Remedi 2023 Approved Main Rules

REMEDI MEDICAL AID SCHEME

RULE **TABLE OF CONTENTS** **PAGE**

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REGISTRAR OF MEDICAL SCHEMES

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.

4.16 **“Creditable coverage”**, means any period in which a Late Joiner was –

4.16.1 A Member or a Dependant of a medical scheme;

4.16.2 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;

4.16.3 A uniformed Employee of the South African National Defence Force;

4.16.4 Or a Dependant of such Employee, who received medical benefits from the South African National Defence force;

4.16.5 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;

4.17 **"Dependant"**,

4.17.1 A Member’s spouse or partner who is not a Member or a registered Dependant of a Member of a medical scheme;

4.17.2 A Member’s Dependent Child.

4.17.3 The immediate family of a Member in respect of whom the Member is liable for family care and support.

4.17.4 Any person who is recognised by the Board as a Dependant for purposes of these Rules.

4.18 **"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 student at a recognized tertiary institution, who is Dependent upon the Member.

4.19 **"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.

4.20 **"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.

4.21 **"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.

4.22 **"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.

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

4.24 **"Employer"**, Remgro Limited and any of its associated or subsidiary companies nominated by it and any former associated or subsidiary companies, permitted by Remgro Limited to belong to the Scheme.

4.25 **"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.

4.26 **"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 Rat**e.**

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

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

4.28.1 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;

4.28.2 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;

4.28.3 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;

4.29 **"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.

4.30 **"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.

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

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

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

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

4.35 **"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.

4.36 **"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.

4.37 **"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;

4.38 **"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.

4.39 **"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.

4.40 **“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.

4.41 **“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.

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

4.43 **“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.

4.44 “**Remgro Limited**”, refers to an incorporated business organisation registered under the present or the previous Companies Act, 2013 with registration number 1968/006415/06 or its predecessor or successor in title.

4.45 “**Retiree**”, a Member who retires as an Employee (in terms of the rules of the applicable pension or provident fund, or, if the employee is not a member of a pension or provident fund, in terms of any written contract of service with the Employer) or withdraws, as the case may be, from the service of the Employer on or after normal retirement date, or on such earlier date prior to the Member’s normal retirement date, as may be agreed between the Employer and the Employee.

4.46 **“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.

4.47 **"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

(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**

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

6.1.1.1 Employees or former employees of an Employer, irrespective of whether membership to the Scheme is voluntary or compulsory, depending on the Employee's conditions of employment provided that his/her Employer has contracted with the Scheme which contract shall regulate the terms of admission of its employees as Members of the Scheme including but not limited to the condition that all employees (present and prospective) and continuation Members or Retirees of the Employer may not belong to any other Scheme unless the Scheme in writing consents otherwise.

6.1.2 Loss of Eligibility

6.1.2.1 Subject to 6.1.2.2, the eligibility of a person (employee / retiree) to join or continue to belong to the Scheme shall be deemed to have been lost if –

6.1.2.1.1 his/her Employer has terminated its contract as contemplated in Rule 6.1.1.1 with the Scheme provided that such termination shall only take effect if no less than 3 months written notice of such termination is given to the Scheme; or

6.1.2.1.2 Remgro Limited has in writing notified the Employer and the Scheme that it no longer permits the Employer to belong to the Scheme solely by virtue of the Employer no longer being part of Remgro Limited provided that the consequential termination of the contract as contemplated in Rule 6.1.1.1 shall only take effect if no less than 3 months written notice of such termination is given to the Scheme.

6.1.2.2 In the event that the notice as contemplated in Rule 6.1.2.1 has been provided, all existing Members who have lost eligibility, shall be required to terminate their membership to the Scheme before the commencement of the next calendar year or expiry of a 3 months' period after the cancellation of the contract coming into effect whichever is the later, failing which their membership shall be deemed to have lapsed on such date.

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6.1.3 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.

6.1.4 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.

6.1.5 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.

6.1.6 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;

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.

12.3 **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.

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 pay.

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 recommended determined by the medical advisor, and approved by the Board.

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

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:

18.2.6.	Mediclinic Corporation Limited	Two Members
18.2.7.	British American Tobacco SA (Pty)Ltd.	One Member
18.2.8.	Distell Limited	One Member
18.2.9.	Remgro Limited, and the remaining Employer Group Companies	One Member
18.2.10	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;

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;

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

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

26.1.1 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.

26.1.2 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 the 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.

26.1.3 At least 30 Members of the Scheme present in person or virtually (subject to the Scheme's operational requirements on virtual participation in the given year) 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.

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

26.1.5 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 or virtually (subject to the Scheme's operational requirements on virtual participation in the given year) 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

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.

32.4 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.

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

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REMEDI

Administered by Discovery Health

Resolution 1 of 2023

Certified as having been adopted in terms of the Rules**,** at a meeting of the **Board of Trustees held on 21 September 2022** that the following changes to the Annexures of the Remedi Medical Aid Scheme ("the Scheme") **will take effect 1 January 2023 or as specified in this Resolution**:

1. Contribution amounts to increase with effect from 1 April 2023 as follows:

   Increase of 6.9% on all Options.

   The amended contribution table amounts are included with this Certificate for registration by the Council for Medical Schemes ("CMS") with effect from 1 April 2023.

2. Amendments to the Benefit Annexures of the Rules and benefit limits for 2023 are set out below and will take effect 1 January 2023:

2.1 Inflationary increase assumption of 7.0% on average in respect of benefit limits, as well as medicine increases was approved, except where agreed not to be increased, such as the specialised medicine and Classic Option oncology benefit limits;

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

2.3 Amendments to Annexure B to be read in conjunction with existing Annexure D that sets out the funding guidelines for Prescribed Minimum Benefits. Annexure B are enclosed in tracked changes to identify the benefit and managed healthcare initiative changes as approved by the Board of Trustees. These changes are also reflected in Annexures B1,

REGISTERED BY ME ON

Mfana Maswanganyi
2023/01/31
31/01/2023 16:07:29 (UTC+02:00)
Signed by Mfana Maswanganyi,
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REGISTRAR OF MEDICAL SCHEMES

B2 and B3 with tracked changes as part of the submission and includes the following benefit and managed healthcare initiative changes, where "x" indicates that the change is applicable, as approved by the Board of Trustees:

Description of change	Standard	Classic	Comprehensive	Summary of decisions taken, Rules impacted and Reasons if no Rule amendments incorporated
CAD Care for Standard Option members	x			The Board of Trustees **AGREED** to extend the program to members registered on the Standard Option with effect from 1 January 2023. An additional benefit rule 11.1.1 was introduced in Annexure B under the "Patient Management Programmes" to clarify the funding of CTCA prior to an invasive angiogram.
Surgical and Consumables DSP: Funding of Insulin pumps and consumables			x	From 2023 the Board **AGREED** that insulin pumps will be funded for members on the Comprehensive Option from risk, whilst the reservoir and infusions set are to continue to be paid from the member's available Chronic Illness Benefit ("CIB"), to a maximum of 10 of each per month. The "All other appliances" benefit on the Comprehensive Option, Annexure B2, is expanded to make provision for funding for the pumps and consumables as approved by the trustees.
Procedures in rooms	x	x	x	The initiative was approved for adoption on all three benefit options with effect from 1 January 2023. The introduction of a reference to "procedures in rooms" under the "In-hospital visits: General

				practitioners and specialists" benefits in Annexures B1, B2 and B3 to make provision for these procedural codes to fund from the "in hospital" benefit, while these procedures that can be done out of hospital, if approved, will fund from the "in hospital" benefit.
Advanced Illness Benefit ("AIB") enhancements for 2023	x	x	x	Approved to expand the current AIB to members with other life limiting conditions as well, besides the current support already provided to members who was diagnosed with cancer. All members that required access to comprehensive out-of-hospital palliative care to receive care as clinically deemed appropriate from 1 January 2023 and for this benefit to be managed by Discovery Health ("DH") on behalf of the Scheme and funded from the members' available hospital benefit ("Risk"). "End-of-life care" as currently referenced in Annexure B to the Main Rule are expanded and clarified to give effect to the trustees approval of end-of-life care to be expanded to include care for patients with other life limiting conditions as well.
Oncology Pharmacy Designated Service Provider ("DSP") introduction and Oncology limit changes	x	x	x	Approved that only the benefit limits of the Comprehensive Option be increased with inflationary limits for 2023 and that the Classic benefit option limits remain as is. The Standard Option benefit limit for oncology was reviewed and it was agreed to remove the limit, whilst the Standard Option oncology benefit covers

				members for Prescribed Minimum Benefits ("PMB") only and the limit in such instances would not be applicable as funding would continue through benefit limits for PMB level of care. Furthermore, it was **AGREED** to adopt the proposed oncology pharmacy DSP on all benefit options from 1 January 2023 and to align with the recommended preferred pharmacy networks. Oncology benefits referenced in Annexures B1, B2 and B3 has reference per the enclosed tracked change documents. To effect the introduction of an oncology medicine pharmacy network for the Scheme, references in the Rate columns of these benefit rules were updated and the DSP was added to the "Glossary" of these benefit rules.
Bariatric surgery benefit introduction for 2023			x	Approved to be made available to members registered on the Comprehensive Option only, and for the procedure to be funded from the current Specialised Medicine Benefit ("SMB") limit of R210 000.00 per person per year with a 20% copayment for Bariatric surgery. New benefit rule 25.1 was introduced in Annexure B of the Comprehensive Option with funding clarified at 80% of the Remedi Rate in the Rate columns.

Cochlear funding benefit introduction for 2023			x	**AGREED** to introduce the benefit on the Remedi Comprehensive Option only with effect from 1 January 2023 and only to be funded up to agreed and preferred supplier rates, which could result in no co-payments to be experienced by the members. Funding will be limited to the preferred and contracted provider rates for unilateral and bilateral implants as set per person per year and if obtained from the preferred and contracted providers members will experience no co-payments. The "internal prostheses and devices" benefit limits are enhanced to include funding of cochlear implants in Annexure B2, whilst the funding of the repairs and batteries are clarified in the "Comments" column of this benefit rule to allow for funding from the Insured Out-of-Hospital ("IOH") and/or Personal Medical Savings Accounts ("PMSA").
TAVI procedures benefit introduction for 2023	x	x	x	Approved that the procedure be funded for all members in line with industry and international adopted clinical protocols and guidelines. The procedures to be paid from the hospital benefit and to be paid in line with the global fees negotiated. The addition of the funding codes to the hospital benefit does not require a benefit rule change.

Continuous Glucose Monitoring ("CGM") benefit alignment with DH		x	x	Approved to align funding of CGM for 2023 in alignment with the Discovery Health funding recommendations through the removal of the age limitations and to continue to fund the sensors from "Risk" up to a "monthly limit". For members who live with type 1 diabetes mellitus and who is registered on the Scheme's Chronic Illness Benefit ("CIB") or diabetes programme funding was approved up to 100% of the set monthly limits if registered on the Comprehensive Option and up to 75% of the set monthly limits if registered on the Classic Option. No funding for members registered on the Standard Option. The benefit rules required revision to correctly reflect funding for CGM and Annexure B2 and B3 is amended in the "Comments" columns of the "external prostheses and appliances" benefits as set out in the enclosed documents submitted with the Resolution.
Co-payments of Da Vinci Robotic Assisted Prostatectomy	x	x	x	Approved to continue funding for the procedure from the hospital benefit at the Scheme negotiated rates and that the reference to the current limits in the benefit rules be removed. Annexures B1, B2 and B3 was amended by removing the reference to the co-payments and limits in the benefit rules.

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

Annexure B

Paragraph number	Change	Reason for change
New Paragraph 11.1.1 with header "CAD Care"	The insertion of the following paragraph to read: "Where clinically deemed appropriate members has access to the Scheme's CAD Care programme, which gives members access to funding of Computed Tomography Coronary Angiography ("CTCA"), prior to an invasive angiogram. Once authorized, all professional costs, which includes registered treating cardiologist, namely the consultation, electrocardiogram ("ECG"), echocardiogram ("ECHO") and where clinically appropriate, the review of computerized tomography ("CT") angiogram, performing of the angiogram, as well as angioplasty or stenting, are covered."	To clarify the funding of CTCA prior to an invasive angiogram on all benefit options and to make provision for the introduction of this programme approved on the Standard Option with effect from 1 January 2023.
11.2.1: End-of-life care	Deletion of the words: "in partnership with the Hospice Palliative Care Association of South Africa" following the words:	To give effect to the trustees approval of end-of-life care to be expanded to include care for patients with other life limiting conditions as well.

	"End-of-life care is provided by nurses or care workers.." in the first sentence of this paragraph, as well as the insertion of the words "In addition, end-of-life.." at the beginning of the second sentence in this paragraph. The word "Oncology" is deleted at the beginning of this second sentence in this paragraph and the words: ", where deemed clinically appropriate.." is inserted directly after the words "Advanced Illness Benefit ("AIB").." in this sentence. The words "..and members registered on the Oncology Management Programme have access to this comprehensive palliative care programme.." is deleted after the words "Advanced Illness Benefit ("AIB").." in this sentence. The words "This programme.." is deleted in the third sentence and replaced with the acronym "AIB.." to precede the words "offers unlimited cover for approved care at home."	

Annexure B1

Rule number	Change	Reason for change
1 - 21	Amendment of Rules to reflect the revised benefit limit amounts for 2023.	Increases as approved by the Board and set out in the enclosed limit sheet in Excel format
1. "Hospitalisation in private hospitals as well as surgery and medical procedures performed by private practitioners" benefit	In the "Comment" column, the deletion of the following paragraph: "Da Vinci Robotic Assisted Prostatectomy is funded up to a maximum of the cost of a standard Prostatectomy where prostate cancer confirmed by means of a histology report, regardless whether the member is registered on the Oncology Management Programme. Limited to R113 000.00 up to one procedure per beneficiary and must be pre-authorised" and the replacement of this paragraph with the following: "Da Vinci Robotic Assisted Prostatectomy is funded at 100% of the Remedi Rate or negotiated hospital rates where prostate cancer confirmed by means of a histology report, regardless whether the member is registered on the Oncology Management Programme. Limited to one procedure per beneficiary and must be pre-authorised."	To give effect to the Board's decision to continue funding for the Da Vinci procedure from the hospital benefit at the Scheme negotiated rates by removing the reference to the current limits in the benefit rules, as well as any references to percentages of co-payments to be applied.

1. "In-hospital visits" benefit	Insertion of the words "•In-room procedures limited to a defined list of procedures as determined by the Scheme."	To make provision for these procedural codes to fund from the "in hospital" benefit, while these procedures that can be done out of hospital, if approved, will fund from the "in hospital" benefit.
6. Insured Out-of-hospital benefit… "World Health Organisation (WHO).."	The insertion of the word "specific" before the words "global World Health Organisation", deleting the acronym "WHO" reflected twice in this sentence in the Benefit column. And the deletion of the following points in the Benefit column: "•Out-of-hospital healthcare services related to COVID-19 includes: - Screening consultation with a nurse or a GP; - Defined basket of pathology; - Defined basket of x-rays and scans; - Consultations with a nurse or GP; - Supportive treatment; - Vaccines and the administration of the vaccines; - Home-based care in lieu of hospitalisation - Treatment of complications and rehabilitation for Long Covid" Which is replaced with the insertion of the following points in the Benefit column:	As approved by the Board of Trustees, to update the funding of the WHO benefit in line with the latest requirements of Prescribed Minimum Benefits ("PMB"), as and when necessary.

	"-COVID-19 - Monkey pox" In the "Rate" column the deletion of the words: "Save for Prescribed Minimum Benefits (PMB) up to a maximum of 100% of the Remedi Rate" and the insertion of the following sentence instead: "In addition to cover contained in Annexure D, up to a maximum of 100% of the Remedi Rate." In the Limits column the deletion of the following sentences and points that read: "Funded out of a dedicated basket of care as set by the Scheme related to COVID-19 and limited to: -Unlimited screening consultations with a nurse or GP; -Defined basket of pathology up to 3 tests per person per year, except where cover is PMB; -Unlimited home-based care in lieu of hospitalisation" and the insertion of the following sentences instead: "Subject to the Scheme's preferred provider (where applicable), protocols and	

	the condition and treatment meeting the Scheme's entry criteria and guidelines. Basket of care as set by the Scheme per condition." In the Comments column the deletion of the following sentences that reads: "Subject to the Scheme's preferred provider, protocols and the condition and treatment meeting the Scheme's clinical entry criteria and guidelines. Cover for testing is subject to referral. Long Covid activation of the benefit and basket of care provided by the Scheme for a period of 6 months from the date of diagnosis by the treating healthcare provider." and the insertion of the following sentence instead that reads: "PMB requirements and Council for Medical Schemes ("CMS") guidelines prevail."	
10. Oncology	In the "Rate" column the insertion of a sentence to read:	To give effect to the adoption of the proposed oncology pharmacy DSP on all benefit options from 1 January 2023

	"If medicine is received at a Designated Service Provider ("DSP") Network pharmacy or outside of the Remedi DSP oncology pharmacy networks, the medication is funded at 100% of Medicine Rate" and the insertion of the following sentence in the "Comment" column to read: "The provisions in terms of obtaining medicines through the Remedi DSP oncology pharmacy network prevails." In the "Rate" column the deletion of the words: "..of the Remedi Rate up to R235 000 per beneficiary and thereafter funded at 80% of Remedi Rate. PMB treatment is funded at 100%.." following the word "100%.." and the insertion of the words: "..Rate. Provisions of PMB as set out in Annexure D is applicable." In the "Limits" column, the deletion of the words: "..and an Overall Oncology annual limit of R250 000 per beneficiary and family limit per annum.." following the words: "Subject to overall annual limit.." and the insertion of the words:	and to align with the recommended preferred pharmacy networks, as approved. To furthermore give effect to the Board's decision to remove the limits reflected in the Standard Option oncology benefit rules as cover on this benefit option is limited to Prescribed Minimum Benefits ("PMB") level of care only and the limit in such instances would not be applicable as funding would continue through benefit limits for PMB level of care.

	"PMB level of care only and.." before the word "benefit" in the second sentence in the "Limits" column with the insertion of the word "is" after the word "benefit" for the sentence to read: "PMB level of care only and benefit is subject to the prescribed requirements for PMB`s." In the "Comments" column the deletion of the words: "Sub-limit may be increased, subject.." in the beginning of the third sentence, with the deletion of the word "where" following the word "Committee", as well as the addition of the words "may be approved" replacing the words "and will be increased automatically where PMB level of care and clinically appropriate." at the end of the same sentence.	
13. "Preventative and Screening Benefit"	In the "Benefit" column, the deletion of the words: "for identified high risk members" and the insertion of the following words: "in line with latest clinical guidelines."	To update the reference in the benefit rules for the funding of pneumococcal vaccines in line with the latest clinical guidelines and protocols per the in-principle decision taken by the Board of Trustees to align with clinical guidelines and protocols as may be necessary.

14. Internal Prostheses and Devices	In the "Limits" column, the insertion of the words, "excluding cochlear implants" following the words: "All other internal prostheses and devices.."	To clarify that cochlear implants are not funded for members registered on the Standard benefit option.
15. External Prostheses and Appliances…	The insertion of the words: "excluding Insulin Pumps and Continuous Glucose Monitors ("CGM") in the appliance sub-limit that reads: "All other appliances"	To clarify that CGM devices and Insulin Pumps are not funded from the "all other appliances" benefit limit and that members registered on the Standard Option are not covered for these appliances.
Glossary table	The insertion of the following sentences: Oncology Pharmacy Designated Service Provider: 1. Medicine administered in-rooms, such as injectable and infusional chemotherapy, should be obtained from a contracted courier DSP Pharmacy (Dis-Chem's Oncology Courier Pharmacy, Qestmed, Olsens Pharmacy, Medipost Pharmacy or Southern Rx). 2.Medicine scripted and dispensed at a retail pharmacy (Oncology and oncology-related medicine such as supportive medicine, oral chemotherapy and hormonal therapy) will be covered	To list the oncology pharmacy DSP as referenced in the benefit rules of the Scheme.

	in full at MedXpress or any MedXpress Network Pharmacy, Medipost Pharmacy, Qestmed or Dis-Chem's Oncology Courier Pharmacy or Southern Rx	

Annexure B2

Rule number	Change	Reason for change
1 – 25.1	Amendment of Rules to reflect the revised benefit limit amounts for 2023.	Increases as approved by the Board and set out in the enclosed limit sheet in Excel format
1. "In-hospital visits" benefit	Insertion of the words "•In-room procedures limited to a defined list of procedures as determined by the Scheme." In the Comment column.	To make provision for these procedural codes to fund from the "in hospital" benefit, while these procedures that can be done out of hospital, if approved, will fund from the "in hospital" benefit.
6. Insured Out-of-hospital benefit… "World Health Organisation (WHO).."	The insertion of the word "specific" before the words "global World Health Organisation", deleting the acronym "WHO" reflected twice in this sentence in the Benefit column. And the deletion of the following points in the Benefit column: "•Out-of-hospital healthcare services related to COVID-19 includes: - Screening consultation with a nurse or a GP;	As approved by the Board of Trustees, to update the funding of the WHO benefit in line with the latest requirements of Prescribed Minimum Benefits ("PMB"), as and when necessary.

	- Defined basket of pathology; - Defined basket of x-rays and scans; - Consultations with a nurse or GP; - Supportive treatment; - Vaccines and the administration of the vaccines; - Home-based care in lieu of hospitalisation - Treatment of complications and rehabilitation for Long Covid" Which is replaced with the insertion of the following points in the Benefit column: "-COVID-19 - Monkey pox" In the "Rate" column the deletion of the words: "Save for Prescribed Minimum Benefits (PMB) up to a maximum of 100% of the Remedi Rate" and the insertion of the following sentence instead: "In addition to cover contained in Annexure D, up to a maximum of 100% of the Remedi Rate." In the Limits column the deletion of the following sentences and points that read:	

	"Funded out of a dedicated basket of care as set by the Scheme related to COVID-19 and limited to: -Unlimited screening consultations with a nurse or GP; -Defined basket of pathology up to 3 tests per person per year, except where cover is PMB; -Unlimited home-based care in lieu of hospitalisation" and the insertion of the following sentences instead: "Subject to the Scheme's preferred provider (where applicable), protocols and the condition and treatment meeting the Scheme's entry criteria and guidelines. Basket of care as set by the Scheme per condition." In the Comments column the deletion of the following sentences that reads: "Subject to the Scheme's preferred provider, protocols and the condition and treatment meeting the Scheme's clinical entry criteria and guidelines. Cover for testing is subject to referral.	

	Long Covid activation of the benefit and basket of care provided by the Scheme for a period of 6 months from the date of diagnosis by the treating healthcare provider." and the insertion of the following sentence instead that reads: "PMB requirements and Council for Medical Schemes ("CMS") guidelines prevail."	
10. Optical	The insertion of the following words before the header "Or Contact lenses" in respect of the "Preferred Provider Optometrist" and "Non-Preferred Provider Optometrist" optical benefit: "•An additional R50 per lens for Branded Multifocal lenses in addition to the R810 per lens limit"	Alignment of the benefit offering with the agreed benefits of the preferred provider.
11. Oncology	In the "Rate" column the insertion of a sentence to read: "If medicine is received at a Designated Service Provider ("DSP") Network pharmacy or outside of the Remedi DSP oncology pharmacy networks, the medication is funded at 100% of Medicine Rate" and the insertion of the following	To give effect to the adoption the proposed oncology pharmacy DSP on all benefit options from 1 January 2023 and to align with the recommended preferred pharmacy networks, as approved.

	sentence in the "Comment" column to read: "The provisions in terms of obtaining medicines through the Remedi DSP oncology pharmacy network prevails."	
15. "Preventative and Screening Benefit"	In the "Benefit" column, the deletion of the words: "for identified high risk members" and the insertion of the following words: "in line with latest clinical guidelines."	To update the reference in the benefit rules for the funding of pneumococcal vaccines in line with the latest clinical guidelines and protocols per the in-principle decision taken by the Board of Trustees to align with clinical guidelines and protocols as may be necessary.
16. Internal Prostheses and Devices	In the "Rate" column, the insertion of the words: "..or at Cost as indicated" following the words "100% of the Remedi Rate.." In the "Limits" column, the insertion of the words: Cochlear implants - Bilateral implants - Unilateral implants Up to negotiated rates at cost In the "Comments" column, the insertion of the following paragraph: "Cochlear implant is funded at cost at a DSP with no co-payment and subject to the hospital benefit, if obtained from the preferred suppliers at negotiated rates.	To make provision for funding of cochlear implants as approved by the Board of Trustees and to clarify the funding of the repairs and batteries to allow for funding from the Insured Out-of-Hospital ("IOH") and/or Personal Medical Savings Accounts ("PMSA"), as may be necessary.

	Diagnostic work-up for cochlear implants, repairs due to breakage, loss of device, or failure of the device, as well as cochlear implant batteries to fund from the available Insured Out-of-Hospital ("IOH") benefit, available Personal Medical Savings Account ("PMSA") or the member's own pocket, as may be applicable."	
17. External Prostheses and Appliances…	The insertion of the following appliances in the "Limits column": CGM Sensors — Up to monthly agreed and set rates at preferred providers Insulin Pumps — Up to the OAL and provisions as set out in the "Comment" column prevails And the insertion of the words: "excluding Insulin Pumps" in the appliance sub-limit that reads: "All other appliances" As well as the insertion of the following paragraph in the "Comments" column: "Insulin Pumps, if approved are funded from the Overall Annual Limit ("OAL"), while costs related to the reservoir and infusions set are covered from the available Chronic Illness Benefit ("CIB") up	To give effect to the Board's decision to allow for funding of Insulin Pumps and consumables for members registered on the Comprehensive Option, where deemed clinically appropriate and approved.

	to a maximum of 10 of each per month, provided the member is registered on the diabetes management programme."	
16. "External prostheses and appliances (continued)" benefit line	In the "Comments" column the insertion of the words "..Sensors which is part of the Scheme's Continuous Glucose Monitors ("CGM") benefit.." following the words: "With effect from 1 May 2021, Continuous Glucose.." and the deletion of the words: "Monitors ("CGM").." and the insertion of the words: "..and approved are subject to the Overall Annual Limit ("OAL") and paid up to the monthly agreed and set rate at preferred providers, provided members are registered on the Scheme's diabetes management programme. Transmitters and readers.." before the words "..are funded from the "all other appliances".." with the addition of the word "benefit" prior to the word "limit" that follows and the insertion of the words: "and thereafter from the available PMSA," to replace the words "up to the	The benefit rules required revision to correctly reflect the funding split for the sensors and the transmitters/readers of the CGM devices as approved by the trustees in 2021 and the wording in the "Comments" column of the "external prostheses and appliances" benefits were updated to read: "With effect from 1 May 2021, Continuous Glucose Sensors which is part of the Scheme's Continuous Glucose Monitors ("CGM") benefit, where deemed clinically appropriate and approved are subject to the Overall Annual Limit ("OAL") and paid up to the monthly agreed and set rate at preferred providers, provided members are registered on the Scheme's diabetes management programme. Transmitters and readers are funded from the "all other appliances" benefit limit and thereafter from the available PMSA." Instead of stating: With effect from 1 May 2021, Continuous Glucose Monitors ("CGM"), where deemed clinically appropriate are funded from the "all appliances" limit.

	agreed/negotiated rates with preferred providers." that is being deleted.	
25. Specialised Medicine Benefit ("SMB")	In the Limits column, the deletion of the words: "..for a defined list of the latest and most advanced clinically approved Specialised Medicine" following the words "Cover up to R210 000 per beneficiary per annum.." And in the "Comments" column, the insertion of the words: "Specialised Medicine are funded per a defined list of the latest and most advanced clinically approved Specialised Medicine"	To clarify the funding of SMB due to the introduction of the funding of bariatric surgery from the same benefit limit with effect from 1 January 2023.
25. New sub-rule 25.1 to read: "Bariatric Surgery Benefit"	In the "Rate" column the insertion of the words: "80% of Remedi Rate" In the "Limits" column the insertion of the words: "Funded from the SMB benefit limit as set out in benefit rule 25" In the "Comments" column, the insertion of the following sentences:	As approved by the Board of Trustees, an additional benefit rule was introduced to allow for the funding of bariatric surgery for members registered on the Comprehensive Option from the current Specialised Medicine Benefit ("SMB") limit of R210 000.00 per person per year with a 20% co-payment for bariatric surgery to be applied.

<table>
<tr><td></td><td>“Subject to pre-authorisation and pre-approval by the Scheme’s contracted managed healthcare organisation. A co-payment of R3 000 for failing to pre-authorise will apply.”</td><td></td></tr>
<tr><td>Glossary table</td><td>The insertion of the following sentences:

<table><tr><td>Oncology Pharmacy Designated Service Provider</td><td>1. Medicine administered in-rooms, such as injectable and infusional chemotherapy, should be obtained from a contracted courier DSP Pharmacy (Dis-Chem's Oncology Courier Pharmacy, Qestmed, Olsens Pharmacy, Medipost Pharmacy or Southern Rx).
2.Medicine scripted and dispensed at a retail pharmacy (Oncology and oncology-related medicine such as supportive medicine, oral chemotherapy and hormonal therapy) will be covered in full at MedXpress or any MedXpress Network Pharmacy, Medipost Pharmacy, Qestmed or Dis-Chem's Oncology Courier Pharmacy or Southern Rx</td></tr></table></td><td>To list the oncology pharmacy DSP as referenced in the benefit rules of the Scheme.</td></tr>
</table>

Annexure B3

Rule number	Change	Reason for change
1 - 19	Amendment of Rules to reflect the revised benefit limit amounts for 2023.	Increases as approved by the Board and set out in the enclosed limit sheet in Excel format
2. "Hospitalisation in private hospitals as well as surgery and medical procedures performed by private practitioners" benefit	In the "Comment" column, the deletion of the following paragraph: "Da Vinci Robotic Assisted Prostatectomy is funded up to a maximum of the cost of a standard Prostatectomy where prostate cancer confirmed by means of a histology report, regardless whether the member is registered on the Oncology Management Programme. Limited to R113 000.00 up to one procedure per beneficiary and must be pre-authorised" and the replacement of this paragraph with the following: "Da Vinci Robotic Assisted Prostatectomy is funded at 100% of the Remedi Rate or negotiated hospital rates where prostate cancer confirmed by means of a histology report, regardless whether the member is registered on the Oncology Management Programme. Limited to one procedure per beneficiary and must be pre-authorised."	To give effect to the Board's decision to continue funding for the Da Vinci procedure from the hospital benefit at the Scheme negotiated rates by removing the reference to the current limits in the benefit rules, as well as any references to percentages of co-payments to be applied.

1. "In-hospital visits" benefit	Insertion of the words "•In-room procedures limited to a defined list of procedures as determined by the Scheme." In the "Comments" column.	To make provision for these procedural codes to fund from the "in hospital" benefit, while these procedures that can be done out of hospital, if approved, will fund from the "in hospital" benefit. Cross references to Annexures were updated.
6. Insured Out-of-hospital benefit… "World Health Organisation (WHO).."	The insertion of the word "specific" before the words "global World Health Organisation", deleting the acronym "WHO" reflected twice in this sentence in the Benefit column. And the deletion of the following points in the Benefit column: "•Out-of-hospital healthcare services related to COVID-19 includes: - Screening consultation with a nurse or a GP; - Defined basket of pathology; - Defined basket of x-rays and scans; - Consultations with a nurse or GP; - Supportive treatment; - Vaccines and the administration of the vaccines; - Home-based care in lieu of hospitalisation - Treatment of complications and rehabilitation for Long Covid"	As approved by the Board of Trustees, to update the funding of the WHO benefit in line with the latest requirements of Prescribed Minimum Benefits ("PMB"), as and when necessary.

	Which is replaced with the insertion of the following points in the Benefit column: "-COVID-19 - Monkey pox" In the "Rate" column the deletion of the words: "Save for Prescribed Minimum Benefits (PMB) up to a maximum of 100% of the Remedi Rate" and the insertion of the following sentence instead: "In addition to cover contained in Annexure D, up to a maximum of 100% of the Remedi Rate." In the Limits column the deletion of the following sentences and points that read: "Funded out of a dedicated basket of care as set by the Scheme related to COVID-19 and limited to: -Unlimited screening consultations with a nurse or GP; -Defined basket of pathology up to 3 tests per person per year, except where cover is PMB; -Unlimited home-based care in lieu of hospitalisation" and the insertion of the following sentences instead:	

	"Subject to the Scheme's preferred provider (where applicable), protocols and the condition and treatment meeting the Scheme's entry criteria and guidelines. Basket of care as set by the Scheme per condition." In the Comments column the deletion of the following sentences that reads: "Subject to the Scheme's preferred provider, protocols and the condition and treatment meeting the Scheme's clinical entry criteria and guidelines. Cover for testing is subject to referral. Long Covid activation of the benefit and basket of care provided by the Scheme for a period of 6 months from the date of diagnosis by the treating healthcare provider." and the insertion of the following sentence instead that reads: "PMB requirements and Council for Medical Schemes ("CMS") guidelines prevail."	

7. Optical	The insertion of the following words before the header "Or Contact lenses: "•An additional R50 per lens for Branded Multifocal lenses in addition to the R810 per lens limit"	Alignment of the benefit offering with the agreed benefits of the preferred provider.
9. Oncology	In the "Rate" column the insertion of a sentence to read: "If medicine is received at a Designated Service Provider ("DSP") Network pharmacy or outside of the Remedi DSP oncology pharmacy networks, the medication is funded at 100% of Medicine Rate" and the insertion of the following sentence in the "Comment" column to read: "The provisions in terms of obtaining medicines through the Remedi DSP oncology pharmacy network prevails."	To give effect to the adoption the proposed oncology pharmacy DSP on all benefit options from 1 January 2023 and to align with the recommended preferred pharmacy networks, as approved.
12. "Preventative and Screening Benefit"	In the "Benefit" column, the deletion of the words: "vaccine for identified high risk members" and the insertion of the following words: "in line with latest clinical guidelines."	To update the reference in the benefit rules for the funding of pneumococcal vaccines in line with the latest clinical guidelines and protocols per the in-principle decision taken by the Board of Trustees to align with clinical guidelines and protocols as may be necessary.

13. Internal Prostheses and Devices	In the "Limits" column, the insertion of the words, "excluding cochlear implants" following the words: "All other internal prostheses and devices.."	To clarify that cochlear implants are not funded for members registered on the Classic benefit option.
14. External Prostheses and Appliances…	The insertion of the following appliances in the "Limits column": CGM Sensors | Up to monthly agreed and set rates at preferred providers And the insertion of the words: "excluding Insulin Pumps" in the appliance sub-limit that reads: "All other appliances"	To clarify that CGM Sensors are not funded from the "all other appliances" benefit limit and that members registered on the Classic Option are not covered for "Insulin Pumps". See also "external prostheses and appliances (continued) line item.
14. "External prostheses and appliances (continued)" benefit line	In the "Comments" column the deletion of the following paragraph: "With effect from 1 May 2021, Continuous Glucose Monitors ("CGM"), where deemed clinically appropriate are funded from the "all appliances" limit up to the agreed/negotiated rates with preferred providers."	The benefit rules required revision to correctly reflect the funding split for the sensors and the transmitters/readers of the CGM devices as approved by the trustees in 2021 and the wording in the "Comments" column of the "external prostheses and appliances" benefits were updated to read: "With effect from 1 May 2021, Continuous Glucose Sensors which is part of the Scheme's Continuous Glucose Monitors ("CGM") benefit, where deemed clinically appropriate and

	And the insertion of the following paragraph: "With effect from 1 May 2021, Continuous Glucose Sensors which is part of the Scheme's Continuous Glucose Monitors ("CGM") benefit, where deemed clinically appropriate and approved are subject to the Overall Annual Limit ("OAL") and paid up to the monthly agreed and set rate at preferred providers, provided members are registered on the Scheme's diabetes management programme. Transmitters and readers are funded from the "all other appliances" benefit limit and thereafter from the members own pocket." In the "Rate" column the insertion of the following sentence: "75% of the Remedi Rate for funding of CGM Sensor and 100% of the Remedi Rate for funding of the transmitters and readers"	approved are subject to the Overall Annual Limit ("OAL") and paid up to the monthly agreed and set rate at preferred providers, provided members are registered on the Scheme's diabetes management programme. Transmitters and readers are funded from the "all other appliances" benefit limit and thereafter from the available PMSA." Instead of stating: With effect from 1 May 2021, Continuous Glucose Monitors ("CGM"), where deemed clinically appropriate are funded from the "all appliances" limit. The Rate column was updated to align with the Board's decision to increase the funding on the Classic Option to 75% of the Remedi Rate (of which the value paid will be dependent on the monthly rate) for the Sensors.
Glossary table	The insertion of the following sentences: Oncology Pharmacy Designated | 1. Medicine administered in-rooms, such as injectable and infusional chemotherapy, should be obtained from a contracted	To list the oncology pharmacy DSP as referenced in the benefit rules of the Scheme.

	Service Provider	courier DSP Pharmacy (Dis-Chem's Oncology Courier Pharmacy, Qestmed, Olsens Pharmacy, Medipost Pharmacy or Southern Rx). 2.Medicine scripted and dispensed at a retail pharmacy (Oncology and oncology-related medicine such as supportive medicine, oral chemotherapy and hormonal therapy) will be covered in full at MedXpress or any MedXpress Network Pharmacy, Medipost Pharmacy, Qestmed or Dis-Chem's Oncology Courier Pharmacy or Southern Rx	

2.4 Annexure C and D is not submitted as no changes to these benefit annexures for 2023.

2.5 In all instances header and footers were amended to read “2023” and “1 January 2023” as applicable.

The Rule amendments were approved by the Board of Trustees at a Board of Trustees meeting that took place on 21 September 2022 and is submitted herewith for review and registration. **The amended pages are attached and hereby certified for registration.**

Chairperson _____ (Mr JJ Du Plessis)

Trustee_____ (Mr Anton van Wyk)

Principal Officer _____ (Mr J Janse van Vuuren)

Date: 29 September 2022