

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				1,331	1,331	811
	KeyCare Start 10,551 – 15,950	1,952	1,952	878	No Medical Savings Account			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
	Classic Comprehensive	27,876	26,364	5,568
Comprehensive	Classic Smart Comprehensive	14,292	13,200	3,336
	Classic Priority	17,376	13,704	6,948
Priority	Essential Priority	8,964	7,044	3,576
	Classic Saver	10,872	8,580	4,344
Saver	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 R5,550 per person per year when referred by your nominated GP.			This plan does not offer an MSA. Specialist cover up to R5,550 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 your nominated KeyCare Start GP 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.		

	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.	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.											
	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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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.																	
	Medicine cover	You have cover for the 27 Chronic Disease List conditions according to the Prescribed Minimum Benefits																	
	Specialised Medicine and Technology Benefit	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. 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. 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.	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.	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 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.	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 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.	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 our network. If you choose to use any other provider, 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.																	
	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.														

	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								
Mental Wellbeing	Members identified with moderate to severe symptoms of depression following a mental wellbeing assessment, have access 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 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			R1,000 per adult, R500 per child, max R4,000 per family			R2,000 per adult, R1,000 per child, max R8,000 per family			R1,000 per adult, R500 per child, max R4,000 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.