Discovery
Health Medical Scheme

2025

PLAN COMPARISON

EXECUTIVE

COMPREHENSIVE

PRIORITY

SAVER

SMART

CORE

KEYCARE

Discovery Health Medical Scheme 2025 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	Executive Plan	8,573	8,573	1,639	2,857	2,857	546	11,430	11,430	2,185
Comprehensive	Classic Comprehensive	6,975	6,596	1,392	2,323	2,197	464	9,298	8,793	1,856
	Classic Smart Comprehensive	6,754	6,237	1,577	1,191	1,100	278	7,945	7,337	1,855
Priority	Classic Priority	4,348	3,429	1,739	1,448	1,142	579	5,796	4,571	2,318
	Essential Priority	4,234	3,330	1,691	747	587	298	4,981	3,917	1,989
Saver	Classic Saver	3,629	2,862	1,455	906	715	362	4,535	3,577	1,817
	Classic Delta Saver	2,900	2,291	1,164	724	572	291	3,624	2,863	1,455
	Essential Saver	3,271	2,453	1,310	363	272	145	3,634	2,725	1,455
	Essential Delta Saver	2,609	1,969	1,047	289	218	116	2,898	2,187	1,163
	Coastal Saver	3,228	2,427	1,303	569	428	230	3,797	2,855	1,533
Smart	Classic Smart	2,822	2,227	1,127	No Medical Savings Account			2,822	2,227	1,127
	Essential Smart	2,021	2,021	2,021				2,021	2,021	2,021
	Essential Dynamic Smart	1,681	1,681	1,681				1,681	1,681	1,681
	Active Smart	1,350	1,350	1,350				1,350	1,350	1,350
Core	Classic Core	3,652	2,882	1,461	No Medical Savings Account			3,652	2,882	1,461
	Classic Delta Core	2,923	2,305	1,169				2,923	2,305	1,169
	Essential Core	3,138	2,354	1,260				3,138	2,354	1,260
	Essential Delta Core	2,507	1,887	1,006				2,507	1,887	1,006
	Coastal Core	3,011	2,259	1,196				3,011	2,259	1,196
KeyCare*	KeyCare Plus 0 – 9,900	1,817	1,817	661	No Medical Savings Account			1,817	1,817	661
	KeyCare Plus 9,901 – 15,990	2,497	2,497	704				2,497	2,497	704
	KeyCare Plus 15,991 +	3,687	3,687	986				3,687	3,687	986
	KeyCare Core 0 – 9,900	1,381	1,381	361	No Medical Savings Account			1,381	1,381	361
	KeyCare Core 9,901 – 15,990	1,723	1,723	427				1,723	1,723	427
	KeyCare Core 15,991 +	2,636	2,636	598				2,636	2,636	598
	KeyCare Start 0 – 10,550	1,331	1,331	811	No Medical Savings Account			1,331	1,331	811
	KeyCare Start 10,551 – 15,950	1,952	1,952	878				1,952	1,952	878
	KeyCare Start 15,951 – 24,250	3,063	3,063	919				3,063	3,063	919
	KeyCare Start 24,251 +	3,488	3,488	949				3,488	3,488	949
	KeyCare Start Regional 0 – 10,550	1,184	1,184	713	No Medical Savings Account			1,184	1,184	713
	KeyCare Start Regional 10,551 – 15,950	1,790	1,790	805				1,790	1,790	805
	KeyCare Start Regional 15,951 – 24,250	2,790	2,790	854				2,790	2,790	854
	KeyCare Start Regional 24,251 +	3,178	3,178	890				3,178	3,178	890

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.

Annual Medical Savings Account

		MAIN MEMBER (R)	ADULT (R)	CHILD* (R)
Executive	Executive Plan	34,284	34,284	6,552
Comprehensive	Classic Comprehensive	27,876	26,364	5,568
	Classic Smart Comprehensive	14,292	13,200	3,336
Priority	Classic Priority	17,376	13,704	6,948
	Essential Priority	8,964	7,044	3,576
Saver	Classic Saver	10,872	8,580	4,344
	Classic Delta Saver	8,688	6,864	3,492
	Essential Saver	4,356	3,264	1,740
	Essential Delta Saver	3,468	2,616	1,392
	Coastal Saver	6,828	5,136	2,760

* 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.

Annual Threshold Amounts

Annual Threshold

	MAIN MEMBER (R)	ADULT (R)	CHILD* (R)
Executive	39,440	39,440	7,480
Classic Comprehensive	32,250	32,250	6,160
Classic Smart Comprehensive	32,250	32,250	6,160
Priority	25,400	19,090	8,460

Above Threshold Benefit limits

	MAIN MEMBER (R)	ADULT (R)	CHILD* (R)
Executive		Unlimited	
Classic Comprehensive	35,000	35,000	8,500
Classic Smart Comprehensive	30,000	30,000	7,500
Priority	19,370	13,820	6,770

* 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			CORE			KEYCARE			
			CLASSIC	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	ACTIVE	CLASSIC	ESSENTIAL	COASTAL	PLUS	CORE	START	START REGIONAL
PMB	**Prescribed Minimum Benefits (PMB)**	All Discovery Health Medical Scheme (DHMS) plans cover the costs related to the diagnosis, treatment and care of: an emergency medical condition, a defined list of 271 diagnoses and a defined list of 27 chronic conditions. Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit conditions. The treatment 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.	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.		Pays for day-to-day medical expenses like GP consultation fees, prescribed and over-the-counter medicine, radiology and pathology as long as you have money available.		This plan does not offer an MSA. Access to a defined set of benefits including GP consultations, certain acute medicine when prescribed by a Smart GP and over-the-counter medicine, dental check up and optometry check up with fixed co-payments and limits.	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.		These plans do not offer an MSA.			This plan does not offer an MSA. Day-to-day benefits through your nominated 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 R5,500 per person per year when referred by your nominated GP.	This plan does not offer an MSA. Specialist cover up to R5,500 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 R2,780 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 R2,780 per person per year when referred by your nominated KeyCare Start Regional GP.

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

		EXECUTIVE	COMPREHENSIVE		PRIORITY		SAVER			SMART			CORE			KEYCARE			
			CLASSIC	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	ACTIVE	CLASSIC	ESSENTIAL	COASTAL	PLUS	CORE	START	START REGIONAL
DAY-TO-DAY BENEFITS	**Day-to-day Extender Benefit**	Pays for certain day-to-day benefits after you have run out of money in your MSA and before you reach the Annual Threshold. Covers unlimited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have unlimited cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR. You also have additional cover for kids casualty visits.	Pays for certain day-to-day benefits after you have run out of money in your MSA and before you reach the Annual Threshold. Covers 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. You also have additional cover for kids casualty visits.		Pays for certain day-to-day benefits after you have run out of money in your MSA. Covers limited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR. You also have additional cover for kids casualty visits.			These plans do not offer this benefit.						
	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 R3,850 of your MRI or CT scan from your day-to-day benefits. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.								You must pay the first R3,850 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.	These plans do not offer this benefit.		These plans do not offer this benefit.			MRI and CT scans are paid from the Specialist Benefit up to a limit of R5,550 for a person a year.		MRI and CT scans are paid from the Specialist Benefit up to a limit of R2,780 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 R2,700 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 R6,300 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 (wNIPT) 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.	**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.	

		EXECUTIVE	COMPREHENSIVE		PRIORITY		SAVER			SMART			CORE			KEYCARE			
			CLASSIC	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	ACTIVE	CLASSIC	ESSENTIAL	COASTAL	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. 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 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.	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.
	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. 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.					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. On Essential Smart and Essential Dynamic Smart plans, we cover cancer treatment in our network. If you choose to use any other provider, we will cover up to 80% 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. You have cover for cancer treatment in our network. If you choose to use any other provider, we will cover up to 80% of the DHR.		We cover the first R250,000 of your approved cancer treatment over a 12-month cycle in full. All cancer-related healthcare services are covered up to 100% of the 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.	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. If you choose to use any other provider, we will cover up to 80% 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. You have cover for cancer treatment in a state facility. If you choose to use any other provider, we will cover up to 80% of the 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.																	
	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. You will need to pay 25% of the cost of these treatments.	You have cover for a defined list of innovative cancer medicine that meet the Scheme's criteria. You will need to pay 25% of the cost of these treatments. A 50% co-payment applies to a select list of novel and ultra high-cost treatment and conditions.	You have cover for a sub-set of the defined list of innovative cancer medicine, subject to the Scheme's clinical entry criteria. You will need to pay 50% of the cost of these treatments.	You have cover for a sub-set of the defined list of innovative cancer medicine, subject to the Scheme's clinical entry criteria. You will need to pay 50% of the cost of these treatments.							This plan does not offer this benefit.	You have cover for a sub-set of the defined list of innovative cancer medicine, subject to the Scheme's clinical entry criteria. You will need to pay 50% of the cost of these treatments.		These plans do not offer this benefit.					

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

HOSPITAL COVER

	EXECUTIVE	COMPREHENSIVE		PRIORITY		SAVER			SMART			CORE			KEYCARE			
		CLASSIC	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	ACTIVE	CLASSIC	ESSENTIAL	COASTAL	PLUS	CORE	START	START REGIONAL
Private hospital cover in a general ward	Unlimited cover plus private ward cover of up to R2,700 each day.	Unlimited cover plus private ward cover up to R2,700 per day for your delivery.		Unlimited cover		Unlimited cover			Unlimited cover		Neonatal hospitalization: Limited to R70 000 per family per year. Unlimited cover for other admissions.	Unlimited cover			Unlimited cover			
Private hospital	You are covered in any facility approved by the Scheme.	You are covered in any facility approved by the Scheme.	Full cover in the Smart Hospital Network. For planned admissions at hospitals outside of the Smart Hospital Network, you must pay an upfront payment of R12,200 to the hospital.	You are covered in any facility approved by the Scheme. An upfront payment of between R4,800 to R22,850 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 R10,700. 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 R5,250.		Full cover in any approved private hospital in the four coastal provinces network. If you use a hospital outside the coastal network, we pay up to 70% of the DHR of the hospital account and you must pay the difference.	Full cover in the Smart Hospital Network 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 R12,200 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 R14,750 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 R5,250.	You must pay an upfront payment of R7,500 to the hospital for any planned admissions 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 R14,750 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 R5,250.	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 R10,700. 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 R5,250.	Full cover in any approved private hospital in the four coastal provinces network. If you use a hospital outside the coastal network, we pay up to 70% of the DHR of the hospital account and you must pay the difference.	Full cover if you use a hospital in the KeyCare Hospital Network 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 R5,250.	Full cover 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 R5,250.	Full cover 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 R5,250.
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 R7,000 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 R12,200 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 R7,000 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 R7,000 applies for admissions to a facility outside of the Day Surgery Network. An upfront payment of R10,700 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 R12,200 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 R14,750 applies for admission to a facility outside of the Dynamic Smart Day Surgery Network.		An upfront payment of R14,750 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 R7,000 applies for admissions to a facility outside of the Day Surgery Network. An upfront payment of R10,700 applies on the Delta options, if performed outside of the Delta 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			
Reimbursement rate for specialists we do not have a payment arrangement with	300% 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		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		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			

		EXECUTIVE	COMPREHENSIVE		PRIORITY		SAVER			SMART			CORE			KEYCARE			
			CLASSIC	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	ACTIVE	CLASSIC	ESSENTIAL	COASTAL	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 R4,500 and R6,550 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, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit.	Depending on where you have your scope done, we pay a portion of between R4,500 and R6,550 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, 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, an upfront payment of between R4,500 and R7,250 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 upfront 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 deductible will apply.		Depending on where you have your scope done, we pay a portion of between R4,500 and R7,700 from your available 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, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the Day Surgery Network, the highest of the out-of-network upfront payment or scopes co-payment will apply.			Depending on where you have your scope done, you will have to pay a portion of between R4,500 and R7,700 and we pay the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed 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, you will have to pay a portion of between R4,500 and R7,700 and we pay the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed 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.			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 R1,750 of the scope from your day-to-day benefits. Where both a gastroscopy and colonoscopy is done, we pay the first R3,000 from your available day-to-day benefits. The co-payment will not apply if the scope is performed at a network provider.					We pay the first R1,750 of the scope from your day-to-day benefits. Where both a gastroscopy and colonoscopy is done, we pay the first R3,000 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 R1,750 of the scope. Where both a gastroscopy and colonoscopy is done, an upfront payment of R3,000 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 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 R3,850 of the scan from your day-to-day benefits. We pay the balance of the scan from the Hospital Benefit, up to 100% of the DHR. Limited to one scan per spinal and neck region.	We pay the first R3,850 of the scan from your day-to-day benefits. We pay the balance of the scan from the Hospital Benefit, up to 100% of the DHR. Limited to one scan per spinal and neck region.		We pay the first R3,850 of the scan from 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 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.		We pay the first R3,850 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.			You need to pay the first R3,850 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 R5,550 for each person each year.		We pay scans from the Specialist Benefit up to a limit of R2,780 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 R135,000 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.																	
												Members diagnosed with depression must be enrolled on the Mental Health Care Programme to avoid a 20% co-payment on their consultations.									Members diagnosed with depression must be enrolled on the Mental Health Care Programme to avoid a 20% co-payment on their consultations.	

		EXECUTIVE	COMPREHENSIVE		PRIORITY		SAVER			SMART			CORE			KEYCARE			
			CLASSIC	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	ACTIVE	CLASSIC	ESSENTIAL	COASTAL	PLUS	CORE	START	START REGIONAL
ADDITIONAL BENEFITS	**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 R4,700 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. 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 R4,700 per person per year, at 100% of the DHR. 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 R5,250 will apply to the admission.								
		The Scheme also covers defined point of care medical devices up to 75% of the DHR, if you meet the clinical entry criteria.											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.								Access to personalised and evidence-based virtual physical therapy, prescribed by an appropriate healthcare professional. You will have to pay for claims related to Virtual Physical Therapy									
	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.			
	Screening and Prevention Benefit	This benefit covers a health check which is made up of certain tests (including self-sampling kits, where appropriate) 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. 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.																	
	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 action. 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 2025, you will be able to double your limit stated below.																	
		R2,500 per adult, R1,250 per child, max R10,000 per family.			R1,500 per adult, R750 per child, max R6,000 per family		R2,500 per adult, R1,250 per child, max R10,000 per family.	R1,500 per adult, R750 per child, max R6,000 per family		R2,000 per adult, R1,000 per child, max R8,000 per family	R1,500 per adult, R750 per child, max R6,000 per family		R2,000 per adult, R1,000 per child, max R8,000 per family	R1500 per adult, R750 per child, max R6000 per family		R500 per adult, R250 per child, max R1,000 per family			
	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.																	
	WHO Global Outbreak Benefit	Provides cover for approved global disease outbreaks recognised by the World Health Organisation (WHO) such as COVID-19 and Mpox. This benefit provides access to a defined basket of care per disease outbreak, which includes cover for the administration of vaccines (where applicable) and relevant out-of-hospital treatment.																	
	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.															

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

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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 subject to the 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. Discovery Health app, Ask Discovery, Medicine tracker, Track your health, second opinion services from Cleveland Clinic, Connected Care and Discovery Hospital at Home are brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

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