

EXECUTIVE

COMPREHENSIVE

PRIORITY

SAVER

SMART SAVER

SMART

CORE

KEYCARE

PLAN COMPARISON 2026



Discovery Health Medical Scheme 2026 contributions
(1 January 2026 - 31 March 2026)

Series		Contributions (R)			Contributions to Medical Savings Account (R)			Total contributions (R)		
		MAIN MEMBER	ADULT	CHILD**	MAIN MEMBER	ADULT	CHILD**	MAIN MEMBER	ADULT	CHILD**
Executive	Executive	8,573	8,573	1,639	2,857	2,857	546	11,430	11,430	2,185
Comprehensive	Classic Comprehensive	6,975	6,596	1,392	2,323	2,197	464	9,298	8,793	1,856
	Classic Smart Comprehensive	6,754	6,237	1,577	1,191	1,100	278	7,945	7,337	1,855
Priority	Classic Priority	4,348	3,429	1,739	1,448	1,142	579	5,796	4,571	2,318
	Essential Priority	4,234	3,330	1,691	747	587	298	4,981	3,917	1,989
Saver	Classic Saver	3,629	2,862	1,455	906	715	362	4,535	3,577	1,817
	Classic Delta Saver	2,900	2,291	1,164	724	572	291	3,624	2,863	1,455
	Essential Saver	3,271	2,453	1,310	363	272	145	3,634	2,725	1,455
	Essential Delta Saver	2,609	1,969	1,047	289	218	116	2,898	2,187	1,163
	Coastal Saver	3,228	2,427	1,303	569	428	230	3,797	2,855	1,533
Smart Saver	Classic Smart Saver	3,115	2,641	1,302	235	199	98	3,350	2,840	1,400
	Essential Smart Saver	2,557	2,185	832	193	165	63	2,750	2,350	895
Smart	Classic Smart	2,822	2,227	1,127	No Medical Savings Account			2,822	2,227	1,127
	Essential Smart	2,021	2,021	2,021				2,021	2,021	2,021
	Essential Dynamic Smart	1,681	1,681	1,681				1,681	1,681	1,681
	Active Smart	1,350	1,350	1,350				1,350	1,350	1,350
Core	Classic Core	3,652	2,882	1,461	No Medical Savings Account			3,652	2,882	1,461
	Classic Delta Core	2,923	2,305	1,169				2,923	2,305	1,169
	Essential Core	3,138	2,354	1,260				3,138	2,354	1,260
	Essential Delta Core	2,507	1,887	1,006				2,507	1,887	1,006
	Coastal Core	3,011	2,259	1,196				3,011	2,259	1,196
KeyCare*	KeyCare Plus 0 – 9,900	1,817	1,817	661	No Medical Savings Account			1,817	1,817	661
	KeyCare Plus 9,901 – 15,990	2,497	2,497	704				2,497	2,497	704
	KeyCare Plus 15,991 +	3,687	3,687	986				3,687	3,687	986
	KeyCare Core 0 – 9,900	1,381	1,381	361	No Medical Savings Account			1,381	1,381	361
	KeyCare Core 9,901 – 15,990	1,723	1,723	427				1,723	1,723	427
	KeyCare Core 15,991 +	2,636	2,636	598				2,636	2,636	598
	KeyCare Start 0 – 10,550	1,331	1,331	811	No Medical Savings Account			1,331	1,331	811
	KeyCare Start 10,551 – 15,950	1,952	1,952	878				1,952	1,952	878
	KeyCare Start 15,951 – 24,250	3,063	3,063	919				3,063	3,063	919
	KeyCare Start 24,251 +	3,488	3,488	949				3,488	3,488	949
	KeyCare Start Regional 0 – 10,550	1,184	1,184	713	No Medical Savings Account			1,184	1,184	713
	KeyCare Start Regional 10,551 – 15,950	1,790	1,790	805				1,790	1,790	805
	KeyCare Start Regional 15,951 – 24,250	2,790	2,790	854				2,790	2,790	854
	KeyCare Start Regional 24,251 +	3,178	3,178	890				3,178	3,178	890

Shariah Compliant Arrangement available on all health plans.

* Income verification will be conducted for the lower income bands. Income is considered as: The higher of the main member or registered spouse or partner's earnings, commission and rewards from employment; interest from investments; income from leasing of assets or property; distributions received from a trust, pension and/or provident fund; receipt of any financial assistance received from any statutory social assistance programme.

** We count a maximum of three children when we work out the monthly contribution and annual Medical Savings Account, except when a child has been placed in the custody of a member, such as foster care, in which case every child on the membership will be counted.

Discovery Health Medical Scheme 2026 contributions
(1 April 2026 - 31 December 2026)

Series		Plan		Contributions (R)			Contributions to Medical Savings Account (R)			Total contributions (R)		
				MAIN MEMBER	ADULT	CHILD**	MAIN MEMBER	ADULT	CHILD**	MAIN MEMBER	ADULT	CHILD**
Executive	Executive			9,254	9,254	1,769	3,084	3,084	589	12,338	12,338	2,358
Comprehensive	Classic Comprehensive			7,528	7,119	1,502	2,509	2,373	500	10,037	9,492	2,002
	Classic Smart Comprehensive			7,290	6,732	1,702	1,286	1,188	300	8,576	7,920	2,002
Priority	Classic Priority			4,649	3,667	1,859	1,549	1,222	619	6,198	4,889	2,478
	Essential Priority			4,528	3,561	1,808	799	628	319	5,327	4,189	2,127
Saver	Classic Saver			3,880	3,060	1,555	970	765	388	4,850	3,825	1,943
	Classic Delta Saver			3,100	2,450	1,245	775	612	311	3,875	3,062	1,556
	Essential Saver			3,498	2,623	1,401	388	291	155	3,886	2,914	1,556
	Essential Delta Saver			2,790	2,106	1,119	309	233	124	3,099	2,339	1,243
	Coastal Saver			3,484	2,620	1,401	614	462	247	4,098	3,082	1,648
Smart Saver	Classic Smart Saver			3,115	2,641	1,302	235	199	98	3,350	2,840	1,400
	Essential Smart Saver			2,557	2,185	832	193	165	63	2,750	2,350	895
Smart	Classic Smart			3,018	2,381	1,205	No Medical Savings Account			3,018	2,381	1,205
	Essential Smart			2,161	2,161	2,161				2,161	2,161	2,161
	Essential Dynamic Smart			1,797	1,797	1,797				1,797	1,797	1,797
	Active Smart			1,350	1,350	1,350				1,350	1,350	1,350
Core	Classic Core			3,905	3,083	1,562	No Medical Savings Account			3,905	3,083	1,562
	Classic Delta Core			3,126	2,465	1,250				3,126	2,465	1,250
	Essential Core			3,356	2,517	1,347				3,356	2,517	1,347
	Essential Delta Core			2,681	2,018	1,076				2,681	2,018	1,076
	Coastal Core			3,250	2,438	1,291				3,250	2,438	1,291
KeyCare*	KeyCare Plus 0 - 10,250			1,961	1,961	713	No Medical Savings Account			1,961	1,961	713
	KeyCare Plus 10,251 - 16,600			2,695	2,695	760				2,695	2,695	760
	KeyCare Plus 16,601 +			3,980	3,980	1,064				3,980	3,980	1,064
	KeyCare Core 0 - 10,250			1,490	1,490	390	No Medical Savings Account			1,490	1,490	390
	KeyCare Core 10,251 - 16,600			1,859	1,859	461				1,859	1,859	461
	KeyCare Core 16,601 +			2,845	2,845	645				2,845	2,845	645
	KeyCare Start 0 - 10,950			1,436	1,436	875	No Medical Savings Account			1,436	1,436	875
	KeyCare Start 10,951 - 16,550			2,107	2,107	947				2,107	2,107	947
	KeyCare Start 16,551 - 25,150			3,306	3,306	992				3,306	3,306	992
	KeyCare Start 25,151 +			3,765	3,765	1,024				3,765	3,765	1,024
	KeyCare Start Regional 0 - 10,950			1,278	1,278	769	No Medical Savings Account			1,278	1,278	769
	KeyCare Start Regional 10,951 - 16,550			1,932	1,932	869				1,932	1,932	869
	KeyCare Start Regional 16,551 - 25,150			3,011	3,011	922				3,011	3,011	922
	KeyCare Start Regional 25,151 +			3,430	3,430	961				3,430	3,430	961

Shariah Compliant Arrangement available on all health plans.

* Income verification will be conducted for the lower income bands. Income is considered as: The higher of the main member or registered spouse or partner's earnings, commission and rewards from employment; interest from investments; income from leasing of assets or property; distributions received from a trust, pension and/or provident fund; receipt of any financial assistance received from any statutory social assistance programme.

** We count a maximum of three children when we work out the monthly contribution and annual Medical Savings Account, except when a child has been placed in the custody of a member, such as foster care, in which case every child on the membership will be counted.

Day-to-day benefits

		Annual Medical Savings Account		
	PLAN	MAIN MEMBER (R)	ADULT (R)	CHILD (R)*
Executive	Executive	34,284	34,284	6,552
Comprehensive	Classic Comprehensive	27,876	26,364	5,568
	Classic Smart Comprehensive	14,292	13,200	3,336
Priority	Classic Priority	17,376	13,704	6,948
	Essential Priority	8,964	7,044	3,576
Saver	Classic Saver	10,872	8,580	4,344
	Classic Delta Saver	8,688	6,864	3,492
	Essential Saver	4,356	3,264	1,740
	Essential Delta Saver	3,468	2,616	1,392
	Coastal Saver	6,828	5,136	2,760
Smart Saver	Classic Smart Saver	2,820	2,388	1,176
	Essential Smart Saver	2,316	1,980	756

Annual Medical Savings Account amounts displayed above reflects the upfront annual allocation for January 2026 and will be adjusted from April 2026 in line with the annual contribution increase.

* We count a maximum of three children when we work out the annual Medical Savings Account, except when a child has been placed in the custody of a member, such as foster care, in which case every child on the membership will be counted. If you join the medical scheme after January, you won't get the full amount because it is calculated by counting the remaining months in the year.

		Personal Health Fund		
		UP TO A MAXIMUM PER ADULT (R)	UP TO A MAXIMUM PER CHILD (R)	UP TO A MAXIMUM PER FAMILY (R)
Executive	Executive	3,000	1,500	12,000
Comprehensive	Classic Comprehensive	3,000	1,500	12,000
	Classic Smart Comprehensive	3,000	1,500	12,000
Priority	Classic Priority	2,500	1,250	10,000
	Essential Priority	1,500	750	6,000
Saver	Classic Saver (including delta plan)	2,500	1,250	10,000
	Essential Saver (including delta plan)	1,500	750	6,000
	Coastal Saver	1,500	750	6,000
Smart Saver	Classic Smart Saver	2,500	1,250	10,000
	Essential Smart Saver	1,500	750	6,000
Smart	Classic Smart	2,000	1,000	8,000
	Essential Smart	1,000	500	4,000
	Essential Dynamic Smart	1,000	500	4,000
	Active Smart	1,000	500	4,000
Core	Classic Core (including delta plan)	2,000	1,000	8,000
	Essential Core (including delta plan)	1,000	500	4,000
	Coastal Core	1,000	500	4,000
KeyCare	KeyCare Plus	500	250	1,000
	KeyCare Core	500	250	1,000
	KeyCare Start	500	250	1,000
	KeyCare Start Regional	500	250	1,000

All adults can unlock a Challenge Boost on top of their base Personal Health Fund by completing two challenges every year. Boost your Personal Health Fund by up to an additional R3,000 per adult and up to R12,000 per policy by completing two challenges per annum. Your boost value depends on your plan type.

Annual Threshold Amounts

Annual Threshold	Main member (R)	Adult (R)	Child* (R)
Executive	42,570	42,570	8,080
Classic Comprehensive	34,810	34,810	6,650
Classic Smart Comprehensive	34,810	34,810	6,650
Priority	27,160	20,410	9,050

* We count a maximum of three children when we work out the Annual Threshold and Above Threshold Benefit limit, except when a child has been placed in the custody of a member, such as foster care, in which case every child on the membership will be counted. If you join the medical scheme after January, you won't get the full amount because it is calculated by counting the remaining months in the year.

Above Threshold Benefit limits	Main member (R)	Adult (R)	Child* (R)
Executive	Unlimited		
Classic Comprehensive	36,290	36,290	8,810
Classic Smart Comprehensive	31,100	31,100	7,770
Priority	20,080	14,330	7,020

	Executive	Comprehensive		Priority		Saver		Smart Saver		Smart		Core			Keycare														
		CLASSIC	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL		CLASSIC	ESSENTIAL	ACTIVE	CLASSIC	ESSENTIAL	COASTAL	PLUS	CORE	START	START REGIONAL								
PMB	Prescribed Minimum Benefits (PMB)	All Discovery Health Medical Scheme (DHMS) plans cover the costs related to the diagnosis, treatment and care of: an emergency medical condition, a defined list of 271 diagnoses and a defined list of 27 chronic conditions. Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit conditions. The treatment requested must match the treatments in the defined benefits. You must use designated service providers (DSPs) in our network – this does not apply in emergencies. Where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service providers in our network once your condition has stabilised. If your treatment doesn't meet the above criteria, we will pay up to 80% of the Discovery Health Rate (DHR). You will be responsible for the difference between what we pay and the actual cost of your treatment.																											
	Medical Savings Account (MSA) and day-to-day benefits	Pays for day-to-day medical expenses like GP consultation fees, prescribed and over-the-counter medicine, radiology and pathology as long as you have money available. 25% of your monthly contributions are allocated into your MSA.	Pays for day-to-day medical expenses like GP consultation fees, prescribed and over-the-counter medicine, radiology and pathology as long as you have money available. On the Classic Smart Comprehensive, you have cover for consultations with a Smart GP before the annual threshold has been reached, with a fixed co-payment. A percentage of your monthly contributions are allocated into your MSA. On the Classic Comprehensive Plan this is 25% and on the Classic Smart Comprehensive this is 15%.	Pays for day-to-day medical expenses like GP consultation fees, prescribed and over-the-counter medicine, radiology and pathology as long as you have money available. A percentage of your monthly contributions are allocated into your MSA. - On Classic Priority this is 25% - On Essential Priority 15%.	Pays for day-to-day medical expenses like GP consultation fees, prescribed and over-the-counter medicine, radiology and pathology as long as you have money available. A percentage of your monthly contributions are allocated into your MSA. - On Classic Saver this is 20% - Coastal Saver this is 15%. - On Essential Saver this is 10%	The Medical Savings Account pays for day-to-day medical expenses like radiology and pathology as long as you have money available. In addition to your Medical Savings Account, you have access to a defined set of benefits includes GP consultations, certain acute medicine when prescribed by a Smart GP and over-the-counter medicine, contraceptive medicine, dental check up, optometry check up, the Sports Injury Benefit, and the Kids Injury Benefit, with fixed copayments and limits. 7% of your monthly contributions are allocated into your MSA.	The Medical Savings Account pays for day-to-day medical expenses like radiology and pathology as long as you have money available. In addition to your Medical Savings Account, you have access to a defined set of benefits includes GP consultations, certain over-the-counter medicine, dental check up, optometry check up, the Sports Injury and the Injury Benefit for kids under the age of 12, with fixed co-payments and limits. 7% of your monthly contributions are allocated into your MSA.	Access to a defined set of benefits including GP consultations, certain acute medicine when prescribed by a Smart GP and over-the-counter medicine, dental check up, optometry check up, and the Sports Injury Benefit, with fixed co-payments and limits. This plan does not offer an MSA.	Access to a defined set of benefits including GP consultations, certain over-the-counter medicine, dental check up and optometry check up with fixed co-payments and limits. This plan does not offer an MSA.	These plans do not offer an MSA.					Day-to-day benefits through your nominated GP and day-to-day medicine from our medicine list when prescribed by your nominated KeyCare GP. We pay for basic radiology and pathology at a network provider if referred by your nominated GP, as well as basic optometry and dentistry, and specialist cover up to R5,750 per person per year when referred by your nominated GP. This plan does not offer an MSA.	Specialist cover up to R5,750 per person per year when referred by a GP. This plan does not offer an MSA.	Day-to-day benefits through your nominated KeyCare Start GP and day-to-day medicine from our medicine list when prescribed by your nominated KeyCare Start Regional GP. We pay for basic radiology and pathology if referred by your nominated KeyCare Start GP, as well as basic optometry and dentistry, and specialist cover up to R2,850 per person per year when referred by your nominated KeyCare Start GP. This plan does not offer an MSA.	Day-to-day benefits through referral by the KeyCare Online Practice and day-to-day medicine from our medicine list when prescribed by your nominated KeyCare Start Regional GP. We pay for basic radiology and pathology if referred by your nominated KeyCare Start Regional GP. As well as basic optometry and dentistry, and specialist cover up to R2,850 per person per year when referred by your nominated KeyCare Start Regional GP. This plan does not offer an MSA.											
	Personal Health Fund	The Personal Health Fund covers a comprehensive list of out-of-hospital healthcare services according to your individual health needs once you've activated Personal Health Pathways and completed your recommended next best actions. Your Personal Health Fund limit depends on your plan type, the size and make up of your family (according to your policy). If you are a new Discovery Health Medical Scheme members for 2026, you will be able to double your limit stated below. All adults on the policy can earn additional funds in the PHF up to a maximum value for successfully completing a series of next best actions set as a challenge.																											
		Up to R3,000 per adult, up to R1,500 per child, up to a maximum of R12,000 per family. Up to an additional maximum of R12,000 for completing your Personal Health Pathway challenges.		Up to R2,500 per adult, up to R750 per child, up to a maximum of R10,000 per family. Up to an additional maximum of R10,000 for completing your Personal Health Pathway challenges.		Up to R1,500 per adult, up to R750 per child, up to a maximum of R6,000 per family. Up to an additional maximum of R6,000 for completing your Personal Health Pathway challenges.		Up to R2,500 per adult, up to R1,250 per child, up to a maximum of R10,000 per family. Up to an additional maximum of R10,000 for completing your Personal Health Pathway challenges.		Up to R1,500 per adult, up to R750 per child, up to a maximum of R6,000 per family. Up to an additional maximum of R6,000 for completing your Personal Health Pathway challenges.		Up to R2,000 per adult, up to R1,000 per child, up to a maximum of R8,000 per family. Up to an additional maximum of R8,000 for completing your Personal Health Pathway challenges.		Up to R1,000 per adult, up to R500 per child, up to a maximum of R4,000 per family. Up to an additional maximum of R4,000 for completing your Personal Health Pathway challenges.		Up to R2,000 per adult, up to R1,000 per child, up to a maximum of R8,000 per family. Up to an additional maximum of R8,000 for completing your Personal Health Pathway challenges.		Up to R1,000 per adult, up to R500 per child, up to a maximum of R4,000 per family. Up to an additional maximum of R4,000 for completing your Personal Health Pathway challenges.		Up to R500 per adult, up to R250 per child, up to a maximum of R1,000 per family. Up to an additional maximum of R1,000 for completing your Personal Health Pathway challenges.									
DAY-TO-DAY BENEFITS	Day-to-day Extender Benefit	Pays for certain day-to-day benefits after you have run out of money in your MSA and before you reach the Annual Threshold. Covers unlimited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have unlimited cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR. You also have additional cover for kids casualty visits.	Pays for certain day-to-day benefits after you have run out of money in your MSA and before you reach the Annual Threshold. Covers pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR. You also have additional cover for kids casualty visits.	This plan does not offer this benefit.	Pays for certain day-to-day benefits after you have run out of money in your MSA and before you reach the Annual Threshold. Covers pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR.	Pays for certain day-to-day benefits after you have run out of money in your MSA. Covers limited pharmacy clinic consultations in our wellness network, as well as video call consultations with a network GP. You also have cover for consultations with a network GP who meets the digital criteria, when referred. We cover consultations up to the DHR.					These plans do not offer this benefit.																		
					You also have additional cover for kids casualty visits.		You also have additional cover for kids casualty visits.																						
	Above Threshold Benefit	The Scheme continues to cover day-to-day healthcare services once you reach your Annual Threshold. The Above Threshold Benefit is unlimited on the Executive Plan. Annual benefit limits may apply.		The Scheme continues to cover day-to-day healthcare services once you reach your Annual Threshold. The Above Threshold Benefit is limited on these plans. Annual benefit limits may apply.		These plans do not offer this benefit.																							
	MRI and CT scans	We pay the first R4,000 of your MRI or CT scan from your day-to-day benefits. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies per year.																		You must pay the first R4,000 of your MRI or CT scan. We cover the balance of the scan from the Hospital Benefit, up to the DHR. For conservative back and neck scans a limit of one scan per spinal and neck region applies per year.		These plans do not offer this benefit.				MRI and CT scans are paid from the Specialist Benefit up to a limit of R5,750 for a person a year.		MRI and CT scans are paid from the Specialist Benefit up to a limit of R2,850 for a person a year.	
MATERNITY COVER	Cover during your pregnancy and for two years after your baby's birth once the benefit is activated	During pregnancy 12 antenatal consultations with your gynaecologist, GP or midwife - Two 2D ultrasound scans or one 2D ultrasound scan and one nuchal translucency test. 3D and 4D scans are paid up to the rate we pay for 2D scans - One chromosome test or Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria - Private ward cover up to R2,800 per day for your delivery in hospital - A defined basket of blood tests After you give birth - Your baby is covered for up to two visits to a GP, paediatrician or an ENT - You are covered for one six week post-birth consultation at your midwife, GP or gynaecologist either as part of your delivery or if there are any complications Pre- and postnatal care - Five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth - One nutritional assessment at a dietitian - Two mental health consultations with a counsellor or psychologist - One breastfeeding consultation with a registered nurse or a breastfeeding specialist			During pregnancy 8 antenatal consultations with your gynaecologist, GP or midwife - Two 2D ultrasound scans or one 2D ultrasound scan and one nuchal translucency test. 3D and 4D scans are paid up to the rate we pay for 2D scans - One chromosome test or Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria - A defined basket of blood tests After you give birth - Your baby is covered for up to two visits to a GP, paediatrician or an ENT - You are covered for one six week post-birth consultation at your midwife, GP or gynaecologist either as part of your delivery or if there are any complications Pre- and postnatal care - Five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth - One nutritional assessment at a dietitian - Two mental health consultations with a counsellor or psychologist - One breastfeeding consultation with a registered nurse or a breastfeeding specialist			These services are subject to the defined day-to-day benefits on this plan.														During pregnancy 8 antenatal consultations with your gynaecologist, GP or midwife - Two 2D ultrasound scans or one 2D ultrasound scan and one nuchal translucency test. 3D and 4D scans are paid up to the rate we pay for 2D scans - One chromosome test or Non-Invasive Prenatal Test (NIPT) if you meet the clinical entry criteria - A defined basket of blood tests After you give birth - Your baby is covered for up to two visits to a GP, paediatrician or an ENT - You are covered for one six week post-birth consultation at your midwife, GP or gynaecologist either as part of your delivery or if there are any complications Pre- and postnatal care - Five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth - One nutritional assessment at a dietitian - Two mental health consultations with a counsellor or psychologist - One breastfeeding consultation with a registered nurse or a breastfeeding specialist				These services are subject to the defined day-to-day benefits on these plans.			
	Nurture at home	Parents whose babies are admitted to NICU for at least 7 days after birth have access to additional support to help adjust after discharge. A basket of care is available which includes an overnight stay in hospital for one of the parents, virtual coaching sessions, home nurse visits, and paediatrician visits.										These plans do not offer this benefit.				Parents whose babies are admitted to NICU for at least 7 days after birth have access to additional support to help adjust after discharge. A basket of care is available which includes an overnight stay in hospital for one of the parents, virtual coaching sessions, home nurse visits, and paediatrician visits.				These plans do not offer this benefit.									

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

Personal Health Pathways is brought to Discovery Health Medical Scheme members by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes. Personal Health Pathways is enabled by the combination of Discovery Health's healthcare capabilities and Vitality's behaviour change expertise. Discovery Health Medical Scheme, registration number 1125, is an independent non-profit entity governed by the Medical Schemes Act, and regulated by the Council for Medical Schemes. Vitality is a separate wellness product, sold and administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07. Limits, terms and conditions apply.

	Executive	Comprehensive		Priority		Saver		Smart Saver		Smart		Core			Keycare									
		CLASSIC	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	ACTIVE	CLASSIC	ESSENTIAL	COASTAL	PLUS	CORE	START	START REGIONAL				
CHRONIC COVER	Conditions	You have cover for the 27 Chronic Disease List conditions according to the Prescribed Minimum Benefits list as well as additional conditions on our Additional Disease List.		You have cover for the 27 Chronic Disease List conditions according to the Prescribed Minimum Benefits																				
	Medicine cover	Approved medicine on our medicine list covered in full at a network provider (not applicable to ADL conditions). Medicine not on our list, paid up to 100% of the DHR or generic reference price up to a maximum of the monthly Chronic Drug Amount.	Full cover for approved medicine on our medicine list at a network provider (not applicable to ADL). Medicine not on our list, paid up to 100% of the DHR or generic reference price up to a maximum of the monthly Chronic Drug Amount.	Full cover for approved medicine on our medicine list at a network provider. Medicine not on our list, paid up to 100% of the DHR or generic reference price up to a maximum of the monthly Chronic Drug Amount.	Approved medicine on our medicine list covered in full when you use a MedXpress Network Pharmacy. Medicine not on our list, paid up to 100% of the DHR or generic reference price up to a maximum of the monthly Chronic Drug Amount.					Approved medicine on our medicine list covered in full when you use a MedXpress Network Pharmacy. For medicine not on our list, we cover up to the therapeutic reference price of the equivalent medicine or group of medicines.					Approved medicine on our medicine list covered in full when you use a MedXpress Network Pharmacy. Medicines not on our list paid up to 100% of the DHR or generic reference price up to a maximum of the monthly Chronic Drug Amount.			Approved medicine covered in full when you use one of our network pharmacies or your nominated KeyCare Network GP. Your nominated KeyCare Network GP must prescribe the chronic medicine. For medicine not on our list, we cover up to the cost of the therapeutic reference price of the equivalent medicine or group of medicines.		We cover your chronic medicine in a state facility.	We cover your chronic medicine when you use one of our network pharmacies or your nominated KeyCare Start Regional Network GP. Your nominated Regional Network GP must prescribe the chronic medicine. For medicine not on our list, we cover up to the cost of the therapeutic reference price of the equivalent medicine or group of medicines.			
	Specialised Medicine and Technology Benefit	Cover for a defined list of the latest treatments through the Specialised Medicine and Technology Benefit. We pay up to R200,000 per person per year. A co-payment of up to 20% applies.		These plans do not offer this benefit																				
CANCER COVER	Oncology Benefit	We cover the first R500,000 of your approved cancer treatment over a 12-month cycle in full.	We cover the first R375,000 of your approved cancer treatment over a 12-month cycle in full.	We cover the first R250,000 of your approved cancer treatment over a 12-month cycle in full.					We cover the first R250,000 of your approved cancer treatment over a 12-month cycle in full. All cancer-related healthcare services are covered up to 100% of the DHR. Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. If your treatment costs more than the cover amount, we will cover up to 80% of the DHR.			We cover the first R250,000 of your approved cancer treatment over a 12-month cycle in full. All cancer-related healthcare services are covered up to 100% of the DHR. Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. If your treatment costs more than the cover amount, we will cover up to 80% of the DHR.		Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. You have cover for cancer treatment in our network.		We cover the first R250,000 of your approved cancer treatment over a 12-month cycle in full. All cancer-related healthcare services are covered up to 100% of the DHR. Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. All PMB treatment costs add up to the cover amount.		Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. You have cover for cancer treatment in our network.		Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. You have cover for cancer treatment in a state facility.				
		All cancer-related healthcare services are covered up to 100% of the DHR. Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount, we will cover up to 80% of the DHR.		All cancer-related healthcare services are covered up to 100% of the DHR. Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount, we will cover up to 80% of the DHR.		All cancer-related healthcare services are covered up to 100% of the DHR. Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount, we will cover up to 80% of the DHR. If you are on a Delta plan you will need to make use of DSP in the Delta Network.			All cancer-related healthcare services are covered up to 100% of the DHR. Cancer treatment that is a Prescribed Minimum Benefit (PMB) is always covered in full, subject to the use of a designated service provider (DSP), where applicable. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount, we will cover up to 80% of the DHR.			We cover cancer treatment in our network.												
	Extended Oncology Benefit	Once you have reached your cover limit, you have extended cover in full for a defined list of cancers and treatments that meet the Scheme's criteria.		These plans do not offer this benefit.																				
	Oncology Innovation Benefit	You have cover for a defined list of innovative cancer medicine that meet the Scheme's criteria. You will need to pay 30% of the cost of these treatments.	You have cover for a defined list of innovative cancer medicine that meet the Scheme's criteria. You will need to pay 50% of the cost of these treatments.	You have cover for a sub-set of the defined limited list of precision medicine, subject to the Scheme's clinical entry criteria. You will need to pay 50% of the cost of these treatments.	You have cover for a limited sub-set of the defined list of precision medicine, subject to the Scheme's clinical entry criteria. You will need to pay 50% of the cost of these treatments.								This plan does not offer this benefit.		You have cover for a sub-set of the defined list of precision medicine, subject to the Scheme's clinical entry criteria. You will need to pay 50% of the cost of these treatments.		These plans do not offer this benefit.							
HOSPITAL COVER	Private hospital cover in a general ward	Unlimited cover plus private ward cover of up to R2,800 each day.	Unlimited cover plus private ward cover up to R2,800 per day for your delivery.		Unlimited cover								Neonatal hospitalization: Limited to R72,600 per family per year. Unlimited cover for other admissions.		Unlimited cover									
	Private hospital	You are covered in any facility approved by the Scheme.	Full cover in the Smart Hospital Network. For planned admissions at hospitals outside of the Smart Hospital Network, you must pay an upfront payment of R12,650 to the hospital.		You are covered in any facility approved by the Scheme. An upfront payment of between R5,000 to R23,700 applies for a defined list of procedures. Where these procedures form part of the list of procedures to be performed in our Day Surgery Network, the higher of the upfront payments will apply.	You are covered in any facility approved by the Scheme. Full cover on Delta options when using the Delta Hospital Network of private hospitals or our designated service provider (DSP) for home-based care, where clinically appropriate. For planned admissions outside of the Delta Hospital Network, you must pay an upfront payment to the hospital of R11,100. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,450.	Full cover in any approved private hospital in the four coastal provinces network. If you use a hospital outside the coastal network, we pay up to 70% of the DHR of the hospital account and you must pay the difference.		Full cover in the Smart Hospital Network or our designated service provider (DSP) for home-based care, where clinically appropriate. For planned admissions at hospitals outside of the Smart Hospital Network, you must pay an upfront payment of R12,650 to the hospital. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,450.		Full cover in the Smart Hospital Network or our designated service provider (DSP) for home-based care, where clinically appropriate. For planned admissions at hospitals outside of the Smart Hospital Network, you must pay an upfront payment of R12,650 to the hospital. For the Essential Dynamic Smart plan, full cover in the Dynamic Smart Hospital Network as referred by Ask Discovery, or our designated service provider (DSP) for home-based care, where clinically appropriate. For planned admissions at hospitals outside of the Dynamic Smart Hospital Network, you must pay an upfront payment of R15,300 to the hospital. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,450.		You must pay an upfront payment of R7,750 to the hospital for any planned admissions in the Dynamic Smart Hospital Network as referred by Ask Discovery, or our designated service provider (DSP) for home-based care, where clinically appropriate. For planned admissions at hospitals outside of the Dynamic Smart Hospital Network, you must pay an upfront payment of R15,300 to the hospital. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,450.		You are covered in any facility approved by the Scheme. Full cover on Delta options when using the Delta Hospital Network of private hospitals or our designated service provider (DSP) for home-based care, where clinically appropriate. For planned admissions outside of the Delta Hospital Network, you must pay an upfront payment to the hospital of R11,100. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,450.		Full cover in any approved private hospital in the four coastal provinces network. If you use a hospital outside the coastal network, we pay up to 70% of the DHR of the hospital account and you must pay the difference.		Full cover if you use a hospital in the KeyCare Hospital Network or our designated service provider (DSP) for home-based care, where clinically appropriate. If you use a hospital in the Partial Cover Network, we pay up to 70% of the DHR. If you do not use hospitals in the networks, you will have to pay all costs. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,450.		Full cover at your chosen KeyCare Start Regional Network hospital or our designated service provider (DSP) for home-based care, where clinically appropriate. If you do not use your chosen hospital in the network, you will have to pay all costs. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,450.		Full cover at your chosen KeyCare Start Regional Network hospital or our designated service provider (DSP) for home-based care, where clinically appropriate. If you do not use your chosen hospital in the network, you will have to pay all costs. If you are admitted to any facility for planned admissions that meet the criteria for home-based care, you must pay an upfront payment to the hospital of R5,450.	
	Defined list of procedures in our Day Surgery Network	You are covered in any facility approved by the Scheme.	We cover a defined list of procedures in a day surgery facility. An upfront payment of R7,250 applies for admission to a facility outside of the Day Surgery Network.	We cover a defined list of procedures in the Smart Day Surgery Network. An upfront payment of R12,650 applies for admissions to a facility outside of the Smart Day Surgery Network.	We cover a defined list of procedures in a Day Surgery Network. An upfront payment of R7,250 applies for admissions to a facility outside of the Day Surgery Network. Where these procedures form part of the list of in-hospital procedures with an upfront payment, the higher of the upfront payments will apply.	We cover a defined list of procedures in a Day Surgery Network. An upfront payment of R7,250 applies for admissions to a facility outside of the Day Surgery Network. An upfront payment of R11,100 applies on the Delta options, if performed outside of the Delta Day Surgery Network.			We cover a defined list of procedures in the Smart Day Surgery Network. An upfront payment of R12,650 applies for admissions to a facility outside of the Smart Day Surgery Network.			We cover a defined list of procedures in the Smart Day Surgery Network. An upfront payment of R12,650 applies for admissions to a facility outside of the Smart Day Surgery Network as advised by the virtual agent. On the Essential Dynamic Smart plan, an upfront payment of R15,300 applies for admission to a facility outside of the Dynamic Smart Day Surgery Network.	An upfront payment of R15,300 applies for admission to a facility outside of the Dynamic Smart Day Surgery Network.		We cover a defined list of procedures in a Day Surgery Network. An upfront payment of R7,250 applies for admissions to a facility outside of the Day Surgery Network. An upfront payment of R11,100 applies on the Delta options, if performed outside of the Delta Day Surgery Network.		We cover a defined list of procedures in the KeyCare Day Surgery Network.		We cover a defined list of procedures in the KeyCare Start Day Surgery Network.		We cover a defined list of procedures in the KeyCare Start Regional Day Surgery Network.			
	Full cover option for specialists we have a payment arrangement with	Full cover	Full cover		Full cover		Full cover			Full cover		Full cover		Full cover			Full cover							
	Reimbursement rate for specialists we do not have a payment arrangement with	300% of the DHR	200% of the DHR		200% of the DHR		100% of the DHR	200% of the DHR		100% of the DHR	200% of the DHR		100% of the DHR	200% of the DHR		100% of the DHR	200% of the DHR		100% of the DHR					
Reimbursement rate for GPs and other healthcare professionals (not specialists)	200% of the DHR	200% of the DHR		200% of the DHR	200% of the DHR		100% of the DHR	200% of the DHR		100% of the DHR	200% of the DHR		100% of the DHR	200% of the DHR		100% of the DHR	200% of the DHR		100% of the DHR					
Reimbursement rate for radiology and pathology	100% of the DHR	100% of the DHR		100% of the DHR		100% of the DHR			100% of the DHR		100% of the DHR		100% of the DHR			100% of the DHR		100% of the DHR						

		Executive	Comprehensive		Priority		Saver			Smart Saver		Smart		Core			Keycare															
			CLASSIC	CLASSIC SMART	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	COASTAL	CLASSIC	ESSENTIAL	CLASSIC	ESSENTIAL	ACTIVE	CLASSIC	ESSENTIAL	COASTAL	PLUS	CORE	START	START REGIONAL											
HOSPITAL COVER	Cover for scopes (gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy) when performed in-hospital	Depending on where you have your scope done, we pay a portion of between R4,650 and R6,800 from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher co-payment will apply. If scopes are performed as part of a confirmed Prescribed Minimum Benefits (PMB) condition, where indicated and approved for dyspepsia, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit.	Depending on where you have your scope done, we pay a portion of between R4,650 and R6,800 from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher co-payment will apply. If scopes are performed as part of a confirmed Prescribed Minimum Benefits (PMB) condition, where indicated and approved for dyspepsia, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit.	Depending on where you have your scope done, we pay a portion of between R4,650 and R7,500 from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed as part of a confirmed Prescribed Minimum Benefits (PMB) condition, where indicated and approved for dyspepsia, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit.	Depending on where you have your scope done, we pay a portion of between R4,650 and R8,000 from your available day-to-day benefits and the balance of the hospital and related accounts from your Hospital Benefit. Where both a gastroscopy and colonoscopy are performed, a higher upfront payment will apply. If scopes are performed as part of a confirmed Prescribed Minimum Benefits (PMB) condition, where indicated and approved for dyspepsia, or the patient is under the age of 12, you will not have to pay any amount upfront. We pay the account from the Hospital Benefit.													Prescribed Minimum Benefit cover, in the KeyCare Day Surgery Network. If done in the doctor's rooms, we pay the account from the Hospital Benefit.		Prescribed Minimum Benefit cover, in the KeyCare Start Day Surgery Network. If done in the doctor's rooms, we pay the account from the Hospital Benefit.	Prescribed Minimum Benefit cover, in the KeyCare Start Regional Day Surgery Network. If done in the doctor's rooms, we pay the account from the Hospital Benefit.											
	Cover for scopes (gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy) when performed in-rooms	We pay the first R1,800 of the scope from your available day-to-day benefits. Where both a gastroscopy and colonoscopy is done, we pay the first R3,100 from your available day-to-day benefits. The co-payment will not apply if the scope is performed at a network provider.																														
		We pay the balance of the account from the Hospital Benefit up to 300% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 200% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 200% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 100% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 200% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 100% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 200% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 100% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 200% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 100% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 200% of the Discovery Health Rate.	We pay the balance of the account from the Hospital Benefit up to 100% of the Discovery Health Rate.																			
	Cover for MRI and CT scans related to admission	If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.				If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.				If done as part of an approved hospital admission, we will pay up to 100% of the DHR from the Hospital Benefit.				If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.				If done as part of an approved admission, we will pay up to 100% of the DHR from the Hospital Benefit.														
	Cover for MRI and CT scans if not related to admission or for back and neck treatment	We pay the first R4,000 of the scan from your available day-to-day benefits. We pay the balance of the scan from the Hospital Benefit, up to 100% of the DHR. Limited to one scan per spinal and neck region.	We pay the first R4,000 of the scan from your available day-to-day benefits. We pay the balance of the scan from the Hospital Benefit, up to 100% of the DHR. Limited to one scan per spinal and neck region.	We pay the first R4,000 of the scan from available day-to-day benefits. We pay the balance of the scan from the Hospital Benefit up to 100% of the DHR. For conservative back and neck treatment, you must pay the first R5,000 of the hospital account. We pay the balance of the scan from the Hospital Benefit up to 100% of the DHR. Limited to one scan per spinal and neck region.	We pay the first R4,000 of the scan from your available MSA. We pay the balance of the scan from the Hospital Benefit, up to 100% of the DHR. Limited to one scan per spinal and neck region.					You need to pay the first R4,000 of the scan. We pay the balance of the scan from the Hospital Benefit, up to 100% of the DHR. Limited to one scan per spinal and neck region.		These plans do not offer this benefit.		These plans do not offer this benefit.			We pay scans from the Specialist Benefit up to a limit of R5,750 for each person each year.	We pay scans from the Specialist Benefit up to a limit of R2,850 for each person each year.														
ADDITIONAL BENEFITS	Advanced Illness Benefit	Members have access to a comprehensive palliative care programme. This programme offers unlimited cover for approved care at home, care coordination, counselling services and supportive care for appropriate end-of-life clinical and psychologist services. You also have access to a GP consultation to facilitate your palliative care treatment plan.																														
	Africa Evacuation Benefit	Cover for emergency medical evacuations from certain sub-Saharan African countries back to South Africa. Pre-existing conditions are excluded.																	These plans do not offer these benefits.													
	Assisted Reproductive Therapy (ART)	You have cover for up to two cycles of ART if you meet the Scheme's benefit entry criteria. Cover includes a basket of care which includes cover for consultations, ultrasounds, oocyte retrieval, embryo transfer and freezing, admission costs including lab fees, medication and embryo and sperm storage. This benefit also includes cover for egg donated cycles. If you are registered on the Oncology Programme and meet the Scheme's clinical entry criteria, you have access to egg and sperm cryopreservation for up to five years. We pay up to a limit of R140,000 per person per year at 75% of the DHR. A co-payment of 25% will apply.				These plans do not offer these benefits.																										
	Care Programmes	Preventative and condition-specific care programmes for diabetes, mental health, HIV and heart conditions. We cover preventative and condition-specific care programmes that help you to manage diabetes, mental health, HIV or heart-related medical conditions. You have to be registered on these condition-specific care programmes to unlock additional benefits and services. You and your Premier Plus GP can track progress on a personalised dashboard to identify the next steps to optimally manage your condition and stay healthy over time. Cover is subject to the Scheme's clinical entry criteria, treatment guidelines and protocols.																														
														Members diagnosed with depression must be enrolled on the Mental Health Care Programme to avoid a 20% co-payment on their consultations.		Members diagnosed with depression, diabetes, HIV, and/or certain heart-related conditions must be enrolled on the appropriate Care Programme to avoid a 20% co-payment on their out-of-hospital treatment for their condition.																
	Disease management for sleep disorders	Members identified as being at risk following the completion of a validated sleep assessment may have access to a defined basket of care which includes cover for a consultation with an appropriate medical professional, CBT-i and sleep health coaching.																														
	Mental Wellbeing	Members identified with moderate to severe symptoms of depression following a mental wellbeing assessment, have access to a virtual or face-to-face consultation, where applicable, with a Premier Plus GP or network psychologist, coaching sessions with a social worker, two consultations with a dietitian, and a clinically appropriate digital mental wellbeing course.																														
	Care at Home	You have access to hospital-level care in your home instead of having to go to hospital for acute hospital care. The Hospital at Home devices and healthcare services are accessible if you meet the clinical and benefit criteria. You will receive a Home Monitoring Device Benefit for essential home monitoring and home-based care for follow up treatment after an admission.				You have access to hospital-level care in your home instead of having to go to hospital for acute hospital care. The Hospital at Home devices and healthcare services are accessible if you meet the clinical and benefit criteria. Hospital at Home is the designated service provider (DSP) for the Delta, Smart and KeyCare plans for home-based care for qualifying conditions such as chronic obstructive pulmonary disease, pneumonia, complicated urinary tract infection, heart failure, cellulitis, deep vein thrombosis, asthma and diabetes. Should members choose to not make use of Hospital at Home once a healthcare provider has recommended it as part of their care, an upfront deductible of R5,450 will apply to the admission. You will receive a Home Monitoring Device Benefit for essential home monitoring and home-based care for follow up treatment after an admission. The Home Monitoring Device Benefit offers a range of essential and registered home monitoring devices for certain chronic and acute conditions. Approved cover for these devices will not affect your day-to-day benefits. If you meet the scheme's clinical entry criteria, you have healthcare cover up to a limit of R4,850 per person per year, at 100% of the DHR.																										
		The Home Monitoring Device Benefit offers a range of essential and registered home monitoring devices for certain chronic and acute conditions. Approved cover for these devices will not affect your day-to-day benefits. If you meet the scheme's clinical entry criteria, you have healthcare cover up to a limit of R4,850 per person per year, at 100% of the DHR.																														
		The Scheme also covers defined point of care medical devices up to 75% of the DHR, if you meet the clinical entry criteria.												These plans do not offer these benefits.																		
Home-based virtual care for the elderly	Members 65 years and older who have been identified as being at high risk may have access to a basket of care to manage their condition at home. This includes a virtual consultation with a GP or nurse as an alternative to a casualty visit as well as virtual coaching sessions to help coordinate their care.																															
Virtual Physical Therapy	Access to personalised and evidence-based virtual physical therapy, prescribed by an appropriate healthcare professional. Virtual Physical Therapy will be paid from your available day-to-day benefits, if applicable.											Access to personalised and evidence-based virtual physical therapy, prescribed by an appropriate healthcare professional. You will have to pay for claims related to Virtual Physical Therapy																				
Virtual Urgent Care	Skip the waiting room and urgently consult with a doctor 24/7 online and get digital prescriptions – no matter where you are. We cover you up to four virtual urgent care sessions per family per year, subject to clinical entry criteria. Any additional sessions will fund from your available day-to-day benefits, if applicable.											Skip the waiting room and urgently consult with a doctor 24/7 online and get digital prescriptions – no matter where you are. We cover you up to four virtual urgent care sessions per family per year, subject to clinical entry criteria. You will need to fund any additional sessions.				Skip the waiting room and urgently consult with a doctor 24/7 online and get digital prescriptions – no matter where you are. We cover you for one virtual urgent care sessions per member, per year, subject to clinical entry criteria. You will need to fund any additional sessions.																
Screening and Prevention Benefit	This benefit covers a health check which is made up of certain tests at one of our wellness network providers, like blood glucose, blood pressure, cholesterol and body mass index. We also cover a mammogram every two years, Pap smear every three years or one HPV test every 5 years, a mental wellbeing assessment every year, PSA (a prostate screening test) once a year and HIV screening tests. Seasonal flu vaccine during pregnancy, or for members 65 years or older and/or registered for certain chronic conditions. Pneumococcal vaccine for persons over the age of 65 and/or registered for certain chronic conditions, you need a prescription from your doctor to get this vaccine. We also cover bowel cancer screening tests every two years for members between 45 and 75 years. Additional, and/or more frequent screening is available for those who meet our clinical criteria. Consultations that do not form part of Prescribed Minimum Benefits (PMBs) will be paid from your available day-to-day benefits. Kids screening tests include the measurement of weight, height, body mass index and blood pressure at one of our wellness providers.																															
Trauma Recovery Extender Benefit	Extends your cover for out-of-hospital claims for recovery after certain traumatic events for the rest of the year in which the trauma took place, and a year after the trauma. You and your dependants on your health plan also have access to six counselling sessions per person per year by a psychologist, clinical social worker or registered counsellor.																															
WHO Global Outbreak Benefit	Provides cover for approved global disease outbreaks recognised by the World Health Organisation (WHO) such as COVID-19 and Mpox. This benefit provides access to a defined basket of care per disease outbreak, which includes cover for the administration of vaccines (where applicable) and relevant out-of-hospital treatment.																															
Digital Mental Health	Access an on-demand digital mental healthcare platform for evidence-based support programmes and tools with Digital Mental Health. If you are diagnosed with depression your claims will fund from your Prescribed Minimum Benefits (PMBs) or Mental Health Care Programme, if enrolled, subject to clinical entry criteria. If you do not meet the criteria or have used your benefits, claims will fund from your available day-to-day benefits, if applicable.																															
International Travel Benefit	Cover up to \$1 million for each person on each journey for emergency medical costs while travelling outside of South Africa, for a period of 90 days from your departure from South Africa. Specific rules apply and pre-existing conditions are excluded.	Cover up to R5 million for each person on each journey for emergency medical costs while travelling outside of South Africa, for a period of 90 days from your departure from South Africa. Specific rules apply and pre-existing conditions are excluded.																These plans do not offer these benefits.														
Overseas Treatment Benefit	Up to R750,000 for each person travelling for evidence-based healthcare treatment not available in South Africa. You also have cover for R300,000 at a recognised healthcare provider for in-hospital treatment that is available in South Africa. A co-payment of 20% and specific rules apply to these benefits.	Up to R500,000 for each person travelling for evidence-based healthcare treatment not available in South Africa. A co-payment of 20% and specific rules apply to this benefit.	These plans do not offer these benefits.																													

