Retail Medical Scheme

Administered by Discovery Health

RETAIL MEDICAL SCHEME
BENEFIT BROCHURE
2019

CONTACT **DETAILS**

Ambulance and other emergency services:
0860 999 911

Send your claims

Email: claims@discovery.co.za

Post: PO Box 652509,
Benmore, 2010 or
Postnet Suite 116,
Private Bag X19,
Milnerton,
7435

Fax: 0860 329 252

By hand: Drop your claim in any blue Discovery Health Claims box

To confirm your benefits for a hospital stay

Email: preauthorisations@discovery.co.za

Call: 0860 101 252

To arrange approval for your chronic medicine or to register on the oncology or HIVCare programmes

Call: 0860 101 252

To arrange delivery of your chronic medicine using Medirite courier service

Call: 021 983 5119/6

General queries

Email: service@discovery.co.za

Website: www.discovery.co.za

Call: 0860 101 252

For anonymous fraud tip-offs

Fraud hotline: 0800 004 500

Extra services

Internet queries:
0860 100 696

Smart health choices:
0860 999 911 (for medical advice)

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Please note in this brochure specific limits that may apply to the benefits are reflected in the Benefit Schedules, included on pages 23 to 32. We do not reflect these limits in the sections of the brochure where we explain how benefits work.

This brochure gives you a brief outline of the Benefit Options Retail Medical Scheme offers. For more details you can visit our website, www.discovery.co.za. This does not replace the Scheme Rules. The registered Scheme Rules are legally binding and always take precedence.

WELCOME TO **RETAIL** MEDICAL SCHEME

Retail Medical Scheme is a registered Medical Scheme and operates within the requirements of the Medical Schemes Act 1998.

The Scheme is a closed scheme and membership is reserved for employees and pensioners of the Shoprite Group. Should you resign from the Scheme, your membership will terminate on your last working day.

A Board of Trustees, representing the employer and the members, governs the Scheme. These Trustees are either elected or appointed to ensure the financial soundness of the Scheme and to protect the members' interests. The Scheme currently holds reserves that are in excess of the required minimum solvency levels, proof of its prudent management.

AN OUTLINE OF WHAT RETAIL MEDICAL SCHEME OFFERS

Members have different needs, depending on their family size, financial and health circumstances.

The Scheme provides a choice of two Benefit Options to meet these diverse needs. It is important for a member to make the right choice.

You will have to consult the detailed benefit schedule and contribution table, to ensure your choice of Option best suits your needs. Especially if your health status changed during the past year.

If your conditions of service makes it compulsory to join the Scheme and you join immediately, no underwriting will be applied. However, if you are joining the Scheme voluntarily (after your date of employment) waiting periods may apply (3 months General and/or 12 months Condition Specific).

Please note:

- If you intend to add your newly married spouse as a dependant, please notify us within 30 days of date of the marriage to ensure no waiting periods are applied.
- When you get divorced, your ex-spouse is no longer eligible to be a member of the Scheme. You must notify us within 30 days of the divorce being finalised.
- When they become permanently employed, your children are no longer eligible to be registered as dependants on your membership. You must let us know immediately when their employment is confirmed.

Essential Option

The Essential Option provides unlimited hospital and Prescribed Minimum Benefit (PMB) cover. This Option provides limited cover for day-to-day expenses.

Essential Plus Option

The Essential Plus Option provides unlimited hospital and Prescribed Minimum Benefit (PMB) cover. You contribute to a Medical Savings Account (MSA) for all your day-to-day expenses. Once the Medical Savings Account (MSA) is exhausted and the Annual Threshold has been reached, further day-to-day cover will be provided by the Scheme from the limited Above Threshold Benefit (ATB).

RETAIL MEDICAL SCHEME ENABLES YOU TO MANAGE YOUR HEALTHCARE SPEND

Your Medical Savings Account will take care of day-to-day benefits. When you need more cover, the Scheme will pay claims from the Above Threshold Benefit on the Essential Plus Option. On the Essential Option the Scheme pays your day-to-day medical expenses from the Out-of-Hospital Benefit, which is limited.

Retail Medical Scheme's care programmes look after you in times of need

Diabetes and Cardiovascular Disease Management Programmes

For members who are registered on the Chronic Illness Benefit. The Scheme pays for certain GP-related services subject to referral by the Designated Service Provider (DSP) Network GP. These benefits are paid in addition to the normal Prescribed Minimum Benefits Chronic Disease List benefits and baskets of care, etc.

HIVCare Programme

The HIV*Care* Programme offers unlimited cover for HIV- or AIDS-related illnesses. This fully inclusive programme makes sure members get personal and confidential care, including counselling and approval for anti-retroviral medicine.

Home-based care

When you meet certain clinical criteria and receive the services from the Scheme' s Designated Service Provider, Discovery HomeCare, the Scheme pays for home-based wound care, end-of-life care, IV Infusions and postnatal care, etc.

Oncology Programme

If you have been diagnosed with cancer, you can register on the Oncology Programme and get cover in full up to the Scheme Rate and the applicable threshold. The threshold applies in a 12-month cycle from the month of first registration on this programme. Once your non-Prescribed Minimum Benefit treatment costs go over this amount, the Scheme will pay claims up to 80% of the Scheme Rate for all further treatment and you will need to pay the balance from your own pocket. This amount could be more than 20% if your treatment cost is higher than the Scheme Rate.

Patients get support and access to reliable information on cancer and what steps to take to manage the disease. Radiology and pathology approved for your cancer treatment are also covered. Cancer treatment that falls within the Prescribed Minimum Benefit is always covered in full, with no co-payment. Please call us to register on the Oncology Programme.

If you have end-stage cancer, the Advanced Illness Benefit will provide palliative and other home-based care.

> ***To register on either the HIV or the Oncology Programme, call 0860 101 252***

Preventive screening is available on both Options

The Pharmacy Screening and the Preventive Screening Benefit cover certain screening tests from the Core Benefit only if one of the Scheme's contracted providers is used. These tests include amongst others:

- Blood glucose
- Blood pressure
- Cholesterol
- Body Mass Index (BMI)

Additional screening tests covered from this benefit are:

- Mammogram (once every 2 years)
- Pap smear (once every three years)
- Prostate Specific Antigen (PSA)
- HIV tests

This benefit provides cover for certain screening tests from the Core Benefit only at one of the Scheme's contracted providers for children between the ages of 2 and 18 years. These tests are:

- Body Mass Index (BMI) and counseling, if required
- Basic hearing and dental screenings
- Milestone tracking for children aged 8 and younger.

These tests are important because it allows medical conditions to be detected early, giving you a better chance for a healthy life.

Visit **www.discovery.co.za** to find a list of designated providers.

BENEFITS AND THE TERMS WE USE

Above Threshold Benefit (ATB)

The Above Threshold Benefit is a 'safety net' available on the Essential Plus Option. When your day-to-day claims all add up to the Annual Threshold, we start paying for certain non-hospital expenses at the Scheme Rate. This benefit protects you from high expenses related to day-to-day healthcare treatment.

We add up the day-to-day claims you send to us at the Scheme Rate, where applicable. Once your day-to-day claims reach a certain value, known as the Annual Threshold, the Scheme will pay certain day-to-day claims according to the specific benefits for your Benefit Option.

We set the Annual Threshold at the beginning of every year based on the total number of dependants registered on your membership. We will prorate the Above Threshold Benefit if you join the Scheme during the year, based on the number of months left in that year.

Chronic Illness Benefit (CIB)

The Chronic Illness Benefit covers approved medicine for 26 Prescribed Minimum Benefit Chronic Disease List conditions.

You must apply for cover before you can claim for this benefit.

If we have not accepted your application for this benefit, we will pay these expenses from your day-to-day benefits.

Ask us or visit the website at **www.discovery.co.za/medical-aid/find-documents**, for the forms you have to fill in. You and your doctor may have to give extra information for the Scheme to accept your application.

How we pay for medicine authorised under the Chronic Illness Benefit

We will pay your approved medicine in full if it is on our medicine list (formulary). If your approved medicine is not on our medicine list, we will pay your chronic medicine up to a set monthly amount, called the Chronic Drug Amount (CDA), for each medicine class. If you use more than one medicine in the same medicine class, where both medicines are not on the medicine list, or where one medicine is on the medicine list and the other is not, we will pay for both medicines up to the one monthly CDA for that medicine class.

> ***If a condition is listed as a Prescribed Minimum Benefit, by law all medical schemes must cover the medicine and certain treatment and care for the condition.***

Tests, procedures and consultations

If your PMB CDL condition is approved, the Chronic Illness Benefit will automatically open access to cover for a limited number of selected tests, procedures and/or specialist consultations for the diagnosis and ongoing management of your condition. You will also have cover for four (4) GP consultations related to your approved PMB CDL conditions) per year.

The number of tests and consultations are calculated based on the number of months left in the year at the time your condition is approved. If you have cover for the same procedures or tests for more than one condition, we will only pay for the basket that gives you the most procedures or tests.

If you want to access cover from the Chronic Illness Benefit, you must apply for it. You need to complete a Chronic Illness Benefit Application form with your doctor and submit it for review. You can get your latest application form on the website at www.discovery.co.za/medical-aid/find-documents, or call **0860 101 252** to get one.

You must provide information to get access to the Chronic Illness Benefit

For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria that needs to be met. You or your doctor may need to provide certain test results or extra information and motivation to finalise your application. The application form will give you the details as to which documents and extra information you will need to submit. Please ensure that these documents are submitted with your application. Remember, if you leave out any information or do not provide medical test results or documents needed with the application, cover will start from the date we receive the outstanding information

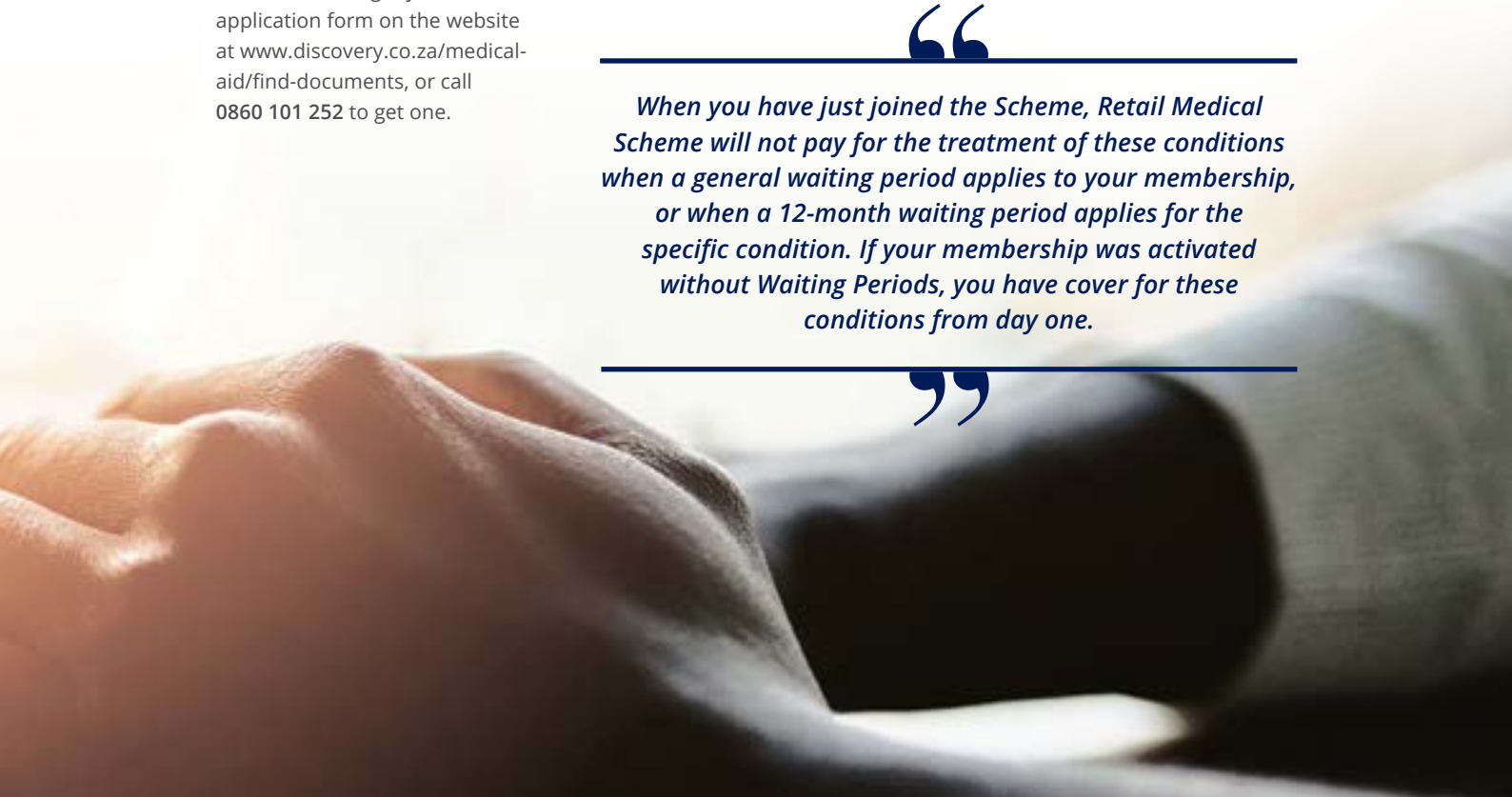
Prescribed Minimum Benefits (PMB)

By law all medical schemes in South Africa must cover a minimum set of medical treatments for certain conditions. This is true even when scheme exclusions apply, when we have applied waiting periods in certain circumstances or when you have reached a limit for an applicable benefit. The PMBs is a package of minimum clinical benefits that the Scheme must pay for. Your available MSA cannot be used to pay for these benefits. The PMB consists of care for:

- Any life-threatening emergency medical condition
- A defined set of 270 diagnoses, and 26 chronic conditions.

We will pay for PMB in full only if treatment is provided by, or at one of the Scheme's DSPs, except in emergencies, unless otherwise indicated.

When you have just joined the Scheme, Retail Medical Scheme will not pay for the treatment of these conditions when a general waiting period applies to your membership, or when a 12-month waiting period applies for the specific condition. If your membership was activated without Waiting Periods, you have cover for these conditions from day one.



When co-payments for PMB medicine will not apply

- Your treating doctor submits an application, supported by an adequate, written clinical motivation for the continuation of medicine not listed on the formulary, or a substitution of the formulary medicine (in cases where the formulary drug would be ineffective or harmful)
- The formulary medicine is not available from the Designated Service Provider appointed by the Scheme, or would not be provided without unreasonable delay.

Designated Service Provider

All MediRite Pharmacies are the Scheme's Designated Service Provider (DSP) for medicine.

If you do not get the Prescribed Minimum Benefit Chronic Disease List (PMB CDL) medicine from a MediRite Pharmacy, you will need to pay a co-payment for the difference between the Scheme Medicine Rate and any other related fee charged, directly to the pharmacy.

Please note: If there isn't a MediRite Pharmacy near your home or place of work, you will still be able to get the medicine from them as they will deliver it to an address of your choice through a courier service. Please call the MediRite call centre on **021 983 5119/6** to arrange this service

Your Chronic Illness Benefits

The Essential and Essential Plus Options provide cover for the following Prescribed Minimum Benefit Chronic Disease List conditions:

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disease
- Chronic renal disease
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus type 1
- Diabetes mellitus type 2
- Dysrhythmia
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosis
- Ulcerative colitis

The following conditions will be covered on both Options based on clinical rules and the Diagnosis Treatment Pairs Minimum Benefit (DTPMB). This is not the complete list. Please ask us to confirm whether your condition is one of the DTPMB conditions.

- Cushing's disease
- Hormone replacement therapy
- Hypoparathyroidism
- Organ transplantation
- Paraplegia
- Pectoris
- Pemphigus
- Peripheral arteriosclerotic disease
- Pituitary microadenoma
- Quadriplegia
- Stroke
- Thrombocytopaenic purpura
- Valvular heart disease

Payment for the diagnosis and medical management of PMB CDL conditions

You do not pay for the diagnosis and medical management costs provided in the treatment basket. These costs are paid in accordance with the Rules of the Scheme from your Core Benefits. Unless approved with further motivation by your doctor, we will pay benefits exceeding those provided for in the treatment basket from your day-to-day benefits.

The Scheme will pay in full (i.e. without any co-payments or deductibles, such as levies) for the diagnosis, treatment and ongoing care of PMB conditions, provided your treating doctor includes the correct ICD-10 code on the account. If the correct code is not included, your claim will be treated as a day-to-day or out-of-hospital claim, and will be paid from your applicable day-to-day benefits.

The cost of any treatment that is not in accordance with the treatment basket may be covered from your day-to-day benefits that are paid from the Core benefits, or you may have to pay for it, unless it is approved by DiscoveryCare, on appeal.

Core Benefit

This covers all your medical expenses when you are admitted to hospital and also certain major out-of-hospital procedures and costs in lieu of hospitalisation.

Day-to-day claims

Day-to-day claims are expenses you incur for which you would not normally be admitted to hospital. We cover these claims through the Medical Savings Account (MSA) and the Above Threshold Benefit (ATB) on the Essential Plus Option or through the limited Out-of-Hospital Benefit on the Essential Option. Some day-to-day expenses are paid from the Core benefits, such as the benefits offered in the Maternity Programme. Examples of day-to-day expenses include: consultations at healthcare professionals (GPs, specialists, dermatologists, homeopaths), prescribed medicine and conservative dentistry.

Designated Service Providers (DSPs)

These are specific providers of healthcare services, for example hospitals, GPs and specialists, who have agreed to provide services according to certain agreed rules. The Scheme pays these providers directly.

If you do not use the services of the DSP

For PMB claims to be funded in full, you must use a DSP for certain services, as indicated in this booklet and your Benefit Schedule. If these providers are not used, the Scheme may apply co-payments.

You will not have to make any co-payments if you have involuntarily obtained a service (had no other choice) from a provider other than a DSP, and:

- it is an emergency, for example hospital admissions
- the service was not available from the DSP or would not have been provided without unreasonable delay
- there was no DSP within a reasonable distance from your place of business or residence.

The Scheme's DSPs for the diagnosis, treatment and ongoing care costs (which may include medicine) for Prescribed Minimum Benefit (PMB) conditions are:

- Certain DSP Premier Rate Specialists and General Practitioners (GPs), who have agreed to deliver services in accordance with their Direct Payment Arrangement (DPA) with the Scheme
- Contracted hospitals for all in-hospital treatment and care
- MediRite Pharmacies (for all medicine)
- National Renal Care (NRC) for care of patients requiring renal care, including dialysis
- SANCA, RAMOT and Nishtara Lodge for all PMB benefits related to drug and alcohol detoxification and rehabilitation
- Other service providers, as selected by the Scheme from time to time

It is likely that the Scheme will contract with and appoint more DSPs, particularly provider networks, in its ongoing efforts to control and reduce costs for members.

Designated Service Providers (DSPs)

When you use the service of a DSP, all claims including Prescribed Minimum Benefits, are paid in full. This means you will not have to make any out-of-pocket payments.

Discovery*Care*

Retail Medical Scheme has contracted Discovery Health (Pty) Ltd as the Scheme's managed healthcare provider to manage the appropriateness and cost effective provision of healthcare services to its members. Discovery*Care* is the area in Discovery Health (Pty) Ltd that manages these initiatives on behalf of the Scheme.

Discovery 911

You have access to Discovery 911, a service that provides highly trained paramedics in response vehicles that will help you with all aspects of a medical emergency. You can call **Discovery 911** for help in an emergency.

General Practitioner (GP) Network

This is an open network of more than 2 000 GPs and you may find information about the nearest one on **www.discovery.co.za** or by calling **0860 101 252**. If you use one of these providers, you will not be liable for any co-payments as the provider will only charge the Scheme Rate. Retail Medical Scheme will pay these claims in full at the amount charged and the provider will not be allowed to ask you to make any co-payments.

If you willingly (choose to) do not use the services of a GP in the Scheme's GP Network to obtain services related to PMB treatment, we will pay these claims to a maximum of 80% of the Scheme Rate only. You will have to pay the shortfall. Non-PMB claims, incurred at non-Network GPs, will only be paid up to 100% of the Scheme Rate.

Home-based care

Certain services, that are normally provided in the hospital, can safely be obtained at home. If authorised, and the services of the Scheme's Designated Service Providers are used, the Scheme will pay for these services from the Major Medical Benefit. We for instance pay wound care, end-of-life care, IV infusions and postnatal care services from this benefit.

Hospital Benefit (Core Benefit)

This benefit covers expenses incurred while you are in hospital, if we have confirmed cover for your admission. Examples of such expenses are theatre and ward fees, X-rays, blood tests and medicine given to you while you are in hospital.

If you are going to hospital for a planned procedure, you must phone us on **0860 101 252** to confirm benefits before being admitted. If it is an emergency, you must let us know as soon as you can after you are admitted, and within at least 48-hours.

If you do not confirm benefits for your admission, or let us know in an emergency, you will be responsible for 30% of the hospital costs.

Medical Savings Account (MSA)

This benefit is used to pay for your day-to-day claims on the Essential Plus Option. The positive balance in the Medical Savings Account carries over from one year to the next.

If you resign from the Scheme and have available funds in your MSA, the balance will be paid to your next scheme (if you choose an MSA-option), or it will be refunded to you after four months of your withdrawal from the Scheme. We follow the stipulations of the Medical Schemes Act for these refunds.

Remember to obtain authorisation before you obtain these services in your home to ensure the Scheme pays for it from the Core benefits.

Oncology Programme

Retail Medical Scheme members and their dependants, who have been diagnosed with cancer, can register on the Oncology Programme. Patients get support and access to reliable information on cancer and what steps a patient can take to manage and live with the disease.

To register, call **0860 101 252.**

We work with your doctor to ensure the most clinically appropriate and cost-effective treatment plan. We pay most claims related to treating cancer from the Core Benefit, and only some claims from the day-to-day benefits.

The Oncology Programme covers the first R200 000 of your approved cancer treatment in full, over a 12-month cycle. Once your treatment costs go over this amount, the Scheme will pay 80% of the Scheme Rate for all further treatment and you will need to pay the balance from your own pocket. This amount could be more than the 20% deductible if your treatment cost is higher than the Scheme Rate.

Advanced Illness Benefit

The Advanced Illness Benefit provides funding for the care of patients with end-of-life stage cancer and covers, amongst others, the following out-of-hospital services: GP and Specialist consultations, including home based care; specialist Hospice nursing care; general nursing care obtained from a Discovery HomeCare provider, where available; oxygen, pain management, wound care, counseling, pathology and medicine (per defined baskets) and appropriate feeds.

PET scans

If we have approved your scan and you have it done in our PET scan network, we will pay your claim as follows:

IF YOU HAVE NOT REACHED THE ONCOLOGY THRESHOLD	IF YOU HAVE REACHED THE ONCOLOGY THRESHOLD
The Scheme will pay up to the agreed rate for your cancer treatment.	The Scheme will pay 80% of the Scheme Rate and you must pay the shortfall. This amount could be more than 20% if your healthcare provider charges higher than the Scheme Rate.

If we have approved your scan and you have it done outside of our PET scan network we will pay your claim as follows:

IF YOU HAVE NOT REACHED THE ONCOLOGY THRESHOLD	IF YOU HAVE REACHED THE ONCOLOGY THRESHOLD
You must pay a portion of the scan cost from your pocket.	The Scheme pays the claims at 80% of the Scheme Rate. You must therefore pay the claims shortfalls as well as a the applicable co-payment.

You have access to local and international bone marrow searches and stem cell transplants

This benefit will be paid at the agreed rate, subject to authorisation, review and clinical criteria.

Over-the-counter medicine (OTC)

Schedule 0-2 (generic and non generic) medicine, whether prescribed or not, is also known as over-the-counter (OTC) medicine. If you buy OTC medicine and you want to claim for these from the Scheme, please make sure of the following:

- You need to get the medicine from a registered healthcare provider with a valid practice number
- The claim needs to display a valid ICD-10 code
- The claim needs to have a NAPPI code.

We will only pay for OTC medicine if you are on the Essential Plus Option and have available funds in your MSA.

Please remember that OTC medicine is not paid from the Above Threshold Benefit and does not add up to the Annual Threshold. This means you may incur a Self Payment Gap, when you have to pay for claims, before the Above Threshold Benefit becomes available.

Pro-rated benefits

We calculate your benefits and limits according to the number of months left in the calendar year, if you join the Scheme during that year.

SANCA, Nishtara Lodge and RAMOT

SANCA, Nishtara Lodge and RAMOT are the Scheme's Designated Service Providers for Prescribed Minimum Benefits. The Scheme will pay in full for their services, at the negotiated rate, for all accommodation, therapeutic sessions, consultations by psychologists and psychiatrists and medicine, to manage the condition and aftercare, on both Options.

SANCA and Nishtara Lodge are organisations that address alcoholism and drug dependence through specialised treatment and services. This enhances the quality of life and restores the self respect and dignity of persons affected by alcohol and drug dependence. Ramot is a partly state-subsidised not-for-profit organisation, providing similar services.

If the services of these providers are not used, benefits are limited. Your benefit schedule provides more details.

Scheme Rate

This is how much the Scheme will pay, and is based either on a rate determined by the Scheme or a specific negotiated rate with the healthcare professional. Unless it is indicated differently in this booklet, claims are paid at 100% of the Scheme Rate, or in the case of participating specialists, at the Premier Rate. Participating GPs are paid at the GP Network rate.

If you do not use the Scheme's DSP when you obtain services related to the Prescribed Minimum Benefits, your claims may be limited, or may only be paid at 80% of the Scheme Rate.

Self-payment Gap (SPG)

If you registered on the Essential Plus Option and you run out of funds in your Medical Savings Account (MSA) before you reach the Annual Threshold, you will experience a Self-payment Gap (SPG).

When you are in your SPG, you may need to pay for certain medical expenses from your own pocket, before Retail Medical Scheme starts paying again.

This happens when you make claims from your MSA for over-the-counter medicine (which does not accumulate to your Threshold).

Your claims statement will indicate when you're likely to be in your Self-payment Gap and have to start paying some claims.

How to get through the Self-payment Gap (SPG)

When you have used up your MSA, but you have not yet reached your Annual Threshold, you must pay for your day-to-day healthcare expenses. Claims that do not add up to your Annual Threshold will make your SPG bigger.

When you are in a Self-Payment Gap, you must remember to keep sending us your claims (and the receipts of payment), so we know when you have reached your Annual Threshold. When you reach your Annual Threshold, the Scheme will again pay for certain day-to-day claims from the Above Threshold Benefit.

Specialist Network

Approximately 80% of Retail Medical Scheme claims are from Premier Rate Specialists in this open network, with whom the Scheme has a Direct Payment Arrangement (DPA). You may find information on **www.discovery.co.za** or by calling **0860 101 252**. If you use one of these providers, Retail Medical Scheme will pay the claims in full at the amount charged, directly to the provider. The specialist will not be allowed to ask you to make any payments in excess of the agreed rate, and you will not be liable for any co-payments.

Premier Rate Specialists are the Designated Service Providers for PMB Specialist treatment and care. If you willingly do not use the services of a Premier Rate Specialist, we will pay you to a maximum of 80% of the Scheme Rate only, and you will be liable for any co-payments. You will have to settle the account as we will only pay the Scheme's portion to you.

Other, non-PMB claims, incurred at non-Network Specialists, will be paid to a maximum of the Scheme Rate only.

Virtual GP consultations

You will be able to make online appointments and book after-hour virtual consultations with your Network GP.

What the Scheme does not cover

There are certain medical expenses the Scheme does not cover. We call these exclusions.

The Scheme will not cover the direct or indirect consequences of the following, except as regulated in the Prescribed Minimum Benefits:

- Cosmetic procedures, for example, otoplasty for jug ears; removal of portwine stains; blepheroplasty (eyelid surgery); removal of keloid scars; hair removal; nasal reconstruction (including septoplasties, osteotomies and nasal tip surgery); and healthcare services related to gender reassignment
- Breast reductions and implants
- Treatment for obesity
- Treatment for infertility, subject to Prescribed Minimum Benefits
- Frail care
- Experimental, unproven or unregistered treatment or practices
- CT angiogram of the coronary vessels and CT colonoscopy
- Alcohol and drug rehabilitation treatment, unless it is PMB-related

The purchase of the following, unless prescribed:

- applicators, toiletries and beauty preparations
- bandages, cotton wool and other consumable items
- patented foods, including baby foods
- tonics, slimming preparations and drugs
- household and biochemical remedies
- anabolic steroids and
- sunscreen agents.

Unless otherwise decided by the Scheme, benefits in respect of these items, on prescription, are limited to one month's supply for every prescription or repeat thereof.

Certain costs

- Costs of search and rescue
- Any costs that another party is legally responsible for
- Facility fees at casualty facilities (these are administration fees that are charged directly by the hospital or other casualty facility), unless stated differently for specific benefits
- Costs for holidays for recuperative purposes
- Costs in excess of the annual maximum benefits to which a member is entitled
- Appointments not kept
- Interest charges for late claims payments caused by members submitting claims late, or due to complaint or disputes processes
- Costs for PMB-related healthcare services when these are received outside of South Africa
- Costs related to services that do not meet the Scheme's clinical protocols and treatment guidelines
- Costs related to fraudulent claims
- Costs for healthcare services rendered during applicable waiting periods.

Always check with us

Please contact us if you have one of the conditions we exclude so we can let you know if there is any cover. In some cases, you might be covered for these conditions if they are part of Prescribed Minimum Benefits.

HOW TO...

Use the website

01 | Go to **www.discovery.co.za**

02 | Click on the Register button

03 | Complete the registration process

04 | Thereafter you will have electronic access to your benefit information

05 | If you need help when registering, please call **0860 100 696**.

Use the Discovery Smartphone App

The Discovery smartphone App puts you fully in touch with your benefits. If your mobile device is with you, so is your Scheme.

- Download the Discovery App from the App Store to your smartphone.
- Set up you own unique login (same as your login for the Scheme's website, if you are already active on the site)
- Log into the App
- Get access to your electronic membership card, submit and track claims and up to date information about your benefits and limits.

If you want to add a dependant to an existing membership, you must complete an *Additional Dependant Application* form. Please attach a copy of your dependant's identity document to the application form. You must give the completed and signed form to your Human Resources Department for approval.

Change your Benefit Option

While you cannot make any Benefit Option changes during the year, you can do so before the end of November each year (this will be effective 1 January of the following year). Be sure to get approval from your employer.

Claim from the Scheme

You are responsible for:

- Checking your personal file with your doctor to ensure all your details are up-to-date
- Checking all your details against your membership card, especially your membership number
- Asking if your doctor charges the Scheme Rate or a higher rate and negotiate with him or her to charge at the Scheme Rate
- Sending us a detailed claim and not just a receipt. We need the details so we can process your claim
- Ensuring your membership number, doctor's details and the practice number are clearly visible on the claim

Note: If your doctor sends the claim to the Scheme electronically, you do not need to send a copy to us.

By law, each claim must contain the following information:

- The surname and initials of the member
- The surname, first name and other initials, if any, of the patient
- The name of the medical scheme
- The membership number
- The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service
- The relevant diagnosis and such other item code numbers that relate to such relevant health service
- The date on which each relevant health service was rendered
- The nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member, and the name, quantity and dosage of and net amount payable by the member in respect of the medicine.

Choose from several ways to send claims

There are various ways of sending claims to the Scheme for processing:

01 | Your doctor can send the claim to us

02 | Scan (take a photo with your phone) and send your claim by email to **claims@discovery.co.za** or fax to **0860 329 252**

03 | Drop your claim at Discovery Health's offices or at any other assigned Discovery Health claims box. You can find these boxes at:

- Virgin Active or Planet Fitness gyms
- At most private hospitals
- At the Shoprite Home Office in Brackenfell

04 | Post your claim to the Scheme by sending it to PO Box 652509, Benmore 2010 or Postnet Suite 116, Private Bag X19, Milnerton 7435

What happens after you send your claim

Once we receive your claim, we scan and capture it on our system. We will then assess the claim and make sure all the information on the claim matches the information we have on record.

The turnaround time for processing claims is 72 hours – from the time we receive a claim to the time we process it. It is then approved or declined for payment. Once we have made the payment, you will receive your claims statement detailing all the claims payments, or a claims notification.

How to check on the status of your claim

To see the status of your claim, you can access our website at **www.discovery.co.z**a or check your claim statement. If we have your email address, you can now receive a claims payment notification, that will provide you with all the information about the latest claims we have processed for you – how it was assessed against your available benefits, how it was paid and what the latest balances are – MSA or others.

Please log in to **www.discovery.co.za** and update your information.

Time limit for claims submission

You must send in your claim as soon as possible. If we do not process and pay it within four months after the treatment date, it will not be valid and we will not pay it.

Complain if you disagree with a decision about your membership or a claim

When you have questions about any of your benefits or contributions, please call us at **0860 101 252** or email **service@discovery.co.za**. If you do not lodge a query within four months of the Scheme first informing you of how that claim was paid, your query will no longer be valid, so try and do it as soon as possible after receiving your claims notification or statement.

If you are not satisfied that your enquiry or complaint was resolved, email **service@discovery.co.za** or send a fax to 021 527 1923 and ask that a Team Leader or the Fund Manager look into your case and give them all the details that they ask for.

If your query is still not resolved, write to the Principal Officer of Retail Medical Scheme at Postnet Suite 116, Private Bag X19, Milnerton, 7435

Report fraudulent activities

It is estimated that at least 10% of the annual spend of any scheme relates to claims that were fraudulently presented for payment.

Some examples of fraud:

- Belonging to two medical schemes at the same time and claiming double
- Sunglasses being billed as prescription glasses
- Allowing your provider to claim for procedures and treatments that were not performed
- Giving non-registered persons access to benefits through misrepresentation, for example when you give your membership card to your neighbour, who is not a Retail Medical Scheme member, to undergo treatment under your name.

Check that all transactions related to your membership are true and correct. Report any suspicions you may have immediately, by contacting Discovery's toll-free, tip-off line on **0800 004 500** or **email forensics@discovery.co.za**

Or you may remain anonymous if you prefer:

- SMS 43477 and include the description of the alleged fraud
- Toll-free fax: 0800 007 788
- Email: discovery@tip-offs.com
- Post: Freepost DN298, Umhlanga Rocks 4320.

All calls or contact will be handled with the strictest confidentiality.

Any person caught committing fraud will be listed on a register and steps will be taken to recover any money you, or the Scheme, may have lost in the process.

Your responsibilities as a member

At all times, you have to:

- provide the Scheme with information that is true and correct
- report any changes to your membership immediately and keep your contact details and other information provided to the Scheme updated
- Use benefits wisely and when necessary only – this helps to contain contribution increases and ensures the Scheme can pay claims now and in the future
- avoid having to pay part of the claim yourself by using the services of the Scheme's Preferred or Designated Service Providers
- report suspected fraud immediately, whether you suspect healthcare providers or members are involved. You can report fraud anonymously
- pay contributions when they are due
- pay any outstanding debt due to the Scheme immediately when you are notified.

BENEFITS **2019**

BENEFITS 2019	ESSENTIAL	ESSENTIAL PLUS
Core Benefits Subject to preauthorisation **Prescribed Minimum Benefits (PMB) will be paid as per the Regulations**		
Allied and Therapeutic extender benefit	Subject to benefit entry criteria requirements for a specific list of conditions and further subject to authorisation	Subject to benefit entry criteria requirements for a specified list of conditions and further subject to authorisation
Bluetooth enabled blood glucose monitoring devices For beneficiaries approved and registered for Diabetes on the Chronic Illness Benefit. Subject to approval based on the use of the Scheme's DSP	100% of the Scheme Rate, limited to one device per beneficiary per year	100% of the Scheme Rate, limited to one device per beneficiary per year
Chronic Illness Benefit: PMB conditions Condition and medicine subject to benefit entry criteria	PMB conditions paid at 100% of the cost, unlimited according to a formulary and distribution by Designated Service Provider (DSP); or chronic drug amount (CDA)	PMB conditions paid at 100% of the cost, unlimited according to a formulary and distribution by Designated Service Provider (DSP); or chronic drug amount (CDA)
Chronic Illness Benefit: PMB Baskets of Care For diagnosis, and ongoing management of approved PMB conditions	100% of Scheme Rate Unlimited according to PMB and rendered by DSP	100% of Scheme Rate Unlimited according to PMB and rendered by DSP
Circumcisions Medically necessary circumcisions performed in- and out-of-hospital (in doctor's rooms)	Paid up to 100% of the Scheme Rate Preauthorisation required if performed in-hospital Unlimited, subject to clinical rules	Paid up to 100% of the Scheme Rate Preauthorisation required if performed in-hospital Unlimited, subject to clinical rules
Cochlear and auditory brain implants	100% of the Scheme Rate Limited to R223 700 per beneficiary	100% of the Scheme Rate Limited to R223 700 per beneficiary
Compassionate care for the terminally ill Includes hospice visits, accommodation, prescribed medicine and materials and home based care, subject to preauthorisation	100% of the Scheme Rate Unlimited, subject to clinical rules and authorisation Subject to PMB	100% of the Scheme Rate Unlimited, subject to clinical rules and authorisation Subject to PMB
Dental and oral surgery Severe life threatening infections, internal temporomandibular joint surgical procedures, cancer and certain trauma related surgery, cleft lip and palate repairs, subject to clinical entry criteria and PMBs	100% of the Scheme Rate Unlimited	100% of the Scheme Rate and authorisation Unlimited
Dental – Final phase surgical dental implants For oncology-related and other specific trauma cases	100% of the Scheme Rate Unlimited	100% of the Scheme Rate Unlimited

BENEFITS 2019	ESSENTIAL	ESSENTIAL PLUS
Dental surgery Elective procedures, in-hospital	100% of Scheme Rate, also for Specialists and GPs with whom the Scheme has agreed rates Unlimited The following deductibles will apply: Adult: Day case R4 000, In-hospital stay R6 200 Child <12 years: Day case R1 100, In-hospital stay R2 400	100% of Scheme Rate, also for Specialists and GPs with whom the Scheme has agreed rates Unlimited The following deductibles will apply: Adult: Day case R4 000, In-hospital stay R6 200 Child <12 years: Day case R1 100, In-hospital stay R2 400
Doctors and allied healthcare services In-hospital	100% of Scheme or negotiated DSP Rate Unlimited If non-DSP is used for PMBs, benefits will be paid subject to certain limits and co-payments	100% of Scheme or negotiated DSP Rate Unlimited If non-DSP is used for PMBs, benefits will be paid subject to certain limits and co-payments
Second opinion specialist consultations Second opinion consultation obtained from Cleveland Clinic (America) Requested by the Scheme's Medical Review Team in consultation with the member's doctor	50% of the cost of the consultation, if obtained from the Scheme's Designated Service Provider (DSP) Subject to clinical rules and authorisation	50% of the cost of the consultation, if obtained from the Scheme's Designated Service Provider (DSP) Subject to clinical rules and authorisation
Diabetes and Cardiovascular Disease Management Programmes For members who are registered on the Chronic Illness Benefit	100% of the Scheme Rate for GP-related services covered in a treatment basket, subject to referral by the DSP GP. If the services of a non-DSP GP are used, a 20% co-payment will apply Paid in addition to the normal Prescribed Minimum Benefits Chronic Disease List benefits and treatment basket	100% of the Scheme Rate for GP-related services covered in a treatment basket, subject to referral by the DSP GP. If the services of a non-DSP GP are used, a 20% co-payment will apply Paid in addition to the normal Prescribed Minimum Benefits Chronic Disease List benefits and treatment basket
Drug and alcohol rehabilitation	21 days in hospital Detox limited to 3 days	21 days in hospital Detox limited to 3 days
Emergency evacuations and transport	100% of the Scheme Rate. Unlimited if the services of Discovery 911 is used	100% of the Scheme Rate. Unlimited if the services of Discovery 911 is used
Endoscopic procedures In hospital: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	100% of Scheme Rate First R4 250 covered by the member. Remainder of the account covered from Core Benefit	100% of Scheme Rate First R4 250 covered from the MSA/ ATB, subject to the Overall ATB limit. Remainder of the account covered from Core Benefit
HIV and AIDS-related illnesses Evidence-based protocols and formularies apply. Subject to the services being rendered by the Scheme's DSP	100% of the cost Unlimited Managed by the Scheme's HIV management programme. 4 GP consults as part of the basket of care services paid in full if obtained from DSP GP in the Premier Plus Network. A 20% co-payment applies if services are not obtained at DSP GP. Subject to PMB	100% of the cost Unlimited Managed by theScheme's HIV management programme. 4 GP consults as part of the basket of care services paid in full if obtained from DSP GP in the Premier Plus Network. A 20% co-payment applies if services are not obtained at DSP GP. Subject to PMB

BENEFITS 2019	ESSENTIAL	ESSENTIAL PLUS
Home-based care Includes wound care, end-of-life care, IV Infusions (drips) and postnatal care	Unlimited Subject to obtaining the services from the Scheme's DSP	Unlimited Subject to obtaining the services from the Scheme's DSP
Hospital benefit Accommodation, theatre fees, materials used, Home-based care or medication for duration of hospitalisation Subject to preauthorisation	100% of Scheme Rate Unlimited Specific Designated Service Provider hospitals for Psychiatric care and major joint replacement procedures. If the procedure is not performed in a Designated Service Provider Hospital, a 20% co-payment applies to the hospital costs	100% of Scheme Rate Unlimited Specific Designated Service Provider hospitals for Psychiatric care and major joint replacement procedures. If the procedure is not performed in a Designated Service Provider Hospital, a 20% co-payment applies to the hospital costs
Influenza immunisation High risk members, who are older than 65 years, and members who are registered for the following CIB conditions: chronic obstructive pulmonary disease, Asthma, HIV and AIDS, Diabetes or Chronic renal failure	100% of the Scheme Rate. Limited to one immunisation per person per year	100% of the Scheme Rate. Limited to one immunisation per person per year
Internal nerve stimulators	100% of the Scheme Rate Limited to R223 700 per beneficiary	100% of the Scheme Rate Limited to R223 700 per beneficiary
Internal prostheses In-hospital	100% of Scheme Rate Unlimited Shoulder joint prosthesis limited to R41 700 and hip/knee joint replacement prosthesis limited to R30 000 per beneficiary per prosthesis if not supplied by the Scheme's preferred provider. Subject to the procedure being performed at a Designated Service Provider hospital. If it is not performed in a Designated Service Provider hospital, a 20% co-payment applies to the hospital costs	100% of Scheme Rate Unlimited Shoulder joint prosthesis limited to R41 700 and hip/knee joint replacement prosthesis limited to R30 000 per beneficiary per prosthesis if not supplied by the Scheme's preferred providers. Subject to the procedure being performed at a Designated Service Provider hospital. If it is not performed in a Designated Service Provider hospital, a 20% co-payment applies to the hospital costs
Maternity Programme **Cover during pregnancy**	100% of the Scheme Rate for medical expenses normally paid for under the Out-of-Hospital Benefit for members registered on the Maternity Programme. If not registered on the Maternity Programme, available Day-to-day Benefits apply 8 antenatal Midwife, GP or Gyneacologist consultations 1 Nuchal Translucency or Non-Invasive Prenatal Test (NIPT), subject to clinical entry criteria 2 2D Ultrasound scans (3D or 4D scans paid up to the cost of a 2D scan only) 5 pre- or post-natal classes or consultations with a registered nurse	100% of the Scheme Rate for medical expenses normally paid for under the Out-of-Hospital Benefit for members registered on the Maternity Programme. If not registered on the Maternity Programme, available Day-to-day Benefits apply 8 antenatal Midwife, GP or Gyneacologist consultations 1 Nuchal Translucency or Non-Invasive Prenatal Test (NIPT), subject to clinical entry criteria 2 2D Ultrasound scans (3D or 4D scans paid up to the cost of a 2D scan only) 5 pre- or post-natal classes or consultations with a registered nurse

BENEFITS 2019	ESSENTIAL	ESSENTIAL PLUS
Cover for newborn baby or toddler up to the age of two years	2 visits to a GP, Paediatrician or Ear, Nose and Throat (ENT) specialist	2 visits to a GP, Paediatrician or Ear, Nose and Throat (ENT) specialist
Cover for the mother of the newborn baby for up to 2 years after the birth	1 consultation at a GP or Gyneacologist for post-natal complications 1 nutritional assessment at a dietician 2 mental health consultations with a counsellor or psychologist 1 lactation consultation with a registered nurse or lactation specialist	1 consultation at a GP or Gyneacologist for post-natal complications 1 nutritional assessment at a dietician 2 mental health consultations with a counsellor or psychologist 1 lactation consultation with a registered nurse or lactation specialist
Medication, materials or external medical appliances (billed by the Hospital as To Take Out)	Paid from the Chronic Illness Benefit, where available, or from the Out-of-Hospital Benefit, as per the prescribed medicine or External Medical Items benefit	Paid from the Chronic Illness Benefit, where available, or from MSA/ATB, subject to the Overall Annual ATB limit, as per the prescribed medicine or External Medical Items benefit
Mental health	21 days in-hospital or 15 psychotherapy sessions. Out-of-Hospital PMB sessions Subject to treatment in a Designated Service Provider hospital. If it is not performed in a Designated Service Provider Hospital, a 20% co-payment applies to the hospital costs	21 days in-hospital or 15 psychotherapy sessions. Out-of-Hospital PMB sessions Subject to treatment in a Designated Service Provider hospital. If it is not performed in a Designated Service Provider Hospital, a 20% co-payment applies to the hospital costs
MRI and CT scans Subject to preauthorisation	100% of Scheme Rate Unlimited	100% of Scheme Rate Unlimited
Oncology-related benefits Subject to authorisation and / or approval and the treatment meeting the Scheme's clinical entry criteria Includes cover for: chemo- and radiotherapy; oncologist's consultations; pathology subject to a defined list; radiology; supportive treatment; stoma therapy; terminal care; other oncology treatment and facility fees	100% of the Scheme Rate Unlimited in a 12-month cycle. All claims accumulate to a threshold of R200 000. Thereafter the benefit is paid at 80% of the Scheme Rate for all further treatment and you will need to pay the balance from your own pocket. This amount could be more than 20% if your treatment cost is higher than the Scheme Rate. PMB oncology-related claims are paid in full You have access to local and international bone marrow donor searches and approved stem cell harvesting and transplants subject to authorisation, clinical criteria and review. Subject to the services being rendered by a Preferred Provider. If not a limit of R1 million applies per beneficiary per year.	100% of the Scheme Rate Unlimited in a 12-month cycle. All claims accumulate to a threshold of R200 000. Thereafter the benefit is paid at 80% of the Scheme Rate for all further treatment and you will need to pay the balance from your own pocket. This amount could be more than 20% if your treatment cost is higher than the Scheme Rate. PMB oncology-related claims are paid in full You have access to local and international bone marrow donor searches and approved stem cell harvesting and transplants subject to authorisation, clinical criteria and review. Subject to the services being rendered by a Preferred Provider. If not a limit of R1 million applies per beneficiary per year.
Advanced Illness Benefit for patients with end-of-life stage cancer Out-of-hospital	Unlimited. Paid up to 100% of the Scheme Rate, subject to a basket of care and registration on the Oncology Management Programme by the treating doctor	Unlimited. Paid up to 100% of the Scheme Rate, subject to a basket of care and registration on the Oncology Management Programme by the treating doctor

BENEFITS 2019	ESSENTIAL	ESSENTIAL PLUS
Organ transplants Hospitalisation and harvesting of the organ, subject to preauthorisation and certain clinical entry criteria	100% of the cost Unlimited Subject to PMB	100% of the cost Unlimited Subject to PMB
Medicine for immuno-suppressive therapy	100% of the Scheme's Medicine Rate Subject to CDA	100% of the Scheme's Medicine Rate Subject to CDA
Oxygen Rental	100% of the Scheme Rate Unlimited if obtained from the Scheme's Designated Service Provider, VitalAire. If DSP is not used, claims will be paid up to the Scheme Rate only	100% of the Scheme Rate Unlimited if obtained from the Scheme's Designated Service Provider, VitalAire. If DSP is not used, claims will be paid up to the Scheme Rate only
PET scans Subject to certain terms and conditions and preauthorisation	If we have approved your scan and you have it done in our PET scan network: The Scheme will pay up to the agreed rate if you have not used up the oncology limit for your cancer treatment. If you have used up this amount, the Scheme will pay 80% of the Scheme Rate and you must pay the shortfall. This amount could be more than 20% if your healthcare provider charges higher than the Scheme Rate	If we have approved your scan and you have it done in our PET scan network: The Scheme will pay up to the agreed rate if you have not used up the oncology limit for your cancer treatment. If you have used up this amount, the Scheme will pay 80% of the Scheme Rate and you must pay the shortfall. This amount could be more than 20% if your healthcare provider charges higher than the Scheme Rate
Pneumococcal vaccine Persons older than 65 years and the following persons with recurrent pneumonia admissions: children under 14 and registered Chronic Illness Benefit (CIB) persons with the following CIB conditions: Asthma, Bronchiectasis, Cardiac failure, Cardiomyopathy, Chronic Obstructive Pulmonary disease (COPD), Chronic Renal Disease, Coronary Artery Disease, Diabetes (Type I and II) and HIV.	Paid up to 100% of the Scheme Rate for one approved pneumococcal vaccine per qualifying person per lifetime	Paid up to 100% of the Scheme Rate for one approved pneumococcal vaccine per qualifying person per lifetime
Renal care Subject to use of the Scheme's DSP	100% of the Scheme Rate If Scheme's DSP is not used, a co-payment equal to the difference between the cost and the Scheme Rate will apply	100% of the Scheme Rate If Scheme's DSP is not used, a co-payment equal to the difference between the cost and the Scheme Rate will apply
Screening Benefit Blood glucose; blood pressure; cholesterol and body mass index (BMI) obtained from the Scheme's DSP	100% of the Scheme Rate Paid once per year, at the Scheme Rate, per beneficiary for a single or basket of these tests. Thereafter paid from Out-of-Hospital Benefit or by member	100% of the Scheme Rate Paid once per year, at the Scheme Rate, per beneficiary for a single or basket of these tests. Thereafter paid from MSA or ATB

BENEFITS 2019	ESSENTIAL	ESSENTIAL PLUS
Screening Benefit for children between the ages of 2 and 18 Body mass index, including counselling if necessary, basic hearing and dental screenings and milestone tracking for children between the ages of two and eight years	100% of the Scheme Rate Paid once per year, at the Scheme Rate, per beneficiary for a single or basket of these tests. Thereafter paid from Out-of-Hospital Benefit or by member	100% of the Scheme Rate Paid once per year, at the Scheme Rate, per beneficiary for a single or basket of these tests. Thereafter paid from MSA or ATB
Screening Benefit Mammograms; Pap smears; Prostate Specific Antigen (PSA) subject to PMBs, obtained from any relevant healthcare provider	100% of the Scheme Rate For the actual test codes only. Related consultations and procedures paid by member. Limited to one mammogram every 2 years, one pap smear every 3 years and one PSA-antigen test per beneficiary per year More frequent testing for repeat pap smears, mammography, MRI breast scans and a once-off BRCA test, subject to clinical criteria and authorisation.	100% of the Scheme Rate For the actual test codes only. Related consultations and procedures paid by member. Limited to one mammogram every 2 years, one pap smear every 3 years and one PSA-antigen test per beneficiary per year More frequent testing for repeat pap smears, mammography, MRI breast scans and a once-off BRCA test, subject to clinical criteria and authorisation.
GP consultations for mammograms and Pap smears, subject to PMBs	100% of the Scheme Rate	100% of the Scheme Rate
Specialised Medical Technology Benefit (SMTB)	No benefit	100% of the Scheme Rate Limited to R200 000 per beneficiary with a variable co-payment up to 20%, based on the condition and the medicine prescribed Overseas SMTB benefits are limited to R535 000 per beneficiary, subject to a 20% co-payment. Claims will be paid at cost, subject to certain stipulations
Spinal Benefit Subject to use of the Scheme's DSP	100% of the Scheme Rate. If the Scheme's Designated Service Provider is not used, limited to R25 500 per level, with an overall annual limit of R51 000 for two or more levels Only one procedure per year will be authorised	100% of the Scheme Rate. If the Scheme's Designated Service Provider is not used, limited to R25 500 per level, with an overall annual limit of R51 000 for two or more levels Only one procedure per year will be authorised
Statutory Prescribed Minimum Benefits (PMB)	Unlimited, subject to PMB approval Paid in full at the Scheme's Designated Service Providers or Preferred Providers If Designated Service Providers or Preferred Providers are not used, claims will be paid at the Scheme Rate and co-payments may apply	Unlimited, subject to PMB approval Paid in full at the Scheme's Designated Service Providers and Preferred Providers If Designated Service Providers or Preferred Providers are not used, claims will be paid at the Scheme Rate and co-payments may apply

BENEFITS 2019	ESSENTIAL	ESSENTIAL PLUS
Trauma recovery extender benefit Subject to clinical entry criteria and protocols Benefits for certain day-to-day care after one of the following traumatic incidents: crime-related injuries, conditions resulting from a near-drowning, poisoning and severe anaphylactic (allergic) reaction; if the trauma results in one of the following: paraplegia, quadriplegia, severe burns and external and internal head injuries. Allied, Therapeutic and Psychology healthcare services: chiropractors, counsellors, dietitians, homeopaths, nursing providers, occupational therapists, podiatrists, physiotherapists, social workers, psychologists, speech and hearing therapists psychometrists	100% of the Scheme Rate paid from Core Benefits to the end of the year following that in which the trauma occurred for all medical expenses normally paid for under the Out-of-Hospital Benefit, excluding cover for optometry and dentistry. The following limits apply per beneficiary: Allied, Therapeutic and Psychology healthcare benefits M: R 7 350 M+1: R11 100 M+2: R13 800 M+3+: R16 650 Prescribed Medicine M: R14 400 M+1: R17 000 M+2: R20 200 M+3+: R24 550 External Medical Appliances R27 400 with a sub-limit for Hearing aids R14 100 Prosthetic limbs R82 000	100% of the Scheme Rate from the Core benefits to the end of the year following that in which the trauma occurred for all medical expenses normally paid for under MSA and ATB benefits, excluding cover for optometry, dentistry and OTC medicine. The following limits apply per beneficiary: Allied, Therapeutic and Psychology healthcare benefits M: R 7 350 M+1: R11 100 M+2: R13 800 M+3+: R16 650 Prescribed Medicine M: R14 400 M+1: R17 000 M+2: R20 200 M+3+: R24 550 External Medical Appliances R27 400 with a sub-limit for Hearing aids R14 100 Prosthetic limbs R82 000
Day-to-day benefits		
Out-of-Hospital Benefit	Cover for the different applicable disciplines provided as per the specific benefits listed for this Benefit Option. Limited to R1 550 per beneficiary to a maximum of R3 100 per family	Cover for the different applicable disciplines provided as per the specific benefits listed for this Benefit Option, subject to MSA and limited overall Above Threshold limit
Annual Threshold	Not applicable	Annual Threshold limit: P R9 000 A R8 400 C R3 480 (Maximum 3 children)
Above Threshold Benefit (ATB) Limit	Not applicable	ATB limit: P R10 700 A R 6 450 C R 2 350 (Maximum 3 children)
Medical Savings Account (MSA)	Not applicable	All day-to-day benefits are first payable from the MSA and thereafter from the limited overall Above Threshold Benefit Limit (ATB): P R9 000 A R8 400 C R3 480 (Maximum 3 children)

BENEFITS 2019	ESSENTIAL	ESSENTIAL PLUS
Acute medicine	Preferentially priced generic and brand medication paid up to a maximum of 100% of the Scheme Rate Non-preferentially priced generic and brand medication: paid up to 75% of the Scheme Rate. Paid subject to the Out-of-Hospital Benefit	Preferentially priced generic and brand medicine paid up to a maximum of 100% of the Scheme Rate. Non-preferentially priced generic and brand medicine: paid up to 75% of the Scheme Rate. Paid from MSA and thereafter from ATB Subject to the following sub-limits (including benefits from MSA) and the overall Above Threshold Benefit Limit: M R13 250 M+1 R15 700 M+2 R18 550 M+3+ R22 500
Allied and alternative healthcare professionals, including: ■ Biokineticists ■ Nursing agencies / HomeCare nurses ■ Occupational therapists ■ Physiotherapists ■ Speech and hearing therapists and acousticians ■ Homeopaths ■ Registered counsellors ■ Registered nurses ■ Dieticians ■ Psychometrists ■ Social workers ■ Podiatrists ■ Chiropractors ■ Psychologists	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit. Biokineticists specifically limited to 15 treatments per year, subject to available funds in the Out-of-Hospital Benefit	100% of the Scheme Rate From MSA and thereafter from ATB, subject to the following sub-limits (including benefits from MSA): Family Size Limit M R13 450 M+1 R18 100 M+2 R22 150 M+3+ R25 500 Subject to overall Above Threshold limit, except PMB Biokineticists limited to 15 treatments per year, and the limits as indicated above
Antenatal care Applies if mother is not registered on the Maternity Programme	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit	100% of Scheme Rate From MSA and thereafter from ATB, subject to a sub-limit (including benefits from MSA) of R1 750 per beneficiary Further subject to overall Above Threshold limit
Dentistry Conservative	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit	100% of the Scheme Rate From MSA and thereafter from ATB Subject to overall Above Threshold limit
Dental devices, appliances and orthodontics (including costs for orthognathic treatment) Includes dental appliances and prostheses (fixed and removable), implant components and orthodontics (surgical and non-surgical)	No benefit	100% of the Scheme Rate From MSA and thereafter from ATB, limited to R17 000 per beneficiary Subject to overall Above Threshold limit

BENEFITS 2019	ESSENTIAL	ESSENTIAL PLUS
Endoscopic procedures Out-of-Hospital: Gastroscopy, Colonoscopy, Sigmoidoscopy and Proctoscopy	100% of Scheme Rate paid from the Core Benefit	100% of Scheme Rate paid from the Core Benefit
External medical items Including prostheses	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit, except for PMBs	100% of the Scheme Rate From MSA and thereafter from ATB, subject to overall Above Threshold limit, except for PMBs
General Practitioners and Specialists, including psychiatrists and virtual consultations with a paediatrician for children aged 10 years and younger Subject to DSP arrangements for Specialists and GPs PMBs paid in full at DSP providers only	100% of the Scheme Rate or the negotiated, applicable DSP Rate. 80% of the Scheme Rate if non-DSP providers are used for PMB services. Subject to the applicable limits in the Out-of-Hospital Benefit, except for PMBs	100% of the Scheme Rate or the negotiated, applicable DSP Rate. 80% of the Scheme Rate if non-DSP providers are used for PMB services. Paid from MSA and thereafter from ATB Subject to overall Above Threshold limit
Optical e.g. spectacles, contact lenses, refractive surgery	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit	100% of the Scheme Rate From MSA and thereafter from ATB, subject to a sub-limit (including benefits from MSA) of R4 800 per beneficiary Subject to overall Above Threshold limit
Optometrists fees	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit	100% of the Scheme Rate From MSA and thereafter from ATB, subject to overall Above Threshold limit
Over-the-Counter Medicine Including Schedule 0,1 and 2 medicine, even if prescribed	No benefit	100% of Scheme Rate From MSA only with no accumulation to the Threshold
MRI/CT scans Out-of-Hospital	100% of the Scheme Rate Paid from the Core Benefit	100% of the Scheme Rate Paid from the Core Benefit
Radiology (including X-Rays) and Pathology	100 % of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit, except for PMBs	100% of Scheme Rate from MSA and thereafter from ATB Subject to overall Above Threshold limit, except for PMBs

CONTRIBUTIONS **2019**

	INCOME	TOTAL CONTRIBUTIONS		
		PRINCIPAL MEMBER	SPOUSE OR ADULT DEPENDANT	CHILD DEPENDANT*
		R	R	R
ESSENTIAL OPTION	R0 – R1 000	848	496	258
	R1 001 – R2 500	972	572	258
	R2 501 – R4 000	1 034	604	280
	R4 001 – R6 000	1 122	646	312
	R6 001 – R8 000	1 160	694	324
	R8 001 – R10 000	1 354	810	356
	R10 001+	1 440	918	366

		CORE CONTRIBUTIONS				MEDICAL SAVINGS ACCOUNT (MSA) CONTRIBUTIONS				TOTAL CONTRIBUTIONS		
	INCOME	P	S/A	C*		P	S/A	C*		P	S/A	C*
		R	R	R		R	R	R		R	R	R
ESSENTIAL PLUS OPTION	R0 – R2 500	2 300	2 260	900						3 050	2 960	1 190
	R2 501 – R4 000	2 822	2 334	908						3 572	3 034	1 198
	R4 001 – R6 000	3 224	2 366	914	+	750	700	290	=	3 974	3 066	1 204
	R6 001 – R8 000	3 596	2 398	924						4 346	3 098	1 214
	R8 001 – R10 000	4 078	2 430	932						4 828	3 130	1 222
	R10 000+	4 432	2 462	938						5 182	3 162	1 228

Key: P = Principal member | S = Spouse | A = Adult dependant | C = Child

Note: Contributions are charged for a maximum of 3 children.

Retail Medical Scheme

Administered by Discovery Health

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