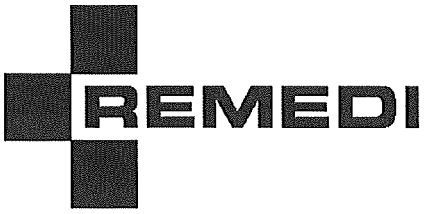


Administered by Discovery Health

# 2021 Remedi Rules

# REMEDI MEDICAL AID SCHEME

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# REMEDI MEDICAL AID SCHEME

# RULES

## 1. NAME

The name of the Scheme is Remedi Medical Aid Scheme, hereinafter referred to as the "Scheme". The above-mentioned name may be abbreviated to REMEDI.

## 2. LEGAL PERSONA

The Scheme, in its own name, is a body corporate, capable of suing and of being sued and of doing or causing to be done all such things as may be necessary for or incidental to the exercise of its powers or the performance of its functions in terms of the Medical Schemes Act and regulations and these rules.

## 3. REGISTERED OFFICE

The registered office of the Scheme is situated at, 1 Discovery Place, Sandhurst, Sandton, 2196, but the Board may transfer such office to any other location in the Republic of South Africa, should circumstances so dictate.

## 4. DEFINITIONS

In these rules, a word or expression defined in the Medical Schemes Act (Act 131 of 1998) bears the meaning thus assigned to it and, unless inconsistent with the context —

(a) A word or expression in the masculine gender includes the feminine;

(b) A word in the singular number includes the plural, and *vice versa*; and

(c) The following expressions have the following meanings:

4.1. **"Act"**, the Medical Schemes Act (Act No 131 of 1998), as amended and the regulations framed there-under.

4.2. **"Approval"**, prior written approval of the Board or its authorised representative, or as provided for in terms of these rules.

4.3. **"Auditor"**, an auditor registered in terms of the Public Accountants' and Auditors' Act, 1991, (Act No. 80 of 1991).

4.4. **"Beneficiary"**, each individual Member and Dependant.

4.5. **"Board"**, the Board of Trustees constituted to manage the Scheme in terms of the Act and these rules.

4.6. **"Capitation agreement"**, means an arrangement entered into between the Scheme and a person whereby the Scheme pays to such person a pre-negotiated fixed fee in return for the delivery or arrangement for the delivery of specified benefits to some or all of the Members of the Scheme.

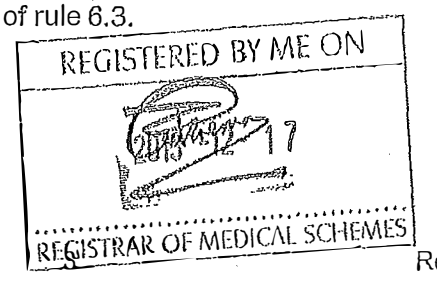
4.7. **"CDA"**, Chronic Drug Amount (monthly reference price) for a medicine class reimbursed from the chronic illness benefit. It only applies to non-formulary listed medication and allows for the reimbursement of non-formulary listed medicines to the equivalent level of the formulary listed medicines in the same drug class.

4.8. **"CDL"**, the Chronic Disease List of Prescribed Minimum Benefit (PMB) chronic conditions

4.9. **"Child"**, a Member's natural Child, or a stepchild or legally adopted Child, or a Child in the process of being legally adopted, or a Child in the process of being placed in foster care, or a Child for whom the Member has a duty of support, or a Child who has been placed in the custody of the Member, or his spouse, or partner and who is not a beneficiary of any other medical scheme.

4.10. **"Condition–specific waiting period"**, a period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for Membership was made.

4.11. **"Continuation Member"**, a Member who retains his Membership of the Scheme in terms of rule 6.2 or a Dependant who becomes a Member of the Scheme in terms of rule 6.3.



4.12. **"Contracted Fee"**, the fee determined in terms of an agreement between the Scheme and a service provider or group of providers in respect of payment of relevant health services.

4.13. **"Contribution"**, in relation to a Member, the amount, exclusive of interest, paid by or in respect of the Member and his registered Dependants if any, as Membership fees and shall include contributions to personal medical savings accounts.

4.14. **"Council"**, the Council for Medical Schemes as contemplated in the Act.

4.15. **"Cost"**, in relation to a benefit, the net amount payable in respect of a relevant health service.

4.14 **"Creditable coverage"**, means any period in which a Late Joiner was –

4.14.1. A Member or a Dependant of a medical scheme;
4.14.2. A Member or a Dependant of an entity doing the business of a medical scheme which, at the time of his or her Membership of such entity, was exempt from the provisions of the Act;
4.14.3. A uniformed Employee of the South African National Defence Force;
4.14.4. Or a Dependant of such Employee, who received medical benefits from the South African National Defence force;
4.14.5. Or a Member or a Dependant of the Permanent Force Continuation Fund;

But excluding any period of coverage as a Dependant under the age of 21 years;

4.15 **"Dependant"**,

4.15.1. A Member's spouse or partner who is not a Member or a registered Dependant of a Member of a medical scheme;
4.15.2. A Member's Dependent Child.
4.15.3. The immediate family of a Member in respect of whom the Member is liable for family care and support.
4.15.4. Any person who is recognised by the Board as a Dependant for purposes of these Rules.

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4.16 **"Dependent"**, in relation to a Child, a Child who, due to a mental or physical disability, is Dependent upon the Member; or a Child who is not older than 26 years, who is a full-time student at a recognized tertiary institution, who is Dependent upon the Member.

4.17 **"Designated service provider"**, a health care provider or group of providers selected by the Scheme as the preferred provider or providers to provide to the Members diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions.

4.18 **"Direct payment arrangements" (DPAs),** are specialist network arrangements whereby specialist providers contracted to and through Discovery Health agree to charge at or below the Remedi Rate for consultations and procedures..

4.19 **"Domicilium citandi et executandi"**, the Members chosen physical address at which notices in terms of Rules 11 and 13, as well as legal process or any action arising wherefrom may be validly delivered and served.

4.20 **"Emergency medical condition"**, the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

4.21 **"Employee"**, a person in the employment of an Employer.

4.22 **"Employer"**, Remgro Limited and any of its associated or subsidiary companies including former associated or subsidiary companies, nominated by it, which have contracted with the Scheme for purposes of admission of its Employees as Members of the Scheme.

4.23 **"Evidence-based medicine"**, the conscientious, explicit and judicious use of current best evidence in making decisions about the care of Beneficiaries whereby individual clinical experience is integrated with the best available external clinical evidence from systematic research.

4.24 **"General Practitioner (GP) Network"**, the network of General Practitioners contracted to and through Discovery Health to provide relevant health care services to Remedi Members at the Remedi Rate.

4.25 **"General waiting period"**, a period in which a beneficiary is not entitled to claim any benefits.

4.26 **"Income"**, for the purposes of calculating contributions in respect of

**4.26.1** A Member who is an Employee;

The remuneration of the Employee as determined by the Employer of such person and in terms of which contributions to the Scheme are made;

**4.26.2** A continuation Member;

The income category at the time of retirement, less two income categories, as defined in the schedules to Annexure A, being Annexure A1, A2 and A3, provided that if such a Member is either on the lowest or the second lowest income category at retirement then the lowest income category shall apply;

**4.26.3** Where both the Member and the Member's spouse or partner are in the service of the Employer, the higher of Member's or spouse's or partner's remuneration;

4.27 **"Late Joiner"**, an applicant or the adult Dependant of an applicant who, at the date of application for Membership or admission as a Dependant, as the case may be, is 35 years of age or older, but excludes any beneficiary who enjoyed coverage with one or more medical scheme as from a date preceding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001.

4.28 **"Managed health care"**, clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes.

4.29 **"Managed health care organisations"**, a person who has contracted with the Scheme in terms of regulation 15A to provide a managed health care service.

4.30 **"Medical Advisory Committee"**, the committee appointed by the Board to advise the Board of Trustees on Clinical matters.

4.31 **"Member"**, any person who is admitted as a Member of the Scheme in terms of these rules.

4.32 **"Member family"**, the Member and all his registered Dependants.

4.33 **"Minimum benefits"**, the benefits in respect of relevant health services as prescribed by the Minister in terms of section 67(1) (g) of the Act.

4.34 **"Partner"**, a person with whom the Member has a committed and serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.

4.35 "**Pre-existing sickness condition**", a sickness condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for Membership was made;

4.36 **"Preferred Provider"**, a health care provider or group of providers selected by the Scheme to provide diagnosis, treatment and care in respect of PMB or non-PMB conditions, because of preferential rates and / or other healthcare related services and benefits offered and provided to the Scheme. For chronic medicine a preferred provider is any pharmacy charging not more than the Single Exit Price for medicines, "SEP", and the dispensing fee equal to that charged by the DSPs.

4.37 **"Prescribed minimum benefits"**, the benefits contemplated in section 29(1)(o) of the Act, and consist of the provision of the diagnosis, treatment and care costs of -

(a) The Diagnosis and Treatment Pairs listed in Annexure A of the Regulations, subject to any limitations specified therein; and

(b) Any emergency medical condition.

4.38 **"Prescribed minimum benefit condition"**, a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations or any emergency medical condition.

4.39 **"Protocol"**, a set of guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standard treatment guidelines, disease management guidelines, treatment algorithms and clinical pathways.

4.40 **"Registrar"**, the Registrar or Deputy Registrar/s of Medical Schemes appointed in terms of section 18 of the Act.

4.41 **"Remedi Rate"**, 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.

4.42 **"Rules–based and clinical management-based programmes"**, a set of formal techniques designed to monitor the use of, and evaluate the clinical necessity, appropriateness, efficacy of, health care services, procedures or settings, on basis of which appropriate managed health care interventions are made.

4.43 **"Spouse"**, the spouse of a Member to whom the Member is married in terms of any law or custom.

## 5. OBJECTS

The objects of the Scheme are to undertake liability, in respect of its Members and their Dependants, in return for a contribution —

(a) To make provision for the obtaining of any relevant health service;

(b) To grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and/or

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(c) To render a relevant health service, either by the Scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person in association with, or in terms of an agreement with, the Scheme.

## 6. MEMBERSHIP

### 6.1 Eligibility

Subject to rule 8, Membership of the Scheme is restricted to:

6.1.1 Employment or former employment by the Employer or his predecessor or successor in title as defined in these rules, and is either voluntary or compulsory, depending on the Employee's conditions of employment.

6.1.2 A Member in the service of the Employer who on secondment by the Employer is employed and resides together with his Dependants outside the Republic of South Africa, who elects upon written notice to the Scheme, given within thirty (30) days of such secondment, to continue with his Membership and that of his Dependants of the Scheme for relevant health care services to be provided to the Member and/or the Member's Dependants only in the Republic of South Africa, during such period of absence outside of the Republic of South Africa.

6.1.3 The Dependants of a Member who is employed and resides outside the Republic of South Africa, on secondment by the Employer, who remain in the Republic of South Africa. The Member must elect upon written notice for such Dependants to continue their Membership of the Scheme within thirty (30) days of the commencement of such secondment.

6.1.4 An Employee who proceeds, with permission of his Employer, to work for such Employer outside the Republic of South Africa and does not elect to continue with his Membership and/or that of his Dependants during such period of absence, shall on application, upon his return be entitled, along with his Dependants, to re-instated Membership without

the imposition of a waiting period or restrictions on account of health status, regardless of the age of the Member.

6.1.5 Where an Employer promotes an Employee to a status where Scheme Membership becomes a condition of employment, such an Employee and his/her Dependants are entitled to Scheme Membership without the imposition of a waiting period or restrictions on account of health status or age. Late Joiner Penalties will also not be applicable.

**6.2 Retirees/Continuation Members**

6.2.1 A Member shall retain his Membership of the Scheme with his registered Dependants, if any, as a retiree / continuation Member, as the case may be, in the event of his

6.2.1.1 Retiring from the service of his Employer;

6.2.1.2 His employment being terminated by his Employer on account of age, ill-health or other disability.

6.2.2 The Scheme shall inform the Member of his right to continue his Membership and of the contribution payable from the date of retirement or termination of his employment. Unless such Member informs the Scheme in writing of his desire to terminate his Membership, he shall continue to be a Member.

**6.3 Dependants of deceased members**

6.3.1 The Dependants of a deceased Member, who are registered with the Scheme as his Dependants at the time of such Member's death, shall be entitled to Membership of the Scheme without any new restrictions, limitations or waiting periods.

6.3.2 The Scheme shall inform the Dependant of his right to Membership and of the contributions payable in respect thereof. Unless such person informs the Scheme in writing of his intention not to become a Member, he shall be admitted as a Member of the Scheme.

6.3.3 Such a Member's Membership terminates if he becomes a Member or a Dependant of a Member of another medical scheme.

6.3.4 Where Child Dependants have been orphaned, the youngest Child may be deemed to be the Member, and any siblings, his Dependants.

## 7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

### 7.1 Registration of Dependants

7.1.1 A prospective Member may apply for the registration of his Dependants at the time that he applies for Membership in terms of Rule 8.

7.1.2 If a Member applies to register a new born or newly adopted Child within 30 days of the date of birth or adoption of the Child, such Child shall thereupon be registered by the Scheme as a Dependant. Increased contributions shall then be due as from the first day of the month following the month of birth or adoption and benefits will accrue as from the date of birth or adoption.

7.1.3 If a Member, who marries subsequent to joining the Scheme, applies within 30 days of the date of such marriage to register his spouse as a Dependant, his spouse shall thereupon be registered by the Scheme as a Dependant. Increased contributions shall then be due as from the first day of the month following the month of marriage and benefits will accrue as from the date of marriage.

7.1.4 In the event of any person becoming eligible for registration as a Dependant other than in the circumstances set out in Rules 7.1.1 to 7.1.3, the Member may apply to the Scheme for the registration of such person as a Dependant, whereupon the provisions of Rule 8 shall apply *mutatis mutandis*.

### 7.2 De-registration of Dependants

7.2.1. A Member shall inform the Scheme within 30 days of the occurrence of any event which results in any one of his Dependants no longer satisfying the conditions in terms of which he may be a Dependant.

7.2.2. Should a member divorce, his former spouse shall no longer be eligible for membership and shall be withdrawn from the Scheme. Reduced contributions shall apply from the first day of the month following the withdrawal of the former spouse.

7.2.3. When a Dependant ceases to be eligible to be a Dependant, he shall no longer be deemed to be registered as such for the purpose of these Rules or entitled to receive any benefits, regardless of whether notice has been given in terms of these Rules or otherwise.

## 8. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

8.1 A minor may become a Member with the consent of his parent or guardian.

8.2 No person may be a Member of more than one medical scheme or a Dependant:

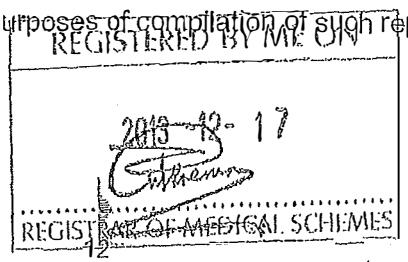
8.2.1 Of more than one Member of a particular medical scheme; or

8.2.2 Of Members of different medical schemes or;

8.2.3 Claim or accept benefits in respect of himself or any of his Dependants from any medical scheme in relation to which he is not a Member or a Dependant of a Member.

8.3 Prospective Members shall, prior to admission, complete and submit the application forms required by the Scheme, together with satisfactory evidence of age, income, state of his health and the health of his Dependants and the Scheme may require of an applicant to provide it with a medical report in respect of any prospective beneficiary regarding any medical advice, diagnosis, care or treatment recommended or obtained within a period of 12 months immediately prior to the date on which application to the Scheme was made.

8.3.1 The Scheme shall pay to the applicant or relevant healthcare provider the cost of any medical tests or examinations required by the Scheme for the purposes of compilation of such report.



8.3.2 Proof of any prior Membership of any other medical scheme must also be submitted.

8.3.3 The Scheme may however designate a provider to conduct such tests or examinations.

8.4 **Waiting Periods**

On admission the Scheme may impose upon a person in respect of whom an application is made for Membership or admission as a Dependant, who was not a beneficiary of a medical scheme for a period of at least 90 days preceding the date of application -

8.4.1 A general waiting period of up to three months, during which period no insured benefits whatsoever shall accrue, but contributions shall be paid to the Scheme in full;

8.4.2 A condition-specific waiting period of up to 9 months on existing pregnancies in respect of pregnancy, confinement and related services; and

8.4.3 A condition-specific waiting of up to 12 months in respect of any condition contemplated in rule 8.3. If both a general waiting period and a condition-specific waiting period are imposed, they will run concurrently, but the provisions of the general waiting period shall predominate. No insured benefits shall accrue for services in respect of a condition for which a waiting period has been imposed, but contributions shall be paid to the Scheme in full.

8.5 The Scheme may impose upon any person in respect of whom an application is made for Membership or admission as a Dependant and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 months, terminating less than 90 days immediately prior to the date of application.

8.5.1 A condition-specific waiting period of up to 12 months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits;

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8.5.2 In respect of any person contemplated in this sub-rule, where the previous medical scheme had imposed a general or condition-specific waiting period, and such waiting period had not expired at the time of termination, a general or condition-specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme

**8.6** The Scheme may impose upon any person in respect of whom an application is made for Membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 months, terminating less than 90 days immediately prior to the ate of application, a general waiting period of up to three months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

**8.7** No waiting period may be imposed on:

8.7.1 A person in respect of whom an application is made for Membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme, terminating less than 90 days immediately prior to the date of application, where the transfer of Membership is required as a result of-

8.7.1.1 Change of employment; or

8.7.1.2. an Employer changing or terminating a medical scheme of its Employees, in which case such transfer shall occur at the beginning of the financial year, or reasonable notice must been furnished to the scheme to which an application is made for such transfer to occur at the beginning of the financial year.



Where the former medical scheme had imposed a general or condition specific waiting period in respect of persons referred to in this rule, and such waiting period had not expired at the time of termination of Membership, the Scheme may impose such waiting period for the unexpired duration of a waiting period imposed by the former medical scheme.

8.7.2 A beneficiary who changes from one benefit option to another within the Scheme unless that beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied;

8.7.3 A Child Dependant born during the period of Membership.

8.8 The registered Dependants of a Member must participate in the same benefit option as the Member.

8.9 Every Member will, on admission to Membership, receive a detailed summary of these rules, which shall include contributions, benefits, limitations, the Member's rights and obligations. Members and their Dependants, and any person who claims any benefit under these Rules or whose claim is derived from a person so claiming are bound by these Rules as amended from time to time.

8.10 A Member may not cede, transfer, pledge or hypothecate or make over to any third party any claim, or part of a claim which he has against the Scheme or any right to a benefit which he may have from the Scheme, as the case may be. The Scheme may withhold, suspend or discontinue the payment of a benefit to which a Member is entitled under these rules, or any right in respect of such benefit or payment of such benefit to such Member, if a Member attempts to assign or transfer, or otherwise cede or to pledge or hypothecate such benefit.



## 9. TRANSFER OF EMPLOYER GROUPS FROM ANOTHER MEDICAL SCHEME

If the Members of a medical scheme who are Members of that scheme by virtue of their employment by a particular Employer, terminate their Membership of such scheme with the object of obtaining Membership of this Scheme, the Board will admit as a Member, without a waiting period or the imposition of new restrictions on account of the state of his health or the health of any of his Dependants, any Member of such first-mentioned scheme including a continuation Member by virtue of their past employment by the particular Employer and register as a Dependant, any person who has been a registered Dependant of such Member.

## 10. MEMBERSHIP CARD AND CERTIFICATE OF MEMBERSHIP

10.1 Every Member shall be furnished with a Membership card, containing such particulars as may be prescribed. This card must be exhibited to the supplier of a service on request. It remains the property of the Scheme and must be returned to the Scheme on termination of Membership.

10.2 The use of a Membership card by any person other than the Member or his registered Dependants, with the knowledge or consent of the Member or his Dependants, is not permitted and such use will be construed as an abuse of the privileges of Membership of the Scheme.

10.3 On termination of Membership or on de-registration of a Dependant, the Scheme must, within 30 days of such termination or at any time on request, furnish such person with a certificate of Membership and cover, containing such particulars as may be prescribed.

## 11. CHANGE OF ADDRESS OF MEMBER

A Member must notify the Scheme within 30 days of any change of address, including his domicilium citandi et executandi. The Scheme shall not be held liable if a beneficiary's rights are prejudiced or forfeited as a result of the Member's neglecting to comply with the requirements of this rule.



## 12. TERMINATION OF MEMBERSHIP

### 12.1 Resignation

12.1.1 A Member who, in terms of his conditions of employment is required to be a Member of the Scheme, may not terminate his Membership while he remains an Employee without the prior written consent of his Employer.

12.1.2 Where a Member in the service of the Employer is employed and resides outside the Republic of South Africa, his Membership of the Scheme and that of his Dependants shall be terminated for the duration of his absence, unless he elects

to continue with his Membership and/or that of his Dependants, as provided in rule 6.1.2 and 6.1.3.

12.1.3 A Member who resigns from the service of the participating Employer shall, on the date of such termination, cease to be a Member and all rights to benefits shall thereupon cease, except for claims in respect of services rendered prior thereto.

**12.2 Voluntary termination of membership**

12.2.1 A Member, who is not required in terms of his conditions of employment to be a Member, may terminate his Membership of the Scheme on giving 3 months written notice. All rights to benefits cease after the last day of Membership.

12.2.2 Such notice period shall be waived in substantiated cases where Membership of another medical scheme is compulsory as a result of a condition of employment.

12.2.3 A participating Employer may terminate his participation with the Scheme on giving 3 months written notice.

**12.3 Death**

Membership of the Scheme terminates on the death of a beneficiary.

**12.4 Failure to pay amounts due to the Scheme**

If a Member fails to pay amounts due to the Scheme, his Membership may be terminated as provided in these rules.

**12.5 Submission of fraudulent claims; committing of any fraudulent act and/or non-disclosure of material information (Sec 29 (2))**

12.5.1 The Board may suspend or terminate the membership of a Beneficiary who submitted fraudulent claims, committed any fraudulent act or failed to disclose material information when applying for membership.

12.5.2 An applicant is obliged to disclose all material information to the medical scheme with regard to any matter concerning the state of health or medical history of the Member concerned or that of any of his or her Dependants, which arose or occurred during the period of 12 months preceding the date of application for membership.

12.5.3 In the case of termination of membership for non-disclosure of material information, Contributions, net of claims, will be refunded to the Member as from the date of inception. No refund of any Contribution or any portion of a Contribution shall be made on termination of membership if such termination was due to fraudulent conduct.

## 13. CONTRIBUTIONS

13.1 The total monthly contributions payable to the Scheme by or in respect of a Member are as stipulated in Annexure A.

13.2 Contributions shall be payable monthly in arrears and although due to the Scheme by the 4th of each month shall be paid to the Scheme not later than the 7th day of the month. Where the contributions have not been paid within thirty (30) days of the due date, the Scheme shall have the right to suspend all benefit payments which have accrued to such Member irrespective of when the claim for such benefit arose, and to give the Member and/or the Employer notice that if contributions are not paid up to date within fourteen (14) days of such notice, Membership may be cancelled.

13.3 In the event that payments are brought up to date, benefits shall be reinstated without any break in continuity subject to the right of the Scheme to levy a reasonable fee to cover any expenses associated with the default and to recover interest at the prime overdraft rate of the Scheme's bankers. If such payments are not brought up to date, no benefits shall be due to the Member from the date of default and any such benefit paid may be recovered by the Scheme.

13.4 Unless specifically provided for in the rules in respect of savings accounts, no refund of any assets of the Scheme or any portion of a contribution shall be paid to any person where such Member's Membership or cover in respect of any Dependant terminates during the course of a month.

13.5 The balance standing to the credit of a Member in terms of any option which provides for a personal medical savings account belongs to the member and will be managed in terms of Regulation 10.

13.6 Where a Member has elected, in terms of rule 12.1.2, to remain a Member of the Scheme for the benefit only of those of his Dependants who remain in the Rand monetary area, contributions shall be payable only in respect of such Dependants, but at the rates in the income band applicable to that Member.

## 14. LIABILITIES OF EMPLOYER AND MEMBER

14.1 The liability of the Employer towards the Scheme is limited to any amounts payable in terms of any agreement between the Employer and the Scheme.

14.2 The liability of a Member to the scheme is limited to the amount of his unpaid contributions together with any sum disbursed by the Scheme on his behalf or on behalf of his Dependants which has not been repaid to the Scheme.

14.3 In the event of a Member ceasing to be a Member, any amount still owing by such Member is a debt due to the Scheme and recoverable by it.

## 15. CLAIMS PROCEDURE

15.1 Every claim submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules, must be accompanied by an account or statement.

15.2 If an account, statement or claim is correct or where a corrected account, statement or claim is received, as the case may be, the Scheme shall, in addition to the payment contemplated in Section 59 (2) of the Act, dispatch to the Member a statement containing at least the following particulars -

15.2.1 The name and the Membership number of the Member;
15.2.2 The name of the supplier of service;
15.2.3 The final date of service rendered by the supplier of service on the account or statement which is covered by the payment;
15.2.4 The total amount charged for the service concerned; and
15.2.5 The amount of the benefit awarded for such service.

15.3 In order to qualify for benefits, any claim must, unless otherwise arranged, be signed and certified as correct and must be submitted to the Scheme not later than the last day of the fourth month following the month in which the service was rendered.

15.4 Where a Member has paid an account, he shall, in support of his claim, submit a receipt.

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15.5 Accounts for treatment of injuries or expenses recoverable from third parties, must be supported by a statement, setting out particulars of the circumstances in which the injury or accident was sustained.

15.6 Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, the Scheme shall notify the Member and the health care provider accordingly within 30 days after receipt thereof. The Scheme shall state the reasons why such claim is erroneous or unacceptable and afford such Member or provider the opportunity to return such corrected claim to the Scheme within sixty (60) days of the notice.

15.7 Particulars to be contained in claims

Every claim submitted by a Member to the Scheme in respect of the rendering of any service or the supply of any medicine, requirement or accommodation in a hospital or nursing home, shall contain the following particulars:

15.7. 1. The surname and initials of the Member;

15.7. 2. The surname, first name and other initials, if any, of the patient;

15.7. 3. The name of the Scheme;

15.7. 4. The Membership number of the Member;

15.7. 5. The name and practice code number, where applicable, of the supplier of the service;

15.7. 6. The date on which each service was rendered;

15.7. 7. The nature and the cost of each service;

15.7. 8. The relevant diagnostic and other item code numbers that relate to the relevant health service;

15.7. 9. Where the account is a photocopy of the original, certification by the supplier of the service by way of a rubber stamp or signature on such photocopy;

15.7. 10. The name of the referring practitioner;

15.7. 11. The name, quantity, dosage and the net price payable by the Member in respect of each supply of medicine, requirement or apparatus and in the case where a pharmacist has prescribed

and supplied such medicine, the diagnosis of the condition for which such medicine was prescribed;

15.7. 12. Mention of, in the case where an account or statement refers to the use of an operating theatre where an operation was performed on a Member or a Dependant of that Member

15.7.12.1. The name and practice number of the practitioner who performed the operation concerned; and

15.7.12.2. The name or names of the practitioner or practitioners who assisted at such operation;

15.7. 13. In the case where a pharmacist supplied medicine on the strength of a prescription to a Member or a Dependant of a Member, as addendum to the account or statement, a photocopy of the original prescription, certified by the pharmacist connected with the pharmacy which supplied such medicine, as a true and exact copy or photocopy of such prescription.

**15.8 Orthodontic treatment**

Where an account refers to a service that is to be rendered in respect of orthodontic treatment or other specialised dentistry, a statement containing the following information shall accompany the first account submitted to the Scheme –

15.8.1. The diagnostic and item code numbers that relate to the treatment;

15.8.2. A plan of treatment indicating the following -

15.8.2.1. The expected total amount in respect of the treatment;

15.8.2.2. The expected duration of the treatment;

15.8.2.3. The initial primary amount payable by the Member; and

15.8.2.4. The monthly amount which the Member must

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### 15.9 Extension of time for submission of claims

It shall be the duty of a Member to obtain accounts for all services rendered, from the supplier thereof. If, because of the extended nature of the treatment or for any other reason whatsoever, a Member is unable to obtain an account for services, or if he has in fact received an account but, because of special circumstances beyond his control, is unable to submit it within the period referred to in rule 15.3 and 15.6 above, the Board may, in its discretion, extend this period on condition that a written application for extension is received by the Principal Officer before the expiration of the said period.

### 15.10 Claims for services rendered outside the Rand monetary area

Members submitting claims for services obtained outside the Rand monetary area must ensure that accounts are specified as detailed above, before submission to the Scheme. Such claims shall reflect the amount(s) in the equivalent South African currency and the rate of exchange used for conversion and shall bear a detailed description, in English, of each service rendered. Benefits on such claims shall be calculated as if the services had been rendered in the Republic of South Africa, and paid at the applicable rate of exchange ruling on the date the service was rendered failing which as determined by the medical advisor, and approved by the board.

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### 15.11 Certification of claims

The Board may require that, where possible, a claim be certified by the Member.

### 15.12 Claim statements

On finalisation of a claim the Scheme shall send to the Member an advice regarding the benefit paid or the reason why a claim was rejected and if the full amount of any benefit is not paid out to the Member, the reason therefore. This advice should be kept and used for income tax purposes

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## 16. BENEFITS

16.1 Members are entitled to benefits during a financial year, as per Annexure B, and such benefits extend through the Member to his registered Dependants. A Member must, on admission, elect to participate in any one of the available options, detailed in Annexure B.

16.2 A Member is entitled to change from one to another benefit option subject to the following conditions:

16.2.1 The change may be made only with effect from 1 January of any financial year. The Board may, in its absolute discretion, permit a Member to change from one to another benefit option on any other date.

16.2.2 Application to change from one benefit option to another must be in writing and lodged with the Scheme by not later than 30 September, or within such period as notified by the Scheme, prior to the year upon which it is intended that the change will take place; provided that the Member has had at least 30 days prior notification of any intended changes in benefits or contributions for the next year.

16.3 The Scheme shall, where an account has been rendered, pay any benefit due to a Member, either to that Member or to the supplier of the relevant health service who rendered the account, within 30 days of receipt of the claim pertaining to such benefit.

16.4 Any benefit option offered in Annexure B covers in full the cost of services rendered in respect of the prescribed minimum benefits rendered by a State hospital, without limitation or exclusions.

16.5 The Scheme may exclude services from benefits as set out in Annexure C.



## 17. PAYMENT OF ACCOUNTS

17.1 Payment of accounts or reimbursement of claims is restricted to the maximum amount of the benefit entitlement in terms of the applicable benefit and option elected.

17.2 The Scheme may, whether by agreement or not with any supplier or group of suppliers of a service, pay the benefit to which the Member is entitled, directly to the supplier or group of suppliers who rendered the service.

17.3 Where the Scheme has paid an account or portion of an account or any benefit to which a Member is not entitled, whether payment is made to the Member or to the supplier of service, the amount of any such overpayment is recoverable by the Scheme.

17.4 Where such overpayment has not been paid within ninety (90) days of the date upon which it was corrected, and provided the Member has been advised in writing, the Scheme shall have the right to suspend all further benefit payments in respect of the Member, until such time as the debt has been paid. If such overpayment has not been repaid to the Scheme within such ninety (90) day period the Scheme shall be entitled to cancel the defaulting Member`s Membership of the Scheme. Such cancellation may only be proceeded with where the Scheme has given the Member and the Employer (where applicable), fourteen (14) days written notice of the Scheme`s intention to terminate such Membership in the event of non-payment by the end of such period.

17.5 Notwithstanding the provisions of this rule, the Scheme has the right to pay any benefit directly to the Member concerned.

17.6 Any benefit payment due to a Member referred to in 6.1.2 and 6.1.3 shall be paid in Rands into his bank account in the republic of South Africa.

## 18. GOVERNANCE

18.1 The affairs of the Scheme shall be managed according to these Rules by a Board consisting of twelve persons who are Members of the Scheme and who are fit and proper to be trustees.

18.2 Six of such trustees must be elected by Members from amongst Members to serve terms of office of five years each, terminating at the Annual General Meeting of the relevant year, provided that such trustees shall be elected by Members from Employer Group Companies, as follows:

| | | |
|---|---|---|
| 18.2.1 | Mediclinic Corporation Limited | Two Members |
| 18.2.2 | British American Tobacco SA (Pty) Ltd. | One Member |
| 18.2.3 | Distell Limited | One Member |

| | | |
|---|---|---|
| 18.2.4 | Remgro Limited, and the remaining Employer Group Companies | One Member |
| 18.2.5 | Tracker Connect (Pty) Ltd | One Member |

The other six trustees are appointed by the Employer Group Companies, to hold office until their appointment is terminated by any such Employer, as follows:

| | | |
|---|---|---|
| 18.2.9. | Mediclinic Corporation Limited | Two Members |
| 18.2.10. | British American Tobacco SA (Pty)Ltd. | One Member |
| 18.2.11. | Distell Limited | One Member |
| 18.2.12. | Remgro Limited, and the remaining Employer Group Companies | One Member |
| 18.2.13 | Tracker Connect (Pty) Ltd | One Member |

The Employer may appoint any Employee to act as an alternate trustee and it shall also be competent for an elected trustee on the Board to nominate an alternate, provided such alternate trustees are from the same Employer and are Members of the Scheme.

18.3 The following persons are not eligible to serve as Members of the Board:

18.3.1 A person under the age of 21 years;

18.3.2 A Director, Employee, Partner, representative, officer, consultant, contractor or agent of the administrator of the Scheme or the holding company, subsidiary, joint venture or associate of that administrator;

18.3.3 A broker;

18.3.4 The Principal Officer of the Scheme; and

18.3.5 The Auditor of the Scheme.

18.4 Retiring Members of the Board are eligible for re-election.

18.5 Nominations to fill vacancies, signed by the candidate signifying his consent to stand for election must be proposed and seconded by a member of the Scheme and accepted by the nominee. The election will be carried out by

secret ballot according to the election notice issued to members. The results of the election will be announced at the annual general meeting of the Scheme.

18.6 The Board may fill by appointment by the remaining members of the Board, any casual vacancy amongst elected trustees, which occurs during its term of office. A person so appointed must retire at the first ensuing annual general meeting and that meeting must fill the vacancy for the un-expired period of office of the vacating Member of the Board.

18.7 The Board may co-opt a knowledgeable person to assist it in its deliberations provided that such person shall not have a vote.

18.8 Half of the Members of the Board plus one is a quorum at meetings of the Board.

18.9 The Board must elect from its number the Chairperson and Vice Chairperson.

18.10 In the absence of the chairperson and vice-chairperson, the Board Members present must elect one of their numbers to preside.

18.11 Matters serving before the Board must be decided by a majority vote and in the event of an equality of votes, the chairperson has a casting vote in addition to his deliberative vote.

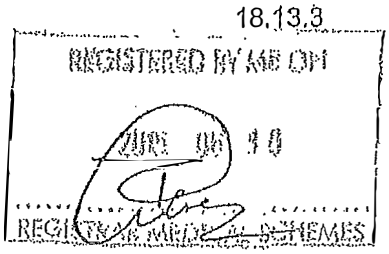
18.12 A Member of the Board may resign at any time by giving written notice to the Board.

18.13 A Member of the Board ceases to hold office if —

18.13.1 He becomes mentally ill or incapable of managing his affairs;

18.13.2 He is declared insolvent or has surrendered his estate for the benefit of his creditors;

18.13.3 He is convicted, whether in the Republic or elsewhere, of theft, fraud, forgery or uttering of a forged document or perjury;



year concerned and the election must be carried out by the members present or represented by proxy at the annual general meeting of the Scheme.

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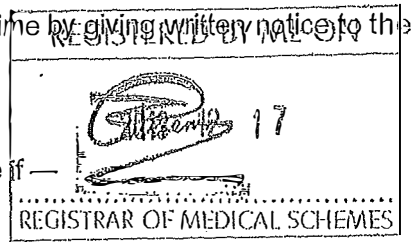


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18.13.2 He is declared insolvent or has surrendered his estate for the benefit of his creditors;

18.13.3 He is convicted, whether in the Republic or elsewhere, of theft, fraud, forgery or uttering of a forged document or perjury;

18.13.4 He is removed by the court from any office of trust on account of misconduct;

18.13.5 He is disqualified under any law from carrying on his profession;

18.13.6 He ceases to be an appointee by the Employer, or he ceases to be a Member of the Scheme;

18.13.7 He absents himself from three consecutive meetings of the Board without the permission of the Chairperson; or

18.13.8 He is removed from office by the Council in terms of Section 46 of the Act.

18.14 The Board must meet at least once every three months or at such intervals as it may deem necessary.

18.15 The chairperson may convene a special Board meeting should the necessity arise. Any two Members of the Board may request the chairperson to convene a special meeting of the Board, stating the matters to be discussed at such meeting.

## 19. DUTIES OF BOARD OF TRUSTEES

19.1 The Board is responsible for the proper and sound management of the Scheme, in terms of these rules.

19.2 The Board must act with due care, diligence, and skill and in good faith.

19.3 Members of the Board must avoid conflicts of interests, and must declare any interest they may have in any particular matter serving before the Board.

19.4 The Board must apply sound business principles and ensure the financial soundness of the Scheme.



19.5 The Board shall appoint a Principal Officer who is fit and proper to hold such office and may appoint any staff which in its opinion are required for the

proper execution of the business of the Scheme, provided that the following persons are not eligible to be a Principal Officer –

19.5.1 An Employee, director, officer, consultant or contractor of the administrator of the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator.

19.5.2 A broker.

19.6 The Board shall determine the terms and conditions of service of the Principal Officer and of any person employed by the Scheme.

19.7 The Chairperson must preside over meetings of the Board and ensure due and proper conduct at meetings.

19.8 The Board must cause to be kept such minutes, accounts, entries, registers and records as are essential for the proper functioning of the Scheme.

19.9 The Board must ensure that proper control systems are employed by and on behalf of the Scheme.

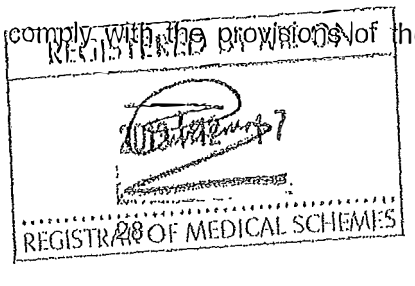
19.10 The Board must ensure that adequate and appropriate information is communicated to the Members regarding their rights, benefits, contributions and duties in terms of the Rules.

19.11 The Board must take all reasonable steps to ensure that contributions are paid timeously to the Scheme in accordance with the Act and these Rules.

19.12 The Board must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.

19.13 The Board must obtain expert advice on legal, accounting and business matters as required, or on any other matter of which the members of the Board may lack sufficient expertise.

19.14 The Board must ensure that the Rules, the operation and administration of the Scheme comply with the provisions of the Act and all other applicable laws.



19.15 The Board must take all reasonable steps to protect the confidentiality of medical records concerning any Member or Dependant's state of health.

19.16 The Board must approve all disbursements.

19.17 The Board must cause to be kept in safe custody, in a safe or strong room at the registered office of the Scheme or with any financial institution approved by the Board, any mortgage bond, title deed or other security belonging to or held by the Scheme, except when in the temporary custody of another person for the purposes of the Scheme.

19.18 The Board must make such provision as it deems desirable, and with due regard to normal practice and recommended guidelines pertaining to retention of documents, for the safe custody of the books, records, documents and other effects of the Scheme.

19.19 The Board shall disclose annually in writing to the registrar, any payment or considerations made to Members of the Board in that particular year by the Scheme as prescribed.

## 20. POWERS OF BOARD

The Board has the power —

20.1 To cause the termination of the services of any Employee of the Scheme;

20.2 To take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfillment of the Scheme's obligations under such appointments as may be made by the Board;

20.3 To appoint a committee consisting of such Board Members and other experts as it may deem appropriate;

20.4 To appoint a duly accredited administrator on such terms and conditions as it may determine, for the proper execution of the business of the Scheme. The terms and conditions of such appointment must be contained in a written contract, which complies with the requirements of the Act and the regulations;

20.5 To contract with managed health care organisations subject to the provisions of the Act and its regulations;

20.6 To purchase movable and immovable property for the use of the Scheme or otherwise, and to sell it or any of it;

20.7 To acquire, hold, alienate, let or hire movable or immovable property;

20.8 In respect of any monies not immediately required to meet current charges upon the Scheme and subject to the provisions of the Act, and in the manner determined by the Board, to invest or otherwise deal with such moneys upon security and to realise, re-invest or otherwise deal with such monies and investments;

20.9 With the prior approval of the Council, to borrow money for the Scheme from the Scheme's bankers against the security of the Scheme's assets for the purpose of bridging a temporary shortage;

20.10 Subject to the provisions of any law, to cause the Scheme, whether on its own or in association with any person, to establish or operate any pharmacy, hospital, clinic, maternity home, nursing home, infirmary, home for aged persons or any similar institution, in the interests of the Beneficiaries of the Scheme;

20.11 To donate to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interests of all or any of the Beneficiaries of the Scheme;

20.12 To grant repayable loans to Members or to make *ex gratia* payments on behalf of Members, or to grant additional benefits to or on behalf of Members, in order to assist such Members to meet commitments in regard to any matter specified in Rule 5, in particular Rule 5b;

20.13 To contribute to any fund conducted for the benefit of Employees of the Scheme;

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20.14 To reinsure obligations in terms of the benefits provided for in these rules in the prescribed manner;

20.15 To authorise the Principal Officer and/or such Members of the Board as it may determine from time to time, and upon such terms and conditions as the Board may determine, to sign any contract or other document binding or relating to the Scheme or any document authorising the performance of any act on behalf of the Scheme;

20.16 To contribute to any association instituted for the furtherance, encouragement and co-ordination of medical schemes;

20.17 In general, do anything, which it deems necessary or expedient to perform its functions in accordance with the provisions of the Act and these rules.

## 21. DUTIES OF PRINCIPAL OFFICER AND STAFF

21.1 The staff of the Scheme must ensure the confidentiality of all information regarding its Beneficiaries.

21.2 The Principal Officer is the Executive Officer of the Scheme and as such shall ensure that:

21.2.1 He acts in the best interests of the Members of the Scheme at all times;

21.2.2 The decisions and instructions of the Board are executed without unnecessary delay;

21.2.3 Where necessary, there is proper and appropriate communication between the Scheme and those parties, affected by the decisions and instructions of the Board;

21.2.4 He keeps the Board sufficiently and timeously informed of the affairs of the Scheme which relate to the duties of the Board as stated in section 57(4) of the Act;

21.2.5 He keeps the Board sufficiently and timeously informed concerning the affairs of the Scheme so as to enable the Board to comply with the provisions of section 57(6) of the Act;

21.2.6 He does not take any decisions concerning the affairs of the Scheme without prior authorisation by the Board and that he at all times observes the authority of the Board in its governance of the Scheme.

21.3 The Principal Officer shall be the Accounting Officer of the Scheme charged with the collection of and accounting for all moneys received and payments authorised by and made on behalf of the Scheme.

21.4 The Principal Officer shall ensure the carrying out of all of his duties as are necessary for the proper execution of the business of the Scheme. He shall attend all meetings of the Board, and any other duly appointed committee where his attendance may be required, and ensure proper recording of the proceedings of all meetings.

21.5 The Principal Officer shall be responsible for the supervision of the staff employed by the Scheme unless the Board decides otherwise.

21.6 The Principal Officer shall keep full and proper records of all moneys received and expenses incurred by, and of all assets, liabilities and financial transactions of the Scheme.

21.7 The Principal Officer shall ensure preparation of the annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto.

21.8 The following persons are not eligible to be a Principal Officer:

21.8.1 An Employee, director, officer, consultant or contractor of the administrator of the Scheme, or of the holding company, subsidiary, joint venture or associate of that administrator.

21.8.2 A broker

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21.9 The provisions of rules 18.13.1 – 18.13.5 apply mutatis mutandis to the Principal Officer.

## 22. INDEMNIFICATION & FIDELITY GUARANTEE

22.1 The Board and any officer of the Scheme is indemnified by the Scheme against all proceedings, costs and expenses incurred by reason of any claim in connection with the Scheme, not arising from their negligence, dishonesty or fraud.

22.2 The Board must ensure that the Scheme is insured against loss resulting from the dishonesty or fraud of any of its officers (including Members of the Board and Principal Officer) having the receipt or charge of moneys or securities belonging to the Scheme.

## 23. FINANCIAL YEAR OF THE SCHEME

The financial year of the Scheme extends from the first day of January to the 31st day of December of that year.

## 24. BANKING ACCOUNT

The Scheme must maintain a banking account with a registered commercial bank. All moneys received must be deposited to the credit of such account and all payments must be made either by electronic transfer or tape exchange under the joint signature of not less than two persons duly authorised by the Board. A separate account will be maintained by the Scheme to hold the personal medical savings account (PMSA) monies as referenced in Rule 13.5 of these Rules.

## 25. AUDITOR & AUDIT COMMITTEE

25.1 An auditor (who must be approved in terms of section 36 of the Act) must be appointed by resolution at each annual general meeting, to hold office from the conclusion of that meeting to the conclusion of the next annual general meeting.

25.2 The following persons are not eligible to serve as auditor of the Scheme:

25.2.1 A Member of the Board;

25.2.2 An Employee, officer or contractor of the Scheme;

25.2.3 An Employee, director, officer or contractor of the Scheme's administrator, or of the holding company, subsidiary, joint venture or associate of the administrator;

25.2.4 A person not engaged in public practice as an auditor; and

25.2.5 A person who is disqualified from acting as an auditor in terms of the Companies Act, 1973.

25.3 Whenever for any reason an auditor vacates his office prior to the expiration of the period for which he has been appointed, the Board must within 30 days appoint another auditor to fill the vacancy for the unexpired period.

25.4 If the Members of the Scheme at a general meeting fail to appoint an auditor required to be appointed in terms of this rule, the Board must within 30 days make such appointment, and if it fails to do so, the Registrar may at any time do so.

25.5 The auditor of the Scheme at all times has a right of access to the books, records, accounts, documents and other effects of the Scheme, and is entitled to require from the Board and the officers of the Scheme such information and explanations as he deems necessary for the performance of his duties.

25.6 The auditor must report to the Members of the Scheme on the accounts examined by him and on the financial statements laid before the Scheme in general meeting.

25.7 The Board must appoint an audit committee of at least five Members of whom at least two must be Members of the Board. The majority, of the Members of such committee, including the chairperson, shall be persons who are not officers of the Scheme or the administrator of the Scheme, the controlling company of the administrator or any subsidiary of its controlling company.

## 26. GENERAL MEETINGS

### 26.1 Annual general meeting

26.1.2 The annual general meeting of Members must be held not later than 30 September of each year, by means of a physical or virtual meeting.

26.1.3 The notice convening the annual general meeting, containing the agenda, highlights of the annual financial statements as per the Council for Medical Schemes (CMS) guidelines and minutes of the previous meeting, advising Members how the annual financial statements, auditor's and annual report may be obtained, must be furnished to members at least 21 days before the date of the meeting. The non-receipt of such notice by a member does not invalidate the proceedings at such meeting.

26.1.4 At least 30 members of the Scheme present in person constitute a quorum. If a quorum is not present after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting must be postponed to a date determined by the Board with notice of such postponed meeting being re-issued in terms of rule 26.1.2 and Members then present shall be deemed to constitute a quorum.

26.1.5 The financial statements and reports specified in rule 26.1.2 must be laid before the meeting.

26.1.6 Notices of motions to be placed before the annual general meeting must reach the principal officer not later than seven days prior to the date of the meeting.

**26.2 Special general meeting**

26.2.1 The Board may call a special general meeting of Members if it is deemed necessary.

26.2.2 The Board shall upon written request of at least 5% of the Members of the Scheme, cause a special general meeting to be called within 21 days from the date of the deposit of the request. The purpose of the meeting shall be set out in the request, which shall be signed by all the petitioners and lodged at the registered office of the Scheme. Only those matters forming the object of the meeting shall be discussed.

26.2.3 The notice convening the special general meeting, containing the agenda, must be furnished to members at least 14 days before the date

of the meeting. The non-receipt of such notice by a member does not invalidate the proceedings at such a meeting.

26.2.4 At least 50 Members present in person constitute a quorum. If a quorum is not present at a special general meeting after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting is regarded as cancelled.

## 27. VOTING AT MEETINGS

27.1 Every Member who is present at a general meeting of the Scheme and whose contributions are not in arrears, has the right to vote, or may, subject to this rule, appoint another Member of the Scheme as proxy to attend, speak and vote in his stead.

27.2 The instrument appointing the proxy must be in writing, in a form determined by the Board and must be signed by the member and the person appointed as the proxy.

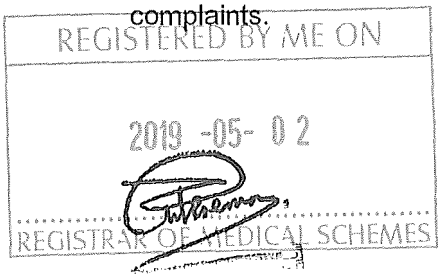
27.3 The Chairperson must determine whether the voting must be by ballot or by a show of hands. In the event of the votes being equal, the chairperson, if he is a Member, has a casting vote in addition to his deliberative vote.

## 28. COMPLAINTS AND DISPUTES

28.1 Any Member may lodge a complaint to the Scheme in terms of these Rules or in terms of the Act to the Registrar. These Rules deal with complaints lodged to the Scheme.

28.2 A "complaint" means a complaint as defined in the Act and for purposes of these Rules, a "complaint" and a "dispute" bears the same meaning.

28.3 Members may lodge their complaints, in writing (whether by post, email or telefax), to the Scheme. The Scheme or its administrators shall also provide a dedicated telephone number which may be used for dealing with telephonic complaints.



28.4 A member lodging a complaint must do so within 2 years of alleged service failure that gave rise to the complaint; failing which the member's right to lodge such complaint shall prescribe.

28.5 A member lodging a complaint in respect of Prescribed Minimum Benefits must do so within 3 years of alleged service failure that gave rise to the complaint; failing which the member's right to lodge such complaint shall prescribe.

28.6 The Scheme shall endeavour to respond to all complaints received in writing within 30 days of receipt thereof, failing which, within a reasonable time.

28.7 If the Scheme finds that there is no merit in the complaint, it must notify the complainant in writing of its finding and the reasons for the finding.

28.8 If dissatisfied with the finding on the complaint the complainant may -

28.8.1 within 60 days of receiving the relevant notice, refer the complaint in writing (by completing the appropriate Dispute Form) to the Principal Officer for consideration by the Scheme's Dispute Committee; or

28.8.2 refer the complaint to the Registrar for consideration in terms of the Act.

28.9 A Disputes Committee of three Members, who may not be Members of the Board, Employees of the administrator of the Scheme or officers of the Scheme, must be appointed by the Board to serve a term of office of 3 years. At least one of such Members shall be a person with legal expertise. Such person shall preside over the Dispute Committee meeting.

28.10 On receipt of a dispute in terms of this rule, the Principal Officer must convene a meeting of the disputes committee by giving not less than 21 days notice in writing to the complainant and all the Members of the Disputes Committee specifying:

28.10.1 the date of the meeting which must not be less than 21 days from the date of submitting the notice or such earlier date as the Principal Officer and Member may agree to;

28.10.2 the commencement time and venue for the meeting

28.10.3 who will comprise the Disputes Committee

28.10.4 the particulars of the complaint; and

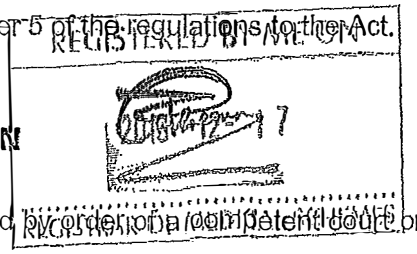
28.10.5 the procedures and Rules to be applied when considering the dispute which must include the right of the complainant to be heard in person or through a representative at the Dispute Committee meeting.

28.11 The parties to any dispute have the right to be heard at the proceedings, either in person or through a representative. The decision of the said Committee shall, subject to Rule 28.8, be final and binding unless overturned by the Council for Medical Schemes appeal process.

28.12 An aggrieved person has the right to appeal to the Council for Medical Schemes against the decision of the disputes committee. Such appeal must be in the form of an affidavit directed to Council and shall be furnished to the Registrar not later than three months after the date on which the decision concerned was made or such further period as the Council may for good cause shown allow, after the date on which the decision concerned was made.

28.13 The operation of any decision which is the subject of any appeal under rule 28.8 shall be suspended pending the decision of the Council on such appeal.

28.14 A Member may appeal to the Council against a decision of a review panel established in terms of Chapter 5 of the regulations to the Act.



## 29. TERMINATION OR DISSOLUTION

29.1. The Scheme may be dissolved by order of a competent court or by voluntary dissolution.

29.2. Members in a general meeting may decide that the Scheme must be dissolved, in which event the Board must arrange for Members to decide by

ballot whether the Scheme must be liquidated. Unless the majority of Members decide that the Scheme must continue, the Scheme must be liquidated in terms of section 64 of the Act.

29.3. Pursuant to a decision by Members taken in terms of rule 29.2 the Principal Officer must, in consultation with the Registrar, furnish to every Member a memorandum containing the reasons for the proposed dissolution and setting forth the proposed basis of distribution of the assets in the event of winding up, together with a ballot paper.

29.4. Every Member must be requested to return his ballot paper duly completed before a set date. If at least 50 per cent of the Members return their ballot papers duly completed and if the majority thereof is in favour of the dissolution of the Scheme, the Board must ensure compliance therewith and appoint, in consultation with the Registrar, a competent person as liquidator.

## 30. AMALGAMATION AND TRANSFER OF BUSINESS

30.1 The Scheme may, subject to the provisions of section 63 of the Act, amalgamate with, transfer its assets and liabilities to, or take transfer of assets and liabilities of any other medical scheme or person. Before such event the Board must arrange for Members to decide by ballot whether the proposed amalgamation or transfer should be proceeded with or not.

30.2 If at least 50 per cent of the Members return their ballot papers duly completed and if the majority thereof is in favour of the amalgamation or transfer then, subject to section 63 of the Act, the amalgamation or transfer may be concluded.

## 31. RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

31.1 Any beneficiary must on request and on payment of a fee of R 20.00 (twenty Rands), be supplied by the Scheme with a copy of the following documents:

31.1.1 The rules of the Scheme;

31.1.2 The latest audited annual financial statements, returns, Trustees' reports and auditor's report of the Scheme; and

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31.1.3 The management accounts in respect of the scheme and all of its benefit options, or other such other information as may be prescribed by law.

31.2 A beneficiary is entitled to inspect free of charge at the registered office of the Scheme any document referred to in rule 31.1 and to make extracts there from.

31.3 This rule shall not be construed to restrict a person's right in terms of the Promotion of Access to Information Act, Act no 2 of 2000.

## 32. AMENDMENT OF RULES

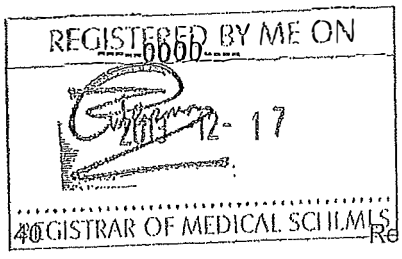
32.1 The Board is entitled to alter or rescind any rule or annexure or to make any additional rule or annexure.

32.2 No alteration, rescission or addition which affects the objects of the Scheme or which increases the rates of contribution or decreases the extent of benefits of the Scheme or of any particular benefit option by more than twenty five percent during any financial year, is valid unless it has been approved by a majority of Members present in a general meeting or a special meeting or by ballot.

32.3 Members must be furnished with a copy of such amendment within 14 days after registration thereof. Should a Member's rights, obligations, contributions or benefits be amended, he/she shall be given 30 days advance notice of such change.

32.5 Notwithstanding the provisions of rule 32.1 above, the Board must, on the request and to the satisfaction of the Registrar, amend any rule that is inconsistent with the provisions of the Act.

32.6 No alteration, rescission or addition shall be valid unless it has been approved and registered by the Registrar in terms of the Act.



**ANNEXURE A1**

# REMEDI MEDICAL AID SCHEME

## CONTRIBUTIONS EFFECTIVE 1 JANUARY 2021



## STANDARD OPTION

| INCOME (in Rand) | MEMBER: | ADULT (**) DEPENDANT: | CHILD (*) DEPENDANT: |
|---|---|---|---|
| 0–3999 | 1478 | 984 | 299 |
| 4000–5499 | 1549 | 1036 | 337 |
| 5500-6999 | 1624 | 1161 | 417 |
| 7000-7999 | 1746 | 1391 | 541 |
| 8000-8999 | 1746 | 1391 | 541 |
| 9000-9999 | 1746 | 1391 | 541 |
| 10000-10999 | 1746 | 1391 | 541 |
| 11000 + | 1751 | 1394 | 542 |

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 JANUARY 2021

## COMPREHENSIVE OPTION

| INCOME (in Rand) | MEMBER: | ADULT (**) DEPENDANT: | CHILD (*) DEPENDANT: |
|---|---|---|---|
| 0–3999 | **3023** | **2290** | **705** |
| 4000–5499 | **3191** | **2445** | **751** |
| 5500-6999 | **3372** | **2605** | **822** |
| 7000-7999 | **3547** | **2679** | **896** |
| 8000-8999 | **3731** | **2828** | **937** |
| 9000-9999 | **3938** | **2963** | **984** |
| 10000-10999 | **4133** | **3112** | **1071** |
| 11000+ | **4357** | **3282** | **1131** |

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 JANUARY 2021



## CLASSIC OPTION

| INCOME (in Rand) | MEMBER: | ADULT (**) DEPENDANT: | CHILD (*) DEPENDANT: |
|---|---|---|---|
| 0–3999 | **2373** | **1686** | **569** |
| 4000–5499 | **2511** | **1807** | **632** |
| 5500-6999 | **2646** | **1924** | **676** |
| 7000-7999 | **2783** | **1974** | **740** |
| 8000-8999 | **2934** | **2084** | **788** |
| 9000-9999 | **3085** | **2190** | **820** |
| 10000-10999 | **3250** | **2307** | **894** |
| 11000+ | **3415** | **2426** | **926** |

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.



## 10. PRESCRIBED MINIMUM BENEFITS (PMB'S)

### 10.1 Designation 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 Contracted private hospital groups;

10.1.2 The Public Health System subject to regulation 8 (3);

10.1.3 Pharmacies at contracted private hospitals; Dischem Pharmacies, Clicks Pharmacies and the Discovery Health Pharmacy Network, including Southern RX Pharmacies;

10.1.4 Specialists contracted on behalf of Remedi by Discovery Health in terms of direct payment arrangements who have agreed to charge for consultations and procedures at the Remedi Rate;

10.1.5 The GP Network of general practitioners contracted through Discovery Health on behalf of the Scheme who have agreed to charge the Remedi Rate.

10.1.6 Preferred Provider negotiators, "PPN"

10.1.7 DRC (Dental Risk Company as the contracted dental management organisation)

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, for any amount in excess of the Chronic Drug Amount, which is applicable for that condition, shall be payable by such Beneficiary.

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

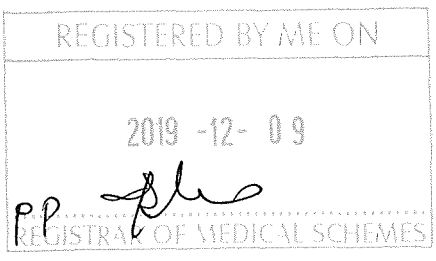
Notwithstanding anything to the contrary contained in these Rules, the Scheme shall pay 100% of the costs of prescribed minimum benefits obtained in a public hospital, without limitation.

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.



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

**10.11 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 a premier basket of care when consulting with a contracted Premier Plus General Practitioner to manage their conditions.

Where registered on the Diabetes*Care* programme an additional biokineticists and dietitian consultation per year is included in the basket of care.

Where registered on the HIV*Care* programme an additional consultation with a social worker per year is included in the basket of care.

Where registered on the CardioCare programme members are eligible to receive and extended consultation with a Premier Plus GP, as well as three standard consultations with a Premier Plus GP and appropriate formulary medicine included in the basket of care.

Where registered on the Mental Health Programme, benefits are provided from Risk over a 6-month period for:

- An extended consultation with a Premier Plus GP
- An initial psychotherapy session if referred by the member's Premier Plus GP;
- Prescribed formulary medicine for episodes of major depression even if the condition is not covered on the specific Option with a limit of R80 per month;
- Two additional GP consultations to allow effective evaluation, tracking and monitoring of treatment;
- And funding of a GP management fee of R25.00 per month from date of registration.

10.12 **Home Care**

Remedi 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:

10.12.1 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. Members need to be registered on the programme by their treating doctor and the additional basket of services is only available once the member is authorised to be registered on the programme.

10.12.2 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.

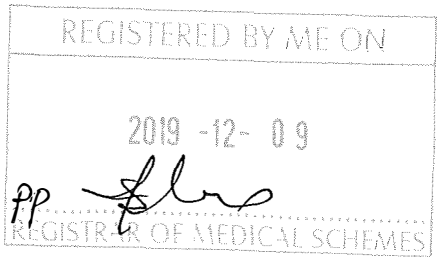
10.12.3 Wound Care

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.

10.12.4 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 is applicable.



# 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

2020/11/20

REGISTRAR OF MEDICAL SCHEMES

## 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, for any amount in excess of the Chronic Drug Amount, which is applicable for that condition, shall be payable by such Beneficiary.

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



10.11 **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.

10.12 **Home Care**

Remedi 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:

10.12.1 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. Members need to be registered on the programme by their treating doctor and the additional basket of services is only available once the member is authorised to be registered on the programme.

10.12.2 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.

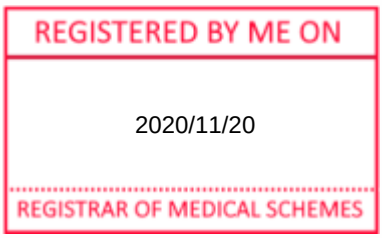
10.12.3 Wound Care

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.

10.12.4 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.



# STANDARD OPTION: BENEFITS 2021

(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** | | **Overall annual limit of:**<br>Per family: R 600 000<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | Subject to management of clinical risk by Discovery*Care* and use of defined DSP network of hospitals.<br>**All non-emergency admissions are subject to pre-authorisation**.<br>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.<br><br>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 R108 000.00 and limited to one procedure per beneficiary and must be pre-authorised. |
| | **Hospital accommodation**<br>• 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<br>**Pre-authorisation of admission required** | Annexures B and D has reference.<br>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**<br>• Surgery and medical procedures, which generally, but not necessarily, require hospitalisation<br>• Confinements and antenatal consultations<br>• Theatre fees and anaesthetics<br>• Treatment for renal dialysis | 100% of the Remedi Rate | Subject to overall annual limit<br>**Pre-authorisation of admission required**<br><br>No benefit for conservative dentistry under anaesthesia<br>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.<br><br>Cosmetic surgery is a listed Scheme exclusion on Remedi |

| | BENEFIT | RATE | LIMITS | COMMENTS |
|---|---|---|---|---|
| | **Hospital and surgical material/ equipment**<br>• As per agreed list | 100% of the Remedi Rate | Subject to overall annual limit<br>**Pre-authorisation of admission required** | Limits set in terms of charging policy for listed items, which may be agreed with DSP and other providers.<br>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**<br>• 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.<br>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<br>• will be liable to pay the provider;<br>• will receive a benefit limited to 100% of the Remedi Rate;<br>• may be required to make co-payments to such provider for fees charged above the Remedi Rate |
| **2.** | **Hospitalisation in ~~public~~ hospitals as well as surgery and medical procedures performed by *public sector practitioners*** | 100% of the Remedi Rate | Limited to Overall annual limit, subject to sub-limit of R 250 000 per family (M+) for treatment in public facilities.<br>**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*Care*.<br>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**<br>• 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<br>**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. |
| | **Surgery and medical procedures**<br>• Surgery and medical procedures, which generally, but not necessarily, require hospitalisation<br>• Confinements and antenatal consultations<br>• Theatre fees and anaesthetics<br>• Treatment for renal dialysis | 100% of the Remedi Rate | Subject to overall annual limit<br>**Pre-authorisation of admission required**<br>• No benefit for conservative dentistry under anaesthesia<br>• No benefit for maxillo-facial and oral surgery (excluding trauma-related surgery) | Cosmetic surgery is a listed Scheme exclusion on Remedi |

| | BENEFIT | RATE | LIMITS | COMMENTS |
|---|---|---|---|---|
| | **Hospital and surgical material/equipment**<br>• As per agreed list | 100% of the Remedi Rate | Subject to overall annual limit<br>**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 the Remedi Rate | Subject to overall annual limit | |
| | **In-hospital visits**<br>• General practitioners and specialists' visits during pre-authorised hospitalization | 100% of the Remedi Rate | Subject to overall annual limit | |
| **3.** | **Medicines**<br>Acute and Chronic Medicine | 100% of the cost on approved drug list (DSP medicine formulary)/Medicine Rate | Unlimited, subject to:<br>Fixed drug list/formulary, as defined by DSP – 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.<br><br>Oral contraceptives are limited to a monthly limit of R160.00 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.<br><br>Over-the-counter (OTC) medicine are limited to R160.00 per script and R320.00 per annum and subject to the overall annual limit. | 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.<br>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. |

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2020/11/20

REGISTRAR OF MEDICAL SCHEMES

| | BENEFIT | RATE | LIMITS | COMMENTS |
|---|---|---|---|---|
| 4. | **Extended physiotherapy, occupational therapy, speech therapy and biokinetics Maintenance therapy (In and Out of Hospital)**<br>• 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: R3 950 per family per annum.<br>**Pre-authorisation required** | This specifically excludes treatment of an acute/minor injury as determined by Remedi's Medical Advisory Committee. |

REGISTERED BY ME ON

2020/11/20

REGISTRAR OF MEDICAL SCHEMES

<table>
<tr><th></th><th>BENEFIT</th><th>RATE</th><th>LIMITS</th><th>COMMENTS</th></tr>
<tr><td></td><td>Rehabilitation therapy post hospitalisation<br>• 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>Subject to Overall Annual Limit with a sub-limit:<br>R3 950 per family per annum<br>Pre-authorisation required</td><td></td></tr>
<tr><td>5.</td><td>Trauma recovery extender benefit<br>Covering out of hospital treatment following a traumatic incident resulting in<br>• paraplegia, quadriplegia, tetraplegia and hemiplegia<br>• conditions resulting from near drowning, severe anaphylactic reaction, poisoning and crime related injuries;<br>• severe burns;<br>• 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<br>Subject to the overall annual limit and the following sub-limits<br><table><tr><td colspan="2">Loss of limb per family</td><td>R85 000</td></tr><tr><td colspan="2">Private nursing</td><td>R10 700</td></tr><tr><td>Prescribed medication :</td><td>M</td><td>R13 700</td></tr><tr><td></td><td>M + 1</td><td>R16 150</td></tr><tr><td></td><td>M + 2</td><td>R19 250</td></tr><tr><td></td><td>M + 3 or more</td><td>R23 250</td></tr><tr><td colspan="2">External medical items</td><td>R32 000</td></tr><tr><td colspan="2">Hearing Aids</td><td>R15 200</td></tr><tr><td colspan="2">Mental health benefit</td><td>R19 300</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<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES</td></tr>
<tr><td>6.</td><td>Out-of-hospital benefit for<br>• general practitioners;<br>• dentistry;<br>• pathology and radiology (excluding MRI and CT scans) benefits<br>• Vacuum Assisted Breast Biopsy (VABB)</td><td>100% of the Remedi Rate</td><td>Out-of-hospital benefit unlimited via the DSP contracted network of practitioners<br>• general practitioner consultations, including small procedures;<br>• basic dentistry, viz. consultations, extractions and fillings, including resin fillings up to level 3, i.e. 3 surface fillings per tooth;<br>• basic x-rays, namely black and white x-rays of chest, abdomen, pelvis and limbs<br>pathology tests as limited by agreement;<br>• VABB per beneficiary limited to two procedures per year at negotiated fees</td><td>Excludes dentures and special dentistry.</td></tr>
<tr><td></td><td>• World Health Organisation (WHO) Global Outbreak Benefit for out-of-hospital management and appropriate supportive treatment of global WHO recognized disease outbreaks:</td><td>Save for Prescribed Minimum Benefits (PMB), up to a maximum of 100% of the Remedi Rate</td><td>Funded out of a dedicated basket of care as set by the Scheme related to COVID-19 and limited to:<br>- Unlimited screening consultations with a nurse or GP;<br>- Defined basket of pathology up to 3 tests per person per year, except where cover is PMB;<br>- Up to a maximum of R400 per day for accommodation in an accredited isolation</td><td>Subject to the Scheme's preferred provider, protocols and clinical entry criteria and guidelines.<br><br>Cover for testing is subject to referral.</td></tr>
</table>

| | BENEFIT | RATE | LIMITS | COMMENTS |
|---|---|---|---|---|
| | Out-of-hospital healthcare services related to COVID-19 includes:<br>- Screening consultation with a nurse or a GP;<br>- Defined basket of pathology;<br>- Defined basket of x-rays and scans;<br>- Consultations with a nurse or GP;<br>- Supportive treatment;<br>- Accommodation in accredited isolation facilities | | facility up to a maximum of 14 days accommodation per person per year. | |
| | • 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:<br>Per Principal Member: R2 620<br>Per Adult dependent: R1 660<br>Per Child dependent: R 530 up to a maximum of 3 children<br>All benefits will be limited to the above sub-limit after which the cost related to the diagnosis and medical management of 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 hospitals, subject to rules 10.3, 10.4 and 10.5 of Annexures B and D.<br><br>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. | 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.<br>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.<br><br>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<br>• will be liable to pay the provider;<br>• will receive a benefit limited of maximum 100% of the Remedi Rate;<br>• may be required to make co-payments to such provider for fees charged above the Remedi Rate. |
| 7. | **Maternity**<br>• Pregnancy Scans, pregnancy related tests and antenatal consults<br>• Limited consultations, pregnancy scans and a specified range of pathology tests<br><br>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:<br><br>- 2 x 2D pregnancy scans;<br>- Limited to 9 consultations at a Network GP, Midwife or Gynaecologist;<br>- 9 x urine dipstick tests;<br>- 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.<br><br>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. |



S. Botha

REGISTERED BY ME ON

2021 -02- 12

Mpho Sehloho
25/02/2021 11:53:52 (UTC+02:00)
Signed by Mpho Sehloho;
m.sehloho@medicalschemes.co.za

REGISTRAR OF MEDICAL SCHEMES

SIGNFLOW.COM

| | BENEFIT | RATE | LIMITS | COMMENTS |
|---|---|---|---|---|
| | | | | 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.<br><br>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<br>• will be liable to pay the provider;<br>• will receive a benefit limited to 100% of the Remedi Rate;<br>• may be required to make co-payments to such provider for fees charged above the Remedi Rate. |
| 8. | **Specialised dentistry**<br>Inlays, crown and bridgework, study models, dentures and the repair thereof, orthodontics, periodontics, prosthodontics and osseo-integrated implants | | Nil Benefit | |
| 9. | **Optical**<br>• Eye tests<br><br>• Spectacles<br><br>Frames and/or lens enhancements<br><br>• Refractive eye surgery and Corneal Cross Linking | 100% of the Remedi Rate | A composite consultation inclusive of refraction, tonometry and visual field screening at Preferred Provider every 24 months up to R365 per beneficiary.<br><br>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 R575 may be provided.<br><br>Standard frame and/or lens enhancements up to R300 per beneficiary every two years.<br><br>Nil Benefit | Benefit available via DSP contracted Optometrist Network only. |



REGISTERED BY ME ON

2021 -02- 12

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25/02/2021 11:53:56 (UTC+02:00)
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MEDICAL SCHEMES

| | BENEFIT | RATE | LIMITS | COMMENTS |
|---|---|---|---|---|
| 10. | **Oncology**<br>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 R225 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 R225 000 per beneficiary and family limit per annum over a 12 month rolling period from date of diagnosis.<br><br>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.<br><br>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.<br><br>To read Annexure D in conjunction with this Rule. |
| 11. | **Frail care and private nursing**<br><br>**Hospicare**<br><br>**Sub-Acute facilities** | 100% of the Remedi Rate<br><br>100% of Cost<br><br>100% of the Remedi Rate | Unless PMB, subject to overall annual limit with a sub-limit of R13 800 per family.<br>**Pre-authorisation required.**<br><br>Subject to overall annual limit<br>**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.<br><br>Sub-limit may be increased, subject to approval of the Scheme`s Medical Advisory Committee.<br><br>**Where pre-authorisation is not obtained, no benefits will apply**<br><br>**Advanced Illness Benefit (AIB) available upon application and pre-approval where clinically appropriate** |

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2020/11/20

REGISTRAR OF MEDICAL SCHEMES

| | BENEFIT | RATE | LIMITS | COMMENTS |
|---|---|---|---|---|
| 12. | **Radiology and pathology**<br>• Radiology: In hospital<br>• Pathology: In hospital<br>• 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.** | 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.<br><br>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<br>• will be liable to pay the provider;<br>• will receive a benefit limited to 100% of the Remedi Rate;<br>• may be required to make co-payments to such provider for fees charged above the Remedi Rate |

REGISTERED BY ME ON

2020/11/20

REGISTRAR OF MEDICAL SCHEMES

| | BENEFIT | RATE | LIMITS | COMMENTS |
|---|---|---|---|---|
| 13. | **Preventative and Screening benefit**<br>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.<br><br>Pneumococcal vaccine for identified high risk members.<br><br>Preventative dentistry is provided through the contracted DSP.<br><br>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.<br><br>One LDL cholesterol screening is available per high risk beneficiary where clinically indicated at network pharmacy.<br><br>HbA1c is funded from the Insured Out of Hospital benefit, where clinically appropriate.<br><br>A group of age appropriate screening tests and additional screening assessments for members 65 years and older. (Senior Screening Tests)-.<br><br>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 | 100% of the Remedi Rate | Subject to overall annual limit.<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | 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.<br><br>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<br>• will be liable to pay the provider;<br>• will receive a benefit limited to 100% of the Remedi Rate;<br>• may be required to make co-payments to such provider for fees charged above the Remedi Rate.<br><br>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:<br><br>• 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.<br><br>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. |

<table>
<tr><th></th><th>BENEFIT</th><th>RATE</th><th>LIMITS</th><th>COMMENTS</th></tr>
<tr><td>14.</td><td>Internal Prostheses and Devices</td><td>100% of the Remedi Rate</td><td>Subject to the Overall Annual Limit with the following sub-limits:<br><table><tr><td>Total hip replacement</td><td>R37 600***</td></tr><tr><td>Revision hip</td><td>R44 500***</td></tr><tr><td>Knee replacement</td><td>R29 600***</td></tr><tr><td>Revision knee replacement</td><td>R37 600***</td></tr><tr><td>Total shoulder replacement</td><td>R34 600</td></tr><tr><td>Spinal benefit (one procedure per year)<br>first level<br>two or more levels</td><td><br>**<br>**</td></tr><tr><td>Bare metal cardiac stents max. 3 p.a. (each)</td><td>**</td></tr><tr><td>Drug eluting cardiac stents (each) max. 3 p.a.</td><td>**</td></tr><tr><td>Pacemaker with Leads</td><td>R62 700</td></tr><tr><td>Pacemaker Biventricular</td><td>R80 600</td></tr><tr><td>Cardiac valves (each)</td><td>R40 800</td></tr><tr><td>Artificial limbs (below knee)</td><td>R24 500</td></tr><tr><td>Artificial Limbs (above knee)</td><td>R44 600</td></tr><tr><td>Artificial eyes(prosthesis plus apparatus)</td><td>R23 000</td></tr><tr><td>All other internal prostheses and devices</td><td>*<br>R19 600</td></tr></table></td><td>Subject to pre-authorisation and clinical protocols the prescribed requirements for PMB's.<br><br>Spinal benefit limit:<br>• applies to the prosthetic device only<br>• PER LEVEL LIMIT (artificial disc replacement, interspinous process devices & spinal fusion)<br><br>*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.<br>** Negotiated reference price list is applicable.<br>*** Hip and Knee Arthroplasty Procedures:<br>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.</td></tr>
<tr><td>15.</td><td>External Prostheses and Appliances. (including the External components of external prosthesis, incontinence products, etc)</td><td>100% of the Remedi Rate</td><td>Subject to Overall Annual Limit with the following sub-limits:<br><table><tr><td>Colostomy equipment</td><td>R13 700 per beneficiary per annum</td></tr><tr><td>Hearing aids</td><td>R17 600 per beneficiary per annum</td></tr><tr><td>Wheelchairs</td><td>R12 100 per beneficiary per annum</td></tr><tr><td>Oxygen appliances (includes oxygen)</td><td>R1 985 per beneficiary per month</td></tr><tr><td>All other appliances</td><td>R3 250 per beneficiary per annum</td></tr></table></td><td>Colostomy equipment can be obtained via Cancer Society.<br><br>Oxygen benefit subject to registration for the use of oxygen on the Chronic Illness Benefit Programme managed by DiscoveryCare.<br><br>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.</td></tr>
</table>

| | BENEFIT | RATE | LIMITS | COMMENTS |
|---|---|---|---|---|
| 16. | **Paramedical services**<br><br>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.<br>**Pre-authorisation required with preferred provider**.<br>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**<br>(including the treatment of alcoholism and drug dependency) | 100% of the Remedi Rate | Subject to overall annual limit, limited to 21 days per annum.<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | **Subject to pre-authorisation** and the management of clinical risk by Discovery*Care* and the prescribed requirements for PMB`s and use of defined DSPs.<br>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.<br>Benefit may be increased, subject to approval of the Remedi's Medical Advisory Committee. |
| 18. | **Out-of-area benefit (OOA)**<br>(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 775 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.<br>If no DSP contracted service provider is available member may access Non-DSP Provider.<br>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**<br>(Including harvesting of organs, consultations/visits and post-operative anti-rejection medicines required by recipient) | PMB will be paid at 100% of Cost.<br>Non-PMB is paid at 100% of the Remedi Rate | PMB unlimited at the DSP.<br>Non-PMB will be subject to the Overall Annual Limit. | **Subject to pre-authorisation** and the management of clinical risk by Discovery*Care*.<br>Provisions of Annexures B and D is applicable. |
| 20. | **Renal Failure & Dialysis**<br>(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*Care*.<br>Provisions of Annexures B and D is applicable. |

| | BENEFIT | RATE | LIMITS | COMMENTS |
|---|---|---|---|---|
| 21. | **Other Health Care Services**<br>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. |
| | |
| 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 Medicinic 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 | Medicinic Private Hospital Facilities as contracted for Designated Service Provider ("DSP") purposes |



S.Botha

REGISTERED BY ME ON

2021 -02- 12

Mpho Sehloho
25/02/2021 11:54:00 (UTC+02:00)
Signed by Mpho Sehloho
m.sehloho@medicalschemes.co.za

REGISTRAR OF MEDICAL SCHEMES

SIGNIFLOW.COM

# COMPREHENSIVE OPTION: BENEFITS 2021

(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<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | Subject to the management of clinical risk by Discovery*Care* and use of defined DSP network of hospitals.<br>**All non-emergency admissions are subject to pre-authorisation**.<br>Emergencies must be authorised within 24 hours of admission or first working day after an emergency treatment or admission.<br>A co-payment of R1 000 for failing to pre-authorise will apply.<br><br>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**<br>• 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<br>**Pre-authorisation of admission required** | Annexures B and D has reference.<br>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**<br>• Surgery and medical procedures, which generally, but not necessarily, require hospitalisation<br>• Confinements<br>• Conservative dentistry under anaesthesia in patients not older than 7 years | 100% of the Remedi Rate | Subject to overall annual limit<br>**Pre-authorisation of admission required**<br><br>Anaesthetics and hospitalisation subject to overall annual limit.<br>**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.<br><br>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<br>**Pre-authorisation of admission required** | Limits set in terms of charging policy for listed items, which may be agreed with DSP and other Providers<br>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**<br>• 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<br>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<br>• will be liable to pay the provider;<br>• will receive a benefit limited to 150% of the Remedi Rate;<br>• may be required to make co-payments to such provider for fees charged above the Remedi Rate. |
| **2.** | **Hospitalisation in ~~public~~ hospitals as well as surgery and medical procedures performed by *public sector practitioners*** | 100% of the Remedi Rate | Limited to Overall annual limit, subject to sub-limit of R 540 000 per family (M+) for treatment in public facilities.<br>**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*Care*.<br>All non-emergency admissions **are subject to pre-authorisation**.<br>Emergencies must be authorised within 24 hours of admission or on the first working day after such emergency treatment or admission.<br>A co-payment of R1 000 for failing to pre-authorise will apply. |

| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| | **Hospital accommodation**<br>• 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<br>**Pre-authorisation of admission required** | |
| | **Surgery and medical procedures**<br>• Surgery and medical procedures, which generally, but not necessarily, require hospitalisation<br>• Confinements and antenatal consultations<br>• Theatre fees and anaesthetics<br>• Conservative dentistry under anaesthesia in patients not older than 7 years | 100% of the Remedi Rate | Subject to overall annual limit<br>**Pre-authorisation of admission required**<br>Anaesthetics and hospitalisation subject to overall annual limit.<br>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.<br><br>Cosmetic surgery is a listed exclusion on Remedi. |
| | **Hospital and surgical material/equipment**<br>• As per agreed list | 100% of the Remedi Rate | Subject to overall annual limit<br>**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 the Remedi Rate | Subject to overall annual limit | |
| | **In-hospital visits**<br>• General practitioner and specialist visits during pre-authorised hospitalisation | 100% of the Remedi Rate | Subject to overall annual limit | |
| **3.** | **Chronic medication**<br>PMB Conditions<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | 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)<br>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, the managed health care provider appointed by Remedi. |

| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| | 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 R2 090 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.<br><br>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**<br><br>**Maintenance therapy (In and Out of hospital)**<br>• 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**<br>Subject to Overall Annual Limit with sub-limit: R13 980 per family (M+) per annum | This specifically excludes treatment of an acute (minor) injury as determined by Remedi's Medical Advisory Committee. |

REGISTERED BY ME ON

2020/11/20

REGISTRAR OF MEDICAL SCHEMES

<table>
<tr><th></th><th>BENEFIT</th><th>RATE</th><th>LIMITS</th><th>COMMENT</th></tr>
<tr><td></td><td>Rehabilitation therapy post hospitalisation<br>• 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<br>Subject to overall annual limit</td><td></td></tr>
<tr><td>5.</td><td>Trauma recovery extender benefit<br>Covering out of hospital treatment following a traumatic incident resulting in<br>• paraplegia, quadriplegia, tetraplegia and hemiplegia<br>• conditions resulting from near drowning, severe anaphylactic reaction, poisoning and crime related injuries;<br>• severe burns;<br>• 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.<br>Subject to the overall annual limit and the following sub-limits.<br><table><tr><td colspan="2">Loss of limb per family</td><td>R85 000</td></tr><tr><td colspan="2">Private nursing</td><td>R10 700</td></tr><tr><td>Prescribed medication :</td><td>M</td><td>R29 650</td></tr><tr><td></td><td>M + 1</td><td>R34 750</td></tr><tr><td></td><td>M + 2</td><td>R40 500</td></tr><tr><td></td><td>M + 3 or more</td><td>R46 050</td></tr><tr><td colspan="2">External medical items</td><td>R72 000</td></tr><tr><td colspan="2">Hearing Aids</td><td>R26 300</td></tr><tr><td colspan="2">Mental health benefit</td><td>R25 900</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 benefit for:<br>Consultations, procedures, radiology (excluding MRI and CT scans) and pathology outside hospital, including in the outpatient department of a hospital and inclusive of the facility fee for outpatients<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES</td><td>100% of the Remedi Rate or<br>100% of cost at the Designated Service Provider (DSP) /Medicine Rate</td><td>Subject to Overall Annual Limit and the following sub-limits:<br>Per Principal Member: R8 980<br>Per Adult Dependent:: R5 300<br>Per Child Dependent: R1 490 (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.<br>Special and advanced dentistry is specifically excluded<br><br>Including consultation for insertion of Mirena contraceptive device in gynaecologist's rooms, provided pre-approval obtained and subject to Scheme clinical protocols and guidelines.<br><br>All other oral contraceptives are funded up to a monthly limit of R160.00 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.<br>Once, the monthly limit of R160.00 is reached, costs related to oral contraceptives are covered from the Personal Medical Savings Account ("PMSA")</td></tr>
</table>

| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| | • Specialists;<br>• General Practitioners;<br>• Acute and self-medication<br>• Dentistry;<br>• Physiotherapists;<br>• Biokineticists;<br>• Occupational Therapists;<br>• Speech Therapists<br>• Audiologists And Audiometrists<br>• Clinical Psychologists;<br>• Social Workers;<br>• Pathology and radiology (excluding MRI and CT scans) benefits<br>• 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.<br><br>VABB per beneficiary is limited to two procedures per year at negotiated fees. | Self-medication applies to medicines classified as Schedules 0, 1 and 2, which can be purchased over the counter without a doctor's prescription.<br><br>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.<br><br>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.<br><br>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.<br><br>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<br>• will be liable to pay the provider;<br>• will receive a benefit limited to 100% of the Remedi Rate;<br>• may be required to make co-payments to such provider for fees charged above the Remedi Rate. |

REGISTERED BY ME ON

2020/11/20

REGISTRAR OF MEDICAL SCHEMES

| | 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:<br>• Out-of-hospital healthcare services related to COVID-19 includes:<br>- Screening consultation with a nurse or a GP;<br>- Defined basket of pathology;<br>- Defined basket of x-rays and scans;<br>- Consultations with a nurse or GP;<br>- Supportive treatment;<br>- Accommodation in accredited isolation facilities | 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:<br>- Unlimited screening consultations with a nurse or GP;<br>- Defined basket of pathology up to 3 tests per person per year, except where cover is PMB;<br>- 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. | Subject to the Scheme's preferred provider, protocols and clinical entry criteria and guidelines.<br><br>Cover for testing is subject to referral. |
| 7. | **GP Benefit**<br>• 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:<br>M0: 3 additional GP consultations<br>M+: 5 additional GP consultations | Additional consultations will only be funded for services provided by a practitioner in the GP Network. |
| 8. | **Maternity**<br>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:<br>- 2 x 2D pregnancy scans;<br>- 9 GP consultations at a Network GP, Midwife or Gynaecologist;<br>- 9 x urine dipstick tests;<br>- 2 x glucose strip tests; | 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.<br><br>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 HIV Elisa, Rubella, RPR and TPHA and bHCG tests;<br>• 2x RH antigen, Haemoglobin, A B and O antigens<br>• 1 x Nuchal Translucency (NT) and/or Non-Invasive Prenatal Test (NIPT) and T21 screening per pregnancy<br>• | |
| 9. | **Specialised dentistry**<br>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 000 per beneficiary and R42 100 per family | |
| 10. | **Optical**<br>***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:<br>1. Annual benefit cycle<br>2. Beneficiary limited to R3 511 subject to overall family limit of R7 022<br>3. The following sub-limits will apply within the overall beneficiary/family limit:<br>*Consultations*<br>A composite consultation inclusive of refraction, tonometry and visual field screening at Preferred Provider Optometrist is paid at 100% of Cost.<br>*And either Spectacles*<br>Frame limit/Lens Enhancements<br>R1 688 toward the cost of a Frame and/or Lens enhancements paid to the Preferred Provider limited to OAL and<br>*Clear* lens limit:<br>• Single Vision lenses at Preferred Provider Optometrist R210 per lens;<br>• Bifocal lenses at R445 per lens or<br>• Base Multifocal spectacle lenses R770 per lens.<br>*Or Contact lenses*<br>Contact lenses limited to the value of R2 315. | • 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.<br>• 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.<br>• 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<br>• 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.<br>• 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.<br>• All clinical/prescribed information must be submitted on all claims to ensure payment. |

| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| | ***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:<br>1. Annual benefit cycle<br>2. Beneficiary limited to R3 511 subject to overall family limit of R7 022<br>3. The following sub-limits will apply within the overall beneficiary/family limit:<br>*Consultations*<br>A composite consultation inclusive of refraction, tonometry and visual field screening limited to R365.<br>*And either Spectacles*<br>Frame limit<br>R1 224 towards the cost of a frame and/or lens enhancements and<br>Clear lenses limit:<br>• Single vision lenses at R210 per lens or<br>• Bifocal lenses at R445 per lens or<br>• Multifocal lenses at R770 per lens.<br>*Or*<br>Contact lenses limited to the value of R2 315. | • Co-payments may be applicable on services obtained from non-preferred provider optometrists.<br>• All claims must be submitted to PPN for adjudication and payment of benefits.<br>• 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.<br>• Members can obtain either spectacles or contact lenses within a benefit cycle not both |
| | **Refractive eye surgery**<br>**Members with severely restricted vision**<br>(Including Corneal Cross Linking) | 100% of the Remedi Rate | Annual sub-limit of R28 600 per beneficiary | Pre-authorisation in accordance with approved clinical protocols is required. Where pre-authorisation is not obtained, no benefits will apply. |
| 11. | **Oncology**<br>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 R390 000 per beneficiary plus a further R575 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 R390 000 per beneficiary at 100% of the Remedi Rate and a further R575 000 per beneficiary at 80% of the Remedi Rate, limited to an overall Oncology annual limit of R965 000 per family per annum over a 12 month rolling period from date of diagnosis.<br><br>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*Care*, 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.<br><br>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.<br><br>To read Annexure D in conjunction with this Rule. |
| 12. | **Frail care and private nursing** | 100% of the Remedi Rate | Unless PMB, subject to the overall annual limit with a sub-limit of R39 300.<br>**Subject to pre-authorisation.** | Subject to hospital risk management programme, prior approval of Remedi and only available as an alternative to hospitalisation. |

REGISTERED BY ME ON
2020/11/20
REGISTRAR OF MEDICAL SCHEMES

| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| | **Hospice**<br><br>**Sub-Acute facilities** | 100% of Cost<br><br>100% of the Remedi Rate | **Unlimited**<br><br>Subject to overall annual limit<br>**Subject to pre-authorisation** | Sub-limit may be increased, subject to approval of Remedi's Medical Advisory Committee.<br>**Where pre-authorisation is not obtained, no benefits will apply.**<br><br>**Advanced Illness Benefit (AIB) available upon application and where pre-approved.** |
| 13. | **Radiology and pathology**<br>• Radiology: In hospital<br>• Pathology: In hospital<br>• 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.<br>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<br>• will be liable to pay the provider;<br>• will receive a benefit limited to 100% of the Remedi Rate;<br>• may be required to make co-payments to such provider for fees charged above the Remedi Rate. |

REGISTERED BY ME ON

2020/11/20

REGISTRAR OF MEDICAL SCHEMES

| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| 14. | **Preventative and Screening benefit**<br>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.<br><br>Pneumococcal vaccine for identified high risk members.<br><br>One (1) preventative dental examination per beneficiary per annum, including the oral examination, infection control, prophylaxis, polishing and fluoride of adults and children<br><br>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.<br><br>One LDL cholesterol screening is available per high risk beneficiary where clinically indicated at network pharmacy.<br><br>HbA1c is funded from the Insured Out of Hospital benefit, where clinically appropriate.<br><br>A group of age appropriate screening tests and additional screening assessments for members 65 years and older (Senior Screening Tests).<br><br>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. | 100% of the Remedi Rate | Subject to Overall Annual Limit<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | 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.<br>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<br>• will be liable to pay the provider;<br>• will receive a benefit limited to 100% of the Remedi Rate;<br>• may be required to make co-payments to such provider for fees charged above the Remedi Rate.<br><br>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:<br><br>• 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.<br><br>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. |

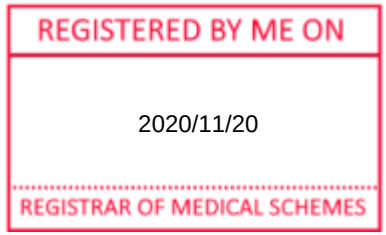
| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| 15. | **Internal prostheses and devices** | 100% of the Remedi Rate | Subject to the Overall Annual Limit with following sub-limits:<br>Total hip replacement: R48 700***<br>Revision hip: R58 800***<br>Knee replacement: R39 200***<br>Revision knee replacement: R49 700***<br>Total shoulder replacement: R45 700<br>Spinal benefit (one procedure per year) first level: **<br>two or more levels<br>Bare metal cardiac stents max. 3 p.a. (each): **<br>Drug eluting cardiac stents (each) max. 3 p.a.<br>Pacemaker with Leads: R83 400<br>Pacemaker Biventricular: R107 500<br>Cardiac valves (each): R55 800<br>Artificial limbs (below knee): R32 100<br>Artificial Limbs (above knee): R59 200<br>Artificial eyes (prosthesis plus apparatus): R30 400<br>All other internal prostheses and devices: * R25 800 | Subject to pre-authorisation and the hospital risk management programme and the requirements prescribed for PMB's.<br><br>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)<br><br>*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.<br><br>** Negotiated reference price list is applicable.<br>*** Hip and Knee Arthroplasty Procedures:<br>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:<br>Colostomy equipment: R26 400 per beneficiary per annum<br>Hearing aids: R24 350 per beneficiary per annum<br>Wheelchairs: * R18 200 per beneficiary per annum<br>Oxygen appliances (includes oxygen): R1 985 per beneficiary per month<br>All other appliances: * R6 850 per beneficiary per annum | Colostomy equipment can be obtained via Cancer Society.<br><br>Oxygen benefit subject to registration for the use of oxygen on the Chronic Illness Benefit Programme managed by DiscoveryCare.<br><br>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<br><br>*Sub-limit may be increased, subject to approval of the Scheme's Medical Advisory Committee. |



J. Botha

REGISTERED BY ME ON
2021 -02- 12
REGISTRAR OF MEDICAL SCHEMES

Mpho Sehloho
25/02/2021 11:53:48 (UTC+02:00)
Signed by Mpho Sehloho
m.sehloho@medicalschemes.co.za

| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| 17. | **Paramedical services**<br>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.<br>Pre-authorisation required with Preferred Provider.<br>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**<br>(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. | **Subject to pre-authorisation** and the management of clinical risk by DiscoveryCare and the requirements prescribed for PMBs. Benefits may be granted for out-of-hospital consultations and/or treatment in lieu of hospitalisation only.<br>Benefit may be increased, subject to approval of Remedi's Medical Advisory Committee. |
| 19. | **Organ Transplants**<br>(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.<br>Non-PMB will be subject to the Overall Annual Limit. | **Subject to pre-authorisation** and the management of clinical risk by DiscoveryCare.<br>Provisions of Annexures B and D is applicable. |
| 20. | **Renal Failure & Dialysis**<br>(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 DiscoveryCare.<br>Provisions of Annexures B and D is applicable. |
| 21. | **Other Health Care Services**<br>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 | 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 recognised under enabling statute e.g. The Allied Health Professions Act, Act 63 of 1982. |
| 22. | Overseas Treatment Benefit<br>  | 80% of cost | Subject to Overall Annual Limit and limited to R650 000 per annum per beneficiary. | Conditions:<br>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. |

| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| 24. | **Personal Savings Account**<br>a. *General practitioners<br>b. *Medical specialists<br>c. *Conservative dentistry<br>d. Specialized dentistry<br>e. *Prescribed acute medicine and injection material<br>f. *Physiotherapy, speech therapy, and occupational therapy<br>g. *Clinical psychologists<br>h. *Social Workers<br>i. Chiropractor, homeopath, osteopath, herbalist, naturopath or dietician<br>j. *Eye tests, spectacles or contact lenses and refractory eye surgery<br>k. *Radiology: Out of hospital (excluding MRI and CT scans)<br>l. *Pathology: Out of hospital<br>m. Medical costs in excess of the benefit amount under the Comprehensive Option<br>n. Condoms and preventive medication for malaria. Appliances other than the Mirena and emergency pill.<br>o. *Contraceptives<br>p. Immunisations, except influenza and pneumococcal vaccines where clinically indicated, which is funded from the Preventative and Screening Benefit and Human Papillomavirus (HPV) vaccine which is funded from Preventative and Screening Benefit first | 100% of cost | Annual benefit amount equals 10% of the total contribution payable to the Scheme.<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | * Initial benefit available from Comprehensive insured Benefit or OAL, as detailed above |
| 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:**

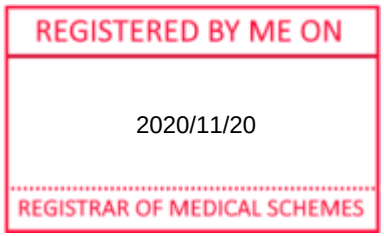
| | |
|---|---|
| CDL | Chronic Disease List |
| DSP | A Designated Service Provider for the Prescribed Minimum Benefits - "PMBs" - selected by Remedi, being contracted private hospitals, Clicks Pharmacies and Dis-Chem Pharmacies, Discovery Health Pharmacy Network, as well as specialists contracted by 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 |

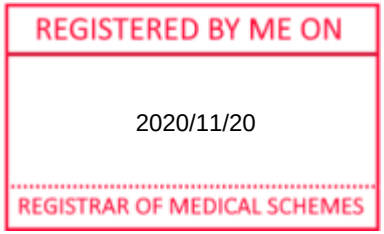
# CLASSIC OPTION: BENEFITS 2021

(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.**<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | | **Overall annual limit of:**<br>R2 050 000 per family (M+) per annum | Subject to the management of clinical risk by Discovery*Care* and use of defined DSP network of hospitals.<br>**All non-emergency admissions are subject to pre-authorisation**.<br>Emergencies must be authorised within 24 hours of admission or first working day after an emergency treatment or admission.<br>A co-payment of R1 000 for failing to pre-authorise will apply.<br><br>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 R108 000.00 up to one procedure per beneficiary and must be pre-authorised |
| | **Hospital accommodation**<br>• 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<br>**Pre-authorisation of admission required** | Annexures B and D has reference.<br>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**<br>• Surgery and medical procedures, which generally, but not necessarily, require hospitalisation<br>• Confinements<br><br>• Conservative dentistry under anaesthesia in patients not older than 7 years | 100% of the Remedi Rate | Subject to overall annual limit<br>**Pre-authorisation of admission required**<br><br>Anaesthetics and hospitalisation subject to overall annual limit.<br>**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.<br>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<br>**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**<br>• 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<br>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<br>• will be liable to pay the provider;<br>• will receive a benefit limited to 100% of the Remedi Rate;<br>• may be required to make co-payments to such provider for fees charged above the Remedi Rate. |
| 2. | **Hospitalisation in public hospitals as well as surgery and medical procedures performed by *public sector practitioners*** | 100% of the Remedi Rate | Limited to Overall annual limit, subject to sub-limit of R 525 000 per family (M+) for treatment in public facilities.<br>**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*Care*.<br>All non-emergency admissions **are subject to pre-authorisation.**<br>Emergencies must be authorised within 24 hours of admission or on the first working day after such emergency treatment or admission. |
| | **Hospital accommodation**<br>• 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<br>**Pre-authorisation of admission required** | |
| | **Surgery and medical procedures**<br>• Surgery and medical procedures, which generally, but not necessarily, require hospitalisation<br>• Confinements and antenatal consultations<br>• Theatre fees and anaesthetics<br>• Conservative dentistry under anaesthesia in patients not older than 7 years | 100% of the Remedi Rate | Subject to overall annual limit<br>**Pre-authorisation of admission required**<br>Anaesthetics and hospitalisation subject to overall annual limit.<br>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.<br><br>Cosmetic surgery is a listed Scheme exclusion on Remedi. |
| | **Hospital and surgical material/equipment**<br>• As per agreed list | 100% of the Remedi Rate | Subject to overall annual limit<br>**Pre-authorisation of admission required** | Benefit for medicines to take home (TTO's), limited to 5 days. |

| | 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**<br>• General practitioner and specialist visits during pre-authorised hospitalisation | 100% of the Remedi Rate | Subject to overall annual limit | |
| 3. | **Chronic medication**<br>PMB Conditions<br>  | 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)<br>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, 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 740 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.<br><br>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**<br><br>**Maintenance therapy (In and Out of hospital)**<br>• 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**<br>Subject to Overall Annual Limit with sub-limit: R13 280 per family (M+) per annum | This specifically excludes treatment of an acute (minor) injury as determined by Remedi's Medical Advisory Committee. |

<table>
<tr><th></th><th>BENEFIT</th><th>RATE</th><th>LIMITS</th><th>COMMENT</th></tr>
<tr><td></td><td>Rehabilitation therapy post hospitalisation<br>• 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<br>Subject to overall annual limit</td><td></td></tr>
<tr><td>5.</td><td>Trauma recovery extender benefit<br>Covering out of hospital treatment following a traumatic incident resulting in<br>• paraplegia, quadriplegia, tetraplegia and hemiplegia<br>• conditions resulting from near drowning, severe anaphylactic reaction, poisoning and crime related injuries;<br>• severe burns;<br>• 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.<br>Subject to the overall annual limit and the following sub-limits:<br><table><tr><td colspan="2">Loss of limb per family</td><td>R85 000</td></tr><tr><td colspan="2">Private nursing</td><td>R10 700</td></tr><tr><td>Prescribed medication :</td><td>M</td><td>R13 700</td></tr><tr><td></td><td>M + 1</td><td>R16 150</td></tr><tr><td></td><td>M + 2</td><td>R19 250</td></tr><tr><td></td><td>M + 3 or more</td><td>R23 250</td></tr><tr><td colspan="2">External medical items</td><td>R32 000</td></tr><tr><td colspan="2">Hearing Aids</td><td>R15 200</td></tr><tr><td colspan="2">Mental health benefit</td><td>R19 300</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<br>  </td></tr>
<tr><td>6.</td><td>Insured Out-of-hospital (IOH) benefit for:<br>Consultations, procedures, radiology (excluding MRI and CT scans) and pathology outside hospital, including in the outpatient department of a hospital and inclusive of the facility fee for outpatients<br>• General Practitioners<br>• Acute and self-medication<br>• Basic and Specialised dentistry;<br>• Specialists;<br>• Optical (including contact lenses)<br>• Physiotherapists;<br>• Biokineticists;<br>• Occupational Therapists;<br>• Speech Therapists<br>• Audiologists And Audiometrists<br>• Clinical Psychologists;<br>• Social Workers;</td><td>100% of the Remedi Rate<br>or<br>100% of cost at the Designated Service Provider (DSP)/ Medicine Rate</td><td>Subject to Overall Annual Limit and the following sub-limits:<br>Per Principal Member: R7 960<br>Per Adult Dependent: R4 700<br>Per Child Dependent: R1 320 (up to a maximum of 3 children)<br><br>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.<br><br>VABB per beneficiary is limited to two procedures per year at negotiated fees</td><td>Where the sub-limit is exceeded, benefits for non-PMB conditions to be paid by member.<br>.<br>Self-medication applies to medicines classified as Schedules 0, 1 and 2, which can be purchased over the counter without a doctor's prescription.<br>Including consultation for insertion of Mirena contraceptive device in gynaecologist's rooms, provided pre-approval obtained and subject to Scheme clinical protocols and guidelines.<br><br>All other oral contraceptives are funded up to a monthly limit of R160.00 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.</td></tr>
</table>

| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| | • Pathology and radiology (excluding MRI and CT scans) benefits<br>• Vacuum Assisted Breast Biopsy (VABB)<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | | | 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.<br><br>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.<br><br>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<br>• will be liable to pay the provider;<br>• will receive a benefit of maximum 100% of the Remedi Rate;<br>• 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:<br>• Out-of-hospital healthcare services related to COVID-19 includes:<br>- Screening consultation with a nurse or a GP;<br>- Defined basket of pathology;<br>- Defined basket of x-rays and scans;<br>- Consultations with a nurse or GP;<br>- Supportive treatment;<br>- Accommodation in accredited isolation facilities | 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:<br>- Unlimited screening consultations with a nurse or GP;<br>- Defined basket of pathology up to 3 tests per person per year, except where cover is PMB;<br>- 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. | Subject to the Scheme's preferred provider, protocols and clinical entry criteria and guidelines.<br><br>Cover for testing is subject to referral. |

| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| 7. | **Optical**<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | | 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.<br>1. An Annual benefit cycle.<br>2. Beneficiary limited to R3 305 subject to overall family limit of R6 610<br>3. The following sub-limits will apply within the overall beneficiary/family limit:<br><br>Consultations<br>A composite consultation inclusive of refraction, tonometry and vision field screening at 100% of cost for a PPN contracted network provider and up to R365 for a non-PPN network provider;<br><br>*and either Spectacles*<br>Frame Limit/Lens enhancements<br>R1 065 toward the cost of a frame and/or Lens enhancements at a PPN provider per beneficiary per year.<br><br>At a non PPN provider R1 065 towards a frame and/or lens enhancement per beneficiary is funded towards spectacles subject to the annual overall family limit<br><br>Clear lens Limit:<br>Single, Bifocal or base Multifocal lenses are funded at a PPN provider and non PPN provider as follows:<br>Single Vision lenses at R210 per lens;<br>Bifocal lenses at R445 per lens; or<br>Multifocal lenses at R770 per lens.<br>Or Contact Lenses<br>Contact lenses limited to the value of R1 930. | The following further conditions apply to the obtaining of any optical benefits<br>• Payment of any claim is subject to available benefits irrespective of confirmation the Member or provider<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• All clinical/prescribed information must be submitted on all claims to ensure payment.<br>• Co-payments may be applicable on services obtained from non-preferred provider optometrists.<br>• All claims must be submitted to PPN for adjudication and payment of benefits.<br>• Member refunds may be applicable on services obtained from non-preferred provider optometrists without an agreement for direct payment<br>• Members can obtain either spectacles or contact lenses within a benefit cycle not both. |
| 7. | **Refractive eye surgery**<br>Members with severely restricted vision (Including Corneal Cross Linking) | 100% of the Remedi Rate | Annual sub-limit of R25 600 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**<br>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:<br>- 2 x 2D pregnancy scans;<br>- 9 GP consultations at a Network GP, Midwife or Gynaecologist;<br>- 9 x urine dipstick tests;<br>- 2 x glucose strip tests;<br>- 1 x HIV Elisa, Rubella, RPR and TPHA and bHCG tests;<br>- 2x RH antigen, Haemoglobin, A B and O antigens<br>- 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.<br><br>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**<br>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 R390 000 per beneficiary plus a further R255 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 R390 000 per beneficiary at 100% of the Remedi Rate and a further R255 000 per beneficiary at 80% of the Remedi Rate, limited to an overall Oncology annual limit of R645 000 per family per annum over a 12 month rolling period from date of diagnosis.<br><br>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 DiscoveryCare, 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.<br><br>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.<br><br>To read Annexure D in conjunction with this Rule. |
| 10. | **Frail care and private nursing**<br><br>**Hospice**<br>**Sub-Acute facilities** | 100% of the Remedi Rate<br><br>100% of Cost<br><br>100% of the Remedi Rate | Unless PMB, subject to the overall annual limit with a sub-limit of R37 450 per family.<br>**Subject to pre-authorisation .**<br>Unlimited<br>Subject to overall annual limit<br>**Subject to pre-authorisation** | **Subject to hospital risk management programme, prior approval of Remedi and only available as an alternative to hospitalisation.**<br>Sub-limit may be increased, subject to approval of Remedi's Medical Advisory Committee.<br>**Where pre-authorisation is not obtained, no benefits will apply.**<br><br>**Advanced Illness Benefit (AIB) is available upon application and where pre-approved** |



J. Botha

REGISTERED BY ME ON
2021 -02- 12
REGISTRAR OF MEDICAL SCHEMES

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25/02/2021 11:53:20 (UTC+02:00)
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| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| 11. | **Radiology and pathology**<br>• Radiology: In hospital<br>• Pathology: In hospital<br>• 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.<br>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<br>• will be liable to pay the provider;<br>• 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. | **Preventative and Screening benefit** | | | |

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2020/11/20

REGISTRAR OF MEDICAL SCHEMES

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|---|---|---|---|---|
| | 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<br><br>Pneumococcal vaccine for identified high risk members.<br><br>One (1) preventative dental examination per beneficiary per annum, including the oral examination, infection control, prophylaxis, polishing and fluoride of adults and children.<br><br>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.<br><br>One LDL cholesterol screening is available per high risk beneficiary where clinically indicated at network pharmacy.<br><br>HbA1c is funded from the Insured Out of Hospital benefit, where clinically appropriate.<br><br>A group of age appropriate screening tests and additional screening assessments for members 65 years and older (Senior Screening Tests).<br><br>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. | 100% of the Remedi Rate | Subject to Overall Annual Limit<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | 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.<br>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<br>• will be liable to pay the provider;<br>• will receive a benefit limited to 100% of the Remedi Rate;<br>• may be required to make co-payments to such provider for fees charged above the Remedi Rate.<br><br>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:<br><br>• 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.<br><br>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. |

| | | | | |
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| 13. | **Internal prostheses and devices** | 100% of the Remedi Rate | Subject to the Overall Annual Limit with following sub-limits:<br><br>Total hip replacement R42 700<br>Revision hip R50 300<br>Knee replacement R33 500<br>Revision knee replacement R42 700<br>Total shoulder replacement R39 200<br>Spinal benefit (one procedure per year) first level / two or more levels **<br>Bare metal cardiac stents max. 3 p.a. (each) **<br>Drug eluting cardiac stents (each) max. 3 p.a. **<br>Pacemaker with Leads R70 700<br>Pacemaker Biventricular R91 100<br>Cardiac valves (each) R47 200<br>Artificial limbs (below knee) R27 800<br>Artificial Limbs (above knee) R50 400<br>Artificial eyes (prosthesis plus apparatus) R25 800<br>All other internal prostheses and devices R22 200 | Subject to pre-authorisation and the hospital risk management programme and the requirements prescribed for PMB's.<br><br>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)<br><br>*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.<br><br>** Negotiated reference price list is applicable.<br><br>*** Hip and Knee Arthroplasty Procedures:<br>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 |



S. Botha

REGISTERED BY ME ON
2021 -02- 12
COUNCIL FOR MEDICAL SCHEMES

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| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| 14. | **External prostheses and appliances**<br>(Including the external components of external prosthesis, incontinence products, etc.)<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | 100% of the Remedi Rate | Subject to Overall Annual Limit with following sub-limits:<br><br>Colostomy equipment: R26 400 per beneficiary per annum<br>Hearing aids: R24 350 per beneficiary per annum<br>Wheelchairs: R15 250 per beneficiary per annum<br>Oxygen appliances (includes oxygen): R1 985 per beneficiary per month<br>All other appliances: * R5 750 per beneficiary per annum | Colostomy equipment can be obtained via Cancer Society.<br><br>Oxygen benefit subject to registration for the use of oxygen on the Chronic Illness Benefit Programme managed by DiscoveryCare.<br><br>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.<br><br>*Sub-limit may be increased, subject to approval of the Scheme's Medical Advisory Committee. |
| 15. | **Paramedical services**<br>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.<br>Pre-authorisation required with Preferred Provider.<br>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**<br>(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. | **Subject to pre-authorisation** and the management of clinical risk by DiscoveryCare 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.<br><br>Benefit may be increased, subject to approval of Remedi's Medical Advisory Committee. |
| 17. | **Organ Transplants**<br>(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.<br>Non-PMB will be subject to the Overall Annual Limit. | **Subject to pre-authorisation** and the management of clinical risk by DiscoveryCare.<br>Provisions of Annexures B and D is applicable. |
| 18. | **Renal Failure & Dialysis**<br>(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 DiscoveryCare.<br>Provisions of Annexures B and D is applicable. |
| 19. | **Other Health Care Services**<br>Chinese medicine & acupuncture, therapeutic aromatherapy, ayurveda, chiropody/podiatry, chiropractics (including x-rays), dietetics, | | Nil Benefit | |

| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| | homeopathy, iridology, naturopathy, orthoptics, osteopathy, therapeutic reflexology, therapeutic massage therapy, phytotherapy and traditional healing | | | |
| | | | | |

**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. |

REGISTERED BY ME ON

2020/11/20

REGISTRAR OF MEDICAL SCHEMES

| | BENEFIT | RATE | LIMITS | COMMENT |
|---|---|---|---|---|
| | homeopathy, iridology, naturopathy, orthoptics, osteopathy, therapeutic reflexology, therapeutic massage therapy, phytotherapy and traditional healing | | | |
| | | | | |

**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 |



REGISTERED BY ME ON
2021 -02- 12
REGISTRAR OF MEDICAL SCHEMES

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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

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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REGISTERED BY ME ON

2020/11/20

REGISTRAR OF MEDICAL SCHEMES

# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

**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.
-



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: 2021

| 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") : –**<br><br>**Out-of-Hospital Consultations** | **Specialists:**<br>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.<br><br>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.<br><br>The co-payment, which the member is liable for is any amount the provider charges above Scheme Rate. |
| REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | **GPs:**<br>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.<br><br>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.<br><br>The co-payment, which the member is liable for is any amount the provider charges above Scheme Rate. |
| **CDL and DTPMB:**<br><br>**Out-of-Hospital Diagnosis** | **Specialists:**<br>Any specialist participating in the KeyCare or Premier Rate Specialist Network.<br><br>**GPs:**<br>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. |



S. Botha

# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

| 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:**<br><br>**Out-of-Hospital Medicine**<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | 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.<br><br>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) 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 Reference Price List (RPL) 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).<br><br>If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to CDA. Where the pharmacy and/or provider charges more than the Scheme Medication Rate or Reference Price List, an additional co-payment may apply. |
| **DTPMB:**<br><br>**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.<br>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) 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 Reference Price List (RPL) for medication obtained voluntarily from a non-DSP, subject to the Scheme's Formulary.<br><br>If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to the maximum of CDA. |

# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

| 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 and DTPMB:**<br><br>**Out-of-Hospital Pathology**<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | 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.<br><br>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.<br><br>The co-payment, which the member is liable for is any amount the provider charges above Scheme Rate. |
| **CDL and DTPMB:**<br><br>**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.<br><br>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.<br><br>The Scheme shall pay 100% of the Costs or the agreed rate for services obtained from a DSP. |
| **DTPMB:**<br><br>**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.<br><br>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: 2021

| 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:**<br><br>**In-Hospital Consultations**<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | **Specialists:**<br>Any specialist participating in the KeyCare or Premier Rate Specialist Network.<br><br>**GPs:**<br>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.<br><br>The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate. |
| **DTPMB:**<br><br>**Mental Illness** | **Drug and Alcohol abuse facilities:**<br>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.<br><br>The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate. |
| | **All other conditions:**<br>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.<br><br>The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate. |

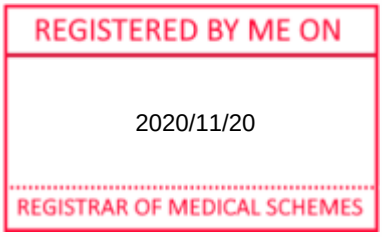
# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

| 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:**<br><br>**Terminal Care facilities**<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | 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.<br><br>The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate. |
| **Oncology/Cancer:**<br><br>**Out-of-Hospital Treatment** | **Specialists:**<br>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:**<br>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. |
| **Oncology/Cancer:**<br><br>**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:**<br><br>**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. |

# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

| 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:**<br><br>**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:**<br><br>**Out-of-Hospital Consultations** | **Specialists:**<br>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. |
| REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | **GPs:**<br><br>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. |
| **HIV:**<br><br>**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:**<br><br>**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 |

# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

| 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:**<br><br>**Medicine**<br><br>  | 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.<br><br>If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to maximum of the chronic drug amount (CDA) 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 for medication obtained voluntarily from a non-DSP, subject to the Scheme's Formulary.<br><br>If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to CDA. |
| **HIV:**<br><br>**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:**<br><br>**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.<br><br>The co-payment, which the member is liable for is any amount the provider charges above Scheme Rate. |

# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

**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. 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.

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

8. 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.

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

REGISTERED BY ME ON

2020/11/20

REGISTRAR OF MEDICAL SCHEMES

# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

**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.
-



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: 2021

| 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") : –**<br><br>**Out-of-Hospital Consultations** | **Specialists:**<br>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.<br><br>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.<br><br>The co-payment, which the member is liable for is any amount the provider charges above Scheme Rate. |
| REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | **GPs:**<br>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.<br><br>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.<br><br>The co-payment, which the member is liable for is any amount the provider charges above Scheme Rate. |
| **CDL and DTPMB:**<br><br>**Out-of-Hospital Diagnosis** | **Specialists:**<br>Any specialist participating in the KeyCare or Premier Rate Specialist Network.<br><br>**GPs:**<br>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. |



S. Botha

# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

| 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:**<br><br>**Out-of-Hospital Medicine**<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | 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.<br><br>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) 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 Reference Price List (RPL) 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).<br><br>If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to CDA. Where the pharmacy and/or provider charges more than the Scheme Medication Rate or Reference Price List, an additional co-payment may apply. |
| **DTPMB:**<br><br>**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.<br>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) 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 Reference Price List (RPL) for medication obtained voluntarily from a non-DSP, subject to the Scheme's Formulary.<br><br>If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to the maximum of CDA. |

# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

| 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 and DTPMB:**<br><br>**Out-of-Hospital Pathology**<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | 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.<br><br>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.<br><br>The co-payment, which the member is liable for is any amount the provider charges above Scheme Rate. |
| **CDL and DTPMB:**<br><br>**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.<br><br>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.<br><br>The Scheme shall pay 100% of the Costs or the agreed rate for services obtained from a DSP. |
| **DTPMB:**<br><br>**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.<br><br>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: 2021

| 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:**<br><br>**In-Hospital Consultations**<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | **Specialists:**<br>Any specialist participating in the KeyCare or Premier Rate Specialist Network.<br><br>**GPs:**<br>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.<br><br>The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate. |
| **DTPMB:**<br><br>**Mental Illness** | **Drug and Alcohol abuse facilities:**<br>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.<br><br>The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate. |
| | **All other conditions:**<br>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.<br><br>The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate. |

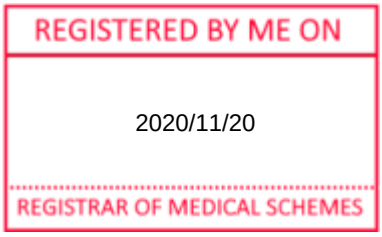
# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

| 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:**<br><br>**Terminal Care facilities**<br><br>REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | 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.<br><br>The co-payment, which the member is liable for is equal to any amount the provider charges above the Scheme Rate. |
| **Oncology/Cancer:**<br><br>**Out-of-Hospital Treatment** | **Specialists:**<br>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:**<br>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. |
| **Oncology/Cancer:**<br><br>**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:**<br><br>**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. |

# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

| 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:**<br><br>**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:**<br><br>**Out-of-Hospital Consultations** | **Specialists:**<br>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. |
| REGISTERED BY ME ON<br>2020/11/20<br>REGISTRAR OF MEDICAL SCHEMES | **GPs:**<br><br>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. |
| **HIV:**<br><br>**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:**<br><br>**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 |

# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

| 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:**<br><br>**Medicine**<br><br>  | 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.<br><br>If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to maximum of the chronic drug amount (CDA) 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 for medication obtained voluntarily from a non-DSP, subject to the Scheme's Formulary.<br><br>If the medication is not listed on the Scheme's Formulary, the Scheme will pay up to CDA. |
| **HIV:**<br><br>**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:**<br><br>**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.<br><br>The co-payment, which the member is liable for is any amount the provider charges above Scheme Rate. |

# Annexure D
# Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2021

**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. 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.

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

8. 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.

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

REGISTERED BY ME ON

2020/11/20

REGISTRAR OF MEDICAL SCHEMES