Discovery
Health Medical Scheme

2021

PLAN COMPARISON

		EXECUTIVE	COMPREHENSIVE			PRIORITY		SAVER			SMART		CORE			KEYCARE		
			Classic	Essential	Classic Smart	Classic	Essential	Classic	Essential	Coastal	Classic	Essential	Classic	Essential	Coastal	Plus	Core	Start
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 270 diagnoses, a defined list of 27 chronic conditions. Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit conditions. The treatment needed must match the treatments in the defined benefits. You must use designated service providers (DSPs) in our network – this does not apply in emergencies. Where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service providers in our network once your condition has stabilised. If your treatment doesn't meet the above criteria, we will pay up to 80% of the Discovery Health Rate (DHR). You will be responsible for the difference between what we pay and the actual cost of your treatment.																
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.		This plan does not offer a Medical Savings Account. Access to a defined set of benefits including GP consultations, certain specialist visits, certain acute medicine when prescribed by a Smart GP and over-the-counter medicine, dental check up and optometry check up with fixed co-payments and limits.	Pays for day-to-day medical expenses like GP consultation fees, prescribed and over-the-counter medicine, radiology and pathology as long as you have money available.					This plan does not offer a Medical Savings Account. Access to a defined set of benefits including GP consultations, certain acute medicine when prescribed by a Smart GP and over-the-counter medicine, dental check up and optometry check up with fixed co-payments and limits.	This plan does not offer a Medical Savings Account. Access to a defined set of benefits including GP consultations, certain over-the-counter medicine, dental check up and optometry check up with fixed co-payments and limits.	This plan does not offer a Medical Savings Account.	This plan does not offer a Medical Savings Account. Day-to-day benefits through your chosen GP and day-to-day medicine from our medicine list when prescribed by your chosen KeyCare GP. We pay for basic radiology and pathology at a network provider.	This plan does not offer a Medical Savings Account.	This plan does not offer a Medical Savings Account. Day-to-day benefits through your chosen KeyCare Start GP and day-to-day medicine from our medicine list when prescribed by your chosen KeyCare Start GP. We pay for basic radiology and pathology if referred by your chosen KeyCare Start GP.
	Day-to-day Extender Benefit	Pays for certain day-to-day benefits after you have run out of money in your MSA and before you reach the Annual Threshold. Covers unlimited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have unlimited cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR. You also have additional cover for kids casualty visits.	Pays for certain day-to-day benefits after you have run out of money in your MSA and before you reach the Annual Threshold. Covers unlimited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have unlimited cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR. On Classic, you also have additional cover for kids casualty visits.		This plan does not offer this benefit.	Pays for certain day-to-day benefits after you have run out of money in your Medical Saving Account and before you reach the Annual Threshold.		Pays for certain day-to-day benefits after you have run out of money in your Medical Savings Account.			These plans do not offer this benefit.					
						Covers unlimited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have unlimited cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR. You also have additional cover for kids casualty visits.	Covers unlimited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have unlimited cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR.	Covers limited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR. You also have additional cover for kids casualty visits.	Covers limited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR.										
	Above Threshold Benefit	The Scheme continues to cover day-to-day healthcare services once you reach your Annual Threshold. The Above Threshold Benefit is unlimited. Annual benefit limits may apply.				The Scheme continues to cover day-to-day healthcare services once you reach your Annual Threshold. The Above Threshold Benefit is limited. Annual benefit limits may apply.		These plans do not offer this benefit.									
	MRI and CT scans	We pay the first R3 130 of your MRI or CT scan from your day-to-day benefits. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.	We pay the first R3 130 of your MRI or CT scan from your day-to-day benefits. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.		You have to pay the first R3 130 of your MRI or CT scan until you reach the Annual Threshold. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.	We pay the first R3 130 of your MRI or CT scan from your day-to-day benefits. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.		We pay the first R3 130 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. For conservative back and neck scans a limit of one scan per spinal and neck region applies.		You must pay the first R3 130 of your MRI or CT scan. We cover the balance of the scan from your Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies.	This plan does 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 R4 530 for a person a year.	MRI and CT scans are paid from the Specialist Benefit up to a limit of R2 270 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 including 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 220 per day for your delivery in hospital ▪ Cover for up to R5 350 for essential registered devices with 25% co-payment ▪ A defined basket of blood tests ▪ Five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth.	**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 as part of your delivery or if there are any complications ▪ 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 including 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 ▪ Five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth.					**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 ▪ 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. To access these benefits on KeyCare Start, your chosen GP must refer you.			

		EXECUTIVE	COMPREHENSIVE			PRIORITY		SAVER			SMART		CORE			KEYCARE		
			Classic	Essential	Classic Smart	Classic	Essential	Classic	Essential	Coastal	Classic	Essential	Classic	Essential	Coastal	Plus	Core	Start
CHRONIC COVER	Conditions	You have cover for the 27 Chronic Disease List conditions according to the Prescribed Minimum Benefits list as well as additional conditions on our Additional Disease List.	You have cover for the 27 Chronic Disease List conditions according to the Prescribed Minimum Benefits															
	Medicine cover	Approved medicine on our medicine list covered in full (not applicable to ADL conditions). Medicine not on our list paid up to 100% of the DHR up to a maximum of the monthly Chronic Drug Amount.	Full cover for approved medicine on our medicine list (not applicable to ADL). Full cover for Delta options if you use MedXpress or a MedXpress network pharmacy. Medicine not on our list paid up to 100% of the DHR up to a maximum of the monthly Chronic Drug Amount.		Full cover for approved medicine on our medicine list. Medicine not on our list paid up to 100% of the DHR up to a maximum of the monthly Chronic Drug Amount.	Approved medicine on our medicine list covered in full when you use MedXpress or a MedXpress network pharmacy. Medicine not on our list paid up to 100% of the DHR up to a maximum of the monthly Chronic Drug Amount.		Approved medicine on our medicine list covered in full when you use MedXpress or a MedXpress network pharmacy. Medicine not on our list paid up to 100% of the DHR up to a maximum of the monthly Chronic Drug Amount.			Approved medicine on our medicine list covered in full when you use MedXpress or a MedXpress Network Pharmacy. For medicine not on our list, we cover up to the cost of the lowest formulary drug.		Approved medicine on our medicine list covered in full when you use MedXpress or a MedXpress network pharmacy. Medicines not on our list paid up to 100% of the DHR up to a maximum of the monthly Chronic Drug Amount.			Approved medicine covered in full when you use one of our network pharmacies or your chosen GP. Your chosen GP must prescribe the chronic medicine. For medicine not on our list, we cover up to the cost of the lowest formulary drug.		We cover your chronic medicine in a state facility.
CANCER COVER	Oncology Benefit	We cover the first R400 000 of your approved cancer treatment over a 12-month cycle in full.			We cover the first R300 000 of your approved cancer treatment over a 12-month cycle in full.	We cover the first R200 000 of your approved cancer treatment over a 12-month cycle in full. All cancer-related healthcare services are covered up to 100% of the Discovery Health Rate (DHR). Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount, we will cover up to 80% of the additional costs.					We cover the first R200 000 of your approved cancer treatment over a 12-month cycle in full. All cancer-related healthcare services are covered up to 100% of the Discovery Health Rate (DHR). Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. If your treatment costs more than the cover amount, you will need to pay 20% of the subsequent additional costs. On **Essential Smart**, we cover cancer treatment in our network.		We cover the first R200 000 of your approved cancer treatment over a 12-month cycle in full. All cancer-related healthcare services are covered up to 100% of the Discovery Health Rate (DHR). Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount, we will cover up to 80% of the additional costs.		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 Discovery Health Rate (DHR). Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount, we will cover up to 80% of the additional costs.																
	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 medicines that meet the Scheme's criteria. You will need to pay 25% of the account.	These plans do not offer this benefit.															
	Advanced Illness Benefit	Members with cancer have access to a comprehensive palliative care programme. This programme offers unlimited cover for approved care at home, care coordination, counselling services and supportive care for appropriate end-of-life clinical and psychologist services. You also have access to a GP consultation to facilitate your palliative care treatment plan.																
HOSPITAL COVER	Private hospital cover in a general ward	Unlimited cover plus private ward cover of up to R2 220 each day.	Unlimited cover plus private ward cover up to R2 220 per day for your delivery.			Unlimited cover		Unlimited cover			Unlimited cover		Unlimited cover			Unlimited cover		
	Private hospital	You are covered in any facility approved by the Scheme.	You are covered in any facility approved by the Scheme. Full cover on Delta options when using the Delta Hospital Network of private hospitals. For planned admissions outside of the Delta Hospital Network, you must pay an upfront payment to the hospital of R8 700.		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 R9 950 to the hospital.	You are covered in any facility approved by the Scheme. An upfront payment of between R3 850 to R18 600 applies for a defined list of procedures. Where these procedures form part of the list of procedures to be performed in our day surgery network, the higher of the upfront payments will apply.		You are covered in any facility approved by the Scheme. Full cover on Delta options when using the Delta Hospital Network of private hospitals. For planned admissions outside of the Delta Hospital Network, you must pay an upfront payment to the hospital of R8 700.		Full cover in any approved private hospital in the four coastal provinces network. If you use a hospital outside the coastal network, we pay up to 70% of the DHR of the hospital account and you must pay the difference.	Full cover in the Smart Hospital Network. For planned admissions at hospitals outside of the Smart Hospital Network, you must pay an upfront payment of R9 950 to the hospital.		You are covered in any facility approved by the Scheme. Full cover on Delta options when using the Delta Hospital Network of private hospitals. For planned admissions outside of the Delta Hospital Network, you must pay an upfront payment to the hospital of R8 700.		Full cover in any approved private hospital in the four coastal provinces network. If you use a hospital outside the coastal network, we pay up to 70% of the DHR of the hospital account and you must pay the difference.	Full cover if you use a hospital in the KeyCare Hospital Network. If you use a hospital in the Partial Cover Network, we pay up to 70% of the DHR. If you do not use hospitals in the networks, you will have to pay all costs.		Full cover at your chosen KeyCare Start Network hospital. If you do not use your chosen hospital in the network, you will have to pay all costs.
	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 R5 700 applies for admission to a facility outside of the day surgery network. An upfront payment of R8 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 R9 950 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 R5 700 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 R5 700 applies for admissions to a facility outside of the day surgery network. An upfront payment of R8 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 R9 950 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 R5 700 applies for admissions to a facility outside of the day surgery network. An upfront payment of R8 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.
	Full cover option for specialists we have a payment arrangement with	Full cover	Full cover			Full cover		Full cover			Full cover		Full cover			Full cover		
	Reimbursement rate* for specialists we do not have a payment arrangement with	300% of the DHR	200% of the DHR	100% of the DHR	200% of the DHR	200% of the DHR	100% of the DHR	200% of the DHR	100% of the DHR		200% of the DHR	100% of the DHR	200% of the DHR	100% of the DHR		100% of the DHR		
	Reimbursement rate* for GPs and other healthcare professionals (not specialists)	200% of the DHR	200% of the DHR	100% of the DHR	200% of the DHR	200% of the DHR	100% of the DHR	200% of the DHR	100% of the DHR		200% of the DHR	100% of the DHR	200% of the DHR	100% of the DHR		100% of the DHR		
	Reimbursement rate* for radiology and pathology	100% of the DHR	100% of the DHR			100% of the DHR		100% of the DHR			100% of the DHR		100% of the DHR			100% of the DHR		

		EXECUTIVE	COMPREHENSIVE			PRIORITY		SAVER			SMART		CORE			KEYCARE		
			Classic	Essential	Classic Smart	Classic	Essential	Classic	Essential	Coastal	Classic	Essential	Classic	Essential	Coastal	Plus	Core	Start
HOSPITAL COVER (cont.)	Cover for scopes (gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy)	Depending on where you have your scope done, we pay a portion of between R3 650 and R5 300 from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher co-payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit.	Depending on where you have your scope done, we pay a portion of between R3 650 and R5 300 from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher co-payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the day surgery network, the highest of the out-of-network upfront payment or scopes co-payment will apply.			Depending on where you have your scope done, an upfront payment of between R3 650 and R5 900 applies. We pay the balance of the hospital and related accounts from your Hospital Benefit. When both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the day surgery network, the highest of the out-of-network upfront payment or scopes co-payment will apply.	Depending on where you have your scope done, we pay a portion of between R3 650 and R6 250 from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher co-payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the day surgery network, the highest of the out-of-network upfront payment or scopes co-payment will apply.		Depending on where you have your scope done, you will have to pay a portion of between R3 650 and R6 250 and we pay the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the day surgery network, the highest of the out-of-network upfront payment or scopes co-payment will apply.		Depending on where you have your scope done, you will have to pay a portion between R3 650 and R6 250 and we pay the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the day surgery network, the highest of the out-of-network upfront payment or scopes co-payment will apply.		Prescribed Minimum Benefit cover, in the KeyCare Day Surgery Network. If done in the doctor's rooms, we pay the account from the Hospital Benefit.		Prescribed Minimum Benefit cover, in the KeyCare Start Day Surgery Network. If done in the doctor's rooms, we pay the account from the Hospital Benefit.
	Cover for MRI and CT scans related to admission	If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.	If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.			If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.		If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.			If done as part of an approved 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 130 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 130 of the scan from your day-to-day benefits. We pay the balance of the scan from the Hospital Benefit, up to 100% of the DHR. Limited to one scan per spinal and neck region.	You need to pay the first R3 130 of your MRI or CT scan until you reach the Annual Threshold. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per body region applies.		We pay the first R3 130 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 also pay the first R3 850 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 130 of the scan from your day-to-day benefits. We pay the balance of the scan from the Hospital Benefit, up to 100% of the DHR. Limited to one scan per spinal and neck region.			You need to pay the first R3 130 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.	This plan does not offer this benefit.	These plans do not offer this benefit.			We pay scans from the Specialist Benefit up to a limit of R4 530 for each person each year.		We pay scans from the Specialist Benefit up to a limit of R2 270 for each person each year.
ADDITIONAL BENEFITS	Screening and Prevention Benefit	Covers certain tests at one of our wellness network providers, like blood glucose, blood pressure, cholesterol and body mass index. We also cover a mammogram every two years, Pap smear every three years or one HPV test every 5 years, PSA (a prostate screening test) once a year and HIV screening tests. Seasonal flu vaccine during pregnancy, or for members 65 years or older and/or registered for certain chronic conditions. 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. Kids screening tests include a growth assessment and health and milestone tracking at any one of our wellness network providers.																	
	Connected Care	You have access to care at home, including a Home Monitoring Device Benefit for essential home monitoring and home-based care for follow up treatment after an admission. The Home Monitoring Device Benefit gives you access to a range of essential and registered home monitoring devices for certain chronic and acute conditions. Approved cover for these devices will not affect your day-to-day benefits. If you meet the scheme's clinical entry criteria, you have healthcare cover up to a limit of R4 000 per person per year, at 100% of the Discovery Health Rate (DHR) The Scheme also covers defined point of care medical devices up to 75% of the Discovery Health Rate (DHR), if you meet the clinical entry criteria. You will need to pay 25% towards the cost of these devices.																	
	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.	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.			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.		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.			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.	This plan does not offer this benefit.	These plans do not offer these benefits.			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.	This plan does not offer this 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.
	Assisted Reproductive Therapy (Art)	You have cover for up to two cycles of ART if you meet the Scheme's benefit and clinical entry criteria. Cover includes a basket of care which includes cover for consultations, ultrasounds, oocyte retrieval, embryo transfers, admission costs including lab fees, medication and embryo and sperm storage. We pay up to a limit of R110 000 per person per year at the Discovery Health Rate (DHR). A co-payment of 25% will apply.				These plans do not offer these benefits.												
	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.												
	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.		

Discovery
Health Medical Scheme

Discovery Health Medical Scheme 2021 contributions

Series	Plan	Contributions			Contributions to Medical Savings Account			Total contributions		
		Main member	Adult	Child**	Main member	Adult	Child**	Main member	Adult	Child**
Executive	Executive Plan	5 443	5 443	1 039	1 814	1 814	346	7 257	7 257	1 385
Comprehensive	Classic Comprehensive	4 466	4 225	891	1 488	1 408	297	5 954	5 633	1 188
	Classic Delta Comprehensive	4 022	3 808	802	1 340	1 269	267	5 362	5 077	1 069
	Essential Comprehensive	4 253	4 022	857	750	709	151	5 003	4 731	1 008
	Essential Delta Comprehensive	3 831	3 619	769	676	638	135	4 507	4 257	904
	Classic Smart Comprehensive	4 327	3 994	1 378	No Medical Savings Account			4 327	3 994	1 378
Priority	Classic Priority	2 861	2 256	1 145	953	752	381	3 814	3 008	1 526
	Essential Priority	2 787	2 191	1 114	491	386	196	3 278	2 577	1 310
Saver	Classic Saver	2 468	1 947	989	822	649	329	3 290	2 596	1 318
	Classic Delta Saver	1 971	1 557	792	657	519	264	2 628	2 076	1 056
	Essential Saver	2 223	1 667	891	392	294	157	2 615	1 961	1 048
	Essential Delta Saver	1 773	1 339	712	312	236	125	2 085	1 575	837
	Coastal Saver	2 087	1 570	843	521	392	210	2 608	1 962	1 053
Smart	Classic Smart	1 954	1 542	781	No Medical Savings Account			1 954	1 542	781
	Essential Smart	1 400	1 400	1 400				1 400	1 400	1 400
Core	Classic Core	2 449	1 931	980	No Medical Savings Account			2 449	1 931	980
	Classic Delta Core	1 960	1 545	784				1 960	1 545	784
	Essential Core	2 104	1 577	846				2 104	1 577	846
	Essential Delta Core	1 681	1 265	675				1 681	1 265	675
	Coastal Core	1 946	1 462	774				1 946	1 462	774
KeyCare*	KeyCare Plus 0 - 8 550	1 207	1 207	439	No Medical Savings Account			1 207	1 207	439
	KeyCare Plus 8 551 - 13 800	1 659	1 659	468				1 659	1 659	468
	KeyCare Plus 13 801+	2 450	2 450	656				2 450	2 450	656
	KeyCare Core 0 - 8 550	949	949	245	No Medical Savings Account			949	949	245
	KeyCare Core 8 551 - 13 800	1 183	1 183	292				1 183	1 183	292
	KeyCare Core 13 801+	1 809	1 809	410				1 809	1 809	410
	KeyCare Start 0 - 9 150	914	914	550	No Medical Savings Account			914	914	550
	KeyCare Start 9 151 - 13 800	1 538	1 538	601				1 538	1 538	601
	KeyCare Start 13 801+	2 394	2 394	650				2 394	2 394	650

* 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.

Discovery
Health Medical Scheme

Annual Medical Savings Account

Series	Plan	Main member	Adult	Child*
Executive	Executive Plan	21 768	21 768	4 152
Comprehensive	Classic Comprehensive	17 856	16 896	3 564
	Classic Delta Comprehensive	16 080	15 228	3 204
	Essential Comprehensive	9 000	8 508	1 812
	Essential Delta Comprehensive	8 112	7 656	1 620
Priority	Classic Priority	11 436	9 024	4 572
	Essential Priority	5 892	4 632	2 352
Saver	Classic Saver	9 864	7 788	3 948
	Classic Delta Saver	7 884	6 228	3 168
	Essential Saver	4 704	3 528	1 884
	Essential Delta Saver	3 744	2 832	1 500
	Coastal Saver	6 252	4 704	2 520

* We count a maximum of three children when we work out the annual Medical Savings Account.

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	Adult	Child*
Executive	26 300	26 300	5 000
Classic, Essential and Delta Comprehensive	21 700	21 700	4 150
Classic Smart Comprehensive	24 850	24 850	850
Priority	17 550	13 200	5 850

ABOVE THRESHOLD BENEFIT LIMITS

	Main member	Adult	Child*
Executive	unlimited		
Comprehensive			
Priority	14 850	10 600	5 200

* We count a maximum of three children when we work out the Annual Threshold and Above Threshold Benefit limit.

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.

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