Discovery News

for Discovery Health members

D&A DORMAN & ASSOCIATES

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Cover for Scopes

Scopes must be pre-authorised.

In-Hospital or Day Clinic Procedures
Discovery will cover scopes during an emergency, where indicated and approved for dyspepsia, and for children aged 12 and under without any co-payment or upfront payment.

Where scopes are done in-hospital or at a day-clinic, a co-payment or upfront payment may apply to the hospital account. The co-payment or upfront payment will vary depending on the place of service. This payment will be paid from your available day-to-day benefits or by you, depending on your chosen health plan. If the co-payment or deductible amount is higher than the amount charged for the healthcare service, you will have to pay for the cost of the healthcare service. A higher co-payment or deductible will apply if both a gastroscopy and colonoscopy is performed in the same admission. The amount depends on your chosen health plan and where the scope is being done.

Discovery pays the balance of the hospital account and all the other approved accounts that are related to the procedure from your Hospital Benefit up to the Discovery Health Rate (DHR). You must let Discovery know beforehand and preauthorise your scope.

Where the scope is used as part of a defined list of approved in-hospital procedures, the co-payment or upfront amount on the hospital account will not apply. When you preauthorise your procedure, Discovery will advise you whether you can expect to pay a co-payment, which depends on the procedure you are having done. This will be determined by the codes given by your doctor. If these codes change, the co-payment or upfront amount may change, so it is important to keep Discovery informed about changes to the codes.

In Doctor's Rooms
No co-payment or deductible applies if you have your scope done by an in-rooms network provider. If you have your scope done in the doctor's rooms at any other provider, a co-payment or deductible of R1,800 for a single scope or R3,100 for a bidirectional scope will apply.

When no Co-Payment applies
There are some instances where no co-payment will apply:

- Scopes performed as part of a confirmed Prescribed Minimum Benefit
- Where indicated and approved for dyspepsia. (See info on the Dyspepsia Conservative Care Programme)
- Where a patient is aged 12 or younger
- For in-rooms scopes performed at a network provider.

KeyCare Plans
On the KeyCare plans Discovery only covers scopes done on children aged 12 and under, scopes related to surgery, or when it is covered as a Prescribed Minimum Benefit (PMB) under certain conditions. These scopes need to be performed within the KeyCare Day Surgery Network. Scopes that fall outside of these criteria are not covered in hospital or in a day clinic as it is not a benefit covered on the KeyCare plans. Scopes done in the doctor's rooms will be covered from your Hospital Benefit.

Prescribed Minimum Benefits (PMB)
Discovery will pay the claim as a PMB if the scope report confirms a PMB diagnosis. No co-payment will apply in this instance. You or your doctor must send Discovery the report confirming the diagnosis.

This email is written by an independent commentator and not by Discovery Health. Any Discovery Health member is welcome to subscribe. Queries regarding this email can be sent to keith@dorman.co.za.

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Discovery Emergency Number
0860 999 911

2026 Discovery Health Plans
Executive Plan
Classic Comprehensive
Classic Smart Comprehensive
Classic & Essential Priority
Classic & Classic Delta Saver and Core
Essential & Essential Delta Saver and Core
Coastal Saver and Core
Classic and Essential Smart Saver
Classic, Essential, Essential Dynamic and Active Smart
KeyCare Plus, Core, Start and Start Regional

2026 Discovery Rewards
Vitality Active
Vitality

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MRI and CT Scans

You can go ahead with an out-of-hospital MRI or CT scan without contacting Discovery, as long as a specialist – or a trauma GP in an emergency – refers you. If your scan is part of a hospital stay and relates to the reason you were admitted, Discovery will cover the scan from your Hospital Benefit. If the scan is not related to the hospital admission, Discovery will pay it as if it was done outside of hospital and a co-payment may apply.

IN-HOSPITAL
If you're admitted to hospital for conservative (non-surgical) treatment, Discovery covers MRI or CT scans in the same way they cover out-of-hospital scans. A co-payment may apply, and only one scan per spinal or neck region is covered. On the Essential Smart Saver, Essential Smart, Essential Dynamic Smart, Active Smart, and KeyCare plans, there is no cover for conservative back or neck treatment or related scans.

OUT-OF-HOSPITAL
On certain plans, a co-payment applies when done out-of-hospital.

- On Executive, Comprehensive, Priority, Saver, and Smart Saver plans, Discovery pays the first R4,000 of the scan from your available day-to-day benefits. If your Medical Savings Account is used up and you haven't reached your Annual Threshold (where applicable), you'll need to pay this amount out-of-pocket. Discovery will pay the balance of the scan from the Hospital Benefit, up to the Discovery Health Rate (DHR). If your provider charges more than this rate, you'll need to pay the difference.
- On the Classic Smart Plan, you have to pay the first R4,000 of the scan.
- On Essential Smart, Essential Dynamic Smart, Active Smart, and Core plans, you do not have cover for out-of-hospital scans.
- On KeyCare Plus and KeyCare Core, Discovery will cover approved scans from your Specialist Benefit (up to R5,750 per person a year).
- On KeyCare Start and KeyCare Start Regional, the same applies but up to R2,850 per person a year.

PRESCRIBED MINIMUM BENEFITS (PMB)
If your MRI or CT scan results confirm a diagnosis that qualifies as a PMB, Discovery will cover the scan in full and the co-payment will not apply. Your doctor will need to send us the report confirming the diagnosis. If the scan does not result in confirmation of a Prescribed Minimum Benefit (PMB) diagnosis, these scans are not considered to be a PMB.

Vitality Points for Chronic Condition Management

You can earn Vitality points for managing your Chronic Condition. You need to manually request these points, via the Chat Bot on the website or the Ask Discovery WhatsApp number. You can earn up to 2500 points per year.

Diabetes:
250 points twice a year for completing an HbA1c lab test, 250 points twice a year for blood pressure test, 250 points for cholesterol test, 250 points for kidney function test, 250 points twice a year for seeing your designated GP, 250 points for an ophthalmologist consultation and 250 points for a podiatrist consultation.

Hyperlipidaemia:
250 points for cholesterol test, and 250 points twice a year for seeing your designated GP

Hypertension:
250 points for blood pressure test, 250 points for kidney function test, 250 points for urine dipstick test, and 250 points for an ECG

Ischemic Heart Disease:
250 points twice a year for blood pressure test, 250 points for kidney function test, 250 points for urine dipstick test, 250 points for an ECG, 250 points twice a year for seeing your designated GP, and 250 points for a cardiologist consultation.

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