are various types of authorisations. Where we may have granted a patient a 'special authorisation', we pay from the CIB up to the monthly CDA. The patient will be liable for a co-payment when exceeding the CDA.

The higher dispensing fee applies to authorised chronic medicine claims if the SEP unit price of the dispensed item is lower or equal to the PBR benchmark unit price for the active ingredient. For instance, bisoprolol is on the formulary for cardiac failure, in which case, when authorised, the patient will have a 'chronic authorisation'. Where bisoprolol has been authorised for hypertension as a 'special authorisation', we will pay from the CIB up to the CDA. The patient will be liable for a co-payment when exceeding the CDA. The higher dispensing fee applies when the SEP unit price of the dispensed item falls within the bisoprolol PBR benchmark unit price. Please note that in these 'special authorisation' cases, the system responds with reason code '479: Non-formulary item. Please substitute'. This happens because the authorisation has, in this case, not followed normal protocols.

Patients have sometimes been granted a 'special appeal authorisation' that is specific to the NAPPI code. Medical scheme members with a 'special appeal authorisation' will not automatically have access to a generic substitution, unless Discovery Health changes the appeal to a standard authorisation. Pharmacies need to call 0860 44 55 66 for the change in authorisation.

What happens if I do not receive PBR compliance or payment reports?

Make sure that your pharmacy participates in the PBR network and that Discovery Health has received your signed PBR contract.

Call 0860 44 55 66 or email Provider_administration@discovery.co.za to check that your pharmacy's dispensing email address is correct on the system. You will be responsible for making sure that the dispensing email address on our system remains updated. You can also contact the call centre to ask for your compliance figures.



How do I know I have been paid accordingly?

Your PBR payment is a line item on your statement. It will be flagged as 'PBR independent'. The PBR payment amount will be included and the total claims amount will appear in your bank account as a single payment.

What happens when items are out of stock?

When an item is out of stock:

- Report out-of-stock items by emailing CIBAPPFORMS@discovery.co.za or calling 0860 44 55 66. Alerting us will assist us to follow up with the company.
- Please substitute with alternative PBR formulary or benchmark items because, due to over-coding, most items do not need reauthorisation.
- Where necessary, please obtain authorisation for alternative items:
 - By following the normal application process by sending an email to CIBAPPFORMS@discovery.co.za
 - By obtaining telephonic authorisation for a replacement item by calling 0860 44 55 66 if it is urgent and the client is waiting at the dispensary.

Please note: Depending on the availability of preferentially priced generics, there may not always be a new generic replacement item added to the formulary.

Document list

Find the following documents by following the link:

- Chronic Illness Benefit medicine [formulary](#).
- KeyCare Acute medicine [formulary](#)
- HIV Antiretroviral medicine [formulary](#)
- Discovery Health DSP & Standard Pharmacy Network [agreement](#).
- Discovery Health formularies, benchmark pricing, and preferred products list per NAPPI and per active ingredient are listed twice a year on [Pharmacy communiqués](#).



• Contact us

Please send your enquiries to the correct email address listed below. We keep all past communication on our website on the [Pharmacy communiqués](#) page.

<p>Real-time medicine claims queries</p> <ul style="list-style-type: none"> • Claims transmission queries • Price differences • Reason code 98 where a paper claim is requested 	ProPBM call centre	<p>0860 77 67 26 (immediate resolution) or ProPBM_QUERIES@discovery.co.za (48-hour resolution).</p> <p>Please have the following information ready for positive identification of the claim:</p> <ul style="list-style-type: none"> • Pharmacy name and BHF number • Scheme • Membership number • Date of claim • Item • Reason code
<p>Remittance advices and payment run</p> <ul style="list-style-type: none"> • Reconciliations • Remittances • PBR and MedXpress participation 	Healthcare provider call centre	<p>0860 44 55 66</p> <p>healthpartnerinfo@discovery.co.za</p>
Payment for clinical exceptions		ruleexceptionpayment@discovery.co.za
<p>Chronic medicine</p> <ul style="list-style-type: none"> • Add-a-line (telephonic authorisations) • Extended supply of medicine • CIB application forms or prescription updates 	Healthcare provider call centre	<p>0860 44 55 66</p> <p>healthpartnerinfo@discovery.co.za</p>
<p>Out-of-stock chronic formulary items</p> <ul style="list-style-type: none"> • Substitute with alternative formulary items as communicated in the monthly out-of-stock communication as these do not need reauthorisation • Alternatively, obtain authorisation by emailing a list of your patients per item, providing the membership number, patient information and details of the item that is out of stock • Where necessary, obtain telephonic authorisation for a replacement item 	<ul style="list-style-type: none"> • Healthcare provider call centre • Chronic reauthorisations 	<p>0860 44 55 66</p> <p>CIBAPPFORMS@discovery.co.za</p>
Report out-of-stock formulary products	<ul style="list-style-type: none"> • Healthcare provider call centre • Chronic reauthorisations 	<p>0860 44 55 66</p> <p>PRICE_AND_PRODUCT_FILE@discovery.co.za</p>
<p>Oncology and HIV</p> <ul style="list-style-type: none"> • Oncology ICD-10 diagnosis codes 	Healthcare provider call centre	<p>0860 44 55 66</p> <p>Provider_administration@discovery.co.za</p>
<p>Pharmacy Management Administrators</p> <ul style="list-style-type: none"> • System and integration enquiries • (Pharmacy software vendors) 	Electronic Transmission Management	ETM_OPERATIONS@discovery.co.za
<p>Preferred pharmacy networks</p> <ul style="list-style-type: none"> • Joining network or altering of rates • PBR and MedXpress participation • PBR report: Top ranking items that affect compliance • Update contact details 	Provider administration	Provider_administration@discovery.co.za
<p>Discovery Wellness Network</p> <ul style="list-style-type: none"> • Joining the Wellness or HIV Network 	Vitality call centre	<p>011 529 8898</p> <p>vitalitypartnerrelations@discovery.co.za</p>



<ul style="list-style-type: none">Ongoing operational matters		
Discovery fraud hotline	Fraud hotline	0800 00 45 00 discovery@tip-offs.com
Communications <ul style="list-style-type: none">Network arrangementsPBR informationGeneral claims information	Website	Pharmacy communiqués
Registering a pharmacy and formularies <ul style="list-style-type: none">CIB formulary or KeyCare informationRegistration forms for a new pharmacy	Website	Pharmacy overview