

# PLAN COMPARISON

**2023**

Executive | Comprehensive | Priority | Saver | Smart | Core | KeyCare





# Discovery Health Medical Scheme **2023 contributions** April to December

SERIES	PLAN	CONTRIBUTIONS (R)			CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNT (R)			TOTAL CONTRIBUTIONS (R)		
		MAIN MEMBER	ADULT	CHILD**	MAIN MEMBER	ADULT	CHILD**	MAIN MEMBER	ADULT	CHILD**
Executive	Executive Plan	6 842	6 842	1 309	2 280	2 280	435	9 122	9 122	1 744
Comprehensive	Classic Comprehensive	5 616	5 311	1 120	1 871	1 770	373	7 487	7 081	1 493
	Classic Delta Comprehensive	5 057	4 787	1 007	1 685	1 595	335	6 742	6 382	1 342
	Essential Comprehensive	5 349	5 052	1 079	943	890	190	6 292	5 942	1 269
	Essential Delta Comprehensive	4 818	4 550	965	849	802	169	5 667	5 352	1 134
	Classic Smart Comprehensive	5 441	5 022	1 730	No Medical Savings Account			5 441	5 022	1 730
Priority	Classic Priority	3 597	2 837	1 440	1 198	945	478	4 795	3 782	1 918
	Essential Priority	3 503	2 755	1 399	618	485	246	4 121	3 240	1 645
Saver	Classic Saver	3 045	2 402	1 220	1 015	800	406	4 060	3 202	1 626
	Classic Delta Saver	2 433	1 922	977	811	640	325	3 244	2 562	1 302
	Essential Saver	2 744	2 059	1 100	483	362	193	3 227	2 421	1 293
	Essential Delta Saver	2 189	1 652	879	385	291	154	2 574	1 943	1 033
	Coastal Saver	2 577	1 937	1 040	643	483	260	3 220	2 420	1 300
Smart	Classic Smart	2 412	1 903	963	No Medical Savings Account			2 412	1 903	963
	Essential Smart	1 727	1 727	1 727				1 727	1 727	1 727
	Essential Dynamic Smart	1 565	1 565	1 565				1 565	1 565	1 565
Core	Classic Core	3 022	2 384	1 209	No Medical Savings Account			3 022	2 384	1 209
	Classic Delta Core	2 419	1 907	967				2 419	1 907	967
	Essential Core	2 597	1 947	1 043				2 597	1 947	1 043
	Essential Delta Core	2 075	1 561	832				2 075	1 561	832
	Coastal Core	2 403	1 804	955				2 403	1 804	955
KeyCare*	KeyCare Plus 0 – 9,450	1 489	1 489	542	No Medical Savings Account			1 489	1 489	542
	KeyCare Plus 9,451 – 15,250	2 047	2 047	577				2 047	2 047	577
	KeyCare Plus 15,251 +	3 023	3 023	809				3 023	3 023	809
	KeyCare Core 0 – 9,450	1 170	1 170	306	No Medical Savings Account			1 170	1 170	306
	KeyCare Core 9,451 – 15,250	1 459	1 459	362				1 459	1 459	362
	KeyCare Core 15,251 +	2 232	2 232	507				2 232	2 232	507
	KeyCare Start 0 – 10,100	1 127	1 127	687	No Medical Savings Account			1 127	1 127	687
	KeyCare Start 10,101 – 15,250	1 897	1 897	743				1 897	1 897	743
	KeyCare Start 15,251 +	2 954	2 954	803				2 954	2 954	803
	KeyCare Start Regional 0 – 10100	1 003	1 003	604	No Medical Savings Account			1 003	1 003	604
	KeyCare Start Regional 10,101 – 15,250	1 516	1 516	669				1 516	1 516	669
KeyCare Start Regional 15,251 +	2 363	2 363	723	2 363				2 363	723	

Shariah Compliant Arrangement available on all health plans.

\* Income verification will be conducted for the lower income bands. Income is considered as: The higher of the main member or registered spouse or partner's earnings, commission and rewards from employment; interest from investments; income from leasing of assets or property; distributions received from a trust, pension and/or provident fund; receipt of any financial assistance received from any statutory social assistance programme.

\*\* We count a maximum of three children when we work out the monthly contribution and annual Medical Savings Account, except when a child has been placed in the custody of a member, such as foster care, in which case every child on the membership will be counted.

The Annual Medical Savings Account amounts displayed above reflects the adjusted allocation for 2023 following the annual contribution increase from April 2023.

# Annual Medical Savings Account

		MAIN MEMBER (R)	ADULT (R)	CHILD* (R)
Executive	Executive Plan	26 742	26 742	5 103
	Classic Comprehensive	21 945	20 760	4 374
Comprehensive	Classic Delta Comprehensive	19 764	18 708	3 930
	Essential Comprehensive	11 061	10 440	2 229
	Essential Delta Comprehensive	9 960	9 408	1 983
Priority	Classic Priority	14 052	11 085	5 610
	Essential Priority	7 248	5 691	2 886
Saver	Classic Saver	11 955	9 426	4 785
	Classic Delta Saver	9 552	7 539	3 828
	Essential Saver	5 691	4 266	2 274
	Essential Delta Saver	4 536	3 429	1 815
	Coastal Saver	7 575	5 691	3 063

\* We count a maximum of three children when we work out the annual Medical Savings Account, except when a child has been placed in the custody of a member, such as foster care, in which case every child on the membership will be counted.

If you join the medical scheme after January, you won't get the full amount because it is calculated by counting the remaining months in the year.

The Annual Medical Savings Account amounts displayed above reflects the adjusted allocation for 2023 following the annual contribution increase from April 2023.

# Annual Threshold Amounts

## Annual Threshold

	MAIN MEMBER (R)	Adult (R)	CHILD* (R)
Executive	31,200	31,200	5,920
Classic, Essential and Delta Comprehensive	25,740	25,740	4,910
Classic Smart Comprehensive	29,480	29,480	1,000
Priority	20,820	15,650	6,930

## Above Threshold Benefit limits

	MAIN MEMBER (R)	ADULT (R)	CHILD* (R)
Executive	Unlimited		
Comprehensive	Unlimited		
Priority	17,620	12,570	6,160

\* We count a maximum of three children when we work out the Annual Threshold and Above Threshold Benefit limit, except when a child has been placed in the custody of a member, such as foster care, in which case every child on the membership will be counted.

If you join the medical scheme after January, you won't get the full amount because it is calculated by counting the remaining months in the year.

The Annual Threshold and Above Threshold Benefit limit amounts are calculated for January 2023 to December 2023.

		EXECUTIVE			COMPREHENSIVE			PRIORITY			SAVER			SMART		CORE			KEYCARE	
		CLASSIC	ESSENTIAL	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	PLUS	CORE	START	START REGIONAL		
PMB	Prescribed Minimum Benefits (PMB)	All Discovery Health Medical Scheme (DHMS) plans cover the costs related to the diagnosis, treatment and care of: an emergency medical condition, a defined list of 271 diagnoses and a defined list of 27 chronic conditions. Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit conditions. The treatment needed must match the treatments in the defined benefits. You must use designated service providers (DSPs) in our network – this does not apply in emergencies. Where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service providers in our network once your condition has stabilised. If your treatment doesn't meet the above criteria, we will pay up to 80% of the Discovery Health Rate (DHR). You will be responsible for the difference between what we pay and the actual cost of your treatment.																		
	Medical Savings Account (MSA) and day-to-day benefits	Pays for day-to-day medical expenses like GP consultation fees, prescribed and over-the-counter medicine, radiology and pathology as long as you have money available.	Pays for day-to-day medical expenses like GP consultation fees, prescribed and over-the-counter medicine, radiology and pathology as long as you have money available.	This plan does not offer a Medical Savings Account. Access to a defined set of benefits including GP consultations, certain specialist visits, certain acute medicine when prescribed by a Smart GP and over-the-counter medicine, dental check up and optometry check up with fixed co-payments and limits.	Pays for day-to-day medical expenses like GP consultation fees, prescribed and over-the-counter medicine, radiology and pathology as long as you have money available.			This plan does not offer a Medical Savings Account. Access to a defined set of benefits including GP consultations, certain acute medicine when prescribed by a Smart GP and over-the-counter medicine, dental check up and optometry check up with fixed co-payments and limits.			These plans do not offer a Medical Savings Account. Access to a defined set of benefits including GP consultations, certain over-the-counter medicine, dental check up and optometry check up with fixed co-payments and limits.		This plan does not offer a Medical Savings Account.			These plans do not offer a Medical Savings Account. Day-to-day benefits through your chosen KeyCare GP. We pay for basic radiology and pathology at a network provider if referred by your chosen GP, as well as basic optometry and dentistry, and specialist cover up to R4,730 per person per year when referred by your chosen GP.		This plan does not offer a Medical Savings Account. Specialist cover up to R4,730 per person per year when referred by a GP.	This plan does not offer a Medical Savings Account. Day-to-day benefits through your chosen KeyCare Start GP and day-to-day medicine from our medicine list when prescribed by your chosen KeyCare Start GP. We pay for basic radiology and pathology if referred by your chosen KeyCare Start GP, as well as basic optometry and dentistry, and specialist cover up to R2,370 per person per year when referred by your chosen KeyCare Start GP.	This plan does not offer a Medical Savings Account. Day-to-day benefits through referral by the KeyCare Online Practice and day-to-day medicine from our medicine list when prescribed by your chosen KeyCare Start GP. We pay for basic radiology and pathology if referred by your chosen KeyCare Start Regional GP. As well as basic optometry and dentistry, and specialist cover up to R2,370 per person per year when referred by your chosen GP.
DAY-TO-DAY BENEFITS	Day-to-day Extender Benefit	Pays for certain day-to-day benefits after you have run out of money in your MSA and before you reach the Annual Threshold. Covers unlimited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have unlimited cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR. You also have additional cover for kids casualty visits.	Pays for certain day-to-day benefits after you have run out of money in your MSA and before you reach the Annual Threshold. Covers unlimited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have unlimited cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR. On Classic, you also have additional cover for kids casualty visits.	This plan does not offer this benefit.	Pays for certain day-to-day benefits after you have run out of money in your Medical Saving Account and before you reach the Annual Threshold.	Covers unlimited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have unlimited cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR. You also have additional cover for kids casualty visits.	Covers unlimited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have unlimited cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR.	Covers limited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR. You also have additional cover for kids casualty visits.	Covers limited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR.	These plans do not offer this benefit.										

		EXECUTIVE			COMPREHENSIVE			PRIORITY			SAVER			SMART		CORE			KEYCARE		
		CLASSIC	ESSENTIAL	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	PLUS	CORE	START	START REGIONAL			
DAY-TO-DAY BENEFITS	Above Threshold Benefit	The Scheme continues to cover day-to-day healthcare services once you reach your Annual Threshold. The Above Threshold Benefit is unlimited. Annual benefit limits may apply.						The Scheme continues to cover day-to-day healthcare services once you reach your Annual Threshold. The Above Threshold Benefit is limited. Annual benefit limits may apply.						These plans do not offer this benefit.							
	MRI and CT scans	We pay the first R3,470 of your MRI or CT scan from your day-to-day benefits. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.	We pay the first R3,470 of your MRI or CT scan from your day-to-day benefits. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.	You have to pay the first R3,470 of your MRI or CT scan until you reach the Annual Threshold. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.	We pay the first R3,470 of your MRI or CT scan from your day-to-day benefits. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.	We pay the first R3,470 of your MRI or CT scan from your day-to-day benefits. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.	We pay the first R3,470 of your MRI or CT scan from your day-to-day benefits. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.	You must pay the first R3,470 of your MRI or CT scan. We cover the balance of the scan from your Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.	These plans do not offer this benefit.	These plans do not offer this benefit.	MRI and CT scans are paid from the Specialist Benefit up to a limit of R5,000 for a person a year.	MRI and CT scans are paid from the Specialist Benefit up to a limit of R2,500 for a person a year.	MRI and CT scans are paid from the Specialist Benefit up to a limit of R2,500 for a person a year.								
MATERNITY COVER	Cover during your pregnancy and for two years after your baby's birth once the benefit is activated	<b>During pregnancy</b> <ul style="list-style-type: none"> <li>12 antenatal consultations with your gynaecologist, GP or midwife</li> <li>Two 2D ultrasound scans including one nuchal translucency test. 3D and 4D scans are paid up to the rate we pay for 2D scans</li> <li>One chromosome test or Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria</li> <li>Private ward cover up to R2,460 per day for your delivery in hospital</li> <li>Cover for up to R5,350 for essential registered devices with 25% co-payment</li> <li>A defined basket of blood tests</li> <li>Five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth.</li> </ul>			<b>After you give birth</b> <ul style="list-style-type: none"> <li>Your baby is covered for up to two visits to a GP, paediatrician or an ENT</li> <li>You are covered for one six week post-birth consultation at your midwife, GP or gynaecologist as part of your delivery or if there are any complications</li> <li>One nutritional assessment at a dietitian</li> <li>Two mental health consultations with a counsellor or psychologist</li> <li>One breastfeeding consultation with a registered nurse or a breastfeeding specialist.</li> </ul>			<b>During pregnancy</b> <ul style="list-style-type: none"> <li>8 antenatal consultations with your gynaecologist, GP or midwife</li> <li>Two 2D ultrasound scans including one nuchal translucency test. 3D and 4D scans are paid up to the rate we pay for 2D scans</li> <li>One chromosome test or Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria</li> <li>A defined basket of blood tests</li> <li>Five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth.</li> </ul>						<b>After you give birth</b> <ul style="list-style-type: none"> <li>Your baby is covered for up to two visits to a GP, paediatrician or an ENT</li> <li>You are covered for one six week post-birth consultation at your midwife, GP or gynaecologist either as part of your delivery or if there are any complications</li> <li>One nutritional assessment at a dietitian</li> <li>Two mental health consultations with a counsellor or psychologist</li> <li>One breastfeeding consultation with a registered nurse or a breastfeeding specialist.</li> </ul>							
		To access these benefits on KeyCare Start, your chosen GP, or chosen Regional GP on KeyCare Start Regional, must refer you.																			
CHRONIC COVER	Conditions	You have cover for the 27 Chronic Disease List conditions according to the Prescribed Minimum Benefits list as well as additional conditions on our Additional Disease List.						You have cover for the 27 Chronic Disease List conditions according to the Prescribed Minimum Benefits													
	Medicine cover	Approved medicine on our medicine list covered in full (not applicable to ADL conditions). Medicine not on our list paid up to 100% of the DHR up to a maximum of the monthly Chronic Drug Amount.	Full cover for approved medicine on our medicine list (not applicable to ADL). Full cover for Delta options if you use MedXpress or a MedXpress Network Pharmacy. Medicine not on our list paid up to 100% of the DHR up to a maximum of the monthly Chronic Drug Amount.	Full cover for approved medicine on our medicine list. Medicine not on our list paid up to 100% of the DHR up to a maximum of the monthly Chronic Drug Amount.	Approved medicine on our medicine list covered in full when you use MedXpress or a MedXpress Network Pharmacy. Medicine not on our list paid up to 100% of the DHR up to a maximum of the monthly Chronic Drug Amount.	Approved medicine on our medicine list covered in full when you use MedXpress or a MedXpress Network Pharmacy. Medicine not on our list paid up to 100% of the DHR up to a maximum of the monthly Chronic Drug Amount.	Approved medicine on our medicine list covered in full when you use MedXpress or a MedXpress Network Pharmacy. For medicine not on our list, we cover up to the cost of the lowest formulary drug.	Approved medicine on our medicine list covered in full when you use MedXpress or a MedXpress Network Pharmacy. Medicines not on our list paid up to 100% of the DHR up to a maximum of the monthly Chronic Drug Amount.	Approved medicine covered in full when you use one of our network pharmacies or your nominated KeyCare Network GP. Your nominated KeyCare Network GP must prescribe the chronic medicine. For medicine not on our list, we cover up to the cost of the lowest formulary drug.	We cover your chronic medicine in a state facility.	We cover your chronic medicine when you use one of our network pharmacies or your chosen KeyCare Start Regional Network GP. Your chosen Regional Network GP must prescribe the chronic medicine. For medicine not on our list, we cover up to the cost of the lowest formulary drug.										
CANCER COVER	Oncology Benefit	We cover the first R500,000 of your approved cancer treatment over a 12-month cycle in full.	We cover the first R375,000 of your approved cancer treatment over a 12-month cycle in full.	We cover the first R250,000 of your approved cancer treatment over a 12-month cycle in full. All cancer-related healthcare services are covered up to 100% of the Discovery Health Rate (DHR). Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount, we will cover up to 80% of the Discovery Health Rate (DHR).	We cover the first R250,000 of your approved cancer treatment over a 12-month cycle in full. All cancer-related healthcare services are covered up to 100% of the Discovery Health Rate (DHR). Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount, we will cover up to 80% of the Discovery Health Rate (DHR).	We cover the first R250,000 of your approved cancer treatment over a 12-month cycle in full. All cancer-related healthcare services are covered up to 100% of the Discovery Health Rate (DHR). Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount, we will cover up to 80% of the Discovery Health Rate (DHR).	We cover the first R250,000 of your approved cancer treatment over a 12-month cycle in full. All cancer-related healthcare services are covered up to 100% of the Discovery Health Rate (DHR). Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount, we will cover up to 80% of the Discovery Health Rate (DHR).	Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. You have cover for cancer treatment in a state facility. If you choose to use any other provider, we will cover up to 80% of the Discovery Health Rate (DHR).	Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. You have cover for cancer treatment in a state facility. If you choose to use any other provider, we will cover up to 80% of the Discovery Health Rate (DHR).												
	Extended Oncology Benefit	Once you have reached your cover limit, you have extended cover in full for a defined list of cancers and treatments that meet the Scheme's criteria.																			
	Oncology Innovation Benefit	You have cover for a defined list of innovative cancer medicine that meet the Scheme's criteria. You will need to pay 25% of the cost of these treatments.																			
		You have cover for a sub-set of the defined list of innovative cancer medicine, subject to the Scheme's clinical entry criteria. You will need to pay 50% of the cost of these treatments.						These plans do not offer this benefit.													

Discovery Health Rate (DHR) is a rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services.

		EXECUTIVE		COMPREHENSIVE			PRIORITY		SAVER			SMART		CORE			KEYCARE				
		CLASSIC	ESSENTIAL	CLASSIC SMART		CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL		CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL		PLUS	CORE	START	START REGIONAL
HOSPITAL COVER	Private hospital cover in a general ward	Unlimited cover plus private ward cover of up to R2,460 each day.		Unlimited cover plus private ward cover up to R2,460 per day for your delivery.			Unlimited cover		Unlimited cover			Unlimited cover		Unlimited cover			Unlimited cover				
	Private hospital	You are covered in any facility approved by the Scheme.		You are covered in any facility approved by the Scheme. Full cover on Delta options when using the Delta Hospital Network of private hospitals. For planned admissions outside of the Delta Hospital Network, you must pay an upfront payment to the hospital of R9,650.		Full cover in the Smart Hospital Network. For planned admissions at hospitals outside of the Smart Hospital Network, you must pay an upfront payment of R11,000 to the hospital.	You are covered in any facility approved by the Scheme. An upfront payment of between R4,300 to R20,600 applies for a defined list of procedures. Where these procedures form part of the list of procedures to be performed in our Day Surgery Network, the higher of the upfront payments will apply.		You are covered in any facility approved by the Scheme. Full cover on Delta options when using the Delta Hospital Network of private hospitals. For planned admissions outside of the Delta Hospital Network, you must pay an upfront payment to the hospital of R9,650.	Full cover in any approved private hospital in the four coastal provinces network. If you use a hospital outside the coastal network, we pay up to 70% of the DHR of the hospital account and you must pay the difference.		Full cover in the Smart Hospital Network. For planned admissions at hospitals outside of the Smart Hospital Network, you must pay an upfront payment of R11,000 to the hospital. For the Essential Dynamic Smart plan, full cover in the *Essential Dynamic Smart Hospital Network as referred by the virtual assistant. For planned admissions at hospitals outside of the *Essential Dynamic Smart Hospital Network, you must pay an upfront payment of R13,250 to the hospital.		You are covered in any facility approved by the Scheme. Full cover on Delta options when using the Delta Hospital Network of private hospitals. For planned admissions outside of the Delta Hospital Network, you must pay an upfront payment to the hospital of R9,650.	Full cover in any approved private hospital in the four coastal provinces network. If you use a hospital outside the coastal network, we pay up to 70% of the DHR of the hospital account and you must pay the difference.		Full cover if you use a hospital in the KeyCare Hospital Network. If you use a hospital in the Partial Cover Network, we pay up to 70% of the DHR. If you do not use hospitals in the networks, you will have to pay all costs.	Full cover at your chosen KeyCare Start Network hospital. If you do not use your chosen hospital in the network, you will have to pay all costs.	Full cover at your chosen KeyCare Start Regional Network hospital. If you do not use your chosen hospital in the network, you will have to pay all costs.		
	Defined list of procedures in our Day Surgery Network	You are covered in any facility approved by the Scheme.		We cover a defined list of procedures in a day surgery facility. An upfront payment of R6,300 applies for admission to a facility outside of the Day Surgery Network. An upfront payment of R9,650 applies on the Delta options, if performed outside of the Delta day surgery network.		We cover a defined list of procedures in the Smart Day Surgery Network. An upfront payment of R11,000 applies for admissions to a facility outside of the Smart Day Surgery Network.	We cover a defined list of procedures in a Day Surgery Network. An upfront payment of R6,300 applies for admissions to a facility outside of the Day Surgery Network. Where these procedures form part of the list of in-hospital procedures with an upfront payment, the higher of the upfront payments will apply.		We cover a defined list of procedures in a Day Surgery Network. An upfront payment of R6,300 applies for admissions to a facility outside of the Day Surgery Network. An upfront payment of R9,650 applies on the Delta options, if performed outside of the Delta Day Surgery Network.		We cover a defined list of procedures in the Smart Day Surgery Network. An upfront payment of R11,000 applies for admissions to a facility outside of the Smart Day Surgery Network as advised by the virtual agent. On the Essential Dynamic Smart plan, an upfront payment of R13,250 applies for admission to a facility outside of the *Essential Dynamic Smart Day Surgery Network.		We cover a defined list of procedures in a Day Surgery Network. An upfront payment of R6,300 applies for admissions to a facility outside of the Day Surgery Network. An upfront payment of R9,650 applies on the Delta options, if performed outside of the Delta Day Surgery Network.	We cover a defined list of procedures in a Day Surgery Network. An upfront payment of R6,300 applies for admissions to a facility outside of the Day Surgery Network.		We cover a defined list of procedures in the KeyCare Day Surgery Network.	We cover a defined list of procedures in the KeyCare Start Day Surgery Network.	We cover a defined list of procedures in the KeyCare Start Day Surgery Network.			
	Full cover option for specialists we have a payment arrangement with	Full cover		Full cover			Full cover		Full cover			Full cover		Full cover			Full cover				
	Reimbursement rate for specialists we do not have a payment arrangement with	300% of the DHR		200% of the DHR	100% of the DHR	200% of the DHR		200% of the DHR	100% of the DHR		200% of the DHR	100% of the DHR	200% of the DHR	100% of the DHR	200% of the DHR	100% of the DHR		100% of the DHR			
	Reimbursement rate for GPs and other healthcare professionals (not specialists)	200% of the DHR		200% of the DHR	100% of the DHR	200% of the DHR		200% of the DHR	100% of the DHR		200% of the DHR	100% of the DHR	200% of the DHR	100% of the DHR	200% of the DHR	100% of the DHR		100% of the DHR			
	Reimbursement rate for radiology and pathology	100% of the DHR		100% of the DHR			100% of the DHR		100% of the DHR			100% of the DHR		100% of the DHR			100% of the DHR				
	Cover for scopes (gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy)	Depending on where you have your scope done, we pay a portion of between R4,050 and R5,900 from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher co-payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the Day Surgery Network, the highest of the out-of-network upfront payment or scopes co-payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit.		Depending on where you have your scope done, we pay a portion of between R4,050 and R5,900 from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher co-payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the Day Surgery Network, the highest of the out-of-network upfront payment or scopes co-payment will apply.		Depending on where you have your scope done, we pay a portion of between R4,050 and R6,500 from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the Day Surgery Network, the highest of the out-of-network upfront payment or scopes co-payment will apply.	Depending on where you have your scope done, we pay a portion of between R4,050 and R6,950 from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher co-payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the Day Surgery Network, the highest of the out-of-network upfront payment or scopes co-payment will apply.		Depending on where you have your scope done, we pay a portion of between R4,050 and R6,950 from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the Day Surgery Network, the highest of the out-of-network upfront payment or scopes co-payment will apply.	Depending on where you have your scope done, you will have to pay a portion of between R4,050 and R6,950 and we pay the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the Day Surgery Network, the highest of the out-of-network upfront payment or scopes co-payment will apply.		Depending on where you have your scope done, you will have to pay a portion of between R4,050 and R6,950 and we pay the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the Day Surgery Network, the highest of the out-of-network upfront payment or scopes co-payment will apply.	Depending on where you have your scope done, you will have to pay a portion of between R4,050 and R6,950 and we pay the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the Day Surgery Network, the highest of the out-of-network upfront payment or scopes co-payment will apply.		Depending on where you have your scope done, you will have to pay a portion of between R4,050 and R6,950 and we pay the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the Day Surgery Network, the highest of the out-of-network upfront payment or scopes co-payment will apply.	Depending on where you have your scope done, you will have to pay a portion of between R4,050 and R6,950 and we pay the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the Day Surgery Network, the highest of the out-of-network upfront payment or scopes co-payment will apply.		Prescribed Minimum Benefit cover, in the KeyCare Day Surgery Network. If done in the doctor's rooms, we pay the account from the Hospital Benefit.	Prescribed Minimum Benefit cover, in the KeyCare Start Day Surgery Network. If done in the doctor's rooms, we pay the account from the Hospital Benefit.	Prescribed Minimum Benefit cover, in the KeyCare Start Regional Day Surgery Network. If done in the doctor's rooms, we pay the account from the Hospital Benefit.	
	Cover for MRI and CT scans related to admission	If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.		If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.			If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.		If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.			If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.		If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.			If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.				
	Cover for MRI and CT scans if not related to admission or for back and neck treatment	We pay the first R3,470 of the scan from your day-to-day benefits. We pay the balance of the scan from the Hospital Benefit, up to 100% of the DHR. Limited to one scan per spinal and neck region.		We pay the first R3,470 of the scan from your day-to-day benefits. We pay the balance of the scan from the Hospital Benefit, up to 100% of the DHR. Limited to one scan per spinal and neck region.	You need to pay the first R3,470 of your MRI or CT scan until you reach the Annual Threshold. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per body region applies.		We pay the first R3,470 of the scan from your day-to-day benefits. We pay the balance of the scan from the Hospital Benefit up to 100% of the DHR. For conservative back and neck treatment, you must also pay the first R4,050 of the hospital account. We pay the balance of the scan from the Hospital Benefit up to 100% of the DHR. Limited to one scan per spinal and neck region.		We pay the first R3,470 of the scan from your day-to-day benefits. We pay the balance of the scan from the Hospital Benefit, up to 100% of the DHR. Limited to one scan per spinal and neck region.	You need to pay the first R3,470 of the scan. We pay the balance of the scan from the Hospital Benefit, up to 100% of the DHR. Limited to one scan per spinal and neck region.		These plans do not offer this benefit.	These plans do not offer this benefit.			We pay scans from the Specialist Benefit up to a limit of R5,000 for each person each year.	We pay scans from the Specialist Benefit up to a limit of R2,500 for each person each year.				

Discovery Health Rate (DHR) is a rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services.

\* The full extent of Essential Dynamic Smart Hospital Network will become available during the second quarter of 2023. Members on the Essential Dynamic Smart plan are encouraged to use healthcare providers in the Smart Network until the new network is available.



		EXECUTIVE			COMPREHENSIVE			PRIORITY		SAVER			SMART		CORE			KEYCARE		
		CLASSIC	ESSENTIAL	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	PLUS	CORE	START	START REGIONAL		
ADDITIONAL BENEFITS	<b>Advanced Illness Benefit</b>	Members have access to a comprehensive palliative care programme. This programme offers unlimited cover for approved care at home, care coordination, counselling services and supportive care for appropriate end-of-life clinical and psychologist services. You also have access to a GP consultation to facilitate your palliative care treatment plan.																		
	<b>Africa Evacuation Benefit</b>	Cover for emergency medical evacuations from certain sub-Saharan African countries back to South Africa. Pre-existing conditions are excluded.														These plans do not offer these benefits.				
	<b>Assisted Reproductive Therapy (ART)</b>	You have cover for up to two cycles of ART if you meet the Scheme's benefit entry criteria. Cover includes a basket of care which includes cover for consultations, ultrasounds, oocyte retrieval, embryo transfer and freezing, admission costs including lab fees, medication and embryo and sperm storage. This benefit also includes cover for egg donated cycles. If you are registered on the Oncology Programme and meet the Scheme's clinical entry criteria, you have access to egg and sperm cryopreservation for up to five years. We pay up to a limit of R122,000 per person per year at 75% of the Discovery Health Rate (DHR). A co-payment of 25% will apply.					These plans do not offer these benefits.													
	<b>Care Programmes</b>	Preventative and condition-specific care programmes for diabetes, mental health, HIV and heart conditions. We cover preventative and condition-specific care programmes that help you to manage diabetes, mental health, HIV or heart-related medical conditions. You have to be registered on these condition-specific care programmes to unlock additional benefits and services. You and your Premier Plus GP can track progress on a personalised dashboard to identify the next steps to optimally manage your condition and stay healthy over time. Cover is subject to the Scheme's clinical entry criteria, treatment guidelines and protocols.																		
	<b>Connected Care</b>	You have access to hospital-level care in your home instead of having to go to hospital for acute hospital care. This includes cover and treatment for COVID-19 and/or follow-up care once discharged. You have access to the Hospital at Home devices and healthcare services if you meet the clinical and benefit criteria. You have access to care at home, including a Home Monitoring Device Benefit for essential home monitoring and home-based care for follow up treatment after an admission. The Home Monitoring Device Benefit gives you access to a range of essential and registered home monitoring devices for certain chronic and acute conditions. Approved cover for these devices will not affect your day-to-day benefits. If you meet the scheme's clinical entry criteria, you have healthcare cover up to a limit of R4,250 per person per year, at 100% of the Discovery Health Rate (DHR). The Scheme also covers defined point of care medical devices up to 75% of the Discovery Health Rate (DHR), if you meet the clinical entry criteria.																	These plans do not offer these benefits.	
	<b>Screening and Prevention Benefit</b>	This benefit covers a health check which is made up of certain tests at one of our wellness network providers, like blood glucose, blood pressure, cholesterol and body mass index. We also cover a mammogram every two years, Pap smear every three years or one HPV test every 5 years, PSA (a prostate screening test) once a year and HIV screening tests. Seasonal flu vaccine during pregnancy, or for members 65 years or older and/or registered for certain chronic conditions. Pneumococcal vaccine for persons over the age of 65 and/or registered for certain chronic conditions. We also cover bowel cancer screening tests every two years for members between 45 and 75 years. Additional, and/or more frequent screening is available for those who meet our clinical criteria. Consultations that do not form part of Prescribed Minimum Benefits (PMBs) will be paid from your available day-to-day benefits. Kids screening tests include a growth assessment and health and milestone tracking at any one of our wellness network providers.																		
	<b>WELLTH Fund</b>	The WELLTH Fund covers a comprehensive list of screening and prevention healthcare services according to your individual health needs. This benefit is separate from and additional to the Screening and Prevention Benefit and is available once per lifetime for all members and dependants who have completed their health checks. Your WELLTH Fund can be used for appropriate screening and prevention healthcare services, up to your WELLTH Fund limit. Cover is subject to the Scheme's clinical entry criteria, treatment guidelines and protocols.																		
	<b>Trauma Recovery Extender Benefit</b>	Extends your cover for out-of-hospital claims for recovery after certain traumatic events for the rest of the year in which the trauma took place, and a year after the trauma. You and your dependants on your health plan also have access to six counselling sessions per person per year by a psychologist, clinical social worker or registered counsellor. You need to apply for this benefit.																		
	<b>WHO Global Outbreak Benefit</b>	Provides cover for approved global disease outbreaks recognised by the World Health Organisation (WHO) such as COVID-19 and monkeypox. This benefit provides access to a defined basket of care per disease outbreak, which includes cover for vaccines (where applicable) and relevant out-of-hospital treatment.																		
	<b>International Travel Benefit</b>	Cover up to \$1 million for each person on each journey for emergency medical costs while travelling outside of South Africa, for a period of 90 days from your departure from South Africa. Specific rules apply and pre-existing conditions are excluded.		Cover up to R5 million for each person on each journey for emergency medical costs while travelling outside of South Africa, for a period of 90 days from your departure from South Africa. Specific rules apply and pre-existing conditions are excluded.													These plans do not offer these benefits.			
<b>Overseas Treatment Benefit</b>	Up to R750,000 for each person travelling for evidence-based healthcare treatment not available in South Africa. You also have cover for R300,000 at a recognised healthcare provider for in-hospital treatment that is available in South Africa. A co-payment of 20% and specific rules apply to these benefits.		Up to R500,000 for each person travelling for evidence-based healthcare treatment not available in South Africa. A co-payment of 20% and specific rules apply to this benefit.													These plans do not offer these benefits.				

Discovery Health Rate (DHR) is a rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services.

Discovery Health Medical Scheme is regulated by the Council for Medical Schemes.

Complaints process: The following channels are available for your complaints: 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](http://www.discovery.co.za). We would also love to hear from you if we have exceeded your expectations. 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](http://www.discovery.co.za) or by e-mailing [principalofficer@discovery.co.za](mailto:principalofficer@discovery.co.za). Step 3 – 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. Step 4 – 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](mailto:complaints@medicalschemes.co.za) | 0861 123 267 | [www.medicalschemes.co.za](http://www.medicalschemes.co.za)

The benefits explained in this brochure are provided by Discovery Health Medical Scheme, registration number 1125, administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes. This brochure is only a summary of the key benefits and features of Discovery Health Medical Scheme plans. In all instances, Discovery Health Medical Scheme Rules prevail. Please consult the Scheme Rules on [www.discovery.co.za](http://www.discovery.co.za). When reference is made to 'we' in the context of benefits, members, payments or cover, in this brochure this is reference to Discovery Health Medical Scheme. We are continuously improving our communication to you. The most up to date and detailed benefit information is available on [www.discovery.co.za](http://www.discovery.co.za). Discovery Health Medical Scheme, registration number 1125, administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes. Discovery app, Ask Discovery, MedXpress, Medicine tracker, Track your health, second opinion services from Cleveland Clinic, Connected Care and Discovery Hospital at Home are brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes