

DISCOVERY DAY
SEPTEMBER 2021

BENEFIT AND
CONTRIBUTION UPDATES

HEALTH | VITALITY | BANK

2021

DISCOVERY HEALTH MEDICAL SCHEME POST-LAUNCH

FREQUENTLY ASKED QUESTIONS

VERSION 1



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Contributions

TECHNICAL QUESTIONS RELATING TO CONTRIBUTION INCREASE STRATEGY

How did Discovery determine the 7.9% contribution increase?

The 2022 contribution increase strategy for Discovery Health Medical Scheme balances long-term sustainability and short-term affordability. These factors include:

- The cost of healthcare services in 2022 will increase by 4.4% on average, based on projections of 2022 Consumer Price Inflation (CPI).
- Changes in demographic risk profile occur irrespective of COVID-19 utilisation discontinuities. The demographics risk for Discovery Health Medical Scheme is therefore expected to increase by 3% in 2022, in line with prior years.
- Healthcare utilisation increases in 2022 are expected to be in line with existing utilisation trends. While COVID-19 discontinuities may persist, they will be temporary in nature and will not impact systemic medical inflation trends. Utilisation changes are expected to increase healthcare claims by 1.5% in 2022.
- Additionally, the impact of Discovery Health's risk management interventions, such as tariff negotiations and fraud interventions, as well as the improved healthcare outcomes as a result of member's engagement in Vitality leads to an expected overall reduction in claims by 1% for 2022.

Contributions for 2022 must increase to match the expected increase in healthcare claims for 2022. Accounting for each of the above factors results in an increase in contributions of 7.9% for 2022.

Through the contribution freeze, DHMS members will only pay the increased contribution rate from 1 May 2022 resulting in an average increase of 5.3% for 2022 on the current annualised rate.

What is the difference between a 7.9% contribution increase from May 2022 and the average contribution increase of 5.3% on the current annualised rate?

This is the second year that DHMS has adopted a contribution freeze. Last year, the Scheme was the first and only medical scheme in South Africa to implement a freeze on contribution increases effective from January to July 2021. Monthly contributions for all DHMS members will increase by 7.9% from 1 May 2022. Through the delayed implementation of the 2022 contribution increases, members will only experience a 5.3% effective increase based on their current annualised rates.

The example below illustrates the total contributions paid by a single member on a DHMS Classic Saver policy in 2022 compared to the current annualised rate for 2021.

- The contribution freeze means that a single member will pay the same level of monthly contributions for the first 4 months of 2022 as they did for the second half of 2021. For a Classic Saver plan the monthly contributions are R3 485 from 1 January 2022 to 30 April 2022.
- This member would therefore pay a total of R13 940 for their contributions from January 2022 to April 2022. In May 2022, contributions will increase by 7.9%. The member pays R3 762 for their Classic Saver plan per month from May 2022, with total contributions from May 2022 to December 2022 amounting to R30 096.

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- By the end of 2022, the total contribution paid by the member from January to December will then be **R44 036** (R13 940 + R30 096).
- The current monthly contribution for a Classic Saver plan is R3 485. The total contributions paid at this rate, for 12 months is R41 820 (3 465 x 12). The total contributions that will be paid by a single member in 2022, for the same plan, will be **R44 036**. This represents an annual increase from R41 820 to R44 036 for 2022, only a 5.3% effective increase in contributions due to the 2022 contribution freeze.

Why has Discovery not simply implemented a 5.3% increase for the entire year, commencing 1 January 2022?

While medical scheme claims are currently depressed because of COVID-19, the trend is temporary and not reflective of underlying medical inflation. The DHMS claims experience for 2021 shows that healthcare claims between COVID-19 waves are higher than pre-pandemic levels. Healthcare claims for 2022 are expected to increase in line with medical inflation, at 7.9% between 2021 and 2022.

Contribution increases must be priced correctly to allow for expected future healthcare claims. Setting contributions lower than expected future medical inflation will result in contributions falling behind claims and lead to ongoing medical scheme losses, ultimately resulting in future contribution 'shocks' to maintain sustainability.

Setting contributions at 5.3% from 1 January 2022 would create a gap between future healthcare claims, which are expected to increase by 7.9%. This gap would have to be corrected in the form of a future price shock, with contributions requiring an increase well in excess of CPI.

Instead, delaying the implementation of the contribution increase across 2021 and 2022 has ensured that contributions have remained in line with expected increases in medical inflation, while effectively reducing the impact of contributions increases by 50% in 2021 and by a third in 2022.

Overall, the deferred implantation of the contribution increase effectively balances short-term member affordability with long-term scheme sustainability, while appropriately accounting for the expected medical inflation trends in 2022¹

How does DHMS' views of medical inflation compare with international trends?

The 2021 DHMS claims experience clearly indicates healthcare utilisation is returning in excess of pre-pandemic levels during periods of low COVID-19 infections. Similar experience has been recorded across other healthcare sectors globally. DHMS' expectations on future medical inflation are consistent with global healthcare trends¹, with 50 out of 53 insurers in the United States stating that COVID-19 will have either no impact or an upward impact on 2022 healthcare costs. Under these assumptions, insurers are expecting medical inflation for 2022 to be in line with prior years². Under these expectations of future medical inflation, insurers that have increased premiums or contributions lower than expected future medical inflation, will require a price shock or a correction in benefits in the future.

¹ Health System Tracker, Insurer filings suggest COVID-19 will not drive health spending in 2022, October 2021

² PWC Health Research Institute, Medical cost trend: Behind the numbers 2022



Why have increases only been deferred to 1 May 2022?

The strengthened reserve position of Discovery Health Medical Scheme enables the scheme to delay the implementation of the 7.9% contribution increase to 1 of May 2022. Delaying the increase further would require an additional release of reserves which may compromise the schemes solvency position after taking into account the deferred non-COVID-19 demand as well as the continued demand for COVID-19 related claims.

Does the 7.9% contribution increase apply to all DHMS plans?

Yes.

Will the savings portion be adjusted in May?

According to the Medical Schemes Act, the Medical Savings Account allocation cannot exceed 25% of medical scheme contributions. Therefore, increases to the Medical Savings Account will be in line with the contribution increases made in May 2022.

BENEFIT ADJUSTMENTS RELATED TO THE DEFERRED INCREASE

Will members be able to change plan selections in May 2022 due to the contribution increase?

Members will have the opportunity to upgrade their health plan effective 1 January 2022 and then again effective 1 May 2022. Plan downgrade requests are processed throughout the year. Advisors will be able to process upgrade requests on the Financial Advisor Zone from mid-March 2022. All mid-year upgrade requests must be submitted by 30 April 2022.

By how much will a member’s Medical Savings Account increase at 1 May 2022?

All members on plan options with a Medical Savings Account will be allocated an additional amount in their savings accounts from 1 May 2022. The example below illustrates the impact of the 7.9% increase in MSA allocation for a single member on the Classic Saver plan in 2022.

	Total Monthly Contribution	MSA Portion of Monthly Contribution	Total MSA for the period	Total MSA Balance
Jan – April	R 3 485	R 871 +	R 3 484	R 11 004
May – Dec	R 3 762	R 940 +	R 7 520	

How will the additional Medical Savings Account allocation affect members who are in their Self-Payment Gap (SPG) by 1 May 2022?

While in the SPG, members will be able to use the additional Medical Savings Account until this is depleted. Members that have reached their above threshold benefit (ATB) before 1 May 2022 will remain in their ATB and continue to access the associated risk funded benefits. The additional Medical Savings Account allocation will be carried over to the next year or can be used for healthcare expenses not funded from the member’s ATB in 2022.

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When will the thresholds on the Annual Threshold Benefit be increased?

Thresholds for the Above Threshold Benefit on the Executive, Comprehensive and Priority plans will be increased by 7.9% in line with medical inflation from 1 January 2022.

Will the KeyCare income bands be increased in May 2022?

Adjustments to the KeyCare income bands will form part of the 2022 contribution increase, as such KeyCare income bands will not increase on 1 January 2022 but rather on 1 May 2022. New income verification timelines will be communicated during the course of next year as part of contribution increases expected in May 2022.

OPERATIONAL ROLLOUT OF THE 2022 DEFERRED INCREASE

How will members be notified of the 2022 increase?

During March 2022, members will receive communication from Discovery Health Medical Scheme detailing:

- their chosen health plan's updated contribution for May 2022
- the specifics of the May 2022 increase to their contributions
- changes to available plan components if applicable (e.g. increases in Medical Savings Account)
- the opportunity to upgrade their plans, effective 1 May 2022 including all operational details relating to plan upgrades.

Where can advisors apply for an upgrade for their client's plan?

Advisors will be able to change their client's plans on the Financial Advisor Zone from mid-March 2022 to 30 April 2022. If you are experiencing any difficulties with this process, please contact your Corporate Health Manager or Servicing Specialist.

2022 DHMS Benefit Updates

Enhancements to the Assisted Reproductive Therapy (ART) Benefit

Have enhancements to the ART benefit affected the overall benefit limit and eligibility criteria?

The ART benefit limit will increase to R115 000, in line with the Scheme's general benefit limit increase for 2022. The benefit criteria remain unchanged with members on the Comprehensive and Executive plans, between the ages of 25 and 42 years, being able to access cover for assisted reproductive therapy up to 75% of the Discovery Health Rate per member per year, subject to the Scheme's benefit criteria, limits and SASREG clinical criteria, protocols and treatment guidelines.

The 2022 ART benefit enhancements, which include funding for cryopreservation, embryo freezing and egg donated cycles are subject to the overall ART Benefit limit, 25% member co-payment and benefit criteria. Cover for egg donated cycles will be extended to members aged 43 to 50 years. This extended age limit relates specifically to this

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enhancement as the egg being donated will be from a younger donor that meets the SASREG treatment guidelines in terms of egg donation viability.

ENHANCED PALLIATIVE CARE OFFERING

How does this benefit differ from the current Advanced Illness benefit and the Compassionate Care Benefit?

At present, the Scheme provides separate cover for palliative and end-of-life care through the unlimited Advanced Illness Benefit (AIB) for oncology patients, and the Compassionate Care Benefit for non-oncology patients, across all DHMS plans.

From January 2022, the Scheme will merge the Compassionate Care Benefit with the Advanced Illness Benefit to provide members with a single and holistic benefit for end-of-life and palliative care. The Advanced Illness Benefit will provide unlimited cover for palliative and end-of-life care for both oncology and non-oncology patients with advanced illness. Cover is subject to authorisation, approved treatment guidelines and managed care criteria.

NOMINATION OF A PRIMARY GP TO MANAGE PMB CHRONIC CONDITIONS

Why is it necessary for a member to nominate a single/primary GP to manage all PMB chronic conditions?

Primary care GPs manage the day-to-day healthcare needs of members. A patient's primary GP will establish their health history, conduct screening and prevention tests, coordinate specialist referrals where necessary, and make recommendations to improve health and wellness. This continuum and coordination of care is particularly important for the effective management of complex health conditions.

Both internal and international research show clear evidence that an established relationship with a single primary care doctor improves the long-term health outcomes of members managing chronic conditions. These efficiencies arise through the provision of an efficient and consistent access point to the healthcare system, with better management and coordination of care. According to a recent World Health Organisation report, patients have a preference to see a single provider for coordinated care and place greater value on seeing a provider they know and trust. Patients who saw the same doctor recorded 13% fewer hospital admissions and 27% fewer visits to the emergency department, substantially improving the quality of care for members with complex healthcare needs.

Will members be allowed to nominate any GP to manage their PMB chronic conditions?

Affected members will need to nominate a GP participating in the Discovery Health GP Network or nominated Network GP, depending on the member's chosen health plan, to treat all PMB chronic conditions.

KeyCare members must use their nominated primary KeyCare network GP and members on the Smart plans must make use of a Smart network GP.

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How does a member nominate a primary GP?

Members will be able to nominate a primary doctor from January 2022. Members will either be able to complete this nomination process on the Connected Care platform or alternatively, for those without access to Connected Care, by contacting the service centre.

Affected members and financial advisors will be receiving additional information in this regard as part of the Scheme's year-end communication.

Will a member be able to change their nominated GP?

Yes, a member will have the option to change their nominated GP once per year.

Can different beneficiaries on the same health policy nominate a different primary doctor to treat their individual chronic conditions?

Yes.

What will happen if a member does not nominate a GP before the co-payments and related benefit changes are implemented in May 2022?

Where existing patient information and claims history is available, the Scheme will automatically allocate a primary GP to a member, based on the member's previous consultations and location.

Will a 20% co-payment be implemented for the consultation and referred services if a member completes a consultation with a non-nominated GP for the treatment of their chronic condition as well as other acute symptoms?

The 20% co-payment will only be implemented for the claims relating to the treatment of chronic conditions, including care provided by the GP such as the consultation and consumables, as well as referred services such as radiology and pathology. Other items covered under the basket of care will continue to be covered at 100% of the DH rate.

Should a registered CIB member consult their nominated doctor for the treatment of acute conditions, this consultation and any referred services and medication will be funded from available day-to-day benefit, according to the chosen healthcare plan.

Does the nomination of a primary GP need to take place for both Chronic Disease List (CDL) and Additional Disease List (ADL) conditions?

Members are required to nominate a primary GP for the treatment of Chronic Disease List and OH DTP-PMB chronic conditions. While no co-payment will be incurred for the treatment of ADL conditions by GPs outside of the Discovery GP network, members are strongly encouraged to use the same doctor to treat and manage all their chronic conditions.

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Can a member select a medical practice or group instead of one primary GP for the treatment of their PMB chronic conditions?

Yes, provided the medical practice forms part of the network (e.g. Intercare medical centres).

Do members need to be referred by their nominated GP to receive cover for a specialist consultation?

No referral is required. Specialist consultations will fund according to the members chosen healthcare plan and registered condition treatment guidelines.

Members who currently have their chronic condition managed via a specialist, will not be impacted and can continue to access their specialist benefits and chronic basket of care via the managing specialist, subject to benefit and plan limits.

What discussions are taking place with non-DSP healthcare providers?

Various communication and engagement all GPs have been actioned for the coming months prior to the change being implemented. This includes:

- Provider society engagement
- Informative webinars
- Targeted communication to GPs throughout the year importance of a single provider care management
- Training on new electronic platform, registration, consults, fee structures
- Communication on changes to the Care Programme

NOMINATION OF A PRIMARY GP WHEN REGISTERED ON A CARE PROGRAMME INCLUDING DIABETES CARE, HIV CARE AND CARDIO CARE

How does the Premier Plus GP network and the Discovery Health GP Network differ for the management of specific chronic conditions such as Diabetes, HIV or Hypertension?

A Premier Plus GP remains the point of contact for registration on these Care Programmes. Existing Premier Plus GPs form part of the GP network, enabling members to be both registered and treated by their Premier Plus GP. The member's registered Care Programme doctor will also be their nominated GP for the treatment of chronic conditions.

Will members continue to incur co-payments if they do not register on the Diabetes Care Programme?

The introduction of the nomination of a primary GP to manage members' chronic PMB conditions, including diabetes, mean that the current co-payment applied to members who do not register on the Diabetes Care Programme will be removed in 2022. Members registered on CIB for the treatment of diabetes must however nominate and visit their primary GP to avoid the 20% co-payment being applied to a non-nominated GP consultation and referred services.

Will members on the Diabetes Care Programme that are currently being treated by a Specialist need to be referred by a nominated GP?

Members who are currently registered for Diabetes Care via a Specialist on the Discovery Care Coordination Network (DCCN), will not be impacted and can continue to be managed by the Specialist benefits, subject to the member's registered chronic basket of care.

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LIMITS, CO-PAYMENTS, DEDUCTIBLES AND THRESHOLDS

Why are certain benefit limits not increasing?

Every year, Discovery Health Medical Scheme reviews benefit limits across the scheme to ensure that members continue to receive exceptional cover, while balancing the need to manage medical inflation and contribution increases for all members. For 2022, certain increases on targeted benefits were not required:

Specialised Medicine and Technology Benefit

Favourable price negotiations for the specialised medicine and technology offered through this benefit resulted in reductions in treatment costs, effectively increasing the level of cover for members without requiring an increase in the benefit limit.

Day to day benefit limits, including dentistry, external medical items, optometry

The extent of cover offered through these benefits was analysed both pre-COVID-19 over 2020 and 2021. From members who utilized these benefits, pre-COVID-19, only 5.5% reached their benefit cap. With lower utilisation across these benefits during COVID-19, comprehensive existing cover levels, and the need to manage medical inflation to support affordability for all members, certain targeted benefit limits were not increased for 2022.

Oncology

DHMS members receive exceptional oncology cover relative to the rest of the market, delivered through effective benefit design. DHMS offers members the following market differentiating cover for oncology:

- The use of thresholds, offering members 80% cover for non-PMB oncology treatment once the threshold is reached. This offers members substantially greater cover than the use of limits, which offers no cover beyond the benefit limit.
- DHMS also offers cover for biologics, brachytherapy, specialized medication, in addition of the standard treatments typically offered across the rest of the industry.
- Oncology treatment is delivered without restriction of service providers across most DHMS plans.

These benefit design differentiators have shown substantial value for DHMS members with 93% of all active oncology claimants in 2020 receiving full cover for oncology treatment, with no co-payments. An additional 2% have only incurred co-payments of less than R1000.

Oncology limits are often treated as targets for available benefits. An increased limit is typically met with all oncology care being claimed at the maximum available benefit without a change in availability of treatment. Increasing oncology limits therefore does not provide members with improved care, nor does it significantly reduce co-payments for the treatment required. Instead of increasing limits annually, DHMS instead uses introduces targeted benefit enhancements aimed at reducing co-payments for members. These have been delivered through:

- The introduction of the Advanced Illness Benefit (AIB) and the Oncology Extender Benefit (OEB) in 2019 which increased access to high-cost oncology care and substantially reduced co-payments for new, innovative cancer treatment.
- The extension of partial oncology cover for precision medication for small cell lung cancer and colorectal cancer to mid-range plans (excluding KeyCare) in 2022.

These enhancements are targeted to reduce co-payments of high-cost cancer care, offering real benefit enhancements for members.

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Hospital at Home

How does Hospital at Home differ to Connected Care for Acute Care at Home?

In 2020, Discovery Health launched Connected Care for acute care at home, which provides qualifying members with clinically appropriate hospital-level care in their homes. During the course of 2021, over 100 DHMS members were successfully treated for COVID-19 in their homes with similar or improved levels of clinical outcomes and a better patient experience.

Instead of limiting care to a list of low acuity medical conditions, Hospital at Home will be offering a list of services and/procedures that can be delivered safely to a larger group of members, including medical as well as post-surgical conditions, who require acute hospital-level care in the convenience of their homes.

Furthermore, to ensure that we are delivering care at the same quality whilst aiming to provide superior care, qualifying DHMS members enjoy value-added risk-funded benefits as part of their episode of care, such as transport services, daily meals and a full-time carer where the treating provider and the scheme deems it to be necessary for recovery.

How does a member access the Hospital at Home benefit?

Members will not be able to apply to be treated at home. Treating providers, in conjunction with Discovery Health's in-hospital case managers, will identify members and inform them of the programme based on clear criteria. Their treating doctor will then be required to complete the Hospital at Home application form which will be emailed to Discovery Health. Members will subsequently be notified as to whether they qualify to be treated at home, and if approved, they will continue on the Hospital at Home journey.

How is the Hospital at Home benefit funded?

Hospital at Home will be funded from a member's unlimited major medical hospital benefit. A valid pre-authorisation for treatment at home in lieu of hospitalisation will unlock risk-based funding for approved devices and healthcare services for those who meet the clinical and benefit criteria.

All services offered as part of Discovery Health's Hospital at Home programme will fund from the member's hospital benefit in accordance with their chosen health plan.

Will Discovery Gap fund in-hospital co-payments and specialist shortfalls in the same way as the product does during a hospital admission?

Yes, gap cover benefits will apply as per an equivalent in-hospital related admission.

How often will the dedicated care team visit?

Members will have access to the patient companion app. Through this app, patients are able to conduct online consultations and receive their recovery plan over the course of their treatment.

Members have 24/7 access to an in person and a virtual care team. This real time connection ensures that patients can always reach a clinician if they have questions or concerns. Depending on a patient's specific needs, consultations with the clinical care team will be incorporated into their treatment plan.

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What remote monitoring devices will be used and how are these devices funded?

Qualifying members will have access to either the Biofourmis Everion device or the Biobeat chest monitor, depending on the condition being treated. Both devices enable a real-time view of a member's health status with up to 22 physiological signals including oxygen levels, respiration rate, temperature and pulse rate.

Approved devices will be funded by the Scheme from the Home Monitoring Device Benefit, subject to the annual benefit limit of R4 000. The current benefit limit will sufficiently cover either of these devices.

What is meant by a suitable home setting?

Qualifying criteria for Hospital at Home includes a suitable home set up with adequate home support and easy access to a smart phone and WiFi and/or mobile data.

The technology requires consistent connectivity to be able to allow the 24/7 clinical command centre to monitor a patient's real-time physiological signals.

What happens during a power failure or scheduled load-shedding?

HomeCare nurses will travel with external power banks and mobile data, that can be loaded on behalf of patients, to ensure connectivity and remote monitoring remains unaffected during load shedding.

Is Hospital at Home available nationwide?

Initially this service will be offered within metropolitan areas however the Scheme aims to expand access to this service across all nine provinces, subject to members meeting qualifying criteria.

Is Hospital at Home available to members on all Discovery Health Medical Scheme plans?

Yes, the programme is available to all members on a Discovery Health Medical Scheme plan including KeyCare, although benefits may vary depending on the chosen health plan.

What is the expected waiting time for approval to be treated at home as opposed to being admitted to hospital?

Confirmation of the patient's ability to use Hospital at Home will be communicated within an hour of the application being received. Once approved, a member can expect to have a treating nurse dispatched to the patient's home within 4 hours.

Digital Patient Communities

How many digital patient communities can DHMS members access on the myHealth Teams platform?

Currently, DHMS members can access any of the myHealth Teams communities free of charge. Discovery Health has however, invested in three specific platforms to enhance the experience for its members. Members who join the myDiabetes, myHeartDisease and myLong-Covid Teams will have access to accurate and relevant clinical information

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and condition-specific curated content. These communities were selected based on the increasing prevalence of heart disease, diabetes and the emergence of long-COVID trends amongst DHMS members.

How do members access the community platforms?

DHMS members can access and enrol on any of Discovery selected patient community platforms offered by myHealthTeams, at no additional cost, through the following channels:

- The Discovery Connected Care platform on the Discovery corporate app
- The myHealthTeams website by navigating to the 'Log in with Discovery' landing page.

Discovery Pay

What is Discovery Pay?

Discovery Pay is a sophisticated integrated payments platform which makes payments faster and more convenient. By integrating the healthcare provider networks of Discovery Health and fitness facility networks of Vitality with the payment infrastructure of Discovery Bank, Discovery Pay allows clients to transact seamlessly across the healthcare system, access Pay as you Gym facilities nationwide and pay Discovery Bank clients using just a cellphone number.

To summarise, Discovery Pay consists of three elements:

- Health payments, enabling instant settlement of medical bills by integrating all funding sources with Discovery Pay.
- Vitality payments, providing access to Vitality's network of Pay as you Gym health and fitness partners.
- Contact payments, allowing members to pay other Discovery clients in the Contact list using just a cellphone number.

What is the Discovery Pay account?

In 2022, all Discovery Health Medical Scheme and Vitality Health members can get access to a Discovery Pay account at no monthly costs. This account is a virtual transactional account, enabling a digital wallet for all clients, including all the features of a transactional account such as the ability to make payments, transfer funds from and to other accounts and earn interest on positive balances.

Any member with an existing Discovery Bank account or the free Discovery Pay account can activate Discovery Pay on the Discovery Bank app. During the activation process, members will be able to select which Discovery account they would like to link their Discovery Pay to so that they can fund their different transactions. They will have the option to link the same account for each of the different transactions, or they will be able to select a different account for their Health, Vitality and contactless payments if they have other Discovery Bank products. Access to utilise the full suite of Discovery Pay transactions may be limited depending on the underlying Discovery products the member has.

Who is eligible to activate the Discovery Pay account?

The main member and any adult or spouse dependents on DHMS or Vitality Health are able to activate the Discovery Pay account.

All eligible members can download the Discovery Bank app and activate the Discovery Pay account to receive a free virtual card.

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How do non-Discovery Bank clients fund the Discovery Pay account?

The Discovery Pay account functions as a normal transactional account, allowing clients to transfer funds between their bank accounts. Therefore, members that have bank accounts with banks other than Discovery Bank will be able to transfer money from these accounts into their virtual Discovery Pay account.

Will members be able to go into credit when using Discovery Pay?

Members that only have the Discovery Pay account activated and linked for their Discovery Pay transactions will be limited to the funds available in the account when making payments. If in addition to the Discovery Pay account the member has a Discovery Bank account that has credit facilities available, and has linked this account for Discovery Pay transactions, they will be able to use their available credit facility to fund purchases enabled by Discovery Pay.

If you use Discovery Pay, how is the claim logged on your medical aid for tax purposes?

Discovery Pay simply provides a seamless payments system for clients to submit claims in real-time to Discovery Health for processing. Once the claim is submitted, it is processed in the same way as all claims are today, with the co-payment typically paid by the member, automatically being paid from the linked Bank account. All tax records and rules remain unaffected by Discovery Pay.

DISCOVERY PAY - HEALTH PAYMENTS

Who can make health payments through Discovery Pay?

Only Discovery Health Medical Scheme members will have access to the health payment functionality of Discovery Pay. Members that have access to Discovery Pay but are on a different medical scheme will not be able to settle their health payments through Discovery Pay.

Discovery Pay is activated on a policy level by the Bank account holder. Whoever activates Discovery Pay first will be the nominated account holder, however all dependents on that DHMS policy will have their healthcare claims paid from the nominated Discovery Bank account.

Where can members use Discovery Pay for health payments?

Discovery Pay allows DHMS members to make seamless health payments at any Discovery Pay enabled provider across the country. Any healthcare provider can participate in allowing the use of Discovery Pay and does not have to be a part of the Discovery Network.

Discovery Pay will be going live during quarter 1 in 2022, and will include health payments at:

Most pharmacies and hospitals nationally

More than 6 400 GPs across the country

Partnered pathology labs

Members will be able to identify Discovery Pay enabled providers using the Find-a-Provider tool in the Discovery app. Providers that are Discovery Pay enabled will also have a QR code at the reception desk of the facility, indicating that Discovery Pay functionality is available.

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How can members use Discovery Pay to settle health payments?

There are two different journeys that a member can experience when using Discovery Pay to fund healthcare claims. The first journey involves healthcare providers with a direct billing arrangement with Discovery Health submitting the claim on behalf of the patient. DHMS will check the Scheme benefits and the patient will receive confirmation of full settlement by DHMS and the nominated Discovery Pay account.

The second journey is used when the healthcare provider does not have a direct billing arrangement with Discovery Health. The patient or member will submit their claim for reimbursement by scanning a QR code, capturing their claim details and submitting the claim. The patient will receive proof and confirmation of payment, which will conclude their seamless health payment experience through Discovery Pay.

DISCOVERY PAY - VITALITY PAYMENTS

Do you need access to Vitality to use the Pay as you Gym functionality of Discovery Pay?

No, members do not need to have Vitality to use Pay as you Gym. Anyone with an existing Discovery Bank account or the free Discovery Pay enabled account will be able to use Pay as you Gym. However, only DHMS members will be able to settle their healthcare claims through Discovery Pay.

Each adult dependent on the policy will need to activate and link a nominated bank account to be able to settle their Vitality payments through Discovery Pay.

Other

How do I access the year-end revision support?

Support material is located under the Financial Advisor Toolkit tab on the Financial Advisor Zone or by following this [link](#)