Discovery Health Medical Scheme

TRAINING GUIDE 2021

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INTRODUCTION TO DISCOVERY HEALTH AND DISCOVERY HEALTH MEDICAL SCHEME

This section includes:

- The Discovery Group
- Understanding the medical landscape
- Discovery Health (Pty) Ltd
- Discovery Health Medical Scheme
- Reasons to choose Discovery Health Medical Scheme

Discovery

Discovery was established in March 1992. Discovery currently covers over 5.1 million clients, across various products.

Our main clients are large-, medium-, and small-sized employers for health insurance, as well as individual clients who buy health and life insurance and investment products from us. Through our repeatable business model, we export the Discovery intellectual property to other industries and markets, including the UK, US, China, Singapore, and Australia.

The illustrations below show the Discovery global network of insurers.

Understanding the medical landscape

It is important to understand the medical landscape that we operate in. There are two areas in relation thereto, Discovery Health Medical Scheme and Discovery Health (Pty) Ltd.

Discovery Health (Pty) Ltd

- Is a registered company with directors and forms part of the Discovery Group.
- Is an Administrator and Managed Care Organisation and is accredited with the Council of Medical Schemes as such.
- Is contracted to medical schemes to provide services to the scheme and scheme members.
- Receives a monthly administration fee and managed care fee per medical scheme member.

Discovery Health Medical Scheme

- Is registered with the Council of Medical Schemes as a medical scheme and belongs to its members. It is not part of the Discovery Group.
- Is a non-profit organisation that must keep 25% of its contributions in reserve.
- Elects a board of trustees of which at least 50% have to be selected by the members.
- Trustees appoint the Principal Officer who sets up the scheme office. The Principal Officer manages the day to day operations.
- Trustees and the scheme office are responsible for protecting the best interest of the members of the medical scheme and answer to the members.

The difference is of utmost importance and you need to ensure that you refer to these correctly when representing either Discovery Health (Pty) Ltd or the Scheme.

Frequently asked questions

Why do you need medical aid?

Everyone needs some form of medical aid cover. Few of us could afford the costs of long hospital stays or care for serious injuries, surgery, or chronic illnesses – for example, it costs R8 500 a night for a premature baby to stay in a private hospital's neonatal unit (some stay for five months), and that's just the bed, without any consultations, medicine or medical supplies. Medical schemes help us finance life's curved balls when we can't do it alone.

It's advisable to evaluate your medical aid coverage each year to make sure you have adequate cover for your needs or for any changes in your health, for example, deciding to have a child or being diagnosed with a chronic condition.

More importantly, traumatic events like a car accident, crime-related incidents or sport-related incidents can happen to anyone at any age. The costs associated with one of these random, high-risk events can run into many thousands of rands, which few people can afford at any life stage – especially when you're young.

How do medical schemes work?

Medical schemes (or medical aids) are the main funders of private healthcare in South Africa. Members of a medical scheme such as Discovery Health Medical Scheme pay contributions to the scheme each month.

This money is pooled and then used to pay healthcare expenses in accordance with the scheme's rules and the member's choice of plan, protecting members against the possibility of facing significant unexpected medical costs.

All medical schemes in South Africa operate in accordance with the Medical Schemes Act 131 of 1998, and are regulated by the Council for Medical Schemes.

Can medical schemes make money?

A medical scheme is a non-profit organisation, governed by a board of trustees, and must be registered with the Council for Medical Schemes.

This means it does not have shareholders or pay dividends, and all surpluses are invested on behalf of the members in accordance with regulations.
A medical scheme therefore does not make any profits.

Schemes exist for their members as all funds are pooled and safeguarded, to be used to pay claims in accordance with the scheme's rules, and ensure that all members are equitably and fairly cared for (relative to their choice of benefit plan).

Why does Discovery Health (Pty) Ltd administer the Scheme?

Schemes can either outsource its administration or perform this function in-house. The medical scheme environment is complex. It requires expertise to manage a scheme effectively, to provide the infrastructure required and to make sure it meets the needs of all its stakeholders, while keeping that scheme affordable, both now and into the future.

Most schemes in South Africa use external administration organisations to provide these expert services to their members. It is essential that schemes and their administrators work with the same objectives in mind – to care for their members at an acceptable cost – even though administrators are able to make a profit, unlike schemes.

Frequently asked questions source: www.discovery.co.za

Introduction to Discovery Health Medical Scheme

Ms Charlotte Mbewu, BCom(Hons) Accounting; CA (SA), is the principal officer of Discovery Health Medical Scheme

The **core purpose** of the Discovery Health Medical Scheme (DHMS) is to **achieve**, in a **sustainable manner**, the **best possible value** for its members, compromising of **benefits**, **quality of care** and **service levels** to members **relative** to their **contribution** to the Scheme.

DHMS is a **non-profit organisation** which **pools** and **safeguards** its **members' funds** in order to **provide healthcare** funding to members **who need it**, **when they need it**.

Discovery Health Medical Scheme, administered by Discovery Health, is the largest private healthcare funder with over 2.8 million beneficiaries – this equates to a market share of over 56% of the industry today. The growth has been entirely organic, and is a function of the administrator's ability to manage the complexities of the South African healthcare funding environment in a way that offers consumers certainty, sustainability and value.

Discovery Health Medical Scheme members have the certainty that they belong to a financially sound scheme that offers the most comprehensive benefits in the industry and continues to deliver value for money.

Discovery Health Medical Scheme has continued to be recognised as the most financially sound scheme in the industry. Discovery has maintained the highest Global Credit Rating in the industry for numerous consecutive years. The scheme was upgraded to an AA+ rating in 2010 and to an AAA rating in 2018. The upgrade of the Global Credit Rating follows the removal of the previous industry ceiling of AA+.

The rating assesses a scheme based on its size, cash flow, operational strength, past performance, management expertise and reserves. The financial stability of the Discovery Health Medical Scheme is evident from the R17.6 billion the scheme holds in reserves.

For almost two decades, our innovative thinking and commitment to service have helped us to live up to our core purpose:

Discovery Health Medical Scheme is South Africa's largest and most stable medical scheme with comprehensive benefits, competitive contributions offering better health and better healthcare to our members. Discovery Health Medical Scheme received the Gran Prix awards as the 2018 overall Favourite Brand in the business category. Discovery was voted most-loved brand in the medical aid category at the 21st Sunday Times Top Brands Awards in 2019. This and excellent service has resulted in us being voted South Africa's No.1 choice by consumers and business (members, healthcare practices, employers and financial advisers) for the ninth consecutive year.

With our members centred at everything we do, we pioneered products such as the Medical Savings Account and the Vitality Wellness Programme. DHMS empowers members to take control of their health and manage their day-to-day spend. Embracing innovation to benefit our members, we offer unique solutions and make sure their healthcare needs are covered in an ever-changing environment.

DHMS is a not-for-profit entity. Like with any other medical scheme the members of the Discovery Health Medical Scheme pay contributions every month, which are paid into the scheme - a pool of money owned by its members. This money funds healthcare services claims and administration fees.

Reasons to choose DHMS

Discovery Health Medical Scheme gives members complete peace of mind that their healthcare is in good hands at every stage of their health journey.

HEALTH UNDERWRITING AND NEW BUSINESS

This section includes:

- Underwriting
- Medical Schemes Act 131 of 1998
- Individual underwriting categories
- Underwriting tools
- Waiting periods
- Late joiner penalties
- Status D schemes
- Classification of dependants
- Continuation options
- Group underwriting

Underwriting

Underwriting is a risk management tool that assists medical schemes in maintaining their long-term sustainability by:

- minimising abusive claiming behaviour;
- reducing potential costs; and
- protecting the scheme against anti-selection.

Anti-selection is when a member only uses a medical scheme when needed without paying the appropriate contribution. Example: John should have joined DHMS when he started working but he only joins the scheme when he is ill. He has therefore not made a substantial contribution towards scheme's risk pool over an extended period, but now wants to make use of the funds that he hasn't contributed towards.

Medical Schemes Act 131 of 1998

The first Medical Schemes Act was introduced in 1967. Many changes were made over the years, many of a deregulatory nature in 1993. In 1998 new medical schemes legislation responded to these challenges by:

- Introducing a compulsory minimum benefits package for all schemes (Prescribed Minimum Benefits)
- Prohibiting discrimination on the basis of age, medical history and health status
- Requiring that contributions be determined only on the basis of income and/or number of dependants
- Enabling schemes and public hospitals to have an agreement for the provision of minimum benefits to its members with payment for hospitals
- Forbidding schemes from excluding applicants or their dependants for membership except on certain prescribed conditions
- Regulating administrators and other contractors to medical schemes, for example brokers and managed care organisations.

A major concern of the new legislation was equity of access to medical scheme membership and cross-subsidisation between the elderly and young and between low and high earners.

The 1993 changes to the Act allowed detailed and individual-specific risk rating and many variations in both the level and structuring of benefits, while the 1998 changes brought about community risk rating and more controlled levels and structuring of benefits.

The amended Medical Schemes Act 131 of 1998 was released by the Council for Medical Schemes in collaboration with the Department of Health and became operative on 1 February 1999. Full implementation began on 1 January 2000.

Individual underwriting categories

Individual applicants, groups or members who only join compulsory groups after three months from the date of employment will receive individual underwriting. These individuals can be divided into three categories for the purposes of underwriting:

Category A	Category B	Category C
Members who have not belonged to a registered South African medical scheme and members who have allowed a break of more than 90 days since resigning from their previous medical scheme	Members who have belonged to a registered South African medical scheme for a period of less than two years and have applied to join DHMS less than 90 days since the date of ending their membership with the previous scheme	Members who have belonged to a registered South African medical scheme for a period of two years or more and have applied to join DHMS less than 90 days since the date of ending their membership with the previous scheme

Underwriting tools

The Medical Schemes Act states that medical schemes are not allowed to decline membership to anyone. However the Act allows for medical schemes to protect their risk pool by using the following types of underwriting:

- A three-month general waiting period
- A 12-month condition-specific waiting period
- A late-joiner penalty (LJP).

Three-month general waiting period

- Is often called the General Waiting Period (GWP) and it is applied to those members who fall into a high/medium risk category.
- A member who has a three-month general waiting period will not be able to claim for any medical expenses for a period of three months. This means that the member will not have cover for any day-to-day or in-hospital expenses, both elective and emergency-related, unless the member is Category C and has access to the Prescribed Minimum Benefits according to the specific PMB criteria.
- As per the Act, a three-month general waiting period cannot be applied to a category B member.
- A three-month general waiting period cannot be bought out (effective 1 March 2002).

12-month condition specific waiting period

When members suffer from a particular illness or condition before their membership with DHMS commences, it is called a pre-existing condition. Members must disclose the details of this condition on their application form.

- When a pre-existing condition is disclosed, DHMS will apply a 12-month waiting period to the pre-existing condition.
- Members with this waiting period will not be able to claim for any medical expense that is a consequence of, or in any way related to, the pre-existing condition for a period of 12 months from the date of joining the scheme, unless the member is Category B or C and has access to the Prescribed Minimum Benefits according to the specific PMB criteria.

Late-joiner penalty (LJP)

A late-joiner is an applicant, or the adult dependant of an applicant, who at the date of application:

- Is 35 years or older
- Was not a member or dependant of a registered medical scheme on or before the 1st of April 2001
- Has allowed more than three consecutive months' break in membership since the 1st of April 2001

Late-joiner penalties apply to all persons who have not previously belonged to a South African medical scheme. Membership with foreign schemes is not recognised.

Why does DHMS implement late-joiner penalties?

DHMS's role is to fund affordable and sustainable health care for our entire membership base. Our funding decisions are based on clinical protocols, which are developed using an evidence-based decision-making process, using extensive research as well as a clinical and funding filter.

How are waiting periods imposed?

Category	Underwriting applicable	Access to PMBs
A	▪ Three-month general waiting period ▪ 12-month condition-specific waiting period ▪ Late-joiner penalty	No – specific to the condition listed in the imposed waiting periods
B	▪ 12-month condition-specific waiting period (duration carried over from previous scheme) ▪ Late-joiner penalty	Yes
C	▪ Three-month general waiting period ▪ Late-joiner penalty	Yes

Waiting periods applied to HIV/AIDS

In order to protect member confidentiality, the waiting period will not reflect on the acceptance letter and members are not compelled to discuss their status on the application form.

What impact do PMBs have on waiting periods?

- If a member has a three-month waiting period imposed, the member will be covered as stipulated by the Prescribed Minimum Benefits for hospitalisation at a designated service provider for an acute or chronic condition, as long as the procedure or condition, for which the member is seeking treatment, is listed as a Prescribed Minimum Benefit.
- If a 12-month waiting period on a pre-existing condition has been imposed on the member, the member will be covered as stipulated by the Prescribed Minimum Benefits for hospitalisation at the designated service provider for a condition, as long as the procedure or condition, for which the member is seeking treatment, is listed as a Prescribed Minimum Benefit.
- If a 12-month waiting period on maternity benefits has been imposed on the member, she will be covered by the Prescribed Minimum Benefits for hospitalisation at the designated service provider, as long as the procedure or condition, for which the member is seeking treatment, is listed as a Prescribed Minimum Benefit.

Although Discovery Health Medical Scheme is allowed to apply underwriting against a membership, the applicable underwriting might be waived under certain circumstances. Discovery Health Medical Scheme makes use of a bespoke underwriting model to assess the holistic risk profile across the family unit on each Discovery Health Medical Scheme application. The underwriting model determines whether underwriting should be applied or waived, based on specific circumstances of each unique profile.

Classification of employer statuses

When a member applies to join Discovery Health, they will be linked to one of four statuses:

- Individual - Individual employer - Group employer - Status D

Individuals and individual employers

Individuals are regarded as applicants joining in their own capacity. An individual employer is:

- A group with less than 10 members
- A group who is not granted a group concession
- A non-compulsory group who is granted a once-off group concession.

Members joining as individuals or part of an individual employer are subject to full underwriting according to category and must complete one of the following application forms:

- Applying to become a member of Discovery Health Medical Scheme
- Joining Discovery Health moving from another medical scheme, if they are Category C

Group employers

Group underwriting is done according to the size of the company versus average age and pensioner ratio of the main members joining the scheme for groups that are made up of 10 main members and more. There are set criteria in place that a group needs to satisfy in order for a group concession to be granted.

Only members who have an employee-employer relationship with the group are allowed to join a group employer. Groups have the option of compulsory or non-compulsory:

- A compulsory group is where all employees of the company are required to join Discovery Health as a condition of their employment. However, if some employees are already members on their spouse's medical scheme, this rule will not apply to them. Compulsory employers may also require only a section of the workforce to join Discovery Health. This is called a defined compulsory nature, e.g. compulsory for administration staff only or compulsory for all employees earning more than R10 000.
- A non-compulsory group is where the employees of the company are able to choose whether they want to apply for membership. Non-compulsory groups are defaulted to an individual employer on system once the period agreed upon ends.

Status D employers

Amendments to the Medical Schemes Act make provision for transferability of employers that meet specific criteria which allows employer groups to switch between medical schemes on 1 January each year. Employers must meet the following criteria to qualify for a Status D concession:

- There must be two or more principal lives within the group
- DOC must be the beginning of the financial year (in Discovery's case 1 January)
- All applicants/members must be employees or pensioners of the same company
- The company and all members joining must currently belong to a registered South African medical scheme
- All individuals must agree to transfer memberships to Discovery Health on 1 January
- The employer must agree to provide reasonable notice of withdrawal to the employees' current medical scheme/s

- Employer groups are allowed to switch between medical schemes effective 1 January each year without any waiting periods. Discovery Health Medical Scheme refers to this concession as Status D.

Late-joiner penalties

Late-joiner penalties are applicable to:

Individual members	All cases where members have not belonged to a registered medical scheme an are older than 35 years of age.
Group employers	Spouses and adult dependants who are older than 35 years of age and who join the scheme after the main member, or who were not dependants on the previo medical scheme, or Main members, spouses and adult dependants who join the scheme more than three months after the main member's employment start date.
Status D schemes	All cases where members have not belonged to a registered medical scheme an are older than 35 years of age.

Late-joiner penalty fee

The late-joiner penalty fee is a percentage increase in a member's contributions. Depending on the number of years they have not belonged to a medical scheme, an additional penalty fee (worked out as a percentage of the risk contribution) will be added to the member's monthly contribution, as shown in the table below:

Number of years applicant was not a member of a registered medical scheme	Maximum penalty or percentage increase in contributions
1 – 4 years	5%
5 – 14 years	25%
15 – 24 years	50%
25 years or more	75%

Applying the late-joiner penalty to members

- If a member joins DHMS and does not provide proof of membership and/or previous medical aid details, the system will automatically apply the late joiner penalty.
- If a member subsequently provides proof of membership after membership activation, the late-joiner penalty fee will be reviewed from the current date only. If previous membership details

were provided initially and were not loaded by Discovery's new business department in error, the late-joiner penalty will be reviewed from inception date.

If the member has the three-month waiting period or a 12-month condition-specific waiting period as well as the late-joiner penalty applied, the case will be sent to the underwriters for review when the member provides proof of membership after the activation of membership.

Will DHMS waive the LJP?

DHMS will look at waiving the LJP under the following conditions:

	The LJP will be waived if clients joining the scheme meet the following conditions (all apply)	DHMS will need the following requirements or notes
Ex-patriots returning to South Africa	Ex-patriots returning to South Africa within five years of leaving	Copy of passport
	They were previously members of DHMS	Proof of overseas travel
	They must have left South Africa within three months from their last day of previous membership	Important! If members had a late-joiner penalty on their DHMS membership before leaving to go overseas, the same penalty will apply when they join the scheme again
	They must join DHMS within three months of returning to South Africa	
Members under the age of 46 on all DHMS plans	Under the age of 46	Important! To qualify, all members listed on the application form must be under the age of 46 with no pre-existing medical conditions
	Have no pre-existing conditions	
	The calculated late-joiner penalty percentage is equal to 5% or 25%	

Let's have a look at two examples:

John is 45 years old and has not belonged to another medical scheme for more than two years immediately before joining DHMS on 1 May 2001. He has, however, attached membership certificates from other medical schemes indicating the following:

Medical scheme	Years on the scheme	Coverage
ABC Health	01 Jan 1999 – 31 July 2000	1 year, 7 months
XYZ Healthcare	01 Jan 1985 – 31 July 1985*	3 years, 7 months
No cover (10 years)	35 – 45 years	0

Years on a registered SA medical scheme: 5.2 years
Years not on a registered medical scheme: 10 – 5.2 = 4.8 years
Maximum penalty: 5%

*The years on XYZ Healthcare can be taken into consideration, as the member was older than 21.

John would like to join DHMS on the Essential Core plan. The calculation will be applied as:

Risk premium + (Risk premium x 5%) = contribution
R1 931 + (R1 931 x 5% (R96.55)) = R2 027.55

Should John want to join DHMS on the Essential Saver plan, the calculation will be applied as:

Risk premium + (Risk premium x 5%) + MSA= contribution
R2 040 + (R2 040 x 5% (R102)) + R360 = R2 502

Classification of dependants

A dependant is:

- A member's spouse or partner who is not a member or a registered dependant of a member of a medical scheme
- An adult dependant
- A member's child who is not a member or a registered dependant of a member of a medical scheme
- The immediate family of a member for whom the main member is responsible for family care and financial support
- Such other persons whom the Board of Trustees of the Medical Scheme recognise as dependants in relation to their rules.

Spouse dependant

A spouse is a person married to the main member or in a union with the main member in accordance with any law or custom recognised in South Africa.

The addition of a spouse to an existing membership means the spouse will be fully underwritten, subject to the following underwriting guidelines:

- A newly-wed spouse will be accepted free of underwriting if he or she provides a copy of the marriage certificate or proof that the marriage was registered. This includes civil union and customary marriages.

- This needs to be done within three months of the date of the registered marriage or civil union.

The addition of a common law spouse will be underwritten if he or she does not fit into the above criteria.

Adult dependant

DHMS rules define an 'adult dependant' as:

- 'A person who does not qualify for child dependant status in terms of the aforementioned child dependant definition, is 21 (twenty-one) years or older, is wholly or partially dependent on the principal member for financial support and related to the principal member whether by affinity or consanguinity (blood, marriage, adoption etc.)', or
- 'The divorced spouse of a member', or
- 'The second spouse of a member', under a customary union according to indigenous black law or custom or under a union recognised as a marriage under the tenets of any religion, or
- 'A person with whom, in the opinion of DHMS, the member enjoys a relationship similar to the relationship of legally married spouses provided that the legally married spouse of the member shall not be an adult dependant'.

The underwriting rules applicable to the main member extend to adult dependants:

- Individual underwriting applies to adult dependants where individual underwriting applies to the main member.
- Adult dependants are assessed as part of the group wherever group underwriting applies, if the dependant is on the same application as the main member and not an addition to an existing membership.
- Group underwriting members who were permitted as adult dependants on their previous scheme (before joining DHMS and the break in membership is fewer than 90 days) will be permitted to keep their adult dependant status on DHMS. A copy of the membership certificate must be attached.

Underwriting reserves the right to investigate the eligibility of adult dependants.

Child dependant

A child dependant is the unmarried child of a member, including a stepchild, adopted child or foster child, who is under the age of twenty-one years and is not self-supporting, or who is a full-time student under the age of twenty-one years.

Adding child dependants to DHMS:

Stepchildren

- Stepchildren can be accepted onto a policy without additional information provided a biological parent is on the policy or part of the application.
- When the biological parent is not on the policy or part of the application, we will allow a stepchild onto a policy under the following circumstances with supporting documentation:
- Member has acquired the child as a result of a divorce agreement. We require a copy of the divorce agreement as proof.
- The biological parent cannot join the policy. We require a legal marriage certificate to confirm that the principal member is a legal spouse to the child dependant's biological parent, as well as an unabridged birth certificate which stipulates the parents' names, surnames and ID numbers. This information will allow us to confirm that the principal member's spouse is the biological parent of the stepchild.

Biological newborns

DHMS allows members to register their newborns free of underwriting if:

- The newborn is registered within 90 days of birth; and
- The cover start date is the same date as the newborn's date of birth.

However, we recommend that members register their newborns within 30 days of birth. When a newborn is registered on the scheme within 30 days of the birth:

- The newborn dependant will have immediate access to healthcare benefits offered on the health plan; and
- The member's contributions will be up to date, creating no concerns around financial implications.

Non-biological (adopted) child dependants:

Adopted newborn

- If the adoption is still in progress, the baby can be added from their date of birth, free of underwriting, if we receive the DHMS affidavits completed by the main member and the social worker and the application within 90 days of the baby's birth.
- If the adoption is final, the baby can be added from their date of birth, free of underwriting, if we receive the legal proof and the application within 90 days of the baby's birth.

Adopted child

- If the application for an adopted child under the age of 18 to join the scheme is sent to us within 90 days of the date of legal adoption, we will add the child to the adoptive parents'

membership free of underwriting with proof of legal adoption. The start date of cover for the adopted child must be the first of the month in which the legal adoption took place.

- If the application for an adopted child under the age of 18 to join the scheme is sent to us after 90 days from the date of legal adoption, we will add the child to the adoptive parents' membership and apply full underwriting with proof of legal adoption.
- If the adoption for a child under the age of 18 is still in progress, we need the DHMS affidavits completed by the main member and social worker or the letter from the social worker or courts confirming that the adoption is in process and has not yet been finalised. In this case the child will be free of underwriting provided that the application is done within 90 days of the child being placed in the adoptive parents' care. The start date of the child's cover needs to be the first of the month that they were placed in the care of the adoptive parents. We would need a letter from the social worker or courts confirming the date that the child was placed in the adoptive parents' care. DHMS will not bill for the first month's premium. To arrange for the waiver of the first month's premium, underwriting must email the billing team on Billing_Functional_Team_Support. If the member wants a start date other than the month that the child was placed in their care, the child will be fully underwritten.
- If the request to add the adopted child is received after 90 days from the adoption or the child being placed in the care of the adoptive parents, full underwriting will apply.
- If the adopted child is older than 18 we require a copy of the adoption papers showing that the dependant was placed in the main member's care up until the age of 18.

Foster child

- For a foster child under the age of 18, full underwriting will apply and the application must be accompanied by supporting legal documentation.
- For a foster child older than 18 we require a copy of the foster agreement showing that the dependant was placed in the main member's care up until the age of 18.

Grandchildren

A grandchild can only be a dependant on a membership if:

- There is at least one biological parent of the grandchild on the policy (or part of the new business application); and
- The biological parent is eligible as per the child or adult dependant eligibility criteria of the scheme; or
- The grandparents have proof of legal adoption, legal guardianship or a foster arrangement of the grandchild, if the biological parents are not on the policy. In this instance, proof of legal documentation is required.

Siblings

A sibling can be a dependant on a membership if the biological parents are not on the policy in the following scenario:

- Sibling is 18 years and older (without legal proof of guardianship / adoption)
- From the age of 18 to 20 we will not assess according to eligibility rules, i.e. income, financial dependency, legal proof of guardianship or adoption.
- From the age of 21 and above we will assess and apply eligibility rules in terms of income and financial dependency.

Continuation options

Members can use the continuation option in the following events:

- Retirement from employment. Subject to the conditions of the member's employment agreement, the member can choose to remain with DHMS when he or she retires.
- Death of the main member
- Divorce
- Child dependant who becomes a self-supporting adult and moves to his or her own DHMS membership

Existing members can continue their DHMS memberships on the same terms and conditions that applied during the main member's membership, without providing extra medical evidence.

If there has been a break in membership, full underwriting will apply.

Group Health Underwriting

Group application process

Quotation

Send demographics as raw data to quotationsrequests_health@discovery.co.za before requesting a group decision.

Application process and requirements

A completed employer application form and the employer demographics report must be sent to HEALTH_GROUP_UNDERWRITERS@discovery.co.za.

- Joining the scheme has to be compulsory for current and future employees; this should be clearly marked in the field provided.
- If there is a difference between those employed and those joining, then a compulsory definition must be in place (salary bands, income categories or only salaried employees, or excluding those on spouse's medical scheme).
- The number of employees joining must be the same as the number of employees on the employer application form.
- If there are any changes on the employer application form, the employer must correct, sign and date these changes.

Employer demographics

Surname	Name / Initials	Date of birth	Income	Spouse	Spouse DOB	Adult Dependant	Adult DOB	Child Dependants	Child DOB

Example of the report

- The total on the demographics must be the same as the total on the employer application form for those who will be covered.
- The demographic profile must fit the profile for group acceptance.
- The underwriters will evaluate the data and if it meets all the criteria, they will issue an acceptance letter.
- The employer contact must sign and date the DHMS employer application form.
- Send the signed acceptance to HEALTH_GROUP-UNDERWRITERS@discovery.co.za.
- Underwriters will then request that the employer capture and forward the employer application form and the signed acceptance to acquisitions@discovery.co.za.
- The employer will be captured and an employer number allocated.
- The underwriters will update the employer to group status and make all the necessary remarks for the group acceptance.
- The underwriters will advise the franchise as well as new business about the update.
- The franchise can now submit or capture the member applications (starting date on all members must be the same as the starting date on the employer acceptance).

We will only release the employer once we have received the following percentages:

- Groups between 10 and 34 principal lives – 100% of the total quoted on
- Groups of 35 and more – 70% of the total quoted on
- Once we have accepted the employer, the members will be activated

Do not capture any employer before submitting the relevant information to HEALTH UNDERWRITERS. The underwriters must first make a decision before any capturing can be done. Please involve your Franchise and/or Business Consultant in this process, as it is necessary for them to collate the data and act as the link between underwriting and the financial adviser.

New members joining a current employer group – bulk addition of new members

An employer group may want to offer DHMS memberships to employees who fall outside their defined compulsory definition. This can be done either because of acquisitions or amalgamations of companies. We need confirmation of the group's status to confirm if the extra members would negatively affect the current active members' group decision. The following information has to be sent to the underwriting department for consideration:

- A letter from the employer with information about the employees to be included with confirmation of whether or not membership will be made compulsory for these employees.
- Demographic reports of current active members under the employer group; a demographic report of new employees joining (to be supplied on a quotation spreadsheet by the employer); combined demographics of current active members and new employees. This may be requested from the quotations department at: quotationrequests_health@discovery.co.za
- You will receive a response within 24 hours from receipt of the request to review the decision.

Summary of group underwriting

- 10 or more main members
- Membership of DHMS is compulsory
- Require fully completed group application forms
- Employer underwritten according to demographics supplied on quotation
- Group acceptance will be offered or declined
- Industry and occupation of employees will be considered
- Future additions to the group will be accepted at the group decision subject to the group definition.

Quick group underwriting reference tool

This checklist will assist you when you complete the applications for new employees to join DHMS. Please use it to ensure you have given us all the information to process your application without delay. When you submit your applications, please attach a signed copy of the necessary checklist (available on www.discovery.co.za).

Type of request	Checklist
New group decision request	▪ 10 or more employees ▪ Up-to-date employer application form attached ▪ Demographics attached
Addition of new branch	▪ Letter from the employer asking to add a new branch to the attached group employer ▪ Up-to-date employer application attached ▪ Demographics of current group attached ▪ Demographics of new branch attached

	▪ Combined demographics attached
Bulk additions to an existing group	▪ Letter from the employer requesting a bulk addition of new members of employees to the existing employer group ▪ Demographics on existing employees attached ▪ Demographics on employees to be added attached ▪ Combined demographics attached
Breakaways	▪ Confirmation from the employer about the breakaway attached ▪ Revised employer application ▪ Demographics of employees to remain with this employer attached
Mergers	▪ Employer application form ▪ Letter about the merger ▪ A breakdown of the demographics in the current business ▪ A separate demographic breakdown for each of the employers planning to merge ▪ Combined demographics for the merged companies
Once-off group decision	▪ Up-to-date employer application form attached ▪ Demographics attached
Secondment agreement	Letter from the employer attached, confirming: ▪ List of countries where employees are sent to work ▪ Term of contract (duration of stay, it being compulsory to re-join on return) ▪ Demographics attached

PRESCRIBED MINIMUM BENEFITS (PMBS)

This section includes:

- Overview and purpose of PMBs
- Designated service providers (DSP)
- Emergency medical conditions
- Diagnostic Treatment Pairs (DTP)
- Chronic Disease List (CDL)

Overview and purpose of PMBs

What are Prescribed Minimum Benefits (PMBs)?

A set of minimum benefits that, by law, must be provided to all medical scheme members. The cover it gives includes the diagnosis, treatment and cost of ongoing care for a list of conditions.

There is a list of medical conditions that are defined in the Medical Schemes Act 131 of 1998 as qualifying for Prescribed Minimum Benefits (PMBs).

The regulations define 270 diagnoses and their associated treatment and 25 chronic conditions with their treatment as PMBs.

Why have PMBs?

- To ensure that all members have access to minimum, acceptable medical treatment for certain conditions.
- Ensures the same access to minimum, acceptable healthcare regardless of scheme or plan type.

What PMB cover does DHMS member get?

- Emergency conditions (refer to page 32 for a definition)
- A limited set of 270 medical conditions, defined as Diagnostic Treatment Pairs PMBs (DTP PMBs). Oncology is included in the 270 conditions
- 27 chronic conditions.

Members are entitled to full cover as long as three requirements are met

- **Valid medical condition:** The medical scheme needs to be provided with sufficient diagnostic information to identify the condition and determine if the severity qualifies for the treatment requested.
- **Chosen treatment is included in the defined benefits:** There are standard treatments, procedures, investigations and consultations for each PMB condition. The scheme is only required to provide cover for these defined benefits (except possibly on appeal).
- **Participating healthcare professional and or hospital:** The medical scheme is required to ensure that members do not experience shortfalls if they make use of healthcare providers (hospitals and doctors) that the scheme has a specific payment arrangement with (except in the case of emergencies).

Designated service providers

Why are designated service providers important?

A designated service provider (DSP) means a health care provider or group of providers selected by the medical scheme concerned as the preferred provider or providers to provide for its members' diagnosis, treatment and care in respect of one or more Prescribed Minimum Benefit conditions.

Designated service providers enable medical schemes to manage their PMB risk. Medical schemes must ensure that their members do not experience shortfalls when their members make use of the scheme's designated service providers.

If a member chooses not to use the DSP selected by the scheme, they may have to pay a portion of the bill as a co-payment. This could either be a percentage co-payment or the difference between the DSPs tariff and that charged by the provider the member went to.

Medical schemes have to ensure that DSP coverage is widely available to beneficiaries. If there is no DSP within reasonable distance of the member's work or home, then they can visit any provider and the scheme is obliged to pay without applying a co-payment.

When members suffer an emergency condition, or are involved in an accident, they may go to the nearest healthcare facility for treatment, even if it is not a DSP. The scheme will have to cover the costs in full without applying a co-payment.

Schemes also have to ensure that the DSPs of their choice can deliver the services needed and without members having to wait unreasonably long. Where a DSP is unable to accommodate or treat a member, the medical scheme remains liable for all the costs of treating the PMB condition at a non-DSP.

The State's healthcare facilities can be, but are not necessarily, DSPs. Before they can be listed as such, schemes have to make sure that their beneficiaries can get to the facilities and that the required treatment, medication and care are available and accessible.

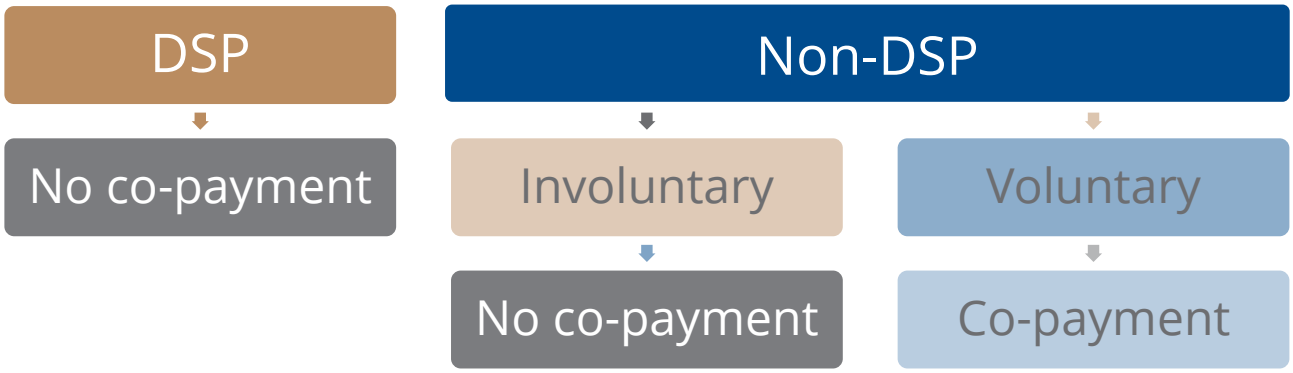
Treatment at DSPs can be handled in two ways:

- Schemes can insist that members go to a DSP as soon as their condition is diagnosed, in which case the scheme covers the costs from the start. Treatment at a DSP will be covered in full by the medical scheme under the PMB conditions when delivered according to scheme protocols and formularies.
- If the member's benefit option allows for this, the member can be treated by the doctor of their choice. If the member chooses to use a provider of their choice for these services, the scheme may apply a co-payment, as registered in their rules.

Why are designated service providers important?

Co-payments can only be levied when members voluntarily choose not to go to a DSP for a specific service, and/or when beneficiaries voluntarily decide not to use protocol or formulary medication or treatments.

Co-payments have to be specified in the medical scheme rules and may never be 100% of the cost of the service or medication. Schemes are also not allowed to recover co-payments from beneficiaries' savings accounts.



Emergency medical conditions

Definition of an emergency medical condition

According to the Medical Schemes Act, an emergency medical condition is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

Funding of an emergency admission

The Discovery Health Medical Scheme will pay the conditions that are defined on our emergency list in full. We will fund an emergency admission into any hospital at cost for the number of emergency days approved. Once the member is stable and if the hospital or healthcare provider is not one of our DSPs, we will arrange for the member to transfer to a DSP. However, we will apply our "non-DSP" rules if the member continues receiving treatment from the non-DSP provider once they are stable.

Transferring members to a designated service provider

Members have the choice to transfer to a DSP facility or provider, or to remain in the non-DSP hospital and with the same healthcare provider. If the member chooses to be transferred to a DSP, Discovery

Health will arrange and fund the transfer as soon as it is clinically safe to do so. If the member chooses to stay on in the non-DSP facility or with a non-DSP healthcare provider, we will then pay the hospital and non-DSP related provider's accounts at 80% of the Discovery Health Rate and the member will be responsible for the balance, as a co-payment.

Diagnostic treatment pairs

The diagnosis and treatment of conditions that are related to Prescribed Minimum Benefits consist of diagnostic treatment pairs. This refers to a diagnosis linked to a treatment or procedure. For example, diagnosis of appendicitis can be treated with medical or surgical management.

There are 270 treatment pairs that cover serious and acute medical problems that include the cost of diagnosis, treatment and care of these conditions as set out by the Council for Medical Schemes.

The Prescribed Minimum Benefits were defined according to a specific set of principles to protect members in the case of serious illnesses. The Council for Medical Schemes considered the following issues when they defined them:

- The cost-effectiveness of the treatment or procedure (State guidelines are used to determine this); and
- The availability of the type of treatment in a State facility as the minimum cost intervention the scheme should offer.

A list of these conditions is available from the Council for Medical Schemes' website www.medicalschemes.com

Applying for cover for the diagnostic treatment pairs

In some instances, members need to apply for a claim to be paid as a PMB, preferably before the actual event or treatment (or both). We will assess the application against our clinical entry criteria, which guides our funding decisions. Based on the information provided, we can communicate to the member how we will pay the claims: either in full, or by applying a co-payment.

Hospitalisation for diagnostic treatment pairs (DTPMBs)

Members need to follow the normal hospital authorisation process by calling DHMS on 0860 99 88 77.

Out-of-hospital management of diagnostic treatment pairs (DTPMBs)

Members need to send us a completed out of hospital PMB application form which is available on www.discovery.co.za or members can call to request an application form.

Chronic Illness Benefit

Members need to send us a completed CIB application form which is available on www.discovery.co.za or members can call to request an application form.

Oncology

Members need to send us a completed Discovery Care Oncology Programme application form which is available on www.discovery.co.za or members can call to request an application form.

HIV and AIDS

Members need to send us a completed HIV Care Programme application form which is available on www.discovery.co.za or members can call to request an application form.

PMB Chronic Disease List

The Prescribed Minimum Benefits require medical schemes to cover the diagnosis, medical management and medicines for a specified list of 25 chronic conditions known as the Chronic Disease List.

These below 25 conditions must be covered by all medical schemes:

Addison's disease	Epilepsy
Asthma	Glaucoma
Bipolar Mood Disorder	Haemophilia
Bronchiectasis	Hyperlipidaemia
Cardiac failure	Hypertension
Cardiomyopathy	Hypothyroidism
Chronic obstructive pulmonary disorder	Multiple sclerosis
Chronic renal disease	Parkinson's disease
Coronary artery disease	Rheumatoid arthritis
Crohn's disease	Schizophrenia
Diabetes insipidus	Systemic lupus erythematosus
Diabetes mellitus Type 1 and Type 2	Ulcerative colitis
Dysrhythmias	

Cover for consultations and diagnostic tests

The Discovery Health Medical Scheme will pay the cost of certain consultations and diagnostic tests associated with the 27 conditions on the Chronic Disease List, based on positive clinical guidelines and registration on the Chronic Illness Benefit.

The number of tests and consultations we cover is limited

- DHMS carefully manages the Chronic Illness Benefit to ensure our members have cover for quality, appropriate healthcare that is cost-effective, affordable and sustainable. We use clinical guidelines and expert advice to make sure we fund the most appropriate healthcare.
- The average number of diagnostic tests and consultations we pay is determined based on clinical best practice and evidence. We will only pay claims listed in the Prescribed Minimum Benefits treatment guidelines from the Chronic Illness Benefit and according to our designated service provider rules.

How do members claim from the Prescribed Minimum Benefits for tests, consultations and medicine?

- If we have approved cover for a PMB condition, members must send the accounts for any tests or consultations that form part of the treatment for the condition to us as usual. The accounts must have the diagnostic ICD-10 code and be within the scheme's basket of care for that condition.
- We will pay accounts without valid ICD-10 codes from available funds in the member's day-to-day benefits (Medical Savings Account and Above Threshold Benefit) subject to the plan type and the availability of funds and benefits; this is because we cannot identify these claims as PMB claims.

What is an ICD-10 code?

One of the types of codes that appear on healthcare provider accounts is known as ICD-10 codes. These codes are used to inform medical schemes about what conditions their members were treated for so that claims can be settled correctly.

DISCOVERY HEALTH MEDICAL SCHEME PRODUCT PLATFORM

This section includes:

- Screening and Prevention Benefit
- Chronic Illness Benefit (CIB)
- Managed care programmes
- Hospital cover
- Discovery Health Rate (DHR)
- Medical Savings Account (MSA)
- Self-payment Gap (SPG)
- Day-to-day Extender Benefit
- Maternity Benefit
- Above Threshold Benefit (ATB)

Screening and Prevention Benefit

Preventative screening is important in making sure that members detect medical conditions early and we can ensure the best care for them. The Screening and Prevention Benefit covers preventative tests, screenings and flu vaccinations (during pregnancy, for members registered for certain chronic conditions and members over the age of 65 years) on all DHMS plans.

The Screening and Prevention Benefit does not cover the cost of any related consultations. Consultations are covered from the available funds in the member's day-to-day benefits, unless it relates to a Prescribed Minimum Benefit diagnosis.

Screening for adults

The Vitality Health Check

The Scheme will fund each of the below preventative screening tests, per year from Risk, up to a maximum of the Discovery Health Rate. The group of tests include:

- Blood glucose
- Blood pressure
- Cholesterol
- Body mass index or weight assessment
- Waist circumference
- HIV screening (included in the Vitality Health Check for DHMS)

Members who register higher than normal cholesterol results, and who meet the Scheme's clinical entry criteria, will automatically receive cover for a lipogram test as part of the screening process.

DHMS covers up to a maximum of R247.90 if the group of tests are all done at the same time at a network provider. This benefit is available on all plans and members are not required to have an active Vitality policy.

Additional screenings

In addition to the Vitality Health Check, the following tests will be paid up to the Discovery Health Rate, if the member has them done at an appropriately registered pathologist or radiologist.

Test	Cover	High-risk members
Mammogram	One every two years, up to a maximum of the Discovery Health Rate	One mammogram every year
Pap smear	One every three years, up to a maximum of the Discovery Health Rate	One Pap smear every year

Prostate-specific antigen (PSA)	One per year, up to a maximum of the Discovery Health Rate	
Colorectal screening (bowel cancer screening)	One fecal occult blood test or fecal immunochemical test every two years, up to a maximum of the Discovery Health Rate *Members must be between the age of 45 and 75	Member with a positive fecal occult blood test have cover for a colonoscopy for bowel cancer screening
HIV screening	Unlimited amount of tests	
Seasonal flu vaccines	One seasonal fly vaccine, up to a maximum of the Discovery Health Rate *Member must be 65 years or older	

Seasonal flu vaccine

Members qualify for one seasonal flu vaccine each year if they are older than 65 years or are registered for one of the following chronic conditions:

- Asthma
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disease (COPD)
- Chronic renal disease
- Coronary artery disease
- Diabetes (Types 1 and 2)
- HIV.

Kids screening

We also cover some growth assessment tests for children at one of our network pharmacies, at the agreed rate. This consists of tests including:

- BMI available to children between the ages of two up until their 18th birthday
- Head circumference for children between two and five years old
- Blood pressure available to children between the ages of three up until their 18th birthday
- Health behaviour and milestone tracking available to children between the ages of two up until their 18th birthday.

This is limited to four screening tests per child per year and all test must be done at the same time.

Chronic Illness Benefit

The Chronic Illness Benefit (CIB) covers medicine for a specified list of 27 chronic conditions on the Chronic Disease List (CDL) according to a member's plan type.

Executive and Comprehensive plan members have access to an Additional Disease List of 23 conditions.

The CIB covers the following for the Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions:

- A specified list of consultations
- Limited procedures and diagnostic tests
- Specified medicines.

Conditions

Chronic Disease List

All DHMS members have access to CIB cover for:

Addison’s disease	Epilepsy
Asthma	Glaucoma
Bipolar Mood Disorder	Haemophilia
Bronchiectasis	HIV
Cardiac failure	Hyperlipidaemia
Cardiomyopathy	Hypertension
Chronic obstructive pulmonary disorder	Hypothyroidism
Chronic renal disease	Multiple sclerosis
Coronary artery disease	Parkinson’s disease
Crohn's disease	Rheumatoid arthritis
Diabetes insipidus	Schizophrenia
Diabetes mellitus Type 1	Systemic lupus erythematosus
Diabetes mellitus Type 2	Ulcerative colitis
Dysrhythmias	

Additional Disease List

Executive and Comprehensive plan members have access to CIB cover for a further 23 conditions:

Ankylosing spondylitis	Obsessive compulsive disorder
Bechet's disease	Osteoporosis
Cystic fibrosis	Paget's disease
Delusional disorder	Panic disorder
Dermatopolymyositis (or polymyositis)	Polyarteritis nodosa
Generalised anxiety disorder	Post-traumatic stress disorder
Huntington's disease	Psoriatic arthritis
Isolated growth hormone deficiency	Pulmonary interstitial fibrosis
Major depression	Sjörgen's syndrome
Motor neuron disease	Systemic sclerosis
Muscular dystrophy	Wegener's granulomatosis
Myasthenia gravis	

Medicines

Medicine that is on the DHMS medicine list (formulary) is covered in full up to the Discovery Health Medication Rate and medicine that is not on the list (non-formulary medicine) is covered up to a set monthly rand amount or Chronic Drug Amount (CDA), or cost of the lowest formulary listed drug on the Smart and KeyCare plans.

- Members on KeyCare Start have cover for chronic medicine through a state facility.
- All other plans provide access to medicine on the medicine list, for treatment of CDL conditions.
- All plans except KeyCare and Smart plans provide access to medicine that is not on the medicine list, paid up to the CDA, for treatment of CDL conditions.
- KeyCare and Smart plans provide access to medicine that is not on the medicine list, paid up to the lowest-cost medicine on the medicine list, for treatment of CDL conditions.
- Executive and Comprehensive plans provide access to cover for treatment of ADL conditions to which no formulary medicine is applicable, paid up to the CDA.

Executive Plan members have access to an exclusive list of branded medicine in addition to the CDA and formulary:

Condition	Medicine
Asthma	Symbicord
Cardiac failure	Bilocor

Depression	Venlor Venlafaxine adco Lilly-flouxetine
Diabetes	Glucophage Levemir Optisulin
Hypertension	Co-migroben Co-pritor Co-tareg Co-zomevek Prexum Pritor Tareg
Hyperlipidaemia	Rosvator Storwin Vusor Zuvamor

CIB application process

For a condition to be covered from the Chronic Illness Benefit, there are certain criteria the member needs to meet. This ensures that members receive sustainable funding for cost-effective treatment. Members need to apply for each chronic condition to be covered from the Chronic Illness Benefit. We will only pay for the medicine and treatment from the Chronic Illness Benefit if the condition and medicine is approved.

Members may need to send the scheme the results of the medical tests and investigations that confirm the diagnosis of the condition for which they are applying for cover. This will help us to identify that the condition qualifies for the chronic medicine.

Members can send the completed Chronic Illness Benefit application form:

- By fax to: 011 539 7000
- By email to: CIB_APP_FORMS@discovery.co.za
- By post to: Discovery Health, CIB Department, PO Box 652919, Benmore, 2010.

Managed care programmes

Discovery Care Oncology Programme

Discovery Health Medical Scheme provides cover for cancer patients who have registered on our Discovery Care Oncology Programme. The programme has a flexible range of options available for all members diagnosed with cancer.

The benefit is subject to application and dependent on the member's plan type.

Benefits

Members have full cover for approved cancer-related treatment up to a rand amount over a 12-month cycle. Once the treatment costs go over this amount, Discovery Health will pay 80% of the costs of all further treatment and the member will need to pay the balance from their pocket. This amount could be more than 20% if the treatment cost is higher than the Discovery Health Rate.

Benefit thresholds	
Executive and Comprehensive plans	R400 000
Classic Smart Comprehensive Plan	R300 000
Priority, Saver, Smart and Core plans	R200 000
KeyCare Plus and KeyCare Core	PMB cover only
KeyCare Start	Cover for oncology treatment through a state facility

This includes cover for chemotherapy, radiotherapy and other treatment prescribed by the member's cancer specialists. Members also have access to donor searches for bone marrow transplants.

Members on the Essential Smart Plan must make use of an Independent Clinical Oncology Network (ICON) specialist in the greater Independent Clinical Oncology Network for their oncology treatment.

Members on the Executive and Comprehensive plans (excluding the Classic Smart Comprehensive Plan) have access to the Oncology Innovation Benefit. The benefit provides members with cover for a defined list of innovative cancer treatments, subject to a 25% co-payment from the first rand. The benefit aims to provide members access to new technology and treatment, including high-cost treatment. The approved treatment will accumulate to the benefit threshold of R400 000. Clinical entry criteria must be met.

Members on the Executive and Comprehensive plans (excluding the Classic Smart Comprehensive Plan) also have access to the Extended Oncology Benefit. The benefit provides members with full cover for a defined list of oncology treatments that are not considered Prescribed Minimum Benefits. The benefit aims to provide members with sustainable access to specific oncology treatments that offer clinical value. Members will not have to make any co-payment once the R400 000 cover amount is reached.

Any cancer-related treatment that falls within the Prescribed Minimum Benefits is always covered in full, with no co-payment if the member uses service providers who we have an agreement with. PMB treatment accumulates to the cover amount.

Oncology medicine

Members are required to make use of network pharmacies for their oncology medicine. Oncology medicine obtained from a non-network pharmacy will result in a 20% co-payment. The network will

both enhance service and provide significant cost efficiencies, which can extend the cover for members receiving treatment.

Medicine administered in the doctor's room:

Members are required to obtain their oncology medicine, like chemotherapy, from a network pharmacy. Members should confirm with their oncologist that they are using a designated service provider.

Medicine scripted and dispensed at a retail pharmacy:

Members are required to obtain their oncology medicine, like supportive medicine and oral chemotherapy, from any MedXpress network pharmacy.

How to apply

To register, the member's treating doctor needs to send copies of laboratory results confirming the diagnosis, the treatment plan including ICD-10 codes and the application form. The application form is available on our website www.discovery.co.za.

Advanced Illness Benefit

Through the Advanced Illness Benefit (AIB), Discovery Health Medical Scheme aims to ensure that members with advanced stages of cancer have access to comprehensive palliative care that offers quality in care.

Palliative care is provided by nurses or care workers in partnership with the Hospice Palliative Care Association of South Africa and Discovery HomeCare, where available. Enrolled patients have access to this service through the Advanced Illness Benefit (AIB).

Benefits

Support from a dedicated care coordinator:
A dedicated care coordinator; either a registered nursing sister or a social worker, will contact you (or your family member) once we have registered you on the Advanced Illness Benefit. The care coordinator will support you and your family and will work closely with your GP or specialist to ensure you receive the best of care at all times.

Personalised high-touch care:
Members registered on the Advanced Illness Benefit and their family will have access to counselling services for support during this difficult time.

Care through Discovery HomeCare:
Members registered on the Advanced Illness Benefit will have access to personalised home-based care services such as oxygen, pain management and home nursing through Discovery HomeCare, where available.

Access to 24-hour specialised telephonic support:
During working hours, members registered on the AIB can contact 0860 99 88 77 for assistance with AIB authorisations, oxygen or benefit and claims related enquiries. After hours, they will have access to their palliative team for emergency assistance.

DHMS will pay for healthcare services provided by any of the healthcare professionals represented in the palliative multidisciplinary team, according to a specific basket of care and the agreed individual member care plan. These costs will not affect a member's day-to-day benefits, and will be paid at the Discovery Health Rate from the Hospital Benefit.

How to apply

To register, the member's doctor needs to complete the Advanced Illness Benefit application form and submit it via HealthID or email it to AIB@discovery.co.za. The AIB application form is available on our website www.discovery.co.za. Upon successful registration, members will gain access to a comprehensive basket of care.

Discovery HomeCare

Discovery HomeCare offers members quality home-based care services in the comfort of their home. Using the services of Discovery HomeCare, members can receive care from a qualified caregiver and continue to live in the familiar surroundings of their homes despite their illness or condition.

Discovery HomeCare is an accredited service provider that offers high quality service provided by professional nurses or qualified care workers who have received additional quality training from Discovery Health (Pty) Ltd.

Benefits

Service	What it entails	How is it covered
End-of-life care	End-of-life care provided by nurses or caregivers in partnership with the Hospice Palliative Care Association of South Africa.	Paid from the Compassionate Care Benefit up to a set limit for a person once in their lifetime. Oncology related conditions are paid from the Advanced Illness Benefit.

IV infusions (drips)	The administration of IV antimicrobials, iron treatment, steroids and immunoglobulins for patients whose condition is stable and hospital admission is not required.	Paid from the Hospital Benefit if funding is approved (for example in lieu of hospitalisation).
Wound care	Wound care for venous ulcers, diabetic foot ulcers, pressure sores and other moderate to severe wounds for patients whose condition is stable and hospital admission is not required.	This type of care could be paid either from available day-to-day benefits or from the Hospital Benefit if funding is approved (for example in lieu of hospitalisation).
Postnatal care	This service offers home visits for healthy mothers and their babies if they choose to be discharged a day early from hospital. This service includes three day visits by a midwife, within a six-week period.	This type of care will be paid from the Hospital Benefit if funding is approved (for example in lieu of hospitalisation).

How to apply

To register, the member's doctor needs to complete the HomeCare application form, call us on 0860 462 273 or email homecare@discovery.co.za.

Please note: this service is only available in Gauteng, Cape Town, KwaZulu-Natal and selected services are available in Port Elizabeth.

How can members benefit from HomeCare?

Improved patient experience and service
Members do not have to travel to a facility to receive care, they can receive treatment and have accredited nurses or caregivers take care of them in the comfort of their own home.

Maintaining and improving quality of care and patient outcomes
Highly skilled nurses and caregivers deliver quality homecare in a professional manner.

Prevention of hospital admissions and shortening length of stays
Certain treatment can be rendered in a home environment, making it possible to receive care without being admitted to hospital. Discovery HomeCare can also assist to reduce the standard number of days in hospital, making it possible for patients to recover in the familiar surroundings of their homes.

HIV Care Programme

The HIV Care Programme is tailored to meet the special needs of our members who have been diagnosed with Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS).

With guidance and support from the best HIV experts in the industry, Discovery works in partnership with members and their doctors to ensure that enrolled members have access to the most clinically sound and cost-effective treatment plans available.

This fully inclusive programme will ensure that members receive confidential service, which includes counselling and approval for antiretroviral medicine. Our dedicated and experienced HIV case managers, supported by our panel of external doctors (who come in daily to review complex cases as requested) will assist members with all aspects of their HIV treatment and lifestyle modification.

They offer additional support services and access to reliable information on HIV and AIDS, and what steps members and their families can take to fight and manage the disease.

Benefits

- Voluntary counselling and testing, with Vitality incentivisation
- Counselling through ER24
- Lifestyle and HIV and AIDS-specific education
- Highly Active Antiretroviral Therapy (HAART) application and approval
- Education on HAART and assistance in the member's choice of medication delivery
- Compliance monitoring to ensure that the HAART is effective (this includes follow-up calls to the member to assist in management of HAART)
- Education and counselling for members requiring prophylactic antiretroviral therapy
- Ensuring appropriate claims are funded by the Scheme.

Our HIV protocols are based on the Southern African HIV Clinicians' Society treatment guidelines. When members register for our HIVCare Programme, they are covered for the care they need, which includes additional cover for social workers. Members can be assured of confidentiality at all times. Members on a **Priority, Saver, Smart, Core or KeyCare Plans**, will have to use a Premier Plus GP to manage their condition to avoid a 20% co-payment.

How to apply

All Discovery Health members who have been diagnosed with HIV and AIDS can register on the HIVCare Programme by calling 0860 99 88 77, by emailing HIV_Diseasemanagement@discovery.co.za or completing the application form found on www.discovery.co.za.

Designated service providers (DSPs) for HIV medicine

All members who are registered on the HIV Care Programme must use designated service providers (DSPs) to get their monthly HIV medicine to avoid a 20% non-designated service provider co-payment.

Currently, Discovery MedXpress is the designated service provider for HIV medicines for all members registered on the HIVCare Programme. Members on the Smart Plan also have the option to use their selected designated network pharmacy (Clicks or Dis-Chem) for their HIV medicine.

MedXpress

Discovery Health launched its own medication delivery service called Discovery MedXpress in 2011. This service allows members and their adult dependants to order their repeatable medication and have it delivered to an address of their choice or may choose to collect it in-store from a participating pharmacy. Discovery manages the ordering and tracking of the medication.

- Repeatable medication can be chronic or acute medication for which a doctor has given the member a script containing multiple repeats.
- The Discovery MedXpress service is free. Members do not pay any additional administration fees or delivery costs.

DSP for Priority, Saver, Core, Delta and Smart plans

MedXpress is the designated pharmacy provider for chronic medication on the Priority, Saver, Core and Delta plans. A 20% co-payment will apply when the members on the Priority, Saver, Delta and Core plans choose to get their chronic medication elsewhere (not from MedXpress or a qualifying MedXpress status pharmacy). Smart Plan members may use Clicks or Dis-Chem.

Members on the Priority and Saver plans that are already registered on the Chronic Illness Benefit have until 1 April 2019 before they have to start using MedXpress. Newly registered members on the Chronic Illness Benefit must immediately start making use of MedXpress as their designated service provider.

Members will be responsible to pay this co-payment. However, this does not apply to members that get their medication from dispensing general practitioners (GPs).

Advantages of using MedXpress:

	It is quick and convenient		Provides an advisory service to help you reduce co-payments for regular medicine claims
	Free delivery to your door, anywhere in South Africa		Get updates on any medicine changes and avoid unnecessary shortfalls and co-payments on medicines
	Able to collect orders from your nearest Dis-Chem or Clicks pharmacy		Provide a convenient SMS reorder service for chronic medicine

Steps to using MedXpress: New order

01 | Send prescription by email to medxpress@discovery.co.za, upload it on the website under "Order medicine using MedXpress", upload it using the Discovery app, or fax on 011 539 1020. Write "MedXpress" and medical aid membership number on the prescription. We will send a confirmation SMS when we receive your prescription.
02 | Place order by calling us after the confirmation SMS has been received from us. The SMS will be sent approximately two hours after the prescription has been faxed or emailed to us.

If the prescription contains schedule 5, 6 and 7: We need the original prescription to process the order for all schedule 6 and 7 medicines, and the second fill of schedule 5 medicine. This can be sent to Discovery MedXpress by registered mail or handed in at the Discovery walk-in centres. For in-store collections, the original prescription must be handed in at the respective stores on first collection.

Steps to using MedXpress: In-store collection

01 | Upload the prescription on www.discovery.co.za/neworder, email it to medxpresscollect@discovery.co.za or upload it using the Discovery app.
02 | Choose a pharmacy from the list.
03 | If the order has a co-payment, members will receive a SMS to call us to facilitate payment.
04 | The order will be ready for collection within three hours (or six hours if there is a delay).
05 | The original prescription must be handed in at the store when collecting a first order.

Steps to using MedXpress: re-order

01 | SMS reorder service: members will receive an SMS reminding them that their repeat medicine is due. Reply "Yes" or "No". When the member replies 'Yes', MedXpress will place an order with the exact medicines and dosages from the month before. It can be delivered or collected the same way as the previous order.
02 | Website, mobile app or telephone: Once the member has placed and received their first order with MedXpress, they can re-order repeat prescriptions on the web, mobile app or call every month to confirm. When the prescription expires they will need to send us their renewed prescription and call the call centre on 0860 9988 77 to confirm the first order.

Compassionate Care Benefit

Through the Compassionate Care Benefit (CCB), Discovery Health Medical Scheme aims to ensure that members with advanced diseases (non-cancer related conditions) have access to comprehensive palliative care that offers them or their loved ones, quality care in the comfort of their own home, or in a hospice-type facility, with minimum disruption to their normal routine and family life. Palliative care is provided by nurses or care workers in partnership with the Hospice Palliative Care Association of South Africa and Discovery HomeCare, where available.

Benefits

The Compassionate Care Benefit aims to provide holistic care to ensure comfort and relief, which includes cover for:

- Hospice care at home and in-patient units, where available
- Limited nursing care, where approved
- Medical care by palliative care trained doctors
- Psychosocial support
- Pain management
- Supportive medication
- Oxygen
- Physiotherapy
- Limited radiology and pathology.

These services will be provided by Discovery HomeCare, where available. The costs of these services will not affect a member's day-to-day benefits, and will be paid at the Discovery Health Rate from the Hospital Benefit.

Benefit limits	
Executive, Comprehensive, Priority, Saver, Smart and Core plans	R70 150 for each person in a lifetime
KeyCare plans	R49 650 for each person in a lifetime

How to apply

Discovery Health members who would like to register on the Compassionate Care Benefit, must have their treating doctor, nurse, hospice or loved one contact the DHMS call centre on 0860 99 88 77.

Diabetes Care Programme

Our Diabetes Care Programme, together with a member's Premier Plus GP, will help members actively manage their diabetes. A Premier Plus GP is a network GP that has contracted with us on quality-based metrics.

Once registered on the Chronic Illness Benefit, members are able to join the Diabetes Care Programme. The programme gives members and their Premier Plus GP access to various tools to actively monitor and manage their condition, while ensuring access to high-quality coordinated care.

Benefits

The programme has four key elements:

- Access to the best GP network to coordinate care:

  - Members are enrolled in the Diabetes Care Programme by their chosen Premier Plus GP. The Premier Plus GP that the member has chosen to enrol them into the programme will then become the member's designated service provider (DSP) for ongoing management of the condition.
  - The Premier Plus GP Network is a national network of GPs that will provide high quality treatment in the management of patients with chronic conditions. Premier Plus GPs have access to HealthID. The Premier Plus GP Network will be the designated service provider (DSP) for members registered on the Chronic Illness Benefit for diabetes on all plans except the Executive plan.
- Additional funding for allied healthcare services:
  - Enrolment on Diabetes Care unlocks an additional visit to a biokineticist and a dietitian.
- Incentives to motivate a journey to better health:
  - Members have the option to join the Vitality programme (for an additional fee), and can maintain a healthy lifestyle by enrolling in personalised physical activity and weight–loss programmes through Vitality Active Rewards and Weight Loss Rewards. Note: This is not a Discovery Health Medical Scheme benefit.
- Access to real-time, clinically verified data on their condition:
  - Monthly progress dashboard: members are motivated and empowered to engage in managing their condition via regular, personalised and insightful updates, delivered through the member dashboard on the web, member app and by email.

Nurse Educator Programme (part of the Diabetes Care Programme)

Members with diabetes, who are registered on the Chronic Illness Benefit for diabetes, not only have access to the Diabetes Care Programme, but also have access to the Diabetes Care Nurse Educator Programme. The programme supports the Premier Plus GP by giving members with diabetes access to a nurse educator to help them with the effective monitoring and day-to-day management of their condition. This includes support, education and coaching of members.

Members have to see a Premier Plus GP on the network to avoid a 20% co-payment. This excludes members on the Executive Plan. Members on KeyCare and Smart plans have to use their respective network GPs who are also Premier Plus GPs.

Benefits

The Nurse Educator Programme includes:

- Medicine adherence coaching
- Disease education support
- Effective eye and foot care support
- Promotion of healthy nutrition and physical activity to manage the health of members with diabetes effectively.

How to apply

Discovery Health members can speak to their Premier Plus GP or visit www.discovery.co.za to find a Premier Plus GP.

Cardio Care Programme

Members registered on the Chronic Illness Benefit for hypertension, hyperlipidaemia and ischaemic heart disease can register for the Cardio Care Programme. Cardiovascular disease is a non-communicable disease. Inactivity, unhealthy diet, smoking and excessive alcohol consumption are named as the four main risk factors which lead to four major non-communicable diseases, responsible for over 60% of deaths worldwide today. Cardiovascular disease can be modified and managed by lifestyle interventions and changes.

The Cardio Care Programme gives members access to a defined basket of care, which includes a risk-funded extended consultation with their Premier Plus GP, to help manage and modify their cardiovascular disease.

To learn more, please refer to the Connected Care for members section in the training guide.

Benefits

The Cardio Care Programme includes:

- An annual cardiovascular assessment, with recommended clinical care pathways
- A personalised member scorecard to track clinical improvements measures over time.

How to apply

Discovery Health Medical Scheme members diagnosed with hypertension, hyperlipidaemia and ischaemic heart disease can speak to their Premier Plus GP or visit www.discovery.co.za to find a Premier Plus GP.

Mental Health Care Programme

Members diagnosed with acute and/or episodic major depression, that meet the Scheme's clinical entry criteria, have access to the Mental Health Care Programme.

The benefit is available to all DHMS plans. The clinical entry criteria differs for:
Acute or newly diagnosed members must have no history of major depression in the last 12 months, which is calculated from date of enrolment

Members with episodic depression must have made no claims within the previous 12 months (365 days from enrolment).

Benefits

The Mental Health Care Programme includes:

- An extended consultation with a Premier Plus GP
- Based on the clinical requirements of the individual case, members also have access to a network of a nationwide of psychologist through the Psychologist Network. For complex individual cases, the member's Premier Plus GP and psychologist will have access to a network of psychiatrists to support them in the management of these cases
- Prescribed formulary medicine for episodes of major depression (including plans where major depression is not covered on the Additional Disease List)
- Two follow-up GP consultations, to allow effective evaluation, tracking and monitoring of treatment
- One virtual consultation
- Free access to Vitality Active Rewards Personal Health Goals where they can track their health progress and be rewarded for completing mental health checks and tracking their mental wellbeing

Relapse Prevention Programme

The programme will provide clinical support and benefits for members that are at risk of a recurrence of a major depressive episode.

The programme has been designed to focus on recovery and stabilisation of symptoms and prevention of relapse through effective self-management supported by a dedicated counsellor.

Members enrolled on the programme get access to a risk-funded basket of care to support relapse prevention including additional psychiatrist visits, counselling sessions with contracted allied healthcare professional and access to end-to-end care coordination services by a team of healthcare professionals.

The programme is available to members who have been diagnosed with a major depressive episode. This includes members who have previously been admitted to hospital for depression, and/or who are registered for out-of-hospital PMBs for depression, and/or who are enrolled on the Mental Health Programme.

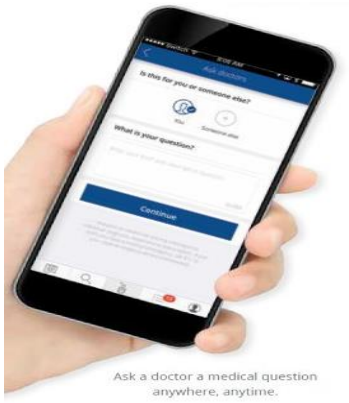
How to apply

Discovery Health Medical Scheme members diagnosed with major depression can speak to their Premier Plus GP or visit www.discovery.co.za to find a Premier Plus GP.

DrConnect

DrConnect is a platform that gives members access to high quality medical information from a worldwide network of doctors and facilitates personalised interactions between patients and their doctors. Discovery Health has partnered with HealthTap Inc. in Palo Alto, to provide a tailored offering for members of the Discovery Health Medical Scheme.

105 000 doctors available worldwide to answer medical questions in 174 countries and 5 billion doctor-created medical answers. The **member platform is called Discovery DrConnect** and the provider platform is called HealthID DrConnect.



Benefits

- Access to high quality health information from general practitioners (GPs) and specialists
- Members can ask doctors clinical questions and receive trusted advice from the members treating doctor or a network of doctors around the world
- Members can conduct virtual consultations with existing doctors, who already treat them. The doctor will show as part of their Care Team. A member's Care Team is made up of any GP/ specialist they have seen in the last 12 months for which they have submitted a claim
- Access to an extensive library of medical questions and health topics
- Virtual follow-up consultations using video, voice or text with their existing doctors who already treat them in a completely secure, private environment
- Personalised tips and checklists created by doctors to help meet their health goals. Health Goals are a pre-structured checklist for various conditions that have been designed by clinicians. Members can opt into any checklist and use it as a reminder service associated with managing their condition.

Funding

- Members do not have to pay to ask a question or to browse the library.
- They will be charged for virtual consults out of their day-to-day benefits.
- DrConnect is available for all Discovery Health Medical Scheme plans.

HealthID

HealthID is an application that Health Professionals (HPs) can download on a Samsung or iPad device to enhance the quality of care for Discovery Health members, by providing HPs with an integrated view of a member's medical history. HealthID was developed using the latest technology to facilitate a change in the quality of care, as well as the member's experience of the healthcare system.

The core functionality of Discovery HealthID provides a suite of tools which will:

- Enhance the quality of care for Discovery Health members by providing doctors with an integrated view of a patient's medical history;
- Reduce the administrative burden on members and doctors by allowing for a seamless co-ordination of downstream care through online referrals, scripting and chronic applications; and
- Minimise the risk of co-payments by providing details of a member's plan coverage and the ability to search for and prescribe medicines covered on a member's plan option.

The Hospital Benefit

The Hospital Benefit covers members if they are admitted to hospital and DHMS has confirmed their admission and treatment.

The hospital cover is made up of:

- The cover for the account from the hospital (the ward and theatre fees) at the rate agreed with the hospital.
- The cover for the accounts from the treating healthcare professionals, such as the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology are separate from the hospital account and are called related accounts.

Remember: Limits, clinical guidelines and policies apply to some healthcare services and procedures in hospital.

Hospital authorisation

We cover members in hospital for emergency and planned hospital admissions. In an emergency, members should go straight to hospital but should call or get someone to call DHMS within 12 hours to obtain authorisation.
For planned hospital admissions, members must call Discovery 48 hours before going into hospital to confirm their admission and obtain authorisation.

DHMS needs to be informed of a member's admission so we can manage their costs effectively and supply them with information that is relevant to how we will cover their hospital stay. If members do

not confirm their admission, we will only pay 70% of the hospital and related accounts for the admission; the member will be liable for the balance.

Contact details for hospital authorisation

Members can use any of the following channels to obtain their hospital authorisation:

- Telephone: 0860 99 88 77 and select the option for hospital authorisation
- Fax: 011 539 2192
- Email: preauthorisations@discovery.co.za

Discovery Day Surgery Network

The Discovery Day Surgery Network provides national cover for a range of medical or surgical procedures that can be performed on a same-day basis. The network includes both day-surgery centres and acute hospitals.

The list of defined procedures and network facilities are available on the Discovery website. The below procedures are covered on the Discovery Day Surgery Network, subject to annual review.

B Biopsies

- Skin, subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes

Breast Procedures

- Mastectomy for gynaecomastia
- Lumpectomy (fibroadenoma)

E Ear, nose and throat Procedures

- Tonsillectomy and/or adenoidectomy
- Repair nasal turbinates, nasal septum
- Simple procedures for nose bleed (extensive cautery)
- Sinus lavage
- Scopes (nasal endoscopy, laryngoscopy)
- Middle ear procedures (tympanoplasty, mastoidectomy, myringoplasty, myringotomy and/or grommets)

Eye Procedures

- Cataract surgery
- Corneal transplant
- Treatment of glaucoma
- Other eye procedures (removal of foreign body, conjunctival surgery (repair laceration, pterygium), glaucoma surgery, probing & repair of tear ducts, vitrectomy, retinal surgery, eyelid surgery, strabismus repair)

G Ganglionectomy

Gastrointestinal

- Gastrointestinal scopes (oesophagoscopy, gastroscopy, colonoscopy, sigmoidoscopy, proctoscopy, anoscopy)
- Anorectal procedures (treatment of haemorrhoids, fissure, fistula)

Gynaecological Procedures

- Diagnostic Dilatation and Curettage
- Endometrial ablation
- Diagnostic Hysteroscopy
- Colposcopy with LLETZ
- Examination under anaesthesia

O Orthopaedic Procedures

- Arthroscopy, arthrotomy (shoulder, elbow, knee, ankle, hand, wrist, foot, temporomandibular joint), arthrodesis (hand, wrist, foot)
- Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty)
- Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy). Subject to individual case review
- Repair bunion or toe deformity
- Treatment of simple closed fractures and/or dislocations, removal of pins and plates. Subject to individual case review

R Removal of foreign body

- Subcutaneous tissue, muscle, external auditory canal under general anaesthesia

S Simple superficial lymphadenectomy

Skin Procedures

- Debridement
- Removal of lesions (dependent on site and diameter)
- Simple repair of superficial wounds

U Urological

- Cystoscopy
- Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocoele, vasectomy)

The Discovery Day Surgery Network is the designated service provider for all plans except for the Executive Plan. Members will have cover for approved and defined procedures if they use a facility in the Discovery Day Surgery Network. Claims are paid at the Discovery Health Rate.

Members on KeyCare Plus and KeyCare Core must use a designated service provider in the Discovery Day Surgery Network. Members on KeyCare Start must use a designated service provider in the

KeyCare Start Day Surgery Network. Members on other network plans, such as Coastal, Smart and Delta, must use a designated service provider applicable to the network of their plan.

Members will pay an upfront deductible of R5 700 for procedures performed outside of the Discovery Day Surgery Network. For members on the Delta plans, the deductible is R8 700 and for members on the Smart plans the deductible is R9 950. KeyCare members will have no cover if the procedure is performed outside of the network. In the case of an emergency, no deductible will be applied outside of the network.

Where a benefit co-payment applies to the procedure and it is performed outside of the Discovery Day Surgery Network the higher of the co-payment and the deductible will apply.

Discovery Health Rate

When members visit a healthcare provider they often hear "We charge private rates; we do not deal with medical aids. You can confirm with your medical aid what rates they will pay for the procedure as you might have a shortfall."

Members of medical schemes often do not understand private rates vs medical aid rates and why medical schemes do not simply pay providers the rate they charge. To add to the confusion, providers often refer to BHF and NHRPL rates. What does this mean?

Board of Healthcare Funders (BHF)

Up until 2004, the Board of Healthcare Funders (BHF) published the Scale of Benefit Rate for medical services. This was discontinued, after the Competition Commission ruled that it amounted to price fixing and anti-competitive behaviour. The Commission felt that by setting these rates, medical schemes and healthcare professionals were making it difficult for the consumer to benefit from healthy competition in the private healthcare market.

Medical schemes and healthcare professional groups would now need to set their rates independently.

National Health Reference Price List (NHRPL)

The system was then replaced by the NHRPL process which was based on the rate calculated on an average a practice charged, as opposed to a negotiated rate. Legislation ruled that the Reference Price List (RPL) must be made redundant in July 2010. All medical schemes were then forced to adopt a different rate of reimbursement or develop their own. Independently, Discovery then developed the Discovery Health Rate. This rate is based on what the medical scheme can afford to pay.

Discovery Health Rate (DHR)

We set the Discovery Health Rate for all medical expenses every year, with a view to finding a balance between protecting our members' best interests and those of other stakeholder groups, like hospitals and healthcare professionals. We base our annual contribution increases on consumer inflation, projected rate increases and how much we anticipate it will cost the Discovery Health Medical Scheme to pay all our members' claims in the year ahead, based on our past claims history.

- Our decisions are not based on what we think healthcare professionals should charge for their services, but on what we know the Discovery Health Medical Scheme can afford to pay for those services without compromising the long-term sustainability of members' benefits and contributions. If they wish, members may still make use of the services of healthcare professionals who charge more than the Discovery Health Rate and can fund the difference in rates from their own pockets.
- Currently, some healthcare professionals prefer to be paid directly by the medical aid while others prefer to deal directly with their patients at a rate agreed with them.

DHMS might not pay for members' treatment in full

- Cover is subject to DHMS rules.
- Once we confirm a member's hospital admission, we might not pay for the treatment in full. A member's cover is according to our scheme rules, funding guidelines and clinical rules. Members can find out more about our clinical rules on www.discovery.co.za.
- There are some expenses members may incur while they are in hospital that the Hospital Benefit does not cover, for example private wards. Certain procedures, medicines or new technologies need extra benefit confirmation while in hospital.
- DHMS will only pay for medically appropriate hospitalisation.
- DHMS will not always cover the full cost of healthcare professionals:
  - The accounts a member receives from healthcare professionals are separate from the hospital account. These may include specialist accounts and other related accounts, for example accounts from a surgeon, anaesthetist, pathologist or radiologist.
- Healthcare professionals are free to set their own rates:
  - If they charge the Discovery Health Rate, we will pay them directly.
  - If they charge more than the Discovery Health Rate, we will pay the member. The member will be able to see this on the claims statement we send to them. They will have to make sure they pay their healthcare professionals the full amount.
  - If the specialist has entered into a payment arrangement with Discovery Health, we will pay the specialist directly at the agreed rate.

Direct Payment Arrangements

DHMS implemented payment arrangements in an effort to reduce payment frustration for both our members and healthcare professionals. Participating doctors agree to charge a set rate, as determined by DHMS. This rate is based on what we believe is affordable to the scheme as well as an appropriate rate for healthcare professionals. Some of the payment arrangements include:

Classic Direct Payment Arrangement

Applies to the Executive and Classic plans. Participating specialists are paid according to the agreed rate per plan type and are not allowed to balance bill a member for in-hospital consultations. Balance billing is only allowed on the Classic plans for out-of-hospital consults.

Premier Rate Payment Arrangement

Applies to all DHMS plans, except KeyCare and is only available to medical specialists excluding radiologists, pathologists and nuclear medicine providers. The Premier Rate arrangement applies to consultation and procedure codes only. No balance billing is allowed. There are two payment arrangement options available under the Premier Rate:

- Premier Rate A
- Premier Rate B

If members do not go to a specialist who charges the Premier Rate or Classic Direct Rate, their choice of health plan will decide the rate we will pay for their related claims in hospital as follows:

Plan	Related accounts payment
Executive Plan	Up to 300% of the Discovery Health Rate
Classic plans	Up to 200% of the Discovery Health Rate
Essential and Coastal plans	Up to 100% of the Discovery Health Rate

Medical Saving Account (MSA)

The Medical Savings Accounts (MSA) covers the cost of day-to-day expenses such as visits to the general practitioner and dentist, as well as the cost of medicine. The Medical Schemes Act limits the amount that may be contributed to the Medical Savings Account to a maximum of 25% of the total medical scheme contribution. A member has access to the full amount immediately, like a loan, and each month the member pays the amount through the monthly contributions.

Day-to-day accounts are paid subject to the availability of funds in the MSA. What is not claimed from the MSA is carried over for use in the following year.

MSA allocation

- At the beginning of each year, the member receives a sum of money that is put into the MSA for immediate use (a percentage of their total contribution).
- The member pays this money back over the calendar year, through the monthly contributions.
- The calendar year runs from 01 January to 31 December.

Executive and Classic	Essential plans	Coastal plans
MSA fixed at 25%	MSA fixed at 15%	MSA fixed at 20%

Classic Comprehensive Zero MSA plan, Smart plans, Core plans and KeyCare plans do not have an MSA. DHMS pays for day-to-day medical expenses from the MSA subject to availability of funds. When the MSA is exhausted, the member becomes personally responsible for day-to-day expenses.

- Core Plans do not have an MSA and day-to-day expenses are the member's responsibility.
- KeyCare Plans do not have an MSA but the KeyCare Start and KeyCare Plus plans cover certain day-to-day medical expenses.
- The Smart Series do not have an MSA, however certain day-to-day medical expenses are covered.
- Executive, Comprehensive and Priority plans: When the MSA is exhausted, members may become personally responsible for their day-to-day expenses, if they have a Self-payment Gap. The Classic Comprehensive Zero MSA has no Medical Savings Account.
- Members must continue to submit their claims when they run out of money in their MSA so that these claims can accumulate towards the Annual Threshold.
- What is not claimed from the MSA is carried over for use in the following year.
- If the member joins partway through the year, the MSA will be pro-rated.
  Example:

John decides to join Discovery Health Medical Scheme on an Executive Plan.

We know that the Executive Plan contribution is calculated as follows:
R5 443 to the Risk contribution + R1 814 to the MSA portion = R7 257 total contribution

Should John join in January, he will receive R21 768 (R1 814 * 12 months) upfront as his MSA allocation.

Should he join in September, he will receive R1 814 * 4 = R7 256 as his MSA allocation for the year.

Discovery Health Medical Scheme pays interest on positive balances in Medical Savings Accounts.

Rate of reimbursement

Members on the Executive, Comprehensive, Priority and Saver plans have a choice of how their claims are reimbursed from the Medical Savings Account.

They need to make the choice between either:

- Discovery Health Rate
- Cost.

The Medical Savings Account pays out at the Discovery Health Rate, meaning:

- The healthcare professional will be paid at the agreed rate that DHMS has negotiated with them
- Claims are paid from the Medical Savings Account subject to the availability of funds

What does it mean if the Medical Savings Account pays out at Cost?

- Where the provider has billed more than the Discovery Health Rate and is not part of a Direct Payment Arrangement, we will pay the member
- It is important to note that claims for medicine will be paid up to a maximum of the Discovery Health Medication Rate (DHMR)
- Claims are paid from the Medical Savings Account subject to the availability of funds

What will happen if the healthcare professional charges a higher rate than the Discovery Health Rate?

If the healthcare professional charges a higher rate than the Discovery Health Rate, the member will be refunded for the claim at the Discovery Health Rate, and they are then required to pay the healthcare professional directly if they have not already done so. If the healthcare professional charges for the service at the Discovery Health Rate, DHMS will refund the provider directly.

Members are encouraged to select 'Discovery Health Rates' as their reimbursement option in order to minimise the Self-payment Gap.

Accrued balance

An accrued balance = contributions to the MSA minus claims paid from the MSA. The answer may be positive or negative.

Positive balance:

John contributes R500 per month towards the MSA. In March, he spends R1 400, and he has contributed a total of R1 500. John has therefore contributed R100 more than he has spent. John has a positive accrued balance of R100.

Negative balance:

John contributes R500 per month towards the MSA. In March, he spends R1 600 but he has contributed a total of R1 500. John has therefore spent R100 more than he has contributed. John has a negative accrued balance of R100.

Moving to a plan option that does not offer an MSA

- If the member moves to a plan type that does not offer a MSA, e.g. a Core Plan, and the member has an MSA carry-over or a positive accrued MSA balance, we are required to pay out the positive accrued MSA balance to the member four months after the plan change. This is because plan options that do not allow MSAs are also not allowed to 'house' carry-over balances. Valid day-to-day claims will still be paid from the remaining positive accrued MSA balance until such time as the MSA is paid out to the member and will be paid according to the rules of the Discovery Health Medical Scheme and according to the rules of the member's current plan type, irrespective of the date of the plan change or the date of service.
- If the member wants to move to a plan type that does not offer a Medical Savings Account and the member has a negative accrued MSA balance (the member has spent more from the MSA than what has been contributed), the member must pay off the negative accrued balance via the active member debt collection process.

If a member has an MSA pay-out due, this will be paid 4 months after the change has taken place. This is to allow for payment of late claims to be made. Members can confirm the MSA pay-out date with Client Services on 0860 99 88 77.

Self-payment Gap (SPG)

A Self-payment Gap (SPG) occurs when members on the Executive, Comprehensive and Priority plans run out of funds in the Medical Savings Account (MSA) before reaching the Annual Threshold.

During this period, the member is personally responsible for the payment of all day-to-day medical expenses until the Annual Threshold is reached.

Who will have a Self-payment Gap?

- Members who select the Executive, Comprehensive and Priority plans will have automatic SPGs. The value of the gap will differ from plan to plan and will further depend on the family profile.
- As the MSA is calculated at 15% or 25% of the total medical scheme contribution this will not meet or exceed the Annual Threshold, therefore creating an automatic SPG.

Reasons for the Self-payment Gap

There are several reasons why members may experience an SPG:

- The MSA values are less than the Annual Thresholds.
- When claims are paid from the MSA at Cost, only the applicable Discovery Health Rate is accumulated towards the Annual Threshold.

- When a member's MSA pays out at Cost, the member can exceed the annual limits. If the member exceeds the limit, the excess will not count towards the Annual Threshold.
- Having a previous year's claims paid from the current year's MSA because the claims do not add up to this year's Annual Threshold.
- Having over-the-counter medicine (possibly including schedule 0, 1 and 2 drugs, as well as life-style enhancing products) paid from the MSA, as these claims do not count towards the Annual Threshold.
- Applying for a special payment from the MSA that does not count towards the Annual Threshold.

Members can track their SPGs on their DHMS claims statements.
Members should still submit claims whilst in the Self-payment Gap so that DHMS can add the Discovery Health Rate of the claims towards the Annual Threshold.

Day-to-day Extender Benefit

When a member's annual MSA allocation has been spent, they get extra cover of essential healthcare services in the Discovery Network. Claims paid from the DEB do not accumulate to the Annual Threshold.

Consultations

The Day-to-day Extender Benefit covers video call consultations with a network GP, using our Discovery DrConnect platform, or pharmacy clinic consultations in our defined wellness network, supported virtually by a GP via video call. Members also have cover for face-to-face GP consultations with a network GP, when referred by either their DrConnect GP or the pharmacy clinic.

Unlimited consultations on the following plans:

• Executive plan
• Comprehensive plans except the Classic Smart Comprehensive plan
• Priority plans

Cover for consultations in our network pharmacy clinics or through DrConnect is unlimited on these plans. There is a defined number of Day-to-day Extender Benefit consultations on the Saver plans. Please refer to the table below for information specific to the Saver plans.

Number of consultations for Saver plans:

	Single member	**Family**
Classic and Coastal	3 consultations	6 consultations
Essential	2 consultations	4 consultations

Kid's casualty cover

Casualty visits for children under the age of 10-year-old at a network facility on the following plans:

- Executive Plan
- Classic Comprehensive Plan
- Classic Delta Comprehensive Plan
- Classic Priority Plan
- Classic Saver Plan
- Classic Delta Saver Plan.

Above Threshold Benefit (ATB)

All members on Executive, Comprehensive and Priority plans are given Annual Thresholds at the beginning of each year which vary according to the number of people that are on the plan. This ensures that the Annual Thresholds are reasonable.

When members' cumulative expenses equal the Annual Threshold amount, the member enters the Above Threshold Benefit. Once the member enters the Above Threshold Benefit, Discovery Health covers the cost of certain day-to-day medical expenses.

Advantages

- Once the member enters the Above Threshold Benefit, they have extended cover for their day-to-day claims (and related accounts incurred in hospital for Executive Plan members).
- Any excess funds that members have saved in the MSA will not be used when they enter the Above Threshold Benefit.

Limits and exclusions

- Certain claims, such as those for schedule 0, 1 or 2 medicines, are not paid for once members are in the Above Threshold Benefit.
- When the member enters the Above Threshold Benefit, their medical expenses are covered at the applicable Discovery Health Rates according to the plan type, subject to certain annual limits. Annual limits apply to claims paid from ATB and MSA.

Schedule 0, 1 and 2 medicines and special payments from the MSA do not accumulate to the Annual Threshold.
Certain medicine only accumulates up to a certain percentage.

Maternity Benefit

Discovery Health Medical Scheme members on all plans will have access to comprehensive maternity and post-birth benefits. Members will experience cover according to a defined maternity basket of care. Claims will be paid at the Discovery Health Rate.

Note: Benefits are subject to change and can vary according to the members chosen plan. Member do not automatically have access to the Maternity Benefit. They have to activate the Maternity Benefit to gain access to the comprehensive benefits.

Caring for mother and baby

Caring for mother and baby: Quality healthcare is critical during pregnancy. Prenatal care and screening benefit both mother and baby. For the average healthy pregnancy and birth, the estimated medical costs can be in excess of R120 000. Expectant parents should be able to depend on comprehensive health cover for complete peace of mind.

Raising a healthy child involves optimal health, nutritional and physical wellbeing and future education needs. Average medical costs for the first two years of a child's life, including GP and specialist visits can be as much as R80 000. In the unfortunate event that a child is admitted to neonatal ICE, ultra-high cost claims can be in excess of R4 million. Complete cover for the health of a young family should provide access to comprehensive healthcare, alongside access to vital clinical support and knowledge.

Members will have access to the following during their pregnancy:

- Antenatal consultations with the gynaecologist, GP or midwife
  - 12 consultations: Executive and Comprehensive plans
  - 8 consultations: Priority, Saver, Core and KeyCare plans
- Two ultrasound scans and one nuchal translucency or Non-Invasive Prenatal Test (NIPT): all plans
- A defined basket of blood tests per pregnancy: all plans
- Up to R2 220 per day in a private ward for delivery in-hospital: Executive and Comprehensive plans
- Essential registered devices e.g. breast pumps and smart thermometers up to R5 350 with a 25% co-payment: Executive and Comprehensive plans
- Up to five pre- or post-natal classes or consultations with a registered nurse: all plans.

Members will have access to the following (up to two years after childbirth): all plans:

- The baby is covered for up to two visits with GP, paediatrician or an ENT
- The mother will be covered for the following:
  - One six week post-birth consultation with a midwife, GP or gynaecologist
  - One nutrition assessment with a dietitian
  - Two mental health consultations with a counsellor or psychologist

- One lactation consultation with a registered nurse or lactation specialist.

Technical details

- The benefits do not affect a member's day-to-day Medical Savings Account benefits
- Healthcare services are covered through this benefit at the Discovery Health Rate
  - The **benefits depend on the selected plan of the member**
  - The benefits only apply after the benefits have been activated by the member
- Technical details related to maternity benefits prior to delivery:
  - The benefits can be activated either by
    - creating a pregnancy profile in the Discovery app; or
    - creating a pregnancy profile at www.discovery.co.za; or
    - preauthorising the delivery.
  - Members are able to preauthorise their delivery by calling the Discovery Health Medical Scheme call centre or via the maternity preauthorisation functionality on the Discovery website
  - Members that preauthorised their delivery during 2020 will have automatic access to the benefits from January 2021
  - The benefits do not cover healthcare services received prior to the activation of the benefit
- Technical details related to the post-birth benefits:
  - The baby has to be registered on the Scheme to activate the benefits
  - The benefits for babies born on Discovery Health Medical Scheme prior to January 2018 have to be activated through www.discovery.co.za

The new app called 'My Pregnancy and My Baby' will give members access to 24/7 clinical support, advice and guidance once a member has activated the benefits and created a pregnancy profile.

My Pregnancy dashboard

Track how far along you are in your pregnancy, upload a picture or scan and get a sense of how big your baby is each week. Using an easy to navigate menu, access an array of tools and features personalised for your pregnancy.

Pregnancy care checklist

A personalised step-by-step view of what to do for each week of your pregnancy, to help you make the best health and lifestyle choices for both you and your baby.

Pregnancy health record

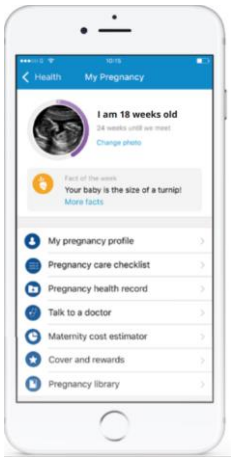
A comprehensive view of your personalised pregnancy-related health information in one place that you can share with your doctors.

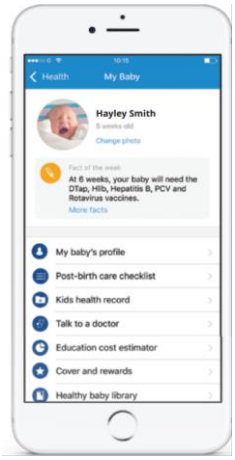
Connect with doctors

Get trusted medical advice, on your device from doctors anywhere, anytime.

Maternity cost estimator

Get an estimate for the typical healthcare costs associated with your pregnancy, based on your plan type, how your baby will be delivered and choice of doctor and hospital.





My Baby dashboard

Activate the My Baby programme. Create your baby's profile and save all their key birth information.

Digital health record

Get instant access to your child's medical record, with a view of their vaccinations, screenings, milestones and development. Opt in to schedule reminders for when you should book your child's preventative screenings and vaccinations.

Digital vaccination card

Keep track of your baby's vaccinations by receiving reminders and by having access to their updated immunisation card, which you can share when you need to.

Education cost estimator

Get an estimate of the total cost of education from pre-school to university.

DISCOVERY HEALTH MEDICAL SCHEME COVER ENHANCEMENTS AND MORE

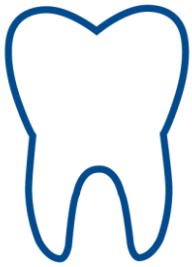
This section includes:

- How is it covered: dental benefits and optical benefits and savings
- How is it covered: scans and scopes
- Africa Benefit
- Allied, Therapeutic and Psychology health benefits
- External Medical Items Extender Benefit
- International Travel Benefit
- International Second Opinion services
- Netcells ® Biosciences
- Overseas Treatment Benefit
- Precision Medicine
- Specialised In-hospital Psychiatry Network
- Specialised Medicine and Technology Benefit
- Trauma Recovery Extender Benefit
- COVID-19 benefits
- Discovery Connected Care
- Discovery Prepaid Health
- Infertility and Assistive Reproductive Therapy Benefit

Dental benefits

Dentistry is the treatment of diseases, disorders or conditions and their impact on the human body, of the oral cavity, the maxillo-facial area and the adjacent and associated structures.

There are a few procedures that fall within dentistry and it is important to understand what the member is going for and under what circumstances. Included are:



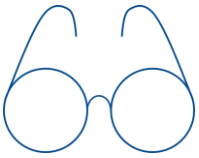
- General, day-to-day dentistry such as fillings and polishing
- Severe dental and oral surgery - dental work done during maxillo-facial surgery
- Orthognathic surgery (realignment of the jaw)
- Inserting dental appliances and orthodontics (braces)
- Whether or not the member is being sedated during a dental procedure
- Cover for dentistry is also dependent on the member's plan type

Limits are applicable to all plan types and in-hospital dentistry on the KeyCare Series is excluded, but certain maxillo-facial procedures will be covered. Please refer to the Discovery Health Medical Schemes plan range section to view the benefits and limits per plan type.

Optical benefits and savings

Optometry is a healthcare profession concerned with eyes and deals with vision, visual systems and the processing of visual information. Optometry is one of three eye care professions, the others being ophthalmology and orthoptics.

Limits are applicable to all plan types. Any treatment, product or healthcare service that remedies or corrects refractive errors of the eye, will accumulate to the optical limit. This includes:



- Spectacles/lenses and their frames
- Contact lenses
- Refractive eye treatments or surgery such as lasik surgery, laser keratotomy, excimer laser surgery and lens implants.

Consultations and investigations do not directly treat refractive errors of the eye and therefore, do not accumulate to the optical limit and will be paid from the member's day-to-day benefits. Please refer to the Discovery Health Medical Schemes plan range section to view the benefits and limits per plan type.

20% off all frames and lenses

Members can get 20% discount on frames and eyeglass lenses when they visit an optometrist in the Discovery Health Optometry Network.

MRI and CT scans

A CT scan is a radiographic technique that uses ionizing radiation to produce cross-sectional images of the body.

MRI is short for Magnetic Resonance Imaging and is a safe procedure that creates images of the human body without the use of x-rays.

The funding of MRI and CT scans depends on the following:

- Was the scan done in-hospital and related to a hospital admission?
- Was the scan done in-hospital and unrelated to a hospital admission?
- Was the scan done out-of-hospital?
- Was the scan related to conservative back or neck treatment?
- The member's plan type and the limits applicable.

Please refer to the Discovery Health Medical Schemes plan range section to view the benefits and limits per plan type.

Scopes

Endoscopies (also called scopes) are used to investigate certain medical and surgical conditions such as gastric ulcers, reflux and infections. Members can have a scope done in the doctor's rooms or the doctor may prefer to do it in hospital or at a day-case facility.

The cover of an endoscopy for a member depends on the type of scope the member is having, as well as the member's plan type. Please refer to Discovery Health Medical Scheme's plan range section to view the benefits and limits for each plan type. Preauthorisation is required!

The information here specifically relates to how we cover scopes of the digestive system. These are gastroscopies, sigmoidoscopies, colonoscopies and proctoscopies. Please note arthroscopies, hysteroscopies and laparoscopies are excluded.

Scopes done in-hospital

Where scopes are done in-hospital, a co-payment or deductible applies to the hospital account. These will be payable upfront to the hospital. We pay the balance of the hospital account and all the other approved accounts that are related to the procedure from the Hospital Benefit.

We do not apply a co-payment or deductible for scopes done in-hospital that are done together with a defined list of procedures.

When a gastroscopy and a colonoscopy is performed together, a higher deductible per admission will apply.

On all KeyCare plans, scopes are funded for children under 12 years, if related to a surgical procedure or if a PMB. For adults, if the scope is a PMB it will be funded according to PMB guidelines.

Scopes done in the doctor's rooms

No co-payment applies for scopes done in the doctor's rooms. We pay the cost of the scope from your Hospital Benefit up to the Discovery Health Rate.

Africa Benefit

This benefit covers members working and/or living in certain African countries.

An increasing number of employers are sending employees on assignments to other African countries. As a result, the demand for medical emergency evacuation benefits is growing. The Africa Benefit fulfils this need. The Africa Benefit is available on all DHMS plans except Keycare plans. Members do not have to register to gain access to the benefit.

Included in the Africa Benefit is cover for members and their dependants:

- for the usual, reasonable costs of medical emergency treatment, which must be from a qualified healthcare professional
- for emergency transport and evacuation to an appropriate facility in South Africa
- to enable them or their dependant to stabilise for the return to South Africa. If they are capable of being repatriated and elect not to return to South Africa, they will be responsible for all expenses incurred after the decision to repatriate.

When travelling to a country covered under the Africa Benefit, certain healthcare services in the first 90 days after a member's departure from South Africa will be covered according to the International Travel Benefit.

African countries that are covered:

Angola	Equatorial Guinea	Republic of Congo
Benin	Gabon	Reunion
Botswana	Ghana	Rwanda
Burundi	Kenya	Seychelles
Cameroon	Lesotho	Somalia
Central African Republic	Madagascar	Swaziland
Comoros	Malawi	Tanzania
Democratic Republic of Congo	Mauritius	Togo
Djibouti	Mozambique	Uganda
Eritrea	Namibia	Zambia
Ethiopia	Nigeria	Zimbabwe

Medical emergency evacuation

- If members need a medical emergency evacuation, they have to call ER24 on +27 11 529 6900. Once they have given the go-ahead for the evacuation after verification, they will also arrange it.
- Members will be evacuated to South Africa, where they will receive medical treatment. Healthcare services given in South Africa are covered according to the chosen health plan and the Scheme rules.
- The minimum requirements for evacuation are as follows:
  - There must be an airport or runway in good enough condition for aircraft accessibility
  - There should be no security risks in accessing the destination at the time of evacuation
  - There should be no Civil Aviation Authority restrictions in respect of airspace
- Medical claims incurred in the African country where members live, immediately before and relating to the emergency evacuation, are also covered by the Scheme. Payment will be according to what would have been paid locally in South Africa, based on past claims experience, according to the chosen health plan type.
- We will only cover the return transport to the African country where the member lives, if they need a medical escort.
- The Africa Benefit only covers evacuations due to medical emergencies. For elective or planned treatments, members can still contact ER24 for help and members will be responsible for paying all costs related to the evacuation.

Out of hospital, non-emergency or elective treatment

The Africa Benefit covers non-emergency or elective treatment if the following conditions are met:

- The treatment must be readily available in South Africa
- The treatment must be covered in terms of the Scheme rules

If the treatment meets these criteria, the member will need to pay for these medical expenses upfront. They can then submit the claims to us. We will reimburse claims into their South African bank account. We will cover healthcare services related to the treatment, according to the South African benchmark equivalent. This is known as a global fee. This cover only applies to healthcare services received in the covered African countries.

Global fee

A global fee is a single amount that we calculate based on the average claims experience on a member's specific plan. Clinical protocols apply. We only pay medically appropriate claims. The cover is subject to the rules of the Scheme, funding guidelines and clinical policies.

Procedure for submitting claims

Members can send claims to Discovery Health by post to PO Box 784262, Sandton 2146 or fax to 0860 329 252. Alternatively, claims may be scanned and emailed to claims@discovery.co.za.

Members must include:

- A detailed, original account from the healthcare provider
- The International Travel Benefit (ITB) claim form, completed in full and including proof of payment for all attached claims.

Members must send claims to us within four months of the date of service and remember to keep copies for their records. They must mark their claims as "International claim" and put their membership number on each page.

Allied, Therapeutic and Psychology health benefits

The Allied, Therapeutic and Psychology Benefit covers out-of-hospital allied, therapeutic and psychology healthcare services up to an annual limit on Executive, Comprehensive and Priority plans.

The limit depends on the family size as well as the plan type. Please refer to the Discovery Health Medical Schemes plan range section to view the benefits and limits per plan type.

We pay out-of-hospital allied, therapeutic and psychology healthcare services from the Medical Savings Account. When the money in the Medical Savings Account is used up and the member has reached their Annual Threshold, they have cover from their Above Threshold Benefit. The Classic Smart Comprehensive Plan does not have a Medical Savings Account and so there is no benefit for day-to-day medical expenses until they reach the Annual Threshold. After this, we pay claims from the Above Threshold Benefit. The benefit is automatic and funds like other day-to-day benefits.

Cover from the Allied, Therapeutic and Psychology Benefit includes services from the following healthcare professionals:

- Acousticians
- Art therapists
- Biokineticists
- Chiropractors
- Counsellors
- Dietitians
- Homeopaths
- Occupational therapists
- Physiotherapists
- Podiatrists
- Psychologists (clinical, counselling and educational)
- Psychometrists
- Registered nurses
- Social workers
- Speech-language therapists and audiologists

Allied, Therapeutic and Psychology Extender Benefit

The Allied, Therapeutic and Psychology Extender Benefit is available on the Executive and Comprehensive plans only.

It gives members with severe, complex conditions, who need short-or-long-term care from allied, therapeutic and psychology healthcare professionals, access to clinically appropriate care.

Members can apply for the benefit before depleting the day-to-day Allied, Therapeutic and Psychology family limit.

Access will be given for the appropriate period (limited or ongoing) based on the member's condition and the set criteria for it.

The benefit provides unlimited cover for a defined list of healthcare professionals.

Members can complete the application form at any time. The application form is available online on www.discovery.co.za. The completed application form should be sent to:

- Email: Clinicalhelp@discovery.co.za
- Fax: 011 539 7012
- Post: Discovery Health, PO Box 784262, Sandton, 2146.

External Medical Items Benefit

An external medical item (EMI) acts as a substitute or assists parts of the body that are missing or non-functional. Use of these items is usually recommended by a variety of medical professionals such as medical doctors, physiotherapists, occupational therapist, prosthesis and orthotists as well as other allied healthcare professionals.

We will consider payment of these devices, if they are medically required and if the provider who supplies the device, is appropriately registered with the Board of Healthcare Funders (BHF).

We cover all external medical items (EMIs) from the member’s available Medical Savings Account (MSA), Above Threshold Benefit (ATB), or limited ATB on the Priority Series. This is also subject to the member's annual EMI limit and certain items have a frequency limit. Please refer to the Discovery Health Medical Schemes plan range section to view the benefits and limits per plan type.

External Medical Items Extender Benefit

The External Medical Items (EMI) Extender Benefit is only available on the Executive and Comprehensive plans and provides members with specific severe and complex medical conditions,

extended cover for clinically appropriate and cost effective External Medical Items, as determined by the Scheme.

The External Medical Items (EMI) Extender Benefit can only be accessed after the annual External Medical items (EMI) Benefit has been depleted. Funding through this benefit is from the Above Threshold Benefit, with no rand value limit. However, the application process must be followed for all external medical items that are required.

International Travel Benefit

The International Travel Benefit offers emergency medical cover for members travelling outside the borders of the Republic of South Africa (RSA). It is available on the Executive Plan, Comprehensive, Priority, Saver, Core and Smart Series, and is not available to members who are on the KeyCare Series.

Medical emergency cover is limited to US $1 million for each person for each journey for members on the Executive Plan and R5 million for each person for each journey for members on Classic, Essential and Coastal plans.

International emergency number: +27 11 529 6900

Advantages of the International Travel Benefit

- The member is guaranteed "peace of mind" in the event of any medical emergency whilst travelling outside the borders of Republic South Africa. All approved evacuations and medically appropriate repatriation costs are covered.
- Members don't need to worry about paying doctors directly. To cover the cost of approved accounts incurred in hospital or day-to-day claims in excess of US $150 or €100 per journey, members can call ER24 for approval on +2711 529 6900.
- If their claims meet the criteria for payment, ER24 will provide them with authorisation and will liaise with their health professional overseas to ensure they're paid directly. However, if members prefer to pay their day-to-day emergency medical claims upfront and claim back from Discovery on their return to South Africa, they can do that.

Benefits

Medical evacuation: In the event of a medical emergency, ER24 will arrange for emergency medical transportation by road and/or air ambulance (under appropriate medical supervision) to the nearest medical facility capable of providing adequate care.

Approved medical costs: Discovery Health will cover the member's in-hospital or day-to-day medical costs in an international country. The costs must be as the result of an emergency and must be approved by ER24. These costs are only covered if the member is unable to be repatriated to South Africa. If the member elects to stay in the international country even though they are medically fit to be medically repatriated, all costs from the date and time of refusal will cease.

Where the cost of the member's day-to-day claims exceeds US$150 or €100 per journey and these meet the criteria for payment, ER24 will provide the member with authorisation and will liaise with their health professional overseas to ensure they are paid directly. However, the member may also pay for their day-to-day emergency medical claims upfront and claim back from Discovery on their return to South Africa. For this, the member must complete an international claims form and submit that to us together with their claims and proof of payment per invoice and proof of travel.

Medical repatriation: If the member is hospitalised outside of the Republic of South Africa (RSA), ER24 will arrange for the repatriation to their hometown providing that a medical escort is required.

Escorted return of minors: The International Travel Benefit does not cover the escorted return of minor children, should they be stranded as a result of an emergency or accident.

In-hospital medical monitoring: ER24 will monitor the member's medical condition if they are hospitalised internationally and will authorise payment. The member's family and Discovery Health will be updated regularly on their condition.

Hospital benefits

The hospital cover is limited to 90 days from the date of departure from the Republic of South Africa (RSA), irrespective of the journey's duration. Once the member reaches the 90-day limit, Discovery is not liable to cover any medical costs or travel costs to return to South Africa for treatment.

Day-to-day benefits

The member will be liable for the first US$150 or €100 of the out-of-hospital emergency medical claim, and Discovery Health will cover the balance of the out-of-hospital claim in full. The member's Medical Savings Accounts (MSA) will not be affected in any way. The International Travel Benefit will cover emergency treatment to teeth in certain circumstances.

Members can send the claim details to us:

- A detailed, original account from the healthcare provider
- The International Travel Benefit (ITB) claim form, completed in full and including:
  - Proof of travel dates in the form of air ticket stubs or passport stamps
  - Proof of payment for all attached claims.

Members must remember to keep copies for their own records.

Elective or non-emergency claims and claims outside of the 90-day travel period

Elective treatment and treatment received outside of the 90-day period is excluded. However, the member's Discovery Health plan will cover this treatment as long as the treatment is readily available and normally covered in South Africa. All Scheme rules and limits apply per plan type.

Members will need to pay these medical expenses upfront and submit the claims to Discovery Health. Discovery Health will reimburse claims into a South African bank account at the South African benchmarked equivalent based on the claims experience of the member's plan type.

International Second Opinion services

We are offering members the opportunity to obtain an online second opinion from a Cleveland Clinic physician specialist. This service is available to members on any DHMS plan.

This service enables a member to ask their specialist to assist them in obtaining a second opinion for a condition and for conditions that affect the quality of their life. We have collaborated with Cleveland Clinic, an international non-profit, multi-speciality academic and medical centre in the United States, which is recognised worldwide as a leader in healthcare.

It also offers specialists the option to collaborate with other experts in a certain field of medicine, especially when their patients are facing life-threatening and life-changing conditions, particularly when this involves the use of new treatment modalities.

Cleveland Clinic MyConsult® offers online medical second opinions for more than 1 200 diagnoses. These diagnoses include conditions that affect a person’s quality of life, or life-threatening conditions, including inborn errors of metabolism and unusual conditions in children.

How to access the second opinion service

The treating doctor must request an online second opinion from a Cleveland Clinic’s physician specialist on the member’s behalf by emailing Cleveland@discovery.co.za, faxing 011 539 7460 or through the partner website.

Members need to pay Discovery Health Medical Scheme within 10 days for the second opinion process to start and send proof of payment. The cost for an online second opinion from Cleveland Clinic is $565. If a pathology review is required to complete the consultation, there will be an additional charge of $180.

As soon as we receive the final medical report from Cleveland Clinic, Discovery Health Medical Scheme will reimburse the member 50% of the amount paid for all DHMS plan members except Executive Plan members. This amount does not affect a member’s benefits as the Scheme pays this amount.

> Through a specialist, Executive Plan members have access to second opinion services from Cleveland Clinic for life-threatening and life-changing conditions and we will cover 100% of the cost of the second opinion service.

Members must send signed consent forms when they send the proof of payment. Both Discovery Health Medical Scheme and Cleveland Clinic require consent forms to be completed. The case manager will send the member the consent forms, Cleveland Clinic terms and conditions and a cover letter that will assist them when completing the form.

We will send the case details to a Cleveland Clinic MyConsult® physician specialist. The expert specialist at Cleveland Clinic will review the case and provide Discovery Health's case manager with a detailed second opinion report including treatment recommendations. Our case manager will give the report to the member's doctor who will share the report and discuss the Cleveland Clinic physician's recommendations with the member.

Netcells ® Biosciences

In a unique offering, we have been able to arrange an exclusive offer for medical scheme members with Next Biosciences – Africa's leading Biotech Company that combines medicine, science and technology to create innovative products and services, enabling you to invest in your future health.

Netcells, Next Biosciences' umbilical cord stem cell banking service, gives expectant parents the opportunity to collect their newly born baby's umbilical cord blood and tissue stem cells and cryogenically store them for potential future medical use.

Benefit for members

Members of selected schemes administered by Discovery Health can get up to 25% off the stem cell banking fee when they register to store their baby's stem cells with Netcells.

The discount applies to the Netcells banking fee and the amount depends on the payment plan you choose:

- 25% discount on payment upon registration,
- 20% discount on payment on stem cells being successfully banked or
- 15% discount on payment on a payment plan

Netcells offers flexible storage options and flexible interest-free payment plans allowing you to tailor-make a plan to suit your needs.

It is advisable for members to register with Netcells at about 30 weeks of pregnancy.

Once the registration and confirmation of initial payment is received, an arrangement will be made to get a Netcells collection kit to the member. The member must take the collection kit box to the birth of the baby so that the obstetrician or midwife can collect the stem cells after the baby has been delivered.

For more information about umbilical cord stem cell banking, please contact Netcells:

- Telephone: 011 697 2900
- Email: info@nextbio.co.za
- Website: www.nextbio.co.za/netcells

Infertility and Assistive Reproductive Therapy Benefit

To support families affected by infertility Discovery Health Medical Scheme (DHMS) is offering members access to the Infertility and Assistive Reproductive Therapy Benefit.

The benefit covers for the following Assisted Reproductive Technologies (ART):

- In vitro fertilisation (IVF)
- Intra-uterine insemination (UIU)
- Frozen embryo transfer (FET) and
- Intracytoplasmic sperm injection (ICS).

This benefit is only available to female members, between the ages of 25-42 years-old on an Executive or Comprehensive plan.

These members have cover for up to two annual cycles of ART subject to the Scheme's benefit and clinical entry criteria.

- Cover includes a defined basket of care which includes cover for:
- Consultations
- Ultrasounds
- Oocyte retrieval
- Embryo transfers
- Admission costs including lab fees
- Medication
- Embryo and sperm storage.

Discovery Health Medical Scheme will pay up to a limit of R110 000 per person per year at the Discovery Health Rate. Members are liable for a 25% co-payment for the costs of the treatment, as well as any excess amounts above the Discovery Health Rate.

The benefit will be accessible at the Southern African Society of Reproductive Medicine and Gynaecological Endoscopy (SASREG) accredited centres only. This is subject to clinical pathways and protocols. SASREG is therefore the Designated Service Provider for this treatment.

Overseas Treatment Benefit

The Overseas Treatment Benefit is included in the Specialised Medicine and Technology Benefit and covers evidence-based treatment that is not available in South Africa. A registered healthcare professional must provide the treatment.

The Overseas Treatment Benefit is available to members on Executive and Comprehensive plans.

Executive Plan members have a limit of R750 000 per person per year.
There is more: Executive Plan members also have additional cover for R300 000 at a registered healthcare provider for in-hospital treatment that is available in South Africa.
Comprehensive Series members have a limit of R500 00 per person per year.

A co-payment of 20% applies. Members will need to pay the medical provider and claim back from us when they return to South Africa.
Discovery pays or guarantees upfront payment of 80% for a member's approved claim to the provider.

Cover includes pathology testing or analysis that cannot be done in South Africa where the pathology samples are couriered overseas for testing.

The member must always call us to confirm their benefits before they receive treatment overseas. If the member is an Executive or Comprehensive Plan (including the Delta Comprehensive network options) we will send the member a benefit application form, which they need to complete.

We will review the details on this form to determine whether their treatment qualifies for cover from the Overseas Treatment Benefit. We may ask the member for more information before we can confirm their cover from the Overseas Treatment Benefit.

Communication will be sent to the member and ER24 to confirm the payment process. ER24 will guarantee payment of 80% of the cost up to a limit of R500 000 and the member will be liable for the balance of the account, ER24 will then communicate the payment with the member and provider.

When they return to South Africa, they need to send us:

- Clear, legible claims (detailed, original accounts from the healthcare providers)
- Proof of payment
- A completed claim form
- Proof of travel (e.g. airplane tickets and exit and entry visas)
- The member must keep copies of everything for their own records
- If possible, the member must scan the claim form and other documents and email it to overseasbenefit@discovery.co.za. Alternatively, they can fax it to 011 539 2421 or post the required documents to us. If the member posts their claims, they should write "Overseas Treatment Benefit" on their claims

Precision Medicine

Discovery Health Medical Scheme (DHMS) members have the opportunity to access advanced genetic testing services, one of the most exciting developments in modern medicine - the study of DNA. Not available on Smart, Core and KeyCare plans.

Newborn screening

Newborn screening detects genetic, metabolic and endocrine disorders in babies. This test involves a heel-prick usually performed between 48 to 72 hours after birth. A paediatrician will refer the member for this test. We will pay for newborn screening from available funds in the Medical Savings Account (MSA) up to 100% of the Discovery Health Rate.

Non-invasive prenatal testing

For women with an intermediate or high-risk pregnancy, the non-invasive prenatal test (NIPT) is a simple blood test that screens the DNA of an unborn baby, found in the mothers' blood, to detect certain chromosomal conditions in pregnancy, such as Down syndrome.

This test involves taking blood from the pregnant woman, from 10 weeks into a women's pregnancy. A gynaecologist will refer the member for this test.

We pay for non-invasive prenatal screening from available funds in the Medical Savings Account (MSA) and Annual Threshold Benefit (ATB) up to 100% of the Discovery Health Rate. The test may be performed by any registered pathologist or medical technologist, the member will be responsible for the difference between what is charged and what the Scheme covers.

The fee charged by the Schemes preferred provider, Genesis Genetics, a Next Biosciences company, is covered in full by the scheme.

Specialised Medicine and Technology Benefit

The Specialised Medicine and Technology Benefit is only available on the Executive Plan and Comprehensive Series.

Over the past decade the emergence of new medical treatments and technologies has increased exponentially. In 2006, Discovery Health Medical Scheme took the lead in the South African market by providing defined funding for high-cost medicines through the Specialty Medication Benefit. Since then the benefit has been broadened to cater for new medical technologies and procedures.

Members must meet the clinical entry criteria to gain access to the benefit.

Members have cover of up to R200 000 per person per year, with a co-payment of up to a maximum of 20% which will be the member's responsibility.

Treatment	Indication	Co-payment
Revellex®	Rheumatoid arthritis Crohn's disease Ulcerative colitis	0%
Revellex®	Ankylosing spondylitis Psoriatic arthritis	20%
MabThera®	Rheumatoid arthritis	0%
Enbrel®	Rheumatoid arthritis	0%
Enbrel®	Ankylosing spondylitis Psoriatic arthritis	20%
Humira®	Rheumatoid arthritis Crohn's disease (maintenance treatment) Ulcerative colitis	0%
Humira®	Ankylosing spondylitis Psoriatic arthritis	20%
Actemra®	Rheumatoid arthritis	0%
Simponi®	Rheumatoid arthritis	0%
Simponi®	Ankylosing spondylitis Psoriatic arthritis	20%
Orencia®	Rheumatoid arthritis	0%
Sensipar®	Chronic renal disease	0%
TOBI®	Cystic fibrosis	20%
Bariatric surgery	Obesity	20%
Balloon sinuplasty	Chronic sinusitis	20%
Pradaxa®	Atrial fibrillation	20%
Victoza®	Diabetes type 2	20%
Tysabri	Multiple sclerosis	20%
Xarelto	Atrial fibrillation	20%
Fosrenol	Chronic renal failure	20%
Ozurdex®	Macular oedema following retinal vein occlusion	20%
Forteo®	Osteoporosis	20%
Pegasys®	Hepatitis C	20%
PegIntron®	Hepatitis C	20%
HALO oesophageal ablation system	Barrett's oesophagus with high grade dysplasia	0%

No co-payment applies to medicine for the treatment related to Rheumatoid Arthritis, Crohn's disease or Ulcerative Colitis. From 1 January 2020, as a result of favourable price negotiations for certain medicine the Scheme will be introducing reference pricing on medicine related to the treatment of Rheumatoid Arthritis, Crohn's disease and Ulcerative Colitis. Where the full cover option medicine is not selected, the Scheme will fund up to the monthly reference price of the full cover medicine.

Members have to complete a Chronic Illness Benefit application form (for conditions covered on the Chronic Illness Benefit), or call the DiscoveryCare hospital preauthorisation team and meet the clinical entry requirements to gain access to cover from the Specialised Medicine and Technology Benefit.

Trauma Recovery Extender Benefit

Certain traumatic events can result in extremely high costs after members leave the hospital.

The Trauma Recovery Extender Benefit (TREB) covers certain out-of-hospital costs related to the member's registered condition that would previously have been funded from the member's Medical Savings Account (MSA) or their own pocket. Certain out-of-hospital claims related to the member's registered condition will be paid from this benefit without affecting the MSA and cumulative expenses for the calendar year.

The Trauma Recovery Extender Benefit is unlimited and is available on all Discovery Health Medical Scheme plans, except the Classic Comprehensive Zero MSA, Essential Smart Plan, Core Series and KeyCare Core plan. However, certain sub-limits, some of which are prorated to the date of entry, are applicable.

The same healthcare services that are usually limited in the day-to-day benefit on the Executive Plan, Comprehensive and Priority Series will be limited under the Trauma Recovery Extender Benefit. The Saver Series, KeyCare Plus and KeyCare Start plans do not have day-to-day benefit limits. Therefore, sub-limits have been developed on these plans specifically for the Trauma Recovery Extender Benefit. These limits are the same as on the Essential Priority plan. Members must meet the clinical entry criteria to qualify for the benefit.

Members qualifying for the benefit will have automatic access to this benefit if they meet the criteria. It will be applicable within the same benefit year related to the member's registered condition and one year thereafter. The benefit will be activated after the member has been admitted to hospital for a related event and the event has been appropriately reviewed and approved by an appointed case manager.

TREB Rules

- Members have to be a member of DHMS at the time that the trauma happens to qualify for TREB cover.

- TREB covers day-to-day healthcare costs related to the trauma in the year the trauma occurred and in the year following the trauma, as long as the member is still on a plan type that offers this benefit.
- Members will not qualify for TREB if the traumatic event happened in a previous benefit year while they were on a plan type that did not offer this benefit or while they were a member of another medical scheme.
- The benefit covers only the claims for the member who is registered for the benefit and claims that are related to the original diagnosis after the specific trauma.

COVID-19 benefits

In response to the COVID-19 pandemic that first broke in South Africa in March 2020, DHMS launched a range of benefits to assist members to understand and manage their health risk during COVID-19.

World Health Organization (WHO) Outbreak Benefit

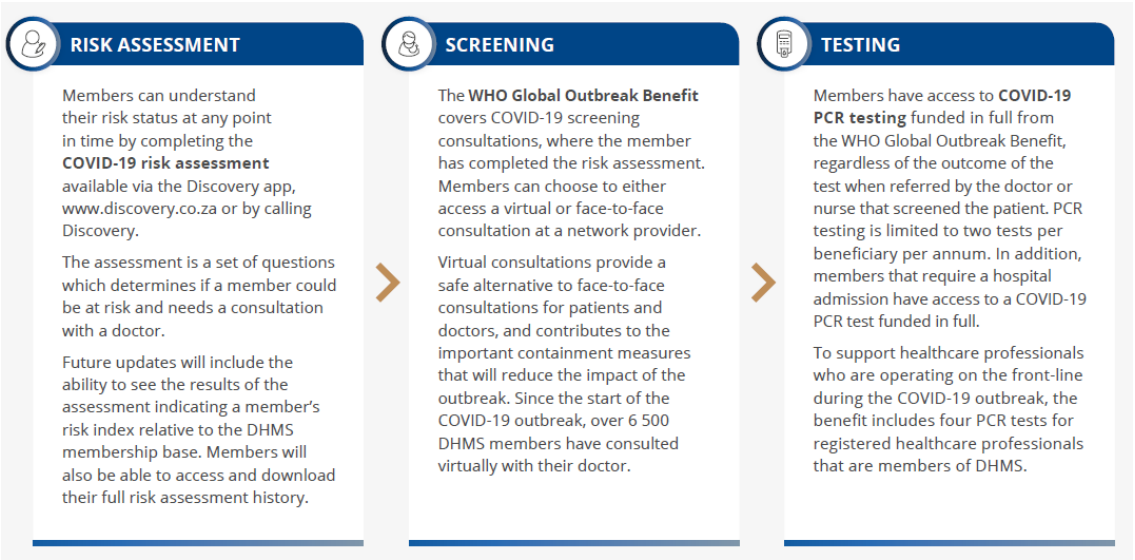
The WHO Global Outbreak Benefit is available to all members of DHMS during a declared outbreak period.

This benefit ensures members have access to screening consultations, testing, and management and appropriate supportive treatment as long as they meet the Scheme's Benefit entry criteria.

The WHO Global Outbreak Benefit provides cover for healthcare services related to any outbreak disease as well as a defined basket of care for out-of-hospital healthcare services related to COVID-19.

During the COVID-19 pandemic, members have access to a defined basket of care for:

- Screening consultations with a network GP (either virtual consultations, telephone or face-to-face)
- COVID-19 PCR screening tests if referred by a network GP following completion of the Discovery risk assessment
- A defined basket of pathology for COVID-19 positive members
- A defined basket of x-rays and scans for COVID-19 positive members
- Supportive treatment, including medicine and a home monitoring device to track oxygen saturation levels for at risk members who meet the clinical entry criteria
- Accommodation in accredited isolation facilities.



Financial support

Discovery Health and DHMS have developed a comprehensive combined response to the COVID-19 outbreak, drawing on the resources, capacity and assets of both entities to assist members, employers and healthcare professionals. The following concessions have been designed to assist in addressing the impact of the economic downturn on members and employers during the COVID-19 outbreak:

- Funding medical scheme contributions from Medical Savings Account (MSA).
- Contribution concession for Small and Medium Enterprises (SME) businesses with employees on the medical scheme.
- Premium concession for SME businesses with employees covered by health insurance products.

Members with a positive MSA balances

Members are able to use their positive MSA balance to pay for their medical scheme contributions, for up to three months. A positive MSA balance refers to the accrued amount and not the upfront amount members are allocated at the start of each year. Members must have a positive MSA balance equivalent to at least one month's medical scheme contribution, to qualify for this offer.

Medical scheme contributions for SME businesses

Qualifying SME businesses are able to apply for a concession to defer up to two months of medical scheme contributions of their employees, which will need to be repaid over a 12-month period. No interest will be charged on the deferred contributions.

Interested SME businesses need to meet the below criteria:

- Proactively request a contribution concession
- Employ between 10 and 200 employees
- Be an employer on DHMS in good standing

Online doctor consultations available to all South Africans

Discovery and Vodacom have partnered to deliver a free virtual healthcare platform for all South Africans during the COVID-19 pandemic. The two companies have jointly created a COVID-19 Healthcare Fund to pay for the first 100 000 consultations.

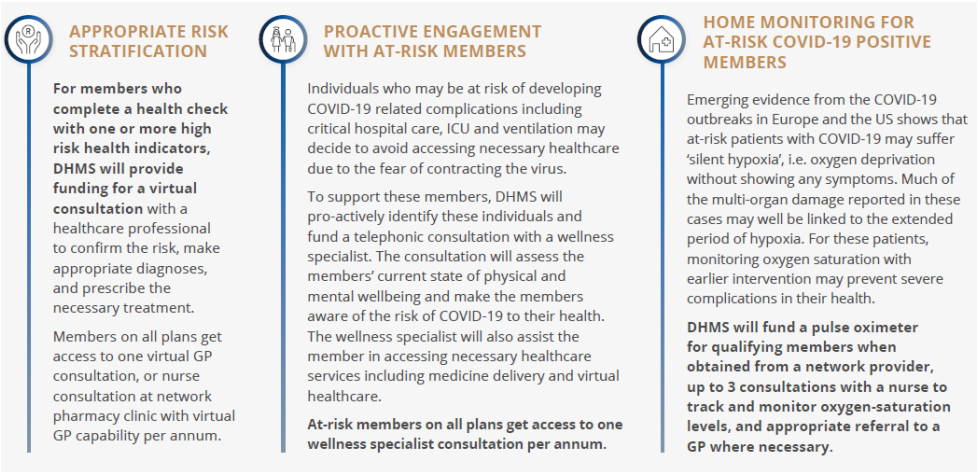
Isolation hotels

Discovery Health has partnered with reputable hotels, such as the Capital Hotels, to create specifically managed isolation hotels, where members positively diagnosed or awaiting test results for COVID-19, are able to safely self-isolate away from their families. Daily rates start at R950 per person per night, reflecting the Scheme's negotiated rate reduction of approximately 60%, and include:

- Three meals
- Cleaning services
- Nursing assistance

Virtual consultations and medicine are funded form the member's day-to-day benefits.

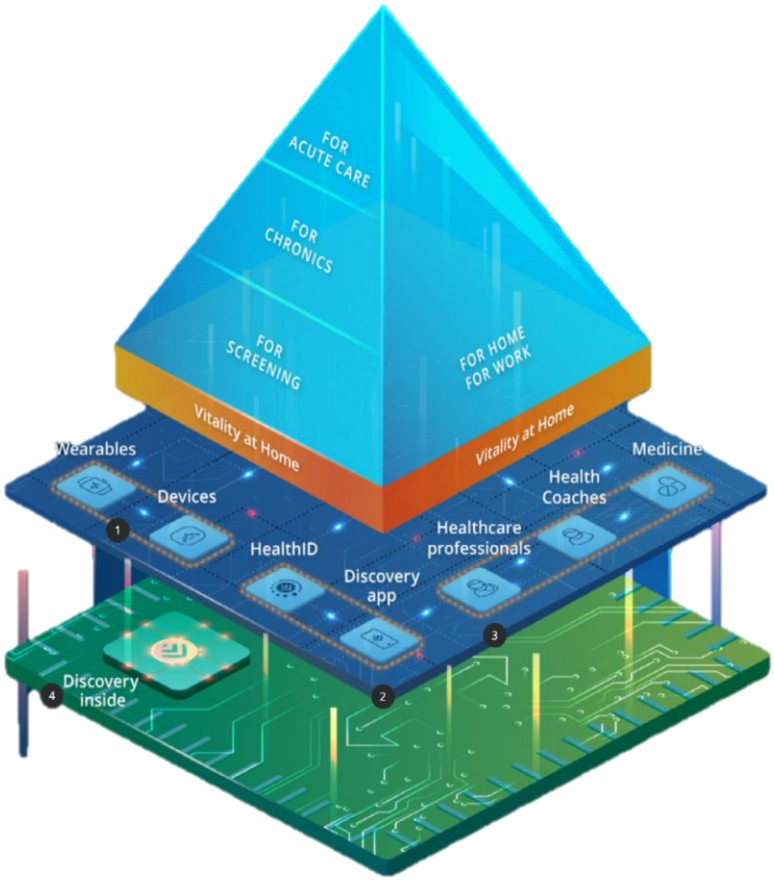
Support for members who are at risk of developing COVID-19 complications



Discovery Health has developed a comprehensive set of COVID-19 support services to assist employers and their management teams in formulating and executing an effective response to COVID-19 as their employees return to work, given the importance of protecting their employees, and ensuring the continuity of their operations. These services include:

- COVID-19 resource hub and 24/7 hotline
- Identification and management of at-risk employees
- COVID-19 employee screening and health checks
- COVID-19 case management
- COVID-19 contact tracing in the workplace.

Discovery Connected Care



Over the past few years, Discovery Health has invested extensively in the creation of a digital healthcare ecosystem. This includes the adoption and funding of digital healthcare technology, digital tools for members and doctors, integration with health monitoring devices and sophisticated data analytics.

In 2020, the world as we knew it changed drastically. The COVID-19 pandemic has highlighted the importance of this digital health ecosystem, and allowed Discovery Health to offer members virtual consultations with doctors, remote monitoring of COVID-19 symptoms to manage early interventions, and risk segmentation of employees for management of return-to-work plans by businesses.

The increased adoption of digital healthcare, accelerated by COVID-19, has also highlighted the patient's home as an important and relevant setting for healthcare.

Discovery Connected Care for members at home

Through Discovery Connected Care for members at home, members are able to book a remotely-guided consultation with a doctor by connecting the TytoHome device to their virtual consultation.

The device sends the doctor a live feed of clinical-grade images and sounds during a virtual consultation, so that the doctor can accurately diagnose and prescribe treatment. Members are then able to get their medicine e-scripted, ordered and delivered to their homes.

The TytoHome kit includes:

- TytoHome device with an exam camera and Thermometer
- Otoscope
- Stethoscope
- Tongue Depressor

Device features:

With the TytoHome device, a healthcare provider can examine a patient's heart, lungs, throat, ears, skin, abdomen, heart rate, and body temperature, and diagnose and treat many of the most common conditions, such as but not limited to the examples listed below:

• Ear infections	• Sinus pain
• Colds and flu	• Allergies
• Fever	• Sore throat
• Headaches	• Coughs and upper respiratory issues
• Eye irritation	• Bug bites and rashes
• Congestion	• Constipation and stomach aches
• Pink eye	• Nausea
• Asthma	• Bronchitis
• Common skin conditions	

The Connected Care platform enables a digital end-to-end healthcare journey, this enable members to:

Connect with a nationwide network of doctors in the Connected Care GP Network, available 24/7

Members get trusted medical advice and an accurate clinical diagnosis from a nationwide network of experienced healthcare providers who are trained in and equipped to facilitate Tyto-enabled virtual consults. Members are able to locate a doctor in the Connected Care GP Network through the Connected Care app.

Receive an accurate diagnosis

The Tyto-enabled doctor can view a patient's metrics in real-time as the device sends a live feed of clinical grade images and sounds to the doctor who can then provide a more accurate diagnosis. A doctor will be able to examine the member's heart, lungs, throat, ears, skin, abdomen, heart rate and body temperature.

Automatic updates to Electronic Health Record

Members are able to view their key heath measures and full medical history, which is updated in real-time with outcomes from the consultation. Members receive a post-consultation information dashboard including their updated Electronic Health Record, e-script, treatments plan, sick note and relevant referral appointments.

View electronic scripts and get medicine delivered

Enabled by Discovery Connected Care and our on-demand delivery partner Zulzi, members are able to get their medicine e-scripted, ordered and delivered to their homes. Members are also able to track their medicine delivery from pharmacy-to-door in real time

TytoCare is partially funded by the Scheme for eligible DHMS members:

Qualifying members:

Qualifying members include members on all plans (excluding Core and KeyCare plans) who:

- Have activated their maternity and early childhood benefits through the My Baby Programmes, up until the youngest child on the plan turns six years' old.
- Are confirmed Covid-19 positive members who are classified as being at risk

Qualifying members will have risk-based cover up to 75% of the Discovery Health Rate (DHR) for the cost of the device and the first year's annual user fee. The member will be responsible for the balance of 25% as a deductible.

Subsequent annual fees will be covered, for qualifying members, from Risk in full at 100% of the DHR for the TytoHome annual user fee.

Non-qualifying members:

- DHMS members can purchase the TytoHome kit from available day-to-day benefits (MSA and/or ATB), with accumulation to the External Medical Items limit, where applicable. Subsequent annual user fees will be covered from MSA/ATB in full at 100% of the DHR for the TytoHome annual user fee

- Claims will be paid at 100% of the DHR from the MSA and will accumulate to and pay from the ATB at 75% of the DHR

A frequency limit applies. Only one kit per policy can be claimed every five years.

Price of the TytoHome kit

DHMS members and other Discovery clients have exclusive access to a discounted Discovery price:

- DHMS members and Discovery clients qualify for the Discovery price, which is 20% less than the recommended retail price.
- Non-Discovery clients will pay the recommended retail price.

The price of the TytoHome kit includes the first annual user fee:

	Price for the TytoHome kit (inclusive of VAT)
DHMS members and other Discovery clients	R6 284
Non-Discovery clients	R7 855

Purchasing the kit

DHMS members can order and claim for TytoHome from their Scheme benefits using MedXpress at www.discovery.co.za. The device will be delivered to the members chosen address.

**DHMS members can purchase the TytoHome kit from October 2020 but will only be able to use the device in a virtual consultation from December 2020.*

Alternatively, any person can order and pay for the TytoHome device at the iStore online for home delivery or to collect in-store. Scheme funding does not apply to the iStore or in-store collection purchase journey.

**Discovery clients and the general public will be able to purchase the TytoHome kit from the end of October 2020 and will be able to conduct virtual consultations from January 2021*

Discovery clients qualify for 20% discount off the recommended retail price

To get this discount, Discovery clients must visit www.discovery.co.za or access their Discovery App to generate a unique voucher code:

- Discovery clients will be directed from www.discovery.co.za or the Discovery app to another website, where they must log in by providing their cellphone number to verify that they are a Discovery client.
- Once logged in, a unique discount code will be issued. The Discovery client can choose to receive the discount code by SMS or email.
- The client should then go to the iStore online (https://www.istore.co.za/) or in store.
- This discount code must then be applied by the client at checkout on iStore online or in store to unlock the Discovery price (20% less than the recommended selling price).

Discovery Connected Care for members with chronic conditions

The purpose of the Discovery Connected Care for members with chronic conditions platform, is to assist members with chronic conditions become healthier by giving them access to digitally enhanced chronic condition management.

Through Discovery Connected Care, members with chronic conditions will have access to:

- Digital condition-specific clinical content

To improve the patient's ability to self-manage their chronic conditions, members have access to a range of health and wellness content related to their condition.

- Remote health monitoring devices appropriate with their condition

Qualifying members on the Diabetes Care and Cardio Care programme have access to 100% funding up to an annual limit for remote monitoring devices and supporting apps to self-monitor their conditions.

The devices are directly linked to the member's healthcare provider's clinical dashboard. Changes in health metric readings, or signs of non-medicine adherence are automatically triggered to the treating doctor.

- Personalised health coaching consultations

Qualifying members have access to consultations with a wellness specialist. The wellness specialist will support the patient with lifestyle changes, navigating through the clinical content and advise members on Scheme benefits.

Eligibility

- Discovery Health Medical Scheme (DHMS) members who are registered for the Chronic Illness Benefit (CIB) for one of the target conditions:
    - Diabetes
    - Mental health

    - Cardiac diseases (including Hyperlipidaemia, Hypertension and Ischemic Cardiovascular Disease)
- Condition specific criteria applies.

Devices

- Qualifying members with diabetes have access to cover of up to 100% of the Discovery Health Rate (DHR), for a glucometer, funded through the Home Monitoring Device Benefit.

- Members with cardiac conditions registered for Discovery Connected Care for acute care at home will have funding for a defined list of devices.

- All members have access to multiple devices up to a rand limit of R4 000 per person, per year. Device specific reference pricing and frequency limits apply.

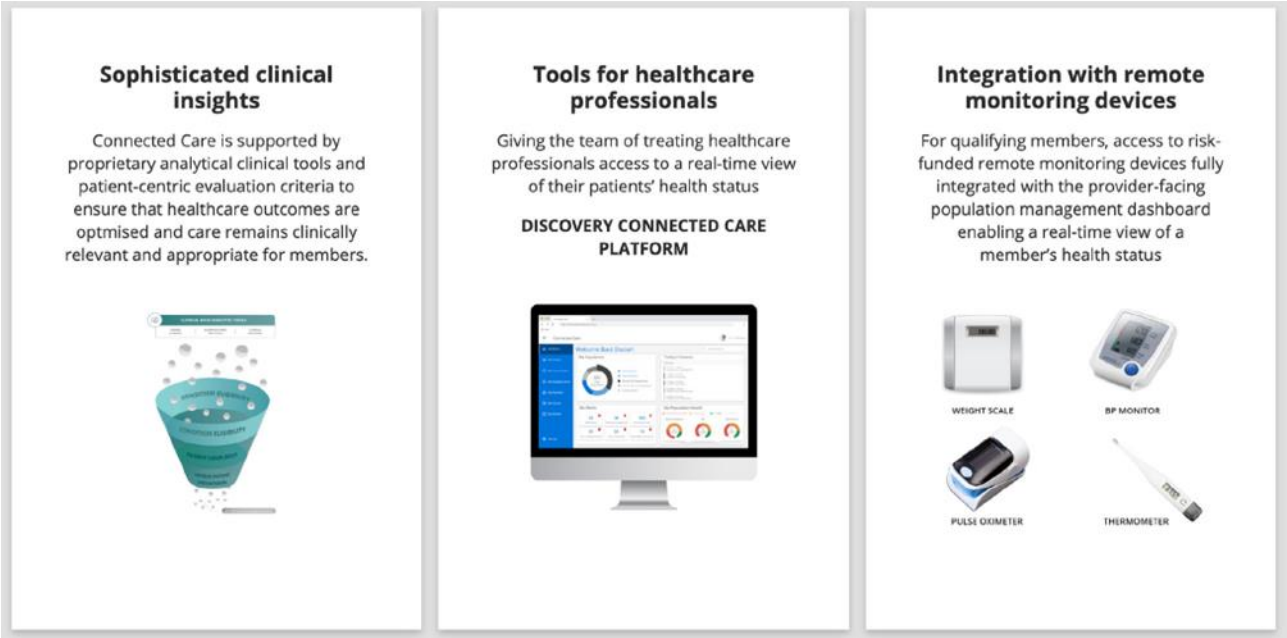
The applicable registered remote monitoring devices will be delivered directly to qualifying members or members will be able to purchase devices via the dispensary in-store at pharmacies or through registered providers.

Discovery Connected Care for acute care

Discovery Connected Care for acute care at home provides qualifying Discovery Health Medical Scheme (DHMS) members with clinically appropriate and patient-centric hospital-level care in their homes, as a substitute for acute hospital care. The programme is facilitated by a dedicated care team which includes doctors and nurses who provide 24-hour clinical support and remote monitoring of the member's condition using smart health devices, supported by appropriate medical scheme benefits. Home-based care is available in the following instances:

- For members that are at risk of re-admission after hospitalisation
- For members who are discharged early from hospital
- For members in-lieu of hospitalisation
- For end-of-life care

Discovery Connected Care for acute care at home is enabled by Discovery Health's sophisticated clinical insight, the comprehensive digital toolkit for healthcare professionals, and integration with healthcare devices for remote monitoring.



Home-based care for members at risk of re-admission after hospitalisation
The programme aims to reduce the re-admission after a member is discharged from hospital. The programme is available on all DHMS plans with a defined basket of care for qualifying members for clinically appropriate conditions such as congestive heart failure.

The basket of care includes:

- Initial clinical assessment prior to the member being discharged
- Cover for a bedside medicine reconciliation prior to the member being discharged
- Cover for a follow-up consultation with a GP or specialist post discharge
- Supportive care at home that includes one face-to-face consultation at home and up to three virtual consultations with a Discovery Home Care nurse
- Access to condition-specific remote monitoring devices

For members who are discharged early from hospital

Enhancing the Discovery Home Care offering, enables members who have conditions that require therapeutic interventions covered by Discover Home Care, to be discharged from hospital earlier and to continue their treatment at home.

Examples include:

- Doctor-initiated clinical appropriate IVI therapy
- Wound care
- Oxygen support for patients recovering from pneumonia

The programme is available on all DHMS plans with a defined basket of care for clinically appropriate conditions.

For members in-lieu of hospitalisation

The programme is available on all DHMS plans with a defined basket of care for clinically appropriate conditions such as wound care and IV infusions.

The basket of care includes:

- Initial clinical assessment
- Supportive care at home that includes two daily physical nurse visits for all conditions for the duration of treatment, daily virtual consults with a doctor, and 24-hour virtual monitoring by a nurse/GP panel
- Access to condition-specific remote monitoring devices
- Access to any other clinically appropriate at home treatment required as prescribed by the treating doctor

For end-of-life care

Members with cancer already have access to the Advanced Illness Benefit for comprehensive palliative care. Through Discovery Connected Care for acute care at home, members also have:

Cover for the coordination of the patient's care

- Cover for counselling services for the patient and their immediate family members
- Supportive care for appropriate end-of-life clinical and psychologist services
- Cover for a GP consultation to facilitate the palliative care treatment plan

Discovery Prepaid Health

Discovery Prepaid Health is a unique product that provides access to primary healthcare on a pre-paid basis at rates that are below the current pay-as-you-go rates. This means that anyone, including an employer or a family member, can purchase or share a variety of healthcare services.

Discovery Prepaid Health is a simple and intuitive digital vouchering solution for purchasing and sharing a variety of accessible healthcare services at a significantly discounted rate supported by a wide distribution network and a free-to-use digital platform.

There are four relevant Prepaid Health options available (each option includes medicine):

- Prepaid medicine
- Nurse consultations and medicine
- Virtual consultations and medicine
- GP consultations and medicine

Discovery prepaid vouchers can be purchased at select retail stores, in addition Discovery clients can purchase Prepaid Health vouchers through;

- Discovery app
- Discovery Active Rewards mall using Discovery Miles
- Discovery Bank app

Non-Discovery clients will be required to register online via www.discovery.co.za which will grant access to the standalone web-based app, enabling the purchase of Discovery Prepaid Health vouchers.

Discovery Health has made use of the latest digital technology in the development of Discovery Prepaid Health, to simplify access and minimise associated mobile data cost.

Register for Discovery Prepaid Health

Discovery clients are not required to register for Discovery Prepaid Health. Non-Discovery clients must follow a simple online registration process.

Top-up your Discovery Prepaid Health balance

Top-up using prepaid vouchers, available from leading retailers and Discovery Bank. Discovery clients can also use Discovery Miles and the Active Rewards Mall to purchase vouchers. Users can then load the voucher to their prepaid Health balance using WhatsApp, online or through the Discovery Prepaid app.

Select a healthcare service

All options include medicine:

- Medicine
- Nurse consultations and medicine
- Virtual consultations and medicine
- GP consultations and medicine

Buy or share healthcare with Discovery Prepaid Health

- Simple, digital payment process at pharmacies or GP practices
- Send prepaid healthcare to someone else by purchasing a voucher or service.

DISCOVERY HEALTH MEDICAL SCHEME PLAN RANGE

This section includes:

- Executive Plan
- Comprehensive Series
- Priority Series
- Smart Series
- Saver Series
- Core Series
- KeyCare Series
- General Scheme Exclusions

The Discovery Health Medical Scheme Shari'ah Compliant Arrangement

Members of DHMS can choose to have their contributions and claims on any DHMS plan managed in accordance with Shari'ah principles through this arrangement.

The Shari'ah Compliant Arrangement was designed in accordance with Shari'ah principles:

- In line with the principles of Shari'ah Law regarding interest, there will be no interest earned or paid on the Shari'ah Compliant Arrangement. Funds will be invested in a compliant manner thereby allowing members the opportunity to earn a profit on Medical Savings Account balances
- Participating members gain the assurance that their contributions, and balances remaining after the settlement of claims and other relevant expenditure will be invested in Shari'ah compliant investments.

Executive Plan

Key features

Key
FEATURES

01
UNLIMITED COVER FOR HOSPITAL ADMISSIONS
READ MORE

02
FULL COVER IN HOSPITAL FOR SPECIALISTS
READ MORE

03
FULL COVER FOR CHRONIC MEDICINES
READ MORE

04
SCREENING AND PREVENTION
READ MORE

05
CONNECTED CARE
READ MORE

06
ACCESS TO THE GLOBAL TREATMENT PLATFORM
READ MORE

07
EXTENSIVE COVER FOR PREGNANCY
READ MORE

08
COMPREHENSIVE DAY-TO-DAY COVER
READ MORE

Vitality is a separate wellness product sold and administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07. Limits, terms and conditions apply.

HOSPITAL
cover

The Executive Plan offers unlimited hospital cover.

The table below shows how we pay for your approved hospital admissions:

Healthcare providers and services	What we pay
The hospital account	▪ The full account at the agreed rate with the hospital ▪ Up to R2 220 per day in a private ward
Specialists we have a payment arrangement with	The full account at the agreed rate
Specialists we don't have a payment arrangement with	Up to three times the Discovery Health Rate (DHR) (300%)
GPs and other healthcare professionals	Up to twice the Discovery Health Rate (DHR) (200%)
X-rays and blood tests (radiology and pathology) accounts	Up to the Discovery Health Rate (DHR) (100%)
MRI & CT scans	▪ Up to the Discovery Health Rate (DHR) if the scan is related to your hospital admission from your Hospital Benefit ▪ If it is not related to your admission or for conservative back and neck treatment, we pay the first R3 130 from your available day-to-day benefits and the balance from your Hospital Benefit, up to the Discovery Health Rate (DHR). For conservative back and neck scans a limit of one scan per spinal and neck region applies

SCOPES (GASTROSCOPY, COLONOSCOPY, SIGMOIDOSCOPY AND PROCTOSCOPY)

Admissions for scopes

Depending on where you have your scope done we pay the following amount from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. If you do not have enough funds available in your day-to-day benefits, you will need to pay this amount.

Upfront payments for scope admissions:

Day clinic account	Hospital account
R3 650	R5 300
If both a gastroscopy and colonoscopy are performed in the same admission	
R4 450	R6 600

No upfront payment applies:

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.

Benefits with an **ANNUAL LIMIT**

COCHLEAR IMPLANTS, AUDITORY BRAIN IMPLANTS AND PROCESSORS

READ MORE

INTERNAL NERVE STIMULATORS

READ MORE

MAJOR JOINT SURGERY

READ MORE

SHOULDER JOINT PROSTHESIS

READ MORE

PROSTHETIC DEVICES USED IN SPINAL SURGERY

READ MORE

MENTAL HEALTH

READ MORE

ALCOHOL AND DRUG REHABILITATION

DENTAL TREATMENT IN HOSPITAL

Dental limit

There is no overall limit for basic dental treatment. However, all dental appliances, their placement, and orthodontic treatment (including related accounts for orthognathic surgery) are paid at 100% of the Discovery Health Rate (DHR) and up to 300% of the DHR for anaethetists. We pay these claims from your day-to-day benefits, up to an annual limit of R30 750 per person. If you join the Scheme after January, you won't get the full limit because it is calculated by counting the remaining months in the year.

Severe dental and oral surgery in hospital

The Severe Dental and Oral Surgery Benefit covers a defined list of procedures, with no upfront payment and no overall limit. This benefit is subject to authorisation and the Scheme's Rules.

Other dental treatment in hospital

You need to pay a portion of your hospital or day clinic account upfront for dental admissions. This amount varies, depending on your age and the place of treatment.

We pay the balance of the hospital account from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR). We pay the related accounts, which include the dentist and other related accounts, from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR). We pay specialists up to 300% of the Discovery Health Rate (DHR).

For members 13 years and older, we cover routine conservative dentistry, such as preventive treatment, simple fillings and root canal treatment, from your available day-to-day benefits.

Upfront payment for dental admissions:

Hospital account	Day clinic account
Members 13 years and older:	
R7 050	R4 500
Members under 13:	
R2 750	R1 240

Day-to-day COVER

We cover your day-to-day healthcare expenses from your Medical Savings Account (MSA), Day-to-day Extender Benefit (DEB) and Above Threshold Benefit (ATB).

We add these amounts to the Annual Threshold and pay these amounts when you reach your Above Threshold Benefit (ATB). We add up the amount to the benefit limit available. If the claimed amount is less than the Discovery Health Rate (DHR), we will pay and add the claimed amount to the Annual Threshold. Claims paid from your Day-to-day Extender Benefit (DEB) will not accumulate to the Annual Threshold.

Some day-to-day healthcare services have limits. These are not separate benefits. Limits apply to claims paid from your MSA, claims paid by you and paid from the ATB.

The tables below show you how much we pay for your day-to-day healthcare expenses on the Executive Plan.

When you claim, we add up the following amounts to get to the Annual Threshold.

Healthcare providers and medicine	What we pay
Specialists we have a payment arrangement with	Up to the rate we have agreed with the specialist
Specialists we do not have a payment arrangement with	Three times the Discovery Health Rate (DHR) (300%)
GPs and other healthcare professionals	The Discovery Health Rate (DHR) (100%)
Preferred medicine	The Discovery Health Rate (DHR) (100%)
Non-preferred medicine	Up to 75% of the Discovery Health Rate (DHR) if the price of the medicine is within 25% of the preferred equivalent, or up to 50% of the DHR if the price of the medicine is more than 50% of the price of the preferred equivalent

Professional services	Single member	One dependant	Two dependants	Three or more dependants
Allied, therapeutic and psychology healthcare services* (acousticians, biokineticists, chiropractors, counsellors, dietitians, homeopaths, nurses, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrists, social workers, speech and language therapists, and audiologists)	R26 250	R31 550	R36 950	R44 300
Dental appliances and orthodontic treatment*	R30 750 per person			
Antenatal classes	R1 960 for your family			

** If you join the Scheme after January, you won't get the full amount because it is calculated by counting the remaining months in the year.*

Medicine	Single member	One dependant	Two dependants	Three or more dependants
Prescribed medicine* (schedule 3 and above)	R43 850	R51 400	R58 850	R66 350
Over-the-counter medicine, vaccines, immunisations and lifestyle-enhancing products	We pay these claims from the available funds in your Medical Savings Account (MSA). These claims do not add up to the Annual Threshold and are not paid from the Above Threshold Benefit (ATB).			

Appliances and equipment

Optical* (this limit covers lenses, frames, contact lenses and surgery or any healthcare service to correct refractive errors of the eye)	R9 010 per person
External medical items* (like wheelchairs, crutches and prostheses)	R60 550 for your family
Hearing aids	R26 600 for your family

** If you join the Scheme after January, you will not get the full limit because it is calculated by counting the remaining months in the year.*

Additional benefits for allied, therapeutic, psychology services and external medical items

You have access to unlimited, clinically appropriate cover for biokineticists, acousticians, social workers, physiotherapists or chiropractors, psychologists, occupational therapists, speech and language therapists and external medical items, for a defined list of conditions. You need to apply for these benefits.

Comprehensive Series

Key features

Key
FEATURES

01 UNLIMITED COVER FOR HOSPITAL ADMISSIONS — READ MORE

02 FULL COVER IN HOSPITAL FOR SPECIALISTS — READ MORE

03 FULL COVER FOR CHRONIC MEDICINES — READ MORE

04 SCREENING AND PREVENTION — READ MORE

05 CONNECTED CARE — READ MORE

06 COVER WHEN TRAVELLING — READ MORE

07 EXTENSIVE COVER FOR PREGNANCY — READ MORE

08 COMPREHENSIVE DAY-TO-DAY COVER — READ MORE

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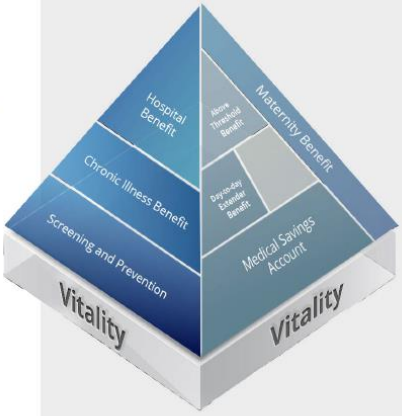

Shariah compliant arrangement available on all health plans.

THE BENEFITS

on the different Comprehensive plans

The five plan options have differences in benefits, as shown in the table. All other benefits not mentioned in the table are the same across all plan options.

	Classic Comprehensive	Classic Delta Comprehensive	Essential Comprehensive	Essential Delta Comprehensive	Classic Smart Comprehensive
Day-to-day cover					
Medical Savings Account (MSA)	25% of your monthly contribution		15% of your monthly contribution		The Medical Savings Account (MSA) and Day-to-day Extender Benefit (DEB) are not available on this plan. We cover a defined set of day-to-day benefits, including Smart GP visits, certain specialist consultations and other essential healthcare services with fixed co-payments and/or limits
Day-to-day Extender Benefit (DEB)	The Day-to-day Extender Benefit (DEB) extends your day-to-day cover for essential healthcare services in our network				
MRI & CT scans	We pay the first R3 130 from your available day-to-day benefits and the balance from your Hospital Benefit. For conservative back and neck scans a limit of one scan per spinal and neck region applies				You pay the first R3 130 before the Annual Threshold is reached and the balance will be paid from the Hospital Benefit. For conservative back and neck scans a limit of one scan per spinal and neck region applies
Additional Chronic cover					
Specialised Medicine and Technology Benefit	You have cover for a defined list of the latest treatments through the Specialised Medicine and Technology Benefit, up to R200 000 per person per year				Not available on this plan
Medicine cover for the Additional Disease List (ADL)	Cover for medicine for an additional list of life-threatening or degenerative conditions called the Additional Disease List (ADL)				
Cancer cover					
Oncology Benefit	We cover the first R400 000 of your approved cancer treatment over a 12-month cycle in full. Thereafter we pay 80% of any additional costs with no upper limit.				We cover the first R300 000 of your approved cancer treatment over a 12-month cycle in full. Thereafter we pay 80% of any additional costs with no upper limit.
Extended Oncology Benefit	You have extended cover in full for a defined list of cancers and treatments				Not available on this plan
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				
Hospital cover					
Hospitals you can go to	Any private hospital approved by the Scheme	Private hospitals in the Delta Hospital Network	Any private hospital approved by the Scheme	Private hospitals in the Delta Hospital Network	Private hospitals in the Smart Hospital Network
Defined list of procedures in a day surgery network	Private day surgery facility in the day surgery network	Private day surgery facility in the Delta network	Private day surgery facility in the day surgery network	Private day surgery facility in the Delta network	Private day surgery facility in the Smart network
Cover for specialists, GP and other healthcare professionals	Up to twice the Discovery Health Rate (DHR) (200%)		The Discovery Health Rate (DHR) (100%)		Up to twice the Discovery Health Rate (DHR) (200%)

HOSPITAL

cover

The Comprehensive plans offer unlimited hospital cover.

The table below shows how we pay for your approved hospital admissions:

Healthcare providers and services	What we pay
The hospital account	▪ The full account at the agreed rate with the hospital ▪ Up to R2 220 per day in a private ward for the maternity benefit ▪ On the Delta options, you must pay an upfront amount of R8 700 for planned admissions to hospitals not in the Delta Hospital Network ▪ On Classic Smart Comprehensive, you must pay an upfront amount of R9 950 for planned admissions to hospitals not in the Smart Plan Hospital Network
Upfront payment for a defined list of procedures performed outside of the day surgery network	**Classic and Essential:** you will pay an upfront payment of R5 700 **Classic Smart:** you will pay an upfront payment of R9 950 **Delta options:** you will pay an upfront payment of R8 700
Specialists we have a payment arrangement with	The full account at the agreed rate
Specialists we do not have a payment arrangement with and other healthcare professionals	**Classic plans:** up to twice the Discovery Health Rate (DHR) (200%) **Essential plans:** up to the Discovery Health Rate (DHR) (100%)
X-rays and blood tests (radiology and pathology) accounts	Up to the Discovery Health Rate (DHR) (100%)
MRI and CT scans	▪ Up to The Discovery Health Rate (DHR) if the scan is related to your hospital admission from your Hospital Benefit ▪ If it is not related to your admission, or for conservative back and neck treatment we pay the first R3 130 from your available day-to-day benefits and the balance from your Hospital Benefit, up to the Discovery Health Rate (DHR). For conservative back and neck scans a limit of one scan per spinal and neck region applies ▪ On Classic Smart Comprehensive if not related to your hospital admission, you 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 Discovery Health Rate (DHR)

SCOPES (GASTROSCOPY, COLONOSCOPY, SIGMOIDOSCOPY AND PROCTOSCOPY)

Admissions for scopes

Depending on where you have your scope done we pay the following amount from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. If you do not have enough funds available in your day-to-day benefits, you will need to pay this amount. If you are on the Classic Smart Comprehensive Plan you will have to pay this amount until you reach your Annual Threshold.

Upfront payments for scope admissions:

	Day clinic account	Hospital account
Classic, Essential, Classic Smart	R3 650	R5 300
If both a gastroscopy and colonoscopy are performed in the same admission		
Classic, Essential, Classic Smart	R4 450	R6 600

Upfront payments for scopes performed outside of the Day surgery network:

For Classic and Essential plans, an upfront payment of R5 700 will apply.

Where both a gastroscopy and colonscopy are performed the higher upfront payment of R6 600 will apply.

For Delta options, an upfront payment of R8 700 will apply.

For Classic Smart, an upfront payment of R9 950 will apply.

No upfront payment applies:

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.

Benefits with an ANNUAL LIMIT

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PROSTHETIC DEVICES USED IN SPINAL SURGERY

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MENTAL HEALTH

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ALCOHOL AND DRUG REHABILITATION

DENTAL TREATMENT IN HOSPITAL

Dental limit

There is no overall limit for basic dental treatment. However, all dental appliances, their placement, and orthodontic treatment (including related accounts for orthognathic surgery) are paid at 100% of the Discovery Health Rate (DHR) and up to 200% of the DHR for anaethetists on Classic plans. We pay these claims from your day-to-day benefits, up to an annual limit of R30 750 per person. If you join the Scheme after January, you will not get the full limit because it is calculated by counting the remaining months in the year. On Classic Smart Comprehensive these benefits apply once the Annual Threshold is reached.

Severe dental and oral surgery in hospital

The Severe Dental and Oral Surgery Benefit covers a defined list of procedures, with no upfront payment and no overall limit. This benefit is subject to authorisation and the Scheme's Rules.

Other dental treatment in hospital

You need to pay a portion of your hospital or day clinic account upfront for dental admissions. This amount varies, depending on your age and the place of treatment.

We pay the balance of the hospital account from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR). We pay the related accounts, which include the dental surgeon's account, from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR). On Classic plans, we pay anaesthetists up to 200% of the Discovery Health Rate (DHR).

For members 13 years and older, we cover routine conservative dentistry, such as preventive treatment, simple fillings and root canal treatment, from your available day-to-day benefits.

Upfront payment for dental admissions:

Hospital account	Day clinic account
Members 13 years and older:	
R7 050	R4 500
Members under 13:	
R2 750	R1 240

Day-to-day COVER

Depending on the plan you choose, we cover your day-to-day healthcare expenses from your Medical Savings Account (MSA), Day-to-day Extender Benefit (DEB), Above Threshold Benefit (ATB) or defined day-to-day benefits.

We add these amounts to the Annual Threshold and pay these amounts when you reach your Above Threshold Benefit (ATB). We add up the amount to the benefit limit available. If the claimed amount is less than the Discovery Health Rate (DHR), we will pay and add the claimed amount to the Annual Threshold. Claims paid from your Day-to-day Extender Benefit (DEB) will not accumulate to the Annual Threshold.

Some day-to-day healthcare services have limits. These are not separate benefits. Limits apply to claims paid from your MSA, paid by you and paid from the ATB.

The tables below show you how much we pay for your day-to-day expenses on all Comprehensive plans.

When you claim, we add up the following amounts to get to the Annual Threshold.

Healthcare providers and medicine	What we pay
Specialists we have a payment arrangement with	Up to the rate we have agreed with the specialist
Specialists we do not have a payment arrangement with	The Discovery Health Rate (DHR) (100%)
GPs and other healthcare professionals	The Discovery Health Rate (DHR) (100%)
Preferred medicine	The Discovery Health Rate (DHR) (100%)
Non-preferred medicine	Up to 75% of the Discovery Health Rate (DHR) if the price of the medicine is within 25% of the preferred equivalent, or up to 50% of the DHR if the price of the medicine is more than 50% of the price of the preferred equivalent

Professional services	Single member	One dependant	Two dependants	Three or more dependants
Allied, therapeutic and psychology healthcare services* (acousticians, biokineticists, chiropractors, counsellors, dietitians, homeopaths, nurses, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrists, social workers, speech and language therapists, and audiologists)				
Classic	R20 950	R28 450	R34 700	R40 250
Essential	R12 600	R17 850	R23 150	R27 350
Dental appliances and orthodontic treatment*	R30 750 per person			
Antenatal classes	R1 960 for your family			

** If you join the Scheme after January, you won't get the full amount because it is calculated by counting the remaining months in the year.*

Medicine	Single member	One dependant	Two dependants	Three or more dependants
Prescribed medicine* (schedule 3 and above)				
Classic	R35 750	R41 950	R48 700	R55 550
Essential	R22 950	R27 950	R33 650	R36 700
Over-the-counter medicine, vaccines, immunisations and lifestyle-enhancing products	We pay these claims from the available funds in your Medical Savings Account (MSA). These claims do not add up to the Annual Threshold and are not paid from the Above Threshold Benefit (ATB).			

Appliances and equipment

Optical* (this limit covers lenses, frames, contact lenses and surgery or any healthcare service to correct refractive errors of the eye)		R6 180 per person
External medical items* (like wheelchairs, crutches and prostheses)	Classic	R60 550 for your family
	Essential	R40 550 for your family
Hearing aids	Classic	R26 600 for your family
	Essential	R21 350 for your family

** If you join the Scheme after January, you will not get the full limit because it is calculated by counting the remaining months in the year.*

Priority Series

Key features

Key
FEATURES

01
UNLIMITED COVER FOR HOSPITAL ADMISSIONS
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02
FULL COVER IN HOSPITAL FOR SPECIALISTS
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03
FULL COVER FOR CHRONIC MEDICINES
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04
SCREENING AND PREVENTION
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COVER WHEN TRAVELLING
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EXTENSIVE COVER FOR PREGNANCY
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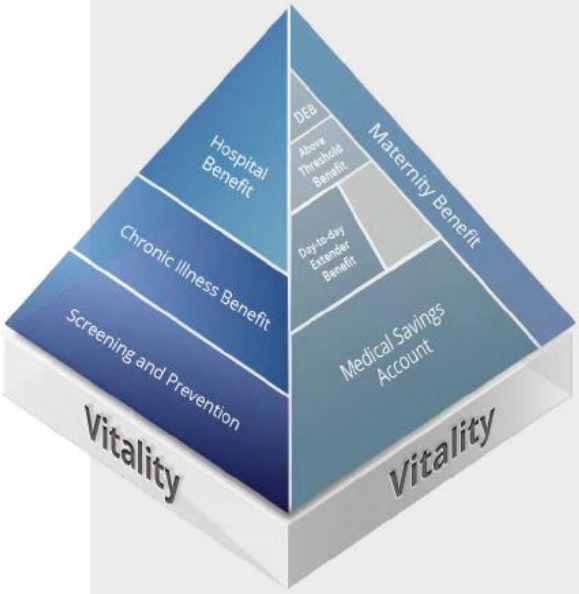

Shari'ah Compliant Arrangement available on all health plans.

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THE BENEFITS
on the different Priority plans

The two plan options have differences in benefits, as shown in the table. All other benefits not mentioned in the table are the same across both plan options.

	Classic	Essential
Day-to-day cover		
Medical Savings Account (MSA)	25% of your monthly contribution	15% of your monthly contribution
Day-to-day Extender Benefit (DEB)	The Day-to-day Extender Benefit (DEB) extends your day-to-day cover for essential healthcare services in our wellness network. You also have additional cover for kids casualty visits.	The Day-to-day Extender Benefit (DEB) extends your day-to-day cover for essential healthcare services in our wellness network.
Hospital cover		
Cover for healthcare professionals in hospital	Twice the Discovery Health Rate (DHR) (200%)	The Discovery Health Rate (DHR) (100%)

HOSPITAL

cover

The Priority Plans offer unlimited hospital cover. The table below shows how we pay for your approved hospital admissions:

Healthcare providers and services	What we pay
The hospital account	The full account at the agreed rate with the hospital
Specialists we have a payment arrangement with	The full account at the agreed rate
Specialists we do not have a payment arrangement with and other healthcare professionals	**Classic plans:** up to twice the Discovery Health Rate (DHR) (200%) **Essential plans:** up to the Discovery Health Rate (DHR) (100%)
X-rays and blood tests (radiology and pathology accounts)	Up to the Discovery Health Rate (DHR) (100%)
Upfront payments for in-hospital procedures:	
Upfront payment for a defined list of procedures performed outside the Day Surgery Network	R5 700
You need to pay an amount upfront to the hospital when one of the procedures listed below is performed during a hospital admission, including procedures performed in the Day Surgery Network:	
Conservative back and neck treatment, adenoidectomy, myringotomy (grommets), tonsillectomy	R3 850
Arthroscopy, functional nasal procedures, hysterectomy (except for pre-operatively diagnosed cancer), laparoscopy, hysteroscopy, endometrial ablation	R9 050
Nissen fundoplication (reflux surgery), spinal surgery (back and neck), joint replacements	R18 600
If the procedure can be done out of hospital, for example in the doctor's rooms you won't have to pay the hospital an amount upfront. If any of these procedures are on the day surgery procedures list, you will have to pay the higher of the two upfront amounts if the procedure is done at a facility outside of the Day Surgery Network:	
MRI and CT Scans	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 Discovery Health Rate (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

SCOPES (GASTROSCOPY, COLONOSCOPY, SIGMOIDOSCOPYAND PROCTOSCOPY)

Admissions for scopes

Depending on where you have your scope done, you will have to pay the following amount, and we will pay the balance of the hospital and related accounts from your Hospital Benefit.

Upfront payments for scope admissions:

	Day clinic account	Hospital account
Classic and Essential	R3 650	R5 900
If both a gastroscopy and colonoscopy are performed in the same admission		
Classic and Essential	R4 450	R7 350

Upfront payments for scopes performed outside of the Day Surgery Network:

Where a scope is performed in a facility outside of the Day Surgery Network an upfront payment of R5 700 will apply, except if performed in a hospital outside the Day Surgery Network where an upfront payment of R5 900 will apply. Where both a gastroscopy and colonoscopy are performed the upfront payment of R7 350 will apply.

No upfront payment applies:

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.

Benefits with an **ANNUAL LIMIT**

COCHLEAR IMPLANTS, AUDITORY BRAIN IMPLANTS AND PROCESSORS

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PROSTHETIC DEVICES USED IN SPINAL SURGERY

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MENTAL HEALTH

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ALCOHOL AND DRUG REHABILITATION

DENTAL TREATMENT IN HOSPITAL

Dental limit

There is no overall limit for basic dental treatment. However, all dental appliances, their placement, and orthodontic treatment (including related accounts for orthognathic surgery) are paid at 100% of the Discovery Health Rate (DHR) and up to 200% of the DHR for anaethetists on Classic plan. We pay these claims from your day-to-day benefits, up to an annual limit of R19 150 per person. If you join the Scheme after January, you won't get the full limit because it is calculated by counting the remaining months in the year.

Severe dental and oral surgery in hospital

The Severe Dental and Oral Surgery Benefit covers a defined list of procedures, with no upfront payment and no overall limit. Certain procedures are covered in our Day Surgery Network. This benefit is subject to authorisation and the Scheme's Rules.

Other dental treatment in hospital

You need to pay a portion of your hospital or day clinic account upfront for dental admissions. This amount varies, depending on your age and the place of treatment. We pay the balance of the hospital account from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR).

We pay the related accounts, which include the dental surgeon's account, from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR). On Classic plan, we pay anaesthetists up to 200% of the Discovery Health Rate (DHR).

For members 13 years and older, we cover routine conservative dentistry, such as preventive treatment, simple fillings and root canal treatment, from your available day-to-day benefits.

Upfront payment for dental admissions:

Hospital account	Day clinic account
Members 13 years and older:	
R7 050	R4 500
Members under 13:	
R2 750	R1 240

Day-to-day **COVER**

We cover your day-to-day healthcare expenses from your Medical Savings Account (MSA), Day-to-day Extender Benefit (DEB) and limited Above Threshold Benefit (ATB).

We add these amounts to the Annual Threshold and pay these amounts when you reach your limited Above Threshold Benefit (ATB). We add up the amount to the benefit limit available. If the claimed amount is less than the Discovery Health Rate (DHR), we will pay and add the claimed amount to the Annual Threshold. Claims paid from your Day-to-day Extender Benefit (DEB) will not accumulate to the Annual Threshold.

Some day-to-day healthcare services have limits. These are not separate benefits. Limits apply to claims paid from your MSA, claims paid by you and paid from the ATB. We pay day-to-day benefits up to the ATB limit or up to the limit that applies, depending on the one you reach first.

The tables below show how much we pay for your day-to-day healthcare expenses on the Priority plans.

When you claim, we add up the following amounts to get to the Annual Threshold.

Healthcare providers and medicine	What we pay
Specialists we have an arrangement with	Up to the rate we have agreed with the specialist
Specialists we do not have an arrangement with	The Discovery Health Rate (DHR) (100%)
GPs and other healthcare professionals	The Discovery Health Rate (DHR) (100%)
Preferred medicine	The Discovery Health Rate (DHR) (100%)
Non-preferred medicine	Up to 75% of the Discovery Health Rate (DHR) if the price of the medicine is within 25% of the preferred equivalent, or up to 50% of the DHR if the price of the medicine is more than 50% of the price of the preferred equivalent

Professional services	Single member	One dependant	Two dependants	Three or more dependants
Allied, therapeutic and psychology healthcare services* (acousticians, biokineticists, chiropractors, counsellors, dietitians, homeopaths, nurses, occupational therapists, physiotherapists, podiatrists, psychologists, psychometrists, social workers, speech and language therapists, and audiologists)				
Classic	R12 500	R17 700	R22 900	R27 050
Essential	R8 300	R12 500	R15 550	R18 750
Dental appliances and orthodontic treatment*	R19 150 per person			
Antenatal classes	R1 960 for your family			

** If you join the Scheme after January, you won't get the full amount because it is calculated by counting the remaining months in the year.*

Medicine	Single member	One dependant	Two dependants	Three or more dependants
Prescribed medicine* (schedule 3 and above)				
Classic	R22 850	R27 700	R33 350	R36 400
Essential	R16 200	R19 150	R22 750	R27 650
Over-the-counter medicine, vaccines, immunisations and lifestyle-enhancing products	We pay these claims from the available funds in your Medical Savings Account (MSA). These claims do not add up to the Annual Threshold and are not paid from the Above Threshold Benefit (ATB).			

Appliances and equipment

Optical* (this limit covers lenses, frames, contact lenses and surgery or any healthcare service to correct refractive errors of the eye)	R5 610 per person	
External medical items* (like wheelchairs, crutches and prostheses)	Classic	R40 550 for your family
	Essential	R27 250 for your family
Hearing aids	Classic	R21 350 for your family
	Essential	R15 200 for your family

* *If you join the Scheme after January, you will not get the full limit because it is calculated by counting the remaining months in the year.*

Saver Series

Key features

Key
FEATURES

01 UNLIMITED COVER FOR HOSPITAL ADMISSIONS — READ MORE

02 FULL COVER IN HOSPITAL FOR SPECIALISTS — READ MORE

03 EXTENSIVE COVER FOR PREGNANCY — READ MORE

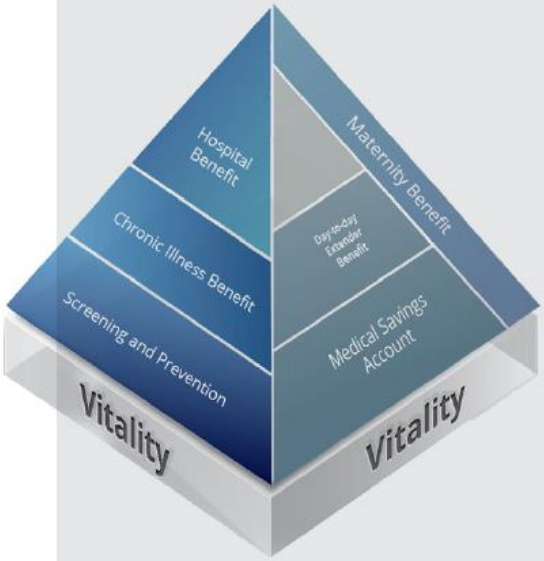
04 CONNECTED CARE — READ MORE

05 FULL COVER FOR CHRONIC MEDICINES — READ MORE

06 DAY-TO-DAY COVER — READ MORE

07 SCREENING AND PREVENTION — READ MORE

08 COVER WHEN TRAVELLING — READ MORE



Shari'ah Compliant Arrangement available on all health plans.

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THE BENEFITS
on the different Saver plans

The five plan options have differences in benefits, as shown in the table. All other benefits not mentioned in the table are the same across all plan options.

	Classic Saver	Classic Delta Saver	Essential Saver	Essential Delta Saver	Coastal Saver
Day-to-day cover					
Medical Savings Account (MSA)	25% of your monthly contribution		15% of your monthly contribution		20% of your monthly contribution
Day-to-day Extender Benefit (DEB)	The Day-to-day Extender Benefit (DEB) extends your day-to-day cover for essential healthcare services in our network. You also have cover for kids casualty visits		The Day-to-day Extender Benefit (DEB) extends your day-to-day cover for essential healthcare services in our network		
Hospital cover					
Hospitals you can go to	Any private hospital approved by the Scheme	Private hospitals in the Delta Network	Any private hospital approved by the Scheme	Private hospitals in the Delta Network	Any private hospital in the four coastal provinces approved by the Scheme
Defined list of procedures in a Day Surgery Network	Private day surgery facility in the Day Surgery Network	Private day surgery facility in the Delta Network	Private day surgery facility in the Day Surgery Network	Private day surgery facility in the Delta Network	Private day surgery facility in our Coastal Network
Cover for healthcare professionals in hospital	Twice the Discovery Health Rate (DHR) (200%)		The Discovery Health Rate (DHR) (100%)		

HOSPITAL
cover

The Saver Plans offer unlimited hospital cover.

The table below shows how we pay for your approved hospital admissions:

Healthcare providers and services	What we pay
The hospital account	▪ The full account at the agreed rate with the hospital ▪ On the Delta options, you must pay an upfront amount of R8 700 for planned admissions to hospitals not in the Delta Hospital Network ▪ On the Coastal option you must go to an approved hospital in the Coastal region for planned admissions. We pay 70% of the Discovery Health Rate (DHR) if you go to a hospital outside of the coastal regions
Upfront payment for a defined list of procedures performed outside of the Day Surgery Network	**Classic, Essential and Coastal:** you must pay an upfront payment of R5 700 **Delta options:** you must pay an upfront payment of R8 700
Specialists we have a payment arrangement with	The full account at the agreed rate
Specialists we don't have a payment arrangement with and other healthcare professionals	**Classic plans:** Up to twice the Discovery Health Rate (DHR) (200%) **Essential and Coastal:** Up to the Discovery Health Rate (DHR) (100%)
X-rays and blood tests (radiology and pathology accounts)	The Discovery Health Rate (DHR) (100%)
MRI and CT scans	▪ Up to the Discovery Health Rate (DHR) if the scan is related to your hospital admission from your Hospital Benefit ▪ If it is not related to your admission or for conservative back and neck treatment, we pay the first R3 130 from your available day-to-day benefits and the balance from your Hospital Benefit, up to the Discovery Health Rate (DHR). Limited to one scan per spinal and neck region

SCOPES (GASTROSCOPY, COLONOSCOPY, SIGMOIDOSCOPY AND PROCTOSCOPY)

Admissions for scopes

Depending on where you have your scope done we pay the following amount from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. If you do not have enough funds available in your Medical Savings Account (MSA), you will need to pay this amount.

Upfront payments for scope admissions:

	Day clinic account	Hospital account
Classic, Essential, Coastal and Delta options	R3 650	R6 250
If both a gastroscopy and colonoscopy are performed in the same admission		
Classic, Essential, Coastal and Delta options	R4 450	R7 800

Upfront payments for scopes performed outside of the Day Surgery Network:

Where a scope is performed in a facility outside of the Day Surgery Network an upfront payment of R5 700 will apply, except if performed in a hospital outside the Day Surgery Network where an upfront payment of R6 250 will apply. Where both a gastroscopy and colonoscopy are performed the upfront payment of R7 800 will apply. For Delta options, the out-of-network upfront payment of R8 700 will apply.

No upfront payment applies:

If scopes are performed in the doctor's rooms, as part of a confirmed Prescribed Minimum Benefit (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.

Benefits with an **ANNUAL LIMIT**

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ALCOHOL AND DRUG REHABILITATION

DENTAL TREATMENT IN HOSPITAL

Dental limit

There is no overall limit for basic dental treatment. However, all dental appliances, their placement, and orthodontic treatment (including related accounts for orthognathic surgery) are paid at 100% of the Discovery Health Rate (DHR) from your available Medical Savings Account (MSA).

Severe dental and oral surgery in hospital

The Severe Dental and Oral Surgery Benefit covers a defined list of procedures, with no upfront payment and no overall limit. Certain procedures are covered in our Day Surgery Network. This benefit is subject to authorisation and the Scheme's Rules.

Other dental treatment in hospital

You need to pay a portion of your hospital or day clinic account upfront for dental admissions.

This amount varies, depending on your age and the place of treatment. We pay the balance of the hospital account from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR). We pay the related accounts, which include the dental surgeon's account, from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR). On Classic plans, we pay anaesthetists up to 200% of the Discovery Health Rate (DHR).

For members 13 years and older, we cover routine conservative dentistry, such as preventive treatment, simple fillings and root canal treatment, from your available Medical Savings Account (MSA).

Upfront payment for dental admissions:

Hospital account	Day clinic account
Members 13 years and older:	
R7 050	R4 500
Members under 13:	
R2 750	R1 240

Day-to-day **BENEFITS**

We cover your day-to-day healthcare expenses from your Medical Savings Account (MSA) or your Day-to-day Extender Benefit (DEB).

The Medical Savings Account (MSA)

We pay your day-to-day medical expenses such as GP and specialist consultations, medicine (excluding registered chronic medicine), radiology and pathology from your available funds allocated to your MSA. Any amount that is left over will carry over to the next year.

The Day-to-day Extender Benefit

Pays for certain day-to-day benefits after you have run out of money in your MSA. Covers video call consultations with a network GP as well as pharmacy clinic consultations in our defined wellness network. You also have cover for consultations with a network GP, when referred.

We cover consultations up to the Discovery Health Rate (DHR). Depending on your plan type, you have access to:

Saver Plans	Single member	Family
Classic and Coastal	3 consultations	6 consultations
Essential	2 consultations	4 consultations

On Classic plans, kids younger than 10 years have access to two kids casualty visits a year.

Smart Series

Key features

Key
FEATURES

01 UNLIMITED COVER FOR HOSPITAL ADMISSIONS — READ MORE

02 FULL COVER IN HOSPITAL FOR SPECIALISTS — READ MORE

03 FULL COVER FOR CHRONIC MEDICINES — READ MORE

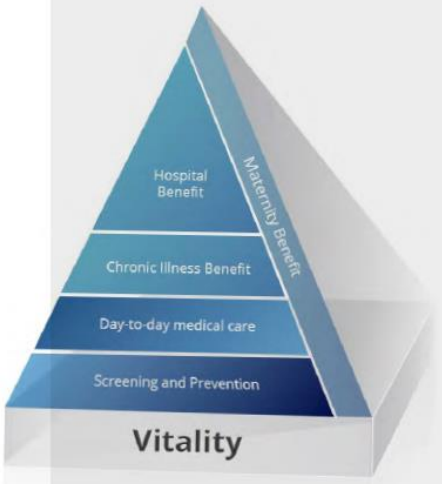
04 SCREENING AND PREVENTION — READ MORE

05 CONNECTED CARE — READ MORE

06 COVER WHEN TRAVELLING — READ MORE

07 EXTENSIVE COVER FOR PREGNANCY — READ MORE

08 COMPREHENSIVE DAY-TO-DAY COVER — READ MORE



Shari'ah Compliant Arrangement available on all health plans.

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Discovery Home Care is a service provider. Practice 080 000 8000190, Grove Nursing Services (Pty) Ltd registration number 2015/191080/07, trading as Discovery HomeCare.

THE BENEFITS
on the different Smart plans

The two plan options have differences in benefits, as shown in the table.
All other benefits not mentioned in the table are the same across both plan options.

	Classic Smart	Essential Smart
Day-to-day cover		
Cover for a defined set of day-to-day benefits	Unlimited consultations with GPs in the Smart Network, with a R55 co-payment for each consultation	Unlimited consultations with GPs in the Smart Network, with a R110 co-payment for each consultation
	One eye test at a network optometrist with a payment of R55 for the test Covered up to 100% of the Discovery Health Rate (DHR)	One eye test at a network optometrist with a R110 co-payment for the test. Cover up to 100% of the Discovery Health Rate (DHR)
	One defined dental check-up at any dentist, dental therapist or oral hygienist with a R110 co-payment for the check-up. Covered up to 100% of the Discovery Health Rate (DHR)	One defined dental check-up at any dentist, dental therapist or oral hygienist with a R165 co-payment for the check-up. Covered up to 100% of the Discovery Health Rate (DHR)
	Cover for over-the-counter (OTC) medicine obtained from a network pharmacy, up to an annual limit of R710 per family per year	Cover for over-the-counter (OTC) medicine obtained from a network pharmacy, up to an annual limit of R475 per family per year
	Cover for defined acute medicine categories prescribed by a Smart Network GP. A limit of R1 550 a member a year and R2 580 a family a year for schedule 3 and above medicine, at a network pharmacy	Not available on this plan
	Cover for sports-related injuries: basic X-rays, two specialist visits and a total of four visits to a physiotherapist, biokineticist or chiropractor when referred by a Smart Network GP. You will have to pay R110 for each X-ray or for each visit. We will cover up to 100% of the Discovery Health Rate (DHR) for these visits and for specialists who we don't have a payment arrangement with	Not available on this plan
Chronic dialysis	Full cover if we approve your treatment plan and you use a provider in our network. If you go elsewhere, we pay up to 80% of the Discovery Health Rate (DHR)	You have cover at a state facility
Cancer	Covered at any provider up to the Discovery Health Rate (DHR)	We will allocate you to a network provider
Hospital cover		
Cover for healthcare professionals in hospital	Up to twice the Discovery Health Rate (DHR) (200%)	Up to the Discovery Health Rate (DHR) (100%)
MRI and CT scans	If not related to your admission, or for conservative back and neck treatment, you must pay the first R3 130 and the balance will be paid from your Hospital Benefit up to the Discovery Health Rate (DHR)	If not related to your admission, or for conservative back and neck treatment, we do not pay for it

HOSPITAL

cover

The Smart plans offer cover for hospital stays. There is no overall limit for the Hospital Benefit.

The table below shows how we pay for your approved hospital admissions:

Healthcare providers and services	What we pay
The hospital account	■ The full account at the agreed rate with the hospital ■ You will pay an upfront payment of R9 950 for planned admissions to hospitals not in the Smart Plan Hospital Network
Upfront payment for certain procedures when they are performed outside of our Day Surgery Network	You will pay an upfront payment of R9 950
Specialists we have a payment arrangement with	The full account at the agreed rate
Specialists we don't have a payment arrangement with and other healthcare professionals	■ **Classic:** up to twice the Discovery Health Rate (DHR) (200%) ■ **Essential:** up to the Discovery Health Rate (DHR) (100%)
X-rays and blood tests (radiology and pathology accounts)	Up to the Discovery Health Rate (DHR) (100%)
MRI & CT scans	■ If related to your admission, we cover your scan up to the Discovery Health Rate (DHR) (100%) from your Hospital Benefit ■ **Classic:** if not related to your admission or for conservative back and neck treatment, you will have to pay the first R3 130 and the balance will be paid from the Hospital Benefit up to the Discovery Health Rate (DHR). For conservative back and neck scans a limit of one scan per spinal and neck region applies ■ **Essential:** You will have to pay if not related to your admission or if for conservative back and neck treatment

SCOPES (GASTROSCOPY, COLONOSCOPY, SIGMOIDOSCOPY AND PROCTOSCOPY)

Admissions for scopes

Depending on where you have your scope done, you have to pay the following amount and we pay the balance of the hospital and related accounts from your Hospital Benefit.

Upfront payments for scope admissions:

	Day clinic account	Hospital account
Classic and Essential options	R3 650	R6 250
If both a gastroscopy and colonoscopy are performed in the same admission		
Classic and Essential options	R4 450	R7 800

Upfront payments for scopes performed outside of the Day Surgery Network:

Where a scope is performed in a facility outside of the Day Surgery Network, an upfront payment of R9 950 will apply.

No upfront payment applies:

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.

Benefits with an **ANNUAL LIMIT**

COCHLEAR IMPLANTS, AUDITORY BRAIN IMPLANTS AND PROCESSORS

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INTERNAL NERVE STIMULATORS

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MAJOR JOINT SURGERY

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SHOULDER JOINT PROSTHESIS

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PROSTHETIC DEVICES USED IN SPINAL SURGERY

READ MORE

MENTAL HEALTH

READ MORE

ALCOHOL AND DRUG REHABILITATION

DENTAL TREATMENT IN HOSPITAL

Dental limit

There is no overall dental limit. However, you must pay for the cost of all dental appliances, their placements and orthodontic treatment (including the related accounts for orthognathic surgery).

Severe dental and oral surgery in hospital

The Severe Dental and Oral Surgery Benefit covers a defined list of procedures, with no upfront payment and no overall limit. Certain procedures are covered in our Day Surgery Network. This benefit is subject to authorisation and the Scheme's Rules.

Other dental treatment in hospital on the Classic Smart Plan

You need to pay a portion of your hospital or day clinic account upfront for dental admissions. This amount varies, depending on your age and the place of treatment.

We pay the balance of the hospital account from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR). We pay the related accounts, which include the dental surgeon's account, from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR). We pay anaesthetists up to 200% of the Discovery Health Rate (DHR).

For members 13 years and older, you must pay for routine conservative dentistry, such as preventive treatment, simple fillings and root canal treatment.

Upfront payment for dental admissions:

Hospital account	Day clinic account
Members 13 years and older:	
R7 050	R4 500
Members under 13:	
R2 750	R1 240

Day-to-day **COVER**

UNDERSTANDING YOUR DAY-TO-DAY BENEFITS

On the Smart plans you have access to day-to-day cover for your GP consultations, certain specialist consultations, acute and over-the-counter (OTC) medicine, eye and dental check-ups and sports-related injuries, with fixed co-payments and/or limits. This cover depends on the plan you choose.

Day-to-day cover	What we pay
Unlimited GP visits to GPs in the Smart Network	You pay R55 on Classic and R110 on Essential of the consultation fee with the balance of this fee covered at 100% of the Discovery Health Rate (DHR). Video consultations with your Smart Network GP are covered in full up to the DHR
Eye test at an optometrist in the Smart Optometry Network	One eye test is covered per year with an upfront payment of: ▪ R55 on Classic ▪ R110 on Essential The balance will be covered up to the Discovery Health Rate (DHR)
Defined dental check-up at any dentist, dental therapist or oral hygienist	One defined dental check-up per year with an upfront payment of: ▪ R110 on Classic ▪ R165 on Essential The balance will be covered up to the Discovery Health Rate (DHR)
Over-the-counter medicine obtained from any MedXpress Network Pharmacy	You are covered for over-the-counter medicine up to R710 a family a year on Classic, and R475 a family a year on Essential. The categories of medicine we cover can be found on www.discovery.co.za
Acute medicine prescribed by your Smart GP and obtained from any MedXpress Network Pharmacy (schedule 3 and above)	On the Classic Smart Plan you are covered for certain acute prescribed medicine categories with a limit of R1 550 per person a year or R2 580 a family a year
Sports injuries when referred by your Smart Network GP	On the Classic Smart Plan you have cover for basic X-rays, two specialist visits and a total of four visits to a physiotherapist, biokineticist or chiropractor when related to a sports injury and if referred by your Smart Network GP. You will have to pay R110 for each X-ray or for each visit. We will cover up to the Discovery Health Rate (DHR) for these visits and for specialists who we don't have a payment arrangement with

Note: Members on the Essential Smart Plan have cover for renal dialysis through a provider in a state facility. Should members voluntarily make use of a provider outside of the designated service provider network, Discovery Health Medical Scheme will cover 80% of the healthcare expenses, up to the Discovery Health Rate.

Core Series

Key features

Key
FEATURES

01
UNLIMITED COVER FOR HOSPITAL ADMISSIONS
READ MORE

02
FULL COVER IN HOSPITAL FOR SPECIALISTS
READ MORE

03
FULL COVER FOR CHRONIC MEDICINES
READ MORE

04
SCREENING AND PREVENTION
READ MORE

05
CONNECTED CARE
READ MORE

06
COVER WHEN TRAVELLING
READ MORE

07
EXTENSIVE COVER FOR PREGNANCY
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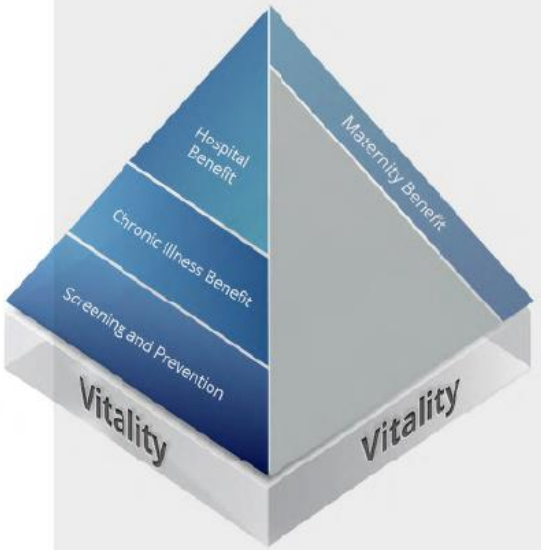

Shariah Compliant Arrangement available on all health plans.

THE BENEFITS
on the different Core plans

The five plan options have differences in benefits, as shown in the table. All other benefits not mentioned in the table are the same across all plan options.

	Classic Core	Classic Delta Core	Essential Core	Essential Delta Core	Coastal Core
Hospital cover					
Hospitals you can go to	Any private hospital approved by the Scheme	Private hospital in the Delta Network	Any private hospital approved by the Scheme	Private hospital in the Delta Network	Any approved hospital in the four coastal provinces
Defined list of procedures in a Day Surgery Network	Private day surgery facility in the Day Surgery Network	Private day surgery facility in the Delta Network	Private day surgery facility in the Day Surgery Network	Private day surgery facility in the Delta Network	Private day surgery facility in our Coastal Network
Cover for healthcare professionals in hospital	Twice the Discovery Health Rate (DHR) (200%)		The Discovery Health Rate (DHR) (100%)		

HOSPITAL
cover

The Core plans offer unlimited hospital cover.

The table below shows how we pay for your approved hospital admissions:

Healthcare providers and services	What we pay
The hospital account	■ The full account at the agreed rate with the hospital ■ On the Delta options, you will pay R8 700 upfront if you go to a hospital outside of the Delta Hospital Network ■ On the Coastal plan you will go to an approved hospital in the Coastal region for planned admissions We pay 70% of the Discovery Health Rate (DHR) if you go to a Scheme approved hospital outside of the coastal network
Upfront payment for a defined list of procedures performed outside of the Day Surgery Network	**Classic, Essential and Coastal plans:** You will pay an upfront payment of R5 700 **Delta options:** You will pay an upfront payment of R8 700
Specialists we have a payment arrangement with	The full account at the agreed rate
Specialists we don't have a payment arrangement with and other healthcare professionals	**Classic plans:** Twice the Discovery Health Rate (DHR) (200%) **Essential and Coastal plans:** The Discovery Health Rate (DHR) (100%)
X-rays and blood tests (radiology and pathology accounts)	The Discovery Health Rate (DHR) (100%)
MRI & CT scans	The Discovery Health Rate (DHR) (100%) if it is related to your hospital admission from your Hospital Benefit. If it is not related to your admission, or for conservative back and neck treatment, we do not pay for it.

SCOPES (GASTROSCOPY, COLONOSCOPY, SIGMOIDOSCOPY AND PROCTOSCOPY)

Admissions for scopes

Depending on where you have your scope done, you have to pay an upfront amount and we pay the balance of the hospital and related accounts from your Hospital Benefit.

Upfront payments for scope admissions:

	Day clinic account	Hospital account
Classic, Essential, Coastal and Delta options	R3 650	R6 250
If both a gastroscopy and colonoscopy are performed in the same admission		
Classic, Essential, Coastal and Delta options	R4 450	R7 800

Upfront payments for scopes performed outside of the Day Surgery Network:

Where a scope is performed in a facility outside of the Day Surgery Network an upfront payment of R5 700 will apply, except if performed in a hospital outside the Day Surgery Network where an upfront payment of R6 250 will apply. Where both a gastroscopy and colonoscopy are performed the upfront payment of R7 800 will apply. For Delta options, an upfront payment of R8 700 will apply.

No upfront payment applies:

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.

Benefits with an **ANNUAL LIMIT**

COCHLEAR IMPLANTS, AUDITORY BRAIN IMPLANTS AND PROCESSORS — READ MORE

INTERNAL NERVE STIMULATORS — READ MORE

MAJOR JOINT SURGERY — READ MORE

SHOULDER JOINT PROSTHESIS — READ MORE

PROSTHETIC DEVICES USED IN SPINAL SURGERY — READ MORE

MENTAL HEALTH — READ MORE

ALCOHOL AND DRUG REHABILITATION

DENTAL TREATMENT IN HOSPITAL

Dental limit

You are responsible for paying the cost of all dental appliances, their placements and orthodontic treatment (including the related accounts for orthognathic surgery).

Severe dental and oral surgery in hospital

The Severe Dental and Oral Surgery Benefit covers a defined list of procedures, with no upfront payment and no overall limit. Certain procedures are covered in our Day Surgery Network. This benefit is subject to authorisation and the Scheme's Rules.

Other dental treatment in hospital

You need to pay a portion of your hospital or day clinic account upfront for dental admissions. This amount varies, depending on your age and the place of treatment. We pay the balance of the hospital account from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR).

We pay the related accounts, which include the dental surgeon's account, from your Hospital Benefit, up to 100% of the Discovery Health Rate (DHR). On Classic plans, we pay anaesthetists up to 200% of the Discovery Health Rate (DHR).

Upfront payment for dental admissions:

Hospital account	Day clinic account
Members 13 years and older:	
R7 050	R4 500
Members under 13:	
R2 750	R1 240

KeyCare Series

Key features

Key
FEATURES

01
UNLIMITED COVER FOR HOSPITAL ADMISSIONS
READ MORE

02
FULL COVER IN HOSPITAL FOR SPECIALISTS
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DAY TO DAY COVER
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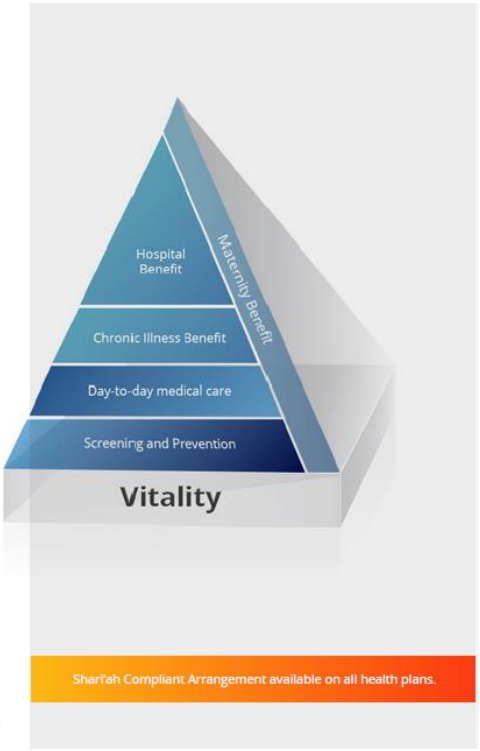


THE BENEFITS
on the different KeyCare plans

The three plan options have differences in benefits, as shown in the table.
All other benefits not mentioned in the table are the same across all plan options.

	Plus	Core	Start
Day-to-day cover	Day-to-day cover at your chosen KeyCare GP. Medicine from our medicine list is covered at a network pharmacy Specialists are covered up to R4 530 per person per year, if you are referred by your KeyCare Network GP	Specialists are covered up to R4 530 per person per year. This plan does not offer any additional day-to-day cover	Primary care is covered at your chosen KeyCare Start GP Medicine from our medicine list is covered in full if you use a network pharmacy Two specialist visits up to R2 270 per person per year, if you are referred by your KeyCare Start Network GP
Non-emergency casualty visits	Cover for one casualty visit per person per year in any casualty unit at a hospital in the KeyCare network Unlimited for emergencies You pay the first R405 of the consultation You must get approval before your visit	Not covered	We cover after-hours care at your chosen KeyCare Start GP or network provider
Chronic medicine prescriptions	Your approved chronic medication must be dispensed by your KeyCare GP, or you must get your approved chronic medicine from a pharmacy in the network	Any KeyCare Network GP can prescribe your approved chronic medicine and you must get your approved chronic medicine from a pharmacy in the network	Your chronic medicine is covered in a state facility
Cancer	We cover your treatment if it is a Prescribed Minimum Benefit (PMB). You must use a network provider		Your treatment is covered in a state facility
Chronic Dialysis	You must use a network provider once you are registered, or you can go to a state facility. If you go elsewhere we will pay 80% of the Discovery Health Rate (DHR)		You are covered at a provider in a state facility
Full Cover Hospital Network	We pay up to the Discovery Health Rate (DHR) (100%)		We pay the Discovery Health Rate (DHR) at your chosen KeyCare Start Network Hospital
Partial Cover Hospital Network	We pay up to 70% of the hospital account and you must pay the balance of the account. If the admission is a Prescribed Minimum Benefit (PMB), we will pay 80% of the Discovery Health Rate (DHR)		No cover for non-emergency admissions
Defined list of procedures in a Day Surgery Network	Covered in the KeyCare Day Surgery Network		Covered in the KeyCare Start Day Surgery Network

HOSPITAL

cover

The KeyCare Plans offer unlimited hospital cover. The table below shows how we pay for your approved hospital admissions:

	Plus	Core	Start
Full Cover Hospital Network	We pay up to the Discovery Health Rate (DHR) (100%).		Covered in full at your chosen KeyCare Start Network Hospital.
	If you do not use your chosen hospital in the networks, you will have to pay all the costs. This does not apply in an emergency.		
Partial Cover Hospital Network	We pay up to 70% of the hospital account and you must pay the balance of the account. If the admission is a Prescribed Minimum Benefit, we will pay 80% of the Discovery Health Rate (DHR).		No cover for non-emergency admissions.
Defined list of procedures in a Day Surgery Network	Covered in the KeyCare Day Surgery Network.		Covered in the KeyCare Start Day Surgery Network.
Non-network hospitals	We will not pay the hospital and related accounts if you are admitted to a non-network hospital for a planned procedure. If the admission is a Prescribed Minimum Benefit (PMB), we will pay 80% of the Discovery Health Rate (DHR).		
Specialists and healthcare professionals in our network	Full cover.		Full cover at a contracted provider in your KeyCare Start Network Hospital.
Specialists and healthcare professionals not in our network	The Discovery Health Rate (DHR). If they charge more, you must pay the balance of the account.		We will pay the Discovery Health Rate (DHR) for providers at your KeyCare Start hospital who we do not have a payment arrangement with, you must pay the balance of the account.
X-rays and blood tests (radiology and pathology accounts)	The Discovery Health Rate (DHR).		The Discovery Health Rate (DHR).
Cover for scopes (gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy)	Prescribed Minimum Benefit (PMB) cover in the KeyCare Day Surgery Network. Authorised scopes done in the doctor's rooms will be covered from your Hospital Benefit.		Prescribed Minimum Benefit (PMB) cover in the KeyCare Start Day Surgery Network. Authorised scopes done in the doctor's rooms will be covered from your Hospital Benefit.
Alcohol and drug rehabilitation	We pay for 21 days of rehabilitation per person per year. Three days per approved admission per person for detoxification.		
Mental health	21 days for admissions or up to 15 out-of-hospital consultations per person for major affective disorders, anorexia and bulimia, and up to 12 out-of-hospital consultations for acute stress disorder accompanied by recent significant trauma. Three days per approved admission for attempted suicide. 21 days for other mental health admissions. All mental health admissions are covered in full at a network facility. If you go elsewhere, we will pay up to 80% of the Discovery Health Rate (DHR) for the hospital account.		

EXCLUSIONS

Healthcare services that are not covered on your plan

Discovery Health Medical Scheme has certain exclusions. We do not pay for healthcare services related to the following, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits (PMBs). For a full list of exclusions, please visit www.discovery.co.za.

Medical conditions during a waiting period

If we apply waiting periods because you have never belonged to a medical scheme or you have had a break in membership of more than 90 days before joining Discovery Health Medical Scheme, you will not have access to the Prescribed Minimum Benefits (PMB) during your waiting periods. This includes cover for emergency admissions. If you had a break in cover of less than 90 days before joining Discovery Health Medical Scheme, you may have access to Prescribed Minimum Benefits (PMBs) during waiting periods.

The general exclusion list includes:

- Reconstructive treatment and surgery, including cosmetic procedures and treatments
- Otoplasty for bat ears, port-wine stains and blepharoplasty (eyelid surgery)
- Breast reductions or enlargements and gynaecomastia
- Obesity
- Infertility
- Frail care
- Alcohol, drug or solvent abuse
- Wilful and material violation of the law
- Wilful participation in war, terrorist activity, riot, civil commotion, rebellion or uprising
- Injuries sustained or healthcare services arising during travel to or in a country at war
- Experimental, unproven or unregistered treatments or practices
- Search and rescue.

We also do not cover the complications or the direct or indirect expenses that arise from any of the exclusions listed above, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits (PMBs).

Extra exclusions specific to KeyCare plans

In addition to the general exclusions that apply to all plans, KeyCare plans do not cover the following, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits (PMBs).

1 Hospital admissions related to, among others:

- Dentistry
- Nail disorders
- Skin disorders, including benign growths and lipomas Investigations
- Functional nasal surgery
- Elective caesarean section, except if medically necessary
- Surgery for oesophageal reflux and hiatus hernia
- Back and neck treatment or surgery
- Knee and shoulder surgery
- Arthroscopy
- Joint replacements, including but not limited to hips, knees, shoulders and elbows
- Cochlear implants, auditory brain implants and internal nerve stimulators (this includes procedures, devices, processors and hearing aids)
- Healthcare services that should be done out of hospital and for which an admission to hospital is not necessary
- Endoscopic procedures

2 Correction of hallux valgus (bunion) and Tailor's bunion (bunionette)

3 Removal of varicose veins

4 Refractive eye surgery

5 Non-cancerous breast conditions

6 Healthcare services outside South Africa.

KeyCare contributions

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.

Discovery Health Medical Scheme 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

Annual Medical Savings Account

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.

Above Threshold amounts

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.

We count a maximum of three children when we work out:

- The monthly contribution
- The annual Medical Savings Account
- The Annual Threshold

- The Above Threshold Benefit limit.

General Scheme Exclusions

Discovery Health Medical Scheme has certain exclusions. We do not pay for healthcare services related to the following, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits. For a full list of exclusions, please visit www.discovery.co.za.

- Cosmetic procedures and treatments
- Otoplasty for bat ears, port-wine stains and blepharoplasty (eyelid surgery)
- Breast reductions or enlargements and gynaecomastia
- Obesity
- Frail care
- Infertility
- Wilfully self-inflicted illness or injury
- Alcohol, drug or solvent abuse
- Wilful and material violation of the law
- Wilful participation in war, terrorist activity, riot, civil commotion, rebellion or uprising
- Injuries sustained or healthcare services arising during travel to or in a country at war
- Experimental, unproven or unregistered treatments or practices
- Search and rescue
- Any costs for which a third party is legally responsible
- We also do not cover the complications or the direct or indirect expenses that arise from any of the exclusions listed above, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits.

DISCOVERY FLEXICARE

This section includes:

- Flexicare

Flexicare

Flexicare has replaced Discovery Primary Care for all new business. Flexicare is administrated by Discovery Health.

On the 26 November 2020 a strategic collaboration was concluded between Discovery and Auto & General. This collaboration enabled Auto & General to offer their Flexicare product range to employer groups with existing Primary Care contracts, providing a valid continuation solution, with no compromise to the value proposition Discovery had provided their employees to date.

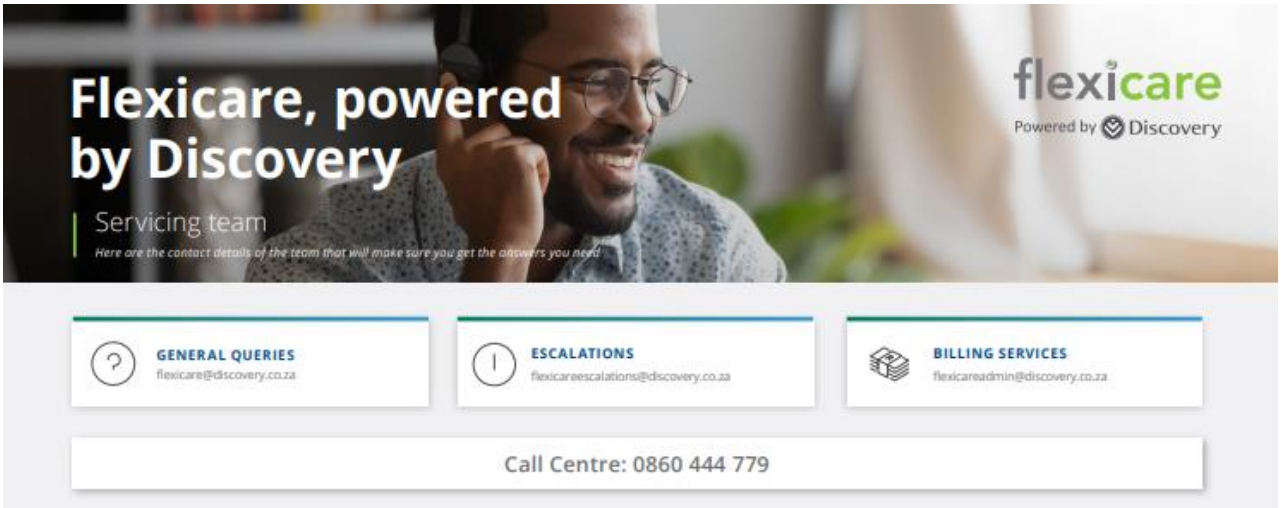
Employees whose cover commenced prior to 26 November 2020 will remain on the Primary Care product until 31 May 2021, while employees whose cover commenced from 1 December 2020 will be covered on the Flexicare product.

From 1 June 2021, all existing Primary Care employers will be migrated to the Flexicare product. This transition requires all existing Primary Care employers and advisors operating on a Primary Care lisence to sign a new Flexicare agreement. The process of re-contracting is underway.

FlexiCare gives employer groups, the opportunity to provide access to affordable, private primary healthcare services to their employees. These benefits are administered by Discovery Health and offer equivalent benefits to Discovery Primary Care Advanced at an equivalent cost.

Flexicare Servicing Channels

To ensure minimal impact to advisers and their employer clients, new business and servicing channels will remain largely unchanged and can be used for both Primary Care and Flexicare servicing.



DAY-TO-DAY BENEFITS	
SERVICE	**FLEXICARE**
GP consultations	Unlimited network GP visits
Medical procedures in GP rooms	Cover for a defined list of medical procedures that can be performed in a network GP's rooms
Day to day medicine	Cover for medicine on the defined medicine list when prescribed or dispensed by a network provider
Over The Counter Medicine	Up to R140/script – max R420 per beneficiary per annum Self-medication items for the treatment of day-to-day ailments
Chronic Medicine	Cover for chronic medicine on defined medicine list for 27 chronic conditions (including HIV)
HIV management	Access to HIV treatment, counselling and education Cover for antiretroviral medication, multivitamins and supportive medicine, blood tests, X-rays and post-exposure prophylaxis medication All HIV-related queries or cases are treated with complete confidentiality
Basic pathology and radiology	Cover for basic pathology (blood tests) through network pathologist. Basic radiology (black-and-white X-rays) is covered when done in the radiology network and referred by a network GP
Dentistry	Cover for dentist visits, fillings and tooth removals at a dentist in the network
Optometry	Cover for one eye test in our optometry network and one pair of glasses or contact lenses every 24 months
Flu vaccine	Cover for an annual flu vaccine at a network pharmacy
Maternity	Unlimited network GP visits throughout the pregnancy Unlimited acute medicine in line with a defined medicine list prescribed or dispensed by a network provider and collected from a network pharmacy

	Essential blood and screening tests through network radiologist when referred by a network healthcare professional Two ultrasound scans per pregnancy at a network provider
COVID Testing	Access to out-of-hospital management and appropriate supportive treatment, protocols and entry criteria apply
Ambulance	Access to emergency medical services, through Netcare 911 ambulance services. You can call Netcare 911 on 0860 999 911 or the Flexicare call centre on 0860 444 779
Casualty Treatment	Limit of R18 750 per Casualty Treatment **Covered for:** Burns, head injuries, chest injuries or severe fractures as a result of a fall, loss of an arm, hand, leg or foot, near drowning, poisoning or a serious allergic reaction that may cause death, injuries resulting from a crime, sexual assault, a fall, a car accident or an injury at work
To Take Out (TTO) Medicines	Limit of R300 per event per Casualty Treatment
Accidental Death Cover	R16 600 per insured party

SUPPLEMENTARY BOOSTERS FOR HEALTH AND WELLNESS	
SERVICE	**FLEXICARE**
Discovery Prepaid Health (accessible from 1 July 2021)	The employees of qualifying employers* receive a R180 Prepaid Health voucher
Employee Support (accessible from 1 July 2021)	The employees of qualifying employers* have access to legal and financial support through Discovery Healthy Company
**Flexicare members, who belong to compulsory employers and voluntary employers, with over 250 employees.*	

OPTIONAL BENEFITS	
SERVICE	**FLEXICARE**
Emergency Trauma Benefit	Access to emergency private healthcare services for a defined range of traumatic events at any

	private hospital. Two cover limits of either R370 000 or R1 million are available. **Covered for:** Burns, head injuries, chest injuries or severe fractures as a result of a fall, loss of an arm, hand, leg or foot, near drowning, poisoning or a serious allergic reaction that may cause death, injuries resulting from a crime, sexual assault, a fall, a car accident or an injury at work
Funeral Cover	Up to R5 000 funeral cover for employees and qualifying dependants who are covered by Flexicare

Visiting a healthcare provider

Flexicare members need to take their membership card and their ID, passport or drivers license with them when they visit their healthcare provider. This is so that the healthcare provider can confirm that they are a Flexicare member. Flexicare members can confirm with their healthcare provider that their treatment and medicine is on our list of benefits.

Felxicare contact details

Felxicare members can contact Discovery Health using the following channels:

USSD self-service	*120*DISCO# or *120*34726#
Call	0860 44 47 79
Email	flexicare@discovery.co.za
Complaints	Felxicareescalations@discovery.co.za

HEALTHY COMPANY

This section includes:

- Introduction to Healthy Company
- Healthy Company key elements
- Healthy Company in action
- Healthy Company cutting-edge technology

Healthy Company

Introduction to Healthy Company

Studies by the Oxford Health Alliance, together with findings from the World Health Organisation indicates that today, four risk factors (poor diet, physical inactivity, tobacco use and excess alcohol intake) lead to four chronic diseases (cardiovascular disease, diabetes, chronic lung disease and various cancers) that contribute to 60% of deaths worldwide.

South Africa is no exception. Our own shocking statistics speak for themselves: 52% of South Africans are overweight or obese, 47% are physically inactive, 17% use tobacco products and 10% are classified as heavy episodic drinkers.

Healthy Company is Discovery's digitally-enabled, comprehensive employee assistance programme and wellness solution that identifies and proactively supports both at-risk employees and those that are well, through their work and life journey.

Discovery has combined extensive local and international experience and capabilities in managing the healthcare and wellness of large employer groups, to create Healthy Company. Healthy Company is an effective programme with a fully integrated approach, from screening and identifying risks on an ongoing basis; proactive tailored and relevant interventions; to insightful reporting for the employee and employer.

Key features of Healthy Company

Screening

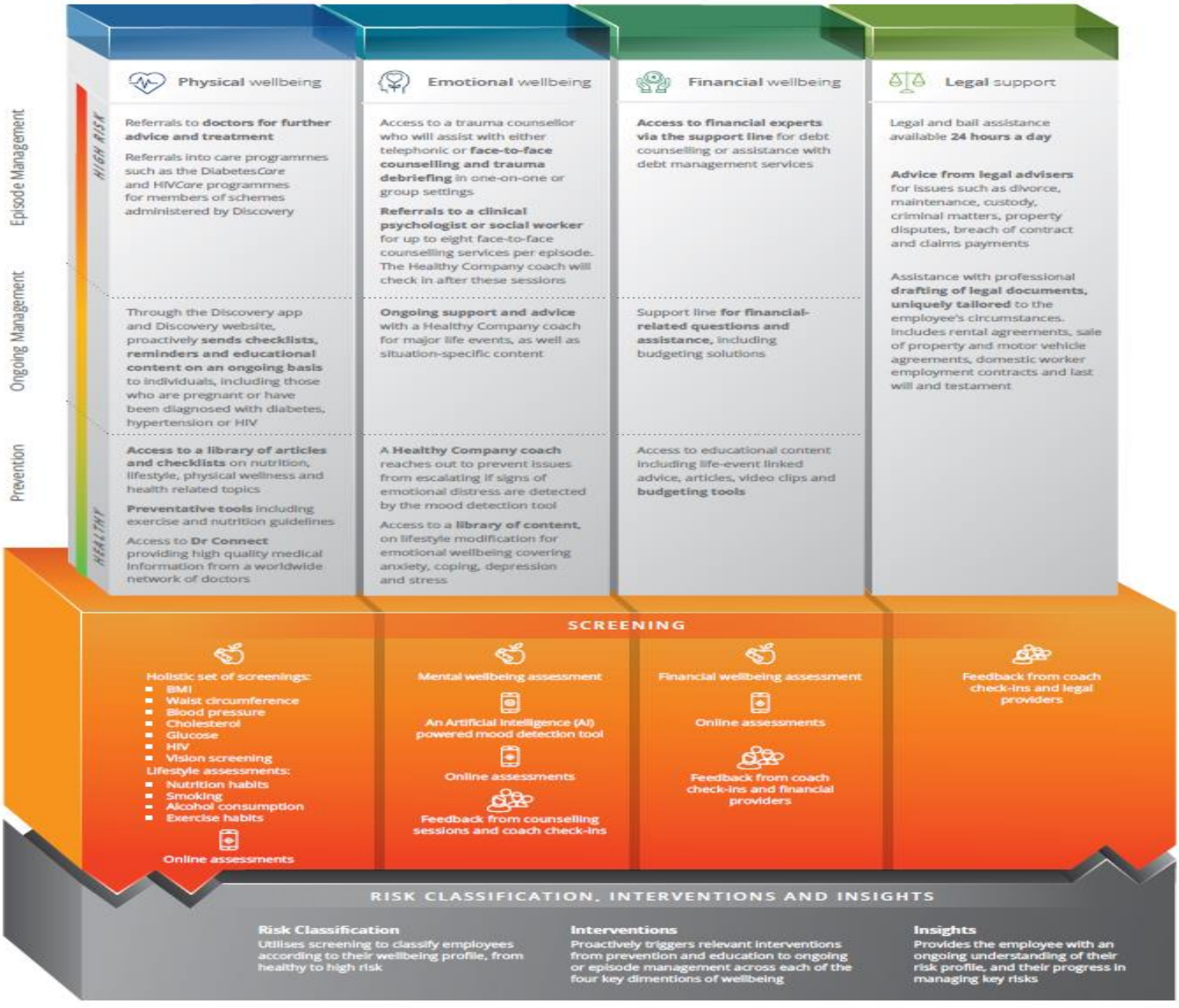
Employees have access to the Discovery Wellness Experience, at no additional charge. The screening includes risk assessments across physical, emotional and financial wellbeing. After the screening,

employees have access to one-on-one consultation with a Wellness Specialist. The Wellness Specialist will discuss their results, discuss the impact of their lifestyle risk factors and explain how they can address their individual health risks.

Proactive support

Based on the health and wellbeing profile of the employee from the screening, Healthy Company will proactively reach out to employees. Healthy Company coaches are multi-skilled that provide counselling, support and advice to employees. The Healthy Company coaches are registered professionals and include clinical psychologists, medical professionals and social workers with extensive experience. Healthy Company Coaches contact employees telephonically or through the Discovery app and website with tailored interventions in the areas where a risk or opportunity has been identified.

Support across four dimensions of wellbeing



Physical wellbeing

The physical wellbeing screening includes:

- Body Mass Index
- Waist circumference
- Body fat percentage
- Blood pressure
- Cholesterol
- Glucose
- HIV
- Vision screening.

The lifestyle questionnaire covers:

- Nutrition habits
- Smoking and alcohol consumption
- Exercise habits
- Stress management.

Should key metrics be out of range, employees will be classified as high-risk and be referred to their doctor. Healthy Company will reach out to the employee by sending checklists, information and reminders to assist with the management of their condition.

Employees that are members of Discovery Health administered schemes will be referred to programmes such as Diabetes Care and HIV Care programmes.

Emotional wellbeing

Emotional wellbeing is evaluated using international recognised methodologies. These assessments are conducted during screenings, online assessments or during telephonic conversations with a Healthy Company Coach.

Employees can also able to capture their daily mood with a tool on the Discovery app or website that uses artificial intelligence (AI) to detect signs of emotional distress. Based on the assessment results and the mood capture tool, a Healthy Company Coach will reach out telephonically to provide advice and support to prevent issues from escalating.

Should the employee be flagged as high-risk, the employee will be referred to a clinical psychologist or social worker for up to eight face-to-face counselling services per episode.

In the event of traumatic experiences such as road accidents, assault, crime-related injury or the traumatic death of a family member, employees can access a trauma counsellor at any time of the day. The counsellor will assist with either telephonic counselling or face-to-face trauma debriefing in both one-on-one and group settings.

Financial wellbeing

Financial wellbeing will be assessed at the Discovery Wellness Experience by understanding the employee's concerns around financial issues. The assessment focuses on improving financial education and literacy.

Should the employee be flagged as moderate to high-risk, the Healthy Company coach will reach out to them and send them:

- Life-event linked advice
- Articles
- Video clips
- Budgeting tools.

Employees can contact a financial expert for support with debt counselling or assistance with debt management services including:

- Insurance reviews
- Debt consolidation
- Reducing credit life premiums.

Legal support

Employees can contact a legal adviser during working hours for assistance with:

- Divorce
- Maintenance
- Custody
- Criminal matters
- Property disputes
- Breach of contract.

Emergency legal support will be available 24 hours. This includes legal and bail assistance should an employee be arrested.

Employees can also get assistance with legal documents which include:

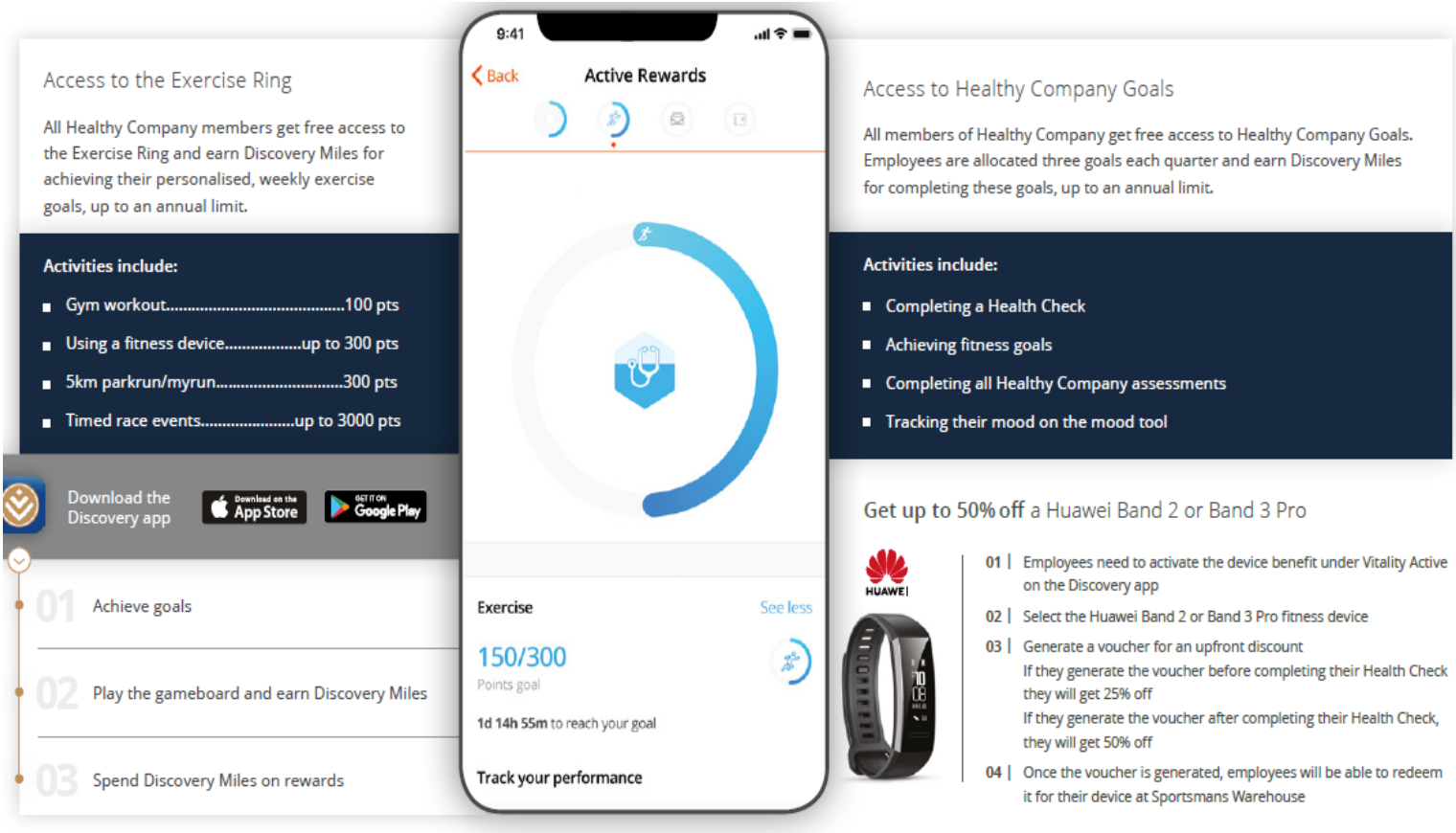
- Rental agreements
- Domestic worker employment contracts
- Last will and testaments
- Antenuptial contracts
- Loan agreements
- Sale of property or motor vehicle agreements
- Acknowledgment of debt
- Trust deeds or power of attorney.

Healthy Company coaches can also refer employees to the following professionals:

- Psychologist and social workers
- Trauma counsellors
- Legal advisers
- Debt counsellors.

Vitality Health Tracker

Research shows that employees who are physically active on a regular basis are more productive than their peers. Healthy Company incentivises employees to get active and provides them with a platform to track their exercise and a benefit for a fitness device. They also have access to Healthy Company Goals, which rewards them for regularly engaging with Healthy Company to improve and sustain healthy behaviours.

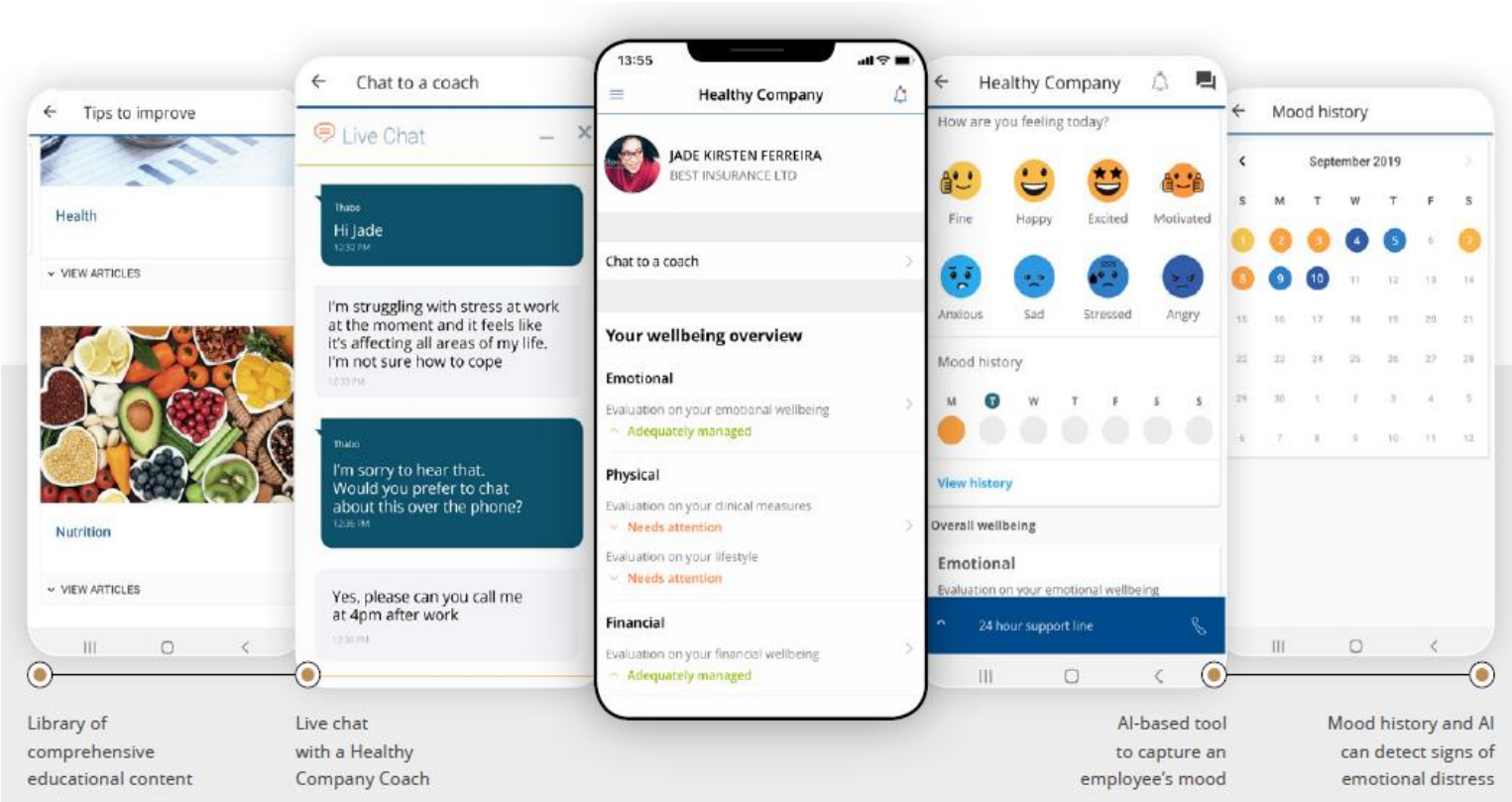


Digital tools

Employees are able to view an overview of their health and wellbeing profile on the Discovery website and app. They also have access to wellbeing assessments and relevant interventions.

The benefits of this technology include:

- A private and confidential means for the Healthy Company Coaches to reach out and check in with the employees, through live chat.
- A library of comprehensive educational content, containing lifestyle articles, exercise and nutrition guidelines, doctor-authored checklists and short videos on lifestyle change and financial educational courses and budgeting tools.
- Risk assessment through financial, lifestyle and mental wellbeing assessments which employees can access on an ongoing basis.
- An AI-based tool to capture an employee's mood and detect signs of emotional distress.

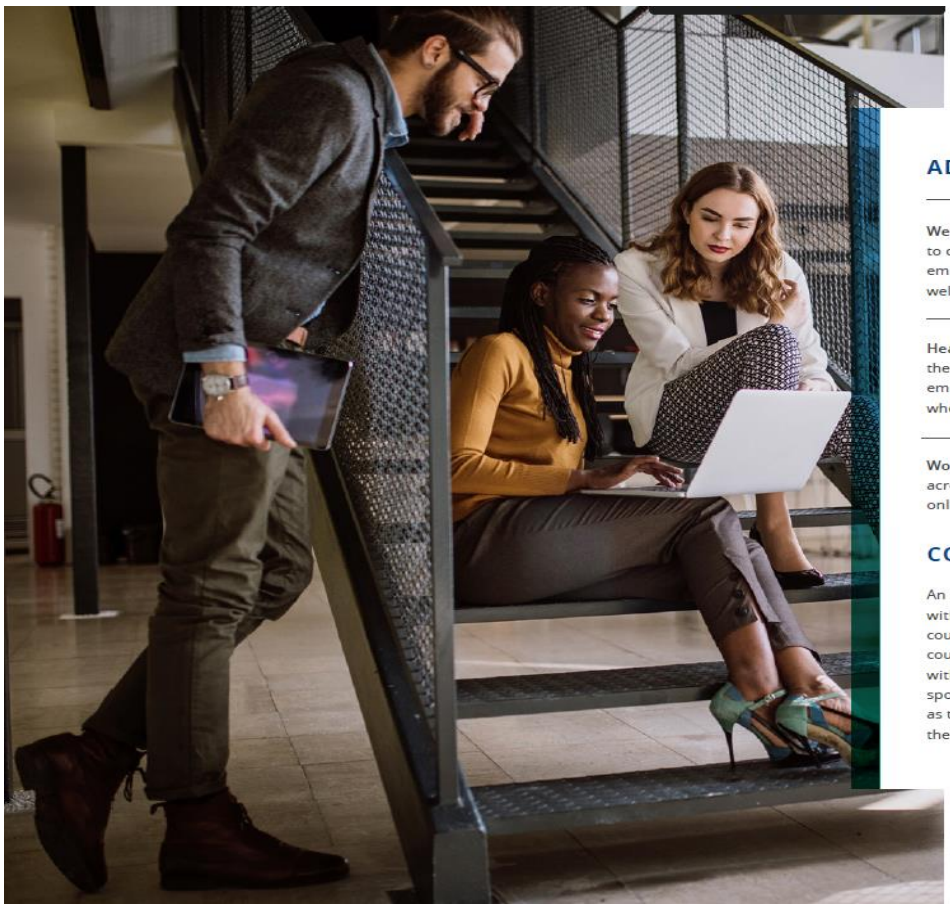


Employer insights and support

Healthy Company delivers intelligent, actionable insights and reporting for each individual employee, as well as the employer. These reports cover an employee's health and wellbeing risks and their progress in managing these risks.

The interactive dashboard includes comprehensive reporting for the employer around the risk classification of employees, utilisation and engagement with all Discovery related interventions, yearly trends and benchmarking linked to the Discovery Absenteeism Index.

The dashboard also provides tailored recommendations on how employers can manage these risks, and how Healthy Company and other available Discovery-related products can assist employees.



ADDITIONAL EMPLOYER BENEFITS

Wellness calendar and self-service tools which enable employers to conduct wellness campaigns, assist in seamlessly onboarding employees, submit queries and make bookings for workshops and wellness days on the Employer Zone on www.discovery.co.za

Healthy Company Wellness Advisers will guide employers along their company's wellness journey. Wellness Advisers will assist employers in identifying Wellness Champions within the company who will be trained to drive employee engagement.

Workshops and training programmes focusing on a range of topics across the four dimensions of wellbeing which can be accessed online or on site.

COVER FOR DEPENDANTS

An employee's dependants can access advice and assistance with episode management, including telephonic support and counselling with a Healthy Company Coach, legal adviser, debt counsellors or trauma counsellors and face-to-face consultations with registered psychologists or social workers. Dependants are spouses, children or parents, anyone living in the same household as the main member, or someone who is financially dependent on the member.

Pricing

Pricing is based on the employer's unique circumstances, including the size and demographic profile of employees. For employer groups where a high proportion of employees are members of a medical scheme administered by Discovery Health or are members of Discovery Primary Care, price discounts may apply based on integration with these products.

DISCOVERY COACHES

This section includes:

- Introduction to Discovery Coaches
- Key features of Discovery Coaches

Discovery Coaches

Introduction to Discovery Coaches

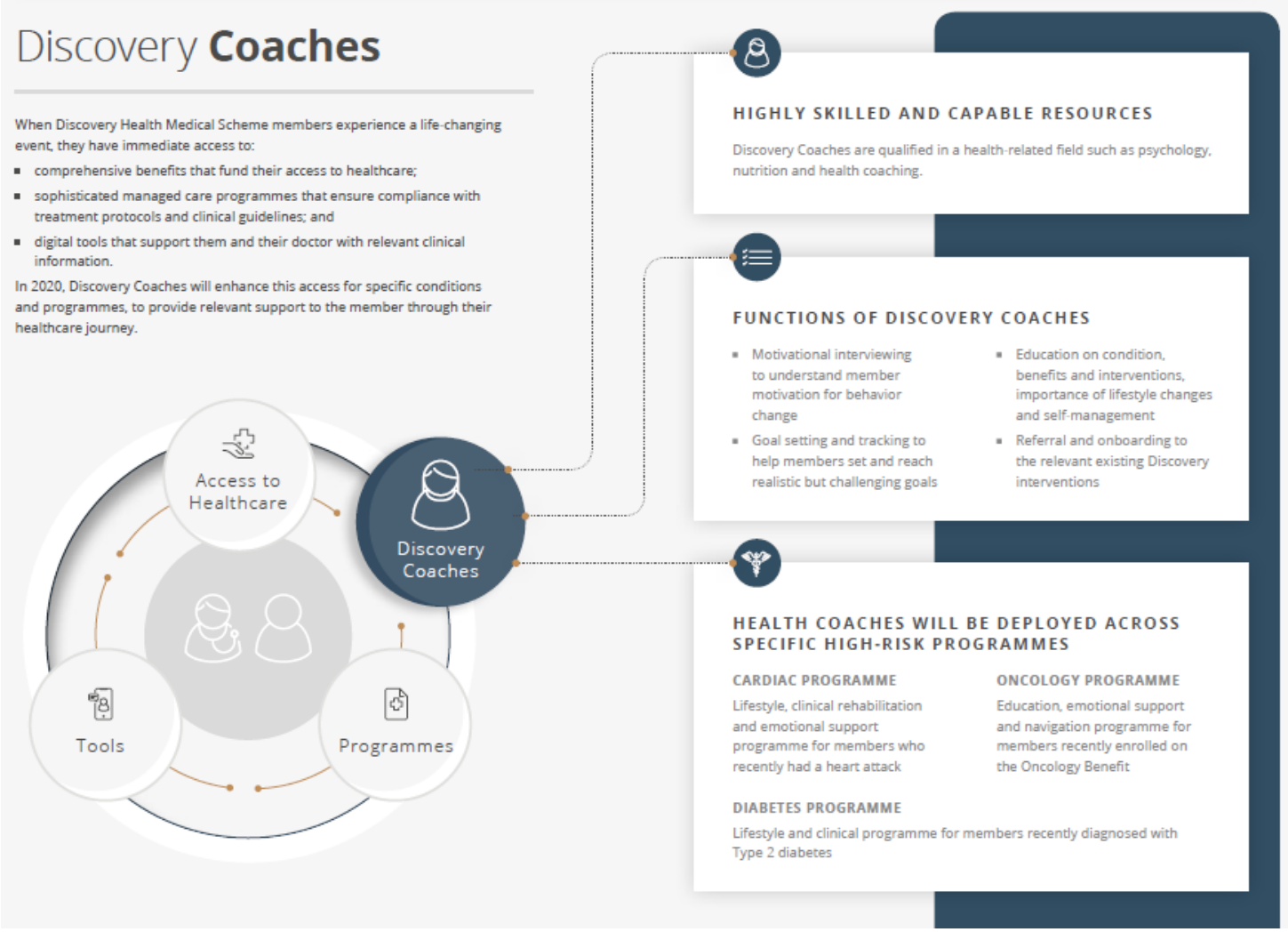
Large numbers of Discovery Health Medical Scheme members experience life-changing events on a daily basis.

24 DHMS members are diagnosed with cancer

8 DHMS members suffer a non-fatal heart attack

313 DHMS members are diagnosed with a new chorinic condition

Dealing with life-changing health events or the ongoing management of a chronic disease can be a significant burden. Life-changing diagnoses require complex medical intervention. The greater the complexity and frequency of care, the more important it is to coordinate this care. Discovery Health has extensive experience in guiding members with complex medical conditions through their healthcare journeys.



Benefits for the members:

- Better quality of care across multiple providers
- Better management of their health and wellbeing
- Improved understanding of the benefits on the DHMS plan
- Support and guidance through human interaction.

Benefits for DHMS:

- Clinically appropriate care without unnecessary healthcare costs
- Reduced service interactions and increased engagement with existing tools
- Healthier members with lower healthcare costs and improved satisfaction levels.

Benefits for doctors:

- Better patient outcome
- Reduced administration burden
- Increased members' adherence to treatment guidelines and benefit protocols.

THE HEALTHCARE FUND

This section includes:

- Introduction to the Healthcare Fund
- Examples of Healthcare Fund cases

The Healthcare Fund

Introduction to the Healthcare Fund

The Healthcare Fund allows employers to offer tailored benefits to their employees, over and above the benefits they receive through their medical scheme, Primary Care and Gap Cover.

The Healthcare Fund is a bespoke employer-funded offering, catering to the unique healthcare and wellness needs employers and their employees have.

In addition to the bespoke offering, the Healthcare fund could be used to offer relevant employer benefits:

HEALTH

Using Discovery's network and administration capabilities to provide flexible benefits tailored for specific healthcare needs:

- Cover during Self-payment Gap
- Flu vaccines
- Trauma and Stabilisation Benefit
- Maternity benefits for Primary Care

WELLNESS

Using Vitality's expertise and partnerships to provide discounted access to benefits that incentivise healthy behaviour:

- Wearable devices
- Corporate gym
- HealthyFood for all employees
- Executive wellness

Examples of Healthcare Fund cases

Maternity benefits for Primary Care members

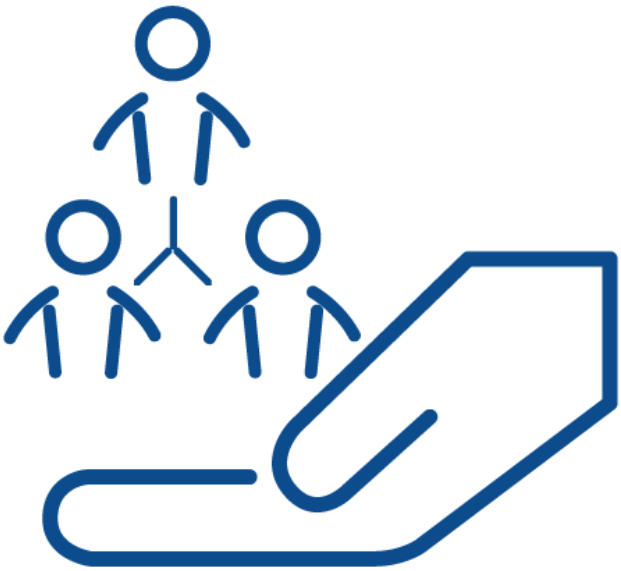
Several hundred employees of ABC Retailers are members of Primary Care. The employer identifies the need for additional maternity benefits and chooses to set up a Healthcare Fund for low-risk pregnancies. The benefits in the Healthcare Fund cover childbirth-related healthcare services for the employee or their spouse on their policy, such as antenatal visits with a GP or midwife and childbirth and post-natal consultations with a midwife. All related claims are covered through the Healthcare Fund when a Discovery network provider is used.

Cover during Self-payment Gap for medical aid members

XYZ Telecoms fully subsidises the cost of a comprehensive medical aid plan for all of their employees. However, employees might be exposed to shortfalls in their day-to-day benefits, once they have depleted the funds in their Medical Savings Accounts. To meet this need for their employees, the company introduces the Healthcare Fund to cover any day-to-day expenses until the member enters their Above Threshold Benefit. This ensures that their employees have extensive levels of cover for day-to-day benefits.

Wearable device benefit for employees

CD Logistics implements a corporate wellness programme, using the Healthcare Fund and leveraging Vitality's partnership with wearable device manufacturers. As part of the programme, CD Logistics covers the cost of Vitality Active, which provides employees with a discounted gym membership and weekly rewards for physical activity. In addition, the company purchases discounted wearable devices for all employees to help them monitor their physical activity and earn points to reach their goals. Employees can track their performance using the corporate leaderboard, with the company sponsoring quarterly prizes.



INTEGRATED CORPORATE BENEFITS

This section includes:

- Introduction to Integrated Corporate Benefits
- Key features of Integrated Corporate Benefits

Introduction to Integrated Corporate Benefits

Through the Discovery Shared-value Insurance model, employers who have Discovery administered healthcare solution and retirement funds and are clients of Discovery Group Risk can now unlock benefits that target specific, modifiable behaviours creating a healthier, more productive and financially secure workforce.

The impact of employees that engage in healthy behaviours:

- Live longer
- Claim less
- More productive

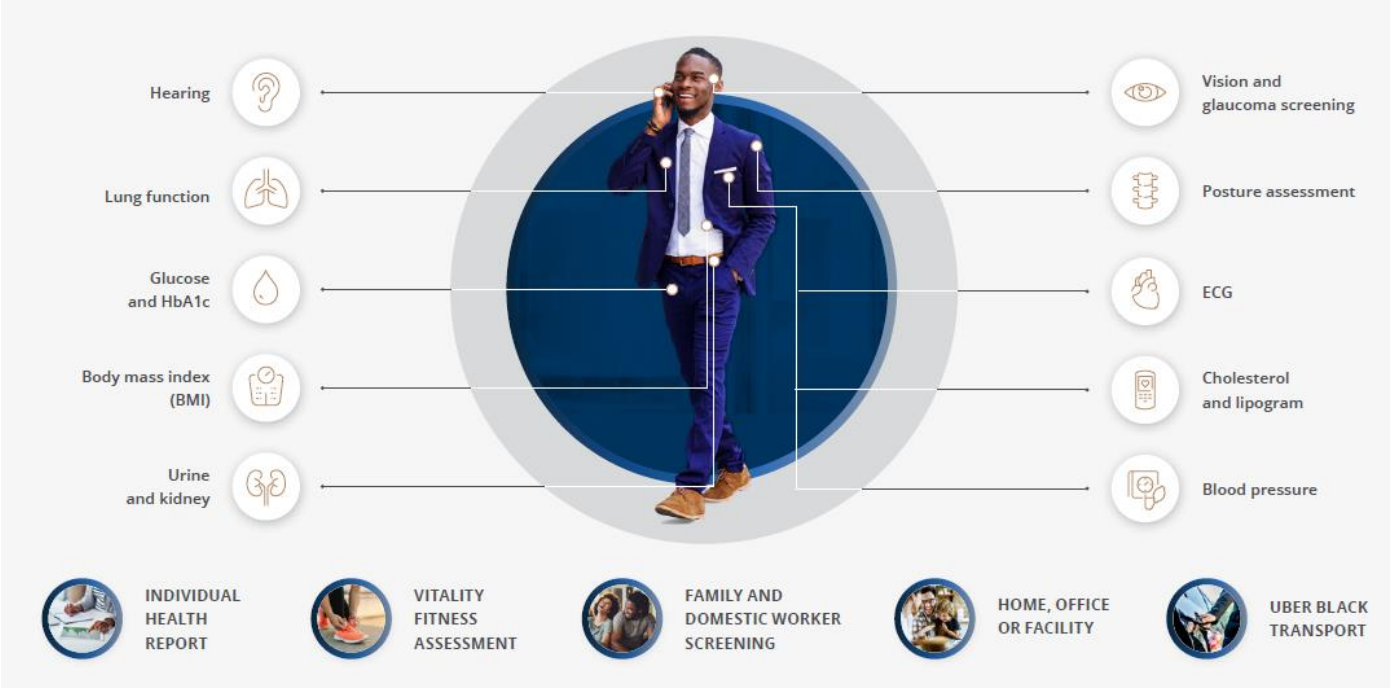
Through the Shared-value Insurance model, employers can integrate Discovery products to unlock a unique set of benefits:

- Executive Wellness Experience
- On-site clinics
- Healthy Company Core

Executive Wellness Experience

Executive Wellness Plus is available at no additional cost to all Group Risk members requiring physical medical underwriting where their employer has Discovery administered healthcare solutions and is a client of Discovery Group Risk. This personalised, high-touch experience, valued at R 2 950, will replace the traditional underwriting process.

In addition to providing key screenings, a fitness assessment, and at-home screening for the executive's family, this experience also includes a range of additional screening benefits that help executive to understand and manage lifestyle and health conditions that frequently go undetected.



	STANDARD UNDERWRITING	EXECUTIVE WELLNESS PLUS
Individual health questionnaire	✓	✓
Random glucose blood test, full lipogram test, total cholesterol test and blood pressure test	✓	✓
Body Mass Index (BMI) and waist circumference checks	✓	✓
Point-of-care (POC) tests for urine and kidney	✓	✓
Individual health report	✗	✓
HbA1C and ECG tests (resting & stress)	✗ (only for at-risk individuals)	✓
Vision screening	✗	✓
Glaucoma screening	✗	✓ (only at assessment centre)
Hearing screening	✗	✓
Lung function test	✗	✓
Posture assessment	✗	✓
Vitality Fitness Assessment	✗	✓ (only at assessment centre)
Family and domestic worker screenings	✗	✓ (only at executive's home)
Uber Black transport to assessment centre, limited to a 25km trip	✗	✓

The Executive Wellness Offering also provides screening for the executive's family, including a complimentary domestic worker assessment, all of which can be completed at their home even if they have chosen to complete their assessment elsewhere.

An executive can elect to complete their assessment at the Discovery state-of-the-art assessment centre or any convenient location including their office, home, a Discovery Store, a designated Virgin Active gym. Discovery will arrange Uber Black transport for the executive to an assessment centre (limited to a 25km trip).

Technical details:

The below criteria must be met by the employer in order to qualify for the Executive Wellness Experience integrated benefit:

- At least 50% of the employees must be members of a medical scheme administered by Discovery Health or members of Discovery Primary Care
- The employer must have a Discovery Group Risk policy with the Income Continuation Benefit and at least 2 x annual salary Life Cover Benefit
- The employer must have at least 100 employees

Discovery's on-site clinics provide employees with access to primary healthcare services and wellness screenings delivered at their workplace.

On-site clinics are available at no additional cost in the first year when an employer has Discovery administered healthcare solutions and Discovery Group Risk. The number of employees that completed their Vitality Health Checks will determine the cost of the on-site clinic in year two and onwards.

On-site clinic services include:

Primary healthcare services

Employees have access to treatment of acute and chronic conditions, including illnesses and minor injuries, as well as prevention activities such as flu vaccines and Pap smears.

The on-site clinic is able to dispense medicine in line with legal requirements and Discovery's medicine list in accordance with the employee's chosen health product.

Screening

Health screening across physical, emotional and financial wellbeing. The screening tests include:

- Body Mass Index
- Blood Pressure
- Blood Glucose
- Total Cholesterol
- Voluntary HIV counselling and testing
- Financial and emotional screening

Virtual GP consultations

Employer groups will have the option to equip the on-site clinics with telemedicine functionality at an additional cost per employee per month.

If a GP referral is required, a virtual GP-enabled clinic allows the nurse to connect to a panel of expert GPs via a real-time video connection. The clinic nurse conducts the diagnostic consultation using the TytoCare device guided by a GP virtually.

The TytoCare device instantly sends a live feed of diagnostic images to the GP who can provide an accurate diagnosis. The doctor can see the patient and nurse, as well as all examinations and investigations conducted by the nurse, providing diagnoses and prescriptions as necessary.

The on-site clinic has access to e-scripting and medication dispensing on-site or if required app-based medicine delivery.

Technical details:

- The below criteria must be met by the employer in order to qualify for the on-site clinics integration benefit: At least 50% of the employees must be members of a medical scheme administered by Discovery Health or members of Discovery Primary Care
- The employer must have a Discovery Group Risk policy with the Income Continuation Benefit and at least 2 x annual salary Life Cover Benefit
- The employer must have at least 400 employees

Frequency of clinic

On-site clinics are offered as either a permanent or mobile clinic, depending on the size of the employer.

Employer size	Half-day or full-day	Days per week	Total hours per week
400	Half-day clinic	One day per week	4
800	Half-day clinic	Two days per week	8
1 250	Half-day clinic	Three days per week	12
1 500	Full-day clinic	Two days per week	16
2 000	Full-day clinic	Five days per week	20
2 250	Full-day clinic	Three days per week	24
3 000	Full-day clinic	Four days per week	32
4 000	Full-day clinic	Five days per week	40

On-site clinic funding:

	Year 1	Year 2*
New employers	Free	Discount is based on a sliding scale of the previous year's health check take-up. For example: • Employers with a 60% health check take-up at the on-site clinic qualify for a 100% discount on the cost of the clinic • Employers with a 20% health check take-up at the on-site clinic qualify for a 33% discount on the cost of the clinic • If the employer has more than 50% of employees on Primary Care, a bespoke funding structure will be agreed **If the employers has more than 250 uncovered employees, a shortfall fee applies*
Existing employers	50% discount	

Healthy Company Core

Healthy Company Core will be available from August 2020. Qualifying employers will have access Health Company Core at no additional cost for the first three years, with the additional option to purchase Healthy Company Comprehensive at a discounted rate

Key features of Healthy Company Core:

- Digital assessments and risk classification
- Interventions
- Data-Driven insights

Technical details:

The below criteria must be met by the employer to qualify for the Healthy Company integration benefit:

- At least 50% of the employees must be members of a medical scheme administered by Discovery Health or members of Discovery Primary Care
- The employer must be a client of Discovery Retirement Funds with a minimum of R25 million under management
- The employer must have at least 400 employees

Integration matrix

Depending on the type and level of Discovery product integration, employers are able to unlock a unique set of benefits for their employees.

Option 1:

Healthcare and Group Risk

- Executive Wellness Plus
- On-site clinics

Option 2:

Healthcare and Retirement Funds

- Healthy Company Core

Option 3:

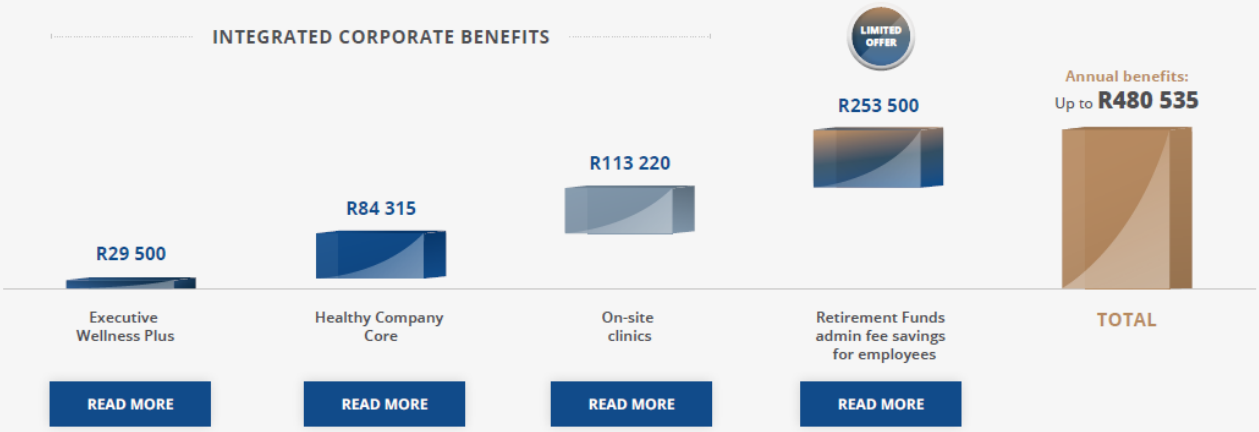
Healthcare, Group Risk and Retirement Funds

- Executive Wellness Plus
- On-site clinics
- Healthy Company Core

Case study

VALUE OF NEW INTEGRATED CORPORATE BENEFITS AND LIMITED OFFER

The following shows the breakdown of the total annual value of the integration benefits Craft Consulting receives from moving their group risk and retirement fund benefits to Discovery.



DISCOVERY CONTACT NUMBERS

This section includes:

- Discovery Health quick contact numbers

Discovery Health quick contact numbers

Discovery Health Medical Scheme contact details	
Telephone	0860 99 88 77 +27 11 529 6006 (international)
Email	healthinfo@discovery.co.za
Post	PO Box 784262 Sandton 2146
Claims submission channels	
Fax	0860 329 252
Email	claims@discovery.co.za
Drop-off boxes	Located in pharmacies and medical practices, as well as at Virgin Active or Planet Fitness gyms.
KeyCare contact details	
Telephone	0860 102 877
Email	keycare@discovery.co.za
Discovery Primary Care contact details	
Telephone	0860 444 779
Email	primarycarequeries@discovery.co.za
ER24	
Telephone	+27 11 529 6900
Health Technical Marketing (positioning / technical product queries only, not marketing material)	
Telephone	0860 actuary (22 88 729)
Email	Health_Support_Centre@discovery.co.za
General contact details	
Discovery911(medical emergencies)	0860 999 911
Compliance officer	compliance@discovery.co.za
Preauthorisation requests	Telephone 0860 99 88 77 Fax: 011 539 2192 Email: Preauthorisations@discovery.co.za
Chronic Illness Benefit call centre	0860 400 600
Discovery MedXpress	Telephone 0860 99 88 77 Fax: 011 539 1020 Email: medxpress@discovery.co.za
Discovery Trauma Support service	Telephone: 011 529 8765 (Mon - Fri 08h00 - 17h00) 0860 999 911 (after hours) Email: health_concierge_team@discovery.co.za
HIV and AIDS call centre	0860 99 88 77
Oncology call centre	0860 100 417
Commission queries	Telephone : 0860 345 678 option 3 Email: commissions@discovery.co.za
Marketing material requests	healthtechmarketingconsultantnews@discovery.co.za