Discovery
Health Medical Scheme

EXECUTIVE PLAN | 2023

We're here for your health

For the best quality healthcare to support life's inevitable moments, Discovery Health Medical Scheme provides comprehensive healthcare that is just right for you.

Read this guide to understand more about your health plan including:

- What to do when you need to go to a doctor or to a hospital
- How you are covered for preventative screening, diagnosis and treatment of medical conditions
- Which benefits you need to apply for and if there are any limits for certain benefits
- Tips on how you can use technology to conveniently manage and access healthcare and all the information you need through the Discovery app and website

We want you to have complete comfort knowing that you and your family's health is secure.

The benefits explained in this brochure are provided by Discovery Health Medical Scheme, registration number 1125, administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider. This brochure is only a summary of the key benefits and features of Discovery Health Medical Scheme plans, awaiting formal approval from the Council for Medical Schemes. In all instances, Discovery Health Medical Scheme Rules prevail. Please consult the Scheme Rules on www.discovery.co.za. When reference is made in this brochure to 'we' in the context of benefits, members, payments or cover, this refers to Discovery Health Medical Scheme. We are continuously improving our communication to you. The latest version of this guide as well as detailed benefit information is available on www.discovery.co.za.

Contents page

Key terms

About some of the terms we use in this document

A

Above Threshold Benefit (ATB)

Once the day-to-day claims you have sent to us add up to the Annual Threshold, we pay the rest of your day-to-day claims from the Above Threshold Benefit (ATB), at the Discovery Health Rate (DHR) or a portion of it. The Executive plan has an unlimited ATB.

Additional Disease List (ADL)

Once approved on the Chronic Illness Benefit (CIB), you have cover for medicine for an additional list of life-threatening or degenerative conditions, as defined by us.

Annual Threshold

We set the Annual Threshold amount at the beginning of each year. The number and type of dependants (spouse, adult or child) on your plan will determine the amount.

The Annual Threshold is an amount that your claims need to add up to before we pay your day-to-day claims from the Above Threshold Benefit (ATB).

C

Chronic Disease List (CDL)

A defined list of chronic conditions we cover according to the Prescribed Minimum Benefits (PMBs).

Chronic Drug Amount (CDA)

The Chronic Drug Amount (CDA) is the monthly amount that we pay up to for a medicine class, subject to a member's plan type. This applies to chronic medicine that is not listed on the formulary or medicine list.

Chronic Illness Benefit (CIB)

The Chronic Illness Benefit (CIB) covers you for a defined list of chronic conditions. You need to apply to have your medicine and treatment covered for your chronic condition.

Connected Care

Connected Care is an integrated healthcare ecosystem of benefits, services and connected digital capabilities to help you manage your health and wellness.

Co-payment

This is an amount that you need to pay towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service or if the amount the service provider charges is higher than the rate we cover. If the co-payment amount is higher than the amount charged for the healthcare service, you will have to pay for the cost of the healthcare service.

Cover

Cover refers to the benefits you have access to and how we pay for these healthcare services such as consultations, medicine and hospitals, on your health plan.

D

Day-to-day benefits

These are the available funds allocated to the Medical Savings Account (MSA) and Above Threshold Benefit (ATB).

Day-to-Day Extender Benefit (DEB)

Day-to-day Extender Benefit (DEB) extends your day-to-day cover for essential healthcare services in our network if you have spent your annual Medical Savings Account (MSA) allocation and before you reach the Annual Threshold.

Key terms

About some of the terms we use in this document

D

Deductible

This is the amount that you must pay upfront to the hospital or day clinic for specific treatments/procedures or if you use a facility outside of the network. If the upfront amount is higher than the amount charged for the healthcare service, you will have to pay for the cost of the healthcare service.

Designated service provider (DSP)

A healthcare provider (for example doctor, specialist, allied healthcare professional, pharmacist or hospital) who we have an agreement with to provide treatment or services at a contracted rate. Visit **www.discovery.co.za** or click on Find a healthcare provider on the Discovery app to view the full list of DSPs.

Discovery Health Rate (DHR)

This is a rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services.

Discovery Health Rate for medicine

This is the rate we pay for medicine. It is the Single Exit Price of medicine plus the relevant dispensing fee.

Discovery Home Care

Discovery Home Care is an additional service that offers you quality home-based care in the comfort of your home for healthcare services like IV infusions, wound care, post-natal care and advanced illness care.

Discovery MedXpress

Discovery MedXpress is a convenient and cost-effective medicine ordering and delivery service for your monthly chronic medicine, or you can choose to collect your medicine in-store at a MedXpress Network Pharmacy.

E

Emergency medical condition

An emergency medical condition, also referred to as an emergency, is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical and 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.

An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency.

F

Find a healthcare provider

Find a healthcare provider is a medical and provider search tool which is available on the Discovery app or website.

H

HealthID

HealthID is an online digital platform that gives your doctor fast, up-to-date access to your health information. Once you have given consent, your doctor can use HealthID to access your medical history, make referrals to other healthcare professionals and check your relevant test results.

Key terms

About some of the terms we use in this document

M

Medical Savings Account (MSA)

The Medical Savings Account (MSA) is an amount that is allocated to you at the beginning of each year or when you join the Scheme. You pay this amount back in equal portions as part of your monthly contribution. We pay your day-to-day medical expenses such as GP and specialist consultations, acute medicine, radiology and pathology from the available funds allocated to your MSA. You can choose to have your claims paid from the MSA either at the Discovery Health Rate, or at cost. Any unused funds will carry over to the next year. Should you leave the Scheme or change your plan partway through the year and have used more of the funds than what you have contributed, you will need to pay the difference to us.

Medicine list (formulary)

A list of medicine we cover in full for the treatment of approved chronic condition(s). This list is also known as a formulary.

P

Payment arrangements

The Scheme has payment arrangements with various healthcare professionals and providers to ensure that you can get full cover with no co-payments.

Preferred medicine

Preferred medicine includes preferentially priced generic and branded medicine.

Premier Plus GP

A Premier Plus GP is a network GP who has contracted with us to provide you with coordinated care and enrolment on one of our care programmes for defined chronic conditions.

Prescribed Minimum Benefits (PMB)

In terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- An emergency medical condition
- A defined list of 271 diagnoses
- A defined list of 27 chronic conditions.

To access Prescribed Minimum Benefits (PMBs), there are rules defined by the Council for Medical Schemes (CMS) that apply:

- Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit (PMB) conditions
- The treatment needed must match the treatments in the defined benefits
- You must use designated service providers (DSPs) in our network. This does not apply in emergencies. Where appropriate and according to the Rules of the Scheme, you may be transferred to a hospital or other service providers in our network, once your condition has stabilised.

R

Related accounts

Any account other than the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology.

S

Shariah compliant arrangement

An arrangement which enables you to have their health plan administered in accordance with principles that are Shariah compliant.

W

Who Global Outbreak Benefit

The WHO Global Outbreak Benefit provides cover for approved global disease outbreaks recognised by the World Health Organization (WHO) such as COVID-19 and monkeypox. This benefit provides access to a defined basket of care per disease outbreak, which includes cover for vaccines (where applicable) and relevant out-of-hospital treatment.

Key **features**

Unlimited cover for hospital admissions

There is no overall limit for hospital cover on the Comprehensive plans.

Full cover for chronic medicine

Full cover for chronic medicine on our formulary for all Chronic Disease List (CDL) conditions. Depending on the plan you choose you have access to an additional list of conditions (ADL) as well as the Specialised Medicine and Technology Benefit which covers specific new treatments and medicine.

Connected Care

You have access to remote care at home, including a Home Monitoring Device Benefit for essential home monitoring, home-based hospital related care and follow-up treatment after an admission and access to Hospital at Home progamme for quality care in the comfort of your own home.

Extensive cover for pregnancy

You get comprehensive benefits for maternity and early childhood that cover certain healthcare services before and after birth.

WELLTH Fund

The WELLTH Fund covers a comprehensive list of additional screening and prevention healthcare services according to your individual health needs.

Full cover in hospital for related accounts

Guaranteed full cover in hospital for specialists who we have a payment arrangement with, and up to 300% of the Discovery Health Rate (DHR) for other healthcare professionals.

Screening and prevention

Screening and prevention benefits that cover vital tests to detect early warning signs of serious illness.

Cover when travelling

Cover for medical emergencies when travelling. Access to specialised, advanced medical care in South Africa and abroad.

Comprehensive day-to-day cover

We pay your day-to-day medical expenses from the available funds allocated to your Medical Savings Account (MSA). This empowers you to manage your spend. The Day-to-day Extender Benefit (DEB) extends your day-to-day cover for essential healthcare services in our network. You have an unlimited ATB that gives you further day-to-day cover once you have reached your Annual Threshold.

Shariah compliant arrangement available on all health plans.

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

Connected Care is brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

Emergency cover

What is a medical emergency?

An emergency medical condition, also referred to as an emergency, is the sudden and unexpected onset of a health condition that requires immediate medical or surgical treatment. 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. An emergency does not necessarily require a hospital admission. We may ask you or your treating provider for additional information to confirm the emergency.

Assistance during or after a traumatic event

You have access to dedicated assistance in the event of a traumatic incident or after a traumatic event. By calling Emergency Assist you and your family have access to trauma support 24 hours a day. This service also includes access to counseling and additional benefits for trauma related to gender-based violence.

What we pay for

We pay for all of the following medical services that you may receive in an emergency:

- The ambulance (or other medical transport)
- The account from the hospital
- The accounts from the doctor who admitted you to the hospital
- The anaesthetist
- Any other healthcare provider that we approve.

The Discovery app is brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

Prescribed
Minimum Benefits

What are Prescribed Minimum Benefits?

According to the Prescribed Minimum Benefit (PMB) conditions in terms of the Medical Schemes Act 131 of 1998 and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- *An emergency medical condition*
- *A defined list of 271 diagnoses*
- *A defined list of 27 chronic conditions.*

To access Prescribed Minimum Benefits (PMBs), there are rules defined by the Council for Medical Schemes (CMS) that apply:

- Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit (PMB) conditions.
- The treatment needed must match the treatments in the defined benefits.
- You must use designated service providers (DSPs) in our network. This does not apply in emergencies. Where appropriate and according to the Rules of the scheme, you may be transferred to a hospital or other service providers in our network, once your condition has stabilised. If you do not use a DSP 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.

If your treatment doesn't meet the above criteria, we will pay according to your plan benefits.

You have access to essential **screening and prevention benefits**

This benefit pays for certain tests that can detect early warning signs of serious illnesses. We cover various screening tests at our wellness providers, for example, blood glucose, cholesterol, HIV, Pap smear or HPV test for cervical screening, mammograms and/or ultrasounds and prostate screenings. Once all members on your membership have completed their health check, you also have access to additional screening and prevention healthcare services from the WELLTH Fund, as featured on page 9.

SCREENING FOR KIDS

This benefit covers the assessment of your child's growth and development, which includes the measurement of weight, height, body mass index and blood pressure at one of our wellness providers.

SCREENING FOR ADULTS

This benefit covers a health check which is made up of certain tests such as blood glucose, blood pressure, cholesterol, body mass index and HIV screening at one of our wellness providers. We also cover a mammogram or ultrasound of the breast every two years, a Pap smear once every three years or a HPV test once every five years, PSA test (prostate screening) each year and bowel cancer screening tests every two years for members between 45 and 75 years. These tests are paid from the Screening and Prevention Benefit. Consultations that do not form part of Prescribed Minimum Benefits (PMBs) will be paid from your available day-to-day benefits.

SCREENING FOR SENIORS

In addition to the screening for adults, members aged 65 years and older have cover for an age appropriate falls risk screening assessment in our defined pharmacy network. You may have cover for an additional falls risk assessment when referred to a Premier Plus GP, depending on your screening test results and if you meet the Scheme's clinical entry criteria.

What we pay for

We cover various screening tests at our wellness providers.

These tests are paid from the Screening and Prevention Benefit. Consultations that do not form part of Prescribed Minimum Benefits (PMBs) will be paid from your available day-to-day benefits.

Additional tests

Clinical entry criteria may apply to these tests:

- Defined diabetes and cholesterol screening tests
- Breast MRI or mammogram and once-off BRCA testing for breast screening
- Colonoscopy for bowel cancer screening
- Pap smear or HPV test for cervical screening.

Vaccines (clinical entry criteria may apply):

- Seasonal flu vaccine for members who are pregnant, 65 years or older, registered for certain chronic conditions and healthcare professionals
- Pneumococcal vaccine for members over the age of 65 or those registered for certain chronic conditions
- COVID-19 vaccines are covered from the WHO Global Outbreak Benefit. Please refer to page 10 for more information.

Visit **www.discovery.co.za** to view the detailed Screening and Prevention Benefit guide.

You have access to the **WELLTH Fund**

The WELLTH Fund covers a comprehensive list of screening and prevention healthcare services to ensure that you are empowered to take specific action according to your individual health needs. This benefit is separate from and additional to the Screening and Prevention Benefit and will be available once per lifetime for all members and dependants who have completed their health checks.

Your WELLTH Fund can be used for appropriate screening and prevention healthcare services up to your WELLTH Fund limit. Cover is subject to the Scheme's clinical entry criteria, treatment guidelines and protocols.

General health

You have access to primary healthcare screening which include services for visual, hearing, dental and skin conditions. You also have access to one GP screening consultation.

Physical health

You have access to physical wellbeing screening at a dietician, biokinetisist and/or physiotherapist

Mental health

You have access to a mental wellness check-up to support mental wellbeing.

Women and men's health

You have access to a range of women and men's screening and prevention healthcare services. These include for example a:

- Gynaecological, prostate and/or heart consultation with your doctor
- Bone density check

Children's health

You have access to a children wellness visit which include growth and developmental milestones assessments with a occupational therapist, speech therapist and/or physiotherapist.

Medical monitoring devices

You have access to certain medical monitoring devices which helps measure for example blood pressure, cholesterol and blood sugar.

How to get access

The WELLTH Fund is available for two benefit years once all beneficiaries over the age of two years complete their age-appropriate health check at a provider in our Wellness Network. For new joiners, the benefit is available in the year of joining and the year thereafter. For more on the health check, refer to page 7.

What limits apply

The benefit is available once per beneficiary per lifetime. Qualifying healthcare services are covered up to a maximum of the Discovery Health Rate (DHR), subject to the overall benefit limit.

Your WELLTH Fund limit is dependant on the size and make up of your family on your policy:

- R2,500 per adult dependant
- R1,250 per child dependant two years and older
- Up to a maximum of R10,000 per family

The WELLTH Fund is available to all registered beneficiaries on the membership. The WELLTH Fund will not cover screening and prevention healthcare services already covered by other defined benefits.

World Health Organisation **(WHO) Global Outbreak Benefit**

The WHO Global Outbreak Benefit is available to all members during a declared outbreak period. The benefit provides cover for vaccinations (where applicable) as well as a defined basket of care for out-of-hospital healthcare services related to outbreak diseases such as COVID-19 and monkeypox.

Cover is subject to clinical entry criteria and paid up to the maximum of the Discovery Health Rate (DHR).

How you are covered for COVID-19

The basket of care includes:

- COVID-19 vaccines and the administration thereof in accordance with the National Department of Health COVID-19 guidelines.
- Screening consultations with a network GP (either virtual consultations, telephone or face-to-face).
- COVID-19 PCR and Rapid Antigen screening tests if referred by an appropriate healthcare professional.
- A defined basket of pathology tests 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.

You also have cover for:

- In-hospital treatment related to COVID-19 for approved admissions is covered from the Hospital Benefit based on your chosen health plan and in accordance with Prescribed Minimum Benefits (PMB), where applicable.
- Access to the Long COVID Recovery Programme: a six-month support programme for members with COVID-19 symptoms that persist beyond 21 days of diagnosis of acute COVID-19. The programme includes up to two specialist and GP consultations, a defined basket of pathology tests, allied healthcare professional support, a home monitoring device and a defined basket of x-rays and scans, in accordance with the Scheme's clinical entry criteria and treatment guidelines.

Know your risk

You can understand your risk status at any point by completing the COVID-19 risk assessment. The assessment is a set of questions which determines if you may be presenting with symptoms suggestive of COVID-19 disease or may have been exposed to COVID-19 infection and need a consultation with a doctor. The assessment is available on the Discovery website or app or by calling us and following the prompts to complete the COVID-19 risk assessment.

How you are covered when diagnosed with monkeypox

The basket of care for confirmed cases includes:

- A diagnostic PCR screening test
- Two consultations with a dermatologist or GP
- Supportive medicine formulary for pain management.

Connected Care

Access quality healthcare from home

Discovery Health Medical Scheme gives you access to health and wellness services from the comfort of your home. Connected Care is an integrated healthcare ecosystem of benefits, services and connected digital capabilities to help you manage your health and wellness.

Health monitoring devices

Access to the latest medical examination and remote monitoring and point-of-care devices to enable quality care from home.

Medicine ordering and tracking

Order and track your medicine delivery from dispensary to your door.

Electronic prescriptions

Seamless e-scripting to give you quicker access to your medicine.

Online coaches

Personalised coaching consultations to help you better manage your chronic and acute conditions, including COVID-19, from home.

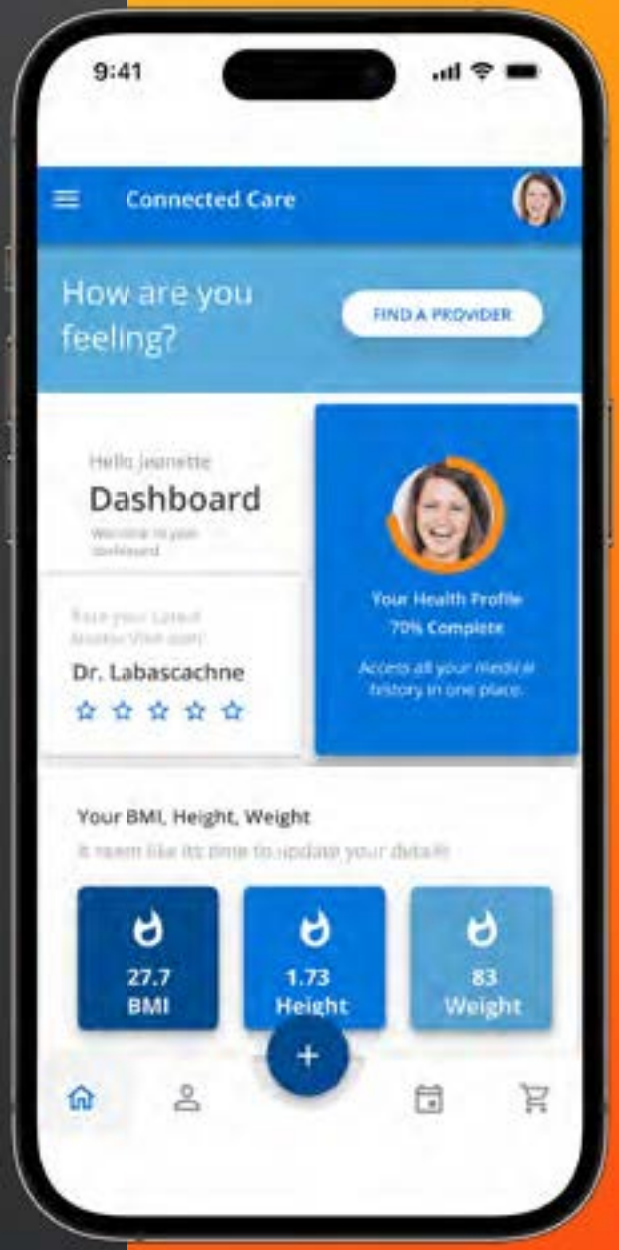
Home nurses

Hospital-related care with home nurses to care for you at home.

Condition-specific information

Educational content specific to your condition, at your fingertips.

Visit **www.discovery.co.za** to view the detailed Connected Care Benefit guide.



Connected Care is brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

Your access to **Connected Care**

Access to quality care from home

Through advanced digital technology and smart health and point-of-care devices, Connected Care enables you and your doctor to access and deliver healthcare whenever you need it from the comfort of your home.

Connected Care for members at home

You can connect to doctors through virtual consultations like never before, from the comfort of your home.

The Home Monitoring Device Benefit gives you access to a range of essential and registered home monitoring devices for certain chronic and acute conditions. Approved cover for these devices will not affect your day-to-day benefits.

Connected Care for members with chronic conditions

You and your doctor can manage your chronic condition through Connected Care in the comfort of your home. You have access to a range of digital services linked to smart remote monitoring and point-of-care devices and personalised coaching consultations, for qualifying members, to help you track and manage your chronic condition from home.

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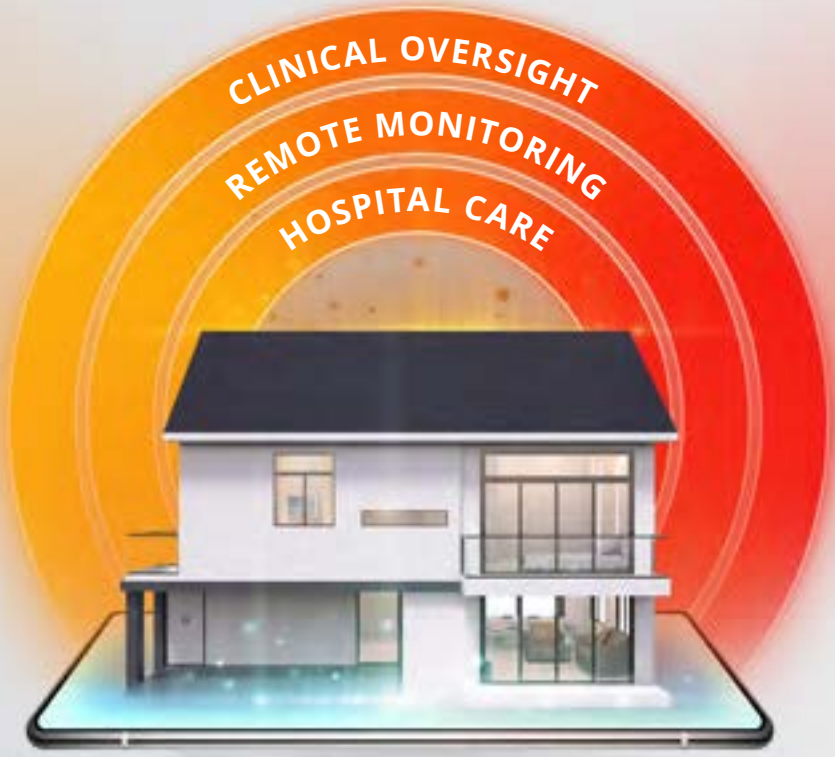
Hospital at Home with Discovery

Delivering hospital-level care safely and effectively in your home for many medical and surgical conditions for which you would otherwise be admitted to hospital.

If you are admitted to Hospital at Home you have access to enhanced benefits and services, delivered through your personalised care team. Together, these benefits and services give you a seamless healthcare experience, making you healthier, and enhancing and protecting lives. We pay all services offered as part of Discovery's Hospital at Home programme from your Hospital Benefit, if you have a valid pre-authorisation for hospitalisation. This unlocks cover for approved devices and healthcare services for those who meet the clinical and benefit criteria.

Visit **www.discovery.co.za** to view the detailed Connected Care Benefit guide.



24/7 Clinical oversight from a care team

Physical and virtual 24-hour care delivery facilitated by a dedicated care team that includes doctors, nurses and allied healthcare professionals. Qualifying members get access to extra Hospital at Home services for a seamless home care delivery experience.

24/7 Real-time remote monitoring supported by cutting-edge digital healthcare technologies

Access to a remote monitoring device that automatically transmits information to a hospital-based care team, 24 hours a day, seven days a week. Healthcare professionals continually assess your health status, monitor your medical stability, track treatment compliance and recommend interventions when necessary.

Hospital-level diagnostics and interventions

Access to an improved range of clinical diagnostic procedures and interventions to manage medical or post-surgical hospital-level care in the home. It is supported by extra benefits paid by the Scheme to improve your experience.

Connected Care for
Acute Care at Home

This includes cover and treatment for COVID-19 and/or follow-up care once discharged. You also have access to the Home Monitoring Device Benefit.

Home Monitoring Device Benefit for essential home monitoring

If you meet the Scheme's clinical entry criteria, you have healthcare cover up to a limit of R4,250 per person per year, at 100% of the Discovery Health Rate (DHR), for the monitoring of defined conditions such as chronic obstructive pulmonary disease, congestive cardiac failure, diabetes, pneumonia and COVID-19.

The Scheme also covers defined point of care medical devices up to 75% of the Discovery Health Rate (DHR), if you meet the clinical entry criteria. You will need to pay 25% towards the cost of these devices. You have access to the latest remote monitoring medical examination device called TytoHome.

TytoHome allows you to conduct a medical examination, sending throat and ear images and heart and lung sounds in real-time to your doctor.

Cover for Home care

Discovery Home Care is a service that offers you quality care in the comfort of your own home when recommended by your doctor as an alternative to a hospital stay. Services include postnatal care, end-of-life care, IV infusions (drips) and wound care. These services are paid from the Hospital Benefit, subject to approval. Discovery Home Care is the designated service provider (DSP) for administration of defined intravenous infusions. Avoid a 20% co-payment by using Discovery Home Care for these infusions.

Home-based care for follow-up treatment after an admission

Clinically appropriate conditions such as chronic obstructive pulmonary disease, chronic cardiac failure, ischaemic heart disease and pneumonia have access to enhanced home-based care once discharged from hospital. If you meet the clinical entry criteria you have cover for bedside medicine reconciliation prior to admission discharge, a follow-up consultation with a GP or specialist, and a defined basket of supportive care at home that includes a face-to-face consultation and virtual consultations with a Discovery Home Care nurse.

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.
Connected Care is brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

Day-to-day benefits

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

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.

You have the option to have your claims paid from the MSA at either the Discovery Health Rate, or at cost.

The Scheme will automatically fund your claims in excess of the DHR, if you have opted to have your claims paid from the MSA at cost. If you have opted to have claims paid from your MSA at the DHR and you wish to have claims paid in excess of the DHR or benefit limits from the available funds in your MSA, you can request a special payment from your MSA.

Claims paid from the MSA in excess of the DHR do not add up to the Annual Threshold.

Any amount that is left over will carry over to the next year.

Day-to-day Extender Benefit (DEB)

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 video call consultations with a network GP as well as pharmacy clinic consultations in our defined wellness network. You also have unlimited cover for face-to-face consultations with a network GP, when referred following a video call consultation or by the pharmacy clinic virtual GP. We cover consultations up to the Discovery Health Rate (DHR). Kids younger than 10 years have access to two kids casualty visits a year.

The Self-payment Gap (SPG)

If your MSA runs out before you reach your Annual Threshold, you will have to pay for claims from your own pocket until your claims reach the Annual Threshold amount. This period is known as the Self-Payment Gap (SPG). It is important that you continue to send your claims during the SPG so that we know when you reach your Annual Threshold for claims.

The Above Threshold Benefit (ATB)

The Above Threshold Benefit starts paying for day-to-day expenses once you reach your Annual Threshold.

Some claims do not add up to your Annual Threshold or pay from the ATB for example:

- Medicine that you do not need a prescription for (over-the-counter medicine)
- Childhood vaccines and immunisations
- Lifestyle-enhancing products
- Claims in excess of the Discovery Health Rate (DHR).
- Claims paid in excess of annual benefit limits.

What we pay for

The Above Threshold Benefit (ATB) is unlimited, which means it covers all day-to-day expenses at the Discovery Health Rate (DHR) or at a portion of it. Certain benefit limits may apply. You will need to pay for any difference between the DHR and the amount claimed, as well as any amount which exceeds the annual benefit limit (where applicable).

For more detail on how you are covered visit *Do we cover* on our website **www.discovery.co.za**.

Day-to-day cover

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

We add these amounts to the Annual Threshold and pay these amounts from your Above Threshold Benefit (ATB), once you reach your Annual Threshold. 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, by you during the self-payment gap and the ATB.

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

MEDICINE	SINGLE MEMBER	ONE DEPENDANT	TWO DEPENDANTS	THREE OR MORE DEPENDANTS
PRESCRIBED MEDICINE* (SCHEDULE 3 AND ABOVE)	R46,450	R54,450	R62,350	R70,300
Over-the-counter medicine, childhood 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).			

* 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.

Day-to-day cover

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

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.

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)	R27,800	R33,450	R39,150	R46,950
Dental appliances and orthodontic treatment*	R32,600 per person			
Antenatal classes	R2,170 for your family			

APPLIANCES AND EQUIPMENT	
OPTICAL* (this limit covers lenses, frames, contact lenses and surgery or any healthcare service to correct refractive errors of the eye)	R9,550 per person
EXTERNAL MEDICAL ITEMS* (like wheelchairs, crutches and prostheses)	R64,200 for your family
HEARING AIDS	R28,200 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.

You have cover for maternity and early childhood

You get cover for healthcare services related to your pregnancy and treatment for the first two years of your baby's life. This applies from the date of activation of the benefit for each pregnancy and for each child from birth until they are two years old.

During pregnancy

Antenatal consultations

We pay for up to 12 consultations with your gynaecologist, GP or midwife.

Ultrasound scans and screenings during pregnancy

You are covered for up to two 2D ultrasound scans, including one nuchal translucency test. 3D and 4D scans are paid up to the rate we pay for 2D scans. You are also covered for one chromosome test or Non-Invasive Prenatal Test (NIPT), if you meet the clinical entry criteria.

Flu vaccinations

We pay for one flu vaccination during your pregnancy.

Private ward for delivery

The healthcare services related to childbirth are covered by your Hospital Benefit. You also have cover up to R2,460 per day in a private ward for your hospital stay for the delivery.

Blood tests

We pay for a defined list of blood tests to confirm your pregnancy.

After you give birth

Essential devices

We pay up to R5,650 for essential registered devices such as breast pumps and smart thermometers. You must pay 25% towards the cost of these devices.

GP and specialists to help you after birth

Your baby under the age of two years is covered for two visits to a GP, paediatrician or an ear, nose and throat specialist.

Other healthcare services

You also have access to postnatal care, which includes a postnatal consultation for complications post delivery, a nutritional assessment with a dietitian and two mental healthcare consultations with a counsellor or psychologist.

Pre- and postnatal care

We pay for a maximum of five antenatal or postnatal classes or consultations with a registered nurse up until two years after you have given birth. We pay for one breastfeeding consultation with a registered nurse or a breastfeeding specialist.

Visit **www.discovery.co.za** to view the detailed Maternity Benefit guide.

How to get the benefit

You can activate the benefit in any of these ways:

- Create your pregnancy or baby profile on the Discovery app or on our website at **www.discovery.co.za**
- When you pre-authorise your delivery or you register your baby as a dependant on the Scheme

You may also have cover for Assisted Reproductive Therapy (ART), see page 30 for more information.

Chronic benefits

The Chronic Illness Benefit (CIB) covers you for a defined list of 27 medical conditions known as the Chronic Disease List (CDL).

You have cover for 22 extra conditions set out on the list of additional diseases on the Additional Disease List (ADL).

What we cover

Prescribed Minimum Benefit (PMB) conditions

You have access to treatment for a list of medical conditions under the Prescribed Minimum Benefits (PMBs). The PMBs cover the 27 chronic conditions on the Chronic Disease List (CDL).

Our plans offer benefits that are richer than PMBs. To access PMBs, certain rules apply.

Medicine cover for the Chronic Disease List

You have full cover for approved chronic medicine on our medicine list. For medicine not on our list, we cover you up to a set monthly Rand amount called the Chronic Drug Amount (CDA).

Medicine cover for the Additional Disease List (ADL)

We offer cover for medicine on the Additional Disease List (ADL). You are covered up to the set monthly CDA for your medicine. No medicine list applies.

Extended chronic medicine list

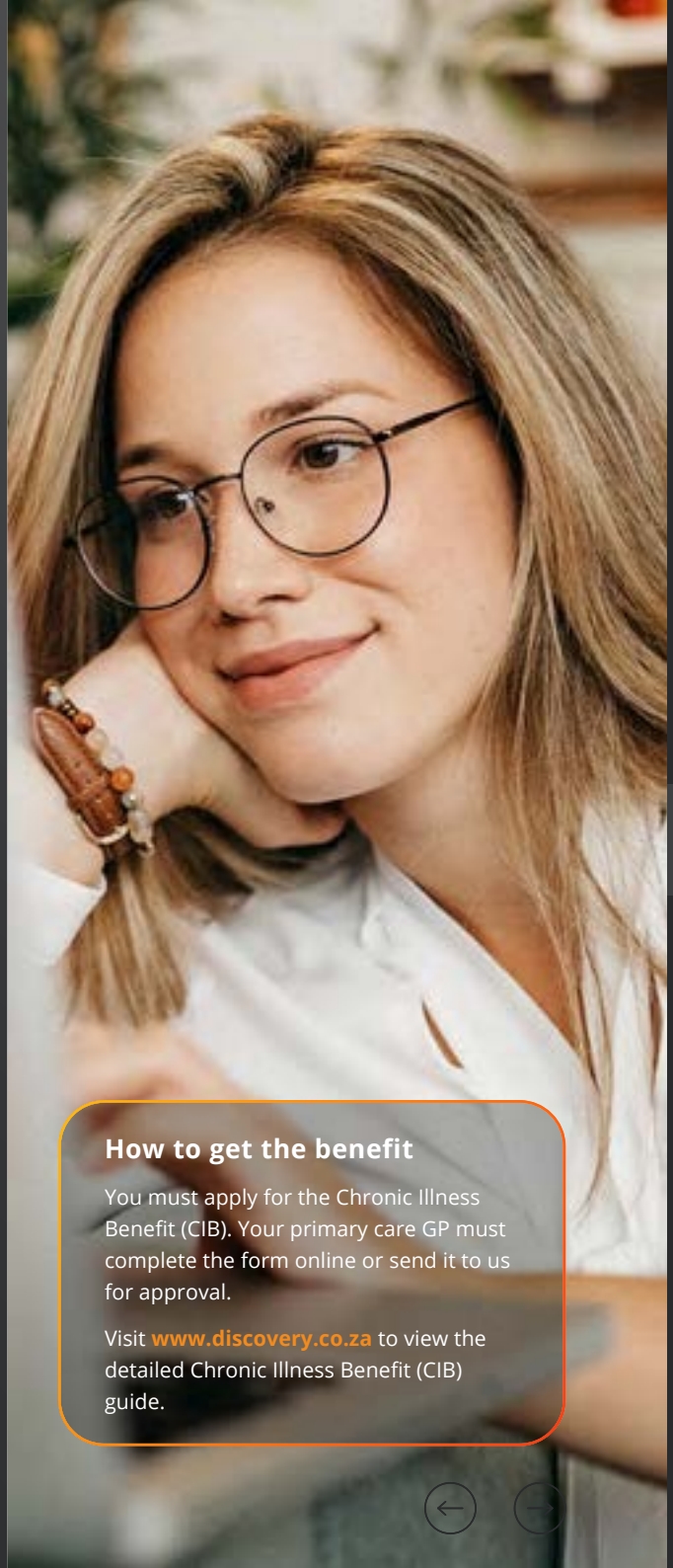
You also have full cover for an exclusive list of brand medicines.

How we pay for consultations and medicine

You must nominate a GP in the Discovery Health Network to be your primary care doctor to manage your chronic conditions. To find a doctor and learn more about the nomination process, use **www.discovery.co.za**, or the Discovery app.

For full cover on your GP consultations you must visit a Discovery Health Network GP. If you use a non-network GP you will have to pay a 20% co-payment. For more information on our Care Programmes and enrolment by your Premier Plus Network GP, please refer to page 22.

We pay for medicine up to a maximum of the Discovery Health Rate (DHR) at one of our network pharmacies. The DHR for medicine is the price of the medicine and the fee for dispensing it.



How to get the benefit

You must apply for the Chronic Illness Benefit (CIB). Your primary care GP must complete the form online or send it to us for approval.

Visit **www.discovery.co.za** to view the detailed Chronic Illness Benefit (CIB) guide.

Chronic benefits

Chronic Disease List (CDL) conditions

Chronic conditions covered on all plans

- **A** Addison's disease, asthma
- **B** Bipolar mood disorder, bronchiectasis
- **C** Cardiac failure, cardiomyopathy, chronic obstructive pulmonary disease, chronic renal disease, coronary artery disease, Crohn's disease
- **D** Diabetes insipidus, diabetes Type 1, diabetes Type 2, dysrhythmia
- **E** Epilepsy
- **G** Glaucoma
- **H** Haemophilia, HIV, hyperlipidaemia, hypertension, hypothyroidism
- **M** Multiple sclerosis
- **P** Parkinson's disease
- **R** Rheumatoid arthritis
- **S** Schizophrenia, systemic lupus erythematosus
- **U** Ulcerative colitis

Additional Disease List (ADL) conditions

Additional chronic conditions covered on The Executive Plan

- **A** Ankylosing spondylitis
- **B** Behçet's disease
- **C** Cystic fibrosis
- **D** Delusional disorder, dermatopolymyositis
- **G** Generalised anxiety disorder
- **H** Huntington's disease
- **I** Isolated growth hormone deficiency
- **M** Major depression, muscular dystrophy and other inherited myopathies, myasthenia gravis, motor neuron disease
- **O** Obsessive compulsive disorder, osteoporosis
- **P** Paget's disease, panic disorder, polyarteritis nodosa, post-traumatic stress disorder, psoriatic arthritis, pulmonary interstitial fibrosis
- **S** Sjögren's syndrome, systemic sclerosis

Where to get your **chronic medicine**

Use a pharmacy in our networks

On the Executive Plan you can get your medicine at any pharmacy in our pharmacy network – there are over 2,500 pharmacies to choose from.

How to get your medicine

You can order or reorder your medicine online through MedXpress and have it delivered to your work or home

or

- Order your medicine online and collect instore at a MedXpress Network Pharmacy

or

- Fill a prescription as usual at any MedXpress Network Pharmacy.

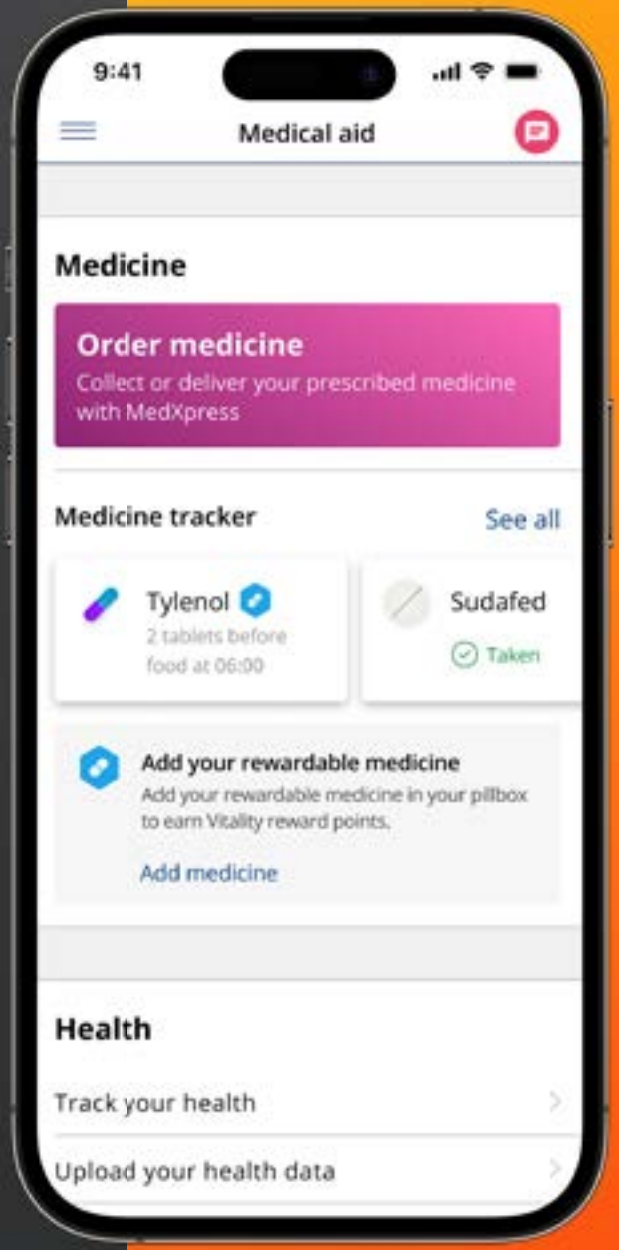
Medicine tracker

You can set up reminders and prompts to assist you with taking your medicine on time and as prescribed. Your approved chronic medicine will automatically be displayed, and you will then be prompted to take your medicine and confirm when each dose is taken.

How to order

Discovery app or **www.discovery.co.za**

View all pharmacy network providers using Find a healthcare provider on the Discovery app



Find a healthcare provider, the Discovery app, MedXpress and Medicine tracker are brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

Care
Programmes

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.

Disease Prevention Programme

If you are identified to be at risk of cardio-metabolic risk syndrome, your Premier Plus GP can enrol you on the Disease Prevention Programme. Your GP, dietitian and health coach will help coordinate your care. Enrolled members have access to a defined basket of care which includes cover for consultations, certain pathology tests and medicine, where appropriate. You will also have access to health coaching sessions to help you with the day-to-day management of your condition.

Diabetes Care Programme

If you are registered on the Chronic Illness Benefit (CIB) for diabetes, your Premier Plus GP can enrol you on the Diabetes Care Programme. The programme unlocks cover for additional glucometer strips and consultations with dietitians and biokineticists. You may also have access to a nurse educator to help you with the day-to-day management of your condition.

Cardio Care Programme

If you are registered on the Chronic Illness Benefit (CIB) for hypertension, hyperlipidaemia or ischaemic heart disease, you have access to a defined basket of care and an annual cardiovascular assessment, if referred by your Premier Plus GP and enrolled on the Cardio Care Programme.

Mental Health Care Programme

Once enrolled on the programme by your network psychologist or Premier Plus GP, you have access to defined cover for the management of major depression. Enrolment on the programme unlocks cover for prescribed medicine, access to either individual or group psychotherapy sessions (virtual and face-to-face therapy) and additional GP consultations to allow for effective evaluation, tracking and monitoring of treatment. Qualifying members will also have access to a relapse prevention programme, which includes additional cover for a defined basket of care for psychiatry consultations, counseling sessions and care coordination services.

HIV Care Programme

If you are registered on the HIV programme by your Premier Plus GP, you are covered for the care you need, which includes additional cover for social workers. You can be assured of confidentiality at all times. You need to get your medicine from a designated service provider (DSP) to avoid a 20% co-payment.

Track your health and the Discovery app are brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

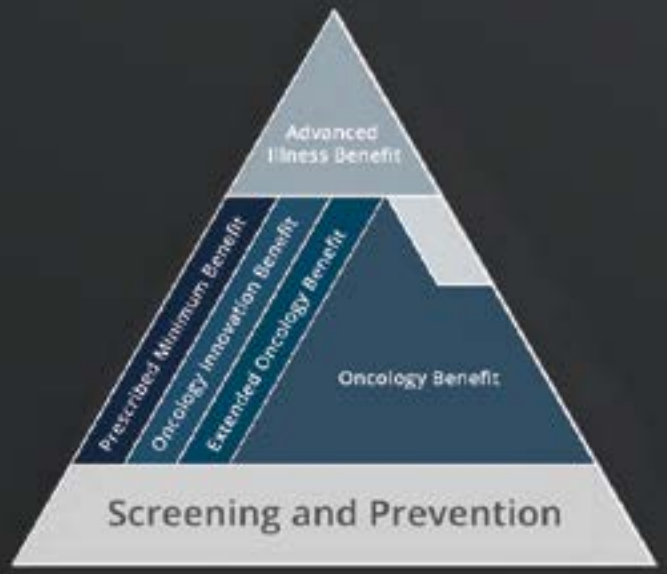
Track your Health

You can get personalised health goals that help you to manage your weight, nutrition and exercise. If you are at risk of developing or you are diagnosed with cardiovascular disease or diabetes, we will give you goals tailored to your circumstances. You can track your progress on the Discovery app and we will reward you for meeting your goals.

Click on Track your Health on the Discovery app to activate the programme

You have comprehensive **cover for cancer**

You have access to comprehensive cover for cancer treatment. This includes access to high cost medicine, innovative treatment and extended cover once you reach certain limits.



Prescribed Minimum Benefits (PMB)

Cancer treatment that is a Prescribed Minimum Benefit (PMB), is always covered in full. All PMB treatment costs add up to the cover amount. If your treatment costs more than the cover amount we will continue to cover your PMB cancer treatment in full.

Oncology Benefit

If you are diagnosed with cancer and once we have approved your cancer treatment, you are covered by the Oncology Care Programme. We cover your approved cancer treatment over a 12-month cycle.

We cover the first R500,000. If your treatment costs more than the cover amount, we will cover up to 80% of the subsequent additional costs, unless the treatment forms part of the extended cover offered by the Oncology Innovation and Extended Oncology Benefit. All cancer-related healthcare services are covered up to 100% of the Discovery Health Rate (DHR). You might have a co-payment if your healthcare professional charges above this rate.

Oncology Innovation Benefit

On the Executive Plan 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 cost of these treatments.

Visit **www.discovery.co.za** to view the detailed Oncology Benefit guide

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.

How we cover medicine

You need to get your approved oncology medicine on our medicine list from a designated service provider (DSP) to avoid a 20% co-payment. Speak to your treating doctor to confirm that they are using our DSPs for your medicine and treatment received in rooms or at a treatment facility

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.

Hospital Benefit

If you need to be admitted to hospital

The Executive plan offers cover for hospital stays. There is no overall limit for the Hospital Benefit.

If you have to go to hospital, we will pay your hospital expenses. There is no overall hospital limit for the year on any of the plans. However, there are limits to how much you can claim for some treatments.

Contact us in good time before you have to go to hospital. We will let you know what you are covered for. If you do not contact us before you go, we might not pay the costs.

What is the benefit?

This benefit pays the costs when you are admitted into hospital.

What we cover

Unlimited cover in any private hospital approved by the Scheme.

You have cover for planned stays in hospital.

How to get the benefit

Get your confirmation first

Contact us to confirm your hospital stay before you are admitted (this is known as pre-authorisation).

Where to go

You can go to any private hospital approved for funding by the Scheme. The funding of newly licensed facilities is subject to approval by the Scheme, on all health plans. An upfront payment applies for specific in-hospital procedures.

What we pay

We pay for planned hospital stays from your Hospital Benefit. We pay for services related to your hospital stay, including all healthcare professionals, services and medicine authorised by the Scheme for your hospital stay.

If you use doctors, specialists and other healthcare professionals that we have an agreement with, we will pay for these services in full. We pay up to 300% of the Discovery Health Rate (DHR) for other healthcare professionals.

You can avoid co-payments by:

- Using healthcare professionals that we have a payment arrangement with.

Pre-operative Management Programme for major surgeries

For a defined list of surgeries such as arthroplasty, colorectal surgery, coronary artery bypass graft, radical prostatectomy and mastectomy, you have cover for a pre-operative assessment with a nurse, a consultation (face-to-face, virtual or telephonic) with your treating healthcare professional and specific laboratory, pathology and radiology tests where required.

Cover is subject to the Scheme's clinical entry criteria, treatment guidelines and protocols.

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 R2,460 per day in a private ward
Defined list of procedures performed in specialist rooms	Up to the agreed rate where authorised by the Scheme
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 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 R3,470 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

Hospital cover

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
R4,050	R5,900, this co-payment will reduce to R4,700 if performed by a doctor who is part of the Scheme's value-based network
If both a gastroscopy and colonoscopy are performed in the same admission	
R4,950	R7,300, this co-payment will reduce to R5,950 if performed by a doctor who is part of the Scheme's value-based network

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 aged 12 or under, 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

R230,400 per person for each benefit.

Internal nerve stimulators

R175,200 per person.

Major joint surgery

No limit for planned hip and knee joint replacements if you use a provider in our network, or up to 80% of the Discovery Health Rate (DHR) if you use a provider outside our network up to a maximum of R30,900 for each prosthesis for each admission. The network does not apply to emergency or trauma-related surgeries.

Shoulder joint prosthesis

No limit if you get your prosthesis from a provider in our network or up to R45,550 if you use a provider outside our network.

Alcohol and drug rehabilitation

We pay for 21 days of rehabilitation for each person each year. Three days per approved admission per person for detoxification.

Prosthetic devices used in spinal surgery

There is no overall limit if you get your prosthesis from our preferred suppliers. If you do not use a preferred supplier, a limit of R26,250 applies for the first level and R52,500 for two or more levels, limited to one procedure per person per year.

You have full cover for approved spinal surgery admissions if you use a provider in our spinal surgery network. Planned admissions outside of our network will be funded at up to 80% of the Discovery Health Rate (DHR) for the hospital account.

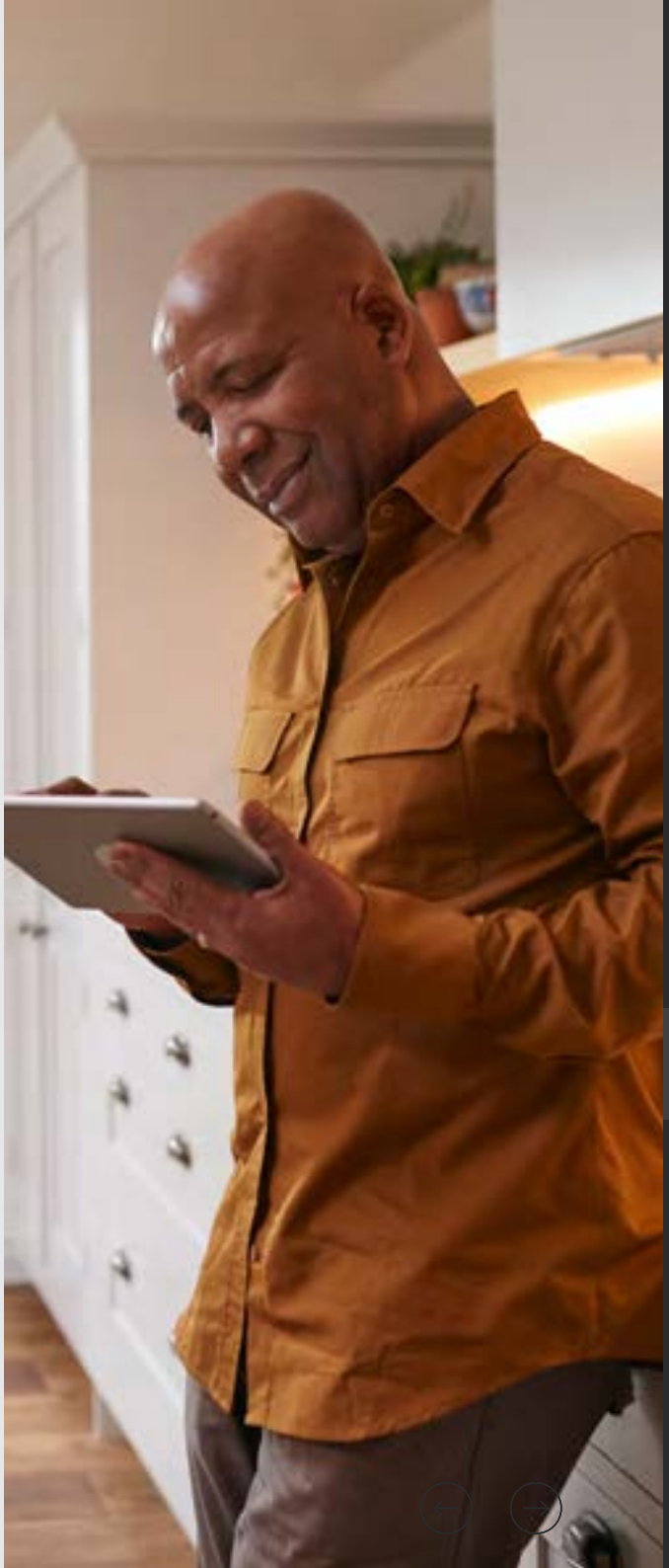
You also have cover for out-of-hospital conservative spinal treatment, see page 30.

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 all 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.



Benefits with an **annual limit**

Dental treatment in hospital

Dental limit

There is no overall limit for basic dental treatment. However, all dental appliances and prostheses, their placement, and orthodontic treatment (including related accounts for orthognathic surgery) are paid at 100% of the Discovery Health Rate (DHR). We pay these claims from your day-to-day benefits, up to an annual limit of R32,600 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.

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.

Basic Dental Trauma Benefit

The Basic Dental Trauma Benefit covers sudden and unanticipated injury to teeth and mouth that requires urgent dental treatment after an accident or trauma injury. Where the clinical entry criteria is met, cover for dental appliances and prostheses and the placement thereof are paid up to an annual limit of R61,500 per person per year.

Dental treatment in hospital

Except where approved for severe dental and oral surgery, 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 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:	
R7,800	R5,000
Members under 13:	
R3,000	R1,350

Extra benefits on your plan

You get the following extra benefits to enrich your cover.

Assisted Reproductive Therapy (ART)

If you meet the Scheme's benefit entry criteria, you have cover for one or two annual cycles of ART, depending on your age.

The benefit includes cover for consultations, ultrasounds, oocyte retrieval, embryo transfer and freezing, admission costs including lab fees, medicine 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 cryopreservation and egg and sperm storage for up to five years.

We pay up to a maximum of 75% of the Discovery Health Rate and up to a limit of R122,000 per person per year.

You will need to pay up to 25% of the costs and any amount in excess of the Discovery Health Rate (DHR).

In rooms procedures

You have cover for a defined list of procedures performed in specialist rooms. Cover is up to the agreed rate, where authorised by the Scheme, from your Hospital Benefit.

Africa Evacuation Cover

You have cover for emergency medical evacuations from certain sub-Saharan African countries back to South Africa. Pre-existing conditions are excluded.

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.

Specialised Medicine and Technology Benefit

You have 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.

Claims related to traumatic events

The Trauma Recovery Extender Benefit extends your cover for out-of-hospital claims related to certain traumatic events. Claims are paid from the Trauma Recovery Extender Benefit for the rest of the year in which the trauma occurred, as well as the year after the event occurred. You and your dependants on your health plan have access to six counselling sessions per person per year by a psychologist, clinical social worker or registered counsellor, for the year in which the trauma event occurred and the year after. You need to apply for this benefit.

International Travel Benefit

You have cover for emergency medical costs of up to US$1 million per person on each journey while you travel outside of South Africa. This cover is for a period of 90 days from your departure from South Africa. Pre-existing conditions are excluded. We may cover you at equivalent local costs for elective treatment received outside of South Africa, as long as the treatment is readily and freely available in South Africa and it would normally be covered by your plan.

International second opinion services

Through your specialist, you have access to second opinion services from The Clinic by Cleveland Clinic for life-threatening and life-changing conditions. We cover 100% for the cost of the second opinion service.

Overseas Treatment Benefit

You have cover for treatment not available in South Africa. The treatment must be provided by a recognised healthcare professional and is paid up to a limit of R750 000 per person. You also have cover up to 100% of the cost of the global fee amount and 80% of the cost above the global fee amount up to a limit of R300 000 at a recognised healthcare provider for in-hospital treatment that is available in South Africa.

You will need to pay and claim back from us when you return to South Africa. A co-payment of 20% applies.

Spinal Care Programme

For conservative spinal treatment out-of-hospital you have access to a defined basket of care which includes cover for virtual and face-to-face consultations with an appropriately registered allied healthcare professional.

The Clinic by Cleveland Clinic online medical second opinion programme is brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

Your contributions, Medical Savings Account and Annual Thresholds

	MAIN MEMBER	ADULT	CHILD*
CONTRIBUTIONS (JANUARY 2023 - MARCH 2023)	R8,298	R8,298	R1,586
ANNUAL MEDICAL SAVINGS ACCOUNT AMOUNTS**	R24,888	R24,888	R4,752
ANNUAL THRESHOLD AMOUNTS**	R31,200	R31,200	R5,920

* We count a maximum of three children when we calculate the monthly contributions, annual Medical Savings Account and Annual Threshold. In the case of foster children, every child added to the policy is charged for.

** 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.

The Annual Medical Savings Account amounts displayed above reflects the upfront annual allocation for January 2023 and will be adjusted from April 2023 in line with the annual contribution increase. The Annual Threshold amounts are calculated for January 2023 to December 2023.

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 (PMBs) 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, unless part of Prescribed Minimum Benefits (PMBs) or the Assisted Reproductive Therapy (ART) Benefit
- 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).

Exclusive access to **value-added offers**

*Our members have exclusive access to value-added offers outside of the Discovery Health Medical Scheme benefits and Rules. Go to **www.discovery.co.za** to access these value-added offers.*

Savings on personal and family care items

You can sign up for Healthy Care to get savings on a vast range of personal and family care products at any Clicks or Dis-Chem. Healthy Care items include a list of baby care, dental care, eye care, foot care, sun care and hand care products, as well as first aid and emergency items and over-the-counter medicine.

Frames and lenses

You get a 20% discount for frames and lenses at an optometrist in your plan's network of optometrists.You will receive the discount immediately when you pay.

Savings on stem cell banking

You get access to an exclusive offer with Netcells that gives expectant parents the opportunity to cryogenically store their newborn baby's umbilical cord blood and tissue stem cells for potential future medical use, at a discounted rate.

Access to Vitality to get healthier

You have the opportunity to join the world's leading science-based wellness programme, Vitality, which rewards you for getting healthier. Not only is a healthy lifestyle more enjoyable, it is clinically proven that Vitality members live healthier, longer lives.

Access support from online patient communities

Discovery Health has partnered with myHealthTeam, a global leader in facilitating highly effective online patient communities. This gives members living with diabetes and heart disease and those impacted by long COVID access to a digital community of patients living with the same illness to help them manage their condition.

Vitality is not part of Discovery Health Medical Scheme. Vitality is a separate wellness product, sold and administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07. Limits, terms and conditions apply. Healthy Care is brought to you by Discovery Vitality (Pty) Ltd, registration number 1997/007736/07, an authorised financial services provider. Netcells and myHealthteam are brought to you by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

If you have a **complaint**

Discovery Health Medical Scheme is committed to providing you with the highest standard of service and your feedback is important to us. The following channels are available for your complaints.

What to do if you have a complaint:

01 | To take your query further

If you have already contacted Discovery Health Medical Scheme and feel that your query has still not been resolved, please complete our online complaints form on **www.discovery.co.za**. We would also love to hear from you if we have exceeded your expectations.

02 | To contact the Principal Officer

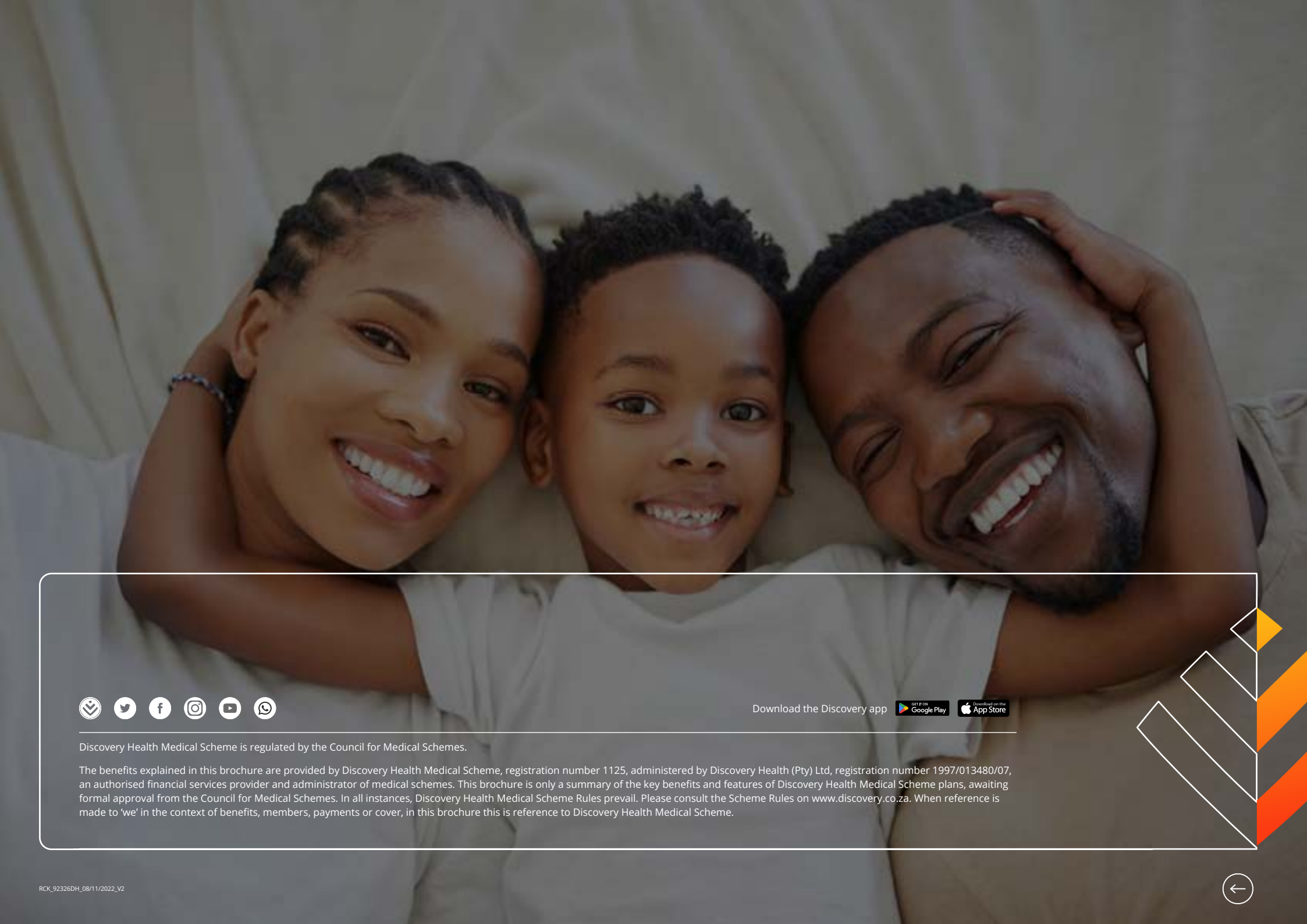
If you are still not satisfied with the resolution of your complaint after following the process in Step 1 you are able to escalate your complaint to the Principal Officer of the Discovery Health Medical Scheme. You may lodge a query or complaint with Discovery Health Medical Scheme by completing the online form on **www.discovery.co.za** or by emailing principalofficer@discovery.co.za.

03 | To lodge a dispute

If you have received a final decision from Discovery Health Medical Scheme and want to challenge it, you may lodge a formal dispute. You can find more information of the Scheme's dispute process on **www.discovery.co.za.**

04 | To contact the Council for Medical Schemes

Discovery Health Medical Scheme is regulated by the Council for Medical Schemes. You may contact the Council at any stage of the complaints process, but we encourage you to first follow the steps above to resolve your complaint before contacting the Council directly. Contact details for the Council for Medical Schemes: Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion 0157 | complaints@medicalschemes.co.za | 0861 123 267 | www.medicalschemes.co.za



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