Discovery
Health Medical Scheme

2022 PLAN COMPARISON

Discovery Health Medical Scheme 2022 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	5 766	5 766	1 101	1 922	1 922	367	7 688	7 688	1 468
Comprehensive	Classic Comprehensive	4 732	4 475	944	1 577	1 491	314	6 309	5 966	1 258
	Classic Delta Comprehensive	4 261	4 034	849	1 420	1 344	283	5 681	5 378	1 132
	Essential Comprehensive	4 506	4 259	909	795	751	160	5 301	5 010	1 069
	Essential Delta Comprehensive	4 059	3 834	814	716	676	143	4 775	4 510	957
	Classic Smart Comprehensive	4 585	4 230	1 459	No Medical Savings Account			4 585	4 230	1 459
Priority	Classic Priority	3 031	2 390	1 213	1 010	796	404	4 041	3 186	1 617
	Essential Priority	2 952	2 322	1 180	520	409	208	3 472	2 731	1 388
Saver	Classic Saver	2 614	2 063	1 048	871	687	349	3 485	2 750	1 397
	Classic Delta Saver	2 088	1 650	839	696	550	279	2 784	2 200	1 118
	Essential Saver	2 355	1 767	944	415	311	166	2 770	2 078	1 110
	Essential Delta Saver	1 878	1 418	754	331	250	133	2 209	1 668	887
	Coastal Saver	2 211	1 663	893	552	415	223	2 763	2 078	1 116
Smart	Classic Smart	2 070	1 634	827	No Medical Savings Account			2 070	1 634	827
	Essential Smart	1 483	1 483	1 483				1 483	1 483	1 483
Core	Classic Core	2 594	2 046	1 038	No Medical Savings Account			2 594	2 046	1 038
	Classic Delta Core	2 076	1 637	830				2 076	1 637	830
	Essential Core	2 229	1 671	896				2 229	1 671	896
	Essential Delta Core	1 781	1 340	715				1 781	1 340	715
	Coastal Core	2 062	1 548	820				2 062	1 548	820
KeyCare*	KeyCare Plus 0 - 8 550	1 279	1 279	464	No Medical Savings Account			1 279	1 279	464
	KeyCare Plus 8 551 - 13 800	1 758	1 758	495				1 758	1 758	495
	KeyCare Plus 13 801+	2 595	2 595	695				2 595	2 595	695
	KeyCare Core 0 - 8 550	1 005	1 005	260	No Medical Savings Account			1 005	1 005	260
	KeyCare Core 8 551 - 13 800	1 253	1 253	310				1 253	1 253	310
	KeyCare Core 13 801+	1 916	1 916	435				1 916	1 916	435
	KeyCare Start 0 - 9 150	968	968	583	No Medical Savings Account			968	968	583
	KeyCare Start 9 151 - 13 800	1 629	1 629	637				1 629	1 629	637
	KeyCare Start 13 801+	2 536	2 536	688				2 536	2 536	688

* 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.

Annual Medical Savings Account

Executive	Executive Plan	23 064	23 064	4 404
Comprehensive	Classic Comprehensive	18 924	17 892	3 768
	Classic Delta Comprehensive	17 040	16 128	3 396
	Essential Comprehensive	9 540	9 012	1 920
	Essential Delta Comprehensive	8 592	8 112	1 716
Priority	Classic Priority	12 120	9 552	4 848
	Essential Priority	6 240	4 908	2 496
Saver	Classic Saver	10 452	8 244	4 188
	Classic Delta Saver	8 352	6 600	3 348
	Essential Saver	4 980	3 732	1 992
	Essential Delta Saver	3 972	3 000	1 596
	Coastal Saver	6 624	4 980	2 676

* 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	28 380	28 380	5 390
Classic, Essential and Delta Comprehensive	23 420	23 420	4 470
Classic Smart Comprehensive	26 820	26 820	910
Priority	18 940	14 240	6 310

Above Threshold Benefit limits

	Main member	Adult	Child*
Executive	Unlimited		
Comprehensive			
Priority	16 030	11 440	5 610

* 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.

		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 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 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 if referred by your chosen GP.	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.								

		Executive	Comprehensive			Priority		Saver			Smart		Core			Keycare		
			Classic	Essential	Classic Smart	Classic	Essential	Classic	Essential	Coastal	Classic	Essential	Classic	Essential	Coastal	Plus	Core	Start
DAY-TO-DAY BENEFITS	**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 270 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 270 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 270 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 270 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 270 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 270 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 730 for a person a year.	MRI and CT scans are paid from the Specialist Benefit up to a limit of R2 370 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 320 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.		
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												
	Consultation and medicine cover	You must nominate a GP in the Discovery Health Network to be your primary care doctor to manage your chronic conditions. For full cover on your GP consultations and referred healthcare services, such as radiology and pathology, you must visit your nominated Discovery Health Network GP. If you use a GP other than your nominated Discovery Health Network GP, a 20% co-payment will apply. You can change your nominated GP once a year.									You must nominate a GP in the Smart GP Network to be your primary care doctor to manage your chronic conditions. For full cover on your GP consultations and referred healthcare services, such as radiology and pathology, you must visit your nominated Smart Network GP. If you use a GP other than your nominated Smart Network GP, a 20% co-payment will apply. You can change your nominated GP once a year.		You must nominate a GP in the Discovery Health Network to be your primary care doctor to manage your chronic conditions. For full cover on your GP consultations and referred healthcare services, such as radiology and pathology, you must visit your nominated Discovery Health Network GP. If you use a GP other than your nominated Discovery Health Network GP, a 20% co-payment will apply. You can change your nominated GP once a year.		You must nominate a GP in the KeyCare GP Network to be your primary care doctor to manage your chronic conditions. For full cover on your GP consultations and referred healthcare services, such as radiology and pathology, you must visit your nominated KeyCare Network GP. If you use a GP other than your nominated KeyCare Network GP, a 20% co-payment will apply. You can change your nominated GP once a year. On KeyCare Start you must visit your nominated KeyCare Start Network GP.	
		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 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 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 Discovery Health Rate (DHR).					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, we will cover up to 80% of the DHR. On **Essential Smart**, we cover cancer treatment in our network. If you choose to use any other provider, we will cover up to 80% of the Discovery Health Rate (DHR).		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 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. 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 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. 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 Discovery Health Rate (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 Discovery Health Rate (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 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.		

HOSPITAL COVER

	Executive	Comprehensive			Priority		Saver			Smart		Core			Keycare		
		Classic	Essential	Classic Smart	Classic	Essential	Classic	Essential	Coastal	Classic	Essential	Classic	Essential	Coastal	Plus	Core	Start
Private hospital cover in a general ward	Unlimited cover plus private ward cover of up to R2 320 each day.	Unlimited cover plus private ward cover up to R2 320 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 R9 100.		Full cover in the Smart Hospital Network. For planned admissions at hospitals outside of the Smart Hospital Network, you must pay an upfront payment to the hospital of R9 400 to the hospital.	You are covered in any facility approved by the Scheme. An upfront payment of between R4 050 to R19 450 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 R9 100.		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 R10 400 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 R9 100.	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 950 applies for admission to a facility outside of the day surgery network. An upfront payment of R9 100 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 R10 400 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 950 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 950 applies for admissions to a facility outside of the day surgery network. An upfront payment of R9 100 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 R10 400 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 950 applies for admissions to a facility outside of the day surgery network. An upfront payment of R9 100 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		
Cover for scopes (gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy)	Depending on where you have your scope done, we pay a portion of between R3 800 and R5 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 in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, 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 R3 800 and R5 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 in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, 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 R3 800 and R6 150 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 in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, indicated and approved for Dyspepsia, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit. If performed outside of the day surgery network, the highest of the out-of-network upfront payment or scopes co-payment will apply.			Depending on where you have your scope done, we pay a portion of between R3 800 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 in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefits (PMB) condition, 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 R3 800 and R6 550 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, 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.
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 270 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 270 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 270 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 270 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 R4 050 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 270 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 270 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 730 for each person each year.		We pay scans from the Specialist Benefit up to a limit of R2 370 for each person each year.

		Executive	Comprehensive			Priority		Saver			Smart		Core			Keycare		
			Classic	Essential	Classic Smart	Classic	Essential	Classic	Essential	Coastal	Classic	Essential	Classic	Essential	Coastal	Plus	Core	Start
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 R115 000 per person per year at 75% of the Discovery Health Rate (DHR). A co-payment of 25% will apply.			These plans do not offer these benefits.												
	Connected Care	You have access to hospital-level care in your home instead of having to go to hospital for acute hospital care. This includes cover and treatment for COVID-19 and/or follow-up care once discharged. You have access to the Hospital at Home devices and healthcare services if you meet the clinical and benefit criteria. 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.																
	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.w													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.												
	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. Pneumococcal vaccine once every five years, or once per lifetime for persons over the age of 65. 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 a growth assessment and health and milestone tracking at any one of our wellness network providers.															
	Trauma Recovery Extender Benefit	Extends your cover for out-of-hospital claims for recovery after certain traumatic events for the rest of the year in which the trauma took place, and a year after the trauma. You and your dependants on your health plan also have access to six counselling sessions per person per year by a psychologist, clinical social worker or registered counsellor. You need to apply for this benefit.																
	The WHO Global Outbreak Benefit	Provides cover for global disease outbreaks recognised by the World Health Organisation (WHO) such as COVID-19. This benefit offers cover for the COVID-19 vaccine, out-of-hospital management, including diagnosis, consultations and appropriate supportive care.																

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