Discovery
Health Medical Scheme

GUIDE TO PRESCRIBED MINIMUM BENEFITS FOR OUT-OF-HOSPITAL TREATMENT

DISCOVERY HEALTH MEDICAL SCHEME
2025

Overview

All registered medical schemes in South Africa need to cover Prescribed Minimum Benefits (PMBs) on all the plans they offer to their members. In terms of the Medical Schemes Act No. 131 of 1998, Prescribed Minimum Benefits (PMBs) are a set of defined benefits that all registered medical schemes in South Africa are obliged to provide for all their members. All members have access to these benefits, irrespective of their chosen plan type. Prescribed Minimum Benefits (PMBs) ensure that all medical scheme members have access to continuous care for a defined list of conditions to improve their health.

Discovery Health Medical Scheme plans are structured in a way that maximises cover no matter which health plan you choose. Some plans cost more but offer more comprehensive benefits, while others have lower contributions with fewer benefits. Regardless of this, all our health plans cover more than just the minimum benefits required by law. Always consult your Health Plan Guide on www.discovery.co.za to see how you are covered.

This document tells you how we cover out-of-hospital Prescribed Minimum Benefits (PMBs). For more information on your in-hospital Prescribed Minimum Benefit (PMB) cover please visit our website www.discovery.co.za under Medical Aid > Find document and certificates.

About some of the terms we use in this document

There may be some terms we refer to in this document that you may not be familiar with. Here are the meanings of these terms.

TERMINOLOGY	DESCRIPTION
Above Threshold Benefit (ATB)	**Available on the Executive, Comprehensive and Priority plans** Once the day-to-day claims that 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, at the Discovery Health Rate or a portion of it. The Executive Plan has an unlimited ATB, and the Comprehensive and Priority plans have a limited ATB.
Chronic Disease List (CDL)	This is a defined list of chronic conditions that we cover according to the Prescribed Minimum Benefits.
Chronic Drug Amount (CDA)	The Chronic Drug Amount is the monthly amount that we pay up to for a medicine class. This amount is subject to a member's plan type. It applies to chronic medicine that is not listed on the medicine list (formulary).
Comprehensive cover	This cover exceeds the essential healthcare services and Prescribed Minimum Benefits that are prescribed by the Medical Schemes Act 131 of 1998. Comprehensive cover offers you extra cover and benefits to complement your basic cover. It gives you the flexibility to choose your healthcare options and service providers. Whether you choose full cover or options outside of full cover, we give you the freedom to decide what suits your needs. Our cover is in line with, or goes beyond, defined clinical best practices. This ensures that you receive treatment that is expected for your condition and that is clinically appropriate. We may review these principles from time to time to stay current with changes in the healthcare landscape. While comprehensive, your cover remains subject to the Scheme's treatment guidelines, protocols and designated service providers. We still prioritise managed care to make sure you get the best outcomes for your health.
Co-payment	This is an amount that you have to pay towards a healthcare service. The amount can vary, depending on the type of healthcare service, the place of service and whether the amount that the service provider charges is higher than the rate that 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.
Day-to-day benefits	The day-to-day benefits are the available money allocated to the Medical Savings Account, cover from the limited Above Threshold Benefit or defined benefits for day-to-day healthcare services. The level of day-to-day benefits depends on the plan you choose.
Designated service provider (DSP)	This refers to a healthcare professional or provider (for example, a doctor, specialist, allied healthcare professional, pharmacy or hospital) who/that has agreed to provide Discovery Health Medical Scheme members with treatment or services at a contracted rate. To view the full list of designated service providers, visit www.discovery.co.za or click on 'Find a healthcare provider' on the Discovery Health app.

TERMINOLOGY	DESCRIPTION
Diagnosis and treatment pair (DTP)	A diagnosis and treatment pair links a specific diagnosis to a treatment based on best practice healthcare and affordability of the treatment and broadly indicates how each of the 271 Prescribed Minimum Benefit (PMB) conditions should be treated.
Discovery Health Rate (DHR)	This is the rate that we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant healthcare services.
Discovery Health Rate formedicine	This is the rate that we pay for medicine. It is the Single Exit Price of medicine plus the relevant dispensing fee.
Emergency medical condition	An emergency medical condition may be referred to, simply, as an emergency. It is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical and surgical treatment. Failure to give this medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or it would place the person's life in serious jeopardy. An emergency does not necessarily need you to be admitted to a hospital and you may be treated in casualty only. We may ask you for more information to confirm the emergency.
ICD-10 code	A clinical code that describes diseases and signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO).
Medical Savings Account (MSA)	**Available on the Executive, Comprehensive, Priority and Saver plans** You have access to a Medical Savings Account (MSA) 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 from the money allocated in your MSA. These day-to-day expenses are for general practitioner (GP) and specialist consultations, acute medicine, and radiology and pathology services, among others. You can choose to have your claims paid from the MSA, either at the Discovery Health Rate or at cost. If you have unused money in the account, this will carry over to the next year. If you leave the Scheme or change your plan during the year and have used more of the MSA money than what you have contributed, you will need to pay the difference to us.
Member	The reference to member in this document also includes dependants, where applicable.
Preferred Supplier	Preferred supplier we will pay at a set amount and the supplier will not claim in excess of this amount. Non-preferred suppliers may charge more, and you will need to pay the excess.
Reference Price	The Reference Price is the set amount that we pay for a medicine category. This applies for medicine that is not listed on the medicine list (formulary).
Related accounts	"Related accounts' refers to any account that is separate from your hospital account but related to in-hospital care that you have received. This could include the accounts for your admitting doctor, anaesthetist, and any approved healthcare expenses, like radiology or pathology.

What is a Prescribed Minimum Benefit (PMB)?

Prescribed Minimum Benefits (PMBs) are guided by a list of medical conditions as defined in the Medical Schemes Act of 1998

According to 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:

1. Any life-threatening emergency medical condition
2. A defined set of 271 diagnostic treatment pairs
3. 27 chronic conditions (Chronic Disease List (CDL) conditions), including HIV.

Please refer to the Council for Medical Schemes website www.medicalschemes.co.za for a full list of the 271 diagnostic treatment pairs. All medical schemes in South Africa have to include the Prescribed Minimum Benefits (PMBs) in the plans they offer to their members.

Requirements you must meet to benefit from Prescribed Minimum Benefits (PMBs)

There are certain requirements before you can benefit from Prescribed Minimum Benefits (PMBs). The requirements are:

1. The condition must qualify for cover and be on the list of defined Prescribed Minimum Benefit (PMB) conditions.
2. The treatment needed must match the treatments in the defined benefits on the Prescribed Minimum Benefit (PMB) list.
3. You must use the Scheme's designated service providers (DSPs) for full cover unless there is no DSP applicable to your plan.

If you do not use a designated service provider (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. This does not apply in emergencies. However, even in these cases, where appropriate and according to Scheme Rules, you may be transferred to a hospital or other service providers in our network once your condition has stabilised, to avoid co-payments. If your treatment doesn't meet the above criteria, we will pay according to your plan benefits.

Claims for services received outside of the borders of South Africa will be covered in accordance with your chosen plan benefits and rules. For more information on cover while travelling, please refer to the guide on the Cover for treatment received abroad, available on our website www.discovery.co.za under Medical Aid > Find documents and certificates.

The medical condition must be part of the list of defined conditions for Prescribed Minimum Benefits (PMBs)

You should send the Scheme the results of your medical tests and investigations that confirm the diagnosis of the condition. This will help us to identify that your condition qualifies for the treatment. Your treating doctor needs to complete an application form and provide the relevant documentation to assist us in confirming the diagnosis.

The treatment needed must match the treatments included in the defined benefits

There are standard treatments, procedures, investigations and consultations for each Prescribed Minimum Benefit (PMB) condition on the 271 diagnostic treatment (DT) Prescribed Minimum Benefit (PMB) list. These defined benefits are supported by thoroughly researched, evidence based clinical protocols, medicine lists (formularies) and treatment guidelines.

Please refer to the Council for Medical Schemes website www.medicalschemes.co.za for a full list of the 271 diagnostic treatment pairs.

An example of a Prescribed Minimum Benefit (PMB) provision

Below is an example of a Prescribed Minimum Benefit (PMB) condition and the treatment that qualifies for PMB cover:

PROVISION	PROVISION DESCRIPTION	TREATMENT	ICD-10 CODE
236K	Iron deficiency; vitamin and other nutritional deficiencies – life-threatening	Medical management	D50.8- Other iron deficiency anaemias

- The Prescribed Minimum Benefit (PMB) Provision is 236K. This is one of the listed 271 Provisions (listed 271 conditions) as published in the Medical Schemes Act and Regulations.
- In this example the Provision Description lists "Iron deficiency; vitamin and other nutritional deficiencies - life threatening". The provision states that the condition should be life threatening. For this provision, if the diagnosis is not a life-threatening episode, the condition does not qualify for Prescribed Minimum Benefit (PMB) funding.
- The Treatment covered as a Prescribed Minimum Benefit (PMB) for this provision includes medical management for example medicine, doctor consultations investigations etc.
- In addition to the above information, the Council for Medical Schemes (CMS) also provides ICD-10 codes (e.g., D50.8) that fall within the 236K Provision, as per the last column in the above table. The ICD-10 codes (diagnosis codes) are an industry guide as to which conditions may qualify for Prescribed Minimum Benefit (PMB) cover, subject to them still meeting the Provision Description and treatment criteria.

For this example, in order to qualify for the out-of-hospital Prescribed Minimum Benefit (OHPMB) funding, you or your healthcare professional may apply for medical management of life-threatening iron deficiency, vitamin and other nutritional deficiencies.

This criterion stated in the Provision description needs to be met to qualify for out-of-hospital Prescribed Minimum Benefit (OHPMB) funding related to the treatment as outlined.

Any application for treatment that is not listed in the "treatment" provision for a condition, cannot be considered as Prescribed Minimum Benefit (PMB) as it does not form part of the prescribed treatment that forms part of PMB level of care. Speak to your healthcare professional to ensure that all criteria for treatment are met before applying for Prescribed Minimum Benefit (PMB) cover.

How we pay claims for Prescribed Minimum Benefits (PMBs) and non-Prescribed Minimum Benefits (non-PMB)

We pay for confirmed Prescribed Minimum Benefits (PMBs) in full if you receive treatment from a designated service provider (DSP) and/or preferred supplier. Treatment received from a non-designated service provider (non-DSP) or medical items from a supplier who is not a preferred supplier may be subject to a co-payment if the healthcare provider or supplier charges more than the amount we pay.

Healthcare outcomes are improved through care coordination with your doctors. On all our plans, except the Executive Plan, you and your dependants need to nominate a primary care GP for the management of your chronic conditions. When you visit your nominated network GP for the management of your chronic condition, the Scheme will cover the consultation in full. If you see a GP who is not your nominated primary care GP, or your nominated GP is not a network GP, you will experience a co-payment. Nominate your GP or manage your existing nomination here.

We have preferred suppliers for external medical items such as CPAP machines or rental oxygen. Where a non-preferred supplier is used you may have a co-payment. To view the External Medical Items Benefit guide visit www.discovery.co.za under Medical Aid > Find documents and certificates.

We pay for benefits not included in the Prescribed Minimum Benefits (PMBs) from your appropriate and available plan benefits, according to the rules of your chosen health plan. Visit www.discovery.co.za or click on Find a healthcare provider using your Discovery Health app or call us on 0860 99 88 77 to find a participating designated service provider (DSP).

There are some circumstances where you do not have cover for Prescribed Minimum Benefits (PMBs)

This can happen when you join a medical scheme for the first time, with no previous medical scheme membership. Also, if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both these cases, the Scheme may impose a waiting period, during which you and your dependants will not have access to the Prescribed Minimum Benefits (PMBs), regardless of the conditions you may have. We will communicate with you at the time of applying for your membership if any waiting periods apply to you or your dependants.

There are a few instances when the Scheme will only pay a claim as a Prescribed Minimum Benefit (PMB)

This happens when you have a waiting period or when you have treatments linked to conditions that are excluded by your health plan. This can be a three-month general waiting period or a 12-month condition-specific waiting period. Depending on the category of waiting periods, you may still qualify for cover from the Prescribed Minimum Benefits (PMBs).

You and your dependants must register to get cover for Prescribed Minimum Benefits (PMBs) and Chronic Disease List (CDL) conditions

How to register your chronic or Prescribed Minimum Benefit (PMB) conditions

There are different types of Prescribed Minimum Benefits (PMBs). These include Prescribed Minimum Benefit (PMB) cover for in-hospital admissions, conditions covered under the Chronic Disease List (CDL), the out-of-hospital management of PMB conditions, and treatment of PMB conditions such as HIV and oncology.

To apply for out-of-hospital Prescribed Minimum Benefits (OHPMBs) or cover for a Chronic Disease List (CDL) condition, you must complete the Prescribed Minimum Benefit or a Chronic Illness Benefit application form.

- Up to date forms are always available on www.discovery.co.za under Medical Aid > Find documents and certificates.
- You can also call 0860 99 88 77 to request any of the above forms.

For more information on the Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions, HIV or Oncology and how to register please refer to the relevant benefit guides available on www.discovery.co.za under Medical Aid > Find documents and certificates.

To confirm your in-hospital cover for Prescribed Minimum Benefit (PMB) conditions, you can call us on 0860 99 88 77 and request an authorisation. We will then tell you about your cover.

Why it is important to register your Prescribed Minimum Benefit (PMB) or chronic condition

We will pay for treatment or medicines that fall outside the defined benefits and that are not approved, from your available day-to-day benefits, according to your chosen health plan. If your health plan does not cover these expenses, you will have to pay these claims.

Who must complete and sign the registration form when applying for Prescribed Minimum Benefit (PMB) or chronic condition cover?

The person with the Prescribed Minimum Benefit (PMB) or chronic condition must complete the relevant application form with the help of their treating doctor. The main member must complete and sign the form if the patient is a minor.

Each person with Prescribed Minimum Benefit (PMB) or chronic condition(s) must register their specific condition(s) separately. You only have to register once for a chronic condition. If your medicine or other treatment changes, your doctor can let us know about these changes.

For new conditions, you will have to register each new condition before we will cover the treatment and consultations from your Prescribed Minimum Benefits (PMBs) and not from your day-to-day benefits.

Additional documents needed to support your application

You must send the Scheme the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying. This will help us to identify whether your condition qualifies as a Prescribed Minimum Benefit (PMB). Remember to keep a copy of the completed form for your records.

Where to send the completed application form(s)

You must send the completed Prescribed Minimum Benefit (PMB) application form using either of the following methods:

1. Email to: PMB_APP_FORMS@discovery.co.za
2. Post to: Discovery Health, PMB Department, PO Box 652919, Benmore, 2010.

You must send the completed Chronic Illness Benefit (CIB) application form using either of the following methods:

1. Email to: CIB_APP_FORMS@discovery.co.za
2. Post to: Discovery Health, CIB Department, PO Box 652919, Benmore, 2010.

We will let you know if we approve your application for Prescribed Minimum Benefit (PMB) or chronic condition cover and what you must do next

We will let you know about the outcome of your application and will send you a letter confirming your cover for the condition, using your preferred method of communication. If your application meets the requirements for cover from Prescribed Minimum Benefits (PMBs), we will automatically pay the associated approved blood tests and other defined investigative tests, treatment, medicine and consultations for the diagnosis and treatment of your condition from your Prescribed Minimum Benefits (PMBs), and not from your day-to-day benefits.

The treatment needed must match the treatments in the published defined benefits on the Prescribed Minimum Benefit (PMB) list as there are standard treatments, procedures, investigations and consultations for each condition on the PMB list. These

defined benefits are supported by thoroughly researched evidence, based on clinical protocols, medicine lists (formularies) and treatment guidelines.

What happens if you need treatment that falls outside of the defined benefits

If you need treatment that falls outside of the defined benefits you and your healthcare professional can send additional clinical information with a detailed explanation of the treatment that is needed and we will review it. If this treatment is not approved as Prescribed Minimum Benefit (PMB), it can be paid from your available day-to-day benefits, according to your chosen health plan. If your health plan does not cover these expenses, you will have to pay the costs of these claims.

You can follow the easy steps below to apply for additional cover for out-of-hospital Prescribed Minimum Benefit (PMB) conditions or for Chronic Disease List (CDL) conditions registered on the Chronic Illness Benefit (CIB):

1. Download the request for additional cover for out-of-hospital Prescribed Minimum Benefit conditions or Request for additional cover for PMB CDL conditions registered on CIB. Up to date forms are always available on www.discovery.co.za under Medical Aid > Find documents and certificates. You can also call 0860 99 88 77 to request any of the above forms.
2. Complete the form with the assistance of your doctor or healthcare professional.
3. Send the completed, signed form, along with any additional medical information, by email to PMB_APP_FORMS@discovery.co.za or to CIB_APP_FORMS@discovery.co.za.

If we approve the request for additional medicine or treatment, we will automatically pay these from either the Prescribed Minimum Benefit (PMB) or Chronic Illness Benefit (CIB), whichever is applicable. If the application for additional cover is unsuccessful and you are not satisfied with the outcome you may also lodge a formal dispute by following the Scheme's disputes process on www.discovery.co.za.

For more information on your cover for Chronic or Prescribed Minimum Benefit (PMB) medicine please visit our website www.discovery.co.za under Medical Aid > Find documents and certificates.

What happens if there is a change in your approved medicine

For chronic conditions, your treating doctor or dispensing pharmacist can make changes to your medicine telephonically by calling 0860 99 88 66 or by emailing the updated prescription to CIB_APP_FORMS@discovery.co.za.

For other PMB conditions, the treating doctor or dispensing pharmacist can only make changes to medicine by sending the updated prescription via email to PMB_APP_FORMS@discovery.co.za.

If you get your medicine or treatment from a provider of your choice who is not part of the Scheme's designated service providers (DSPs)

You must use doctors, specialists and other healthcare providers, including pharmacies, who we have a payment arrangement with, to avoid a co-payment. You must see your nominated network GP for GP management to enjoy cover at 100% of the Discovery Health Rate, according to your plan benefits. This does not apply in the event of an emergency or where the use of a non-designated service provider (non-DSP) is involuntary or when no DSP is available. If you use a healthcare provider who we do not have a payment arrangement with, you will have to pay part of the treatment costs yourself.

In an emergency, you can go directly to hospital and notify the scheme as soon as possible of your admission. In the case of an emergency, you are covered in full for the first 24 hours or until you are stable enough to be transferred.

Go to www.discovery.co.za or click on Find a healthcare provider using your Discovery Health app or call us on 0860 99 88 77 to find a participating designated service provider (DSP).

Get the most out of your benefits

Elective admissions for Prescribed Minimum Benefit (PMB) conditions and procedures are covered in full if you choose to use a designated service provider (DSP) hospital and designated service provider (DSP) treating doctors. Where your primary treating doctor is a designated service provider (DSP), reimbursement will be made in full without any co-payment for any required anaesthetic services you may need during your admission.

The below conditions need to be met for full cover for these providers:

- You are being admitted for a procedure for a Prescribed Minimum Benefit (PMB) condition
- Your chosen hospital or day facility is on the Prescribed Minimum Benefit (PMB) network for your plan
- Your primary treating doctor is on the Prescribed Minimum Benefit (PMB) network for your plan.

If all of the above conditions are met your hospital, doctor and anaesthetist accounts will be covered in full.

Nominate a GP for the management of your PMB chronic conditions

Based on the significant opportunity to improve your healthcare outcomes through care coordination, for all our plans except the Executive Plan, you and your dependants need to nominate a primary care GP for the management of your registered chronic conditions. When you visit your nominated network GP for the management of your chronic condition, the Scheme will cover the consultation in full. If you see a GP who is not your nominated primary care GP, or your nominated GP is not a network GP, you will experience a co-payment. You can nominate your GP or manage your existing nomination here. You can change your nomination three times every calendar year.

Out-of-hospital management of depression

Enrolment and participation in a disease management programme have shown to enhance both the efficiency and effectiveness of managing your condition. Members on the Active Smart, Keycare Start and Keycare Start Regional plans will be required to enroll on the Mental Health Care Programme to be eligible for full cover for the out-of-hospital management of depression. Members who are not enrolled on the Mental Health Care Programme will experience a co-payment on their out-of-hospital psychotherapy sessions. You can find more information on the Mental Health Care Programme here.

What to do if there is no available designated service provider (DSP) at the time of your request

There are some instances when you will still have full cover if you use a healthcare provider who we do not have a designated service provider (DSP) arrangement with. An example of this is in an emergency, cases when the use of a non-designated service provider (non-DSP) is involuntary or when there is no DSP available. If you have nominated your network GP for the management of your chronic condition, you have access to one consultation with a network GP who is not your nominated GP, per calendar year.

In cases where there are no services or beds available at a designated service provider (DSP) when you or one of your dependants need treatment, you can contact us on 0860 99 88 77 and we will make arrangements for an appropriate facility or healthcare provider to accommodate you.

Cover for cancer

Depending on your chosen health plan, once you are registered on the Oncology Programme, the Scheme covers your approved cancer treatment over a 12-month cycle up to the Discovery Health Rate (DHR), in accordance with your plan benefits.

Cancer treatment that is a Prescribed Minimum Benefit (PMB) is covered in full with no co-payment. This is if you use service providers who we have a payment arrangement with. All Prescribed Minimum Benefit (PMB) treatment costs add up to the oncology cover amount for your plan. If your treatment costs more than the cover amount, we will continue to cover your Prescribed Minimum Benefit (PMB) cancer treatment in full.
For more information on your cover for cancer please visit our website www.discovery.co.za under Medical Aid > Find documents and certificates.

Cover for HIV

When your Premier Plus GP enrols you on the HIV Care Programme to manage your condition, you are covered for the care you need, which includes additional cover for social workers. You can be assured of confidentiality at all times.

For more information on your cover for HIV please visit our website www.discovery.co.za under Medical Aid > Find documents and certificates.

Cover for COVID-19

The WHO Global Outbreak Benefit provides cover for global disease outbreaks recognised by the World Health Organization (WHO) such as COVID-19. This benefit offers cover for the out-of-hospital management and appropriate supportive treatment related to the management of acute COVID-19 and long COVID. Please visit our website www.discovery.co.za under Medical Aid > Benefits and cover > COVID-19 Benefits for more information.

Cover for Prescribed Minimum Benefit (PMB) admissions

You must preauthorise all hospital admissions. When you call us to preauthorise your admission, we will tell you how you are covered. You must use designated services 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 designated service provider (DSP) we will pay up to 80% of the Discovery Health Rate (DHR) for the admission.

In instances where a co-payment or deductible is applicable to the admission, additional information such as a scan or scope report will be required. If the Prescribed Minimum Benefit (PMB) condition is confirmed no co-payments or deductibles will be applicable.

For more information on your in-hospital Prescribed Minimum Benefit (PMB) cover please visit our website www.discovery.co.za under Medical Aid > Find documents and certificates.

Working to care for and protect you

Our goal is to provide support for you in the times when you need it most.

How to contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66
Go to www.discovery.co.za to Get Help or ask a question on WhatsApp. Save this number 0860 756 756 on your phone and say "Hi" to start chatting with us 24/7.
PO Box 784262, Sandton, 2146. 1 Discovery Place, Sandton, 2196.

What to do if you have a complaint

01 | TO TAKE YOUR QUERY FURTHER:

If you have already contacted the 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 the website.

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. 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.

Your privacy is important to us

We hold your privacy in the highest regard. Our unwavering commitment to protecting your personal information and ensuring the security and confidentiality of your data is clearly outlined in our Privacy Statement. You can view our latest version on www.discovery.co.za > Medical aid > About Discovery Health Medical Scheme.