ANNEXURE A1

REMEDI MEDICAL AID SCHEME

CONTRIBUTIONS EFFECTIVE 1 JULY 2022

STANDARD OPTION

INCOME (in Rand)	MEMBER:	ADULT (**) DEPENDANT:	CHILD (*) DEPENDANT:
0–3999	1595	1062	323
4000–5499	1671	1118	364
5500-6999	1752	1253	450
7000-7999	1884	1501	584
8000-8999	1884	1501	584
9000-9999	1884	1501	584
10000-10999	1884	1501	584
11000 +	1889	1504	585

Note:

- Contribution rates for children are only applied on the first three (3) children.
- No provision is made for members to contribute towards a Personal Medical Savings Account.

(*) Child contributions are applicable where:

- A dependant is under the age of 21;
- A dependant is over the age of 21, but not over the age of 26 and a registered student at a University or recognised college for higher education and is not self-supporting;
- A dependant is over the age of 21, but not over the age of 26 and is dependent upon the principal member due to mental or physical disability.

(**) Adult contributions are applicable where:

- A principal member's dependant is over the age of 21 and does not qualify for child contribution rates as set out above.

ANNEXURE A2

REMEDI MEDICAL AID SCHEME

CONTRIBUTIONS EFFECTIVE 1 JULY 2022

COMPREHENSIVE OPTION

INCOME (in Rand)	MEMBER:	ADULT (**) DEPENDANT:	CHILD (*) DEPENDANT:
0–3999	**3262**	**2471**	**761**
4000–5499	**3443**	**2638**	**810**
5500-6999	**3638**	**2811**	**887**
7000-7999	**3827**	**2891**	**967**
8000-8999	**4026**	**3051**	**1011**
9000-9999	**4249**	**3197**	**1062**
10000-10999	**4460**	**3358**	**1156**
11000+	**4701**	**3541**	**1220**

Note:

- Contribution rates for children are only applied on the first three (3) children.
- The Personal Medical Savings Account is compulsory.
- The compulsory level of savings, as a percentage of the total contribution has been set at 10%, is included above.

(*) Child contributions are applicable where:

- A dependant is under the age of 21;
- A dependant is over the age of 21, but not over the age of 26 and a registered student at a University or recognised college for higher education and is not self-supporting;
- A dependant is over the age of 21, but not over the age of 26 and is dependent upon the principal member due to mental or physical disability.

(**) Adult contributions are applicable where:

- A principal member's dependant is over the age of 21 and does not qualify for child contribution rates as set out above.

ANNEXURE A3

REMEDI MEDICAL AID SCHEME

CONTRIBUTIONS EFFECTIVE 1 JULY 2022

CLASSIC OPTION

INCOME (in Rand)	MEMBER:	ADULT (**) DEPENDANT:	CHILD (*) DEPENDANT:
0–3999	**2560**	**1819**	**614**
4000–5499	**2709**	**1950**	**682**
5500-6999	**2855**	**2076**	**729**
7000-7999	**3003**	**2130**	**798**
8000-8999	**3166**	**2249**	**850**
9000-9999	**3329**	**2363**	**885**
10000-10999	**3507**	**2489**	**965**
11000+	**3685**	**2618**	**999**

Note:

- Contribution rates for children are only applied on the first three (3) children.
- No provision is made for members to contribute towards a Personal Medical Savings Account.

(*) Child contributions are applicable where:

- A dependant is under the age of 21;
- A dependant is over the age of 21, but not over the age of 26 and a registered student at a University or recognised college for higher education and is not self-supporting;
- A dependant is over the age of 21, but not over the age of 26 and is dependent upon the principal member due to mental or physical disability.

(**) Adult contributions are applicable where:

- A principal member's dependant is over the age of 21 and does not qualify for child contribution rates as set out above.

REMEDI MEDICAL AID SCHEME

ANNEXURE B

CONDITIONS APPLICABLE TO ALL BENEFIT OPTIONS

1. Members paying the contributions as specified in the relevant schedule of Annexure A shall be entitled to the benefits as set out in the corresponding schedule of benefits hereof, both for themselves and for their registered dependants.

2. Pre-authorisation shall be required before non-emergency hospitalisation, surgical procedures and other specified items may qualify for benefits. In the case of an emergency the Scheme must be notified thereof within 24 hours or on the first working day after such an emergency admission or treatment having been initiated, failing which paragraph 3.3 of this preamble will apply. Notwithstanding anything to the contrary, the Scheme shall not refuse such authorisation or pre-authorisation for a prescribed minimum benefit in a public hospital.

3. In respect of benefits set out in this Annexure the following principles will apply in all cases where pre-authorisation is required -

   3.1 If pre-authorisation is obtained and the treatment does not exceed the authorisation, the treatment will qualify for the benefits as stated;

   3.2 If pre-authorisation is obtained and the authorisation is exceeded, benefits will only accrue for the authorised treatment. The cost pertaining to the treatment in excess of that pre-authorised will be payable by the member. In exceptional cases the Board may agree to a retrospective authorisation, subject to such terms and conditions as the Board may determine;

   3.3 If treatment is undergone without pre-authorisation having been obtained, application may be made retrospectively for an authorisation. In the event of such authorisation being granted the benefit may (except in cases of emergency) be subject to a co-payment of the first R1000 per case. If authorisation is declined no benefits will accrue, provided that authorisation for

prescribed minimum benefits will not be refused, but shall be covered in full as provided for in rule 16.4;

4. Claims must be submitted in accordance with the instructions contained in Rule 15.

5. Maximum annual benefits shall be calculated from 1 January to 31 December each year, based on the services rendered during that year.

6. Unexpended benefits cannot be accumulated and are not transferable from one financial year to another or from one category to another.

7. In the case of treatment necessary for rape victims or needle stick injuries; benefits in respect of such treatment shall be payable at 100% of cost and not from a member's PMSA; and in respect of medicines, the benefit entitlement as for chronic medication shall apply, subject to paragraph 10.

8. The Scheme shall establish or cause to be established a programme to manage the treatment of immune deficiency related to HIV/AIDS. Benefit entitlement, in accordance with the treatment protocols governing the Chronic Illness Benefit programme and the HIV/AIDs management programme, as well as clause 10 and shall not be less than those for the regulated Prescribed Minimum Benefits.

9. The Scheme may establish or cause to be established, a designated hospital network, a designated pharmacy network, a hospital risk management programme, a chronic medicine risk programme, a disease risk management programme and any other programme, including without limitation, the establishment of treatment protocols, the use of formularies, capitation agreements and limitations on disease coverage which the Board may find appropriate for the management of the benefits detailed in these rules.

REGISTERED BY ME ON
Mashilo Leboho
24/12/2021 11:15:12(UTC+02:00)
Signed by Mashilo Leboho,
m.leboho@medicalschemes.co.za
REGISTRAR OF MEDICAL SCHEMES
SIGNIFLOW.COM

10. PRESCRIBED MINIMUM BENEFITS (PMB'S)

To be read in conjunction with **Annexure D**.

10.1 Designated Service Providers

The Scheme designates the following service provider(s) for the delivery of relevant health care services relating to the diagnosis, treatment and care of prescribed minimum benefit conditions to its beneficiaries:

10.1.1 A list of private hospitals that entered into tariff arrangements with the Scheme;

10.1.2 A list of pharmacies that entered into preferred provider arrangements with the Scheme, such as Dischem Pharmacies, Clicks Pharmacies and the Discovery Health Pharmacy Network, including Southern RX Pharmacies;

10.1.3 A list of specialists contracted on behalf of Remedi by Discovery Health in terms of direct payment arrangements (Classic Direct/Premier Rate/KeyCare Rate arrangements) who have agreed to charge for consultations and procedures at the Remedi Rate;

10.1.4 The Remedi Standard Option GP Network of general practitioners contracted through Discovery Health on behalf of the Scheme who have agreed to charge the Remedi Rate;

10.1.5 Optical Network (Preferred Provider negotiators, "PPN")

10.1.6 DRC (Dental Risk Company as the contracted dental management organisation) for members on the Standard Option;

10.1.7 SANCA, RAMOT or Nishtara for drug and alcohol, detoxification and rehabilitation;

10.1.8 ER24 as preferred provider for emergency services;

10.1.9 A list of hospitals to obtain services for Prescribed Minimum Benefits known as the PMB Hospital Network;

10.1.10 An in-hospital GP and Specialist Network for services related to PMB;

10.1.11 A Mental Health Network to obtain out-of-hospital services from a list of Psychiatrists and Social Workers who has entered into a preferred provider arrangement with the Scheme.

The above service provider(s) shall for the purposes of this Appendix be referred to as "designated service providers".

10.2 **Prescribed Minimum Benefits obtained from designated service providers**

Notwithstanding any other provisions in these rules, the Scheme will provide members and their dependants with cover at 100% of the cost, without co-payments or the use of deductibles, or of the Remedi Rate, whichever is applicable in respect of diagnosis, treatment and care for conditions specified in the statutory prescribed minimum benefit, in at least one provider or provider network, designated by the Scheme, which shall at all times include the public hospital system.

10.3 **Prescribed minimum benefits voluntarily obtained from other providers**

A co-payment or deductible may be imposed on a member if a member or his or her dependant obtains such services from a provider other than a designated or preferred service provider, of not more than 30% or lower as determined by the Board of the cost of such services, provided that no co-payment or deductible shall be payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.

10.4 **Prescribed minimum benefits involuntarily obtained from other providers**

10.4.1 If a beneficiary involuntarily obtains diagnosis, treatment and care in respect of a prescribed minimum benefit condition from a provider other than a designated service provider, the medical scheme will pay 100% of the cost in relation to those prescribed minimum benefit conditions.

10.4.2 For the purposes of paragraph 10.4.1, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if –

10.4.2.1 The service was not available from the designated service provider and would not be provided without unreasonable delay;

10.4.2.2 Immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or

10.4.2.3 There was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

10.4.3 Except in the case of an emergency medical condition, preauthorisation shall be obtained by a member prior to involuntarily obtaining a service from a provider other than a designated service provider in terms of this paragraph, to enable the Scheme to confirm that the circumstances contemplated in paragraph 10.4.2 are applicable.

10.5 **Medication**

10.5.1 Where a prescribed minimum benefit includes medication, the Scheme will pay 100% of the cost of the medication, if that medication is obtained from a designated service provider or is involuntarily obtained from a provider other than a designated service provider, *and*

10.5.1.1 The medication is included on the applicable formulary in use by the Scheme; or

10.5.1.2 The formulary does not include a medicine that is clinically appropriate and effective for the treatment of that prescribed minimum benefit condition.

10.5.2 Where a prescribed minimum benefit includes medication, and that medication is voluntarily obtained from a provider other than a designated service provider, a co-payment equal to the difference between the actual cost of the medication and the cost that would have been incurred had the designated service provider been used.

10.5.3 Where a prescribed minimum benefit includes medication, and the formulary includes medication that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a Beneficiary, and that Beneficiary knowingly declines the formulary medicine and opts to use another medicine instead, the Scheme will fund the medicine up to a Therapeutic Reference Price ("TRP") or the Chronic Drug Amount ("CDA"), which is applicable for that condition.

10.6 **Prescribed Minimum Benefits obtained from a public hospital**

Notwithstanding anything to the contrary contained in these Rules, the Scheme shall pay 100% of the costs of prescribed minimum benefits obtained in a public hospital, without limitation.

10.7 **Diagnostic tests for all unconfirmed PMB diagnosis**

Where diagnostic tests and examinations are performed but do not result in confirmation of a prescribed minimum benefit condition diagnosis, except for an emergency medical condition, such diagnostic tests or examinations are not considered to be a prescribed minimum benefit.

10.8 **Co-payments**

Co-payments in respect of the costs for PMB's may not be paid out of medical savings accounts, if a member is registered on the Comprehensive Option.

10.9 **Chronic conditions**

Any benefit option covers the full cost for services rendered in respect of the prescribed minimum benefits which includes the diagnosis, medical management and medication to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specified chronic conditions.

10.10 **Diagnosis**

1. Addison's disease
2. Asthma
3. Bipolar mood disorder
4. Bronchiectasis
5. Cardiac failure
6. Cardiomyopathy disease
7. Chronic renal disease
8. Coronary artery disease
9. Chronic obstructive pulmonary disorder (COPD)
10. Crohn's disease
11. Diabetes insipidus
12. Diabetes mellitus type 1
13. Diabetes mellitus type 2
14. Dysrhythmias
15. Epilepsy

16. Glaucoma
17. Haemophilia
18. HIV and AIDS
19. Hyperlipidaemia
20. Hypertension
21. Hypothyroidism
22. Multiple sclerosis
23. Parkinson's disease
24. Rheumatoid arthritis
25. Schizophrenia
26. Systemic lupus erythematosus
27. Ulcerative colitis

11. Managed Care Programmes

11.1 Patient Management Programmes

Members registered on the Chronic Illness Benefit (CIB) and who have been diagnosed with Diabetes Type I and II, HIV, cardiac conditions or major depression have access to Patient Management Programmes and a premier basket of care when consulting with a contracted Premier Plus General Practitioner to manage their conditions. Additional consultations and formulary medicines as deemed clinically and medically appropriate are made available from a basket of care from these Patient Management Programmes.

11.2 Home Care

Discovery Home Care provide quality nursing or care worker support in the member's home by professional nurses who are accredited by Discovery Health (Pty) Ltd and includes the following services:

11.2.1 End-of-life care

End-of-life care is provided by nurses or care workers in partnership with the Hospice Palliative Care Association of South Africa and paid from the frail care and private nursing limits as set out in Annexures B1, B2 and B3.

Oncology-related conditions are paid from the Advanced Illness Benefit (AIB) and members registered on the Oncology Management Programme have access to this comprehensive palliative care programme. This programme offers unlimited cover for approved care at home. The additional basket of services is only available once the member is authorised to be registered on the programme.

11.2.2 IV Infusions

The administration of IV antibiotics, iron treatment, enzymes, steroids, rehydration fluids and immunoglobulins if a member's condition is stable and hospital admission is not required is authorised and paid from the hospital benefit as set out in Annexures B1, B2 and B3.

11.2.3 Wound Care

Wound care for venous ulcers, diabetic foot ulcers, pressure sores and other moderate to severe wounds if a member's condition is stable and hospital admission is not required. This type of care is to be authorised and approved to be paid from the hospital benefit as set out in Annexures B1, B2 and B3.

11.2.4 Postnatal Care

This service offers home visits for healthy mothers, and their babies, if they choose to be discharged a day early from hospital. This service includes three day visits by a midwife, within a six-week postnatal period. It is paid from the hospital benefit as set out in Annexures B1, B2 and B3 if authorised and approved.

The provisions of paragraphs 10.3, 10.4 and 10.5 and Annexure D is applicable.

11.3 **Spinal Care**

The Spinal Care Programme offers a spinal surgery component for members needing spinal surgery, and a conservative care programme for those with

severe back pain, but where surgery can be prevented through out-of-hospital care.

If spinal surgery is the only option to manage the back pain, members can access a facility within the Remedi Spinal Care Surgery Network. Members are covered for conservative back pain management, which includes consultations with physiotherapists or chiropractors who specialise in the management of back pain and are part of the conservative care network.

11.4 Member Care Programme

This customised, outpatient programme helps members who have complex medical needs. The programme facilitates high-quality, planned, person-centred care and chronic condition management to achieve improved outcomes. Members that qualify for the programme are identified via a risk intelligence tool and the member care team. The team will contact members proactively to offer voluntary enrolment if they meet the clinical criteria.

STANDARD OPTION: BENEFITS 2022

(Members and their dependants are entitled to the following benefits, subject to the provisions of these Rules and in particular paragraph 10 of Annexure B and Annexure D concerning the provision of the statutory Prescribed Minimum Benefits, " PMB's",)

	BENEFIT	RATE	LIMITS	COMMENTS
1.	**Hospitalisation in private hospitals as well as surgery and medical procedures performed by private practitioners** REGISTERED BY ME ON Mashilo Leboho 2021/12/23 24/12/2021 11:16:13(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM		**Overall annual limit of:** Per family: R 625 000	Subject to management of clinical risk by Discovery Health as contracted and use of defined DSP network of hospitals. **All non-emergency admissions are subject to pre-authorisation.** Emergencies must be authorised within 24 hours of admission or first working day after such emergency treatment or admission. A co-payment of R1 000 for failing to pre-authorise will apply. Da Vinci Robotic Assisted Prostatectomy is funded up to a maximum of the cost of a standard Prostatectomy, as determined by the Board, where prostate cancer confirmed by means of a histology report, regardless whether the member is registered on the Oncology Management Programme. Limited up to R113 000.00 and limited to one procedure per beneficiary and must be pre-authorised.
	Hospital accommodation • Accommodation in a general ward, intensive care unit, high care unit, maternity ward, as well as theatre and recovery costs	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required**	Annexures B and D has reference. The Scheme may require that a member be transferred to a PMB Network Hospital if admitted into a non-DSP following an emergency admission.
	Surgery and medical procedures • Surgery and medical procedures, which generally, but not necessarily, require hospitalisation • Confinements and antenatal consultations • Theatre fees and anaesthetics • Treatment for renal dialysis	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required** No benefit for conservative dentistry under anaesthesia No benefit for maxillo-facial and oral surgery (excluding trauma-related surgery)	Benefits in respect of services for infertility, limited to the medical and surgical management of those procedures and interventions as defined under PMB Code 902M, subject to the provisions of Regulation 8(3) of the Medical Schemes Act, Act No 101 of 1998. Cosmetic surgery is a listed Scheme exclusion on Remedi

	BENEFIT	RATE	LIMITS	COMMENTS
	Hospital and surgical material/ equipment • As per agreed list	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required**	Limits set in terms of charging policy for listed items, which may be agreed with DSP and other providers. Benefit for medicines to take home (TTO`s), limited to 5 days.
	• Blood transfusions, blood products and transport of blood	100% of the Remedi Rate	Subject to overall annual limit	
	In-hospital visits • General practitioners and specialists' visits during pre-authorised hospitalisation	100% of the Remedi Rate	Subject to overall annual limit	For surgery, medical procedures and in-hospital visits/consultations Remedi will make payment in full directly to the DSP concerned. In such a case the Member will not be liable for any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures B and Annexure D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate
	Readmission Prevention Benefit • Homecare by a healthcare provider and/or qualified nurse for patients considered at high risk of readmission, when discharged from acute care	100% of the Remedi Rate	Subject to overall annual limit	Basket of care as approved by Remedi
2.	**Hospitalisation in public hospitals as well as surgery and medical procedures performed by *public sector practitioners***	100% of Cost	Limited to Overall annual limit, subject to sub-limit of R 260 000 per family (M+) for treatment in public facilities. **For involuntary admissions to Hospitals outside of the PMB Hospital Network, no limits on Prescribed Minimum Benefits (PMB`s), as set out in the Medical Schemes Act;**	Subject to the management of clinical risk by Discovery Health as contracted. All non-emergency admissions are subject to pre-authorisation. Emergencies must be authorised within 24 hours of admission or on the first working day after such emergency treatment or admission.
	Hospital accommodation • Accommodation in a general ward, intensive care unit, high care unit, maternity ward, as well as theatre and recovery costs	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required**	Benefits in respect of services for infertility, limited to the medical and surgical management of those procedures and interventions as defined under PMB Code 902M, subject to the provisions of Regulation 8(3) of the Medical Schemes Act, Act No 101 of 1998.

	BENEFIT	RATE	LIMITS	COMMENTS
	Surgery and medical procedures • Surgery and medical procedures, which generally, but not necessarily, require hospitalisation • Confinements and antenatal consultations • Theatre fees and anaesthetics • Treatment for renal dialysis	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required** • No benefit for conservative dentistry under anaesthesia • No benefit for maxillo-facial and oral surgery (excluding trauma-related surgery)	Cosmetic surgery is a listed Scheme exclusion on Remedi 
	Hospital and surgical material/equipment • As per agreed list	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required**	
	• Blood transfusions, blood products and transport of blood	100% of Cost	Subject to overall annual limit	Benefit for medicines to take home (TTO`s), limited to 5 days.
	In-hospital visits • General practitioners and specialists' visits during pre-authorised hospitalization	100% of Cost	Subject to overall annual limit	
3.	**Medicines** Acute and Chronic Medicine	100% of the cost on approved drug list (DSP medicine formulary)/Medicine Rate/Therapeutic Reference Price ("TRP")	Unlimited, subject to: Fixed drug list/formulary/TRP – unlimited via DSP contracted network of providers, subject to paragraph 10 of Annexures B and Annexure D. A co-payment at non-DSP of 20% is applicable. Oral contraceptives are limited to a monthly limit of R165.00 per female beneficiary per month payable and subject to the overall annual limit. A co-payment of 20% is applicable if a member obtains oral contraceptives from a non-DSP pharmacy. Over-the-counter (OTC) medicine are limited to R165.00 per script and R335.00 per annum and subject to the overall annual limit. One influenza vaccine per beneficiary per year payable and subject to the OTC limit, where a member consult with a network provider.	Benefits for chronic medication relating to the treatment of PMB CDL and DTP conditions, shall be subject to pre-authorisation and paid in accordance with the treatment protocols, relating to the diagnosis, medical management and treatment for such conditions, including clinical entry criteria, in accordance with the Chronic Disease Programme managed by Discovery Health or the HIV/AIDS Programme, or the managed health care providers appointed by Remedi. Benefit for very expensive chronic medicines which have been "carved out" and not on fixed drug list / formulary are subject to approval of the Remedi Medical Advisory Committee. Influenza vaccines for high risk members and members > 65 years and/or members who are pregnant are funded from the Prevention and Screening Benefit. Clinical entry criteria is applicable.

	BENEFIT	RATE	LIMITS	COMMENTS
4.	**Extended physiotherapy, occupational therapy, speech therapy and biokinetics Maintenance therapy (In and Out of Hospital)** • Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a maintenance or conservative nature, based on an **approved and preauthorised treatment plan, typically preceded by a rehabilitation programme and/or arising from a congenital defect of a mental or physical nature.**	100% of the Remedi Rate	Subject to Overall Annual Limit with a sub-limit: R4 130 per family per annum. **Pre-authorisation required**	This specifically excludes treatment of an acute/minor injury as determined by Remedi's Medical Advisory Committee.
	Rehabilitation therapy post hospitalisation • Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a rehabilitative nature that is preceded by hospitalisation; such treatment must be connected to an approved rehabilitative treatment plan and **must commence within two weeks of discharge from hospital.**	100% of the Remedi Rate	Subject to Overall Annual Limit with a sub-limit: R4 130 per family per annum **Pre-authorisation required**	REGISTERED BY ME ON Mashilo Lebohо 2021/12/23 24/12/2021 11:16:34(UTC+02:00) Signed by Mashilo Lebohо, m.lebohо@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM
5.	**Trauma recovery extender benefit** Covering out of hospital treatment following a traumatic incident resulting in • paraplegia, quadriplegia, tetraplegia and hemiplegia • conditions resulting from near drowning, severe anaphylactic reaction, poisoning and crime related injuries; • severe burns; • certain external and internal head injuries and loss of limb, or part thereof.	100% of the Remedi Rate	**Pre-authorisation required** Subject to the overall annual limit **and the following sub-limits** Loss of limb per family — R89 000 Private nursing — R11 200 Prescribed medication : M — R14 300 M + 1 — R16 900 M + 2 — R20 100 M + 3 or more — R24 300 External medical items — R34 000 Hearing Aids — R16 100 Mental health benefit — R20 200	For PMB conditions, mental health treatment to be obtained from a service provider contracted to the Scheme's Mental Health Network.
6.	**Out-of-hospital benefit for** • general practitioners; • dentistry; • pathology and radiology (excluding MRI and CT scans) benefits • Vacuum Assisted Breast Biopsy (VABB)	100% of the Remedi Rate	Out-of-hospital benefit unlimited via the DSP contracted network of practitioners • general practitioner consultations, including small procedures;	Excludes dentures and special dentistry. Point-of-care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria.

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BENEFIT	RATE	LIMITS	COMMENTS
		• basic dentistry, viz. consultations, extractions and fillings, including resin fillings up to level 3, i.e. 3 surface fillings per tooth; • basic x-rays, namely black and white x-rays of chest, abdomen, pelvis and limbs; • pathology tests as limited by agreement, including point-of-care testing as authorised; • VABB per beneficiary limited to two procedures per year at negotiated fees	REGISTERED BY ME ON Mashilo Leboho 24/12/2021 41:16:42(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM
• World Health Organisation (WHO) Global Outbreak Benefit for out-of-hospital management and appropriate supportive treatment of global WHO recognized disease outbreaks: Out-of-hospital healthcare services related to COVID-19 includes: - Screening consultation with a nurse or a GP; - Defined basket of pathology; - Defined basket of x-rays and scans; - Consultations with a nurse or GP; - Supportive treatment; - Vaccines and the administration of the vaccines; - Home-based care in lieu of hospitalisation - Treatment of complications and rehabilitation for Long Covid.	Save for Prescribed Minimum Benefits (PMB), up to a maximum of 100% of the Remedi Rate	Funded out of a dedicated basket of care as set by the Scheme related to COVID-19 and limited to: - Unlimited screening consultations with a nurse or GP; - Defined basket of pathology up to 3 tests per person per year, except where cover is PMB; - Unlimited home-based care in lieu of hospitalisation	Subject to the Scheme's preferred provider, protocols and the condition and treatment meeting the Scheme's clinical entry criteria and guidelines. Cover for testing is subject to referral. Long Covid activation of the benefit and basket of care provided by the Scheme for a period of 6 months from the date of diagnosis by the treating healthcare provider.
• medical specialists and emergency treatment	100% of the Remedi Rate or 100% of cost at the Designated Service Provider (DSP)	Unless PMB, subject to Overall Annual limit with a sub-limit for specialists working at a DSP or Preferred Provider network of hospitals and emergency treatment: Per Principal Member: R2 740 Per Adult dependent: R1 730 Per Child dependent: R 550 up to a maximum of 3 children All benefits will be limited to the above sub-limit after which the cost related to the diagnosis and medical management of a PMB chronic condition, including HIV/AIDS, will be unlimited. Access to the PMB Benefit is subject to referral by contracted DSP to a specialist operating within the DSP or Preferred Provider network of	Including consultation for insertion of Mirena contraceptive device in gynaecologist's rooms, provided pre-approval obtained and subject to Scheme clinical protocols and guidelines. Excluding clinical psychologist and social workers. Remedi will make payment in full to a DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read

	BENEFIT	RATE	LIMITS	COMMENTS
			hospitals, subject to rules 10.3, 10.4 and 10.5 of Annexures B and D. Members diagnosed with HIV/AIDS are encouraged to register on the HIV/AIDS Management Programme and all benefits relating to the diagnosis, medical management and treatment of HIV/AIDS will, following diagnosis by the DSP contracted preferred provider, be payable in line with defined protocols/"baskets of care", subject to the provisions of 10.3 – 10.6 of Annexures B and D to the Rules.	with 10.3 and/or 10.5 of Annexures B and D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited of maximum 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.
7.	**Maternity** • Pregnancy Scans, pregnancy related tests and antenatal consults • Limited consultations, pregnancy scans and a specified range of pathology tests Limited pregnancy scans antenatal consultations and a specified range of pathology tests	100% of Remedi Rate.	Subject to Overall Annual Limit and the requirements prescribed for PMBs the maternity benefit/basket of care includes: - 2 x 2D pregnancy scans; - Limited to 9 consultations at a Network GP, Midwife or Gynaecologist; - 9 x urine dipstick tests; - 1 x Nuchal Translucency (NT) and/or Non-Invasive Prenatal Test (NIPT) and T21 screening per pregnancy	Managed by Discovery Health the Scheme provides benefits in the GP setting or the member's chosen Sonographer, and through the standard Pathology benefits allowed in terms of the negotiated contractual agreements. Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. NT and/or NIPT and T21 screening (Down Syndrome Screening Tests) to be made available in addition to available ultrasound scans. Clinical entry criteria will be applicable. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures B and Annexure D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.
8.	**Specialised dentistry** Inlays, crown and bridgework, study models, dentures and the repair thereof, orthodontics, periodontics, prosthodontics and osseo-integrated implants		Nil Benefit	

	BENEFIT	RATE	LIMITS	COMMENTS
9.	**Optical** • Eye tests • Spectacles Frames and/or lens enhancements • Refractive eye surgery and Corneal Cross Linking	100% of cost at Preferred Provider Optometrist	A composite consultation inclusive of refraction, a glaucoma screening, visual field screening and Artificial intelligence for the detection of diabetic retinopathy at Preferred Provider every 24 months is paid at 100% of cost per beneficiary. One pair of Clear single lenses up to R210 per beneficiary or one pair of Clear bifocal lenses up to R445 per beneficiary every two years (Clear multifocal lenses covered up to the cost of bifocal lenses) or contact lenses in lieu of spectacles up to the value of R595 may be provided at Preferred Providers only. Standard frame and/or lens enhancements up to R315 per beneficiary every two years at Preferred Providers only. Nil Benefit	Benefit available via DSP contracted Optometrist Network only.
10.	**Oncology** Consultations, visits, treatment, medication and materials used in radiotherapy and chemotherapy, including PET-CT scans if pre-authorised	100% of the Remedi Rate up to R235 000 per beneficiary and thereafter funded at 80% of Remedi Rate. PMB treatment is funded at 100% of Cost/Remedi Rate.	Subject to overall annual limit and an Overall Oncology annual limit of R235 000 per beneficiary and family limit per annum over a 12 month rolling period from date of diagnosis. Benefit subject to the prescribed requirements for PMB`s.	Subject to pre-authorisation, an approved all-inclusive treatment plan and to the hospital risk management programme, where applicable. A co-payment of R3 350 is payable for PET-CT scans if not pre-authorised and services are not obtained at a designated service provider. Sub-limit may be increased, subject to approval of the Scheme`s Medical Advisory Committee, where non-PMB level of care and will be increased automatically where PMB level of care and clinically appropriate. To read Annexure D in conjunction with this Rule.
11.	**Frail care and private nursing** **Hospicare**	100% of the Remedi Rate 100% of Cost	Unless PMB, subject to overall annual limit with a sub-limit of R14 400 per family. **Pre-authorisation required.**	Subject to the hospital risk management programme, prior approval of the Scheme and only available as an alternative to hospitalisation in a registered / approved / accredited facility. Sub-limit may be increased, subject to approval of the Scheme`s Medical Advisory Committee.

	BENEFIT	RATE	LIMITS	COMMENTS
				Where pre-authorisation is not obtained, no benefits will apply **Advanced Illness Benefit (AIB) available upon application and pre-approval where clinically appropriate**
	Sub-Acute facilities	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation required.**	
12.	**Radiology and pathology** • Radiology: In hospital • Pathology: In hospital • MRI and CT scans in hospital	100% of the Remedi Rate	Subject to overall annual limit and **benefit confirmation to be obtained for MRI and CT scans.** REGISTERED BY ME ON Mashilo Leboho 24/12/2021 02:17:24 (UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM	Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures B and Annexure D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate
13.	**Prevention and Screening Benefit** Including blood glucose, blood pressure, cholesterol and body mass index screening tests, HIV, mammogram, pap smear, prostate specific antigen (PSA) test and influenza vaccine for identified high risk members, members who are pregnant and members above the age of 65.. Pneumococcal vaccine for identified high risk members. Preventative dentistry is provided through the contracted DSP.	100% of the Remedi Rate	Subject to overall annual limit.	Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures B and Annexure D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.

	BENEFIT	RATE	LIMITS	COMMENTS
	Human Papillomavirus (HPV) vaccine for males between the ages of 11 and 21 and females between the ages of 11 and 26 years. HPV screening tests are limited to 1 x every 5 years if the member is HIV negative and one test every 3 years if the members is HIV positive. These tests are an alternative to pap smears. One LDL cholesterol screening is available per high risk beneficiary where clinically indicated at network pharmacy. HbA1c is funded from the Insured Out of Hospital benefit, where clinically appropriate. A group of age appropriate screening tests and additional screening assessments for members 65 years and older. (Senior Screening Tests)-. Colorectal screening limited to one fecal occult blood test or immunochemical test every 2 years per person for persons between the ages of 45 to 75 years. One colonoscopy where clinically appropriate.			If the member has more than 1 HPV screening test before the 5 years' period expires, if HIV negative (or before the 3 years' period expires where the member is HIV positive) then: • the second and sub-sequent claims during that period will be paid from the member's insured out-of-hospital specialist benefit, if benefits are available and where the result of the screening test is abnormal or after treatment the follow-up tests will be funded yearly until normal. If the member has more than 1 HPV screening tests during the year after an abnormal HPV test result, the second and sub-sequent claims during that year will be paid from the member's insured out-of-hospital specialist benefit, if benefits are available for the member's account.
14.	**Internal Prostheses and Devices**	100% of the Remedi Rate	Subject to the Overall Annual Limit with the following sub-limits: Total hip replacement: R39 300*** Revision hip: R46 500*** Knee replacement: R30 900*** Revision knee replacement: R39 300*** Total shoulder replacement: R36 200 Spinal benefit (one procedure per year): ** first level: ** two or more levels Bare metal cardiac stents max. 3 p.a. (each): ** Drug eluting cardiac stents (each) max. 3 p.a.: **	**Subject to pre-authorisation** and clinical protocols the prescribed requirements for PMB`s. Spinal benefit limit: • applies to the prosthetic device only • PER LEVEL LIMIT (artificial disc replacement, interspinous process devices & spinal fusion) • Funding at network or non-network providers up to 100% of the Remedi Rate

	BENEFIT	RATE	LIMITS	COMMENTS
			Pacemaker with Leads: R65 500 Pacemaker Biventricular: R84 200 Cardiac valves (each): R42 600 Artificial limbs (below knee): R25 600 Artificial Limbs (above knee): R46 600 Artificial eyes(prosthesis plus apparatus): R24 000 All other internal prostheses and devices: * R20 500	*Sub-limit may be increased, subject to approval of the Scheme`s Medical Advisory Committee and where applicable the Scheme's Executive Committee. Funding of temporary and permanent Sacral nerve stimulators is specifically excluded. ** Negotiated reference price list is applicable. *** Hip and Knee Arthroplasty Procedures: The Scheme is contracted with Mediclinic as Designated Service Provider ("DSP") for these procedures. A R2 500.00 co-payment for voluntary non-DSP use will apply. The aforementioned co-payment will be waived for members who reside outside a thirty (30) kilometre radius from a Mediclinic hospital.
15.	**External Prostheses and Appliances. (including the External components of external prosthesis, incontinence products, etc)**	100% of the Remedi Rate	Subject to Overall Annual Limit with the following sub-limits: Colostomy equipment: R14 300 per beneficiary per annum Hearing aids: R18 400 per beneficiary per annum Wheelchairs: R12 650 per beneficiary per annum Oxygen appliances (includes oxygen): R2 075 per beneficiary per month All other appliances: R3 400 per beneficiary per annum	Colostomy equipment can be obtained via Cancer Society. Oxygen benefit subject to registration for the use of oxygen on the Chronic Illness Benefit Programme managed by Discovery Health as contracted. Funding of Mirena contraceptive device payable from all other appliances, subject to pre-approval in line with Scheme clinical protocols and guidelines and provided inserted in gynaecologists' rooms. CPAP devices funded from the "all other appliances" limit as available, where deemed clinically appropriate and limited to the agreed/negotiated rates with preferred providers. Point-of-care devices for point-of-care testing are funded from the "all other appliances" limit as available, where deemed clinically appropriate.

	BENEFIT	RATE	LIMITS	COMMENTS
16.	**Paramedical services** Ambulance	100% of the Remedi Rate	Subject to utilisation of preferred provider, viz. ER24 Emergency Response Service.	Transfers for same event subject to medical justification. **Pre-authorisation required with preferred provider**. If emergency transportation is obtained by service provider other than preferred provider the latter provider must be notified within 24 hours.
17.	**Psychiatric benefit In hospital and in lieu of hospitalisation** (including the treatment of alcoholism and drug dependency) REGISTERED BY ME ON Mashilo Leboho 24/12/2021 11:17:27 (UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM	100% of the Remedi Rate	Subject to overall annual limit, limited to 21 days per annum in hospital or 15 days in an out-of-hospital setting or a combination of in- and out-of-hospital as prescribed in terms of Prescribed Minimum Benefits.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted and the prescribed requirements for PMB`s and use of defined DSPs. Benefits may be granted for out-of-hospital consultations and/or treatment in lieu of hospitalisation. Services and treatment for PMB conditions to be obtained from a DSP (Mental Health Network provider) contracted with the Scheme and funding per Annexure D will be applicable. Benefit may be increased, subject to approval of the Remedi's Medical Advisory Committee.
18.	**Out-of-area benefit (OOA)** (when away from normal residence or nominated DSP contracted network service provider is unavailable after hours)	100% of the Remedi Rate	Limited to 3 visits per family (M+) to a maximum of R1 850 per family per annum.	For after-hours (Mon – Fri 08:00 to 17:00 and Sat 09:00 to 12:00) emergencies when nominated practitioner is not available and/or member is away from normal residence. If no DSP contracted service provider is available member may access Non-DSP Provider. No formulary is applied; payment is based on the Rand value and number of OOA visits per annum. Benefit managed by Discovery Health.
19.	**Organ Transplants** (Including harvesting of organs, consultations/visits and post-operative anti-rejection medicines required by recipient)	PMB will be paid at 100% of Cost. Non-PMB is paid at 100% of the Remedi Rate	PMB unlimited at the DSP. Non-PMB will be subject to the Overall Annual Limit.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted. Provisions of Annexures B and D is applicable.
20.	**Renal Failure & Dialysis** (Including all services and materials associated with the cost of acute and chronic renal dialysis including consultations/visits and medicines)	100% of the Remedi Rate	Subject to Overall Annual Limit and the prescribed requirements for PMB`s.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted. Provisions of Annexures B and D is applicable.

	BENEFIT	RATE	LIMITS	COMMENTS
21.	**Other Health Care Services** Chinese medicine & acupuncture, therapeutic aromatherapy, audiology, ayurvedics, chiropody/podiatry, chiropractics (including x-rays), dietetics, homeopathy, iridology, naturopathy, orthoptics, osteopathy, therapeutic reflexology, therapeutic massage therapy, phytotherapy and traditional healing.		Nil Benefit	

GLOSSARY / EXPLANATORY NOTES:

CDL	Chronic Disease List
DSP	A Designated Service Provider for the Prescribed Minimum Benefits - "PMBs" - selected by Remedi, being the contracted private hospitals, the KeyCare specialist network, Dental Risk Company (DRC) and Preferred Provider Negotiators (PPN) and the following providers for alcohol and drug dependency – The South African National Council on Alcohol and Drug Dependence (SANCA), SANCA's nominated providers and the Ramot Centre for Alcohol and Drug Dependency, as well as any other providers selected by Remedi from time to time.
Direct Payment Arrangements "DPAs"	Are the specialist arrangements concluded between Discovery Health and specialist providers who agree to charge at or below a set rate for consultations and procedures and by reason thereof have also agreed that such rates shall be applicable to Remedi.
GP Network	The network of General Practitioners contracted to and through Discovery Health to provide relevant health care services to Remedi at the Remedi Rate
CDA	Chronic Drug Amount (CDA) is an amount of money that has been allocated to each medicine category each month for a specific condition.
M	Member without dependants
M+	Member plus dependants
Pb/pa	per beneficiary per annum
Pf/pa	per family per annum
PMB/PMB`s	the Prescribed Minimum Benefit(s)
Pre-authorisation	the approval which has been given by the Scheme, or the Scheme`s contracted Managed Healthcare provider for relevant health services, as defined in the Act, to be provided to a beneficiary, in accordance with the protocols/treatment guidelines, accepted or determined by the Scheme.
Preferred Provider	a health care provider or group providers selected by the Scheme to provide diagnosis, treatment and care in respect of PMB or non-PMB conditions. For Chronic medicine any pharmacy charging not more than the SEP and the dispensing fee equal to that charged by the DSPs.
SAOA	South African Optometric Association
Remedi Rate	is the tariff fee / rate for the payment of relevant health services equal to the Discovery Health Rate / DH rate, as prescribed in the Guide to the Discovery Health Rate, or, the fee / rate as determined by Board of Trustees in terms of any agreement between Remedi and any service provider or group of service providers
SEP	Single Exit Price
PMB Hospital Network	A Mediclinic hospital contracted to or nominated by the Scheme established for the provision of services that relates to Prescribed Minimum Benefit (PMB) conditions. See also DSP.
Mental Health Network	A defined list of Psychologists and/or Social Workers contracted or nominated by the Scheme for purposes of providing treatment to members relating to mental health conditions. See also DSP
In-Hospital GP Network	A defined list of GP and specialist authorised by the Scheme to provide in-hospital services to members as part of the Scheme's Premier Practice, Remedi Standard GP Network and Classic DPA Specialist Networks.
Therapeutic Reference Price ("TRP")	A reference price model applicable to all fixed NAPPI formularies, such as the Chronic Disease List ("CDL"), Out of Hospital Diagnostic Treatment Pairs Prescribed Minimum Benefits ("OHDTPMB"), HIV and Oncology medicines, ensuring reimbursement of non-formulary products that link to the formulary drug classes on a generic and therapeutic level.

COMPREHENSIVE OPTION: BENEFITS 2022

(Members and their dependants are entitled to the following benefits, subject to the provisions of these Rules and in particular paragraph 10 of Annexure B and Annexure D concerning the provision of the statutory Prescribed Minimum Benefits, " PMB's")

	BENEFIT	RATE	LIMITS	COMMENT
1.	**Hospitalisation in private hospitals as well as surgery and medical procedures performed by private practitioners.**		**Unlimited Overall annual limit (OAL)** per family per annum 	Subject to the management of clinical risk by Discovery Health as contracted and use of defined DSP network of hospitals. **All non-emergency admissions are subject to pre-authorisation.** Emergencies must be authorised within 24 hours of admission or first working day after an emergency treatment or admission. A co-payment of R1 000 for failing to pre-authorise will apply. Da Vinci Robotic Assisted Prostatectomy is funded at 100% of the Remedi Rate or negotiated hospital rate where prostate cancer confirmed by means of a histology report, regardless whether the member are registered on the Oncology Management Programme. Limited to one procedure per beneficiary and must be pre-authorised.
	Hospital accommodation • Accommodation in a general ward, intensive care unit, high care unit, maternity ward, as well as theatre and recovery costs	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required**	Annexures B and D has reference. The Scheme may require that a member be transferred to a PMB Network Hospital if admitted into a non-DSP following an emergency admission.
	Surgery and medical procedures • Surgery and medical procedures, which generally, but not necessarily, require hospitalisation • Confinements • Conservative dentistry under anaesthesia in patients not older than 7 years	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required** Anaesthetics and hospitalisation subject to overall annual limit. **Note: dentist accounts are payable from available Insured Out-of-Hospital benefit**	Benefits in respect of services for infertility, limited to the medical and surgical management of those procedures and interventions as defined under PMB Code 902M, subject to Regulation 8(3) of the Medical Schemes Act, Act No 131 of 1998. Cosmetic surgery is a listed exclusion on Remedi.

	BENEFIT	RATE	LIMITS	COMMENT
	Hospital and surgical material/ equipment as per agreed list	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required**	Limits set in terms of charging policy for listed items, which may be agreed with DSP and other Providers Benefit for medicines to take home (TTO`s), limited to 5 days.
	Blood transfusions, blood products and transport of blood	100% of the Remedi Rate	Subject to overall annual limit	
	In-hospital visits • General practitioners and specialists' visits during pre-authorised hospitalisation	100% of the Remedi Rate	Subject to overall annual limit	For surgery, medical procedures and in-hospital visits/consultations Remedi will make payment in full directly to the DSP concerned. In such a case the Member will not be liable for any co-payment to be made to such DSP If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures B and D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 150% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.
	Readmission Prevention Benefit • Homecare by a healthcare provider and/or qualified nurse for patients considered at high risk of readmission, when discharged from acute care	100% of the Remedi Rate	Subject to overall annual limit	Basket of care as approved by Remedi
2.	**Hospitalisation in public hospitals as well as surgery and medical procedures performed by *public sector practitioners***	100% of Cost	Limited to Overall annual limit, subject to sub-limit of R 565 000 per family (M+) for treatment in public facilities. **For involuntary admissions to Hospitals outside of the PMB Hospital Network, no limits on Prescribed Minimum Benefits (PMB`s), as set out in the Medical Schemes Act;**	Subject to the management of clinical risk by Discovery Health as contracted. All non-emergency admissions **are subject to pre-authorisation.** Emergencies must be authorised within 24 hours of admission or on the first working day after such emergency treatment or admission. A co-payment of R1 000 for failing to pre-authorise will apply.

	BENEFIT	RATE	LIMITS	COMMENT
	Hospital accommodation • Accommodation in a general ward, intensive care unit, high care unit, maternity ward, as well as theatre and recovery costs	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required**	
	Surgery and medical procedures • Surgery and medical procedures, which generally, but not necessarily, require hospitalisation • Confinements and antenatal consultations • Theatre fees and anaesthetics • Conservative dentistry under anaesthesia in patients not older than 7 years	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required** Anaesthetics and hospitalisation subject to overall annual limit. Note: dentist accounts are payable from available Insured Out-of-hospital benefit	Benefits in respect of services for infertility, limited to the medical and surgical management of those procedures and interventions as defined under PMB Code 902M, subject to Regulation 8(3) of the Medical Schemes Act, Act No 131 of 1998. Cosmetic surgery is a listed exclusion on Remedi.
	Hospital and surgical material/equipment • As per agreed list	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required**	Benefit for medicines to take home (TTO`s), limited to 5 days.
	Blood transfusions, blood products and transport of blood	100% of Cost	Subject to overall annual limit	
	In-hospital visits • General practitioner and specialist visits during pre-authorised hospitalisation	100% of Cost	Subject to overall annual limit	
3.	**Chronic medication** PMB Conditions	100% of Single Exit Price " SEP" plus a dispensing fee as agreed to with the defined DSP	Unlimited benefit, and further subject to a fixed drug list (formulary) Non-formulary drugs are funded up to the Chronic Drug Amount (CDA) for a registered drug class.	Benefits for the diagnosis, medical management and treatment of PMB CDL and DTP conditions – which shall not be less than those for the regulated Prescribed Minimum Benefits – shall subject to pre-authorisation be paid in accordance with the treatment protocols including clinical entry criteria and authorized "baskets of care" governing the Chronic Illness Benefit Programme and/or HIV/AIDS Programme, managed by Discovery Health as contracted, the managed health care provider appointed by Remedi.

REGISTERED BY ME ON
Mashilo Leboho 2021/12/23
24/12/2021 11:17:56(UTC+02:00)
Signed by Mashilo Leboho,
m.leboho@medicalschemes.co.za
REGISTRAR OF MEDICAL SCHEMES
SIGNIFLOW.COM

	BENEFIT	RATE	LIMITS	COMMENT
	Non-PMB Conditions REGISTERED BY ME ON Mashilo Leboho 2021/12/23 24/12/2021 11:18:04(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNFLOW.COM	100% of Single Exit Price " SEP" plus a dispensing fee as agreed to with the defined DSP	Subject to Overall Annual Limit a maximum of R2 185 per month per registered beneficiary, based on individual needs.	Subject to registration on the Chronic Illness Benefit Programme managed by Discovery Health as the Managed Health Care Provider appointed by Remedi. Where chronic medication is obtained from a pharmacy other than a DSP a co-payment for any difference in dispensing fees and/or any related fees will be payable by the member directly to the pharmacy. Any such co-payment will not be refunded to the Member via any credit of the Member`s Personal Medical Savings Account.
4.	**Extended physiotherapy, occupational therapy, speech therapy and biokinetics** **Maintenance therapy (In and Out of hospital)** • Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a maintenance or conservative nature, based on an **approved and pre-authorised treatment plan typically preceded by a rehabilitation programme and/or arising from a congenital defect of a mental or physical nature.**	100% of the Remedi Rate	**Pre-authorisation required** Subject to Overall Annual Limit with sub-limit: R14 610 per family (M+) per annum	This specifically excludes treatment of an acute (minor) injury as determined by Remedi's Medical Advisory Committee.
	Rehabilitation therapy post hospitalisation • Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a rehabilitative nature that is preceded by hospitalisation; such treatment must be connected to an approved rehabilitative treatment plan and must commence within two weeks of discharge from hospital	100% of the Remedi Rate	**Pre-authorisation required** Subject to overall annual limit	

<table>
<tr><th></th><th>BENEFIT</th><th>RATE</th><th>LIMITS</th><th>COMMENT</th></tr>
<tr>
<td>5.</td>
<td>Trauma recovery extender benefit
Covering out of hospital treatment following a traumatic incident resulting in
• paraplegia, quadriplegia, tetraplegia and hemiplegia
• conditions resulting from near drowning, severe anaphylactic reaction, poisoning and crime related injuries;
• severe burns;
• certain external and internal head injuries and loss of limb, or part thereof.</td>
<td>100% of the Remedi Rate</td>
<td>Pre-authorisation required.
Subject to the overall annual limit and the following sub-limits.
<table>
<tr><td colspan="2">Loss of limb per family</td><td>R89 000</td></tr>
<tr><td colspan="2">Private nursing</td><td>R11 200</td></tr>
<tr><td>Prescribed medication :</td><td>M</td><td>R31 000</td></tr>
<tr><td></td><td>M + 1</td><td>R36 300</td></tr>
<tr><td></td><td>M + 2</td><td>R42 300</td></tr>
<tr><td></td><td>M + 3 or more</td><td>R48 100</td></tr>
<tr><td colspan="2">External medical items</td><td>R76 250</td></tr>
<tr><td colspan="2">Hearing Aids</td><td>R27 900</td></tr>
<tr><td colspan="2">Mental health benefit</td><td>R27 100</td></tr>
</table></td>
<td>For PMB conditions, mental health treatment to be obtained from a service provider contracted to the Scheme’s Mental Health Network.

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Mashilo Leboho 2021/12/23
24/12/2021 11:18:12(UTC+02:00)
Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za
REGISTRAR OF MEDICAL SCHEMES
SIGNIFLOW.COM</td>
</tr>
<tr>
<td>6.</td>
<td>Insured Out-of-Hospital (“IOH”) benefit for:
Consultations, procedures, radiology (excluding MRI and CT scans) and pathology outside hospital, point-of-care testing as authorised, including in the outpatient department of a hospital and inclusive of the facility fee for outpatients</td>
<td>100% of the Remedi Rate or
100% of cost at the Designated Service Provider (DSP) /Medicine Rate</td>
<td>Subject to Overall Annual Limit and the following sub-limits:
Per Principal Member: R9 380
Per Adult Dependent:: R5 540
Per Child Dependent: R1 560 (up to a maximum of 3 children)</td>
<td>Where the sub-limit is exceeded, benefits for non-PMB conditions will be paid from the Personal Medical Savings Account.
Special and advanced dentistry is specifically excluded

Including consultation for insertion of Mirena contraceptive device in gynaecologist’s rooms, provided pre-approval obtained and subject to Scheme clinical protocols and guidelines.

All other oral contraceptives are funded up to a monthly limit of R165.00 per female beneficiary per month at 100% of the Remedi Medicine Rate if obtained from a DSP pharmacy and paid from Overall Annual Limit (OAL). A co-payment of 20% is applicable if a member obtains oral contraceptives from a non-DSP pharmacy. Once, the monthly limit of R165.00 is reached, costs related to oral contraceptives are covered from the Personal Medical Savings Account (“PMSA”)

For members who are not high risk and who are < 65 years or who are not pregnant, one influenza vaccine per beneficiary per year is payable from the IOH limit. Influenza vaccines for high risk members and members > 65 years and/or members who are pregnant are funded from the Prevention and Screening Benefit. Clinical entry criteria are applicable.</td>
</tr>
</table>

	BENEFIT	RATE	LIMITS	COMMENT
				Point-of-care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria.
	• Specialists; • General Practitioners; • Acute and self-medication • Dentistry; • Physiotherapists; • Biokineticists; • Occupational Therapists; • Speech Therapists • Audiologists And Audiometrists • Clinical Psychologists; • Social Workers; • Pathology and radiology (excluding MRI and CT scans) benefits • Vacuum Assisted Breast Biopsy (VABB)		Costs relating to the diagnosis and treatment of Prescribed Minimum Benefit Chronic Disease List, "CDL" and Diagnosis and Treatment Pair, "DTP" conditions including HIV/AIDS, will be payable from risk subject to the conditions set out alongside. VABB per beneficiary is limited to two procedures per year at negotiated fees. REGISTERED BY ME ON Mashilo Leboho 2021/12/23 24/12/2021 11:18:21(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM	. Self-medication applies to medicines classified as Schedules 0, 1 and 2, which can be purchased over the counter without a doctor's prescription. Members will receive benefit in accordance with authorized "baskets of care" regarding the diagnosis, medical management and treatment of such PMB CDL and DTP related chronic diseases. If not registered then benefits will be subject to the conditions set out in 10.3, 10.4 and 10.5 of Annexures B and D to the Rules. Services and treatment for PMB conditions to be obtained from a DSP (Mental Health Network provider) contracted with the Scheme and funding per Annexure D will be applicable. Remedi will make payment in full to a DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures B and D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.

	BENEFIT	RATE	LIMITS	COMMENT
	World Health Organisation (WHO) Global Outbreak Benefit for out-of-hospital management and appropriate supportive treatment of global World Health Organisation (WHO) recognised disease outbreaks: • Out-of-hospital healthcare services related to COVID-19 includes: - Screening consultation with a nurse or a GP; - Defined basket of pathology; - Defined basket of x-rays and scans; - Consultations with a nurse or GP; - Supportive treatment; - Vaccines and the administration of the vaccines; - Home-based care in lieu of hospitalisation - Treatment of complications and rehabilitation for Long Covid.	Save for Prescribed Minimum Benefits (PMB) up to a maximum of 100% of the Remedi Rate	Funded out of a dedicated basket of care as set by the Scheme related to COVID-19 and limited to: - Unlimited screening consultations with a nurse or GP; - Defined basket of pathology up to 3 tests per person per year, except where cover is PMB; - Unlimited home-based care in lieu of hospitalisation REGISTERED BY ME ON Mashilo Leboho 24/12/2021 11:18:29 (UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM	Subject to the Scheme's preferred provider, protocols and the condition and treatment meeting the Scheme's clinical entry criteria and guidelines. Cover for testing is subject to referral. Long Covid activation of the benefit and basket of care provided by the Scheme for a period of 6 months from the date of diagnosis by the treating healthcare provider.
7.	**GP Benefit** • Limited GP consultations funded from major risk benefit once both Insured Out-of-hospital benefit and annual allocated PMSA for the year are exhausted	Payment in full to DSP provider (Network GP)	Limited to the following number of consultations: M0: 3 additional GP consultations M+: 6 additional GP consultations	Additional consultations will only be funded for services provided by a practitioner in the GP Network.
8.	**Maternity** Limited pregnancy scans antenatal consultations and a specified range of pathology tests	100% of the Remedi Rate	Subject to Overall Annual Limit and the requirements prescribed for PMBs the maternity benefit/basket of care includes: - 2 x 2D pregnancy scans; - 9 GP consultations at a Network GP, Midwife or Gynaecologist; - 9 x urine dipstick tests; - 2 x glucose strip tests; - HIV Elisa, Rubella, RPR and TPHA and bHCG tests as deemed clinically appropriate; - RH antigen, Haemoglobin, A B and O antigens as deemed clinically appropriate;	The benefit allows for a defined range of services including the first two 2D ultrasound scans in gynecologists' rooms. Medical motivation is required for additional scans. NT and/or NIPT and T21 screening (Down Syndrome Screening Tests) to be made available in addition to available ultrasound scans. Clinical entry criteria will be applicable.

	BENEFIT	RATE	LIMITS	COMMENT
			- 1 x Nuchal Translucency (NT) and/or Non-Invasive Prenatal Test (NIPT) and T21 screening per pregnancy	
9.	**Specialised dentistry** Inlays, crown and bridgework, study models, dentures and the repair thereof, orthagnathic surgery, orthodontics, periodontics, prosthodontics and osseo-integrated implants	100% of the Remedi Rate	Subject to Overall Annual Limit with sub-limits of: R21 950 per beneficiary and R44 000 per family	
10.	**Optical** ***Preferred Provider Optometrist***	100% of cost at Preferred Provider Optometrist	Subject to the requirements prescribed for PMB`s and the Overall Annual Limit with the following limits: 1. Annual benefit cycle 2. Beneficiary limited to R3 595 subject to overall family limit of R7 190 3. The following sub-limits will apply within the overall beneficiary/family limit: *Consultations* A composite consultation inclusive of refraction, a glaucoma screening, visual field screening and Artificial Intelligence for the detection of diabetic retinopathy at Preferred Provider Optometrist is paid at 100% of Cost. *And either Spectacles* Frame limit/Lens Enhancements R1 765 toward the cost of a Frame and/or Lens enhancements paid to the Preferred Provider limited to OAL and Clear lens limit: • Single Vision lenses at Preferred Provider Optometrist R210 per lens; • Bifocal lenses at R445 per lens or • Base Multifocal spectacle lenses R770 per lens. *Or **Contact lenses*** Contact lenses limited to the value of R2 390.	• Payment of any claim is subject to PMB's and Overall Annual Limit irrespective of confirmation of available benefits by either the Member or the selected optometrist. • The spectacle lenses must be prescribed by an optometrist or a medical practitioner who is registered with the Health Professions Council of South Africa, to improve the patient`s visual acuity. • The contact lenses must be prescribed and dispensed by an optometrist or a medical practitioner who is registered with the Health Professions Council of South Africa to improve the patient's visual acuity • Clinical Rules: Scripts less than 0.50 diopter will not be covered; No bifocal or multifocal lenses with a less than 1 Diopter add on will not be covered; No multifocals will be considered for payment for children under the age of 18. • Claims for the following conditions will only be considered for payment when motivated and approved by the DSP motivations committee: bifocals/multifocals for beneficiaries under the age of 40; Contact lenses for children under the age of 18; Composite consultations for children under the age of 5; Vertical prism less than 1 Diopter. • All clinical/prescribed information must be submitted on all claims to ensure payment. • Co-payments may be applicable on services obtained from non-preferred provider optometrists. • All claims must be submitted to PPN for adjudication and payment of benefits. • Member refunds may be applicable on services obtained from a non-preferred provider optometrist without an agreement for direct payment. All member refunds will be refunded up to the benefit limits of Non Preferred providers.
	Non-Preferred Provider Optometrist	100% of the Remedi Rate	Subject to the requirements prescribed for PMB's and the Overall Annual Limit with the following limits: 1. Annual benefit cycle	

	BENEFIT	RATE	LIMITS	COMMENT
			2. Beneficiary limited to R3 595 subject to overall family limit of R7 190 3. The following sub-limits will apply within the overall beneficiary/family limit: *Consultations* A composite consultation inclusive of refraction, a glaucoma screening, visual field screening and Artificial Intelligence for the detection of diabetic retinopathy limited to R365. *And either Spectacles* Frame limit R1 325 towards the cost of a frame and/or lens enhancements and Clear lenses limit: • Single vision lenses at R210 per lens or • Bifocal lenses at R445 per lens or • Multifocal lenses at R770 per lens. *Or* Contact lenses limited to the value of R2 390.	• Members can obtain either spectacles or contact lenses within a benefit cycle not both
	Refractive eye surgery **Members with severely restricted vision** (Including Corneal Cross Linking)	100% of the Remedi Rate	Annual sub-limit of R29 900 per beneficiary	Pre-authorisation in accordance with approved clinical protocols is required. Where pre-authorisation is not obtained, no benefits will apply.
11.	**Oncology** Consultations, visits, treatment, medication and materials used in radiotherapy and chemotherapy, including PET-CT scans if pre-authorised	100% of the Remedi Rate up to R410 000 per beneficiary plus a further R600 000 per beneficiary at 80% of Remedi Rate for non-PMB treatment. PMB treatment is funded at 100% of Cost/Remedi Rate.	Subject to overall annual limit and R410 000 per beneficiary at 100% of the Remedi Rate and a further R600 000 per beneficiary at 80% of the Remedi Rate, limited to an overall Oncology annual limit of R1 010 000 per family per annum over a 12 month rolling period from date of diagnosis. Benefit subject to the requirements prescribed for PMB`s	Subject to pre-authorisation, an approved all-inclusive treatment plan and to the management of clinical risk by Discovery Health as contracted and where applicable. A co-payment of R3 350 is payable for PET-CT scans if not pre-authorised and services are not obtained at a designated service provider. Sub-limit may be increased, subject to approval of the Remedi's Medical Advisory Committee, where non-PMB level of care and will be increased automatically where PMB level of care and clinically appropriate. To read Annexure D in conjunction with this Rule.
12.	**Frail care and private nursing** **Hospice**	100% of the Remedi Rate 100% of Cost	Unless PMB, subject to the overall annual limit with a sub-limit of R41 050. **Subject to pre-authorisation.** **Unlimited**	Subject to hospital risk management programme, prior approval of Remedi and only available as an alternative to hospitalisation.

	BENEFIT	RATE	LIMITS	COMMENT
				Sub-limit may be increased, subject to approval of Remedi's Medical Advisory Committee. **Where pre-authorisation is not obtained, no benefits will apply.** **Advanced Illness Benefit (AIB) available upon application and where pre-approved.**
	Sub-Acute facilities	100% of the Remedi Rate	Subject to overall annual limit **Subject to pre-authorisation**	
13.	**Radiology and pathology** • Radiology: In hospital • Pathology: In hospital • MRI and CT scans in and out of hospital	100% of the Remedi Rate	Subject to overall annual limit and benefit confirmation for **MRI and CT scans.**	Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures B and D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.
14.	**Prevention and Screening Benefit** Including, blood glucose, blood pressure, cholesterol and body mass index screening tests HIV, mammogram, pap smear, prostate specific antigen (PSA) test and, influenza vaccine for identified high risk members, members who are pregnant and members above the age of 65. Pneumococcal vaccine for identified high risk members. One (1) preventative dental examination per beneficiary per annum, including the oral examination, infection control, prophylaxis, polishing and fluoride of adults and children Human Papillomavirus (HPV) vaccine for males between the ages of 11 and 21 and females between the ages of 11 and 26 years. HPV screening tests are limited to 1 x every 5 years if the member is HIV negative and one test every 3 years if the members is HIV positive. These tests are an alternative to pap smears.	100% of the Remedi Rate	Subject to Overall Annual Limit	Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures B and D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.

	BENEFIT	RATE	LIMITS	COMMENT
	One LDL cholesterol screening is available per high risk beneficiary where clinically indicated at network pharmacy. HbA1c is funded from the Insured Out of Hospital benefit, where clinically appropriate. A group of age appropriate screening tests and additional screening assessments for members 65 years and older (Senior Screening Tests). Colorectal screening limited to one fecal occult blood test or immunochemical test every 2 years per person for persons between the ages of 45 to 75 years. One colonoscopy where clinically appropriate.			If the member has more than 1 HPV screening test before the 5 years' period expires, if HIV negative (or before the 3 years' period expires, if HIV positive) then: • the second and sub-sequent claims during that period will be paid from the member's day-to-day acute medicine benefit, if benefits are available and where the result of the screening test is abnormal or after treatment the follow-up tests will be funded yearly until normal. If the member has more than 1 HPV screening tests during the year after an abnormal HPV test result, the second and sub-sequent claims during that year will be paid from the member's day-to-day acute medicine benefit, if benefits are available.

	BENEFIT	RATE	LIMITS	COMMENT
15.	**Internal prostheses and devices** REGISTERED BY ME ON Mashilo Leboho 2021/12/23 24/12/2021 11:19:09(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM	100% of the Remedi Rate	Subject to the Overall Annual Limit with following sub-limits Total hip replacement: R51 900*** Revision hip: R61 400*** Knee replacement: R41 000*** Revision knee replacement: R51 900*** Total shoulder replacement: R47 800 Spinal benefit (one procedure per year) first level two or more levels: ** Bare metal cardiac stents max. 3 p.a. (each): ** Drug eluting cardiac stents (each) max. 3 p.a.: ** Pacemaker with Leads: R87 100 Pacemaker Biventricular: R112 300 Cardiac valves (each): R58 300 Artificial limbs (below knee): R33 500 Artificial Limbs (above knee): R61 800 Artificial eyes (prosthesis plus apparatus): R31 800 All other internal prostheses and devices: * R26 900	Subject to pre-authorisation and the hospital risk management programme and the requirements prescribed for PMB`s. Spinal benefit limit applies to the prosthetic device only- Cervical spinal fusion; Cervical artificial disc replacement; Lumbar spinal fusion; Lumbar artificial disc replacement; Interspinous devices. Clinical protocols apply - PER LEVEL LIMIT (artificial disc replacement, interspinous process devices & spinal fusion). Funding at network or non-network providers up to 100% of the Remedi Rate. *Sub-limit may be increased, subject to approval of Remedi's Medical Advisory Committee. Include funding of temporary and permanent Sacral nerve stimulators, subject to clinical guidelines and protocols of Scheme. ** Negotiated reference price list is applicable. *** Hip and Knee Arthroplasty Procedures: The Scheme is contracted with Mediclinic as Designated Service Provider ("DSP") for these procedures. A R2 500.00 co-payment for voluntary non-DSP use will apply. The aforementioned co-payment will be waived for members who reside outside a thirty (30) kilometre radius from a Mediclinic hospital.
16.	**External prostheses and appliances** (Including the external components of external prosthesis, incontinence products, etc.)	100% of the Remedi Rate	Subject to Overall Annual Limit with following sub-limits: Colostomy equipment: R27 600 per beneficiary per annum Hearing aids: R25 450 per beneficiary per annum Wheelchairs: * R19 000 per beneficiary per annum Oxygen appliances (includes oxygen): R2 075 per beneficiary per month All other appliances: * R7 150 per beneficiary per annum	Colostomy equipment can be obtained via Cancer Society. Oxygen benefit subject to registration for the use of oxygen on the Chronic Illness Benefit Programme managed by Discovery Health as contracted. Funding of Mirena contraceptive device payable from all other appliances, subject to pre-approval in line with Scheme clinical protocols and guidelines and provided inserted in gynaecologists' rooms

	BENEFIT	RATE	LIMITS	COMMENT
				*Sub-limit may be increased, subject to approval of the Scheme's Medical Advisory Committee. CPAP devices funded from the "all other appliances" limit as available, where deemed clinically appropriate and limited to the agreed/negotiated rates with preferred providers. Point-of-care devices for point-of-care testing are funded from the "all other appliances" limit as available, where deemed clinically appropriate. With effect from 1 May 2021, Continuous Glucose Monitors ("CGM"), where deemed clinically appropriate are funded from the "all other appliances" limit up to the agreed/negotiated rates with preferred providers.
17.	**Paramedical services** Ambulance	100% of the Remedi Rate	Subject to utilisation of Preferred Provider, viz. ER24 Emergency Response Service.	Transfers for same event subject to medical justification. Pre-authorisation required with Preferred Provider. If emergency transportation is obtained by a service provider other than ER24, the latter provider must be notified within 24 hours by contacting their call centre.
18.	**Psychiatric benefit** (Including the treatment of alcoholism and drug dependency. In hospital and in lieu of hospitalisation)	100% of the Remedi Rate	Subject to overall annual limit, limited to 21 days per annum in hospital or 15 days in an out-of-hospital setting or a combination of in- and out-of-hospital as prescribed in terms of Prescribed Minimum Benefits.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted and the requirements prescribed for PMBs. Benefits may be granted for out-of-hospital consultations and/or treatment in lieu of hospitalisation only. Benefit may be increased, subject to approval of Remedi's Medical Advisory Committee.
19.	**Organ Transplants** (Including harvesting of organs, consultations/visits and post-operative anti-rejection medicines required by recipient)	PMB will be paid at 100% of Cost. Non-PMB is paid at 100% of the Remedi Rate	PMB unlimited at the DSP. Non-PMB will be subject to the Overall Annual Limit.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted. Provisions of Annexures B and D is applicable.
20.	**Renal Failure & Dialysis** (Including all services and materials associated with the cost of acute and chronic renal dialysis including consultations/visits and medicine)	100% of the Remedi Rate	Subject to Overall Annual Limit and the requirements prescribed for PMB`s	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted. Provisions of Annexures B and D is applicable.
21.	**Other Health Care Services** Chinese medicine & acupuncture, therapeutic aromatherapy, Ayurveda, chiropody/podiatry, chiropractics (including x-rays), dietetics, homeopathy, iridology, naturopathy,	100% of cost	Payable from PMSA	Payment for costs for services rendered will be made on condition that the persons rendering such services are registered as practitioners by the professional body

	BENEFIT	RATE	LIMITS	COMMENT
	orthoptics, osteopathy, therapeutic reflexology, therapeutic massage therapy, phytotherapy and traditional healing			recognised under enabling statute e.g. The Allied Health Professions Act, Act 63 of 1982.
22.	Overseas Treatment Benefit	80% of cost	Subject to Overall Annual Limit and limited to R680 000 per annum per beneficiary.	Conditions: To qualify the services must not be available or cannot be performed anywhere in South Africa, must be evidence-based medicine with sufficient peer-reviewed literature available to prove the treatment is clinically appropriate and indicated for the condition, must be provided by a suitable qualified and recognized medical healthcare professional and will require Scheme review to make sure the treatment meets the clinical criteria for funding.
23.	International Second Opinion Services at Cleveland Clinic	50% of cost	Subject to Overall Annual Limit.	**Subject to pre-authorisation** and pre-approval by the Scheme's contracted managed healthcare organization.
24.	**Personal Savings Account** a. *General practitioners b. *Medical specialists c. *Conservative dentistry d. Specialized dentistry e. *Prescribed acute medicine and injection material f. *Physiotherapy, speech therapy, and occupational therapy g. *Clinical psychologists h. *Social Workers i. Chiropractor, homeopath, osteopath, herbalist, naturopath or dietician j. *Eye tests, spectacles or contact lenses and refractory eye surgery k. *Radiology: Out of hospital (excluding MRI and CT scans) l. *Pathology: Out of hospital m. Medical costs in excess of the benefit amount under the Comprehensive Option n. Condoms and preventive medication for malaria. Appliances other than the Mirena and emergency pill. o. *Contraceptives p. Immunisations, except *influenza and pneumococcal vaccines where clinically indicated, which is funded from the Prevention and Screening Benefit and Human Papillomavirus (HPV) vaccine	100% of cost	Annual benefit amount equals 10% of the total contribution payable to the Scheme.	* Initial benefit available from Comprehensive insured Benefit or OAL, as detailed above

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	BENEFIT	RATE	LIMITS	COMMENT
	which is funded from Prevention and Screening Benefit first			
25.	Specialised Medication Benefit (SMB)	90% of Remedi Rate or cost/100% of Reference Price List	Cover up to R210 000 per beneficiary per annum for a defined list of the latest and most advanced clinically approved Specialised Medicine	**Subject to pre-authorisation** and pre-approval by the Scheme's contracted managed healthcare organization.

GLOSSARY / EXPLANATORY NOTES:

CDL	Chronic Disease List
DSP	A Designated Service Provider for the Prescribed Minimum Benefits - "PMBs" - selected by Remedi, being contracted private hospitals, Clicks Pharmacies and Dis-Chem Pharmacies, Discovery Health Pharmacy Network, as well as specialists contracted by Discovery Health under Direct Payment Arrangements, General Practitioners in the GP Network, Dental Risk Company (DRC) and Preferred Provider Negotiators (PPN) and the following providers for alcohol and drug dependency – The South African National Council on Alcohol and Drug Dependence (SANCA), SANCA's nominated providers and the Ramot Centre for Alcohol and Drug Dependency, as well as any other providers selected by Remedi from time to time
Direct Payment Arrangements "DPAs"	Are the specialist arrangements concluded between Discovery Health and specialist providers who agree to charge at or below a set rate for consultations and procedures and by reason thereof have also agreed that such rates shall be applicable to Remedi.
GP Network	The network of General Practitioners contracted to and through Discovery Health to provide relevant health care services to Remedi at the Remedi Rate
CDA	Chronic Drug Amount (CDA) is an amount of money that has been allocated for each medicine category each month for a specific condition.
M	Member without dependants
M+	Member plus dependants
Pb/pa	per beneficiary per annum
Pf/pa	per family per annum
PMB/PMB`s	the Prescribed Minimum Benefit(s)
Pre-authorisation	the approval which has been given by the Scheme, or the Scheme`s contracted Managed Healthcare provider for relevant health services, as defined in the Act, to be provided to a beneficiary, in accordance with the protocols/treatment guidelines, accepted or determined by the Scheme.
Preferred Provider	a health care provider or group providers selected by the Scheme to provide diagnosis, treatment and care in respect of PMB or non-PMB conditions. For Chronic medicine any pharmacy charging not more than the SEP and the dispensing fee equal to that charged by the DSPs.
SAOA	South African Optometric Association
Remedi Rate	is the tariff fee / rate for the payment of relevant health services equal to the Discovery Health Rate / DH rate, as prescribed in the Guide to the Discovery Health Rate, or, the fee / rate as determined by Board of Trustees in terms of any agreement between Remedi and any service provider or group of service providers
SEP	Single Exit Price
PMB Hospital Network	A Mediclinic hospital contracted to or nominated by the Scheme established for the provision of services that relates to Prescribed Minimum Benefit (PMB) conditions. See also DSP.
Mental Health Network	A defined list of Psychologists and/or Social Workers contracted or nominated by the Scheme for purposes of providing treatment to members relating to mental health conditions. See also DSP
In-Hospital GP Network	A defined list of GP and specialist authorised by the Scheme to provide in-hospital services to members as part of the Scheme's Premier Practice, Remedi Standard GP Network and Classic DPA Specialist Networks.
Hip and Knee Arthroplasty Network	Mediclinic Private Hospital Facilities as contracted for Designated Service Provider ("DSP") purposes

CLASSIC OPTION: BENEFITS 2022

(Members and their dependants are entitled to the following benefits, subject to the provisions of these Rules and in particular paragraph 10 of Annexure B and Annexure D concerning the provision of the statutory Prescribed Minimum Benefits, " PMB's")

	BENEFIT	RATE	LIMITS	COMMENT
1.	**Hospitalisation in private hospitals as well as surgery and medical procedures performed by private practitioners.**		**Overall annual limit of:** R2 150 000 per family (M+) per annum	Subject to the management of clinical risk by Discovery Health as contracted and use of defined DSP network of hospitals. **All non-emergency admissions are subject to pre-authorisation.** Emergencies must be authorised within 24 hours of admission or first working day after an emergency treatment or admission. A co-payment of R1 000 for failing to pre-authorise will apply. Da Vinci Robotic Assisted Prostatectomy is funded up to a maximum of the cost of a standard Prostatectomy where prostate cancer confirmed by means of a histology report, regardless whether the member is registered on the Oncology Management Programme. Limited to R113 000.00 up to one procedure per beneficiary and must be pre-authorised
	Hospital accommodation • Accommodation in a general ward, intensive care unit, high care unit, maternity ward, as well as theatre and recovery costs	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required**	Annexures B and D has reference. The Scheme may require that a member be transferred to a PMB Network Hospital if admitted into a non-DSP following an emergency admission.
	Surgery and medical procedures • Surgery and medical procedures, which generally, but not necessarily, require hospitalisation • Confinements • Conservative dentistry under anaesthesia in patients not older than 7 years	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required** Anaesthetics and hospitalisation subject to overall annual limit. **Note: dentist accounts are payable from available Insured Out-of-Hospital benefit**	Benefits in respect of services for infertility, limited to the medical and surgical management of those procedures and interventions as defined under PMB Code 902M, subject to Regulation 8(3) of the Medical Schemes Act, Act No 131 of 1998. Cosmetic surgery is a listed Scheme exclusion on Remedi.
	Hospital and surgical material/ equipment as per agreed list	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required**	Limits set in terms of charging policy for listed items, which may be agreed with DSP and other Providers.Benefit for medicines to take home (TTO`s), limited to 5 days.

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	BENEFIT	RATE	LIMITS	COMMENT
	Blood transfusions, blood products and transport of blood	100% of the Remedi Rate	Subject to overall annual limit	
	In-hospital visits • General practitioners and specialists' visits during pre-authorised hospitalisation	100% of the Remedi Rate	Subject to overall annual limit	For surgery, medical procedures and in-hospital visits/consultations Remedi will make payment in full directly to the DSP concerned. In such a case the Member will not be liable for any co-payment to be made to such DSP If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures B and D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.
	Readmission Prevention Benefit • Homecare by a healthcare provider and/or qualified nurse for patients considered at high risk of readmission, when discharged from acute care	100% of the Remedi Rate	Subject to overall annual limit	Basket of care as approved by Remedi
2.	**Hospitalisation in public hospitals as well as surgery and medical procedures performed by *public sector practitioners***	100% of Cost	Limited to Overall annual limit, subject to sub-limit of R 550 000 per family (M+) for treatment in public facilities. **For involuntary admissions to Hospitals outside of the PMB Hospital Network, no limits on Prescribed Minimum Benefits (PMB`s), as set out in the Medical Schemes Act;**	Subject to the management of clinical risk by Discovery Health as contracted. All non-emergency admissions **are subject to pre-authorisation.** Emergencies must be authorised within 24 hours of admission or on the first working day after such emergency treatment or admission.

	BENEFIT	RATE	LIMITS	COMMENT
	Hospital accommodation • Accommodation in a general ward, intensive care unit, high care unit, maternity ward, as well as theatre and recovery costs	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required**	
	Surgery and medical procedures • Surgery and medical procedures, which generally, but not necessarily, require hospitalisation • Confinements and antenatal consultations • Theatre fees and anaesthetics • Conservative dentistry under anaesthesia in patients not older than 7 years	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required** Anaesthetics and hospitalisation subject to overall annual limit. Note: dentist accounts are payable from available Insured Out-of-hospital benefit	Benefits in respect of services for infertility, limited to the medical and surgical management of those procedures and interventions as defined under PMB Code 902M, subject to Regulation 8(3) of the Medical Schemes Act, Act No 131 of 1998. Cosmetic surgery is a listed Scheme exclusion on Remedi.
	Hospital and surgical material/equipment • As per agreed list	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required**	Benefit for medicines to take home (TTO`s), limited to 5 days.
	Blood transfusions, blood products and transport of blood	100% of Cost	Subject to overall annual limit	
	In-hospital visits • General practitioner and specialist visits during pre-authorised hospitalisation	100% of Cost	Subject to overall annual limit	
3.	**Chronic medication**			
	PMB Conditions	100% of Single Exit Price " SEP" plus a dispensing fee as agreed to with the defined DSP	Unlimited benefit, and further subject to a fixed drug list (formulary) Non-formulary drugs are funded up to the Chronic Drug Amount (CDA) for a registered drug class.	Benefits for the diagnosis, medical management and treatment of PMB CDL and DTP conditions – which shall not be less than those for the regulated Prescribed Minimum Benefits – shall subject to pre-authorisation be paid in accordance with the treatment protocols including clinical entry criteria and authorized "baskets of care" governing the Chronic Illness Benefit Programme and/or HIV/AIDS Programme, managed by Discovery Health as contracted, the managed health care provider appointed by Remedi.
	Non-PMB Conditions	100% of Single Exit Price " SEP" plus a dispensing fee as agreed to with the defined DSP	Subject to Overall Annual Limit a maximum of R1 820 per month per registered beneficiary, based on individual needs.	Subject to registration on the Chronic Illness Benefit Programme managed by Discovery Health as the Managed Health Care Provider appointed by Remedi. Where chronic medication is obtained from a pharmacy other than a DSP a co-payment for any difference in dispensing fees and/or any related fees will be payable by the member directly to the pharmacy. Any such co-payment will not be refunded to the Member via any credit of the Member`s Personal Medical Savings Account.

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<table>
<tr><th></th><th>BENEFIT</th><th>RATE</th><th>LIMITS</th><th>COMMENT</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">4.</td><td>Extended physiotherapy, occupational therapy, speech therapy and biokinetics

Maintenance therapy (In and Out of hospital)
• Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a maintenance or conservative nature, based on an approved and pre-authorised treatment plan typically preceded by a rehabilitation programme and/or arising from a congenital defect of a mental or physical nature.</td><td>100% of the Remedi Rate</td><td>Pre-authorisation required
Subject to Overall Annual Limit with sub-limit:
R13 880 per family (M+) per annum</td><td>This specifically excludes treatment of an acute (minor) injury as determined by Remedi's Medical Advisory Committee.</td></tr>
<tr><td>Rehabilitation therapy post hospitalisation
• Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a rehabilitative nature that is preceded by hospitalisation; such treatment must be connected to an approved rehabilitative treatment plan and must commence within two weeks of discharge from hospital</td><td>100% of the Remedi Rate</td><td>Pre-authorisation required
Subject to overall annual limit</td><td>REGISTERED BY ME ON
Mashilo Lebohu 2021/12/23
24/12/2021 11:20:05(UTC+02:00)
Signed by Mashilo Lèboho,
m.leboho@medicalschemes.co.za
REGISTRAR OF MEDICAL SCHEMES
SIGNIFLOW.COM</td></tr>
<tr><td>5.</td><td>Trauma recovery extender benefit
Covering out of hospital treatment following a traumatic incident resulting in
• paraplegia, quadriplegia, tetraplegia and hemiplegia
• conditions resulting from near drowning, severe anaphylactic reaction, poisoning and crime related injuries;
• severe burns;
• certain external and internal head injuries and loss of limb, or part thereof.</td><td>100% of the Remedi Rate</td><td>Pre-authorisation required.
Subject to the overall annual limit and the following sub-limits:
<table><tr><td colspan="2">Loss of limb per family</td><td>R89 000</td></tr><tr><td colspan="2">Private nursing</td><td>R11 200</td></tr><tr><td>Prescribed medication :</td><td>M</td><td>R14 300</td></tr><tr><td></td><td>M + 1</td><td>R16 900</td></tr><tr><td></td><td>M + 2</td><td>R20 100</td></tr><tr><td></td><td>M + 3 or more</td><td>R24 300</td></tr><tr><td colspan="2">External medical items</td><td>R34 000</td></tr><tr><td colspan="2">Hearing Aids</td><td>R16 100</td></tr><tr><td colspan="2">Mental health benefit</td><td>R20 200</td></tr></table></td><td>For PMB conditions, mental health treatment to be obtained from a service provider contracted to the Scheme's Mental Health Network</td></tr>
<tr><td>6.</td><td>Insured Out-of-hospital ("IOH") benefit for:
Consultations, procedures, radiology (excluding MRI and CT scans) and pathology outside hospital, point-of-care testing as</td><td>100% of the Remedi Rate
or</td><td>Subject to Overall Annual Limit and the following sub-limits:
Per Principal Member: R8 320</td><td>Where the sub-limit is exceeded, benefits for non-PMB conditions to be paid by member.
.</td></tr>
</table>

	BENEFIT	RATE	LIMITS	COMMENT
	authorised, including in the outpatient department of a hospital and inclusive of the facility fee for outpatients • General Practitioners • Acute and self-medication • Basic and Specialised dentistry; • Specialists; • Optical (including contact lenses) • Physiotherapists; • Biokineticists; • Occupational Therapists; • Speech Therapists • Audiologists And Audiometrists • Clinical Psychologists; • Social Workers; • Pathology and radiology (excluding MRI and CT scans) benefits • Vacuum Assisted Breast Biopsy (VABB)	100% of cost at the Designated Service Provider (DSP)/ Medicine Rate	Per Adult Dependent: R4 910 Per Child Dependent: R1 380 (up to a maximum of 3 children) All out of hospital benefits will be limited to the above sub-limit after which benefit for costs relating to the diagnosis and medical management and treatment of Prescribed Minimum Benefit Chronic Disease List and Diagnosis and Treatment Pair, "DTP", "CDL", conditions and HIV/AIDS, will be payable from risk subject to the conditions set out in the comments alongside. VABB per beneficiary is limited to two procedures per year at negotiated fees REGISTERED BY ME ON Mashilo Leboho 24/12/2021 14:20:23 (UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za SIGNIFLOW.COM REGISTRAR OF MEDICAL SCHEMES	Self-medication applies to medicines classified as Schedules 0, 1 and 2, which can be purchased over the counter without a doctor's prescription. Including consultation for insertion of Mirena contraceptive device in gynaecologist's rooms, provided pre-approval obtained and subject to Scheme clinical protocols and guidelines. All other oral contraceptives are funded up to a monthly limit of R165.00 per female beneficiary per month at 100% of the Remedi Medicine Rate if obtained from a DSP pharmacy and paid from Overall Annual Limit (OAL).). A co-payment of 20% is applicable if a member obtains oral contraceptives from a non-DSP pharmacy. For members who are not high risk and who are < 65 years or who are not pregnant, one influenza vaccine per beneficiary per year is payable from the IOH limit. Influenza vaccines for high risk members and members > 65 years and/or members who are pregnant are funded from the Prevention and Screening Benefit. Clinical entry criteria are applicable. Point-of-care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria. Members will receive benefit in accordance with authorized "baskets of care" regarding the diagnosis, medical management and treatment of such PMB CDL and DTP related chronic diseases. If not registered then benefits will be subject to the conditions set out in 10.3, 10.4 and 10.5 of Annexures B and D to the Rules. Remedi will make payment in full to a DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures B and D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit of maximum 100% of the Remedi Rate;

	BENEFIT	RATE	LIMITS	COMMENT
				• may be required to make co-payments to such provider for fees charged above the Remedi Rate.
	World Health Organisation (WHO) Global Outbreak Benefit for out-of-hospital management and appropriate supportive treatment of global WHO recognised disease outbreaks: • Out-of-hospital healthcare services related to COVID-19 includes: - Screening consultation with a nurse or a GP; - Defined basket of pathology; - Defined basket of x-rays and scans; - Consultations with a nurse or GP; - Supportive treatment; - Vaccines and the administration of the vaccines; - Home-based care in lieu of hospitalisation; - Treatment of complications and rehabilitation for Long Covid.	Save for Prescribed Minimum Benefits (PMB), up to a maximum of 100% of the Remedi Rate	Funded out of a dedicated basket of care as set by the Scheme related to COVID-19 and limited to: - Unlimited screening consultations with a nurse or GP; - Defined basket of pathology up to 3 tests per person per year, except where cover is PMB; - Unlimited home-based care in lieu of hospitalisation	Subject to the Scheme's preferred provider, protocols and condition and treatment meeting the Scheme's clinical entry criteria and guidelines. Cover for testing is subject to referral. Long Covid activation of the benefit and basket of care provided by the Scheme for a period of 6 months from the date of diagnosis by the treating healthcare provider.

	BENEFIT	RATE	LIMITS	COMMENT
7.	**Optical** REGISTERED BY ME ON Mashilo Leboho 2021/12/23 24/12/2021 11:24:29 (UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM		Members have the option of obtaining **Optical Benefits**, subject to the above sub-limits, for services rendered by PPN and non-PPN network providers on the following conditions. 1. An Annual benefit cycle. 2. Beneficiary limited to R3 385 subject to overall family limit of R6 770 3. The following sub-limits will apply within the overall beneficiary/family limit: Consultations A composite consultation inclusive of refraction, a glaucoma screening, vision field screening and Artificial Intelligence for the detection of diabetic retinopathy at 100% of cost for a PPN contracted network provider and up to R365 for a non-PPN network provider; *and either Spectacles* Frame Limit/Lens enhancements R1 115 toward the cost of a frame and/or Lens enhancements at a PPN provider per beneficiary per year. At a non PPN provider R1 115 towards a frame and/or lens enhancement per beneficiary is funded towards spectacles subject to the annual overall family limit Clear lens Limit: Single, Bifocal or base Multifocal lenses are funded at a PPN provider and non PPN provider as follows: Single Vision lenses at R210 per lens; Bifocal lenses at R445 per lens; or Multifocal lenses at R770 per lens. Or Contact Lenses Contact lenses limited to the value of R1 930.	The following further conditions apply to the obtaining of any optical benefits • Payment of any claim is subject to available benefits irrespective of confirmation the Member or provider • The spectacle lenses and contact lenses must be prescribed by an optometrist or a medical practitioner who is registered with the Health Professions Council of South Africa, to improve the patient`s visual acuity. • The contact lenses must be prescribed and dispensed by an optometrist or a medical practitioner who is registered with the Health Professions Council of South Africa, to improve the patient`s visual acuity. • Clinical Rules: Scripts less than 0.50 diopter will not be covered; No bifocal or multifocal lenses will be considered for payment for children under the age of 18. • Claims for the following conditions will only be considered for payment when motivated and approved by the PPN motivations committee: bifocals/multifocals for beneficiaries under the age of 40; Contact lenses for children under the age of 18; Composite consultations for children under the age of 5; Vertical prism less than 1 Diopter. • All clinical/prescribed information must be submitted on all claims to ensure payment. • Co-payments may be applicable on services obtained from non-preferred provider optometrists. • All claims must be submitted to PPN for adjudication and payment of benefits. • Member refunds may be applicable on services obtained from non-preferred provider optometrists without an agreement for direct payment • Members can obtain either spectacles or contact lenses within a benefit cycle not both.
	Refractive eye surgery Members with severely restricted vision (Including Corneal Cross Linking)	100% of the Remedi Rate	Annual sub-limit of R26 700 per beneficiary	Pre-authorisation in accordance with approved clinical protocols is required. Where pre-authorisation is not obtained, no benefits will apply.

	BENEFIT	RATE	LIMITS	COMMENT
8.	**Maternity** Limited pregnancy scans antenatal consultations and a specified range of pathology tests	100% of the Remedi Rate	Subject to Overall Annual Limit and the requirements prescribed for PMBs the maternity benefit/basket of care includes: - 2 x 2D pregnancy scans; - 9 GP consultations at a Network GP, Midwife or Gynaecologist; - 9 x urine dipstick tests; - 2 x glucose strip tests; - HIV Elisa, Rubella, RPR and TPHA and bHCG tests as deemed clinically appropriate; - RH antigen, Haemoglobin, A B and O antigens as deemed clinically appropriate; - 1 x Nuchal Translucency (NT) and/or Non-Invasive Prenatal Test (NIPT) and T21 screening per pregnancy -	The benefit allows for a defined range of services including the first two 2D ultrasound scans in gynecologists' rooms. Medical motivation is required for additional scans. NT and/or NIPT and T21 screening (Down Syndrome Screening Tests) to be made available in addition to available ultrasound scans. Clinical entry criteria will be applicable
9.	**Oncology** Consultations, visits, treatment, medication and materials used in radiotherapy and chemotherapy, including PET-CT scans if pre-authorised	100% of the Remedi Rate up to R410 000 per beneficiary plus a further R265 000 per beneficiary at 80% of Remedi Rate if non-PMB treatment. PMB treatment is funded at 100% of Cost/Remedi Rate. .	Subject to overall annual limit and R410 000 per beneficiary at 100% of the Remedi Rate and a further R265 000 per beneficiary at 80% of the Remedi Rate, limited to an overall Oncology annual limit of R675 000 per family per annum over a 12 month rolling period from date of diagnosis. Benefit subject to the requirements prescribed for PMB`s	Subject to pre-authorisation, an approved all-inclusive treatment plan and to the management of clinical risk by Discovery Health as contracted and where applicable. A co-payment of R3 350 is payable for PET-CT scans if not pre-authorised and services are not obtained at a designated service provider. Sub-limit may be increased, subject to approval of the Remedi's Medical Advisory Committee, where non-PMB level of care and will be increased automatically where PMB level of care and clinically appropriate. To read Annexure D in conjunction with this Rule.
10.	**Frail care and private nursing** **Hospice** **Sub-Acute facilities**	100% of the Remedi Rate 100% of Cost 100% of the Remedi Rate	Unless PMB, subject to the overall annual limit with a sub-limit of R39 100 per family. **Subject to pre-authorisation .** Unlimited Subject to overall annual limit **Subject to pre-authorisation**	Subject to hospital risk management programme, prior approval of Remedi and only available as an alternative to hospitalisation. Sub-limit may be increased, subject to approval of Remedi's Medical Advisory Committee. **Where pre-authorisation is not obtained, no benefits will apply.**

	BENEFIT	RATE	LIMITS	COMMENT
				Advanced Illness Benefit (AIB) is available upon application and where pre-approved
11.	**Radiology and pathology** • Radiology: In hospital • Pathology: In hospital • MRI and CT scans in and out of hospital	100% of the Remedi Rate	Subject to overall annual limit and benefit confirmation for **MRI and CT scans.**	Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures B and D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; **may be required to make co-payments to such provider for fees charged above the Remedi Rate.**
12.	**Prevention and Screening benefit** Including blood glucose, blood pressure, cholesterol and body mass index screening tests HIV, mammogram, pap smear, prostate specific antigen (PSA) test and, influenza vaccine for identified high risk members, members who are pregnant and members above the age of 65. Pneumococcal vaccine for identified high risk members. One (1) preventative dental examination per beneficiary per annum, including the oral examination, infection control, prophylaxis, polishing and fluoride of adults and children. Human Papillomavirus (HPV) vaccine for males between the ages of 11 and 21 and females between the ages of 11 and 26 years. HPV screening tests are limited to 1 x every 5 years if the member is HIV negative and one test every 3 years if the members is HIV positive. These tests are an alternative to pap smears.	100% of the Remedi Rate	Subject to Overall Annual Limit	Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures B and D to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate. If the member has more than 1 HPV screening test before the 5 years' period expires, if HIV negative (or before the 3 years' period expires, if HIV positive) then: • the second and sub-sequent claims during that period will be paid from the member's day-to-day acute medicine benefit, if benefits are available and where the result of the screening test is abnormal or after treatment the follow-up tests will be funded yearly until normal.

	BENEFIT	RATE	LIMITS	COMMENT
	One LDL cholesterol screening is available per high risk beneficiary where clinically indicated at network pharmacy. HbA1c is funded from the Insured Out of Hospital benefit, where clinically appropriate. A group of age appropriate screening tests and additional screening assessments for members 65 years and older (Senior Screening Tests). Colorectal screening limited to one fecal occult blood test or immunochemical test every 2 years per person for persons between the ages of 45 to 75 years. One colonoscopy where clinically appropriate			If the member has more than 1 HPV screening tests during the year after an abnormal HPV test result, the second and sub-sequent claims during that year will be paid from the member's day-to-day acute medicine benefit, if benefits are available.
13.	**Internal prostheses and devices**	100% of the Remedi Rate	Subject to the Overall Annual Limit with following sub-limits: Total hip replacement: R44 600 Revision hip: R52 600 Knee replacement: R35 000 Revision knee replacement: R44 600 Total shoulder replacement: R41 000 Spinal benefit (one procedure per year) first level / two or more levels: ** Bare metal cardiac stents max. 3 p.a. (each): ** Drug eluting cardiac stents (each) max. 3 p.a.: ** Pacemaker with Leads: R73 800 Pacemaker Biventricular: R95 100 Cardiac valves (each): R49 300	Subject to pre-authorisation and the hospital risk management programme and the requirements prescribed for PMB`s. Spinal benefit limit applies to the prosthetic device only- Cervical spinal fusion; Cervical artificial disc replacement; Lumbar spinal fusion; Lumbar artificial disc replacement; Interspinous devices. Clinical protocols apply - PER LEVEL LIMIT (artificial disc replacement, interspinous process devices & spinal fusion). Funding at network or non-network providers up to 100% of the Remedi Rate. *Sub-limit may be increased, subject to approval of Remedi's Medical Advisory Committee. Funding of temporary and permanent Sacral nerve stimulators is specifically excluded.

	BENEFIT	RATE	LIMITS	COMMENT
			Artificial limbs (below knee) R28 800 Artificial Limbs (above knee) R52 600 Artificial eyes (prosthesis plus apparatus) R26 900 All other internal prostheses and devices R23 200	** Negotiated reference price list is applicable. *** Hip and Knee Arthroplasty Procedures: The Scheme is contracted with Mediclinic as Designated Service Provider ("DSP") for these procedures. A R2 500.00 co-payment for voluntary non-DSP use will apply. The aforementioned co-payment will be waived for members who reside outside a thirty (30) kilometre radius from a Mediclinic hospital
14.	**External prostheses and appliances** (Including the external components of external prosthesis, incontinence products, etc.)	100% of the Remedi Rate	Subject to Overall Annual Limit with following sub-limits: Colostomy equipment: R27 600 per beneficiary per annum Hearing aids: R25 450 per beneficiary per annum Wheelchairs: R15 950 per beneficiary per annum Oxygen appliances (includes oxygen): R2 075 per beneficiary per month All other appliances: * R6 000 per beneficiary per annum	Colostomy equipment can be obtained via Cancer Society. Oxygen benefit subject to registration for the use of oxygen on the Chronic Illness Benefit Programme managed by Discovery Health as contracted. Funding of Mirena contraceptive device payable from all other appliances, subject to pre-approval in line with Scheme clinical protocols and guidelines and provided inserted in gynaecologists' rooms. *Sub-limit may be increased, subject to approval of the Scheme's Medical Advisory Committee. CPAP devices funded from the "all other appliances" limit as available, where deemed clinically appropriate and limited to the agreed/negotiated rates with preferred providers.

	BENEFIT	RATE	LIMITS	COMMENT
				Point-of-care devices for point-of-care testing are funded from the "all other appliances" limit as available, where deemed clinically appropriate. With effect from 1 May 2021, Continuous Glucose Monitors ("CGM"), where deemed clinically appropriate are funded from the "all other appliances" limit up to the agreed/negotiated rates with preferred providers.
15.	**Paramedical services** Ambulance	100% of the Remedi Rate	Subject to utilisation of Preferred Provider, viz. ER24 Emergency Response Service.	Transfers for same event subject to medical justification. Pre-authorisation required with Preferred Provider. If emergency transportation is obtained by a service provider other than ER24, the latter provider must be notified within 24 hours by contacting their call centre.
16.	**Psychiatric benefit** (Including the treatment of alcoholism and drug dependency. In hospital and in lieu of hospitalisation)	100% of the Remedi Rate	Subject to overall annual limit, limited to 21 days per annum in hospital or 15 days in an out-of-hospital setting or a combination of in- and out-of hospital as prescribed in terms of Prescribed Minimum Benefits.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted and the requirements prescribed for PMBs. Benefits may be granted for out-of-hospital consultations and/or treatment in lieu of hospitalisation only. Services and treatment for PMB conditions to be obtained from a DSP (Mental Health Network provider) contracted with the Scheme and funding per Annexure D will be applicable. Benefit may be increased, subject to approval of Remedi's Medical Advisory Committee.
17.	**Organ Transplants** (Including harvesting of organs, consultations/visits and post-operative anti-rejection medicines required by recipient)	PMB will be paid at 100% of Cost. Non-PMB is paid at 100% of the Remedi Rate	PMB unlimited at the DSP. Non-PMB will be subject to the Overall Annual Limit.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted. Provisions of Annexures B and D is applicable.
18.	**Renal Failure & Dialysis** (Including all services and materials associated with the cost of acute and chronic renal dialysis including consultations/visits and medicine)	100% of the Remedi Rate	Subject to Overall Annual Limit and the requirements prescribed for PMB`s	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted. Provisions of Annexures B and D is applicable.
19.	**Other Health Care Services** Chinese medicine & acupuncture, therapeutic aromatherapy, ayurveda, chiropody/podiatry, chiropractics (including x-rays), dietetics, homeopathy, iridology, naturopathy, orthoptics, osteopathy, therapeutic reflexology, therapeutic massage therapy, phytotherapy and traditional healing		Nil Benefit	

GLOSSARY / EXPLANATORY NOTES:

CDL	Chronic Disease List
DSP	A Designated Service Provider for the Prescribed Minimum Benefits - "PMBs" - selected by Remedi, being the contracted private hospitals, Clicks Pharmacies and Dis-Chem Pharmacies, Discovery Health Pharmacy Network, as well as specialists contracted by Discovery Health under Direct Payment Arrangements, General Practitioners in the GP Network, Dental Risk Company (DRC), Preferred Provider Negotiators (PPN) and the following providers for alcohol and drug dependency – The South African National Council on Alcohol and Drug Dependence (SANCA), SANCA's nominated providers and the Ramot Centre for Alcohol and Drug Dependency, as well as any other providers selected by Remedi from time to time
Direct Payment Arrangements "DPAs"	Are the specialist arrangements concluded between Discovery Health and specialist providers who agree to charge at or below a set rate for consultations and procedures and by reason thereof have also agreed that such rates shall be applicable to Remedi.
GP Network	The network of General Practitioners contracted to and through Discovery Health to provide relevant health care services to Remedi at the Remedi Rate
CDA	Chronic Drug Amount (CDA) is an amount of money that has been allocated for each medicine category each month for a specific condition.
M	Member without dependants
M+	Member plus dependants
Pb/pa	per beneficiary per annum
Pf/pa	per family per annum
PMB/PMB`s	the Prescribed Minimum Benefit(s)
Pre-authorisation	the approval which has been given by the Scheme, or the Scheme`s contracted Managed Healthcare provider for relevant health services, as defined in the Act, to be provided to a beneficiary, in accordance with the protocols/treatment guidelines, accepted or determined by the Scheme.
Preferred Provider	a health care provider or group providers selected by the Scheme to provide diagnosis, treatment and care in respect of PMB or non-PMB conditions. For Chronic medicine any pharmacy charging not more than the SEP and the dispensing fee equal to that charged by the DSPs.
SAOA	South African Optometric Association
Remedi Rate	is the tariff fee / rate for the payment of relevant health services equal to the Discovery Health Rate / DH rate, as prescribed in the Guide to the Discovery Health Rate, or, the fee / rate as determined by Board of Trustees in terms of any agreement between Remedi and any service provider or group of service providers
SEP	Single Exit Price
PMB Hospital Network	A Mediclinic hospital contracted to or nominated by the Scheme established for the provision of services that relates to Prescribed Minimum Benefit (PMB) conditions. See also DSP.
Mental Health Network	A defined list of Psychologists and/or Social Workers contracted or nominated by the Scheme for purposes of providing treatment to members relating to mental health conditions. See also DSP
In-Hospital GP Network	A defined list of GP and specialist authorised by the Scheme to provide in-hospital services to members as part of the Scheme's Premier Practice, Remedi Standard GP Network and Classic DPA Specialist Networks.
Hip and Knee Arthroplasty Network	Mediclinic Private Hospital Facilities as contracted for Designated Service Provider ("DSP") purposes

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ANNEXURE C

REMEDI MEDICAL AID SCHEME

EXCLUSIONS AND LIMITATIONS

APPLICABLE TO ALL BENEFIT OPTIONS

EXCLUSIONS

Subject to the provisions of regulation 8 of the Act, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions, provided that services are obtained from a designated service provider in respect of that condition as set out in regulation 8 (2) of the Act. A co-payment or deductible, as set out in the rules and annexures to the rules, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider. Furthermore, when a formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary and that beneficiary knowingly declines the formulary drug and opts to use another drug instead, the Scheme may impose a co-payment on the relevant member as set out in regulation 8 (5) of the Act.

1. Therefore, unless benefits are to be afforded to members as prescribed minimum benefits, or unless otherwise provided for, or decided by the Board, expenses incurred in connection with any of the following will not be paid by the Scheme:

    1.1 The member is, entitled to such benefits as provided for in the rules and annexures of the Scheme, however, will be liable to the Scheme for valid claims recovered from any other third party, where the Scheme made payment on behalf of the member for treatment of sickness conditions or injuries sustained by a member or a dependant and

        1.1.1 the member and/or the member's duly authorized representative, administrator or executor, as soon as may be reasonably possible after the incident giving rise to such claim immediately sign and deliver to the Scheme and /or the Scheme's administrators a written undertaking, issued by the Scheme or the Scheme's administrators that

            1.1.1.1 on receipt of any payment arising from any claim for medical expenses, the member, and/or such duly authorized representative, administrator or executor will

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immediately reimburse the Scheme for costs incurred by the Scheme in respect of this benefit,

1.1.1.2 the member, and/or duly authorised representative, administrator or executor shall diligently and expeditiously pursue such claim for the recovery of any benefit paid by the Scheme and to keep the Scheme and/or the Scheme's administrators reasonably and properly informed of progress.

1.1.1.3 the member, such duly authorized representative, administrator or executor shall bear all costs arising from the pursuit of any claim or action against such third party, unless otherwise agreed to in writing by the duly authorized representative of the Scheme.

1.2 All costs in respect of injuries arising from professional sport, speed contests and speed trials, unless PMB.

1.3 All costs for operations, medicines, treatment and procedures for cosmetic purposes.

1.4 All costs for Mammoplastics, i.e. Breast Reductions, unless medically necessary.

1.5 All costs for the treatment of infertility, except for PMB's.

1.6 The artificial insemination of a person as defined in the Human Tissue Act, 1983 (Act of 1983).

1.7 Holidays for recuperative purposes.

1.8 Purchase of:

- Medicines not registered with the Medicines Control Council and proprietary preparations;
- Applicators, toiletries, beauty preparations, soaps, shampoos and other topical applications;
- Cosmetics, emollients and moisturizers, including sun-tan lotions namely; sunscreens and tanning agents;
- Bandages, cotton wool, dressings and other consumable items;
- Food /nutritional supplements and patented foods, including baby foods;
- Tonics, slimming preparations used to treat or prevent obesity and drugs as advertised to the public; and
- Household and biochemical remedies.
- Diagnostic agents
- Aphrodisiacs;
- Anabolic steroids;
- Household remedies or preparations of the type advertised to the public;

1.9 The purchase of medicines not included in a prescription from a person legally entitled to prescribe medicine.

1.10 Unless PMB, all costs that are more than the benefit to which a member is entitled in terms of these rules, unless otherwise agreed to by the Board.

1.11 Charges for appointments which a member or dependant of a member fails to keep.

1.12 Costs for services rendered by –

1.12.1 persons not registered with a recognised professional body constituted in terms of any law; or

1.12.2 any organisation, clinic, institution, nursing home or similar institution except a state or provincial hospital not registered in terms of any law.

1.13 All costs related to the treatment of erectile dysfunction, unless approved by the Scheme.

1.14 All costs related to gender re-alignment for personal reasons and not directly caused by or related to illness, accident or disorder.

1.15 Section 21 medicines not approved and registered with the South African Medicines Control Council.

1.16 All costs for use of gold in dentures or the cost of fold as an alternative to non-precious metal in crowns, inlays and bridges.

1.17 All optical devices which are not regarded by the South African Optometric Association as clinically essential or clinically desirable, including sunglasses and spectacle cases or solution kits for contact lenses.

1.18 No claim shall be payable by the Scheme if, in the opinion of the Medical Advisory Committee, the health care service in respect of which such claim is made, is not appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition at an acceptable level of service. The decision of the Medical Advisory Committee will also take into consideration the current practice, evidence based medicine, cost effectiveness and affordability.

1.19 Appliances: the purchase or hire of special beds, chairs, cushions, commodes, sheepskin, waterproof sheets for beds, bedpans, special toilet seats or repairs of or adjustments to sick room or convalescing equipment, with the exception of the hire of oxygen cylinders and provided where oxygen cylinders and provided where the Scheme has provided prior written approval

for the purchase of these and other appliances unless provided for in Annexure B or a PMB.

1.20 Motherhood: charges for ante-and post-natal exercise classes, mothercraft or breastfeeding instructions.

1.21 War: injury or disablement fur to war, invasion or civil war, except for PMB's.

2 LIMITATIONS

2.1 The maximum benefits to which a member and his dependants are entitled in any Financial year are limited as set out in Annexure B.

2.2 Members admitted during the course of a financial year are entitled to the benefits set out in the schedules appended hereto, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

2.3 Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one month's supply or nearest unbroken pack for every such prescription or repeat thereof.

2.4 In cases of illness of a protracted nature the Board may insist that a member or a dependant must consult a particular specialist that the Board may nominate in consultation with the attending practitioner. If such specialist's advice is not acted upon, no further benefits will be allowed for that particular illness. Subject to evidence based managed care protocol/ formularies, as provided for in regulation 15.

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24/12/2021 21:22:53 (UTC+02:00)
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Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2022

PREAMBLE

The benefits and services in respect of the Prescribed Minimum Benefits (PMB) conditions are funded as set out in this Annexure.

The Scheme has established the following Designated Service Providers (DSP) and Networks:

- SANCA, RAMOT or Nishtara for drug and alcohol, detoxification and rehabilitation;
- Remedi Standard Option GP Network;
- Classic Direct Specialist Direct Payment Arrangements;
- Premier Specialist/GP Direct Payment Arrangements;
- KeyCare Specialist Direct Payment Arrangements;
- A list of pharmacies that entered into preferred provider arrangements with the Scheme (See Annexure B);
- Optical Network (Preferred Provider Negotiators – PPN);
- A list of private hospitals that entered into tariff arrangements with the Scheme;
- Dental management through the Dental Risk Company as a preferred provider for members on the Standard Option;
- ER24 as a preferred provider for emergency services;
- A list of hospitals to obtain services for Prescribed Minimum Benefits known as the PMB Hospital Network;
- An In-hospital GP and Specialist Network for services related to PMB;
- A Mental Health Network to obtain out-of-hospital services from a list of Psychiatrists and Social Workers who has entered into a preferred provider arrangement with the Scheme.
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A Beneficiary will be deemed to have involuntarily obtained a service from a provider other than the abovementioned contracted network providers or DSP, if -

(i) the service was not available from the DSP or would not be provided without unreasonable delay;

(ii) immediate medical or surgical Treatment for a PMB benefit condition was required under circumstances or at locations which reasonably precluded the Beneficiary from obtaining such treatment from a DSP; or

(iii) if there was no DSP within reasonable proximity to the Beneficiary's ordinary place of business or personal residence.

The below tables set out the manner in which the Scheme will fund PMB conditions if:

a) a Beneficiary use the DSP or involuntarily uses a non-DSP or

b) a Beneficiary voluntarily does not use the DSP.

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2022

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary uses the DSP or involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
Chronic Disease List ("CDL") and Diagnostic Treatment Pairs Prescribed Minimum Benefits ("DTPMB") : – **Out-of-Hospital Consultations**	**Specialists:** Any specialist participating in the KeyCare or Premier Rate Specialist Network.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP. The Scheme shall pay the costs of PMB at 100% of the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate. The co-payment, which the member is liable for is any amount the provider charges above Scheme Rate.
	GPs: Any GP participating in the Scheme's GP Network or GP Premier Rate arrangements.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP. The Scheme shall pay the costs of PMB at 100% of the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate. The co-payment, which the member is liable for is any amount the provider charges above Scheme Rate.
CDL and DTPMB: **Out-of-Hospital Diagnosis**	**Specialists:** Any specialist participating in the KeyCare or Premier Rate Specialist Network. **GPs:** Any GP participating in the Scheme's GP Network GP Premier Rate arrangements.	The Scheme shall pay the costs of PMB in full, subject to the Scheme's diagnostic Basket of Care and the member making application to the Scheme for CDL and/or DTPMB cover.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate, subject to the Scheme's diagnostic Basket of Care and the member making application to the Scheme for CDL and/or DTPMB cover.

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2022

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
CDL: **Out-of-Hospital Medicine**	The DSP is a defined list of contracted pharmacies and/or providers.	The Scheme shall pay the costs of PMB medication in full, subject to the Scheme's Formulary. If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to the maximum of the chronic drug amount ("CDA") or Therapeutic Reference Price ("TRP") as specified per the Option the patient is registered on and subject to the Scheme's Medication Rate. This is subject to Regulations 15 H (c) and 15 I (c).	The Scheme shall pay the costs of PMB medication up to the Scheme Medication Rate or Therapeutic Reference Price (TRP) for medication obtained voluntarily from a non-DSP, subject to the Scheme's Formulary. This is subject to Regulations 15 H (c) and 15 I (c). If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to CDA or TRP. Where the pharmacy and/or provider charges more than the Scheme Medication Rate or Therapeutic Reference Price, an additional co-payment may apply.

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2022

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
DTPMB: **Out-of-Hospital Medicine**	The DSP is a defined list of contracted pharmacies and/or providers.	The Scheme shall pay the costs of PMB medication in full, subject to the Scheme's Formulary. If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to the maximum of the chronic drug amount (CDA) or Therapeutic Reference Price (TRP)as specified per the Option the patient is registered on and subject to the Scheme's Medication Rate. This is subject to Regulations 15 H (c) and 15 I (c).	The Scheme shall pay the costs of PMB medication up to the Scheme Medication Rate or Therapeutic Reference Price (TRP) for medication obtained voluntarily from a non-DSP, subject to the Scheme's Formulary. If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to the maximum of CDA or TRP.
CDL and DTPMB: **Out-of-Hospital Pathology**	Any provider that the Scheme has an agreement with for Pathology services.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP. The Scheme shall pay 100% of the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The co-payment, which the member is liable for is any amount the provider charges above Scheme Rate.
CDL and DTPMB: **Out-of-Hospital Radiology**	Any provider charging the Scheme Rate for Radiology services.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP. The Scheme shall pay 100% of the Costs or the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB in full for voluntary use of a non-DSP. The Scheme shall pay 100% of the Costs or the agreed rate for services obtained from a DSP.

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2022

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
DTPMB: **In-hospital admissions**	Any PMB Network Hospital facility as contracted with the Scheme. Subject to Regulation 8 (3) (a) and (b).	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate.
DTPMB: **In-Hospital Consultations**	**Specialists:** Any specialist participating in the KeyCare or Premier Rate Specialist Network. **GPs:** Any GP participating in the Scheme's GP Network and practicing in a PMB Network Hospital facility. Subject to Regulation 8 (3) (a) and (b).	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate.
DTPMB: **Mental Illness**	**Drug and Alcohol abuse facilities:** Any facility and/or provider contracted with the Scheme.	The Scheme shall pay the costs of PMB in full for involuntary use of non-DSP and up to the agreed rate for services obtained from a DSP up to a maximum of 21 days in-hospital.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP, subject to a maximum of 21 days. The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate.

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2022

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
	All other conditions: Any provider contracted with the Scheme and/or a defined list of hospitals with a psychiatric ward as contracted with the Scheme. Subject to the condition meeting clinical entry criteria and the Scheme's Baskets of Care.	The Scheme shall pay the costs of PMB in full, subject to the rate contracted with the hospital for a psychiatric ward/facility. Payment will be equivalent of up to a maximum of 21 days in-hospital, or 12 or 15 days out-of-hospital consultations for conditions as defined in Annexure A of the Regulations.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate.
DTPMB: **Terminal Care facilities**	Hospice and any other compassionate care facility.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP. The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate.
Oncology/Cancer: **Out-of-Hospital Treatment**	**Specialists:** Any Oncologist who has agreed to charge the Premier Rate and/or any specialist contracted with the Scheme. Subject to Regulation 8 (3) (a) and (b).	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate or Cost for voluntary use of a non-DSP.
	GPs: Any GP on the Scheme's GP Network who is a SAOC member;	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate or Cost for voluntary use of a non-DSP.

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2022

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
Oncology/Cancer: **Chemotherapy**		The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate or Cost for voluntary use of a non-DSP.
Oncology/Cancer: **Pathology**	Any provider that the Scheme has an agreement with for Pathology services;	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate or Cost for voluntary use of a non-DSP.
Oncology/Cancer: **Radiology**	Any provider charging the Scheme Rate for Radiology services;	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB in full for voluntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.
HIV: **Out-of-Hospital Consultations**	**Specialists:** Any specialist participating in the KeyCare or all specialists who have agreed to charge the Premier Rate.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP.
	**GPs:** Any Premier Plus or Remedi Standard GP who has contracted with the Scheme.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP.

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2022

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
HIV: **Pathology**	Any provider that the Scheme has an agreement with for Pathology services.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP.
HIV: **Radiology**	Any provider charging the Scheme Rate for Radiology services.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay the costs of PMB in full for voluntary use of a non-DSP and up to the agreed rate for services obtained from a DSP
HIV: **Medicine**	The DSP is a defined list of contracted pharmacies and providers.	The Scheme shall pay the costs of PMB medication in full for involuntary use of a non-DSP, subject to the Scheme's Formulary. If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to maximum of the chronic drug amount (CDA) or Therapeutic Reference Price (TRP) as specified per the Option the patient is registered on and subject to the Scheme's Medication Rate. This is subject to Regulations 15 H (c) and 15 I (c).	The Scheme shall pay the costs of PMB medication up to the Scheme Medication Rate or TRP for medication obtained voluntarily from a non-DSP, subject to the Scheme's Formulary. If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to CDA or TRP.

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2022

Type	Designated Service Provider ("DSP")	a) Reimbursement Rate if the Beneficiary involuntarily uses a non-DSP	b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP
HIV: **Voluntary Counselling and Testing (VCT)**	Any vendor that has contracted with the Scheme.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay up to a maximum of 100% of the Scheme Rate for voluntary use of a non-DSP.
RENAL: **Specifically as regard to Chronic Renal Dialysis, Pathology and Drugs**	Contracted provider, applicable to Member's chosen Option, in respect of the Scheme's chronic renal dialysis network.	The Scheme shall pay the costs of PMB in full for involuntary use of a non-DSP and up to the agreed rate for services obtained from a DSP.	The Scheme shall pay up to 100% of the Scheme Rate for voluntary use of a non-DSP. The co-payment, which the member is liable for is any amount the provider charges above Scheme Rate.

Notes:

1. For approved PMB conditions, all treatment codes and procedure codes must accord with the Scheme's Baskets of Care. The Scheme may have regard to Regulations 15H(c) and 15I(c).

2. "SAOC" means the South African Oncology Consortium.

3. In accordance with what is stated in the main body to these Rules, no healthcare costs associated with a PMB will be paid if such costs are voluntarily incurred outside of the territory of the Republic of South Africa and other territories within the Rand Monetary Area.

4. Where claims are paid in full, Beneficiaries will not be required to make any payments not reimbursable by the Scheme.

5. CDA (Chronic Drug Amount) is the reference price applied by the Scheme to all off-formulary medication claims.

6. TRP (Therapeutic Reference Price) is the reference price model applicable to all fixed NAPPI formularies, such as the Chronic Disease List ("CDL"), Out of Hospital Diagnostic Treatment Pairs Prescribed Minimum Benefits ("OHDTPMB"), HIV and Oncology medicines, ensuring reimbursement of non-formulary products that link to the formulary drug classes on a generic and therapeutic level.

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2022

7. Baskets of Care, is a list of consultations, investigations and other procedures that pertain to the care of a CDL condition (Chronic Disease List condition as per the Medical Schemes Act and its relevant regulations and amendments for Prescribed Minimum Benefits), over a period of time which may be adaptable to the patient's specific needs through a process of interaction and consultation with the Scheme's contracted Managed Care Organisation and/or medical advisors and which will be associated, where applicable, with the drugs as listed in the PMB CDL Algorithms for the specific CDL conditions.

8. PMB services will accumulate to insured limits where these limits exist. Once depleted, the remaining PMB entitlement will apply.

9. In accordance with what is stated in the Scheme's main body of the rules, the Beneficiary must authorise all voluntary DTPMB hospital admissions, which admissions include, but are not limited to, Mental Illness admissions, HIV and Oncology admissions, within 48 hours of the required elective procedure/treatment. Failure to so will entitle the Scheme to apply a co-payment of R1 000.

10. This Annexure to be read in conjunction with **Annexure B**.

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REMEDI

Administered by Discovery Health

Resolution 1 of 2022

Certified as having been adopted in terms of the Rules**,** at a meeting of the **Board of Trustees held on 22 April 2021 and 22 September 2021** that the following changes to the Annexures of the Remedi Medical Aid Scheme ("the Scheme") **will take effect 1 January 2022 or as specified in this Resolution**:

1. Contribution amounts to increase with effect from 1 July 2022 as follows:

   Increase of 7.9% on all Options.

   The amended contribution table amounts are included with this Certificate for registration by the Council for Medical Schemes ("CMS") with effect from 1 July 2022.

2. Amendments to the Benefit Annexures of the Rules and benefit limits for 2022 are set out below and will take effect 1 January 2022:

2.1 Inflationary increase assumptions of 4.5% on average in respect of benefit limits, as well as medicine increases was approved, except where agreed not to be increased, such as the specialized medicine benefit limit;

2.2 Amendments to Annexure A1, A2 and A3 contains the monetary value adjustments;

2.3 Amendments to Annexure B to be read in conjunction with Annexure D that sets out the funding guidelines for Prescribed Minimum Benefits are enclosed in tracked changes to identify the benefit and managed healthcare initiative changes as approved by the Board of Trustees. These changes are also reflected in Annexures B1, B2 and B3 with tracked changes as part of the submission and includes the following benefit and managed healthcare initiative changes, where "x" indicates that the change is applicable:

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Description of change	Standard	Classic	Comprehensive	Summary of Rules impacted and Reasons if no Rule amendments incorporated
Spinal Care Programme	x	x	x	New Paragraph 11.3 in Annexure B has reference. At an Option level Spinal benefits was updated to make provision for funding at network and non-network providers at 100% of the Remedi Rate in Annexures B1 Rule 14, B2 Rule 15 and B3 Rule 13.
Mental Health relapse prevention programme	x	x	x	No impact on Rules as enhancements form part of the Patient Management Programme referenced in Annexure B Paragraph 11.1, which makes provision for funding from a "basket of care".
Point of Care ("POC") Testing	x	x	x	The following is added to all the Options' Rules where pathology testing is referenced: "Point-of-care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria." This change was incorporated into Annexures B1, B2 and B3, Rule 6. For clarity purposes funding for the point-of-care devices from the existing external

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				prostheses Annexure B1 Rule 15, Annexure B2 16 and Annexure B3 14 was incorporated as well.
Readmission Prevention Benefit	x	x	x	Annexure B1, B2 and B3, Rule 1 were updated to make provision for this enhancement ito funding for treatment post hospital treatment in a home care environment.
Oncology Advanced Illness Benefit ("AIB") Enhancements	x	x	x	Annexure B, paragraph 11.2.1 was updated to remove the requirement that a treating doctor register the patient onto the programme as these enhancements don't require the registration to be done by the treating doctor anymore.
Member Care Programme	x	x	x	New Paragraph 11.4 in Annexure B has reference
Funding of CPAPs from external prostheses limits	x	x	x	The funding of CPAP devices from the "all other appliances" limits were clarified in the Rules through the insertion of a paragraph in Annexures B1 Rule 15, B2 Rule 16 and B3 Rule 14.
Long COVID-19 programme	x	x	x	Current WHO out-of-hospital benefit was updated in all Rules 6 of Annexures B1, B2 and B3 to make provision for funding of Long COVID.

Therapeutic Reference Pricing ("TRP")	x			The introduction of this reference price impacts Standard Option only and references to formularies and where funding of medicine is mentioned, was amended to include the provision for funding up to a "Therapeutic Reference Price" in Annexures B, paragraph 10.5.3, Annexure B1 Rule 3 (as well as including a definition in Annexure B1) and Annexure D.
Continuous Glucose Monitoring (CGM)		x	x	The funding of these appliances are only permitted on the Classic and Comprehensive Options. To ensure this funding differentiation is correctly reflected in the Benefit Rules, Annexures B2 and B3 was updated to include reference of funding of CGMs from the "other external appliances" benefit. Annexure B2 Rule 16 and B3 Rule 14 was updated.

Note: Where grammatical and spacing corrections were made, it will reflect in the tracked change documents provided with the submission. Those amendments are not detailed below.

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Annexure B

Paragraph number	Change	Reason for change
10.5.3	Insertion of the words "..,the Scheme will fund the medicine up to a Therapeutic Reference Price ("TRP") or.." and deletion of the words "..for any amount in excess of.." after the words ".. use another medicine instead..". The words ".., shall be payable by such Beneficiary." is also deleted to correct the structure of the sentence.	To provide for funding of chronic medicine up to the Chronic Drug Amount or the Therapeutic Reference Price List as approved by the Board of Trustees.
Amendment of par 10. 11 and subsequent paragraphs to par 11.	The insertion of the header "Managed Care Programmes" as new paragraph 11 in Annexure B.	These programmes do not form part of the Prescribed Minimum Benefits paragraph 10 and was incorrectly numbered in the document.
11.2	Deletion of the word "Remedi" and replacement with the word "Discovery".	The Scheme is contracted with Discovery for these services and not with itself and therefore the reference to "Remedi" was incorrectly reflected in the document.
11.2.1	The deletion of the words: "Members need to be registered on the programme by their treating doctor and…" in the last sentence.	Registration would no longer be considered only in cases where the treating doctor makes application to register the patient on the programme, but members will be proactively registered on the

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		programme as part of the managed healthcare services to the Scheme and its members.
11.3	New paragraph "Spinal Care" is added with the following insertion: "The Spinal Care Programme offers a spinal surgery component for members needing spinal surgery, and a conservative care programme for those with severe back pain, but where surgery can be prevented through out-of-hospital care. If spinal surgery is the only option to manage the back pain, members can access a facility within the Remedi Spinal Care Surgery Network. Members are covered for conservative back pain management, which includes consultations with physiotherapists or chiropractors who specialise in the management of back pain and are part of the conservative care network."	To make provision for the Spinal Care Programme as approved by the Board of Trustees. REGISTERED BY ME ON Mashilo Leboho 2021/12/23 24/12/2021 11:12:04(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM
11.4	New paragraph "Member Care Programme" is added with the following insertion: "This customised, outpatient programme helps members who have complex medical needs. The programme facilitates high-quality, planned, person-centred care	To make provision for the Member Care Programme as approved by the Board of Trustees.

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	and chronic condition management to achieve improved outcomes. Members that qualify for the programme are identified via a risk intelligence tool and the member care team. The team will contact members proactively to offer voluntary enrolment if they meet the clinical criteria.”	

Annexure B1

Rule number	Change	Reason for change
1 - 21	Amendment of Rules to reflect the revised benefit limit amounts for 2022.	Increases as approved by the Board and set out in the enclosed limit sheet in Excel format
1 – 21 where necessary	The deletion of the word “Discovery*Care*” and insertion of the words “Discovery Health as contracted”.	The reference to “Discovery*Care*” is outdated and required to be corrected in these Annexures.
1. New paragraph: “Readmission Prevention Benefit”	Insertion of the following paragraph in the Benefit column: “Homecare by a healthcare provider and/or qualified nurse for patients considered at high risk of readmission, when discharged from acute care”	To make provision for the readmission benefit as approved by the Board of Trustees.

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	Insertion of the following words in the Rate column: "100% of the Remedi Rate" Insertion of the following words in the Limits column: "Subject to overall annual limit" Insertion of the following words in the Comments column: "Basket of care as approved by Remedi"	REGISTERED BY ME ON Mashilo Leboho 24/12/2021 10:12:17(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za SIGNIFLOW.COM REGISTRAR OF MEDICAL SCHEMES
2. Hospitalisation in public hospitals as well as surgery and medical procedures performed by public sector practitioners	Deletion of the words "the Remedi Rate" and insertion of the word "Cost"	The Scheme is not contracted with the public hospitals and cannot pay these claims at an agreed "Remedi Rate" and the correction was requested by the Council for Medical Schemes ("CMS") for submission and correction.
3. Medicines	Insertion of the words "/Therapeutic Reference Price ("TRP")" in the Rate column Subsequent insertion of the abbreviation "TRP" in the Limits column, where necessary, as well as the insertion of the following paragraph in the Limits column:	To allow for funding of chronic medicines up to the newly approved Therapeutic Reference Price List introduced for the Scheme as approved by the Board of Trustees. As agreed with the Board of Trustees, to correctly reflect the funding of flu vaccines in the benefit rules of the Scheme.

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	"One influenza vaccine per beneficiary per year payable and subject to the OTC limit, where a member consult with a network provider." The insertion of the following paragraph in the Comments column: "Influenza vaccines for high risk members and members > 65 years and/or members who are pregnant are funded from the Prevention and Screening Benefit. Clinical entry criteria is applicable."	
6. Out-of-hospital benefit… "pathology.."	The insertion of the following words in the Limits column after the words "pathology tests as limited by agreement..: ", including point-of-care testing as authorised; " The insertion of the following paragraph in the Comments column: "Point-of-care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria."	To make provision for the funding of point-of-care testing as approved by the Board of Trustees.
6. Out of hospital benefit..	The insertion of the following in the Benefit column: "- Vaccines and the administration of the vaccines;	As approved by the Board of Trustees, to update the funding of COVID-19 to align with the requirements of Prescribed Minimum Benefits ("PMB") and to remove the provision of funding in

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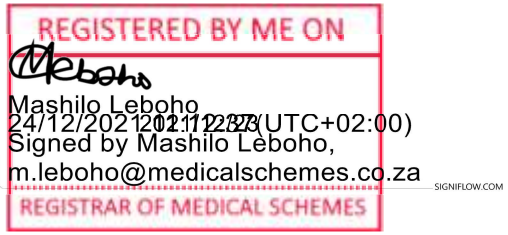
"World Health Organisation (WHO).."	- Home-based care in lieu of hospitalisation - Treatment of complications and rehabilitation for Long Covid" And the deletion of the following sentence in the Benefit column: "- Accommodation in accredited isolation facilities" The insertion of the following in the Limits column: - "Unlimited home-based care in lieu of hospitalisation" And the deletion of the following sentence in the Limits column: - "Up to a maximum of R400 per day for accommodation in an accredited isolation facility up to a maximum of 14 days' accommodation per person per year." The insertion of the following words in the Comments column in the current second sentence following the words: ".. protocols and..":	isolation facilities which are no longer part of the prescribed benefits for COVID-19. REGISTERED BY ME ON Mashilo Leboho 2021/12/23 24/12/2021 11:12:31(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM

	"..the condition and treatment meeting the Scheme's.." and the insertion of the following sentence thereafter: "Long Covid activation of the benefit and basket of care provided by the Scheme for a period of 6 months from the date of diagnosis by the treating healthcare provider."	
9. Optical	The insertion of the following words in the first sentence in the Limits column: "a glaucoma screening, …. and Artificial intelligence for the detection of diabetic retinopathy" before and after the words ".. visual field screening..", as well as the deletion of "..tonometry and.." in this sentence. As well as the insertion of the words ".. at Preferred Providers only.", where necessary.	Alignment of the benefit offering with the agreed benefits of the preferred provider.
13. "Preventative and Screening Benefit" is amended to read "Prevention and Screening Benefit"	The insertion of the following words at the end of the first sentence in the Benefit column: "..members who are pregnant and members above the age of 65"	As agreed with the Board of Trustees, to clarify the co-hort for whom the flu vaccine is paid from the Prevention and Screening Benefit.

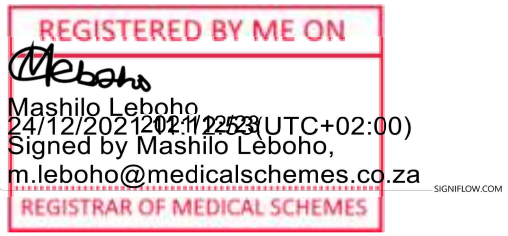
S. Bothra

14. Internal Prostheses and Devices	The insertion of the following sentence in the Comments column under the "Spinal benefit limit" section: • "Funding at network or non-network providers up to 100% of the Remedi Rate"	To make provision for the funding of spinal care treatment at network and non-network providers up to 100% of the Remedi Rate as approved by the Board of Trustees.
15. External Prostheses and Appliances…	The insertion of the following sentences in the Comments column: "CPAP devices funded from the "all other appliances" limit as available, where deemed clinically appropriate and limited to the agreed/negotiated rates with preferred providers. Point-of-care devices for point-of-care testing are funded from the "all other appliances" limit as available, where deemed clinically appropriate."	To make provision for the funding Point-of-care devices from the external prostheses and appliances benefits, to allow for point-of-care testing and to allow funding of CPAP machines as approved by the Board of Trustees. REGISTERED BY ME ON Mashilo Leboho 24/12/2021 12:43 (UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za SIGNIFLOW.COM REGISTRAR OF MEDICAL SCHEMES
17. Psychiatric benefit in hospital and in lieu of hospitalisation	The insertion of the following words in the Limits column: "in hospital or 15 days in an out-of-hospital setting or a combination of in- and out-of-hospital as prescribed in terms of Prescribed Minimum Benefits"	To clarify the funding in alignment with the Prescribed Minimum Benefits ("PMB") to be provided by the Scheme.

S. Botha

<table>
<tr>
<td>Glossery/Explanatory Notes:</td>
<td>The insertion of the following additional explanatory notes:

<table>
<tr><td>Therapeutic Reference Price (“TRP”)</td><td>A reference price model applicable to all fixed NAPPI formularies, such as the Chronic Disease List (“CDL”), Out of Hospital Diagnostic Treatment Pairs Prescribed Minimum Benefits (“OHDTPMB”), HIV and Oncology medicines, ensuring reimbursement of non-formulary products that link to the formulary drug classes on a generic and therapeutic level</td></tr>
</table>
</td>
<td>The introduction of a definition for Therapeutic Reference Pricing as approved by the Board of Trustees.



</td>
</tr>
</table>

Annexure B2

Rule number	Change	Reason for change
1 - 25	Amendment of Rules to reflect the revised benefit limit amounts for 2022.	Increases as approved by the Board and set out in the enclosed limit sheet in Excel format
1 – 25 where necessary	The deletion of the word "Discovery*Care*" and insertion of the words "Discovery Health as contracted".	The reference to "Discovery*Care*" is outdated and required to be corrected in these Annexures.
1. New paragraph: "Readmission Prevention Benefit"	Insertion of the following paragraph in the Benefit column: "Homecare by a healthcare provider and/or qualified nurse for patients considered at high risk of readmission, when discharged from acute care" Insertion of the following words in the Rate column: "100% of the Remedi Rate" Insertion of the following words in the Limits column: "Subject to overall annual limit" Insertion of the following words in the Comments column: "Basket of care as approved by Remedi"	To make provision for the readmission benefit as approved by the Board of Trustees.

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Mashilo Leboho
24/12/2021 11:21:00 (UTC+02:00)
Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za
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2. Hospitalisation in public hospitals as well as surgery and medical procedures performed by public sector practitioners	Deletion of the words “the Remedi Rate” and insertion of the word “Cost”	The Scheme is not contracted with the public hospitals and cannot pay these claims at an agreed “Remedi Rate” and the correction was requested by the Council for Medical Schemes (“CMS”) for submission and correction.
6. Insured Out-of-hospital benefit…	The insertion of the following words in the Benefit column after the words “.. pathology outside hospital,..” “, point-of-care testing as authorised; “ The insertion of the following paragraphs in the Comments column: “For members who are not high risk and who are < 65 years or who are not pregnant, one influenza vaccine per beneficiary per year is payable from the IOH limit. Influenza vaccines for high risk members and members > 65 years and/or members who are pregnant are funded from the Prevention and Screening Benefit. Clinical entry criteria are applicable.” “Point-of-care pathology testing is subject to meeting the Scheme’s treatment	To make provision for the funding of point-of-care testing as approved by the Board of Trustees. As agreed with the Board of Trustees, to correctly reflect the funding of flu vaccines in the benefit rules of the Scheme. REGISTERED BY ME ON Mashilo Leboho 24/12/2021 10:13:08(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM

	guidelines and Managed Health Care criteria."	
6. Insured Out-of-hospital benefit… "World Health Organisation (WHO).."	The insertion of the following in the Benefit column: "- Vaccines and the administration of the vaccines; - Home-based care in lieu of hospitalisation - Treatment of complications and rehabilitation for Long Covid" And the deletion of the following sentence in the Benefit column: "- Accommodation in accredited isolation facilities" The insertion of the following in the Limits column: - "Unlimited home-based care in lieu of hospitalisation" And the deletion of the following sentence in the Limits column: - "Up to a maximum of R400 per day for accommodation in an accredited isolation facility up to a maximum of 14 days' accommodation per person per year."	As approved by the Board of Trustees, to update the funding of COVID-19 to align with the requirements of Prescribed Minimum Benefits ("PMB") and to remove the provision of funding in isolation facilities which are no longer part of the prescribed benefits for COVID-19. REGISTERED BY ME ON Mashilo Leboho 2021/12/23 24/12/2021 11:13:15(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM

	The insertion of the following words in the Comments column in the current second sentence following the words: ".. protocols and..": "..the condition and treatment meeting the Scheme's.." and the insertion of the following sentence thereafter: "Long Covid activation of the benefit and basket of care provided by the Scheme for a period of 6 months from the date of diagnosis by the treating healthcare provider."	
8. Maternity	The insertion of the words ".. as deemed clinically appropriate;" in the Limits column and the deletion of the numeric values as reflected in the following limits: - "HIV Elisa, Rubella, RPR and TPHA and bHCG tests" and "RH antigen, Haemoglobin, A B and O antigens"	The correction of the Rules to allow for more than 1 or two tests where deemed clinically appropriate and as per standard baskets of care.
10. Optical	The insertion of the following words in the first sentence in the Limits column: "a glaucoma screening, …. and Artificial intelligence for the detection of diabetic retinopathy" before and after the words ".. visual field screening..", where necessary , as well as the deletion of "..tonometry and.." in this sentence.	Alignment of the benefit offering with the agreed benefits of the preferred provider.

S. Botha

14. "Preventative and Screening Benefit" is amended to read "Prevention and Screening Benefit"	The insertion of the following words at the end of the first sentence in the Benefit column: "..members who are pregnant and members above the age of 65"	As agreed with the Board of Trustees, to clarify the co-hort for whom the flu vaccine is paid from the Prevention and Screening Benefit.
15. Internal Prostheses and Devices	The insertion of the following sentence in the Comments column under the "Spinal benefit limit" section: • "Funding at network or non-network providers up to 100% of the Remedi Rate"	To make provision for the funding of spinal care treatment at network and non-network providers up to 100% of the Remedi Rate as approved by the Board of Trustees.
16. External Prostheses and Appliances…	The insertion of the following sentences in the Comments column: "CPAP devices funded from the "all other appliances" limit as available, where deemed clinically appropriate and limited to the agreed/negotiated rates with preferred providers. Point-of-care devices for point-of-care testing are funded from the "all other appliances" limit as available, where deemed clinically appropriate.	To make provision for the funding Point-of-care devices from the external prostheses and appliances benefits, to allow for point-of-care testing and to allow funding of CPAP machines as approved by the Board of Trustees at the September 2021 meeting. To clarify the funding of Continuous Glucose Monitors from the other appliances limit, following the approval of CGMs at a Board of Trustees meeting held on 22 April 2021. The benefit funding took effect 1 May 2021.

S. Botha

	With effect from 1 May 2021, Continuous Glucose Monitors (“CGM”), where deemed clinically appropriate are funded from the “all other appliances” limit up to the agreed/negotiated rates with preferred providers.”	REGISTERED BY ME ON Mashilo Leboho 2021/12/23 24/12/2021 11:13:37(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM
18. Psychiatric benefit in hospital and in lieu of hospitalisation	The insertion of the following words in the Limits column: “in hospital or 15 days in an out-of-hospital setting or a combination of in- and out-of-hospital as prescribed in terms of Prescribed Minimum Benefits”	To clarify the funding in alignment with the Prescribed Minimum Benefits (“PMB”) to be provided by the Scheme.

S. Botha

Annexure B3

Rule number	Change	Reason for change
1 - 19	Amendment of Rules to reflect the revised benefit limit amounts for 2022.	Increases as approved by the Board and set out in the enclosed limit sheet in Excel format
1 – 19 where necessary	The deletion of the word "Discovery*Care*" and insertion of the words "Discovery Health as contracted".	The reference to "Discovery*Care*" is outdated and required to be corrected in these Annexures.
1. New paragraph: "Readmission Prevention Benefit"	Insertion of the following paragraph in the Benefit column: "Homecare by a healthcare provider and/or qualified nurse for patients considered at high risk of readmission, when discharged from acute care" Insertion of the following words in the Rate column: "100% of the Remedi Rate" Insertion of the following words in the Limits column: "Subject to overall annual limit" Insertion of the following words in the Comments column: "Basket of care as approved by Remedi"	To make provision for the readmission benefit as approved by the Board of Trustees.

2. Hospitalisation in public hospitals as well as surgery and medical procedures performed by public sector practitioners	Deletion of the words “the Remedi Rate” and insertion of the word “Cost”	The Scheme is not contracted with the public hospitals and cannot pay these claims at an agreed “Remedi Rate” and the correction was requested by the Council for Medical Schemes (“CMS”) for submission and correction.
6. Insured Out-of-hospital benefit…	The insertion of the following words in the Benefit column after the words “.. pathology outside hospital,..” “, point-of-care testing as authorised; “ The insertion of the following paragraphs in the Comments column: “For members who are not high risk and who are < 65 years or who are not pregnant, one influenza vaccine per beneficiary per year is payable from the IOH limit. Influenza vaccines for high risk members and members > 65 years and/or members who are pregnant are funded from the Prevention and Screening Benefit. Clinical entry criteria are applicable.” “Point-of-care pathology testing is subject to meeting the Scheme’s treatment	To make provision for the funding of point-of-care testing as approved by the Board of Trustees. As agreed with the Board of Trustees, to correctly reflect the funding of flu vaccines in the benefit rules of the Scheme. REGISTERED BY ME ON Mashilo Leboho 24/12/2021 11:25:28 (UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za SIGNIFLOW.COM REGISTRAR OF MEDICAL SCHEMES

	guidelines and Managed Health Care criteria."	
6. Insured Out-of-hospital benefit… "World Health Organisation (WHO).."	The insertion of the following in the Benefit column: "- Vaccines and the administration of the vaccines; - Home-based care in lieu of hospitalisation - Treatment of complications and rehabilitation for Long Covid" And the deletion of the following sentence in the Benefit column: "- Accommodation in accredited isolation facilities" The insertion of the following in the Limits column: - "Unlimited home-based care in lieu of hospitalisation" And the deletion of the following sentence in the Limits column: - "Up to a maximum of R400 per day for accommodation in an accredited isolation facility up to a maximum of 14 days' accommodation per person per year."	As approved by the Board of Trustees, to update the funding of COVID-19 to align with the requirements of Prescribed Minimum Benefits ("PMB") and to remove the provision of funding in isolation facilities which are no longer part of the prescribed benefits for COVID-19. REGISTERED BY ME ON Mashilo Leboho 24/12/2021 11:13:59 (UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM

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	The insertion of the following words in the Comments column in the current second sentence following the words: ".. protocols and..": "..the condition and treatment meeting the Scheme's.." and the insertion of the following sentence thereafter: "Long Covid activation of the benefit and basket of care provided by the Scheme for a period of 6 months from the date of diagnosis by the treating healthcare provider."	REGISTERED BY ME ON Mashilo Leboho 2021/12/23 24/12/2021 11:14:06(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM
7. Optical	The insertion of the following words in the first sentence in the Limits column: "a glaucoma screening, …. and Artificial intelligence for the detection of diabetic retinopathy" before and after the words ".. visual field screening..", where necessary, , as well as the deletion of "..tonometry and.." in this sentence.	Alignment of the benefit offering with the agreed benefits of the preferred provider.
8. Maternity	The insertion of the words ".. as deemed clinically appropriate;" in the Limits column and the deletion of the numeric values as reflected in the following limits:	The correction of the Rules to allow for more than 1 or two tests where deemed clinically appropriate and as per standard baskets of care.

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	- "HIV Elisa, Rubella, RPR and TPHA and bHCG tests" and "RH antigen, Haemoglobin, A B and O antigens"	
12. "Preventative and Screening Benefit" is amended to read "Prevention and Screening Benefit"	The insertion of the following words at the end of the first sentence in the Benefit column: "..members who are pregnant and members above the age of 65"	As agreed with the Board of Trustees, to clarify the co-hort for whom the flu vaccine is paid from the Prevention and Screening Benefit.
13. Internal Prostheses and Devices	The insertion of the following sentence in the Comments column under the "Spinal benefit limit" section: • "Funding at network or non-network providers up to 100% of the Remedi Rate"	To make provision for the funding of spinal care treatment at network and non-network providers up to 100% of the Remedi Rate as approved by the Board of Trustees.
14. External Prostheses and Appliances…	The insertion of the following sentences in the Comments column: "CPAP devices funded from the "all other appliances" limit as available, where deemed clinically appropriate and limited to the agreed/negotiated rates with preferred providers. Point-of-care devices for point-of-care testing are funded from the "all other	To make provision for the funding Point-of-care devices from the external prostheses and appliances benefits, to allow for point-of-care testing and to allow funding of CPAP machines as approved by the Board of Trustees at the September 2021 meeting. To clarify the funding of Continuous Glucose Monitors from the other appliances limit, following the approval of CGMs at a Board of

	appliances" limit as available, where deemed clinically appropriate. With effect from 1 May 2021, Continuous Glucose Monitors ("CGM"), where deemed clinically appropriate are funded from the "all other appliances" limit up to the agreed/negotiated rates with preferred providers."	Trustees meeting held on 22 April 2021. The benefit funding took effect 1 May 2021. REGISTERED BY ME ON Mashilo Leboho 24/12/2021 11:24:20(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM
16. Psychiatric benefit in hospital and in lieu of hospitalisation	The insertion of the following words in the Limits column: "in hospital or 15 days in an out-of-hospital setting or a combination of in- and out-of-hospital as prescribed in terms of Prescribed Minimum Benefits"	To clarify the funding in alignment with the Prescribed Minimum Benefits ("PMB") to be provided by the Scheme.

2.4 Annexure C footnote amendments to reflect 2022 where necessary.

S. Botha

2.5 Annexure D changes are set out in the below table:

Type and Header	Change	Reason for change
CDL: Out-of-Hospital Medicine and DTPMB: Out-of-Hospital Medicine	Insertion of the following words in the "a) Reimbursement Rate if the Beneficiary involuntarily uses a non-DSP" column: ".. or Therapeutice Reference Price ("TRP").." after the words "chronic drug amount ("CDA").. in the second sentence. And insertion of the following words in the "b) Reimbursement Rate if the Beneficiary voluntarily does not use a DSP /uses a non-DSP" column: "..Therapeutic.." and "..or TRP.." where necessary with the deletion of the word "List" to correct the framing of the sentences in this column.	To allow for funding up to the approved Therapeutic Reference Price List. REGISTERED BY ME ON Mashilo Leboho 24/12/2021 02:14:28 (UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM
Under Notes:	The insertion of a new sub-note number 6 to read: "TRP (Therapeutic Reference Price) is the reference price model applicable to all fixed NAPPI formularies, such as the Chronic Disease List ("CDL"), Out of Hospital Diagnostic Treatment Pairs	To define Therapeutic Reference Price as referenced in the Annexure.

	Prescribed Minimum Benefits ("OHDTPMB"), HIV and Oncology medicines, ensuring reimbursement of non-formulary products that link to the formulary drug classes on a generic and therapeutic level."	REGISTERED BY ME ON Mashilo Leboho 2021/12/23 24/12/2021 11:14:34(UTC+02:00) Signed by Mashilo Leboho, m.leboho@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES SIGNIFLOW.COM

2.6 In all instances header and footers were amended to read "2022" and "1 January 2022" as applicable.

The Rule amendments were approved by the Board of Trustees at a Board of Trustees meeting that took place on 22 September 2021 and is submitted herewith for review and registration.

The amended pages are attached and hereby certified for registration.

Chairperson _____ (Mr JJ Du Plessis)

Trustee_____ (Mrs S Botha)

Principal Officer _____ (Mr J Janse van Vuuren)

Date: 29 September 2021