

FREQUENTLY ASKED QUESTIONS

DISCOVERY HEALTH

HEALTH LAUNCH 2027 | PRODUCT UPDATES

Enhancements on Flexicare for 2027 are subject to Council for Medical Schemes (CMS) approval



Gap Cover

Discovery Gap 500 Plus Pro

Technical questions related to the introduction of the new Discovery Gap 500 Plus Pro Product

1. What is Discovery Gap 500 Plus Pro?

Gap 500 Plus Pro is Discovery's most comprehensive gap cover offering. It provides cover for the following medical aid shortfalls:

- Shortfalls incurred when providers claim above medical scheme rates.
- Hospital co-payments and deductibles for specified procedures and hospital admissions, subject to the overall annual benefit limit.
- Out-of-network hospital deductibles.
- Casualty shortfalls for emergency casualty treatment for accidents, trauma and qualifying after-hours illness events.
- Oncology shortfalls in-and-out of hospital on specialist claims, and co-payments on approved cancer-related claims once you reach your medical scheme plan's oncology benefit threshold or limit.
- Shortfalls when travelling to ensure any shortfalls on emergencies and unforeseen medical expenses incurred while travelling will be covered.

Gap 500 Plus Pro also offers market-first Protector Benefits: the Oncology Protector which pays a tiered lump-sum per cancer diagnosis, and the Day-to-day Protector which is designed to cover small but frequent shortfalls on day-to-day benefits.

2. What makes Discovery Gap 500 Plus Pro different from traditional gap cover products?

In addition to traditional gap cover benefits, Gap 500 Plus Pro introduces the Protector Benefits, which combines an Oncology Protector and a Day-to-day Protector. The Oncology Protector provides a lump sum of up to R250,000 to help fund treatment shortfalls, non-medical expenses and lifestyle adjustments that may arise when a policyholder is diagnosed with cancer. This cover is in addition to medical-related oncology shortfalls that are covered by traditional gap cover, and included in Discovery Gap 500 Plus Pro. The Day-to-day Protector provides cover for qualifying day-to-day healthcare shortfalls, with benefits of up to R2,000 per policy per year. Traditional gap cover has focused on shortfalls related to in-hospital costs, making these Protector Benefits the first of its kind to be offered on a gap cover product. These benefits can be unlocked through policyholder engagement in health and wellness activities.

3. Who can join Discovery Gap 500 Plus Pro?

Corporate groups: The product is available to all employees of participating employer groups, including members of Discovery Health Medical Scheme (DHMS) as well as members of other medical schemes.

Individuals: For members joining in their individual capacity (and not as part of an employer group), only DHMS members may join Gap 500 Plus Pro (excluding members on KeyCare plans).

More about the Traditional Gap Cover benefits provided by Discovery Gap 500 Plus Pro

4. What level of specialist shortfall cover does the product provide?

The product covers in-hospital and day clinic tariff shortfalls up to 500% of medical scheme rate, over and above what the medical scheme pays. In addition to the traditional specialist shortfall cover, Gap 500 Plus Pro provides cover for additional shortfalls that may arise due to a hospital admission. Cover is provided for qualifying specialists, selected dental specialists including dentists, GP anesthetists, GP oncologists and GPs performing approved in-hospital specialist procedures, as well as qualifying pathology and radiology services.

5. Does the product cover out-of-network hospital deductibles?

Yes. Cover is provided for out-of-network hospital and day clinic deductibles up to R17,000 per event, limited to two events per policy per year.



6. Does the product cover sub-limits?

Yes. This product covers selected shortfalls when a policyholder exceeds their medical scheme benefit limit during a hospital admission. Each sub-limit is covered up to a defined benefit limit as outlined in the following table:

Procedure	Sub-limit
Scopes	R7,800 per person per event
Scans	R6,500 per person per event
Prosthesis	R40,000 per person per event
Rehabilitation in a step-down facility	R10,000 per person per annum
Private room	R3,500 per policy per annum

7. Does the product cover hospital admission deductibles and co-payments?

Yes. The benefit provides cover for qualifying medical scheme deductibles and co-payments for specified procedures and hospital admissions, subject to the overall annual limit (OAL). In particular, the benefit covers the deductibles on elective admissions for members on Active Smart and Active Core plans, as well as the deductibles on procedures for members on Priority plans. Robotic surgery co-payments are covered up to R10,000 per policy per year.

8. Does the product cover casualty shortfalls?

Yes. The benefit covers emergency casualty treatment for accidents, trauma and qualifying after-hours illness event, up to R18,000 per policy per year. This cover accumulates to the OAL.

Accident and trauma:	Up to R18,000 per policy per year
After-hours illness (policyholders <13 years old):	Up to R8,000 per policy per year
After-hours illness (policyholders >12 years old):	Up to R3,000 per policy per year, limited to one event per policy per year

9. What is the Oncology Benefit Extender?

The Oncology Benefit Extender covers oncology-related shortfalls, including specialist shortfalls and oncology treatment co-payments, once the medical scheme's oncology benefit limit has been reached.

10. How do you access the Oncology Benefit Extender?

To use this benefit, you must be registered for oncology as well as have an active oncology authorisation with your medical scheme. You must have reached your scheme's oncology threshold or limit.

11. Do waiting periods apply?

The product includes:

- 3-month general waiting period
 - No claims payable during the first three months of cover.
- 12-month condition-specific waiting period
 - Pregnancy and childbirth
 - Joint replacements
 - Cataracts
 - Scopes
 - Hysterectomies
 - Hernias
 - Reflux surgery
 - Certain dental and ENT procedures
- 12-month pre-existing condition waiting period
 - Treatment for pre-existing conditions is excluded during the first year.

12. What is the Overall Annual Limit?

Discovery Gap 500 Plus Pro has a regulatory Overall Annual Limit of R226,881 per insured life per year. Once an individual reaches this limit, no further benefits are payable for that individual during the remainder of the calendar year. The Oncology Protector sits outside this limit as it is a separate benefit underwritten by Discovery Life.



13. How are claims paid for DHMS members?

Discovery Health automatically identifies eligible shortfalls and processes claims as part of the Discovery Health Medical Scheme claims process, reducing administrative burden on members.

14. Will DHMS members need to submit claims manually?

In most cases, no. Eligible claims are automatically identified and adjudicated.

15. How are claims paid for non-DHMS members?

Non-DHMS members follow a guided digital and/or email claims submission process supported by dedicated servicing teams. The exact process will be confirmed in a policy activation document that will be shared with the member once the policy has been purchased.

More about the Protector Benefits provided by Gap 500 Plus Pro

16. What is the Day-to-day Protector Benefit?

The Day-to-Day Protector provides additional funding for everyday healthcare shortfalls that traditional gap products do not usually cover.

The benefit can help pay for:

- Medical Savings Account shortfalls
- Personal Health Fund shortfalls
- Above Threshold Benefit shortfalls
- Maternity benefit shortfalls
- Sports injury benefit shortfalls
- Smart plan co-payments
- Medicine shortfalls
- Day-to-day benefits that have run out

The benefit specifically covers shortfalls. Thus, if any day-to-day healthcare services are excluded on DHMS then these exclusions would also apply to the gap cover product.

17. How do policyholders unlock the Day-to-day Protector?

Each adult must complete the following:

1. Complete a Health Check annually
2. Activate Personal Health Pathways and link a device
3. Complete a health action annually
4. Complete an exercise goal annually

If you are already a Discovery Health Medical Scheme member when you take out Discovery Gap 500 Plus Pro, we will look retrospectively to 2025 and 2026 to determine which actions you have completed and unlock your benefit accordingly. For example, if the time point is currently March 2027, we will look back from March 2027 to January 2026 to see the actions completed during that time period. If you have not completed all actions before, you must first complete the actions before your benefit is unlocked.

18. What is the level of cover from the Day-to-day Protector?

Policyholders can access up to R2,000 per policy per year, with balances accumulating to a maximum of R8,000 per policy at any point in time. Completing all necessary actions unlocks R1,000 per adult, up to a maximum of R2,000 per policy per year. Given that children (aged 0 – 17) cannot complete the required actions, they will not be able to unlock additional funds. Funds are, however, available for all members (incl. children) on the policy to use for day-to-day shortfalls.

19. If the Day-to-day Protector is not used in full over the course of a year, does it fall away in the following year?

No, unused balances roll over each year and accumulate up to a maximum of R8,000 per policy.



20. Who qualifies for the Day-to-day Protector?

Only DHMS members are eligible for the Day-to-day Protector benefit.

21. What is the Oncology Protector benefit?

The Oncology Protector is a lump-sum cash benefit that pays on a qualifying cancer diagnosis. Discovery Health has partnered with Discovery Life to provide this additional benefit which works differently from the other benefits under Discovery Gap 500 Plus Pro since it is a cash payment directly to the member, not a payment towards a claim. Depending on your underlying medical scheme, you can unlock up to R250,000 per diagnosis which can be used for any costs that may arise during one's cancer journey. The Oncology Benefit provides a tiered lump-sum payout of between 25% and 100% of the benefit amount based on the severity of the diagnosis.

22. How do policyholders unlock the Oncology Protector?

Once a policyholder does a Health Check, they are eligible to receive up to R50,000 in cash on an eligible diagnosis. This benefit will not expire in the future if the member does not do a Health Check again within the required period.

To unlock up to an additional R200,000, policyholders will need to complete all of the following actions:

- Complete a Health Check annually
- Activate Personal Health Pathways and link a device
- Complete a health action annually
- Complete an exercise goal annually

Since the unlock mechanism for the additional R200,000 benefit involves Personal Health Pathways, this benefit is only applicable to DHMS members. If a member does not complete all of these actions within the required period, the additional benefit of up to R200,000 will expire. Once the member completes these required actions again, they will once again be eligible to receive the benefit.

23. Are pre-existing cancer diagnoses covered?

No. Pre-existing cancer diagnoses are excluded from the Oncology Protector.

24. Why are health engagement activities required?

The Protector Benefits are designed to encourage proactive health management and reward policyholders who engage with their health.

25. Do existing DHMS members receive immediate access to benefits?

Existing DHMS members may receive immediate access where qualifying activities have already been completed in the current or previous year.

26. Must these activities be completed every year to maintain access to the Protector Benefits?

Excluding the R50,000 Oncology Protector that can be unlocked in perpetuity from completing a single Health Check, policyholders need to continue completing the required engagement activities to maintain access to their Protector Benefits.

27. What Protector Benefits are available to non-DHMS members?

Non-DHMS members can access up to R50,000 in the Oncology Protector once a single Health Check has been completed. DHMS members, however, can unlock up to R250,000 through this benefit. Additionally, non-DHMS members do not have access to the Day-to-day Protector. This is only accessible to DHMS members.

28. How do non-DHMS members notify Discovery Health that they have completed a Health Check to get access to their benefit?

Non-DHMS members will notify Discovery Health of their completed Health Check by following a similar process to claims submissions. Policyholders will be guided through the process by dedicated servicing teams.



Personal Health Pathways 2027

Technical questions related to Personal Health Pathways (PHP) and the introduction of PHP Insights

29. What are Personal Health Pathways (PHP) Insights?

PHP Insights provide a personalised view of the member's health and wellbeing available through Personal Health Pathways in the Discovery Health app. It brings together a member's available health, wellbeing, exercise and sleep information to help them better understand their overall health. PHP Insights can reveal patterns shaping a member's health and identify opportunities to improve their wellbeing. These insights use available health and lifestyle information powered by Vitality AI to provide personalised insights, explain health trends, and recommend actions that are relevant for each member.

PHP Insights include:

- A summary of the member's overall health and wellbeing
- Health trends and key insights
- Exercise and activity patterns
- Sleep insights
- Personalised recommendations and Next Best Actions.

30. Why has Discovery introduced PHP Insights?

PHP Insights have been introduced as part of Personal Health Pathways to help members better understand their health information and take meaningful action to improve their health and wellbeing. Personal health information can often be spread across different sources and may be difficult to interpret. PHP Insights bring together available health, lifestyle and behavioural information into a single personalised view that is easier to understand and act on.

As part of the PHP experience, the PHP Insights help members:

- Understand their overall health picture and trends
- Better understand why health, exercise and sleep actions and recommendations are relevant to them
- Feel more informed and prepared when discussing their health with a healthcare professional

PHP Insights are designed to support health awareness and engagement by providing personalised insights, recommendations and explanations. It does not diagnose medical conditions, replace professional medical advice or substitute a healthcare professional's independent clinical assessment.

31. Are PHP Insights replacing the member's doctor or healthcare professional's medical recommendations?

No, PHP Insights are intended to support the member's understanding of their health. PHP Insights do not provide a diagnosis of conditions, prescriptions or treatment recommendations, or replace professional medical advice. If a member has concerns about their health or medical condition, they should always consult a healthcare professional.

32. Where can a member find their PHP Insights?

If the member is eligible and has any PHP Insight available, he/she can access it in the Discovery Health app through:

- The Discovery Health app home page, where the PHP Insights will be presented as a personalised card for easy access.
- The Personal Health Pathways landing page, where the member can view and access their insights as part of the broader PHP experience.

PHP Insights form part of the Personal Health Pathways journey and can be accessed through the Discovery Health app whenever an insight is available.

33. When will I see my PHP Insights in the Discovery Health App?

From December 2026, after completing a qualifying Health Check, the member will get access to their PHP Insights. The PHP Insights will be available 3 business days after completing a health check. Once the PHP Insights are available in the Discovery Health app members will receive communication.



34. Can PHP Insights be emailed to members?

No, PHP Insights cannot be communicated via email. To help protect personal health information, the PHP Insights can only be viewed through the Discovery Health App. If the member is eligible and has any PHP Insights available, they can access it directly from the Discovery Health App home page or through a Personal Health Pathways landing page.

35. Who receives PHP Insights?

PHP Insights are available to DHMS members who are 18 years or older, are eligible for Personal Health Pathways and have activated PHP, and who have completed a qualifying health check within the last 12 months.

36. I can't see my PHP Insights in the App, why would this be the case?

If one cannot see their PHP Insights, it may be because:

- They have not activated Personal Health Pathways
- They have not completed a qualifying health check within the last 12 months

Please note: If a member has already activated Personal Health Pathways and completed a qualifying Health Check but cannot yet see their PHP Insights in the Discovery Health App, there is no need to worry. PHP Insights will become available from December 2026 as Discovery rolls out the feature to all members who meet the qualifying criteria.

37. How often are the PHP Insights updated?

PHP Insights are available after completing a Health Check and are not updated or shared daily. New insights may be generated when:

- A member completes a new qualifying Health Check.
- Significant new health information has become available.

If no new information is available, the member may continue seeing the same report until a new version is generated.

38. How does a member know when a new PHP Insight is available?

When new insights become available, the member will receive:

- Communication from Discovery Health that will direct them to the Discovery Health App to view their insights
- Visible PHP Insights entry points within the Discovery Health App

These notifications are intended to help members discover newly available PHP Insights.

39. Why do my PHP Insights differ from someone else's?

PHP Insights are personalised to each member and are generated using the health, lifestyle and behavioural information available to Discovery about their individual health journey. As a result, no two PHP Insights are expected to be the same.

The information, insights, trends, recommendations and Next Best Actions included in an individual's PHP Insights report are based on factors such as health information, health risks, lifestyle data, completed health activities and other relevant information available at the time their report is generated.

40. Can a member's doctor view their PHP Insights?

Member's doctors do not have direct access to their PHP Insights yet on the Discovery Health platform. The insights belong to the member, and it is their choice whether they would like to share it with their doctor or another healthcare professional. If a member chooses to share their PHP Insights with a healthcare professional, it can help support discussions about the member's health by providing a consolidated view of relevant health information, trends, insights and recommended actions. However, PHP Insights are intended to be a support tool only. PHP Insights do not diagnose medical conditions, prescribe treatment, or replace a healthcare professional's expertise and clinical judgement. Healthcare professionals remain responsible for reviewing the individual circumstances of the member, conducting any necessary assessments, and making their own independent clinical decisions regarding diagnosis, treatment and ongoing care.



41. What if the information on the PHP Insights is incomplete or incorrect?

The PHP Insights are generated using the health, lifestyle and behavioural information available to Discovery Health at the time the insights are created. While Discovery Health works to ensure that this information is accurate and up to date, there may be instances where information is missing, incomplete or incorrect.

If a member believes any information in the PHP Insights report is inaccurate, they should contact Discovery Health regarding this. This type of feedback helps improve the quality and accuracy of the information used to generate future insights.

Once the PHP Insights are live a member can:

- Submit feedback through the PHP Insights feedback journey on the Discovery Health app.
- Contact Discovery through the appropriate servicing channels to report any concerns or inaccuracies.

42. Will the member get a new PHP Insight if they share updated information or feedback?

Providing feedback on the PHP Insights helps Discovery Health improve the quality and accuracy of the information used to generate the insights. If a member tells us that information is missing, incomplete, or incorrect, Discovery will review the feedback and update the relevant information where appropriate. A new PHP Insight is not automatically generated every time feedback is submitted. Updated information may be considered for an update on the next insight generated. New insights may also become available following a subsequent qualifying Health Check or when there has been a significant update to the information used to generate the PHP Insights.

43. Why does the member's PHP Insights mention medication and a health condition that they no longer have?

The PHP Insights are based on the information available when the insights were generated and may include historical health information that remains relevant to a member's overall health profile. Health information can change over time, and recent updates may not yet be reflected on one's PHP Insights report. If there are any changes to a member's health and medication, they should provide Discovery Health with feedback to ensure that we update the relevant information.

44. Why might a member's exercise activities not be reflected in their PHP Insights?

A member's PHP Insights only include exercise information that was available when their insights were generated. Some activities may not appear if:

- They were completed after the insight was generated.
- The fitness device or app had not synced recently.
- The activity data was not available at the time that the insights were generated.
- The activity was recorded through a device or application that is not linked to their profile.

Any newly synced physical activity data will be reflected in future insights.

45. Why might a member's sleep data not be reflected in their PHP Insights?

Sleep information will only appear if eligible sleep-tracking data is available when the PHP Insights are generated.

Sleep data may not be included if:

- No supported sleep-tracking device is linked to the member's profile.
- The member's device has not synced.
- There was not enough sleep data available during the reporting period.
- Sleep tracking was not active at the time.

Any newly synced sleep data will be included in future insights.

46. Is the member's personal health information secure?

Protecting a member's personal health information is a priority to Discovery Health. Health information is managed according to Discovery Health's applicable privacy, security, and healthcare governance requirements.



Flexicare Plus - FlexiFund 2027

Frequently asked Questions regarding the FlexiFund Enhancements for 2027

47. What are the changes made to the FlexiFund in 2027?

The FlexiFund continues to provide additional funding for eligible day-to-day healthcare expenses. In 2027, Flexicare Plus members can unlock additional FlexiFund benefits for mental health and maternity care, providing significantly more value in specific circumstances where members may have additional healthcare needs.

48. Who qualifies for the FlexiFund?

All adult members on Flexicare Plus and Flexicare Core can unlock the base FlexiFund by completing a health check. The enhanced FlexiFund benefits for mental health and maternity are available only to eligible Flexicare Plus members who meet the qualifying criteria.

49. What is the base FlexiFund?

The base FlexiFund is an annual benefit available to Flexicare members that can be used towards a range of day-to-day healthcare expenses. The amount available depends on the results of an adult member's first health check completed during the year.

50. What can the base FlexiFund be used for?

Members can use the base FlexiFund for a range of day-day benefits, including:

- GP consultations
- Specialist consultations
- Prescribed medication
- Over-the-counter medication
- Vaccines
- Contraceptives

51. Which Health Check measures are used to determine the base FlexiFund amount?

The following five health measures are assessed:

- Weight assessment (BMI)
- Blood pressure
- Blood glucose
- Cholesterol
- Non-smoker declaration

52. How much can members earn in the base FlexiFund?

Number of Health Check Metrics in Range	Flexicare Core	Flexicare Plus
5	R500	R1,000
3 to 4	R250	R500
0 to 2	R125	R250



53. What is the Enhanced FlexiFund for Mental Health?

The Enhanced FlexiFund for Mental Health provides eligible Flexicare Plus members with an additional R1,500 to support the treatment and management of depression. This brings the total available FlexiFund to up to R2,500. Members also gain access to SilverCloud Internet-based Cognitive Behavioural Therapy (iCBT) at no additional cost.

54. How do members qualify for the Enhanced FlexiFund for Mental Health?

To qualify:

- Members must complete a health check (funded as part of their Flexicare benefits). Members will qualify for the enhanced FlexiFund if they completed a health check within the 12 months prior to their depression diagnosis. Members who have not completed a health check by the diagnosis date can still qualify by completing one within 3 months of the diagnosis date. Additionally, members will be required to complete a mental wellbeing questionnaire (PHQ-9) which can be done through the Connected Care website. A score of 10 or higher on the PHQ-9 assessment will be required to unlock the boost.
- Members can then visit a Flexicare Network GP or psychologist for assessment if they are experiencing symptoms of depression. A claim with the required diagnosis codes is needed as part of the benefit activation.
- If the member meets the PHQ-9 criteria and the assessment supports a diagnosis of depression, the GP will register the member for depression and the Enhanced FlexiFund for Mental Health will be activated automatically. Members will be notified about their access to their Enhanced FlexiFund.

The results of the Health Check do not affect eligibility or the size of the enhanced mental health benefit.

55. What does the Enhanced FlexiFund for Mental Health cover?

The benefit may be used for:

- Up to R110 per month (every 23 days) over a 12-month period for formulary medication
- Approved antidepressant medication (SSRI formulary)
- Access to SilverCloud iCBT for 12 months at no additional charge for the member

The SilverCloud programme (valued up to R2,000) is funded separately and does not reduce the member's FlexiFund balance. The SilverCloud programme offers techniques and practical tools to help members better understand and manage symptoms of depression. Members will be invited to engage with the SilverCloud platform through SMS, email or WhatsApp.

56. What is the Enhanced FlexiFund for Maternity Care?

The Enhanced FlexiFund for Maternity Care provides eligible Flexicare Plus members with an additional R4,000 to support healthcare expenses during pregnancy. This brings the total available FlexiFund to up to R5,000.

57. How do members unlock the Enhanced FlexiFund for Maternity?

- Female adult members can unlock the Enhanced FlexiFund for Maternity by having completed a health check. Members will qualify for the Enhanced FlexiFund if they completed a health check within the 12 months prior to their pregnancy being registered. Members who have not completed a health check by the pregnancy registration date can still qualify for the benefit by completing one within 3 months of the registration date.
- Members can then visit a Flexicare Network GP or gynaecologist, who will confirm the pregnancy.
- Members will need to upload the pregnancy diagnosis confirmation through the Connected Care website. This is essential to activate the benefit.
- Once confirmed, the Enhanced FlexiFund for Maternity Care will be activated automatically.

Members must complete a Health Check to qualify, but the results of the Health Check do not influence the value of the enhanced benefits.



58. What healthcare services are covered by the Enhanced FlexiFund for Maternity?

The benefit may be used for:

- GP consultations
- Gynaecologist consultations
- Paediatrician consultations
- Midwife and postpartum nurse visits
- Antenatal vitamins
- A defined list of blood tests

59. Do I need a positive base FlexiFund balance to access the Enhanced FlexiFund benefits?

No. Members do not need a positive balance in their base FlexiFund to access either the Enhanced FlexiFund for Mental Health or Enhanced FlexiFund for Maternity benefits. Additionally, benefits will be funded from the risk benefit first, where available according to Flexicare policy, with available FlexiFund balances utilised thereafter.

60. Can I qualify for both the mental health and maternity FlexiFund benefits?

Yes. An eligible adult member may qualify for both the additional R1,500 mental health benefit and the additional R4,000 maternity benefit if they meet the relevant qualifying criteria.

61. What is the maximum FlexiFund value available to a Flexicare Plus member?

An eligible Flexicare Plus member can access:

- Up to R1,000 base FlexiFund
- Additional R1,500 mental health FlexiFund
- Additional R4,000 maternity FlexiFund

This means a member who qualifies for all available benefits can access up to R6,500 in FlexiFund support, subject to the applicable qualifying criteria.

62. Do FlexiFund balances carry over into the next year?

Unused base FlexiFund balances carry over from one benefit year to the next. Enhanced FlexiFund funds for mental health and maternity care are available for 12 months from the date they are unlocked and do not accumulate over multiple years. Pregnancy-related benefits become available again for subsequent pregnancies after the required 12-month period. Mental health benefits are available on an ongoing basis, subject to members meeting the applicable qualifying criteria on an ongoing basis (i.e. having completed a health check within the previous 12 months and continuing to meet the criteria for an active depression diagnosis).

63. What happens to FlexiFund balances if a policy is terminated?

The FlexiFund forms part of the Flexicare benefit offering. Any unused FlexiFund balances will be forfeited if the policy is terminated.

64. Are waiting periods applicable?

New members are subject to a three-month general waiting period. In addition, a 12-month condition-specific waiting period applies to members who join Flexicare while already pregnant. These members will not be able to access the enhanced FlexiFund for maternity care during the current pregnancy but may qualify for the benefit after the waiting period has ended if they become pregnant again and meet the qualifying criteria.



65. Can claims be funded retrospectively after qualifying for an enhanced benefit?

No. Eligible claims will not be funded retrospectively if a member only qualifies for one of the Enhanced FlexiFund benefits at a later stage. Claims will only be covered from the point in time when the benefit is activated.

66. How can members check their available FlexiFund balance?

Members can view their available FlexiFund balances through the Connected Care app.

Emergency Cover

Frequently asked Questions regarding the Emergency Cover Enhancements for 2027

67. What changes have been made to Emergency Cover (EC) Benefit and the Discovery Emergency Cover (DEC) Benefit for 2027?

By way of introduction, it should be noted that the Emergency Cover (EC) benefit is a rider benefit on a Flexicare product. The Discovery Emergency Cover (DEC) benefit is a standalone offering by Discovery Health.

Currently, the EC Benefit and DEC benefit provides casualty and in-hospital cover to non-medical scheme members. Since 2025, the EC Benefit offering was extended, offering a new suite of products namely Emergency Cover Plus and Emergency Cover Max.

For 2027, the DEC Benefits will be extended to enhance non-medical scheme members' access to casualty and hospital healthcare by further extending the DEC Benefit by offering a full suite of products.

The existing DEC Core option will become an entry-level product with the new offerings providing casualty and hospital cover enhancements. In total, there will be 3 DEC product options with varying levels of benefit richness regarding casualty and hospital benefits. The 3 product categories for DEC will include DEC Core, Plus and Max.

68. How will the DEC Plus Benefit differ to the DEC Core Benefit?

DEC Plus will include an additional benefit that specifically covers heart attacks and strokes as well as additional (casualty-only) cover for other medical emergency conditions.

69. How will the DEC Max Benefit differ to the DEC Core Benefit?

DEC Plus will include an additional benefit that specifically covers heart attacks and strokes, additional (casualty-only) cover for other medical emergency conditions as well as cover for 9 specified major medical emergency conditions up to a limit of R400,000.

70. What does the new Wound Care post-surgery benefit cover and what plans include this benefit?

This benefit covers professional wound care support following an approved diagnosis or medical procedure. The benefit is for nurse-led treatment and care at a defined network. The number of visits and consumables will be subject to authorisation and approval. This benefit is available on all plans.



71. What does the new Mobility Benefit cover and what plans include this benefit?

This benefit covers a defined list of mobility items that you may need after being discharged from hospital, up to R5,000 per policy per year (and subject to event limit availability). This benefit is available during the members treatment in casualty and/or discharge post admission in hospital. The preferred designated network providers include MedOp, CE Mobility, Sheer Mobility and Chairman Industries. If members do not use one of the network suppliers, the member will be liable for the cost of the external medical equipment. This benefit is available on all EC and DEC plans.

72. Will Emergency Cover use an age-at-entry rating going forward and how will this impact existing members?

Yes, EC and DEC will now apply an age-at-entry (using an age next birthday basis) premium rating to new members as well as to members that are being added on to an existing policy. Age-at-entry pricing will also apply to existing policies following a lapse and re-entry, or an upgrade or downgrade of the policy (whether it be cover limit or option). Please note that age-rated premiums will only apply to retail lives.