Discovery
Health Medical Scheme

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

DISCOVERY HEALTH MEDICAL SCHEME
2026

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.

What are Prescribed Minimum Benefits?

PMBs are a set of essential healthcare services that all medical schemes must cover, according to the Medical Schemes Act (No. 131 of 1998). These benefits include diagnosis, treatment and ongoing care for a defined list of conditions – including emergencies, 27 chronic illnesses, and other specified treatments.

Importantly, you have access to these benefits, regardless of your chosen plan type. In some instances, PMBs will not apply. You can read more about this later in the guide.

More than just the minimum

While every plan includes access to PMBs, we've structured our health plans in a way that maximises cover no matter which health plan you choose. Some plans cost more but offer richer 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. You can always refer to your Health Plan Guide at www.discovery.co.za to see the full range of what's included in your plan.

Understanding your out-of-hospital PMB cover

This guide helps you understand how out-of-hospital PMBs work including how to register for cover and how to access the care you need through our network of designated service providers.

For information on your **in-hospital PMB cover,** simply visit our website and navigate to: *Medical Aid > Find documents and certificates*

About some of the terms we use in this document

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

TERMINOLOGY	DESCRIPTION
Above Threshold Benefit (ATB)	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 Comprehensive and Priority plans have a limited Above Threshold Benefit.
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 defined clinical best practices. This ensures that you receive treatment that is expected for your condition and that is clinically appropriate.

TERMINOLOGY	DESCRIPTION
	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 your Personal Health Fund, Medical Savings Account, cover from the limited Above Threshold Benefit or defined benefits for day-to-day healthcare services.
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
Diagnosis and treatment pair (DTP)	This links a specific medical diagnosis to the recommended treatment for that condition. DTPs guide how each of the 271 Prescribed Minimum Benefit (PMB) conditions should be treated, based on best clinical practice and cost-effectiveness.
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 for medicine	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)	Medical Savings Account (MSA) 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

TERMINOLOGY	DESCRIPTION
	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	In this guide, "member" refers to both the main member and any dependants covered under the same plan.
Preferred Supplier	A preferred supplier has agreed to charge a set price for medical items. We cover these costs in full. If you use a non-preferred supplier who charges more, you'll need to pay the difference.
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.

PMB includes cover for:

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1. Emergency medical conditions that are life-threatening
2. A defined list of 271 diagnosis and treatment pairs (DTPs)
3. 27 chronic conditions, such as diabetes, asthma and HIV etc. (also called the Chronic Disease List or CDL)

You can view the full list of conditions covered on the Council for Medical Schemes website: www.medicalschemes.co.za

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

To ensure that your treatment qualifies for full PMB cover with no co-payments, a few important criteria must be met:

- Your condition must be listed as one of the defined Prescribed Minimum Benefit conditions
- The treatment you need must match with the clinical treatment defined for that condition
- You must use our network of designated service providers (DSPs) for full cover (unless no DSP is available for your plan)

If you don't use a DSP when one is available, you may incur a copayment. Emergencies are an exception to this.

What happens if you don't use a designated service provider (DSP)?

To ensure you receive full cover for Prescribed Minimum Benefits (PMBs), it's important to use a designated service provider (DSP). If you choose to receive treatment from a provider outside of our DSP network, we will cover up to 80% of the Discovery Health Rate (DHR) and you will need to pay the difference.

This co-payment does not apply in emergencies. However, once your condition has stabilised, you may be transferred to a DSP hospital or provider in our network according to your plan type, where appropriate and in line with the Scheme Rules, to avoid additional costs. If the condition or treatment doesn't meet the criteria for PMBs, we'll cover it according to your plan's regular benefits.

Travelling outside of South Africa?

If you receive treatment while outside the country, your claims will be paid according to the benefits and rules of your chosen health plan.

For more information, please refer to our Cover for treatment received abroad guide, available at www.discovery.co.za under: *Medical Aid > Find documents and certificates*

How to qualify for Prescribed Minimum Benefit (PMB) cover

To ensure that your treatment is covered under the Prescribed Minimum Benefits (PMBs), two key requirements must be met:

Your condition must be listed as a Prescribed Minimum Benefit

PMBs apply only to specific medical conditions defined in the Medical Schemes Act. These include 271 diagnosis and treatment pairs (DTPs), which guide how each condition should be treated.

To confirm your condition qualifies:

- Your doctor will need to complete a PMB application form
- You'll need to send us the results of relevant medical tests or investigations that support your diagnosis

This information helps us assess your application accurately and ensure you receive the right level of care.

Your treatment must match what is defined in the PMB guidelines

Each PMB condition has an approved set of treatments based on best clinical practice. This includes:

- Specific consultations, procedures, and investigations
- Approved medicines listed on the formulary
- Treatment aligned with national and evidence-based clinical protocols

Only treatments that fall within these defined benefits qualify for PMB cover.

You can explore the full list of recognised PMB conditions and their defined treatments on the Council for Medical Schemes website: www.medicalschemes.co.za

What's included in PMB treatment

Each condition that qualifies for Prescribed Minimum Benefit (PMB) cover is linked to a specific set of standard treatments, procedures, tests and consultations. These are based on the 271 diagnosis and treatment pairs (DTPs) defined by the Medical Schemes Act. These defined benefits are carefully developed using evidence-based clinical guidelines, approved medicine lists (formularies), and treatment protocols – to ensure you receive care that is safe, appropriate and effective.
To explore the full list of PMB conditions and their associated treatments, visit the Council for Medical Schemes website at www.medicalschemes.co.za

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

An example of how Prescribed Minimum Benefit (PMB) cover works

To help you understand how PMB cover is determined, here's an example using one of the listed conditions:

- 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.

This example shows how important it is to ensure your diagnosis and treatment plan align with PMB guidelines. If you're unsure whether your condition qualifies, speak to your doctor or visit www.discovery.co.za for help with your application.

When treatment qualifies for out-of-hospital PMB cover

In the example of life-threatening iron deficiency or nutritional deficiencies, cover under out-of-hospital Prescribed Minimum Benefits (OHPMBs) may apply – but only if the condition meets the criteria defined in the PMB provision.

To qualify:

- You or your treating doctor must apply for cover based on a confirmed diagnosis
- The diagnosis must match the clinical description in the PMB list (in this case, the condition must be life-threatening)
- The treatment must align with the defined PMB benefits, such as medical management (e.g. consultations, medicine, investigations)

If your treatment or condition does not meet these criteria or is not part of the approved treatment listed in the PMB definition, it unfortunately won't qualify for PMB cover. In such cases, treatment may be funded from your available day-to-day benefits, depending on your plan.

Before applying, it's important to speak to your healthcare provider to ensure that all the criteria are met and that the care you're requesting aligns with the PMB guidelines.

We're here to support you in getting the right care, through the right cover when you need it most. For more on how to apply for PMB cover, visit www.discovery.co.za or call us on 0860 99 88 77.

How we pay for PMB and non-PMB claims

At Discovery Health Medical Scheme, we want to help you get the most from your cover. Here's how your treatment is paid for, depending on whether it's classified as a Prescribed Minimum Benefit (PMB**)** or not.

For PMB claims:

- If your condition and treatment qualify for PMB cover, and you use a designated service provider (DSP) or preferred supplier, we will pay for the treatment in full.
- If you choose to see a non-DSP or use a supplier that isn't part of our preferred network, you may need to pay a co-payment, especially if the provider charges more than the rate we cover.

For non-PMB claims:

- If your treatment doesn't fall under PMBs, we will pay from your **available plan benefits**, in line with the rules of your specific health plan.

To avoid out-of-pocket expenses, we recommend using DSPs or preferred suppliers wherever possible. You can find one by using the, *Find a healthcare provider* feature on the Discovery Health app or at www.discovery.co.za.

Coordinating your chronic care by nominating a GP

Care works best when it's consistent and coordinated. That's why, on all plans (except the Executive Plan), you and your dependants need to nominate a primary care GP for the treatment of any registered chronic conditions.

- If you visit your nominated network GP, we'll cover the consultation in full.
- If you see a GP who isn't your nominated provider – or isn't in the network – a co-payment will apply.

You can nominate or update your GP nomination easily online.

External medical items

We also have preferred suppliers for items like CPAP machines or rental oxygen. Using a non-preferred supplier may lead to a co-payment. You can view full details in our *External Medical Items Benefit Guide* at www.discovery.co.za → Medical Aid → Find documents and certificates

When PMB cover may not apply

While Prescribed Minimum Benefits (PMBs) are included in every Discovery Health Medical Scheme plan, there are certain situations where this cover might be declined.

You may not have access to PMB cover if:

- You're joining a medical scheme for the first time, with no prior membership
- You've had a break in cover of more than 90 days after leaving a previous medical scheme

In these cases, a waiting period may apply during which time you and your dependants will not have access to PMB benefits, even if you have a qualifying condition.

We'll always let you know upfront if a waiting period applies when you apply for membership, so you can plan with confidence.

When we may only pay a claim as a PMB

In certain cases, your cover for a condition may be limited, and we'll only be able to pay your claim under Prescribed Minimum Benefits (PMBs).

This can happen if:

- You are in a general waiting period (typically three months), or
- You have a condition-specific waiting period (usually 12 months), where the condition is temporarily excluded by your plan

Even during these waiting periods, you may still qualify for cover under PMBs, depending on the nature of your condition and the type of waiting period applied.

If your condition qualifies for PMB cover, and you meet the criteria, we'll ensure your receive the care you need, in line with PMBs.

Registering for cover under Prescribed Minimum Benefits (PMBs) and Chronic Disease List (CDL) conditions

To receive full cover for your Prescribed Minimum Benefits (PMBs) or Chronic Disease List (CDL) conditions, you and your dependants need to register the relevant condition with us.

PMBs cover a range of care types – including:

- In-hospital treatment
- Out-of-hospital care
- Chronic conditions listed under the CDL
- Treatment for conditions such as HIV and oncology

How to register

Grant your provider consent on the app or through and OTP while in consultation and they can submit your application through Health ID and receive a real time response. Alternatively,

To apply for cover, you'll need to complete the relevant application form:

- For out-of-hospital PMB conditions: complete the Prescribed Minimum Benefit (PMB) application form
- For CDL conditions: complete the Chronic Illness Benefit (CIB) application form

Accessing the forms:

- Download them at www.discovery.co.za under:
  Medical Aid > Find documents and certificates
- Call us on 0860 99 88 77 and we'll send the forms to you

If your chosen provider is enabled on HealthID, they can submit an application online, provided that you have given them consent to do so.

Need help understanding your cover?

If you'd like to check your in-hospital PMB cover, simply call us on 0860 99 88 77 and request authorisation. We'll confirm what you're covered for and guide you through the next steps.

For more detail about PMBs, CDL conditions, HIV or oncology care, you can also view the relevant benefit guides online in the same section:
Medical Aid > Find documents and certificates

Why it's important to register your PMB or chronic condition

Registering your condition ensures that we can pay for the approved treatment, consultations and medicine from your Prescribed Minimum Benefits (PMBs) and not from your day-to-day benefits.

If your treatment falls outside of the approved PMB benefits and you haven't registered your condition, we'll pay the claims from your available day-to-day benefits, depending on your plan. If you don't have benefits available, you'll need to pay the costs yourself.

Who must complete the registration form?

- The person who has the PMB or chronic condition must complete the application form, together with their treating doctor
- If the person is a minor, the main member must complete and sign the form on their behalf

You only need to register once per condition – but each new condition must be registered separately before we can cover it. An annual application is required for PMB cover for mental health conditions.

If your treatment or medication changes later on, your doctor can send us the updated information to ensure your cover stays aligned.

What documents you need to include with your application

To help us confirm that your condition qualifies for Prescribed Minimum Benefit (PMB) cover, please include the following:

- Medical test results or investigation reports that confirm your diagnosis
- The completed application form, signed by you (or the main member if applying on behalf of a child) and your treating doctor

Tip: Keep a copy of your completed form and supporting documents for your personal records.

Where to send your completed forms

Once your application is ready, you can send it to us using the method that's most convenient for you:

For PMB applications:

- Email: PMB_APP_FORMS@discovery.co.za

For Chronic Illness Benefit (CIB) applications:

- Email: CIB_APP_FORMS@discovery.co.za

What happens after you submit your application

Once we've reviewed your application for Prescribed Minimum Benefit (PMB) or chronic condition cover, we'll let you know the outcome using your preferred method of communication.

If your application is approved, you'll receive a confirmation letter that outlines:

- Your confirmed PMB or chronic condition cover
- What this cover includes
- Any next steps you need to take

From that point forward, we will automatically cover all approved treatment costs related to your condition – including relevant blood tests, investigations, consultations and medicine – from your PMB benefits, not from your day-to-day benefits.

Important to remember

PMBs only cover specific treatments and investigations defined for each condition. These are based on:

- National treatment guidelines
- Evidence-based clinical protocols
- Approved medicine lists (formularies)

This means that the care you receive must match the defined PMB treatment for your condition to qualify for full cover. The details of your approval will be outlined in your confirmation letter.

What to do if you need treatment outside of the defined PMB benefits how to apply for additional treatment cover:

There may be times when your doctor recommends a treatment that isn't included in the defined Prescribed Minimum Benefits (PMB) list or basket of care. In these cases, you can still apply for cover and we'll review your request in detail as a PMB appeal.

how to apply for additional treatment cover:

1. Download the correct application form
    a. Request for additional cover for out-of-hospital PMB conditions
    b. Or, for chronic conditions on the Chronic Disease List (CDL), use the PMB CDL application form
    c. You can find both forms at www.discovery.co.za under *Medical Aid* > *Find documents and certificates*, or call 0860 99 88 77 to request a form
2. Complete the form with your doctor's help, including detailed medical reasons and supporting documents
3. Email the completed form and documents to:
    a. PMB_APP_FORMS@discovery.co.za (for OH DTPMB-related applications)
    b. CIB_APP_FORMS@discovery.co.za (for CDL-related applications)

What happens next

- If we approve the request, we'll automatically cover the treatment from your OHPMB or Chronic Illness Benefit (CIB), whichever applies.
- If the treatment does not qualify for additional cover, we'll let you know. In this case, costs may be paid from your available day-to-day benefits, depending on your chosen plan.

- If your plan doesn't cover these expenses, you'll be responsible for paying the cost of the treatment.

If your application is declined and you're not satisfied with the outcome, you can follow the Scheme's formal dispute process at www.discovery.co.za.

In case of an emergency

You don't need preauthorisation, go directly to the nearest hospital.
You'll be fully covered for the first 24 hours, or until you're stabilised and can be safely transferred to a network facility if needed.
To avoid unexpected costs, always check if your provider is part of our network.

Get the most out of your benefits – and avoid out-of-pocket costs

If you're planning a hospital admission for a condition that qualifies as a Prescribed Minimum Benefit (PMB), you can receive full cover with no co-payments when you use the right healthcare providers.

Here's how to ensure you're fully covered:

Your hospital, doctor and anaesthetist accounts will be paid in full when:

- You're being admitted for a PMB-related procedure
- You choose a hospital or day facility that's part of your plan's PMB network
- Your primary treating doctor is part of the same PMB network

When these three conditions are met, even anaesthetic services related to your procedure will be covered in full with no co-payments required.

Your benefits are designed to protect you — and with the right provider choices, you can access your care with total peace of mind.

To check whether your doctor or hospital is part of the PMB network for your plan:

- Visit www.discovery.co.za
- Use the *Find a healthcare provider* tool on the Discovery Health app
- Or call 0860 99 88 77 for assistance

Nominate a GP to manage your chronic condition and get full cover for your care

When it comes to managing a chronic condition, consistent and coordinated care makes all the difference. That's why, on all Discovery Health Medical Scheme plans (except the Executive Plan), you and your dependants need to nominate a primary care GP to manage your registered chronic conditions.

Why this matters for your cover:

- When you see your nominated GP, who is also part of our network, your consultations for chronic condition management are covered in full.
- If you see a GP who is not your nominated provider, or your nominated GP is not part of our network, a co-payment will apply.

You can nominate or update your GP up to three times per calendar year, giving you flexibility as your needs change.

How to nominate your GP

It's quick and easy:

- Visit www.discovery.co.za
- Use the *Discovery Health app*
- Or call us on 0860 99 88 77 for help

What to do if a DSP isn't available when you need care

We know that accessing the right care at the right time is critical especially when it comes to Prescribed Minimum Benefit (PMB) conditions. While using a designated service provider (DSP) ensures full cover, there are important exceptions where you'll still be fully covered even if a DSP is not available.

You will still be covered in full if:

- You're receiving treatment in an emergency
- You're treated by a non-DSP due to no available DSP at the time
- Your use of a non-DSP was involuntary

For chronic conditions:

If you've already nominated a network GP to manage your chronic condition, you'll also have access to one consultation per calendar year with another network GP who isn't your nominated provider giving you flexibility when it matters.

If a DSP is unavailable:

If there are no services or beds available at a DSP when you or a dependant needs treatment, please call us on 0860 99 88 77. We'll make arrangements to connect you with an appropriate facility or healthcare provider.

Your cancer treatment is fully supported

Being diagnosed with cancer is deeply personal and life changing. At Discovery Health Medical Scheme, we're here to support you with cover that ensures access to the treatment you need when you need it most.

Once you're registered on the Oncology Programme, we cover your approved cancer treatment over a 12-month treatment cycle, up to the Discovery Health Rate (DHR) and according to the benefits of your selected plan.

How we cover cancer treatment:

- If your cancer treatment qualifies as a Prescribed Minimum Benefit (PMB), it will be covered in full with no co-payments when you use a provider, we have a payment arrangement with.
- The costs of all PMB cancer treatments will count towards your plan's annual oncology benefit limit.
- If your total treatment costs exceed your benefit limit, we will still cover all PMB-related treatment in full.

To make the most of your benefits, we encourage you to use providers in our network.

For more detailed information about your cancer cover and how to register for the Oncology Programme, visit:
www.discovery.co.za → Medical Aid → Find documents and certificates

Confidential, compassionate care for HIV

If you're living with HIV, you don't have to navigate your care alone. Discovery Health Medical Scheme provides structured, confidential support through the HIV Care Programme, so you can access the treatment and care you need to live a healthier life.

When your Premier Plus GP enrols you on the programme, you'll receive comprehensive cover that includes:

- Ongoing medical treatment and monitoring
- Access to prescribed medicines
- Additional support from social workers, where needed

Your privacy is our priority. Everything shared as part of your enrolment and care is handled with the utmost confidentiality.

To learn more about the HIV Care Programme and how to access cover, visit:
www.discovery.co.za → Medical Aid → Find documents and certificates

Your cover for COVID-19 care

Your health and safety remain our top priority especially during times of global health challenges. That's why we've created the WHO Global Outbreak Benefit to ensure you're covered for COVID-19 and other global outbreaks recognised by the World Health Organization (WHO).

This benefit includes cover for:

- Out-of-hospital management of acute COVID-19
- Supportive treatment for both acute illness and long COVID symptoms

Whether you're recovering at home or managing long-term effects, this benefit ensures you can access the care you need, with confidence and peace of mind.

For full details on your COVID-19 cover, please visit:
www.discovery.co.za → Medical Aid → Benefits and cover → COVID-19 Benefits

Cover for hospital admissions linked to PMB conditions

If you're being admitted to hospital for a condition that qualifies as a Prescribed Minimum Benefit (PMB), we'll make sure you have access to the care you need with clarity on how your treatment will be covered.

What you need to know before you're admitted:

- Preauthorisation is required for all hospital admissions.
Simply call us before your admission, and we'll confirm how your treatment will be covered.
- You must use one of our designated service providers (DSPs) for full cover.
(In emergencies, this requirement does not apply.)

If you don't use a DSP:

- We will cover up to 80% of the Discovery Health Rate (DHR) for your hospital stay.
You'll need to pay the difference.

Co-payments and confirmed PMB diagnoses

In some cases, we may require additional clinical information (such as a scan or scope report) to confirm that your condition qualifies as a PMB.

- If the condition is confirmed as a PMB, you will not need to pay any co-payments or deductibles for the hospital admission.

For more information about your in-hospital PMB cover, visit:
www.discovery.co.za → Medical Aid → Find documents and certificates

How to contact us

	Members can call us on 0860 99 88 77 Health partners can call us on 0860 44 55 66
	Go to www.discovery.co.za to get help from our chatbot, Ask Discovery.
	You can ask us a question by just saving the number 0860 75 67 56 on your phone and typing 'Hi' to start chatting with us 24/7.
	You can send us a letter to PO Box 784262, Sandton, 2146
	You can visit our offices at 1 Discovery Place, Sandton, 2196

We welcome any feedback about our service

We would love to hear if there's anything we can improve on or if we have exceeded your expectations. Your feedback helps us serve you better. To give us feedback, you can complete our short *Complaints and compliments form* on the right side of the Complaints, compliments or disputes page under **Contact us**.

What to do if you have a complaint

1. To take your query further

If you have already contacted Discovery Health Medical Scheme and feel that your query has not been resolved, you can take the next step. Please complete our short online *Complaints and compliments form.* It's on the right side of the Complaints, compliments and disputes page under section 1, Contact us**.**

2. To contact the principal officer

If you are still not satisfied with the outcome after following the process in Step 1, you can escalate your complaint to the principal officer of Discovery Health Medical Scheme by choosing one of these options:

- Complete our short online *Contact the principal officer form*. You'll find it on the right side of the Complaints, compliments and disputes page under section 2, Contact us.
- Send an email to principalofficer@discovery.co.za.

3. To lodge a dispute

If you have received a final decision from the principal officer of Discovery Health Medical Scheme and want to challenge it, you can lodge a formal dispute. You can find more information online about the Scheme's dispute process.

4. To contact the Council for Medical Schemes

Discovery Health Medical Scheme is regulated by the Council for Medical Schemes. You can contact the Council directly at any stage of the complaints process, but we encourage you to follow the steps above before doing so.

The contact details are:

	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 12 32 67
	www.medicalschemes.co.za

Your privacy matters to us

We take your privacy seriously. We're committed to protecting your personal information and keeping it safe and confidential. You can read our full privacy statement anytime at www.discovery.co.za > **MEDICAL AID** > **About Discovery Health Medical Scheme**.