Discovery
Health Medical Scheme

EXECUTIVE

COMPREHENSIVE

PRIORITY

SAVER

SMART SAVER

SMART

CORE

KEYCARE

PLAN COMPARISON 2027

Discovery Health Medical Scheme 2027 contributions

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	10,082	10,082	1,927	3,360	3,360	642	13,442	13,442	2,569
Comprehensive	Classic Comprehensive	8,201	7,757	1,636	2,733	2,585	545	10,934	10,342	2,181
	Classic Smart Comprehensive	7,942	7,334	1,854	1,401	1,294	327	9,343	8,628	2,181
Priority	Classic Priority	5,064	3,995	2,025	1,688	1,331	675	6,752	5,326	2,700
	Essential Priority	4,933	3,880	1,970	870	684	347	5,803	4,564	2,317
Saver	Classic Saver	4,188	3,303	1,679	1,047	825	419	5,235	4,128	2,098
	Classic Delta Saver	3,346	2,645	1,344	836	661	336	4,182	3,306	1,680
	Essential Saver	3,775	2,831	1,512	419	314	168	4,194	3,145	1,680
	Essential Delta Saver	3,011	2,273	1,208	334	252	134	3,345	2,525	1,342
	Coastal Saver	3,775	2,831	1,512	666	499	266	4,441	3,330	1,778
Smart Saver	Classic Smart Saver	3,363	2,852	1,405	253	214	106	3,616	3,066	1,511
	Essential Smart Saver	2,761	2,360	898	207	177	68	2,968	2,537	966
Smart	Classic Smart	3,257	2,571	1,301	No Medical Savings Account			3,257	2,571	1,301
	Essential Smart	2,332	2,332	2,332				2,332	2,332	2,332
	Essential Dynamic Smart	1,939	1,939	1,939				1,939	1,939	1,939
	Active Smart	1,450	1,450	1,450				1,450	1,450	1,450
Core	Classic Core	4,215	3,328	1,686	No Medical Savings Account			4,215	3,328	1,686
	Classic Delta Core	3,374	2,661	1,349				3,374	2,661	1,349
	Essential Core	3,622	2,718	1,454				3,622	2,718	1,454
	Essential Delta Core	2,894	2,178	1,161				2,894	2,178	1,161
	Coastal Core	3,540	2,657	1,406				3,540	2,657	1,406
	Active Core	1,700	1,550	500				1,700	1,550	500
KeyCare*	KeyCare Plus 0 – 10,650	2,136	2,136	776	No Medical Savings Account			2,136	2,136	776
	KeyCare Plus 10,651 – 17,250	2,936	2,936	828				2,936	2,936	828
	KeyCare Plus 17,251 +	4,336	4,336	1,159				4,336	4,336	1,159
	KeyCare Core 0 – 10,650	1,623	1,623	425	No Medical Savings Account			1,623	1,623	425
	KeyCare Core 10,651 – 17,250	2,025	2,025	502				2,025	2,025	502
	KeyCare Core 17,251 +	3,099	3,099	702				3,099	3,099	702
	KeyCare Start 0 – 11,400	1,564	1,564	953	No Medical Savings Account			1,564	1,564	953
	KeyCare Start 11,401 – 17,200	2,295	2,295	1,031				2,295	2,295	1,031
	KeyCare Start 17,201 – 26,150	3,601	3,601	1,081				3,601	3,601	1,081
	KeyCare Start 26,151 +	4,101	4,101	1,115				4,101	4,101	1,115
	KeyCare Start Regional 0 – 11,400	1,392	1,392	837	No Medical Savings Account			1,392	1,392	837
	KeyCare Start Regional 11,401 – 17,200	2,104	2,104	947				2,104	2,104	947
	KeyCare Start Regional 17,201 – 26,150	3,280	3,280	1,004				3,280	3,280	1,004
	KeyCare Start Regional 26,151 +	3,736	3,736	1,047				3,736	3,736	1,047

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.

Day-to-day benefits

		Annual Medical Savings Account		
SERIES	PLAN	MAIN MEMBER (R)	ADULT (R)	CHILD (R)*
	Executive	40,320	40,320	7,704
Comprehensive	Classic Comprehensive	32,796	31,020	6,540
	Classic Smart Comprehensive	16,812	15,528	3,924
Priority	Classic Priority	20,256	15,972	8,100
	Essential Priority	10,440	8,208	4,164
Saver	Classic Saver	12,564	9,900	5,028
	Classic Delta Saver	10,032	7,932	4,032
	Essential Saver	5,028	3,768	2,016
	Essential Delta Saver	4,008	3,024	1,608
	Coastal Saver	7,992	5,988	3,192
Smart Saver	Classic Smart Saver	3,036	2,568	1,272
	Essential Smart Saver	2,484	2,124	816

* 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.

		Personal Health Fund		
SERIES	PLAN	UP TO A MAXIMUM PER ADULT (R)	UP TO A MAXIMUM PER CHILD (R)	UP TO A MAXIMUM PER FAMILY (R)
	Executive	3,000	1,500	12,000
Comprehensive	Classic Comprehensive	3,000	1,500	12,000
	Classic Smart Comprehensive	3,000	1,500	12,000
Priority	Classic Priority	2,500	1,250	10,000
	Essential Priority	1,500	750	6,000
Saver	Classic Saver (including Delta plan)	2,500	1,250	10,000
	Essential Saver (including Delta plan)	1,500	750	6,000
	Coastal Saver	1,500	750	6,000
Smart Saver	Classic Smart Saver	2,500	1,250	10,000
	Essential Smart Saver	1,500	750	6,000
Smart	Classic Smart	2,000	1,000	8,000
	Essential Smart (including Dynamic plan)	1,000	500	4,000
	Active Smart	1,000	500	4,000
Core	Classic Core (including Delta plan)	2,000	1,000	8,000
	Essential Core (including Delta plan)	1,000	500	4,000
	Coastal Core	1,000	500	4,000
	Active Core	1,000	500	4,000
KeyCare	KeyCare Plus	500	250	1,000
	KeyCare Core	500	250	1,000
	KeyCare Start	500	250	1,000
	KeyCare Start Regional	500	250	1,000

All adults can unlock a Challenge Boost on top of their base Personal Health Fund by completing two challenges every year. Boost your Personal Health Fund by up to an additional R3,000 per adult and up to R12,000 per policy by completing two challenges per annum. Your Challenge boost value depends on your plan type.

Annual Threshold and Above Threshold Benefit Amounts

		Annual Threshold*		
SERIES	PLAN	MAIN MEMBER (R)	ADULT (R)	CHILD (R)*
	Executive	46,380	46,380	8,810
Comprehensive	Classic Comprehensive	37,930	37,930	7,250
	Classic Smart Comprehensive	37,930	37,930	7,250
Priority	Classic Priority	29,590	22,240	9,860
	Essential Priority	29,590	22,240	9,860

		Above Threshold Benefit limits*		
SERIES	PLAN	MAIN MEMBER (R)	ADULT (R)	CHILD (R)*
	Executive	Unlimited		
Comprehensive	Classic Comprehensive	37,640	37,640	9,140
	Classic Smart Comprehensive	32,260	32,260	8,060
Priority	Classic Priority	20,830	14,870	7,280
	Essential Priority	20,830	14,870	7,280

* 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.

		Executive	Comprehensive		Priority		Saver			Smart Saver		Smart			Core				Keycare			
			CLASSIC	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	ACTIVE	CLASSIC	ESSENTIAL	COASTAL	ACTIVE	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 requested 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.																				
DAY-TO-DAY BENEFITS	**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. 25% of your monthly contributions are allocated into your MSA.	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. On the Classic Smart Comprehensive, you have cover for consultations with a Smart GP before the annual threshold has been reached, with a fixed co-payment. A percentage of your monthly contributions are allocated into your MSA. On the Classic Comprehensive Plan this is 25% and on the Classic Smart Comprehensive this is 15%.		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. A percentage of your monthly contributions are allocated into your MSA. ▪ On Classic Priority this is 25% ▪ On Essential Priority 15%.		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. A percentage of your monthly contributions are allocated into your MSA. ▪ On Classic Saver this is 20% ▪ Coastal Saver this is 15% ▪ On Essential Saver this is 10%			The Medical Savings Account pays for day-to-day medical expenses like radiology and pathology as long as you have money available. 7% of your monthly contributions are allocated into your MSA. In addition to your Medical Savings Account, you have access to a defined set of benefits including GP consultations, certain acute medicine when prescribed by a Smart GP and over-the-counter medicine, contraceptive medicine, dental check up, optometry check up, the Sports Injury Benefit, and the Kids Injury Benefit, with fixed co-payments and limits.	The Medical Savings Account pays for day-to-day medical expenses like radiology and pathology as long as you have money available. 7% of your monthly contributions are allocated into your MSA. In addition to your Medical Savings Account, you have access to a defined set of benefits includes GP consultations, over-the-counter medicine, contraceptive medicine, dental check up, optometry check up, the Sports Injury Benefit for kids 12 and younger, and the Kids Injury Benefit, with fixed co-payments and limits.	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, optometry check up, and the Sports Injury Benefit, with fixed co-payments and limits. This plan does not offer an MSA.	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 an MSA.	These plans do not offer an MSA.				Day-to-day benefits through your nominated KeyCare GP and day-to-day medicine from our medicine list when prescribed by your nominated KeyCare GP. We pay for basic radiology and pathology at a network provider if referred by your nominated GP, as well as basic optometry and dentistry, and specialist cover up to R5,970 per person per year when referred by your nominated GP. This plan does not offer an MSA.	Specialist cover up to R5,970 per person per year when referred by a GP. This plan does not offer an MSA.	Day-to-day benefits through your nominated KeyCare Start GP and day-to-day medicine from our medicine list when prescribed by your nominated KeyCare Start GP. We pay for basic radiology and pathology if referred by your nominated KeyCare Start GP, as well as basic optometry and dentistry, and specialist cover up to R2,960 per person per year when referred by your nominated KeyCare Start GP. This plan does not offer an MSA.	Day-to-day benefits through referral by the KeyCare Online Practice and day-to-day medicine from our medicine list when prescribed by your nominated KeyCare Start Regional GP. We pay for basic radiology and pathology if referred by your nominated KeyCare Start Regional GP. As well as basic optometry and dentistry, and specialist cover up to R2,960 per person per year when referred by your nominated KeyCare Start Regional GP. This plan does not offer an MSA.
	Personal Health Fund	The Personal Health Fund covers a comprehensive list of out-of-hospital healthcare services according to your individual health needs once you've activated Personal Health Pathways and completed your recommended next best actions. Your Personal Health Fund limit depends on your plan type, the size and make up of your family (according to your policy). If you are a new Discovery Health Medical Scheme members for 2027, you will be able to double your limit stated below. All adults on the policy can earn additional funds in the PHF up to a maximum value for successively completing a series of next best actions set as a challenge.																			
		Up to R3,000 per adult, up to R1,500 per child, up to a maximum of R12,000 per family. Up to an additional R3,000 per adult and up to a maximum of R12,000 per family for completing your Personal Health Pathway challenges.			Up to R2,500 per adult, up to R1,250 per child, up to a maximum of R10,000 per family. Up to an additional R2,500 per adult and up to a maximum of R10,000 per family for completing your Personal Health Pathway challenges.	Up to R1,500 per adult, up to R750 per child, up to a maximum of R6,000 per family. Up to an additional R1,500 per adult and up to a maximum of R6,000 per family for completing your Personal Health Pathway challenges.	Up to R2,500 per adult, up to R1,250 per child, up to a maximum of R10,000 per family. Up to an additional R2,500 per adult and up to a maximum of R10,000 per family for completing your Personal Health Pathway challenges.	Up to R1,500 per adult, up to R750 per child, up to a maximum of R6,000 per family. Up to an additional R1,500 per adult and up to a maximum of R6,000 per family for completing your Personal Health Pathway challenges.	Up to R2,500 per adult, up to R1,250 per child, up to a maximum of R10,000 per family. Up to an additional R2,500 per adult and up to a maximum of R10,000 per family for completing your Personal Health Pathway challenges.	Up to R1,500 per adult, up to R750 per child, up to a maximum of R6,000 per family. Up to an additional R1,500 per adult and up to a maximum of R6,000 per family for completing your Personal Health Pathway challenges.	Up to R2,000 per adult, up to R1,000 per child, up to a maximum of R8,000 per family. Up to an additional R2,000 per adult up to a maximum of R8,000 per family for completing your Personal Health Pathway challenges.	Up to R1,000 per adult, up to R500 per child, up to a maximum of R4,000 per family. Up to an additional R1,000 per adult up to a maximum of R4,000 per family for completing your Personal Health Pathway challenges.	Up to R2,000 per adult, up to R1,000 per child, up to a maximum of R8,000 per family. Up to an additional R2,000 per adult up to a maximum of R8,000 per family for completing your Personal Health Pathway challenges.	Up to R1,000 per adult, up to R500 per child, up to a maximum of R4,000 per family. Up to an additional R1,000 per adult up to a maximum of R4,000 per family for completing your Personal Health Pathway challenges.	Up to R500 per adult, up to R250 per child, up to a maximum of R1,000 per family. Up to an additional R500 per adult up to a maximum of R1,000 per family for completing your Personal Health Pathway challenges.		
	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 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.		This plan does not offer this 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 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.		Pays for certain day-to-day benefits after you have run out of money in your MSA. 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.											
					You also have additional cover for kids casualty visits.		You also have additional cover for kids casualty visits.														
	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 on the Executive Plan. 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 on these plans. Annual benefit limits may apply.		These plans do not offer this benefit.																
	MRI and CT scans	We pay the first R4,155 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 per year.								We pay the first R4,155 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. Scans related to conservative back and neck scans are not covered on this plan		You must pay the first R4,155 of your MRI or CT scan. 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 per year.	These plans do not offer this benefit.					MRI and CT scans are paid from the Specialist Benefit up to a limit of R5,970 for a person a year.		MRI and CT scans are paid from the Specialist Benefit up to a limit of R2,960 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**	**During pregnancy** ▪ 12 antenatal consultations with your gynaecologist, GP or midwife ▪ 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 ▪ One chromosome test or Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria ▪ Private ward cover up to R2,900 per day for your delivery in hospital ▪ A defined basket of blood tests **After you give birth** ▪ Your baby is covered for up to two visits to a GP, paediatrician or an ENT ▪ 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 ▪ Cover for up to R6,750 for essential registered devices with 25% co-payment **Pre- and postnatal care** ▪ Five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth ▪ One nutritional assessment at a dietitian ▪ Two mental health consultations with a counsellor or psychologist ▪ One breastfeeding consultation with a registered nurse or a breastfeeding specialist			**During pregnancy** ▪ 8 antenatal consultations with your gynaecologist, GP or midwife ▪ 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 ▪ One chromosome test or Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria ▪ A defined basket of blood tests **After you give birth** ▪ Your baby is covered for up to two visits to a GP, paediatrician or an ENT ▪ 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 **Pre- and postnatal care** ▪ Five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth ▪ One nutritional assessment at a dietitian ▪ Two mental health consultations with a counsellor or psychologist ▪ One breastfeeding consultation with a registered nurse or a breastfeeding specialist						These services are subject to the defined day-to-day benefits on this plan.	**During pregnancy** ▪ 8 antenatal consultations with your gynaecologist, GP or midwife ▪ 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 ▪ One chromosome test or Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria ▪ A defined basket of blood tests **After you give birth** ▪ Your baby is covered for up to two visits to a GP, paediatrician or an ENT ▪ 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 **Pre- and postnatal care** ▪ Five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth ▪ One nutritional assessment at a dietitian ▪ Two mental health consultations with a counsellor or psychologist ▪ One breastfeeding consultation with a registered nurse or a breastfeeding specialist						These services are subject to the defined day-to-day benefits on these plans.
	Nurture at home	Parents whose babies are admitted to NICU for at least 7 days after birth have access to additional support to help adjust after discharge. A basket of care is available which includes an overnight stay in hospital for one of the parents, virtual coaching sessions, home nurse visits, and paediatrician visits.										These plans do not offer this benefit.			Parents whose babies are admitted to NICU for at least 7 days after birth have access to additional support to help adjust after discharge. A basket of care is available which includes an overnight stay in hospital for one of the parents, virtual coaching sessions, home nurse visits, and paediatrician visits.			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.

Personal Health Pathways is brought to Discovery Health Medical Scheme members by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes. Personal Health Pathways is enabled by the combination of Discovery Health's healthcare capabilities and Vitality's behaviour change expertise. Discovery Health Medical Scheme, registration number 1125, is an independent non-profit entity governed by the Medical Schemes Act, and regulated by the Council for Medical Schemes. Vitality is a separate wellness product, sold and administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07. Limits, terms and conditions apply.

		Executive	Comprehensive		Priority		Saver			Smart Saver		Smart			Core			Keycare			
			CLASSIC	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	ACTIVE	CLASSIC	ESSENTIAL	COASTAL	ACTIVE	PLUS	CORE	START	START REGIONAL
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 at a network provider (not applicable to ADL conditions). Medicine not on our list, paid up to 100% of the DHR or generic reference price up to a maximum of the monthly Chronic Drug Amount.	Full cover for approved medicine on our medicine list at a network provider (not applicable to ADL). Medicine not on our list, paid up to 100% of the DHR or generic reference price up to a maximum of the monthly Chronic Drug Amount.	Full cover for approved medicine on our medicine list at a network provider. Medicine not on our list, paid up to 100% of the DHR or generic reference price up to a maximum of the monthly Chronic Drug Amount.	Approved medicine on our medicine list covered in full when you use a MedXpress Network Pharmacy. Medicine not on our list, paid up to 100% of the DHR or generic reference price up to a maximum of the monthly Chronic Drug Amount.					Approved medicine on our medicine list covered in full when you use a MedXpress Network Pharmacy. For medicine not on our list, we cover up to the therapeutic reference price of the equivalent medicine or group of medicines.					Approved medicine on our medicine list covered in full when you use a MedXpress Network Pharmacy. Medicines not on our list paid up to 100% of the DHR or generic reference price up to a maximum of the monthly Chronic Drug Amount.			Approved medicine on our medicine list covered in full when you use a MedXpress Network Pharmacy. For medicine not on our list, we cover up to the therapeutic reference price of the equivalent medicine or group of medicines.	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 therapeutic reference price of the equivalent medicine or group of medicines.	We cover your chronic medicine in a state facility. For medicine not on our list, we cover up to the cost of the therapeutic reference price of the equivalent medicine or group of medicines.	We cover your chronic medicine when you use one of our network pharmacies or your nominated KeyCare Start Regional Network GP. Your nominated Regional Network GP must prescribe the chronic medicine. For medicine not on our list, we cover up to the cost of the therapeutic reference price of the equivalent medicine or group of medicines.
	Renal Dialysis	Covered in full if we have approved your treatment plan and you use a provider in the Dialysis Network. If you use any other provider, we will cover your claims up to 80% of the Discovery Health Rate.								Covered in full at a State facility if we have approved your treatment plan. If you use any other provider, we will cover your claims up to 80% of the Discovery Health Rate.		Covered in full if we have approved your treatment plan and you use a provider in the Dialysis Network. If you use any other provider, we will cover your claims up to 80% of the Discovery Health Rate.	Covered in full at a State facility if we have approved your treatment plan. If you use any other provider, we will cover your claims up to 80% of the Discovery Health Rate.		Covered in full if we have approved your treatment plan and you use a provider in the Dialysis Network. If you use any other provider, we will cover your claims up to 80% of the Discovery Health Rate.			Covered in full at a State facility if we have approved your treatment plan. If you use any other provider, we will cover your claims up to 80% of the Discovery Health Rate.	Covered in full if we have approved your treatment plan and you use a provider in the Dialysis Network. If you use any other provider, we will cover your claims up to 80% of the Discovery Health Rate.		Covered in full at a State facility if we have approved your treatment plan. If you use any other provider, we will cover your claims up to 80% of the Discovery Health Rate.	
	Specialised Medicine and Technology Benefit	Cover for a defined list of the latest treatments through the Specialised Medicine and Technology Benefit. We pay up to R200,000 per person per year. A co-payment of up to 20% applies.	These plans do not offer this benefit																			
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.							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 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. If your treatment costs more than the cover amount, we will cover up to 80% of the DHR. We cover cancer treatment in our network.	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 our network.	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 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.	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 our network.	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 our network.	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.
		All cancer-related healthcare services are covered up to 100% of the 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 DHR.		All cancer-related healthcare services are covered up to 100% of the 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 DHR.		All cancer-related healthcare services are covered up to 100% of the 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 DHR. If you are on a Delta plan you will need to make use of DSP in the Delta Network.		All cancer-related healthcare services are covered up to 100% of the 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 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.	These plans do not offer this benefit.																			
	Oncology Innovation Benefit	You have cover for a defined list of innovative cancer medicine that meet the Scheme's criteria.Claims are paid up to 70% of the Discovery Health Rate or Reference Price. You will need to pay the difference.	You have cover for a defined list of innovative cancer medicine that meet the Scheme's criteria. Claims are paid up to 50% of the Discovery Health Rate or Reference Price. You will need to pay the difference.	You have cover for a sub-set of the defined limited list of precision medicine, subject to the Scheme's clinical entry criteria. Claims are paid up to 50% of the Discovery Health Rate or Reference Price. You will need to pay the difference.	You have cover for a limited sub-set of the defined list of precision medicine, subject to the Scheme's clinical entry criteria. Claims are paid up to 50% of the Discovery Health Rate or Reference Price. You will need to pay the difference.								This plan does not offer this benefit.		You have cover for a sub-set of the defined list of precision medicine, subject to the Scheme's clinical entry criteria. Claims are paid up to 50% of the Discovery Health Rate or Reference Price. You will need to pay the difference.	This plan does not offer this benefit.	These plans do not offer this benefit.			
HOSPITAL COVER	**Private hospital cover in a general ward**	Unlimited cover plus private ward cover of up to R2,900 each day.	Unlimited cover plus private ward cover up to R2,900 per day for your delivery.		Unlimited cover									Neonatal hospitalization: Limited to R75,450 per family per year. Unlimited cover for other admissions.	Unlimited cover							
	Private hospital	You are covered in any facility approved by the Scheme.		You are covered in the Smart Hospital Network. For planned admissions at hospitals outside of the Smart Hospital Network, you must pay an upfront payment of R13,150 to the hospital.	You are covered in any facility approved by the Scheme. An upfront payment of between R5,200 to R24,600 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 or our designated service provider (DSP) for home-based care, where clinically appropriate. For planned admissions outside of the Delta Hospital Network, you must pay an upfront payment to the hospital of R11,550. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,650.		You are covered 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.	You are covered in the Smart Hospital Network or our designated service provider (DSP) for home-based care, where clinically appropriate. For planned admissions at hospitals outside of the Smart Hospital Network, you must pay an upfront payment of R13,150 to the hospital. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,650.		You are covered in the Smart Hospital Network or our designated service provider (DSP) for home-based care, where clinically appropriate. For planned admissions at hospitals outside of the Smart Hospital Network, you must pay an upfront payment of R13,150 to the hospital. For the Essential Dynamic Smart plan, full cover in the Dynamic Smart Hospital Network as referred by Ask Discovery, or our designated service provider (DSP) for home-based care, where clinically appropriate. For planned admissions at hospitals outside of the Dynamic Smart Hospital Network, you must pay an upfront payment of R15,900 to the hospital. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,650.		You must pay an upfront payment of R8,050 to the hospital for any planned admissions in the Active Hospital Network as referred by Ask Discovery, For planned admissions at hospitals outside of the Active Hospital Network, you must pay an upfront payment of R15,900 to the hospital. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,650.	You are covered in any facility approved by the Scheme. Full cover on Delta options when using the Delta Hospital Network of private hospitals or our designated service provider (DSP) for home-based care, where clinically appropriate. For planned admissions outside of the Delta Hospital Network, you must pay an upfront payment to the hospital of R11,550. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,650.	You are covered 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.	You must pay an upfront payment of R15,900 to the hospital for any planned admissions in the Active Hospital Network, For planned admissions at hospitals outside of the Active Hospital Network, you must pay an upfront payment of R15,900 to the hospital. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,650.	You are covered if you use a hospital in the KeyCare Hospital Network or our designated service provider (DSP) for home-based care, where clinically appropriate. 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. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,650.	You are covered at your chosen KeyCare Start Network hospital or our designated service provider (DSP) for home-based care, where clinically appropriate. If you do not use your chosen hospital in the network, you will have to pay all costs. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,650.	You are covered at your chosen KeyCare Start Regional Network hospital or our designated service provider (DSP) for home-based care, where clinically appropriate. If you do not use your chosen hospital in the network, you will have to pay all costs. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,650.
	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 R7,550 applies for admission to a facility outside of the Day Surgery Network.	We cover a defined list of procedures in the Smart Day Surgery Network. An upfront payment of R13,150 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 R7,550 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 R7,550 applies for admissions to a facility outside of the Day Surgery Network. An upfront payment of R11,550 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 R13,150 applies for admissions to a facility outside of the Smart Day Surgery Network.		We cover a defined list of procedures in the Smart Day Surgery Network. An upfront payment of R13,150 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 R15,900 applies for admission to a facility outside of the Dynamic Smart Day Surgery Network.		We cover a defined list of procedures in the Smart Day Surgery Network. An upfront payment of R15,900 applies for admission to a facility outside of the Dynamic Smart Day Surgery Network.	We cover a defined list of procedures in a Day Surgery Network. An upfront payment of R7,550 applies for admissions to a facility outside of the Day Surgery Network. An upfront payment of R11,550 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 R15,900 applies for admission to a facility outside of the Active 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 Regional 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				Full cover			
	Reimbursement rate for specialists we do not have a payment arrangement with	300% 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		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	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		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				100% of the DHR			

		Executive	Comprehensive		Priority		Saver			Smart Saver		Smart			Core			Keycare			
			CLASSIC	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	ACTIVE	CLASSIC	ESSENTIAL	COASTAL	ACTIVE	PLUS	CORE	START	START REGIONAL
HOSPITAL COVER	Cover for scopes (gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy) when performed in-hospital	Depending on where you have your scope done, we pay a portion of between R4,850 and R7,100 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 as part of a confirmed Prescribed Minimum Benefits (PMB) condition, where indicated and approved for dyspepsia, or the patient is under the age of 12, no co-payment applies. We pay the account from the Hospital Benefit.	Depending on where you have your scope done, we pay a portion of between R4,850 and R7,100 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 as part of a confirmed Prescribed Minimum Benefits (PMB) condition, where indicated and approved for dyspepsia, or the patient is under the age of 12, no co-payment applies. 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, an upfront payment of between R4,850 and R7,800 applies. We pay 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 as part of a confirmed Prescribed Minimum Benefits (PMB) condition, where indicated and approved for dyspepsia, 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 R4,850 and R8,300 from the available funds in your MSA 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 as part of a confirmed Prescribed Minimum Benefits (PMB) condition, where indicated and approved for dyspepsia, or the patient is under the age of 12, no co-payment applies. 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, an upfront payment of between R4,850 and R8,300 applies. We pay 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 as part of a confirmed Prescribed Minimum Benefits (PMB) condition, where indicated and approved for dyspepsia, 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 applicable 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 scopes (gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy) when performed in-rooms	We pay the first R1,880 of the scope from your available day-to-day benefits. Where both a gastroscopy and colonoscopy is done, we pay the first R3,220 from your available day-to-day benefits. The co-payment will not apply if the scope is performed at a network provider.										You will have to pay the first R1,880 of the scope. Where both a gastroscopy and colonoscopy is done, an upfront payment of R3,220 applies. The co-payment will not apply if the scope is performed at a network provider.										
		We pay the balance of the account from the Hospital Benefit up to 300% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 200% of the Discovery Health Rate.		We pay the balance of the account from the Hospital Benefit up to 200% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 100% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 200% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 100% of the Discovery Health Rate.		We pay the balance of the account from the Hospital Benefit up to 200% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 100% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 100% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 100% of the Discovery Health Rate.		We pay the balance of the account from the Hospital Benefit up to 200% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 100% of the Discovery Health Rate.				
	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 hospital 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 R4,155 of the scan from your available 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 R4,155 of the scan from your available 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 R4,155 of the scan from available 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 pay the first R5,200 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 R4,155 of the scan from your available MSA. 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 R4,155 of your MRI or CT scan from your available MSA. We cover the balance of the scan from the Hospital Benefit, up to the DHR. Scans related to conservative back and neck scans are not covered on this plan		You need to pay the first R4,155 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 R5,970 for each person each year.		We pay scans from the Specialist Benefit up to a limit of R2,960 for each person each year.	
ADDITIONAL BENEFITS	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.																			
	Africa Evacuation Benefit	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.			
	Assisted Reproductive Therapy (ART)	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 R145,450 per person per year at 75% of the DHR. A co-payment of 25% will apply.	These plans do not offer these benefits.																			
	Care Programmes	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.																			
	Disease management for sleep disorders	Members identified as being at risk following the completion of a validated sleep assessment may have access to a defined basket of care which includes cover for a consultation with an appropriate medical professional, CBT-i and sleep health coaching.																			
	Mental Wellbeing	Members identified with moderate to severe symptoms of depression following a mental wellbeing assessment, have access to to a virtual or face-to-face consultation, where applicable, with a Premier Plus GP or network psychologist, coaching sessions with a social worker, two consultations with a dietitian, and a clinically appropriate digital mental wellbeing course. Cover is subject to clinical entry criteria.																			
	Care at Home	You have access to hospital-level care in your home instead of having to go to hospital for acute hospital care. The Hospital at Home devices and healthcare services are accessible if you meet the clinical and benefit criteria. You will receive 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 offers 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 R4,850 per person per year, at 100% of the DHR.	You have access to hospital-level care in your home instead of having to go to hospital for acute hospital care. The Hospital at Home devices and healthcare services are accessible if you meet the clinical and benefit criteria. Hospital at Home is the designated service provider (DSP) for the Delta, Smart and KeyCare plans for home-based care for qualifying conditions such as chronic obstructive pulmonary disease, pneumonia, complicated urinary tract infection, heart failure, cellulitis, deep vein thrombosis, asthma and diabetes. Should members choose to not make use of Hospital at Home once a healthcare provider has recommended it as part of their care, an upfront deductible of R5,450 will apply to the admission. You will receive 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 offers 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 R4,850 per person per year, at 100% of the DHR.																			
	Virtual Chronic Care Programme	High-risk chronic members have access to a supportive out-of-hospital basket of care to help manage their chronic conditions at home. The basket of care may include remote monitoring devices, a home nurse visit, care coordination which includes health coaching sessions, and ongoing patient management by their nominated Premier Plus GP. Cover is subject to meeting the Scheme's clinical entry criteria, treatment guidelines and managed care protocols.																			
	Home-based virtual care for the elderly	Members 65 years and older who have been identified as being at high risk may have access to a basket of care to manage their condition at home. This includes a virtual consultation with a GP or nurse as an alternative to a casualty visit as well as virtual coaching sessions to help coordinate their care.																			
	International medical second opinion service	Through your local treating specialist, you can access a medical second opinion from an international expert or centre of excellence through MediGuide*. This cover is for complex medical conditions. We pay 100% of the cost for the second opinion service.																			
	Conservative Care pathway for Arthroscopy	For selected arthroscopic procedures and clinically appropriate conditions, eligible members may have access to a conservative care pathway which includes physiotherapy sessions before surgery. Cover is subject to meeting the Scheme's clinical entry criteria, treatment guidelines and managed care protocols.																These plans do not offer these benefits			
	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, if applicable.										These plans do not offer these 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 up to 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, if applicable.										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 up to four virtual urgent care sessions per family per year, subject to clinical entry criteria. You will need to fund any additional sessions.							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 one virtual urgent care sessions per member, per year, subject to clinical entry criteria. You will need to fund any additional sessions.			
	Smoking Cessation Programme	If you have activated your Personal Health Pathway you may have to access to the GoSmokeFree*, Smoking Cessation Programme up to three times per lifetime. Cover is subject to clinical entry criteria, treatment guidelines and managed care protocols.																			
	Screening and Prevention Benefit	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, a mental wellbeing assessment every year, 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, you need a prescription from your doctor to get this vaccine. 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 the measurement of weight, height, body mass index and blood pressure at one of our wellness providers.																			
	Trauma Recovery Extender Benefit	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.																			
	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 Prescribed Minimum Benefits (PMBs) or Mental Health Care Programme, if enrolled, 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, if applicable.																			
	International Travel Benefit	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.				
	Overseas Treatment Benefit	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.																

* Independent service provider appointed by the Scheme.

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

www.discovery.co.za @Discovery_SA discoverysouthafrica

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. 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 or by e-mailing 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 | 0861 123 267 | 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, all 2027 updates including contributions and the Active Core Plan are subject to approval from the Council for Medical Schemes. In all instances, Discovery Health Medical Scheme Rules prevail. Please consult the Scheme Rules on 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. The information contained in this document is subject to approval by the Council for Medical Schemes.

ROK_120572DH_30/09/2026_V13