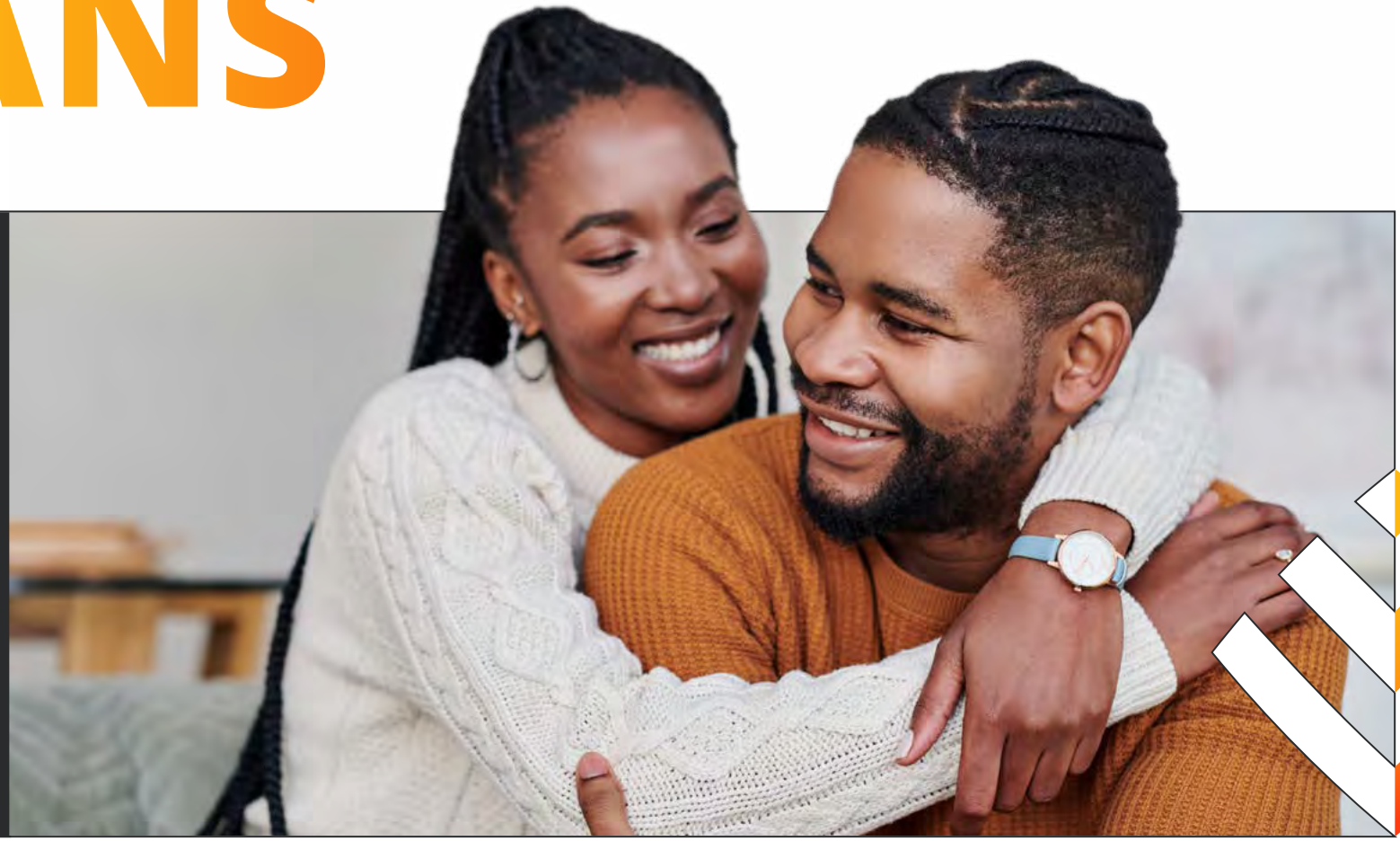
Discovery
Health Medical Scheme

2024

PRIORITY PLANS

CLASSIC

ESSENTIAL



Reimagining **your healthcare**

For the best quality healthcare to support life's inevitable moments, ***Discovery Health Medical Scheme provides comprehensive healthcare that is just right for you.***

Read this guide to understand more about your health plan including:

- What to do when you need to go to a doctor or to a hospital
- How you are covered for preventative screening, diagnosis and treatment of medical conditions
- Which benefits you need to apply for and if there are any limits for certain benefits
- Your access to a truly personalised health journey through the Discovery Health app. This helps you navigate the healthcare system easily.

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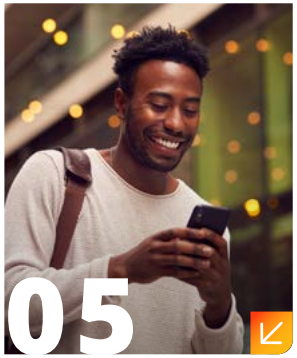
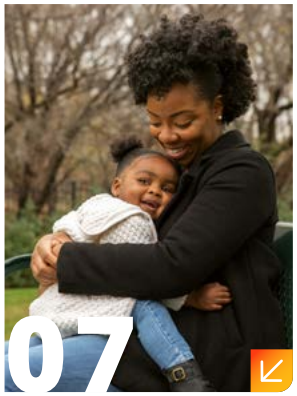
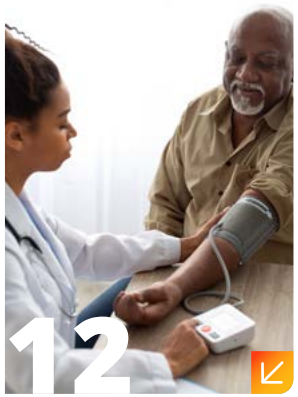






Key terms

About some of the terms we use in this document.

01

A

Above Threshold Benefit (ATB)

Once the day-to-day claims you have sent to us add up to the Annual Threshold, we pay the rest of your day-to-day claims from the Above Threshold Benefit (ATB), at the Discovery Health Rate (DHR) or a portion of it. The Priority plans have a limited ATB.

Annual Threshold

We set the Annual Threshold amount at the beginning of each year. The number and type of dependants (spouse, adult or child) on your plan will determine the amount.

The Annual Threshold is an amount that your claims need to add up to before we pay your day-to-day claims from the limited Above Threshold Benefit (ATB).

C

Chronic Disease List (CDL)

A defined list of chronic conditions we cover according to the Prescribed Minimum Benefits (PMBs).

Chronic Drug Amount (CDA)

The Chronic Drug Amount (CDA) is the monthly amount that we pay up to for a medicine class, subject to a member's plan type. This applies to chronic medicine that is not listed on the formulary or medicine list.

Chronic Illness Benefit (CIB)

The Chronic Illness Benefit (CIB) covers you for a defined list of chronic conditions. You need to apply to have your medicine and treatment covered for your chronic condition.

Co-payment

This is an amount that is payable from the available funds in your Medical Savings Account (MSA) or limited Above Threshold Benefit (ATB) towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service or if the amount the service provider charges is higher than the rate we cover. If the co-payment amount is higher than the amount charged for the healthcare service, you will have to pay for the cost of the healthcare service.

Cover

Cover refers to the benefits you have access to and how we pay for these healthcare services such as consultations, medicine and hospitals, on your health plan.

D

Day-to-day benefits

These are the available funds allocated to the Medical Savings Account (MSA) and limited Above Threshold Benefit (ATB).

D

Day-to-Day Extender Benefit (DEB)

The Day-to-day Extender Benefit (DEB) extends your day-to-day cover for essential healthcare services, in our network, if you have spent your annual Medical Savings Account (MSA) allocation and before you reach the Annual Threshold.

Deductible

This is the amount that you must pay upfront to the hospital or day clinic for specific treatments and/or procedures or if you use a facility outside of the network. If the upfront amount is higher than the amount charged for the healthcare service, you will have to pay for the cost of the healthcare service.

Designated service provider (DSP)

A healthcare provider (for example doctor, specialist, allied healthcare professional, pharmacy or hospital) who we have an agreement with to provide treatment or services at a contracted rate.

Visit **www.discovery.co.za** or click on Find a healthcare provider on the Discovery Health app to view the full list of DSPs.

Discovery Health Rate (DHR)

This is a rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services.

Discovery Health Rate for medicine

This is the rate we pay for medicine. It is the Single Exit Price of medicine plus the relevant dispensing fee.

Discovery Home Care

Discovery Home Care is an additional service that offers you quality home-based care in the comfort of your home for healthcare services like IV infusions, wound care, post-natal care and advanced illness care.

Discovery MedXpress

Discovery MedXpress is a convenient and cost-effective medicine ordering and delivery service for your monthly chronic medicine, or you can choose to collect your medicine in-store at a MedXpress Network Pharmacy.

E

Emergency medical condition

An emergency medical condition, also referred to as an emergency, is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical and surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy.

An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency.

F

Find a healthcare provider

Find a healthcare provider is a medical and provider search tool which is available on the Discovery Health app or website **www.discovery.co.za**

H

HealthID

HealthID is an online digital platform that gives your doctor fast, up-to-date access to your health information. Once you have given consent, your doctor can use HealthID to access your medical history, make referrals to other healthcare professionals and check your relevant test results.

M

Medical Savings Account (MSA)

The Medical Savings Account (MSA) is an amount that is allocated to you at the beginning of each year or when you join the Scheme. You pay this amount back in equal portions as part of your monthly contribution. We pay your day-to-day medical expenses such as GP and specialist consultations, acute medicine, radiology and pathology from the available funds allocated to your MSA. You can choose to have your claims paid from the MSA either at the Discovery Health Rate, or at cost. Any unused funds will carry over to the next year. Should you leave the Scheme or change your plan partway through the year and have used more of the funds than what you have contributed, you will need to pay the difference to us.

Medicine list (formulary)

A list of medicine we cover in full for the treatment of approved chronic condition(s). This list is also known as a formulary.

N

Networks

You may need to make use of specific hospitals, pharmacies, doctors, specialists or allied health professionals in a network. We have payment arrangements with these providers to ensure you get access to quality care at an affordable cost. By using network providers, you can avoid having to pay additional costs and co-payments yourself.

Doctor Networks

You have full cover for GPs, specialists or allied healthcare professionals who we have payment arrangements with.

Day Surgery Networks

You have full cover for a defined list of procedures in our Day Surgery Network.

Medicine Networks

Use MedXpress or a MedXpress network pharmacy to enjoy full cover and avoid co-payments when claiming for chronic medicine on the medicine list.

P

Payment arrangements

The Scheme has payment arrangements with various healthcare professionals and providers to ensure that you can get full cover with no shortfalls.

Preferred medicine

Preferred medicine includes preferentially priced generic and branded medicine.

Premier Plus GP

A Premier Plus GP is a network GP who has contracted with us to provide you with coordinated care and enrolment on one of our care programmes for defined chronic conditions.

Prescribed Minimum Benefits (PMB)

In terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- An emergency medical condition
- A defined list of 271 diagnoses
- A defined list of 27 chronic conditions.

To access Prescribed Minimum Benefits (PMBs), there are rules defined by the Council for Medical Schemes (CMS) that apply:

- Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit (PMB) 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 you do not use a DSP 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.

If your treatment doesn't meet the above criteria, we will pay according to your plan benefits.

Primary care doctor

A primary care doctor helps you take care of your general health. Having one nominated doctor who manages your health and coordinates your care leads to better health outcomes. Your primary care doctor knows your complete medical history and takes the healthcare approach that works best for you.

R

Reference price

The reference price is the set amount we pay for a medicine category. This applies for medicine that is not listed on the medicine list (formulary).

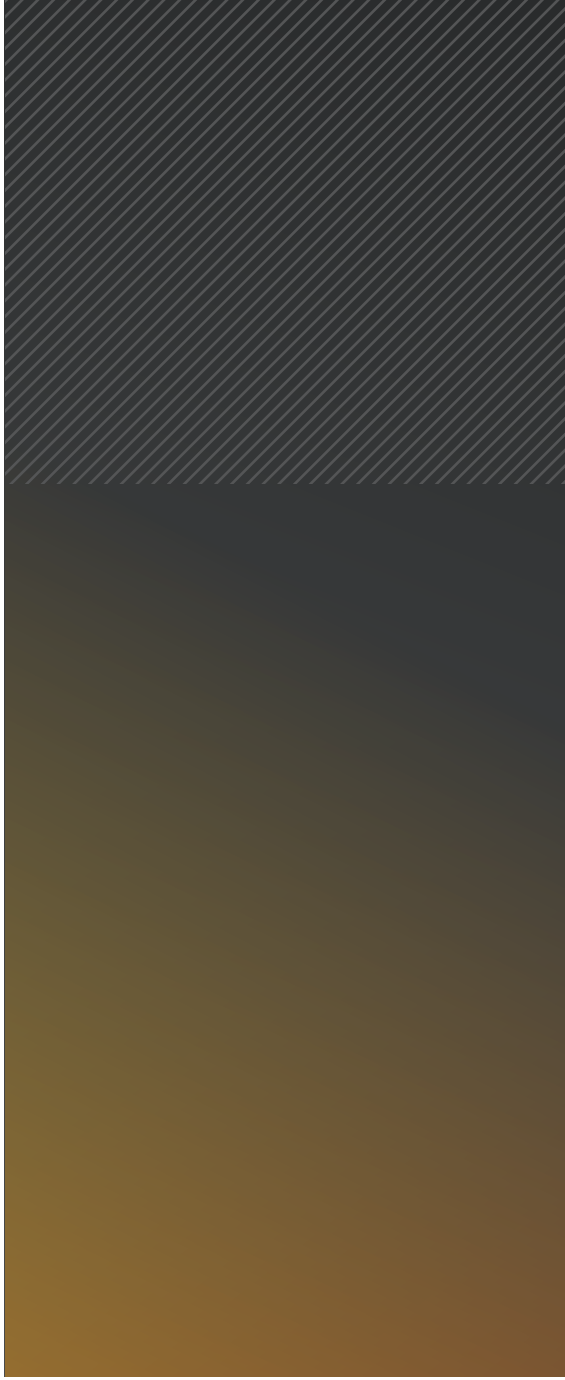
Related accounts

Any account other than the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology.

S

Shariah compliant arrangement

An arrangement which enables you to have your health plan administered in accordance with principles that are Shariah compliant.



Key features

Unlimited cover for hospital admissions

There is no overall limit for hospital cover on the Priority plans.

Full cover for chronic medicine

Full cover for chronic medicine on our formulary forall Chronic Disease List (CDL) conditions when you use MedXpress or a MedXpress Network Pharmacy.

Discovery Health app and virtual benefits

The Discovery Health app gives you access to a truly personalised health journey and a way to navigate the healthcare system easily. Access the advice and healthcare support you need 24/7 through a set of innovative features.

Extensive cover for pregnancy

You get comprehensive benefits for maternity and early childhood that cover certain healthcare services before and after birth.

WELLTH Fund

The WELLTH Fund covers a comprehensive list of additional screening and prevention healthcare services according to your individual health needs.

Full cover in hospital for related accounts

Full cover in hospital for specialists who we have a payment arrangement with, and up to 200% of the Discovery Health Rate (DHR) on Classic, and up to 100% of the DHR on Essential for other healthcare professionals.

Screening and prevention

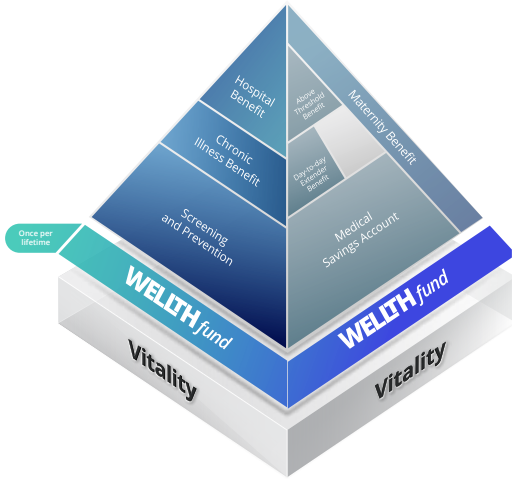
Screening and prevention benefits that cover vital tests to detect early warning signs of serious illness.

Cover when travelling

Cover for medical emergencies when travelling.

Comprehensive day-to-day cover

We pay your day-to-day medical expenses from the available funds allocated to your Medical Savings Account (MSA). This empowers you to manage your spend. The Day-to-day Extender Benefit (DEB) extends your day-to-day cover for essential healthcare services in our network. You have a limited ATB that gives you further day-to-day cover once you have reached your Annual Threshold.



Shariah compliant arrangement available on all health plans.

Vitality is a separate wellness product sold and administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07. Limits, terms and conditions apply.

The benefits

on the different Priority plans

The two plan options have differences in benefits, as shown in the table.

All other benefits not mentioned in the table are the same across both plan options.

	CLASSIC PRIORITY	ESSENTIAL PRIORITY
DAY-TO-DAY COVER		
Medical Savings Account (MSA)	25% of your monthly contribution	15% of your monthly contribution
Day-to-day Extender Benefit (DEB)	The Day-to-day Extender Benefit (DEB) extends your day-to-day cover while you are in the Self-payment Gap for essential healthcare services in our network You also have additional cover for kids casualty visits	The Day-to-day Extender Benefit (DEB) extends your day-to-day cover while you are in the Self-payment Gap for essential healthcare services in our network
HOSPITAL COVER		
Cover for healthcare professionals in hospital	Twice the Discovery Health Rate (DHR) (200%)	The Discovery Health Rate (DHR) (100%)

Your access to Prescribed Minimum Benefits and cover in an emergency

What are Prescribed Minimum Benefits

According to the Prescribed Minimum Benefit (PMB) conditions in terms of the Medical Schemes Act 131 of 1998 and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- An emergency medical condition
- A defined list of 271 diagnoses
- A defined list of 27 chronic conditions.

To access Prescribed Minimum Benefits (PMBs), there are rules defined by the Council for Medical Schemes (CMS) that apply:

- Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit (PMB) 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 you do not use a DSP 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.

If your treatment doesn't meet the above criteria, we will pay according to your plan benefits.

What is a medical emergency?

An emergency medical condition, also referred to as an emergency, is the sudden and unexpected onset of a health condition that requires immediate medical or surgical treatment. Failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy. An emergency does not necessarily require a hospital admission. We may ask you or your treating provider for additional information to confirm the emergency.

Assistance during or after a traumatic event

You have access to dedicated assistance in the event of a traumatic incident or after a traumatic event. By calling Emergency Assist you and your family have access to trauma support 24 hours a day. This service also includes access to counseling and additional benefits for trauma related to gender-based violence.

What we pay for

We pay for all of the following medical services that you may receive in an emergency:

- The ambulance (or other medical transport)
- The account from the hospital
- The accounts from the doctor who admitted you to the hospital
- The anaesthetist
- Any other healthcare provider that we approve.

Discovery Health App and virtual benefits

Don't search your health, discover it.

The Discovery Health app gives Discovery Health Medical Scheme members access to a truly personalised health journey and a way to navigate the healthcare system easily. Access the advice and healthcare support you need 24/7 through these innovative features.

Check your symptoms

Use our Artificial Intelligence (AI) platform to diagnose your symptoms and get guidance, talk to a doctor, or request emergency assistance.

Online Pharmacy

Order your medicine for delivery or shop all other in-store items – delivered to your door.

Emergency assistance

Stay safe with our panic button on the Discovery Health app for emergency medical care. Call for help, request a call back, or we'll locate you and dispatch emergency care.

Manage your plan

Seamlessly manage your medical aid plan – find healthcare providers, submit and track claims, monitor benefits and more.

Personalised health nudges

Access personalised health and wellness recommendations based on your unique health profile.

Virtual Physical Therapy

Access to personalised and evidence-based virtual physical therapy, prescribed by an appropriate healthcare professional. Virtual physical therapy will be paid from your available day-to-day benefits.

Online counselling with Digital Mental Health

Access an on-demand digital mental healthcare platform for evidence-based support programmes and tools with Digital Mental Health. If you are diagnosed with depression your claims will fund from your available Prescribed Minimum Benefits (PMBs), subject to clinical entry criteria. If you do not meet the criteria or have used your benefits, claims will fund from your available day-to-day benefits.

Virtual Urgent Care

Skip the waiting room and urgently consult with a doctor 24/7 online and get digital prescriptions – no matter where you are. We cover you for four virtual urgent care sessions per family, per year, subject to clinical entry criteria. Any additional sessions will fund from your available day-to-day benefits.

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Your access to care at home

04

Home-based Hospital Network

If you are admitted to our Home-based Hospital Network designated service provider, you have access to enhanced benefits and services delivered through your personalised care team. We pay all services offered as part of this network from your Hospital Benefit, if you have a valid pre-authorisation for hospitalisation.

If you meet the Scheme's clinical benefit entry criteria, this gives you access to:

- Physical and virtual 24-hour care delivery facilitated by a dedicated care team
- Access to a remote monitoring device that automatically transmits information to a hospital-based care team, 24 hours a day, seven days a week.
- Access to an improved range of clinical diagnostic procedures and interventions to manage medical or postsurgical hospital-level care in the home

Home Monitoring Device Benefit for essential home monitoring

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.

Cover for Home Care

Discovery Home Care is a service that offers you quality care in the comfort of your own home when recommended by your doctor as an alternative to a hospital stay. Services include postnatal care, end-of-life care, IV infusions (drips) and wound care. These services are paid from the Hospital Benefit, subject to approval. Discovery Home Care is the designated service provider (DSP) for administration of defined intravenous infusions. Avoid a 20% co-payment by using Discovery Home Care for these infusions.

Essential screening
and prevention benefits

This benefit pays for certain tests that can detect early warning signs of serious illnesses. We cover various screening tests at our wellness providers, for example, blood glucose, cholesterol, HIV, Pap smear or HPV test for cervical screening, mammograms and/or ultrasounds and prostate screenings.

03

What we pay for

We cover various screening tests at our wellness providers.

These tests are paid from the Screening and Prevention Benefit. Consultations that do not form part of Prescribed Minimum Benefits (PMBs) will be paid from your available day-to-day benefits.

Screening for kids

This benefit covers the assessment of your child's growth and development, which includes the measurement of weight, height, body mass index and blood pressure at one of our wellness providers.

Screening for adults

This benefit covers a health check which is made up of certain tests such as blood glucose, blood pressure, cholesterol, body mass index and HIV screening at one of our wellness providers. We also cover a mammogram or ultrasound of the breast every two years, a Pap smear once every three years or a HPV test once every five years, a mental wellbeing assessment every year, PSA test (prostate screening) each year and bowel cancer screening tests every two years for members between 45 and 75 years. These tests are paid from the Screening and Prevention Benefit. Consultations that do not form part of Prescribed Minimum Benefits (PMBs) will be paid from your available day-to-day benefits.

Screening for seniors

In addition to the screening for adults, members aged 65 years and older have cover for an age appropriate falls risk screening assessment in our defined pharmacy network. You may have cover for an additional falls risk assessment when referred to a Premier Plus GP, depending on your screening test results and if you meet the Scheme's clinical entry criteria.

Visit **www.discovery.co.za** to view the detailed Screening and Prevention Benefit guide.

Additional tests

Clinical entry criteria may apply to these tests:

- Defined diabetes and cholesterol screening tests
- Breast MRI or mammogram and once-off BRCA testing for breast screening
- Colonoscopy for bowel cancer screening
- Pap smear or HPV test for cervical screening.

Vaccines

(clinical entry criteria may apply):

- Seasonal flu vaccine for members who are pregnant, 65 years or older, registered for certain chronic conditions or healthcare professionals
- Pneumococcal vaccine for members over the age of 65 or those registered for certain chronic conditions
- COVID-19 vaccines are covered from the WHO Global Outbreak Benefit. Refer to section 12 for more information.

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You have access to the WELLTH *fund*

The WELLTH Fund covers a comprehensive list of screening and prevention healthcare services to ensure that you are empowered to take specific action according to your individual health needs.

This benefit is separate from and additional to the Screening and Prevention Benefit and will be 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.

How to get access

The Wellth Fund was introduced in 2023 and is available for two benefit years once all beneficiaries over the age of two years complete their age-appropriate health check as described on the previous page at a provider in our Wellness Network. For new joiners, the benefit is available in the year of joining and the year thereafter.

Visit **www.discovery.co.za** to view the detailed Wellth Fund guide.

What limits apply

The benefit is available once per beneficiary per lifetime. Qualifying healthcare services are covered up to a maximum of the Discovery Health Rate (DHR), subject to the overall benefit limit.

Your WELLTH Fund limit is dependant on the size and make up of your family on your policy:

- R2,500 per adult dependant
- R1,250 per child dependant two years and older
- Up to a maximum of R10,000 per family

The WELLTH Fund is available to all registered beneficiaries on the membership. The WELLTH Fund will not cover screening and prevention healthcare services already covered by other defined benefits.

These include:

- **General health**
- **Women and men's health**
- **Physical health**
- **Children's health**
- **Mental health**
- **Medical monitoring devices**

Day-to-day benefits

We cover your day-to-day healthcare expenses from your Medical Savings Account (MSA), Day-to-day Extender Benefit (DEB) or limited Above Threshold Benefit (ATB).

06

The Medical Savings Account (MSA)

We pay your day-to-day medical expenses such as GP and specialist consultations, medicine (excluding registered chronic medicine), radiology and pathology from your available funds allocated to your MSA. Any amount that is left over will carry over to the next year.

You have the option to have your claims paid from the MSA at either the Discovery Health Rate, or at cost.

The Scheme will automatically fund your claims in excess of the DHR, if you have opted to have your claims paid from the MSA at cost. If you have opted to have claims paid from your MSA at the DHR and you wish to have claims paid in excess of the DHR or benefit limits from the available funds in your MSA, you can request a special payment from your MSA.

Claims paid from the MSA in excess of the DHR do not add up to the Annual Threshold.

The Above Threshold Benefit (ATB)

The Above Threshold Benefit starts paying for day-to-day expenses once you reach your Annual Threshold.

Some claims do not add up to your Annual Threshold or pay from the ATB for example:

- Medicine that you do not need a prescription for (over-the-counter medicine)
- Childhood vaccines and immunisations
- Lifestyle-enhancing products
- Claims in excess of the Discovery Health Rate (DHR).
- Claims paid in excess of annual benefit limits.

What we pay for

The Above Threshold Benefit (ATB) is limited and covers all day-to-day expenses at the Discovery Health Rate (DHR) or at a portion of it. Certain benefit limits may apply. You will need to pay for any difference between the DHR and the amount claimed, as well as any amount which exceeds the annual benefit limit (where applicable) or ATB limit.

For more detail on how you are covered visit *Do we cover* on our website **www.discovery.co.za**.

The Self-payment Gap (SPG)

If your MSA runs out before you reach your Annual Threshold, you will have to pay for claims from your own pocket until your claims reach the Annual Threshold amount. This period is known as the Self-Payment Gap (SPG). It is important that you continue to send in your claims during the SPG so that we know when you reach your Annual Threshold for claims.

Claims will reduce your SPG and accumulate towards your Annual Threshold at 100% of the Discovery Health Rate, or a portion thereof as set out in the first table on the next page. Certain claims will not accumulate.

Day-to-day Extender Benefit (DEB)

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 video call consultations with a network GP as well as pharmacy clinic consultations in our defined wellness network. You also have cover for face-to-face consultations with a network GP, when referred following a video call consultation or by the pharmacy clinic virtual GP. We cover face-to-face consultations up to the Discovery Health Rate (DHR). On the Classic plan, kids younger than 10 years have access to two kids casualty visits a year.

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Day-to-day cover

We cover your day-to-day healthcare expenses from your Medical Savings Account (MSA), Day-to-day Extender Benefit (DEB) and limited Above Threshold Benefit (ATB).

Some day-to-day healthcare services have limits. These are not separate benefits. Limits apply to claims paid from your MSA and the ATB. We pay day-to-day benefits up to the ATB limit or up to the limit that applies, whichever you reach first.

We add these amounts to the Annual Threshold and pay these amounts from your Above Threshold Benefit (ATB), once you reach your Annual Threshold. We add up the amount to the benefit limit available. If the claimed amount is less than the Discovery Health Rate (DHR), we will pay and add the claimed amount to the Annual Threshold. Claims paid from your Day-to-day Extender Benefit. (DEB) will not accumulate to the Annual Threshold.

HEALTHCARE PROVIDERS AND MEDICINE	WHAT WE PAY
Specialists we have an arrangement with	Up to the rate we have agreed with the specialist
Specialists we do not have an arrangement with	The Discovery Health Rate (DHR) (100%)
GPs and other healthcare professionals	The Discovery Health Rate (DHR) (100%)
Preferred medicine	The Discovery Health Rate (DHR) (100%)
Non-preferred medicine	Up to 75% of the Discovery Health Rate (DHR) if the price of the medicine is within 25% of the preferred equivalent, or up to 50% of the DHR if the price of the medicine is more than 50% of the price of the preferred equivalent

MEDICINE	SINGLE MEMBER	ONE DEPENDANT	TWO DEPENDANTS	THREE OR MORE DEPENDANTS
PRESCRIBED MEDICINE* (SCHEDULE 3 AND ABOVE)				
Classic	R25,650	R31,100	R37,450	R40,800
Essential	R18,150	R21,500	R25,500	R31,050
Over-the-counter medicine, childhood vaccines, immunisations and lifestyle-enhancing products	We pay these claims from the available funds in your Medical Savings Account (MSA). These claims do not add up to the Annual Threshold and are not paid from the Above Threshold Benefit (ATB).			

Day-to-day benefits

We cover your day-to-day healthcare expenses from your Medical Savings Account (MSA), Day-to-day Extender Benefit (DEB) and limited Above Threshold Benefit (ATB).

Some day-to-day healthcare services have limits. These are not separate benefits. Limits apply to claims paid from your MSA and the limited ATB. We pay day-to-day benefits up to the ATB limit or up to the benefit limit that applies, whichever you reach first.

We add these amounts to the Annual Threshold and pay these amounts from your limited Above Threshold Benefit (ATB), once you reach your Annual Threshold. We add up the amount to the benefit limit available. If the claimed amount is less than the Discovery Health Rate (DHR), we will pay and add the claimed amount to the Annual Threshold. Claims paid from your defined day-to-day benefits or Day-to-day Extender Benefit (DEB) will not accumulate to the Annual Threshold.

		SINGLE MEMBER	ONE DEPENDANT	TWO DEPENDANTS	THREE OR MORE DEPENDANTS
PROFESSIONAL SERVICES					
Allied, therapeutic and psychology healthcare services* (acousticians, biokineticists, chiropractors, counsellors, dietitians, homeopaths, nurses, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrists, social workers, speech and language therapists, and audiologists)					
Classic		R14,050	R19,850	R25,700	R30,350
Essential		R9,300	R14,050	R17,450	R21,000
Dental appliances and orthodontic treatment*		R21,500 per person			
Antenatal classes		R2,300 for your family			
APPLIANCES AND EQUIPMENT					
Optical* (this limit covers lenses, frames, contact lenses and surgery or any healthcare service to correct refractive errors of the eye)		R6,300 per person			
External medical items* (like wheelchairs, crutches and prostheses)	**Classic**	R43,000 for your family			
	Essential	R28,900 for your family			
Hearing aids	**Classic**	R24,000 for your family			
	Essential	R17,050 for your family			

* If you join the Scheme after January, you will not get the full limit because it is calculated by counting the remaining months in the year.

Maternity benefit

You have cover for maternity and early childhood

You get cover for healthcare services related to your pregnancy and treatment for the first two years of your baby's life. This applies from the date of activation of the benefit for each pregnancy and for each child from birth until they are two years old.

07

During pregnancy

Antenatal consultations

We pay for up to eight consultations with your gynaecologist, GP or midwife.

Ultrasound scans and screenings during pregnancy

You are covered for up to two 2D ultrasound scans or one 2D ultrasound scan and one nuchal translucency test. 3D and 4D scans are paid up to the rate we pay for 2D scans. You are also covered for one chromosome test or Non-Invasive Prenatal Test (NIPT), if you meet the clinical entry criteria.

Flu vaccinations

We pay for one flu vaccination during your pregnancy.

Blood tests

We pay for a defined list of blood tests to confirm your pregnancy.

After you give birth

GP and specialists to help you after birth

Your baby under the age of two years is covered for two visits to a GP, paediatrician or an ear, nose and throat specialist.

Other healthcare services

You also have access to postnatal care, which includes a postnatal consultation for complications post delivery, a nutritional assessment with a dietitian and two mental healthcare consultations with a counsellor or psychologist.

Pre- and postnatal care

We pay for a maximum of five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth. We pay for one breastfeeding consultation with a registered nurse or a breastfeeding specialist.

Visit **www.discovery.co.za** to view the detailed Maternity Benefit guide.

How to get the benefit

You can activate the benefit in any of these ways:

- Create your pregnancy or baby profile on the Discovery Health app or on our website at **www.discovery.co.za**
- When you pre-authorise your delivery or you register your baby as a dependant on the Scheme

Chronic benefits

You have cover for treatment for ongoing medical conditions (chronic conditions). You have cover for the 27 medical conditions set out in the list of chronic conditions (CDL).

What we cover

Prescribed Minimum Benefit (PMB) conditions

You have access to treatment for a list of medical conditions under the Prescribed Minimum Benefits (PMBs). The PMBs cover the 27 chronic conditions on the Chronic Disease List (CDL).

Our plans offer benefits that are richer than PMBs. To access PMBs, certain rules apply.

Medicine cover for the Chronic Disease List

You have full cover for approved chronic medicine on our medicine list. For medicine not on our list, we cover you up to the reference price, where a generic alternative exists up to a set monthly Rand amount called the Chronic Drug Amount (CDA).

How we pay for consultations and medicine

You must nominate a GP in the Discovery Health Network to be your primary care doctor to manage your chronic conditions. You can change your nominated primary care GP three times a year. To find adoctor and learn more about the nomination process, use **www.discovery.co.za**, or the Discovery Health app.

For full cover on your GP consultations you must visit your nominated primary care network GP. If you see a GP that is not your nominated primary care GP, or a nominated GP that is not a network GP, you will have to pay a co-payment. For more information on our Care Programmes and enrolment by your Premier Plus Network GP, please refer to later pages in section 8.

We pay for medicine up to a maximum of the Discovery Health Rate (DHR) at one of our network pharmacies. The DHR for medicine is the price of the medicine and the fee for dispensing it.

How to get the benefit

You must apply for the Chronic Illness Benefit (CIB). Your primary care GP must complete the form online or send it to us for approval.

Visit **www.discovery.co.za** to view the detailed Chronic Illness Benefit (CIB) guide.

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Chronic benefits and where to get your medicine

Chronic Disease List (CDL) conditions

Chronic conditions covered on all plans

- **A** Addison's disease, asthma
- **B** Bipolar mood disorder, bronchiectasis
- **C** Cardiac failure, cardiomyopathy, chronic obstructive pulmonary disease, chronic renal disease, coronary artery disease, Crohn's disease
- **D** Diabetes insipidus, diabetes Type 1, diabetes Type 2, dysrhythmia
- **E** Epilepsy
- **G** Glaucoma
- **H** Haemophilia, HIV, hyperlipidaemia, hypertension, hypothyroidism
- **M** Multiple sclerosis
- **P** Parkinson's disease
- **R** Rheumatoid arthritis
- **S** Schizophrenia, systemic lupus erythematosus
- **U** Ulcerative colitis

Use a pharmacy in our networks

Avoid a 20% co-payment on your chronic medicine by using our designated service providers (DSPs), MedXpress and MedXpress Network Pharmacies.

How to get your medicine

You can order or reorder your medicine online through MedXpress and have it delivered to your work or home

or

- Order your medicine online and collect instore at a MedXpress Network Pharmacy

or

- Fill a prescription as usual at any MedXpress Network Pharmacy.

Medicine tracker

You can set up reminders and prompts to assist you with taking your medicine on time and as prescribed. Your approved chronic medicine will automatically be displayed, and you will then be prompted to take your medicine and confirm when each dose is taken.

If you need chronic dialysis

We cover these expenses in full if we have approved your treatment plan and you use a provider in our network. If you go elsewhere, we will pay up to 80% of the Discovery Health Rate (DHR).

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Care Programmes

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.

Disease Prevention Programme

If you are identified to be at risk of cardio-metabolic risk syndrome, your nominated Premier Plus GP can enrol you on the Disease Prevention Programme. Your Premier Plus GP, dietitian and health coach will help coordinate your care. Enrolled members have access to a defined basket of care which includes cover for consultations, certain pathology tests and medicine, where appropriate. You will also have access to health coaching sessions to help you with the day-to-day management of your condition.

Diabetes Care Programme

If you are registered on the Chronic Illness Benefit (CIB) for diabetes, your nominated Premier Plus GP can enrol you on the Diabetes Care Programme. The programme unlocks cover for additional glucometer strips and consultations with dietitians and biokineticists. You may also have access to a nurse educator to help you with the day-to-day management of your condition.

Cardio Care Programme

If you are registered on the Chronic Illness Benefit (CIB) for hypertension, hyperlipidaemia or ischaemic heart disease, you have access to a defined basket of care and an annual cardiovascular assessment, if referred by your nominated Premier Plus GP and enrolled on the Cardio Care Programme.

Mental Health Care Programme

Once enrolled on the programme by your network psychologist or nominated Premier Plus GP, you have access to defined cover for the management of major depression. Enrolment on the programme unlocks cover for prescribed medicine, access to either individual or group psychotherapy sessions (virtual and face-to-face therapy) and additional GP consultations to allow for effective evaluation, tracking and monitoring of treatment. Qualifying members will also have access to a relapse prevention programme, which includes additional cover for a defined basket of care for psychiatry consultations, counseling sessions and care coordination services.

HIV Care Programme

If you are registered on the HIV programme by your nominated Premier Plus GP, you are covered for the care you need, which includes additional cover for social workers. You can be assured of confidentiality at all times. You need to get your medicine from a designated service provider (DSP) to avoid a 20% co-payment.

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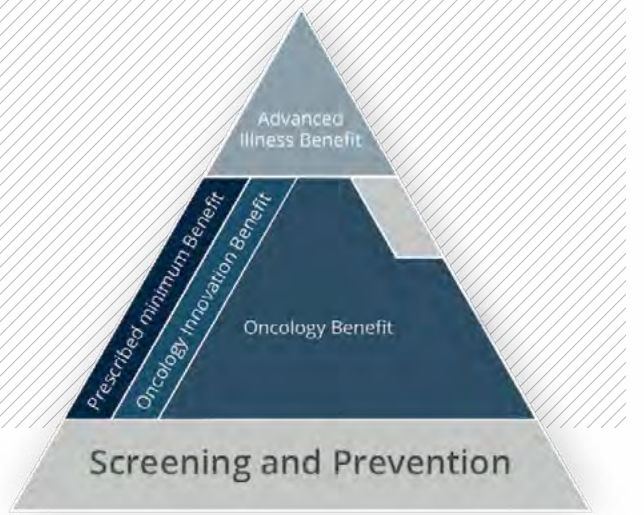
Oncology Care Programme

You have access to comprehensive cover for cancer treatment. This includes access to high cost medicine, supportive treatment and the Discovery Oncology Care Programme.

Visit **www.discovery.co.za** to view the detailed Oncology Benefit guide



Prescribed Minimum Benefits (PMB)

Cancer treatment that is a Prescribed Minimum Benefit (PMB), is always covered in full. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount we will continue to cover your PMB cancer treatment in full.

Oncology Benefit

If you are diagnosed with cancer and once we have approved your cancer treatment, you are covered by the Oncology Care Programme. We cover your approved cancer treatment over a 12-month cycle.

We cover the first R250,000. If your treatment costs more than the cover amount, we will cover up to 80% of the subsequent additional costs.

All cancer-related healthcare services are covered up to 100% of the Discovery Health Rate (DHR). You might have a co-payment if your healthcare professional charges above this rate.

Oncology Innovation Benefit

You have cover for a sub-set of the defined list of innovative cancer medicine covered by the Oncology Innovation Benefit, subject to the Scheme's clinical entry criteria. You will need to pay 50% of the cost of these treatments.

How we cover medicine

You need to get your approved oncology medicine on our medicine list from a designated service provider (DSP) to avoid a 20% co-payment. Speak to your treating doctor to confirm that they are using our DSPs for your medicine and treatment received in rooms or at a treatment facility.

Advanced Illness Benefit

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.

Hospital Benefit

If you need to be admitted to hospital

The Priority plans offer cover for hospital stays. There is no overall limit for the Hospital Benefit.

What is the benefit?

This benefit pays the costs when you are admitted into hospital.

What we cover

You have unlimited cover in any private hospital approved by the Scheme.

How to get the benefit

Get your confirmation first

Contact us to confirm your hospital stay before you are admitted (this is known as pre-authorisation).

Where to go

You can go to any private hospital approved for funding by the Scheme. The funding of newly licensed facilities is subject to approval by the Scheme, on all health plans. An upfront payment applies for specific in-hospital procedures including procedures performed in the Day Surgery Network.

What we pay

We pay for planned hospital stays from your Hospital Benefit.

We pay for services related to your hospital stay, including all healthcare professionals, services and medicines authorised by the Scheme for your hospital stay.

If you use doctors, specialists and other healthcare professionals that we have an agreement with, we will pay for these services in full. We pay up to 200% of the Discovery Health Rate (DHR) on Classic and up to 100% of the DHR on Essential for other healthcare professionals.

You can avoid co-payments by:

- Going to a facility in the Day Surgery Network day procedures
- Using healthcare professionals that we have a payment arrangement with.

If you have to go to hospital, we will pay your hospital expenses. There is no overall hospital limit for the year on any of the plans. However, there are limits to how much you can claim for some treatments.

Contact us in good time before you have to go to hospital. We will let you know what you are covered for. If you don't contact us before you go, you may be responsible for some of the costs.

Hospital cover

The Priority Plans offer unlimited hospital cover.

The table below shows how we pay for your approved hospital admissions:

Healthcare providers and services	What we pay
The hospital account	The full account at the agreed rate with the hospital
Specialists we have a payment arrangement with	The full account at the agreed rate
Specialists we do not have a payment arrangement with and other healthcare professionals	**Classic plan:** up to twice the Discovery Health Rate (DHR) (200%) **Essential plan:** up to the Discovery Health Rate (DHR) (100%)
X-rays and blood tests (radiology and pathology) accounts	Up to the Discovery Health Rate (DHR) (100%)
Defined list of procedures performed in specialist rooms	Up to the agreed rate where authorised by the Scheme
UPFRONT PAYMENTS FOR IN-HOSPITAL PROCEDURES:	
Upfront payment for a defined list of procedures performed outside the Day Surgery Network	R6,650
YOU NEED TO PAY AN AMOUNT UPFRONT TO THE HOSPITAL WHEN ONE OF THE PROCEDURES LISTED BELOW IS PERFORMED DURING A HOSPITAL ADMISSION, INCLUDING PROCEDURES PERFORMED IN THE DAY SURGERY NETWORK:	
Conservative back and neck treatment, adenoidectomy, myringotomy (grommets), tonsillectomy	R4,550
Arthroscopy, functional nasal procedures, hysterectomy (except for pre-operatively diagnosed cancer), laparoscopy, hysteroscopy, endometrial ablation	R10,600
Nissen fundoplication (reflux surgery), spinal surgery (back and neck), joint replacements	R21,800
If the procedure is performed out of hospital, for example in the doctor's rooms, you won't have to pay the amount upfront. If any of these procedures are on the day surgery procedures list, you will have to pay the higher of the two upfront amounts if the procedure is done at a facility outside of the Day Surgery Network	
MRI and CT Scans	We pay the first R3,670 of the scan from day-to-day benefits. We pay the balance of the scan from the Hospital Benefit up to 100% of the Discovery Health Rate (DHR). For conservative back and neck treatment, you must pay the first R4,550 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.

Hospital cover

The Priority Plans offer unlimited hospital cover.

Scopes (gastroscopy, colonoscopy, sigmoidoscopy proctoscopy, cystoscopy and cystourethroscopy)

Admissions for scopes

Depending on where you have your scope done, you will have to pay the following amount, and we will pay the balance of the hospital and related accounts from your Hospital Benefit.

Upfront payments for scope admissions:

	DAY CLINIC ACCOUNT	HOSPITAL ACCOUNT
Classic and Essential	R4,300	R6,900, this co-payment will reduce to R5,600 if performed by a doctor who is part of the Scheme's value-based network
IF BOTH A GASTROSCOPY AND COLONOSCOPY ARE PERFORMED IN THE SAME ADMISSION		
Classic and Essential	R5,250	R8,650, this co-payment will reduce to R7,050 if performed by a doctor who is part of the Scheme's value-based network

Upfront payments for scopes performed outside of the Day Surgery Network:

Where a scope is performed in a facility outside of the Day Surgery Network an upfront payment of R6,650 will apply, except if performed in a hospital outside the Day Surgery Network where an upfront payment of R6,900 will apply. Where both a gastroscopy and colonoscopy are performed the upfront payment of R8,650 will apply.

No upfront payment applies:

If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is aged 12 or under you will not have to pay any amount upfront. We pay the account from the Hospital Benefit.

Benefits with an annual limit

You have access to extra benefits to enhance your cover.

Cochlear implants, auditory brain implants and processors

R244,000 per person for each benefit.

Internal nerve stimulators

R185,550 per person.

Major joint surgery

No limit for planned hip and knee joint replacements if you use a provider in our network, or up to 80% of the Discovery Health Rate (DHR) if you use a provider outside our network up to a maximum of R30,900 for each prosthesis for each admission. The network does not apply to emergency or trauma-related surgeries.

Shoulder joint prosthesis

No limit if you get your prosthesis from a provider in our network or up to R45,550 if you use a provider outside our network.

Alcohol and drug rehabilitation

We pay for 21 days of rehabilitation for each person each year. Three days per approved admission per person for detoxification.

Prosthetic devices used in spinal surgery

There is no overall limit if you get your prosthesis from our preferred suppliers. If you do not use a preferred supplier, a limit of R22,500 applies for the first level and R45,000 for two or more levels, limited to one procedure per person per year.

You have full cover for approved spinal surgery admissions if you use a provider in our spinal surgery network. Planned admissions outside of our network will be funded at up to 80% of the Discovery Health Rate (DHR) for the hospital account.

You also have cover for out-of-hospital conservative spinal treatment. Refer to section 12 for more information.

Mental health

21 days for admissions or up to 15 out-of-hospital consultations per person for major affective disorders, anorexia and bulimia and up to 12 out-of-hospital consultations for acute stress disorder accompanied by recent significant trauma. Three days per approved admission for attempted suicide.

21 days for all other mental health admissions.

All mental health admissions are covered in full at a network facility. If you go elsewhere, we will pay up to 80% of the Discovery Health Rate (DHR) for the hospital account.

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Benefits with an annual limit

You have access to extra benefits to enhance your cover.

Dental treatment in hospital

Dental limit

There is no overall limit for basic dental treatment. However, all dental appliances and prostheses, their placement, and orthodontic treatment (including related accounts for orthognathic surgery) are paid at 100% of the Discovery Health Rate (DHR) and up to 200% of the DHR for anaethetists on the Classic plan. We pay these claims from your day-to-day benefits, up to an annual limit of R21,500 per person or up to the ATB limit, whichever you reach first. If you join the Scheme after January, you won't get the full limit because it is calculated by counting the remaining months in the year.

Severe dental and oral surgery in hospital

The Severe Dental and Oral Surgery Benefit covers a defined list of procedures, with no upfront payment and no overall limit. Certain procedures are covered in our Day Surgery Network. This benefit is subject to authorisation and the Scheme's Rules.

Basic Dental Trauma Benefit

The Basic Dental Trauma Benefit covers sudden and unanticipated injury to teeth and mouth that requires urgent dental treatment after an accident or trauma injury. Where the clinical entry criteria is met, cover for dental appliances and prostheses and the placement thereof are paid up to an annual limit of R65,150 per person per year.

Dental treatment in hospital

Except where approved for severe dental and oral surgery, you need to pay a portion of your hospital or day clinic account upfront for dental admissions. This amount varies, depending on your age and the place of treatment. We pay the balance of the hospital account from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR).

We pay the related accounts, which include the dental surgeon's account, from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR). On the Classic plan, we pay anaesthetists up to 200% of the Discovery Health Rate (DHR).

For members 13 years and older, we cover routine conservative dentistry, such as preventive treatment, simple fillings and root canal treatment, from your available day-to-day benefits.

Upfront payment for dental admissions:

HOSPITAL ACCOUNT	DAY CLINIC ACCOUNT
MEMBERS 13 YEARS AND OLDER:	
R8,250	R5,300
MEMBERS UNDER 13:	
R3,200	R1,450

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Cover for procedures in the Day Surgery Network

We cover specific procedures that can be done in the Day Surgery Network.

About the benefit

We cover certain planned procedures in a day surgery facility. A day surgery may be inside a hospital, in a day clinic or at a standalone facility.

How to get the benefit

View the list of day surgery procedures on the next page. You must contact us to get confirmation of your procedure (called pre-authorisation).

How we pay

We pay these services from your Hospital Benefit. We pay for services related to your hospital stay, including all healthcare professionals, services and medicines authorised by the Scheme.

If you use doctors, specialists and other healthcare professionals that we have a payment arrangement with, we will pay for these services in full. We pay up to 200% of the Discovery Health Rate (DHR) on Classic and up to 100% of the DHR on Essential for other healthcare professionals.

When you need to pay

If you go to a facility that is not in the Day Surgery Network, you will have to pay an upfront amount of R6,650. If any of these procedures form part of the list of procedures with an upfront payment performed during a hospital admission, as outlined in section 10, the higher of the upfront payments will apply.

View all Day Surgery Network facilities using Find a healthcare provider on the Discovery Health app

Find a healthcare provider and the Discovery Health app are brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

List of procedures covered in the Day Surgery Network

The following is a list of procedures to be performed in our Day Surgery Network.

B

Biopsies

Skin, subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes

Breast procedures

- Mastectomy for gynaecomastia
- Lumpectomy (fibroadenoma)

E

Ear, nose and throat procedures

- Tonsillectomy and/or adenoidectomy
- Repair nasal turbinates, nasal septum
- Simple procedures for nose bleed (extensive cautery)
- Sinus lavage
- Scopes (nasal endoscopy, laryngoscopy)
- middle ear procedures (mastoidectomy, myringoplasty, grommets)

Eye procedures

- Cataract surgery
- Corneal transplant
- Treatment of glaucoma
- Other eye procedures (removal of foreign body, conjunctival surgery (repair laceration, pterygium), glaucoma surgery, probing and repair of tear ducts, vitrectomy, retinal surgery, eyelid surgery, strabismus repair)

G

Ganglionectomy

Gastrointestinal

- Gastrointestinal scopes (oesophagoscopy, gastroscopy, colonoscopy, sigmoidoscopy, proctoscopy, anoscopy)
- Anorectal procedures (treatment of haemorrhoids, fissure, fistula)

Gynaecological procedures

- Diagnostic Dilatation and Curettage
- Endometrial ablation
- Diagnostic Hysteroscopy
- Colposcopy with LLETZ
- Examination under anaesthesia
- Diagnostic laparoscopy
- Simple vulval and introitus procedures: Simple hymenotomy, partial hymenectomy, simple vulvectomy, excision of Bartholin's gland cyst
- Vaginal, cervix and oviduct procedures: Excision vaginal septum, cyst or tumour, tubal ligation or occlusion, uterine cervix cerclage, removal cerclage suture
- Suction curettage
- Uterine evacuation and curettage

O

Orthopaedic procedures

- Arthroscopy, arthrotomy (shoulder, elbow, knee, ankle, hand, wrist, foot, temporomandibular joint), arthrodesis (hand, wrist, foot)
- Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty)
- Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy). Subject to individual case review
- Repair bunion or toe deformity
- Treatment of simple closed fractures and/or dislocations, removal of pins and plates. Subject to individual case review

N

Nerve procedures

- Neuroplasty median nerve, ulnar nerve, digital, nerve of hand or foot

R

Removal of foreign body

- Subcutaneous tissue, muscle, external auditory canal under general anaesthesia

S

Simple superficial lymphadenectomy

Skin procedures

- Debridement
- Removal of lesions (dependent on site and diameter)
- Simple repair of superficial wounds

Simple Hernia Procedures

- Umbilical hernia repair
- Inguinal hernia repair

U

Urological

- Cystoscopy
- Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocoele, vasectomy)

Extra benefits on your plan

You get the following extra benefits to enrich your cover.

Claims related to traumatic events

The Trauma Recovery Extender Benefit extends your cover for out-of-hospital claims related to certain traumatic events. Claims are paid from the Trauma Recovery Extender Benefit for the rest of the year in which the trauma occurred, as well as the year after the event occurred. You and your dependants on your health plan have access to six counselling sessions per person per year by a psychologist, clinical social worker or registered counsellor, for the year in which the trauma event occurred and the year after.

Advanced Illness Benefit

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.

Follow-up treatment after an admission

If you qualify, you have access to a readmission prevention programme for clinically appropriate conditions. This programme gives you access to approved follow-up care and a health coaching session within 30 days after you are discharged from hospital. Cover is subject to our treatment guidelines and clinical entry criteria.

Spinal Care Programme

For conservative spinal treatment out-of-hospital you have access to a defined basket of care which includes cover for virtual and face-to-face consultations with an appropriately registered allied healthcare professional.

In rooms procedures

You have cover for a defined list of procedures performed in specialist rooms. Cover is up to the agreed rate, where authorised by the Scheme, from your Hospital Benefit.

Mental wellbeing

Members identified with moderate to severe symptoms of depression following a mental wellbeing assessment, have access to a virtual consultation, where applicable, with a Premier Plus GP or network psychologist. Cover is subject to clinical entry criteria.

Extra benefits on your plan

You get the following extra benefits to enrich your cover.

International Travel Benefit

You have cover for emergency medical costs of up to R5 million per person on each journey while you travel outside of South Africa. This cover is for a period of 90 days from your departure from South Africa. Pre-existing conditions are excluded. We may cover you at equivalent local costs for elective treatment received outside of South Africa, as long as the treatment is readily and freely available in South Africa and it would normally be covered by your plan.

WHO Global Outbreak Benefit

The WHO Global Outbreak Benefit is available to all members during a declared outbreak period. The benefit provides cover for the administration of vaccinations (where applicable) as well as a defined basket of care for out-of-hospital healthcare services related to outbreak diseases such as COVID-19 and monkeypox.

International second opinion services

Through your specialist, you have access to second opinion services from The Clinic by Cleveland Clinic for life-threatening and life-changing conditions. We cover 75% for the cost of the second opinion service.

Africa Evacuation Cover

You have cover for emergency medical evacuations from certain sub-Saharan African countries back to South Africa. Pre-existing conditions are excluded.

The Clinic by Cleveland Clinic online medical second opinion programme is brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

Your contributions, Medical Savings Account and Annual Thresholds

	MAIN MEMBER	ADULT	CHILD*
CONTRIBUTIONS			
Classic Priority	R5,272	R4,158	R2,108
Essential Priority	R4,531	R3,562	R1,809
ANNUAL MEDICAL SAVINGS ACCOUNT AMOUNTS**			
Classic Priority	R15,792	R12,456	R6,312
Essential Priority	R8,136	R6,396	R3,252
ANNUAL THRESHOLD AMOUNTS**			
All plans	R22,890	R17,210	R7,620
LIMITED ABOVE THRESHOLD BENEFIT AMOUNT**			
All plans	R19,370	R13,820	R6,770

* We count a maximum of three children when we calculate the monthly contributions, annual Medical Savings Account, Annual Threshold and Limited Above Threshold amounts. In the case of foster children, every child added to the policy is charged for.

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

Exclusions

Discovery Health Medical Scheme has certain exclusions. We do not pay for healthcare services related to the following, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits (PMBs). For a full list of exclusions, please visit **www.discovery.co.za**

Healthcare services that are not covered on your plan

Medical conditions during a waiting period

If we apply waiting periods because you have never belonged to a medical scheme or you have had a break in membership of more than 90 days before joining Discovery Health Medical Scheme, you will not have access to the Prescribed Minimum Benefits (PMBs) during your waiting periods. This includes cover for emergency admissions. If you had a break in cover of less than 90 days before joining Discovery Health Medical Scheme, you may have access to Prescribed Minimum Benefits (PMBs) during waiting periods.

The general exclusion list includes:

- Reconstructive treatment and surgery, including cosmetic procedures and treatments
- Otoplasty for bat ears, port-wine stains and blepharoplasty (eyelid surgery)
- Breast reductions or enlargements and gynaecomastia
- Obesity
- Infertility, unless part of Prescribed Minimum Benefits (PMBs)
- Frail care
- Alcohol, drug or solvent abuse
- Wilful and material violation of the law
- Wilful participation in war, terrorist activity, riot, civil commotion, rebellion or uprising
- Injuries sustained or healthcare services arising during travel to or in a country and/or territory at war
- Ultra-high cost treatments, experimental, unproven or unregistered treatments or practices
- Search and rescue.

We also do not cover the complications or the direct or indirect expenses that arise from any of the exclusions listed above, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits (PMBs).

Exclusive access to value-added offers

Our members have exclusive access to value-added offers outside of the Discovery Health Medical Scheme benefits and Rules.

Go to www.discovery.co.za to access these value-added offers.

Savings on personal and family care items

You can sign up for Healthy Care to get savings on a vast range of personal and family care products at any Clicks or Dis-Chem. Healthy Care items include a list of baby care, dental care, eye care, foot care, sun care and hand care products, as well as first aid and emergency items and over-the-counter medicine.

Frames and lenses

You get a 20% discount for frames and lenses at an optometrist in your plan's network of optometrists.You will receive the discount immediately when you pay.

Savings on stem cell banking

You get access to an exclusive offer with Netcells that gives expectant parents the opportunity to cryogenically store their newborn baby's umbilical cord blood and tissue stem cells for potential future medical use, at a discounted rate.

Access to Vitality to get healthier

You have the opportunity to join the world's leading science-based wellness programme, Vitality, which rewards you for getting healthier. Not only is a healthy lifestyle more enjoyable, it is clinically proven that Vitality members live healthier, longer lives.

Working to care for and protect you

Our goal is to provide support for you in the times when you need it most.

What to do if you have a complaint:

01 | To take your query further

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

02 | To contact the Principal Officer

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

03 | To lodge a dispute

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

04 | To contact the Council for Medical Schemes

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

We hold your privacy in the highest regard. Our unwavering commitment to protecting your personal information and ensuring the security and confidentiality of your data is clearly outlined in our Privacy Statement.

VIEW NOW

Download the Discovery Health app

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