Remedi 2025 Approved Annexures

ANNEXURE A1

REMEDI MEDICAL AID SCHEME
CONTRIBUTIONS EFFECTIVE 1 JANUARY 2025

STANDARD OPTION

INCOME (in Rand)	MEMBER:	ADULT (**) DEPENDANT:	CHILD (*) DEPENDANT:
0–3999	**1891**	**1312**	**431**
4000–5499	**1980**	**1382**	**486**
5500-6999	**2076**	**1549**	**601**
7000-7999	**2233**	**1856**	**778**
8000-8999	**2233**	**1856**	**778**
9000-9999	**2233**	**1856**	**778**
10000-10999	**2233**	**1856**	**778**
11000 +	**2239**	**1860**	**779**

Note: Contributions will be calculated as follows:

- Contribution rates for children are only applied on the first three (3) children.
- No provision is made for members to contribute towards a Personal Medical Savings Account.
- Member actively employed by a participating employer group – your contribution will be based on your salary and income category as specified by your Employer
- Employment terminated due to retirement, old age, ill-health or disability – your contribution will be based on your last income category whilst employed less two income categories. This adjustment will only be applied once at the time of retirement, termination for old age, ill health or disability or retirement whichever happens first. Contributions will not be based on actual income after termination of employment.

(*) Child contributions are applicable where:

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

(**) Adult contributions are applicable where:

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

ANNEXURE A2

REMEDI MEDICAL AID SCHEME
CONTRIBUTIONS EFFECTIVE 1 JANUARY 2025

COMPREHENSIVE OPTION

INCOME (in Rand)	MEMBER:	ADULT (**) DEPENDANT:	CHILD (*) DEPENDANT:
0–3999	**3873**	**3092**	**1042**
4000–5499	**4089**	**3302**	**1110**
5500-6999	**4320**	**3518**	**1214**
7000-7999	**4545**	**3617**	**1324**
8000-8999	**4781**	**3819**	**1384**
9000-9999	**5046**	**4001**	**1454**
10000-10999	**5296**	**4203**	**1583**
11000+	**5582**	**4431**	**1670**

Note: Contributions will be calculated as follows:

- Contribution rates for children are only applied on the first three (3) children.
- The Personal Medical Savings Account is compulsory.
- The compulsory level of savings, as a percentage of the total contribution has been set at 10%, is included above.
- Member actively employed by a participating employer group – your contribution will be based on your salary and income category as specified by your Employer
- Employment terminated due to retirement, old age, ill-health or disability – your contribution will be based on your last income category whilst employed less two income categories. This adjustment will only be applied once at the time of retirement, termination for old age, ill health or disability or retirement whichever happens first. Contributions will not be based on actual income after termination of employment.

(*) Child contributions are applicable where:

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

(**) Adult contributions are applicable where:

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

ANNEXURE A3

REMEDI MEDICAL AID SCHEME
CONTRIBUTIONS EFFECTIVE 1 JANUARY 2025

CLASSIC OPTION

INCOME (in Rand)	MEMBER:	ADULT (**) DEPENDANT:	CHILD (*) DEPENDANT:
0–3999	**3009**	**2298**	**840**
4000–5499	**3184**	**2464**	**934**
5500-6999	**3355**	**2622**	**998**
7000-7999	**3529**	**2690**	**1092**
8000-8999	**3721**	**2840**	**1164**
9000-9999	**3912**	**2984**	**1211**
10000-10999	**4121**	**3144**	**1321**
11000+	**4330**	**3307**	**1368**

Note: Contributions will be calculated as follows:

- Contribution rates for children are only applied on the first three (3) children.
- No provision is made for members to contribute towards a Personal Medical Savings Account.
- Member actively employed by a participating employer group – your contribution will be based on your salary and income category as specified by your Employer
- Employment terminated due to retirement, old age, ill-health or disability – your contribution will be based on your last income category whilst employed less two income categories. This adjustment will only be applied once at the time of retirement, termination for old age, ill health or disability or retirement whichever happens first. Contributions will not be based on actual income after termination of employment.

(*) Child contributions are applicable where:

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

(**) Adult contributions are applicable where:

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

REMEDI MEDICAL AID SCHEME

ANNEXURE B: Effective 1 January 2025

CONDITIONS APPLICABLE TO ALL BENEFIT OPTIONS

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

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

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

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

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

   3.3 If treatment is undergone without pre-authorisation having been obtained, application may be made retrospectively for an authorisation. In the event of such authorisation being granted the benefit may (except in cases of emergency) be subject to a co-payment of the first R3400 per case. If authorisation is declined no benefits will accrue, provided that authorisation for

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

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

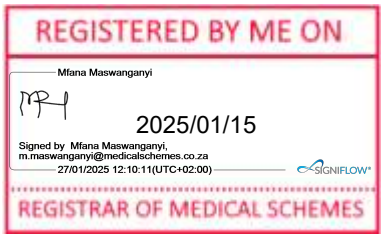
5. Maximum annual benefits shall be calculated from 1 January to 31 December each year, based on the services rendered during that year.

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

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

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

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



10. PRESCRIBED MINIMUM BENEFITS (PMB'S)

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

10.1 **Designated Service Providers** - See also Glossaries of Annexures **B1, B2** and **B3**

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

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

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

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

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

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

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

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

10.1.8 ER24 as preferred provider for emergency services;

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

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

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

10.1.12 A defined list of hospitals and facilities where day surgeries are available, known as the Day Surgery Network. Annexure **B4** has reference.

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

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

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

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

A co-payment or deductible may be imposed on a member if a member or his or her dependant obtains such services from a provider other than a designated or preferred service provider. The Scheme shall fund the cost of such services up to a maximum of 100% of the Scheme Rate. The co-payment the member is liable for is equivalent to any amounts charged above the Scheme Rate as determined by the Board. No co-payment or deductible shall be payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.

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

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

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

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

10.4.2.2 Immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances

or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or

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

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

10.5 **Medication**

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

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

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

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

10.5.3 Where a prescribed minimum benefit includes medication, and the formulary includes medication that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a Beneficiary, and that Beneficiary knowingly declines the formulary medicine and opts to use another medicine instead, the Scheme will

fund the medicine up to a Therapeutic Reference Price ("TRP") or the Chronic Drug Amount ("CDA"), which is applicable for that condition.

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

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

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

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

10.8 **Co-payments**

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

10.9 **Chronic conditions**

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

10.10 **Diagnosis**

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

13. Diabetes mellitus type 2
14. Dysrhythmias
15. Epilepsy
16. Glaucoma
17. Haemophilia
18. HIV and AIDS
19. Hyperlipidaemia
20. Hypertension
21. Hypothyroidism
22. Multiple sclerosis
23. Parkinson's disease
24. Rheumatoid arthritis
25. Schizophrenia
26. Systemic lupus erythematosus
27. Ulcerative colitis

11. Managed Care Programmes

11.1 Patient Management Programmes

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

11.1.1 CAD Care

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.

11.2 **Home Care**

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

11.2.1 End-of-life care

End-of-life care is provided by nurses or care workers and paid from the frail care and private nursing limits as set out in Annexures **B1, B2** and **B3**.

In addition, end-of-life-related conditions are paid from the Advanced Illness Benefit ("AIB"), where deemed clinically appropriate. AIB as provided through the Advanced Illness Benefit Management Programme ("AIBMP") offers unlimited cover for approved care at home. The additional basket of services is only available once the member is authorised to be registered on the programme.

11.2.2 IV Infusions

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

11.2.3 Wound Care

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

11.2.4 Postnatal Care

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

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

11.3 Spinal Care Programme

The Spinal Care Programme offers a spinal surgery component for members needing spinal surgery, and a conservative care programme for those with severe back pain, but where surgery can be prevented through out-of-hospital care.

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

11.4 Member Care Programme

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

STANDARD OPTION: BENEFITS 2025

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

	BENEFIT	RATE	LIMITS	COMMENTS
1.	**Hospitalisation in private hospitals as well as surgery and medical procedures performed by private practitioners**	100% of the Remedi Rate	**Overall annual limit of:** Per family: R 775 000	Subject to management of clinical risk by Discovery Health as contracted and use of defined DSP network of hospitals. **All non-emergency admissions are subject to pre-authorisation.** Emergencies must be authorised within 24 hours of admission or first working day after such emergency treatment or admission. A co-payment of R3 400 for failing to pre-authorise will apply. Wef 1 January 2023, Da Vinci Robotic Assisted Prostatectomy is funded at 90% of the Remedi Rate or negotiated hospital rates where prostate cancer confirmed by means of a histology report, regardless of whether the member is registered on the Oncology Management Programme. Limited to one procedure per person and must be pre-authorised.
	Hospital accommodation • Accommodation in a general ward, intensive care unit, high care unit, maternity ward, as well as theatre and recovery costs	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required.**	Annexures **B** and **D** has reference. The Scheme may require that a member be transferred to a PMB Network Hospital if admitted into a non-DSP following an emergency admission.
	Surgery and medical procedures • Surgery and medical procedures, which generally, but not necessarily, require hospitalisation • Confinements and antenatal consultations • Theatre fees and anaesthetics • Treatment for renal dialysis	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required.** No benefit for conservative dentistry under anaesthesia No benefit for maxillo-facial and oral surgery (excluding trauma-related surgery)	Benefits in respect of services for infertility, limited to the medical and surgical management of those procedures and interventions as defined under PMB Code 902M, subject to the provisions of Regulation 8(3) of the Medical Schemes Act, Act No 101 of 1998. Cosmetic surgery is a listed Scheme exclusion on Remedi.

	BENEFIT	RATE	LIMITS	COMMENTS
	Hospital and surgical material/ equipment			
	• As per agreed list	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required**	Limits set in terms of charging policy for listed items, which may be agreed with DSP and other providers. Benefit for medicines to take home (TTO`s), limited to 5 days.
	• Blood transfusions, blood products and transport of blood	100% of the Remedi Rate	Subject to overall annual limit	
	In-hospital visits			
	• General practitioners and specialists' visits during pre-authorised hospitalisation	100% of the Remedi Rate	Subject to overall annual limit	For surgery, medical procedures and in-hospital visits/consultations Remedi will make payment in full directly to the DSP concerned. In such a case the Member will not be liable for any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures **B** and Annexure **D** to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate. In-room procedures limited to a defined list of procedures as determined by the Scheme.
	Readmission Prevention Benefit • Homecare by a healthcare provider and/or qualified nurse for patients considered at high risk of readmission, when discharged from acute care	100% of the Remedi Rate	Subject to overall annual limit	Basket of care as approved by Remedi
2.	**Hospitalisation in public hospitals as well as surgery and medical procedures performed by *public sector practitioners***	100% of Cost	Limited to Overall annual limit, subject to sub-limit of R 305 000 per family (M+) for treatment in public facilities. **For involuntary admissions to Hospitals outside of the PMB Hospital Network, no limits on Prescribed Minimum Benefits (PMB`s), as set out in the Medical Schemes Act;**	Subject to the management of clinical risk by Discovery Health as contracted. All non-emergency admissions are subject to pre-authorisation. Emergencies must be authorised within 24 hours of admission or on the first working day after such emergency treatment or admission.
	Hospital accommodation • Accommodation in a general ward, intensive care unit, high care unit,	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required**	Benefits in respect of services for infertility, limited to the medical and surgical management

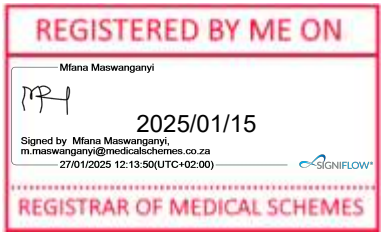
	BENEFIT	RATE	LIMITS	COMMENTS
	maternity ward, as well as theatre and recovery costs			of those procedures and interventions as defined under PMB Code 902M, subject to the provisions of Regulation 8(3) of the Medical Schemes Act, Act No 101 of 1998.
	Surgery and medical procedures • Surgery and medical procedures, which generally, but not necessarily, require hospitalisation • Confinements and antenatal consultations • Theatre fees and anaesthetics • Treatment for renal dialysis	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required.** • No benefit for conservative dentistry under anaesthesia • No benefit for maxillo-facial and oral surgery (excluding trauma-related surgery)	Cosmetic surgery is a listed Scheme exclusion on Remedi. REGISTERED BY ME ON 2025/01/15 REGISTRAR OF MEDICAL SCHEMES
	Hospital and surgical material/equipment • As per agreed list	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required**	Benefit for medicines to take home (TTO`s), limited to 5 days.
	• Blood transfusions, blood products and transport of blood	100% of Cost	Subject to overall annual limit	
	In-hospital visits • General practitioners and specialists' visits during pre-authorised hospitalization	100% of Cost	Subject to overall annual limit	
3.	**Medicines** Acute and Chronic Medicine	100% of the cost on approved drug list (DSP medicine formulary)/Medicine Rate/Therapeutic Reference Price ("TRP")	Unlimited, subject to: Fixed drug list/formulary/TRP – unlimited via DSP contracted network of providers, subject to paragraph 10 of Annexures **B** and Annexure **D**. A co-payment at non-DSP of 20% is applicable. Oral contraceptives are funded up to R200.00 per script per female beneficiary up to R2 800.00 per year payable from the Overall Annual Limit ("OAL"). A co-payment of 20% is applicable if a member obtains oral contraceptives from a non-DSP pharmacy. Medicine rules to apply and script can only be renewed after 23 days from the last script issued. Over-the-counter (OTC) medicine are limited to R200.00 per script and R405.00 per year and subject to the overall annual limit.	Benefits for chronic medication relating to the treatment of PMB CDL and DTP conditions, shall be subject to pre-authorisation and paid in accordance with the treatment protocols, relating to the diagnosis, medical management and treatment for such conditions, including clinical entry criteria, in accordance with the Chronic Disease Programme managed by Discovery Health or the HIV/AIDS Programme, or the managed health care providers appointed by Remedi. Benefit for very expensive chronic medicines which have been "carved out" and not on fixed drug list / formulary are subject to approval of the Remedi Medical Advisory Committee. Influenza vaccines for high-risk members and members > 65 years and/or members who are pregnant are funded from the Prevention and

	BENEFIT	RATE	LIMITS	COMMENTS
			One influenza vaccine per person per year payable and subject to the OTC limit, where a member consult with a network provider.	Screening Benefit. Clinical entry criteria are applicable.
4.	**Extended physiotherapy, occupational therapy, speech therapy and biokinetics** **Maintenance therapy (In and Out of Hospital)**			
	• Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a maintenance or conservative nature, based on an **approved and preauthorised treatment plan, typically preceded by a rehabilitation programme and/or arising from a congenital defect of a mental or physical nature.**	100% of the Remedi Rate	Subject to Overall Annual Limit with a sub-limit: R4 910 per family per year. **Pre-authorisation required.**	This specifically excludes treatment of an acute/minor injury as determined by Remedi's Medical Advisory Committee.
	Rehabilitation therapy post hospitalisation • Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a rehabilitative nature that is preceded by hospitalisation; such treatment must be connected to an approved rehabilitative treatment plan and **must commence within two weeks of discharge from hospital.**	100% of the Remedi Rate	Subject to Overall Annual Limit with a sub-limit: R4 910 per family per year. **Pre-authorisation required.**	

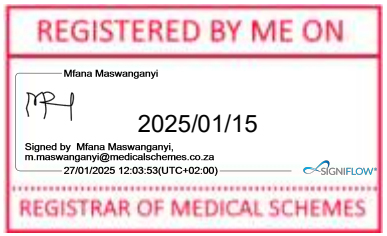
	BENEFIT	RATE	LIMITS	COMMENTS
5.	**Trauma recovery extender benefit** Covering out of hospital treatment following a traumatic incident resulting in • paraplegia, quadriplegia, tetraplegia and hemiplegia • conditions resulting from near drowning, severe anaphylactic reaction, poisoning and crime related injuries; • severe burns; • certain external and internal head injuries and loss of limb, or part thereof.	100% of the Remedi Rate	**Pre-authorisation required.** Subject to the overall annual limit **and the following sub-limits:** Loss of limb **per family** — R106 000 Private nursing **per person** — R13 300 Prescribed medication: **Per Member** — R17 100 **Member + 1** — R20 150 **Member + 2** — R24 000 **Member + 3 or more** — R29 000 External medical items **per person** — R40 500 Hearing Aids **per person** — R19 100 Mental health benefit **per person** — R23 900	For PMB conditions, mental health treatment to be obtained from a service provider contracted to the Scheme's Mental Health Network. REGISTERED BY ME ON Mfana Maswanganyi 2025/01/15 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 27/01/2025 12:08:28(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES
6.	**Out-of-hospital benefit for** • general practitioners; • dentistry; • pathology and radiology (excluding MRI and CT scans) benefits • Vacuum Assisted Breast Biopsy (VABB)	100% of the Remedi Rate	Out-of-hospital benefit unlimited via the DSP contracted network of practitioners • general practitioner consultations, including small procedures; • basic dentistry, viz. consultations, extractions and fillings, including resin fillings up to level 3, i.e. 3 surface fillings per tooth; • basic x-rays, namely black and white x-rays of chest, abdomen, pelvis and limbs; • pathology tests as limited by agreement, including point-of-care testing as authorised; • VABB per person limited to two procedures per year at negotiated fees	Excludes dentures and special dentistry. Point-of-care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria.
	• Benefit for out-of-hospital management and appropriate supportive treatment of specific global World Health Organisation ("WHO") recognised disease outbreaks: - COVID-19 - Monkeypox (Mpox)	In addition to the cover contained in Annexure **D**, up to a maximum of 100% of the Remedi Rate.	Subject to the Scheme's preferred provider network (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.	PMB requirements and Council for Medical Schemes ("CMS") guidelines prevail.

	BENEFIT	RATE	LIMITS	COMMENTS
	• medical specialists and emergency treatment (including funding for Virtual Physical Therapy ("VPT") with effect from 1 July 2025) 	100% of the Remedi Rate or 100% of cost at the Designated Service Provider (DSP)	Unless PMB, subject to Overall Annual limit with a sub-limit for specialists working at a DSP or Preferred Provider network of hospitals and emergency treatment: Per Principal Member: R3 700 Per Adult dependent: R2 330 Per Child dependent: R 750 up to a maximum of 3 children All benefits will be limited to the above sub-limit after which the cost related to the diagnosis and medical management of a PMB chronic condition, including HIV/AIDS, will be unlimited. Access to the PMB Benefit is subject to referral by contracted DSP to a specialist operating within the DSP or Preferred Provider network of hospitals, subject to rules 10.3, 10.4 and 10.5 of Annexures **B** and **D**. Members diagnosed with HIV/AIDS are encouraged to register on the HIV/AIDS Management Programme and all benefits relating to the diagnosis, medical management and treatment of HIV/AIDS will, following diagnosis by the DSP contracted preferred provider, be payable in line with defined protocols/"baskets of care", subject to the provisions of 10.3 – 10.6 of Annexures **B** and **D** to the Rules.	Including consultation for insertion of Mirena contraceptive device in gynaecologist's rooms, provided pre-approval obtained and subject to Scheme clinical protocols and guidelines. Excluding clinical psychologist and social workers. Remedi will make payment in full to a DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures **B** and **D** to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited of maximum 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.
7.	**Maternity** • Pregnancy Scans, pregnancy related tests and antenatal consults • Limited consultations, pregnancy scans and a specified range of pathology tests Limited pregnancy scans antenatal consultations and a specified range of pathology tests	100% of Remedi Rate.	Subject to Overall Annual Limit and the requirements prescribed for PMBs the maternity benefit/basket of care includes: - 2 x 2D pregnancy scans; - Limited to 9 consultations at a Network GP, Midwife or Gynaecologist; - 9 x urine dipstick tests; - 1 x Nuchal Translucency (NT) and/or Non-Invasive Prenatal Test (NIPT) and T21 screening per pregnancy	Managed by Discovery Health the Scheme provides benefits in the GP setting or the member's chosen Sonographer, and through the standard Pathology benefits allowed in terms of the negotiated contractual agreements. Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. NT and/or NIPT and T21 screening (Down Syndrome Screening Tests) to be made available in addition to available ultrasound scans. Clinical entry criteria will be applicable. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures **B** and Annexure **D** to the Rules, then such Member • will be liable to pay the provider;

	BENEFIT	RATE	LIMITS	COMMENTS
				• will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.
8.	**Specialised dentistry** Inlays, crown and bridgework, study models, dentures and the repair thereof, orthodontics, periodontics, prosthodontics and osseo-integrated implants		Nil Benefit	
9.	**Optical** • Eye tests • Spectacles • Frames and/or lens enhancements • Refractive eye surgery and Corneal Cross Linking	100% of cost at Preferred Provider Optometrist	A composite consultation inclusive of refraction, a glaucoma screening, visual field screening and Artificial intelligence for the detection of diabetic retinopathy every 24 months is paid at 100% of cost per person. One pair of Clear single lenses up to R215 per lens per person or one pair of Clear bifocal lenses up to R460 per lens per person or one pair of Base multifocal lenses up to R460 per lens per person every two years. Contact lenses in lieu of spectacles are covered up to the value of R675 per person every 24 months at PPN network only. Standard frame and/or lens enhancements up to R380 per person every two years at PPN network only. Nil Benefit	Benefit available via PPN contracted Optometrist Network only.
10.	**Oncology** Consultations, visits, treatment, medication and materials used in radiotherapy and chemotherapy, including PET-CT scans if pre-authorised	Funded at the Scheme's Designated Service Providers ("DSP"), up to a maximum of 100% of the Remedi Rate/Medicine Rate/Therapeutic Remedi Reference Price List ("TRP"/RPL"), as may be applicable. Prescribed Minimum Benefit ("PMB") provisions apply as set out in Annexure **D.**	Subject to overall annual limit over a 12-month rolling period from date of diagnosis. PMB level of care only and benefit is subject to the prescribed requirements for PMB`s.	Subject to pre-authorisation, an approved all-inclusive treatment plan and to the hospital risk management programme, where applicable. A co-payment of R3 400 is payable for PET-CT scans if not pre-authorised and services are not obtained at a designated service provider. Medication is funded up to 100% of the Medicine Rate/TRP/RPL as may be applicable and dispensed from the Scheme's Oncology Pharmacy Designated Service Providers as referenced in the **Glossary** of this Annexure.

	BENEFIT	RATE	LIMITS	COMMENTS
				Subject to approval of the Scheme`s Medical Advisory Committee, non-PMB level of care may be approved. To read Annexures **D** and **E** in conjunction with this Rule. The provisions in terms of obtaining medicines through the Remedi DSP oncology pharmacy network prevails.
11.	**Frail care and private nursing** **Sub-Acute facilities**	100% of the Remedi Rate 100% of the Remedi Rate	Unless PMB, subject to overall annual limit with a sub-limit of R17 200 per family. **Pre-authorisation required.**	Subject to the hospital risk management programme, prior approval of the Scheme and only available as an alternative to hospitalisation in a registered / approved / accredited facility. Sub-limit may be increased, subject to approval of the Scheme`s Medical Advisory Committee. **Where pre-authorisation is not obtained, no benefits will apply.** **Advanced Illness Benefit ("AIB") provided through the Advanced Illness Benefit Management Programme ("AIBMP") is available upon application and pre-approval where clinically appropriate.**
12.	**Radiology and pathology** • **Radiology: In hospital** • **Pathology: In hospital** • **MRI and CT scans in hospital**	100% of the Remedi Rate	Subject to overall annual limit and **benefit confirmation to be obtained for MRI and CT scans.**	Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in paragraph 10.4 read with 10.3 and/or 10.5 of Annexures **B** and Annexure **D** to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate

	BENEFIT	RATE	LIMITS	COMMENTS
13.	**Prevention and Screening Benefit** Including blood glucose, blood pressure, cholesterol and body mass index screening tests, HIV, mammogram, pap smear, prostate specific antigen (PSA) test and influenza vaccine for identified high risk members, members who are pregnant and members above the age of 65. Pneumococcal vaccine in line with latest clinical guidelines. Preventative dentistry is provided through the contracted DSP. Human Papillomavirus (HPV) vaccine for males between the ages of 11 and 21 and females between the ages of 11 and 26 years. HPV screening tests are limited to 1 x every 5 years if the member is HIV negative and one test every 3 years if the members is HIV positive. These tests are an alternative to pap smears. One LDL cholesterol screening is available per high-risk beneficiary where clinically indicated at network pharmacy. HbA1c is funded from the Insured Out of Hospital benefit, where clinically appropriate. A group of age-appropriate screening tests and additional screening assessments for members 65 years and older. (Senior Screening Tests)-. Colorectal screening limited to one fecal occult blood test or immunochemical test every 2 years per person for persons between the ages of 45 to 75 years. One colonoscopy where clinically appropriate.	100% of the Remedi Rate REGISTERED BY ME ON Mfana Maswanganyi 2025/01/15 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 27/01/2025 12:10:46(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES	Subject to overall annual limit.	Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in paragraph 10.4 read with 10.3 and/or 10.5 of Annexures **B** and Annexure **D** to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate. If the member has more than 1 HPV screening test before the 5 years' period expires, if HIV negative (or before the 3 years' period expires where the member is HIV positive) then: • the second and sub-sequent claims during that period will be paid from the member's insured out-of-hospital specialist benefit if benefits are available and where the result of the screening test is abnormal or after treatment the follow-up tests will be funded yearly until normal. If the member has more than 1 HPV screening tests during the year after an abnormal HPV test result, the second and sub-sequent claims during that year will be paid from the member's insured out-of-hospital specialist benefit if benefits are available for the member's account.

	BENEFIT	RATE	LIMITS	COMMENTS
14.	**Internal Prostheses and Devices** 	100% of the Remedi Rate	Subject to the Overall Annual Limit with the following yearly sub-limits **per person**, unless otherwise stated: Total hip replacement: R46 200*** Revision hip: R54 500*** Knee replacement: R36 300*** Revision knee replacement: R46 200*** Total shoulder replacement: R42 500 Spinal benefit ****: **** Bare metal cardiac stents max. 3 p.a. (each): ** Drug eluting cardiac stents (each) max. 3 p.a.: ** Pacemaker with Leads: R76 800 Pacemaker Biventricular: R98 800 Cardiac valves **(each)**: R50 000 Artificial eyes (prosthesis plus apparatus): R28 100 All other internal prostheses and devices per person, excluding cochlear implants paid per negotiated rates: * R24 000	**Subject to pre-authorisation** and clinical protocols the prescribed requirements for PMB`s.  *Sub-limit may be increased, subject to approval of the Scheme`s Medical Advisory Committee and where applicable the Scheme's Executive Committee. Funding of temporary and permanent Sacral nerve stimulators is specifically excluded. ** Negotiated reference price list is applicable. *** Hip and Knee Arthroplasty Procedures: The Scheme is contracted with Mediclinic as Designated Service Provider ("DSP") for these procedures. A R3 400.00 co-payment for voluntary non-DSP use will apply. The aforementioned co-payment will be waived for members who reside outside a thirty (30) kilometre radius from a DSP. ****With effect 1 January 2022, the Scheme adopted a Spinal Care Programme. Funding at network providers up to 100% of Remedi Rate/negotiated reference price and at non-network providers up to 80% of the Remedi Rate with effect from 1 January 2023.
15.	**External Prostheses and Appliances. (Including the External components of external prosthesis, incontinence products, etc)**	100% of the Remedi Rate	Subject to Overall Annual Limit with the following sub-limits: Colostomy equipment: R16 800 **per person per year** Hearing aids: R21 550 **per person per year** Wheelchairs: R14 850 **per person per year** Oxygen appliances (includes oxygen): R2 435 **per person per month** Artificial limbs (below knee): R30 000 **per person per year** Artificial Limbs (above knee): R54 700 **per person per year**	Colostomy equipment can be obtained via Cancer Society. Oxygen benefit subject to registration for the use of oxygen on the Chronic Illness Benefit Programme managed by Discovery Health as contracted. Funding of Mirena contraceptive device payable from all other appliances, subject to pre-approval in line with Scheme clinical protocols and guidelines and provided inserted in gynaecologists' rooms.

	BENEFIT	RATE	LIMITS	COMMENTS
	REGISTERED BY ME ON 2026/04/08 REGISTRAR OF MEDICAL SCHEMES		All other appliances, **excluding** Insulin Pumps and Continuous Glucose Monitors ("CGM") — R4 000 **per person per year**	CPAP devices funded from the "all other appliances" limit as available, where deemed clinically appropriate and limited to the agreed/negotiated rates with preferred providers. Point-of-care devices for point-of-care testing are funded from the "all other appliances" limit as available, where deemed clinically appropriate.
16.	**Paramedical services** Ambulance	100% of the Remedi Rate	Subject to utilisation of preferred provider, viz. ER24 Emergency Response Service.	Transfers for same event subject to medical justification. **Pre-authorisation required with preferred provider**. .
17.	**Psychiatric benefit in hospital and in lieu of hospitalisation** (Including the treatment of alcoholism and drug dependency)	100% of the Remedi Rate	Subject to overall annual limit, limited to 21 days per year in hospital or 15 days, as well as one guided internet-based Cognitive Behavioural Treatment (iCBT) session in an out-of-hospital setting or a combination of in- and out-of-hospital as prescribed in terms of Prescribed Minimum Benefits.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted and the prescribed requirements for PMB`s and use of defined DSPs. Benefits may be granted for out-of-hospital consultations and/or treatment in lieu of hospitalisation. Services and treatment for PMB conditions to be obtained from a DSP (Mental Health Network provider) contracted with the Scheme and funding per Annexure **D** will be applicable. Benefit may be increased, subject to approval of the Remedi's Medical Advisory Committee.
18.	**Out-of-area benefit (OOA)** (When away from normal residence or nominated DSP contracted network service provider is unavailable after hours)	100% of the Remedi Rate	Out-of-area visits, limited to 3 visits per family (M+) to a maximum of R2 200 per family per year. This benefit to include Virtual Urgent Care ("VUC") consultation(s) with effect from 1 July 2025.	**In person consultations**: For after-hours (Mon – Fri 08:00 to 17:00 and Sat 09:00 to 12:00) emergencies when nominated practitioner is not available and/or member is away from normal residence. If no DSP contracted service provider is available member may access Non-DSP Provider.

	BENEFIT	RATE	LIMITS	COMMENTS
	REGISTERED BY ME ON 2026/04/08 REGISTRAR OF MEDICAL SCHEMES			No formulary is applied; payment is based on the Rand value and number of OOA visits per year. Benefit managed by Discovery Health. **"Virtual Urgent Care consultations:** With effect 1 July 2025, access available through a digital platform outside of the Scheme's DSP arrangements. Where the maximum family benefit limit is reached, consultations will be payable by the member.
19.	**Organ Transplants** (Including harvesting of organs, consultations/visits and post-operative anti-rejection medicines required by recipient)	PMB will be paid at 100% of Cost. Non-PMB is paid at 100% of the Remedi Rate	PMB unlimited at the DSP. Non-PMB will be subject to the Overall Annual Limit.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted. Provisions of Annexures **B** and **D** is applicable.
20.	**Renal Failure & Dialysis** (Including all services and materials associated with the cost of acute and chronic renal dialysis including consultations/visits and medicines)	100% of the Remedi Rate	Subject to Overall Annual Limit and the prescribed requirements for PMB`s.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted. Provisions of Annexures **B** and **D** is applicable.
21.	**Other Health Care Services** Chinese medicine & acupuncture, therapeutic aromatherapy, audiology, ayurvedics, chiropody/podiatry, chiropractics (including x-rays), dietetics, homeopathy, iridology, naturopathy, orthoptics, osteopathy, therapeutic reflexology, therapeutic massage therapy, phytotherapy and traditional healing.		Nil Benefit	

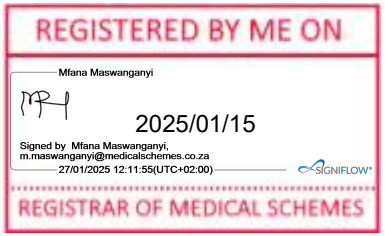
GLOSSARY / EXPLANATORY NOTES:

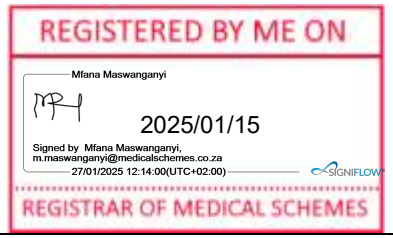
CDL	Chronic Disease List
DSP	A Designated Service Provider for the Prescribed Minimum Benefits - "PMBs" - selected by Remedi, being the contracted private hospitals, the KeyCare specialist network, Dental Risk Company (DRC) and Preferred Provider Negotiators (PPN) and the following providers for alcohol and drug dependency – The South African National Council on Alcohol and Drug Dependence (SANCA), SANCA's nominated providers and the Ramot Centre for Alcohol and Drug Dependency, as well as any other providers selected by Remedi from time to time.
Direct Payment Arrangements "DPAs"	Are the specialist arrangements concluded between Discovery Health and specialist providers who agree to charge at or below a set rate for consultations and procedures and by reason thereof have also agreed that such rates shall be applicable to Remedi.
GP Network	The network of General Practitioners contracted to and through Discovery Health to provide relevant health care services to Remedi at the Remedi Rate
CDA	Chronic Drug Amount (CDA) is an amount of money that has been allocated to each medicine category each month for a specific condition.
M	Member without dependants
M+	Member plus dependants
Pb/py or Pp/py	per beneficiary per year or per person per year
Pf/py	per family per year
PMB/PMB`s	the Prescribed Minimum Benefit(s)
Pre-authorisation	the approval which has been given by the Scheme, or the Scheme`s contracted Managed Healthcare provider for relevant health services, as defined in the Act, to be provided to a beneficiary, in accordance with the protocols/treatment guidelines, accepted or determined by the Scheme.
Preferred Provider	a health care provider or group providers selected by the Scheme to provide diagnosis, treatment and care in respect of PMB or non-PMB conditions. For Chronic medicine any pharmacy charging not more than the SEP and the dispensing fee equal to that charged by the DSPs.
SAOA	South African Optometric Association
Remedi Rate	is the tariff fee / rate for the payment of relevant health services equal to the Discovery Health Rate / DH rate, as prescribed in the Guide to the Discovery Health Rate, or the fee / rate as determined by Board of Trustees in terms of any agreement between Remedi and any service provider or group of service providers
SEP	Single Exit Price
PMB Hospital Network	A Mediclinic hospital contracted to or nominated by the Scheme established for the provision of services that relates to Prescribed Minimum Benefit (PMB) conditions. See also DSP.
Mental Health Network	A defined list of Psychologists and/or Social Workers contracted or nominated by the Scheme for purposes of providing treatment to members relating to mental health conditions. See also DSP
In-Hospital GP Network	A defined list of GP and specialist authorised by the Scheme to provide in-hospital services to members as part of the Scheme's Premier Practice, Remedi Standard GP Network and Classic DPA Specialist Networks.
Therapeutic Reference Price ("TRP")	A reference price model applicable to all fixed NAPPI formularies, such as the Chronic Disease List ("CDL"), Out of Hospital Diagnostic Treatment Pairs Prescribed Minimum Benefits ("OHDTPMB"), HIV and Oncology medicines, ensuring reimbursement of non-formulary products that link to the formulary drug classes on a generic and therapeutic level.
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 in full at MedXpress or any MedXpress Network Pharmacy, Medipost Pharmacy, Qestmed, Olsens Pharmacy, Dis-Chem's Oncology Courier Pharmacy or Southern Rx
Day Surgery Network (DSN)	A defined list of hospitals and facilities where day surgery procedures are available. Annexure **B4** has reference.

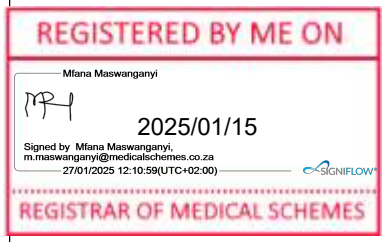
COMPREHENSIVE OPTION: BENEFITS 2025

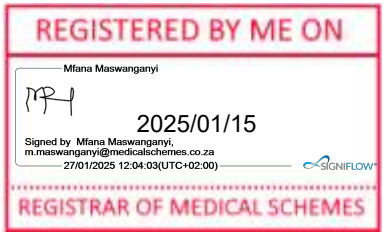
(Members and their dependants are entitled to the following benefits, subject to the provisions of these Rules and in particular paragraph 10 of Annexure **B** and Annexure **D** concerning the provision of the statutory Prescribed Minimum Benefits, "PMB's")

	BENEFIT	RATE	LIMITS	COMMENT
1.	**Hospitalisation in private hospitals as well as surgery and medical procedures performed by private practitioners.**  	100% of the Remedi Rate	**Unlimited Overall annual limit (OAL)** per family per year	Subject to the management of clinical risk by Discovery Health as contracted and use of defined DSP network of hospitals. **All non-emergency admissions are subject to pre-authorisation.** Emergencies must be authorised within 24 hours of admission or first working day after an emergency treatment or admission. A co-payment of R3 400 for failing to pre-authorise will apply. Wef 1 January 2023, Da Vinci Robotic Assisted Prostatectomy is funded at 90% of the Remedi Rate or negotiated hospital rates where prostate cancer confirmed by means of a histology report, regardless of whether the member is registered on the Oncology Management Programme. Limited to one procedure per person and must be pre-authorised. Annexures **B** and **D** has reference. The Scheme may require that a member be transferred to a PMB Network Hospital if admitted into a non-DSP following an emergency admission.
	Hospital accommodation • Accommodation in a general ward, intensive care unit, high care unit, maternity ward, as well as theatre and recovery costs	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required**	

	BENEFIT	RATE	LIMITS	COMMENT
	Surgery and medical procedures • Surgery and medical procedures, which generally, but not necessarily, require hospitalisation. • Confinements • Conservative dentistry under anaesthesia in patients not older than 7 years	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required.** Anaesthetics and hospitalisation subject to overall annual limit. **Note: dentist accounts are payable from available Insured Out-of-Hospital benefit**	Benefits in respect of services for infertility, limited to the medical and surgical management of those procedures and interventions as defined under PMB Code 902M, subject to Regulation 8(3) of the Medical Schemes Act, Act No 131 of 1998. Cosmetic surgery is a listed exclusion on Remedi.
	Hospital and surgical material/ equipment as per agreed list	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required.**	Limits set in terms of charging policy for listed items, which may be agreed with DSP and other Providers. Benefit for medicines to take home (TTO`s), limited to 5 days.
	Blood transfusions, blood products and transport of blood	100% of the Remedi Rate	Subject to overall annual limit	
	In-hospital visits • General practitioners and specialists' visits during pre-authorised hospitalisation  	100% of the Remedi Rate	Subject to overall annual limit	For surgery, medical procedures and in-hospital visits/consultations Remedi will make payment in full directly to the DSP concerned. In such a case the Member will not be liable for any co-payment to be made to such DSP If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in paragraph 10.4 read with 10.3 and/or 10.5 of Annexures **B** and **D** to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 150% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate. In-room procedures limited to a defined list of procedures as determined by the Scheme.
	Readmission Prevention Benefit • Homecare by a healthcare provider and/or qualified nurse for patients considered at high risk of readmission, when discharged from acute care	100% of the Remedi Rate	Subject to overall annual limit	Basket of care as approved by Remedi
2.	**Hospitalisation in public hospitals as well as surgery and medical procedures performed by *public sector practitioners***	100% of Cost	Limited to Overall annual limit, subject to sub-limit of R 675 000 per family (M+) for treatment in public facilities. **For involuntary admissions to Hospitals outside of the PMB Hospital Network, no limits on Prescribed Minimum Benefits**	Subject to the management of clinical risk by Discovery Health as contracted. All non-emergency admissions **are subject to pre-authorisation**.

	BENEFIT	RATE	LIMITS	COMMENT
			(PMB`s), as set out in the Medical Schemes Act;	Emergencies must be authorised within 24 hours of admission or on the first working day after such emergency treatment or admission. A co-payment of R3 400 for failing to pre-authorise will apply.
	Hospital accommodation • Accommodation in a general ward, intensive care unit, high care unit, maternity ward, as well as theatre and recovery costs	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required**	
	Surgery and medical procedures • Surgery and medical procedures, which generally, but not necessarily, require hospitalisation. • Confinements and antenatal consultations • Theatre fees and anaesthetics • Conservative dentistry under anaesthesia in patients not older than 7 years	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required.** Anaesthetics and hospitalisation subject to overall annual limit. Note: dentist accounts are payable from available Insured Out-of-hospital benefit	Benefits in respect of services for infertility, limited to the medical and surgical management of those procedures and interventions as defined under PMB Code 902M, subject to Regulation 8(3) of the Medical Schemes Act, Act No 131 of 1998. Cosmetic surgery is a listed exclusion on Remedi.
	Hospital and surgical material/equipment • As per agreed list	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required**	Benefit for medicines to take home (TTO`s), limited to 5 days.
	Blood transfusions, blood products and transport of blood	100% of Cost	Subject to overall annual limit	
	In-hospital visits • General practitioner and specialist visits during pre-authorised hospitalisation	100% of Cost	Subject to overall annual limit	
3.	**Chronic medication** PMB Conditions 	100% of Single Exit Price "SEP" plus a dispensing fee as agreed to with the defined DSP	Unlimited benefit, and further subject to a fixed drug list (formulary) Non-formulary drugs are funded up to the Chronic Drug Amount (CDA) for a registered drug class.	Benefits for the diagnosis, medical management and treatment of PMB CDL and DTP conditions – which shall not be less than those for the regulated Prescribed Minimum Benefits – shall subject to pre-authorisation be paid in accordance with the treatment protocols including clinical entry criteria and authorized "baskets of care" governing the Chronic Illness Benefit Programme and/or HIV/AIDS Programme, managed by Discovery Health as contracted, the managed health care provider appointed by Remedi.

	BENEFIT	RATE	LIMITS	COMMENT
	Non-PMB Conditions 	100% of Single Exit Price "SEP" plus a dispensing fee as agreed to with the defined DSP	Subject to Overall Annual Limit a maximum of R2 640 per person per month, based on individual needs.	Subject to registration on the Chronic Illness Benefit Programme managed by Discovery Health as the Managed Health Care Provider appointed by Remedi. Where chronic medication is obtained from a pharmacy other than a DSP a co-payment for any difference in dispensing fees and/or any related fees will be payable by the member directly to the pharmacy. Any such co-payment will not be refunded to the Member via any credit of the Member`s Personal Medical Savings Account.
4.	**Extended physiotherapy, occupational therapy, speech therapy and biokinetics** **Maintenance therapy (In and Out of hospital)** • Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a maintenance or conservative nature, based on an **approved and pre-authorised treatment plan typically preceded by a rehabilitation programme and/or arising from a congenital defect of a mental or physical nature.**	100% of the Remedi Rate	**Pre-authorisation required.** Subject to Overall Annual Limit with sub-limit: R17 370 per family (M+) per year	This specifically excludes treatment of an acute (minor) injury as determined by Remedi's Medical Advisory Committee.
	Rehabilitation therapy post hospitalisation • Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a rehabilitative nature that is preceded by hospitalisation; such treatment must be connected to an approved rehabilitative treatment plan and must commence within two weeks of discharge from hospital.	100% of the Remedi Rate	**Pre-authorisation required.** Subject to overall annual limit	

<table>
<tr><th></th><th>BENEFIT</th><th>RATE</th><th>LIMITS</th><th>COMMENT</th></tr>
<tr><td>5.</td><td>Trauma recovery extender benefit
Covering out of hospital treatment following a traumatic incident resulting in
• paraplegia, quadriplegia, tetraplegia and hemiplegia
• conditions resulting from near drowning, severe anaphylactic reaction, poisoning and crime related injuries;
• severe burns;
• certain external and internal head injuries and loss of limb, or part thereof.</td><td>100% of the Remedi Rate</td><td>Pre-authorisation required.
Subject to the overall annual limit and the following sub-limits:
<table><tr><td colspan="2">Loss of limb per family</td><td>R106 000</td></tr><tr><td colspan="2">Private nursing per person</td><td>R13 300</td></tr><tr><td>Prescribed medication:</td><td>Per Member</td><td>R36 950</td></tr><tr><td></td><td>Member + 1</td><td>R43 300</td></tr><tr><td></td><td>Member + 2</td><td>R50 450</td></tr><tr><td></td><td>Member + 3 or more</td><td>R57 400</td></tr><tr><td colspan="2">External medical items per person</td><td>R90 500</td></tr><tr><td colspan="2">Hearing Aids per person</td><td>R33 000</td></tr><tr><td colspan="2">Mental health benefit per person</td><td>R32 200</td></tr></table></td><td>For PMB conditions, mental health treatment to be obtained from a service provider contracted to the Scheme’s Mental Health Network.
  </td></tr>
<tr><td>6.</td><td>Insured Out-of-Hospital (“IOH”) benefit for:
Consultations, procedures, radiology (excluding MRI and CT scans) and pathology outside hospital, point-of-care testing as authorised, including in the outpatient department of a hospital and inclusive of the facility fee for outpatients</td><td>100% of the Remedi Rate or
100% of cost at the Designated Service Provider (DSP) /Medicine Rate</td><td>Subject to Overall Annual Limit and the following sub-limits:
Per Principal Member: R12 680
Per Adult Dependent: R7 480
Per Child Dependent: R2 110 (up to a maximum of 3 children)</td><td>Where the sub-limit is exceeded, benefits for non-PMB conditions will be paid from the Personal Medical Savings Account.
Special and advanced dentistry is specifically excluded.

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

Oral contraceptives are funded up to R200.00 per script per female beneficiary up to R2 800.00 per year payable from the Overall Annual Limit (“OAL”). A co-payment of 20% is applicable if a member obtains oral contraceptives from a non-DSP pharmacy. Once, the script and yearly limits are reached, costs related to oral contraceptives are covered from the Personal Medical Savings Account (“PMSA”). Medicine rules to apply and script can only be renewed after 23 days from the last script issued.

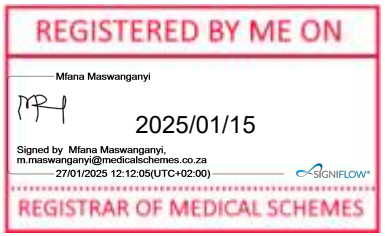
For members who are not high risk and who are < 65 years or who are not pregnant, one influenza vaccine per person per year is payable from the IOH limit. Influenza vaccines for high-risk members and members > 65 years and/or</td></tr>
</table>

	BENEFIT	RATE	LIMITS	COMMENT
				members who are pregnant are funded from the Prevention and Screening Benefit. Clinical entry criteria are applicable. Point-of-care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria.
	• Specialists, including funding for Virtual Physical Therapy ("VPT") with effect from 1 July 2025 from IOH; • General Practitioners; • Acute and self-medication • Dentistry; • Physiotherapists; • Biokineticists; • Occupational Therapists; • Speech Therapists • Audiologists and Audiometrists • Clinical Psychologists; • Social Workers; • Pathology and radiology (excluding MRI and CT scans) benefits; • Vacuum Assisted Breast Biopsy (VABB) REGISTERED BY ME ON 2025/01/15 REGISTRAR OF MEDICAL SCHEMES		Costs relating to the diagnosis and treatment of Prescribed Minimum Benefit Chronic Disease List, "CDL" and Diagnosis and Treatment Pair, "DTP" conditions including HIV/AIDS, will be payable from risk subject to the conditions set out alongside. VABB per person is limited to two procedures per year at negotiated fees. With effect from 1 July 2025, Virtual Urgent Care ("VUC") consultations is funded up to 4 consultations per family (M+) per year at 100% of the Remedi Rate from the Overall Annual Limit ("OAL"), subject to the appropriate emergency consultation and procedure codes and can be accessed through a digital platform outside the Scheme's DSP arrangements. Consultations more than the yearly limit of 4 VUC per family and/or the available maximum family limit per year will be payable by the member. Consultations not recognised as an emergency consultation will be paid from the available IOH benefit.	. Self-medication applies to medicines classified as Schedules 0, 1 and 2, which can be purchased over the counter without a doctor's prescription. Members will receive benefit in accordance with authorized "baskets of care" regarding the diagnosis, medical management and treatment of such PMB CDL and DTP related chronic diseases. If not registered then benefits will be subject to the conditions set out in 10.3, 10.4 and 10.5 of Annexures **B** and **D** to the Rules. Services and treatment for PMB conditions to be obtained from a DSP (Mental Health Network provider) contracted with the Scheme and funding per Annexure **D** will be applicable. Remedi will make payment in full to a DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except as provided for in this benefit rule and except in the involuntary circumstances described in paragraph 10.4 read with 10.3 and/or 10.5 of Annexures **B** and **D** to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.

	BENEFIT	RATE	LIMITS	COMMENT
	Benefit for out-of-hospital management and appropriate supportive treatment of specific global World Health Organisation ("WHO") recognised disease outbreaks: - COVID-19 - Monkeypox (Mpox).	In addition to cover contained in Annexure **D**, up to a maximum of 100% of the Remedi Rate.	Subject to the Scheme's preferred provider network (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.	PMB requirements and Council for Medical Schemes ("CMS") guidelines prevail. REGISTERED BY ME ON Mfana Maswanganyi 2025/01/15 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 27/01/2025 12:02:39(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES
7.	**GP Benefit** • Limited GP consultations funded from major risk benefit once both Insured Out-of-hospital benefit and annual allocated PMSA for the year are exhausted	Payment in full to DSP provider (Network GP)	Limited to the following number of consultations: M0: 3 additional GP consultations M+: 6 additional GP consultations	Additional consultations will only be funded for services provided by a practitioner in the GP Network.
8.	**Maternity** Limited pregnancy scans antenatal consultations and a specified range of pathology tests	100% of the Remedi Rate	Subject to Overall Annual Limit and the requirements prescribed for PMBs the maternity benefit/basket of care includes: - 2 x 2D pregnancy scans; - 9 GP consultations at a Network GP, Midwife or Gynaecologist; - 9 x urine dipstick tests; - 2 x glucose strip tests; - HIV Elisa, Rubella, RPR and TPHA and bHCG tests as deemed clinically appropriate; - RH antigen, Haemoglobin, A B and O antigens as deemed clinically appropriate; - 1 x Nuchal Translucency (NT) and/or Non-Invasive Prenatal Test (NIPT) and T21 screening per pregnancy	The benefit allows for a defined range of services including the first two 2D ultrasound scans in gynecologists' rooms. Medical motivation is required for additional scans. NT and/or NIPT and T21 screening (Down Syndrome Screening Tests) to be made available in addition to available ultrasound scans. Clinical entry criteria will be applicable.
9.	**Specialised dentistry** Inlays, crown and bridgework, study models, dentures and the repair thereof, orthagnathic surgery, orthodontics, periodontics, prosthodontics and osseo-integrated implants	100% of the Remedi Rate	Subject to Overall Annual Limit with sub-limits of: R25 900 per person and R52 000 per family	

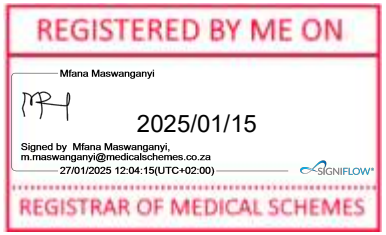
	BENEFIT	RATE	LIMITS	COMMENT
10.	**Optical** ***Preferred Provider Optometrist*** 	100% of cost at Preferred Provider Optometrist	Subject to the requirements prescribed for PMB`s and the Overall Annual Limit with the following limits: 1. Annual benefit cycle 2. Per person limit of R4 225 subject to overall family limit of R8 450 3. The following sub-limits will apply within the overall per person/family limit: *Consultations* A composite consultation inclusive of refraction, a glaucoma screening, visual field screening and Artificial Intelligence for the detection of diabetic retinopathy at Preferred Provider Optometrist is paid at 100% of Cost. *And either Spectacles* Frame limit/Lens Enhancements R2 125 toward the cost of a Frame and/or Lens enhancements paid to the Preferred Provider limited to OAL and Clear lens limit: • Single Vision lenses at Preferred Provider Optometrist R215 per lens; • Bifocal lenses at R460 per lens or • Base Multifocal spectacle lenses R810 per lens. • An additional R50 per lens for Branded Multifocal lenses in addition to the R810 per lens limit *Or* ***Contact lenses*** Contact lenses limited to the value of R2 675.	• Payment of any claim is subject to PMB's and Overall Annual Limit irrespective of confirmation of available benefits by either the Member or the selected optometrist. • The spectacle lenses must be prescribed by an optometrist or a medical practitioner who is registered with the Health Professions Council of South Africa, to improve the patient`s visual acuity. • The contact lenses must be prescribed and dispensed by an optometrist or a medical practitioner who is registered with the Health Professions Council of South Africa to improve the patient's visual acuity. • Clinical Rules: Scripts less than 0.50 diopter will not be covered; No bifocal or multifocal lenses with a less than 1 Diopter add on will not be covered; No multifocals will be considered for payment for children under the age of 18. • Claims for the following conditions will only be considered for payment when motivated and approved by the DSP motivations committee: bifocals/multifocals for beneficiaries under the age of 40; Contact lenses for children under the age of 18; Composite consultations for children under the age of 5; Vertical prism less than 1 Diopter. • All clinical/prescribed information must be submitted on all claims to ensure payment. • Co-payments may be applicable on services obtained from non-preferred provider optometrists. • All claims must be submitted to PPN for adjudication and payment of benefits. • Member refunds may be applicable on services obtained from a non-preferred provider optometrist without an agreement for direct payment. All member refunds will be refunded up to the benefit limits of non-Preferred providers. • Members can obtain either spectacles or contact lenses within a benefit cycle not both
	Non-Preferred Provider Optometrist	100% of the Remedi Rate	Subject to the requirements prescribed for PMB's and the Overall Annual Limit with the following limits: • Annual benefit cycle • Per person limit of R4 225 subject to overall family limit of R8 450 • The following sub-limits will apply within the overall per person/family limit: *Consultations* A composite consultation inclusive of refraction, a glaucoma screening, visual field	

	BENEFIT	RATE	LIMITS	COMMENT
			screening and Artificial Intelligence for the detection of diabetic retinopathy limited to R400. *And either Spectacles* Frame limit R1 594 towards the cost of a frame and/or lens enhancements and Clear lenses limit: • Single vision lenses at R215 per lens or • Bifocal lenses at R460 per lens or • Multifocal lenses at R810 per lens. • An additional R50 per lens for Branded Multifocal lenses in addition to the R810 per lens limit *Or* Contact lenses limited to the value of R2 675.	
	Refractive eye surgery **Members with severely restricted vision** (Including Corneal Cross Linking)	100% of the Remedi Rate	Annual sub-limit of R35 600 per person	Pre-authorisation in accordance with approved clinical protocols is required. Where pre-authorisation is not obtained, no benefits will apply.
11.	**Oncology** Consultations, visits, treatment, medication and materials used in radiotherapy and chemotherapy, including PET-CT scans if pre-authorised	Funded at the Scheme's Designated Service Providers ("DSP") up to a maximum of 100% of the Remedi Rate, Medicine Rate/Therapeutic Remedi Reference Price List ("TRP"/"RPL"), as may be applicable and up to R490 000 per person plus a further R705 000 per person at 80% of Remedi Rate/Medicine Rate/TRP/RPLfor non-PMB treatment where OAL or thresholds are reached. PMB treatment is funded at	Subject to the overall annual limit and R490 000 per person at 100% of the Remedi Rate and a further R705 000 per person at 80% of the Remedi Rate, limited to an overall Oncology annual limit of R1 195 000 per person per year over a 12 month rolling period from date of diagnosis. Benefit subject to the requirements prescribed for PMB`s	Subject to pre-authorisation, an approved all-inclusive treatment plan and to the management of clinical risk by Discovery Health as contracted and where applicable. A co-payment of R3 400 is payable for PET-CT scans if not pre-authorised and services are not obtained at a designated service provider. Medication is funded up to 100% of the Medicine Rate/TRP/RPL as may be applicable and dispensed from the Scheme's Oncology Pharmacy Designated Service Providers as referenced in the **Glossary** of this Annexure. Sub-limit may be increased, subject to approval of the Remedi's Medical Advisory Committee, where non-PMB level of care and will be increased automatically where PMB level of care and clinically appropriate. To read Annexures **D** and **E** in conjunction with this Rule. The provisions in terms of obtaining medicines through the Remedi DSP oncology pharmacy network prevails.

	BENEFIT	RATE	LIMITS	COMMENT
		100% of Remedi Rate/Medicine Rate/ TRP/RPL, as may be applicable. The provisions as set out in Annexure **D** is applicable.		With effect from 1 January 2025, Next Generation Sequencing ("NGS") is payable from the hospital benefit, where authorised and member is registered on the Oncology Management Programme (Annexure **E** has reference).
12.	**Frail care and private nursing**	100% of the Remedi Rate	Unless PMB, subject to the overall annual limit with a sub-limit of R48 950 per person. **Subject to pre-authorisation.** **Unlimited**	Subject to hospital risk management programme, prior approval of Remedi and only available as an alternative to hospitalisation. Sub-limit may be increased, subject to approval of Remedi's Medical Advisory Committee. **Where pre-authorisation is not obtained, no benefits will apply.** **Advanced Illness Benefit ("AIB") provided through the Advanced Illness Benefit Management Programme ("AIBMP") is available upon application and where pre-approved.**
	Sub-Acute facilities	100% of the Remedi Rate	Subject to overall annual limit **Subject to pre-authorisation**	
13.	**Radiology and pathology** • Radiology: In hospital • Pathology: In hospital • MRI and CT scans in and out of hospital	100% of the Remedi Rate	Subject to overall annual limit and benefit confirmation for **MRI and CT scans.**	Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures **B** and **D** to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.

	BENEFIT	RATE	LIMITS	COMMENT
14.	**Prevention and Screening Benefit** Including, blood glucose, blood pressure, cholesterol and body mass index screening tests HIV, mammogram, pap smear, prostate specific antigen (PSA) test and, influenza vaccine for identified high risk members, members who are pregnant and members above the age of 65. Pneumococcal vaccine in line with latest clinical guidelines. One (1) preventative dental examination per person per year, including the oral examination, infection control, prophylaxis, polishing and fluoride of adults and children. Human Papillomavirus (HPV) vaccine for males between the ages of 11 and 21 and females between the ages of 11 and 26 years. HPV screening tests are limited to 1 x every 5 years if the member is HIV negative and one test every 3 years if the members is HIV positive. These tests are an alternative to pap smears.	100% of the Remedi Rate REGISTERED BY ME ON 2025/01/15 REGISTRAR OF MEDICAL SCHEMES	Subject to Overall Annual Limit	Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures **B** and **D** to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.
	One LDL cholesterol screening is available per high-risk beneficiary where clinically indicated at network pharmacy. HbA1c is funded from the Insured Out of Hospital benefit, where clinically appropriate. A group of age-appropriate screening tests and additional screening assessments for members 65 years and older (Senior Screening Tests). Colorectal screening limited to one fecal occult blood test or immunochemical test every 2 years per person for persons between the ages of 45 to 75 years. One colonoscopy where clinically appropriate.			If the member has more than 1 HPV screening test before the 5 years' period expires, if HIV negative (or before the 3 years' period expires, if HIV positive) then: • the second and sub-sequent claims during that period will be paid from the member's day-to-day acute medicine benefit if benefits are available and where the result of the screening test is abnormal or after treatment the follow-up tests will be funded yearly until normal. If the member has more than 1 HPV screening tests during the year after an abnormal HPV test result, the second and sub-sequent claims during that year will be paid from the member's day-to-day acute medicine benefit if benefits are available.

	BENEFIT	RATE	LIMITS	COMMENT
15.	**Internal prostheses and devices** 	100% of the Remedi Rate or at Cost as indicated	Subject to the Overall Annual Limit with following yearly sub-limits **per person**, <u>unless otherwise stated:</u> Total hip replacement — R60 800*** Revision hip — R72 100*** Knee replacement — R48 100*** Revision knee replacement — R60 800*** Total shoulder replacement — R56 100 Spinal benefit **** — **** Bare metal cardiac stents max. 3 **p.y. (each)** — ** Drug eluting cardiac stents **(each)** max. 3 **p.y.** — ** Pacemaker with Leads — R102 200 Pacemaker Biventricular — R131 600 Cardiac valves **(each)** — R68 400 Artificial eyes (prosthesis plus apparatus) — R37 300 Cochlear implants — Up to negotiated rates at cost - Bilateral implants - Unilateral implants All other internal prostheses and devices paid **per person** — * R31 600	Subject to pre-authorisation and the hospital risk management programme and the requirements prescribed for PMB`s. *Sub-limit may be increased, subject to approval of Remedi's Medical Advisory Committee. Include funding of temporary and permanent Sacral nerve stimulators, subject to clinical guidelines and protocols of Scheme. ** Negotiated reference price list is applicable. *** Hip and Knee Arthroplasty Procedures: The Scheme is contracted with Mediclinic as Designated Service Provider ("DSP") for these procedures. A R3 400.00 co-payment for voluntary non-DSP use will apply. The aforementioned co-payment will be waived for members who reside outside a thirty (30) kilometre radius from a DSP. ****With effect 1 January 2022, the Scheme adopted a Spinal Care Programme. Funding at network providers up to 100% of Remedi Rate/negotiated reference price and at non-network providers up to 80% of the Remedi Rate with effect from 1 January 2023. 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. 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.

	BENEFIT	RATE	LIMITS	COMMENT
16.	**External prostheses and appliances** (Including the external components of external prosthesis, incontinence products, etc.) 	100% of the Remedi Rate	Subject to Overall Annual Limit with following sub-limits: Colostomy equipment: R32 350 **per person per year** Hearing aids: R29 900 **per person per year** Wheelchairs: * R22 300 **per person per year** Oxygen appliances (Includes oxygen): R2 435 **per person per month** CGM Sensors **per person**: Up to **monthly agreed and set rates** at preferred providers Artificial limbs (below knee): R39 300 **per person per year** Artificial Limbs (above knee): R72 500 **per person per year** Insulin Pumps: Up to the OAL and provisions **as set out in the "Comment" column** prevails All other appliances, excluding Insulin Pumps: * R8 400 **per person per year**	Colostomy equipment can be obtained via Cancer Society. Oxygen benefit subject to registration for the use of oxygen on the Chronic Illness Benefit Programme managed by Discovery Health as contracted. Funding of Mirena contraceptive device payable from all other appliances, subject to pre-approval in line with Scheme clinical protocols and guidelines and provided inserted in gynaecologists' rooms. 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 a maximum of 10 of each per month **per person**, provided the member is registered on the diabetes management programme.

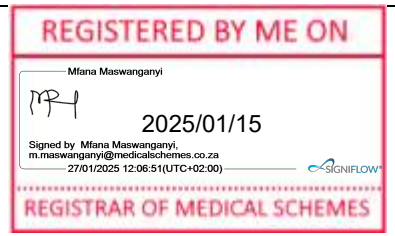
	BENEFIT	RATE	LIMITS	COMMENT
	External prostheses and appliances (continued) REGISTERED BY ME ON 2025/01/15 REGISTRAR OF MEDICAL SCHEMES			*Sub-limit may be increased, subject to approval of the Scheme's Medical Advisory Committee. CPAP devices funded from the "all other appliances" limit as available, where deemed clinically appropriate and limited to the agreed/negotiated rates with preferred providers. Point-of-care devices for point-of-care testing are funded from the "all other appliances" limit as available, where deemed clinically appropriate. With effect from 1 May 2021, Continuous Glucose 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.
17.	**Paramedical services** Ambulance	100% of the Remedi Rate	Subject to utilisation of Preferred Provider, viz. ER24 Emergency Response Service.	Transfers for same event subject to medical justification. Pre-authorisation required with Preferred Provider.
18.	**Psychiatric benefit** (Including the treatment of alcoholism and drug dependency. In hospital and in lieu of hospitalisation)	100% of the Remedi Rate	Subject to overall annual limit, limited to 21 days per year in hospital or 15 days, as well as one guided internet-based Cognitive Behavioural Treatment (iCBT) session in an out-of-hospital setting or a combination of in- and out-of-hospital as prescribed in terms of Prescribed Minimum Benefits.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted and the requirements prescribed for PMBs. Benefits may be granted for out-of-hospital consultations and/or treatment in lieu of hospitalisation only. Benefit may be increased, subject to approval of Remedi's Medical Advisory Committee.
19.	**Organ Transplants** (Including harvesting of organs, consultations/visits and post-operative anti-rejection medicines required by recipient)	PMB will be paid at 100% of Cost. Non-PMB is paid at 100% of the Remedi Rate	PMB unlimited at the DSP. Non-PMB will be subject to the Overall Annual Limit.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted. Provisions of Annexures **B** and **D** is applicable.
20.	**Renal Failure & Dialysis** (Including all services and materials associated with the cost of acute and chronic	100% of the Remedi Rate	Subject to Overall Annual Limit and the requirements prescribed for PMB`s	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted.

	BENEFIT	RATE	LIMITS	COMMENT
	renal dialysis including consultations/visits and medicine)			Provisions of Annexures **B** and **D** is applicable.
21.	**Other Health Care Services** Chinese medicine & acupuncture, therapeutic aromatherapy, Ayurveda, chiropody/podiatry, chiropractics (including x-rays), dietetics, homeopathy, iridology, naturopathy, orthoptics, osteopathy, therapeutic reflexology, therapeutic massage therapy, phytotherapy and traditional healing.	100% of cost	Payable from PMSA	Payment for costs for services rendered will be made on condition that the persons rendering such services are registered as practitioners by the professional body recognised under enabling statute e.g. The Allied Health Professions Act, Act 63 of 1982.
22.	**Overseas Treatment Benefit**	80% of cost	Subject to Overall Annual Limit and limited to R810 000 per year per person.	Conditions: To qualify the services must not be available or cannot be performed anywhere in South Africa, must be evidence-based medicine with sufficient peer-reviewed literature available to prove the treatment is clinically appropriate and indicated for the condition, must be provided by a suitable qualified and recognized medical healthcare professional and will require Scheme review to make sure the treatment meets the clinical criteria for funding.
23.	**International Second Opinion Services at Cleveland Clinic**	50% of cost	Subject to Overall Annual Limit.	**Subject to pre-authorisation** and pre-approval by the Scheme's contracted managed healthcare organization.
24.	**Personal Savings Account** a. *General practitioners b. *Medical specialists c. *Conservative dentistry d. Specialized dentistry e. *Prescribed acute medicine and injection material f. *Physiotherapy, speech therapy, and occupational therapy g. *Clinical psychologists h. *Social Workers i. Chiropractor, homeopath, osteopath, herbalist, naturopath or dietician j. *Eye tests, spectacles or contact lenses and refractory eye surgery k. *Radiology: Out of hospital (excluding MRI and CT scans) l. *Pathology: Out of hospital m. Medical costs in excess of the benefit amount under the Comprehensive Option	100% of cost	Annual benefit amount equals 10% of the total contribution payable to the Scheme.	* Initial benefit available from Comprehensive insured Benefit or OAL, as detailed above

	BENEFIT	RATE	LIMITS	COMMENT
	n. Condoms and preventive medication for malaria. Appliances other than the Mirena and emergency pill. o. *Contraceptives p. Immunisations, except *influenza and pneumococcal vaccines where clinically indicated, which is funded from the Prevention and Screening Benefit and Human Pappilomavirus ("HPV") vaccine which is funded from Prevention and Screening Benefit first q. *Chronic medicine registered on the Advanced Disease List ("ADL")			
25.	**Specialised Medication Benefit ("SMB")**	90% of Remedi Rate or 100% of Reference Price List	Cover up to R210 000 per person per year	**Subject to pre-authorisation** and pre-approval by the Scheme's contracted managed healthcare organisation. Specialised Medicine are funded per a defined list of the latest and most advanced clinically approved Specialised Medicine.
25.1	**Bariatric Surgery Benefit**	80% of Remedi Rate	Funded from the SMB benefit limit as set out in benefit rule 25	Subject to pre-authorisation and pre-approval by the Scheme's contracted managed healthcare organisation. A co-payment of R3 400 for failing to pre-authorise will apply.

GLOSSARY / EXPLANATORY NOTES:

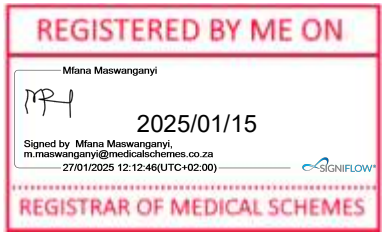
CDL	Chronic Disease List
DSP	A Designated Service Provider for the Prescribed Minimum Benefits - "PMBs" - selected by Remedi, being contracted private hospitals, Clicks Pharmacies and Dis-Chem Pharmacies, Discovery Health Pharmacy Network, as well as specialists contracted by Discovery Health under Direct Payment Arrangements, General Practitioners in the GP Network, Dental Risk Company (DRC) and Preferred Provider Negotiators (PPN) and the following providers for alcohol and drug dependency – The South African National Council on Alcohol and Drug Dependence (SANCA), SANCA's nominated providers and the Ramot Centre for Alcohol and Drug Dependency, as well as any other providers selected by Remedi from time to time
Direct Payment Arrangements "DPAs"	Are the specialist arrangements concluded between Discovery Health and specialist providers who agree to charge at or below a set rate for consultations and procedures and by reason thereof have also agreed that such rates shall be applicable to Remedi.
GP Network	The network of General Practitioners contracted to and through Discovery Health to provide relevant health care services to Remedi at the Remedi Rate
CDA	Chronic Drug Amount (CDA) is an amount of money that has been allocated for each medicine category each month for a specific condition.
M	Member without dependants
M+	Member plus dependants
Pb/py or Pp/py	per beneficiary per year or per person per year
Pf/py	per family per year
PMB/PMB`s	the Prescribed Minimum Benefit(s)
Pre-authorisation	the approval which has been given by the Scheme, or the Scheme`s contracted Managed Healthcare provider for relevant health services, as defined in the Act, to be provided to a beneficiary, in accordance with the protocols/treatment guidelines, accepted or determined by the Scheme.
Preferred Provider	a health care provider or group providers selected by the Scheme to provide diagnosis, treatment and care in respect of PMB or non-PMB conditions. For Chronic medicine any pharmacy charging not more than the SEP and the dispensing fee equal to that charged by the DSPs.
SAOA	South African Optometric Association
Remedi Rate	is the tariff fee / rate for the payment of relevant health services equal to the Discovery Health Rate / DH rate, as prescribed in the Guide to the Discovery Health Rate, or the fee / rate as determined by Board of Trustees in terms of any agreement between Remedi and any service provider or group of service providers
SEP	Single Exit Price
PMB Hospital Network	A Mediclinic hospital contracted to or nominated by the Scheme established for the provision of services that relates to Prescribed Minimum Benefit (PMB) conditions. See also DSP.
Mental Health Network	A defined list of Psychologists and/or Social Workers contracted or nominated by the Scheme for purposes of providing treatment to members relating to mental health conditions. See also DSP
In-Hospital GP Network	A defined list of GP and specialist authorised by the Scheme to provide in-hospital services to members as part of the Scheme's Premier Practice, Remedi Standard GP Network and Classic DPA Specialist Networks.
Hip and Knee Arthroplasty Network	Mediclinic Private Hospital Facilities as contracted for Designated Service Provider ("DSP") purposes
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 in full at MedXpress or any MedXpress Network Pharmacy, Medipost Pharmacy, Qestmed, Olsens Pharmacy, Dis-Chem's Oncology Courier Pharmacy or Southern Rx
Day Surgery Network (DSN)	A defined list of hospitals and facilities where day surgery procedures are available. Annexure **B4** has reference.



CLASSIC OPTION: BENEFITS 2025

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

	BENEFIT	RATE	LIMITS	COMMENT
1.	**Hospitalisation in private hospitals as well as surgery and medical procedures performed by private practitioners.** 	100% of the Remedi Rate	**Overall annual limit of:** R2 575 000 per family (M+) per year	Subject to the management of clinical risk by Discovery Health as contracted and use of defined DSP network of hospitals. **All non-emergency admissions are subject to pre-authorisation.** Emergencies must be authorised within 24 hours of admission or first working day after an emergency treatment or admission. A co-payment of R3 400 for failing to pre-authorise will apply. Wef 1 January 2023, Da Vinci Robotic Assisted Prostatectomy is funded at 90% of the Remedi Rate or negotiated hospital rates where prostate cancer confirmed by means of a histology report, regardless of whether the member is registered on the Oncology Management Programme. Limited to one procedure per person and must be pre-authorised.
	Hospital accommodation • Accommodation in a general ward, intensive care unit, high care unit, maternity ward, as well as theatre and recovery costs	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required**	Annexures **B** and **D** has reference. The Scheme may require that a member be transferred to a PMB Network Hospital if admitted into a non-DSP following an emergency admission.
	Surgery and medical procedures • Surgery and medical procedures, which generally, but not necessarily, require hospitalisation. • Confinements	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required.**	Benefits in respect of services for infertility, limited to the medical and surgical management of those procedures and interventions as defined under PMB Code 902M, subject to Regulation 8(3) of the Medical Schemes Act, Act No 131 of 1998.
	• Conservative dentistry under anaesthesia in patients not older than 7 years		Anaesthetics and hospitalisation subject to overall annual limit. **Note: dentist accounts are payable from available Insured Out-of-Hospital benefit**	Cosmetic surgery is a listed Scheme exclusion on Remedi.

	BENEFIT	RATE	LIMITS	COMMENT
	Hospital and surgical material/ equipment as per agreed list	100% of the Remedi Rate	Subject to overall annual limit **Pre-authorisation of admission required.**	Limits set in terms of charging policy for listed items, which may be agreed with DSP and other Providers. Benefit for medicines to take home (TTO`s), limited to 5 days.
	Blood transfusions, blood products and transport of blood	100% of the Remedi Rate	Subject to overall annual limit	
	In-hospital visits • General practitioners and specialists' visits during pre-authorised hospitalisation 	100% of the Remedi Rate	Subject to overall annual limit	For surgery, medical procedures and in-hospital visits/consultations Remedi will make payment in full directly to the DSP concerned. In such a case the Member will not be liable for any co-payment to be made to such DSP If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures **B** and **D** to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate. In-room procedures limited to a defined list of procedures as determined by the Scheme
	Readmission Prevention Benefit • Homecare by a healthcare provider and/or qualified nurse for patients considered at high risk of readmission, when discharged from acute care	100% of the Remedi Rate	Subject to overall annual limit	Basket of care as approved by Remedi
2.	**Hospitalisation in public hospitals as well as surgery and medical procedures performed by *public sector practitioners***	100% of Cost	Limited to Overall annual limit, subject to sub-limit of R 650 000 per family (M+) for treatment in public facilities. **For involuntary admissions to Hospitals outside of the PMB Hospital Network, no limits on Prescribed Minimum Benefits (PMB`s), as set out in the Medical Schemes Act;**	Subject to the management of clinical risk by Discovery Health as contracted. All non-emergency admissions **are subject to pre-authorisation.** Emergencies must be authorised within 24 hours of admission or on the first working day after such emergency treatment or admission.

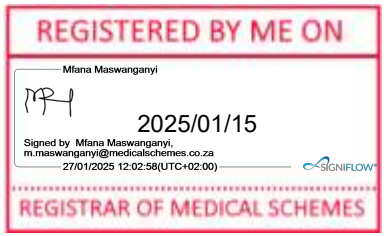
	BENEFIT	RATE	LIMITS	COMMENT
	Hospital accommodation • Accommodation in a general ward, intensive care unit, high care unit, maternity ward, as well as theatre and recovery costs	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required**	
	Surgery and medical procedures • Surgery and medical procedures, which generally, but not necessarily, require hospitalisation. • Confinements and antenatal consultations • Theatre fees and anaesthetics • Conservative dentistry under anaesthesia in patients not older than 7 years	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required.** Anaesthetics and hospitalisation subject to overall annual limit. Note: dentist accounts are payable from available Insured Out-of-hospital benefit	Benefits in respect of services for infertility, limited to the medical and surgical management of those procedures and interventions as defined under PMB Code 902M, subject to Regulation 8(3) of the Medical Schemes Act, Act No 131 of 1998. Cosmetic surgery is a listed Scheme exclusion on Remedi.
	Hospital and surgical material/equipment • As per agreed list	100% of Cost	Subject to overall annual limit **Pre-authorisation of admission required**	Benefit for medicines to take home (TTO`s), limited to 5 days.
	Blood transfusions, blood products and transport of blood	100% of Cost	Subject to overall annual limit	
	In-hospital visits • General practitioner and specialist visits during pre-authorised hospitalisation	100% of Cost	Subject to overall annual limit	
3.	**Chronic medication**			
	PMB Conditions	100% of Single Exit Price "SEP" plus a dispensing fee as agreed to with the defined DSP	Unlimited benefit, and further subject to a fixed drug list (formulary) Non-formulary drugs are funded up to the Chronic Drug Amount (CDA) for a registered drug class.	Benefits for the diagnosis, medical management and treatment of PMB CDL and DTP conditions – which shall not be less than those for the regulated Prescribed Minimum Benefits – shall subject to pre-authorisation be paid in accordance with the treatment protocols including clinical entry criteria and authorized "baskets of care" governing the Chronic Illness Benefit Programme and/or HIV/AIDS Programme, managed by Discovery Health as contracted, the managed health care provider appointed by Remedi.
	Non-PMB Conditions	100% of Single Exit Price "SEP" plus a dispensing fee as agreed to with the defined DSP	Subject to Overall Annual Limit a maximum of R2 200 per person per month based on individual needs.	Subject to registration on the Chronic Illness Benefit Programme managed by Discovery Health as the Managed Health Care Provider appointed by Remedi. Where chronic medication is obtained from a pharmacy other than a DSP a co-payment for any difference in

	BENEFIT	RATE	LIMITS	COMMENT
				dispensing fees and/or any related fees will be payable by the member directly to the pharmacy. Any such co-payment will not be refunded to the Member via any credit of the Member`s Personal Medical Savings Account.
4.	**Extended physiotherapy, occupational therapy, speech therapy and biokinetics** **Maintenance therapy (In and Out of hospital)** • Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a maintenance or conservative nature, based on an **approved and pre-authorised treatment plan typically preceded by a rehabilitation programme and/or arising from a congenital defect of a mental or physical nature.**	100% of the Remedi Rate	**Pre-authorisation required.** Subject to Overall Annual Limit with sub-limit: R16 500 per family (M+) per year	This specifically excludes treatment of an acute (minor) injury as determined by Remedi's Medical Advisory Committee.

<table>
<tr><th></th><th>BENEFIT</th><th>RATE</th><th>LIMITS</th><th>COMMENT</th></tr>
<tr><td></td><td>Rehabilitation therapy post hospitalisation
• Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a rehabilitative nature that is preceded by hospitalisation; such treatment must be connected to an approved rehabilitative treatment plan and must commence within two weeks of discharge from hospital.</td><td>100% of the Remedi Rate</td><td>Pre-authorisation required.
Subject to overall annual limit</td><td></td></tr>
<tr><td>5.</td><td>Trauma recovery extender benefit
Covering out of hospital treatment following a traumatic incident resulting in
• paraplegia, quadriplegia, tetraplegia and hemiplegia
• conditions resulting from near drowning, severe anaphylactic reaction, poisoning and crime related injuries;
• severe burns;
• certain external and internal head injuries and loss of limb, or part thereof.</td><td>100% of the Remedi Rate</td><td>Pre-authorisation required.
Subject to the overall annual limit and the following sub-limits:
<table><tr><td colspan="2">Loss of limb per family</td><td>R106 000</td></tr><tr><td colspan="2">Private nursing per person</td><td>R13 300</td></tr><tr><td>Prescribed medication:</td><td>Per Member</td><td>R17 100</td></tr><tr><td></td><td>Member + 1</td><td>R20 150</td></tr><tr><td></td><td>Member + 2</td><td>R24 000</td></tr><tr><td></td><td>Member + 3 or more</td><td>R29 000</td></tr><tr><td colspan="2">External medical items per person</td><td>R40 500</td></tr><tr><td colspan="2">Hearing Aids per person</td><td>R19 100</td></tr><tr><td colspan="2">Mental health benefit per person</td><td>R23 900</td></tr></table></td><td>For PMB conditions, mental health treatment to be obtained from a service provider contracted to the Scheme’s Mental Health Network</td></tr>
<tr><td>6.</td><td>Insured Out-of-hospital (“IOH”) benefit for:
Consultations, procedures, radiology (excluding MRI and CT scans) and pathology outside hospital, point-of-care testing as authorised, including in the outpatient department of a hospital and inclusive of the facility fee for outpatients.
• General Practitioners
• Acute and self-medication
• Basic and Specialised dentistry;
• Specialists, including funding for Virtual Physical Therapy (“VPT”) with effect from 1 July 2025 from IOH;</td><td>100% of the Remedi Rate
or
100% of cost at the Designated Service Provider (DSP)/ Medicine Rate</td><td>Subject to Overall Annual Limit and the following sub-limits:
Per Principal Member: R11 240
Per Adult Dependent: R6 630
Per Child Dependent: R1 870 (up to a maximum of 3 children)

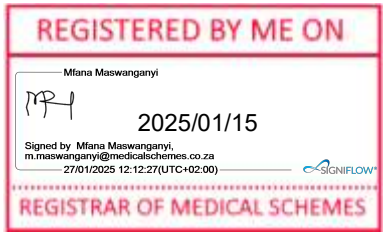
All out of hospital benefits will be limited to the above sub-limit after which benefit for costs relating to the diagnosis and medical management and treatment of Prescribed Minimum Benefit Chronic Disease List and Diagnosis and Treatment Pair, “DTP”, “CDL”,</td><td>Where the sub-limit is exceeded, benefits for non-PMB conditions to be paid by member.
.
Self-medication applies to medicines classified as Schedules 0, 1 and 2, which can be purchased over the counter without a doctor’s prescription.
Including consultation for insertion of Mirena contraceptive device in gynaecologist’s rooms, provided pre-approval obtained and subject to Scheme clinical protocols and guidelines.

Oral contraceptives are funded up to R200.00 per script per female beneficiary up to R2 800.00 per year payable from</td></tr>
</table>

	BENEFIT	RATE	LIMITS	COMMENT
	• Optical (including contact lenses) • Physiotherapists; • Biokineticists; • Occupational Therapists; • Speech Therapists • Audiologists and Audiometrists • Clinical Psychologists; • Social Workers; • Pathology and radiology (excluding MRI and CT scans) benefits; • Vacuum Assisted Breast Biopsy (VABB) 		conditions and HIV/AIDS, will be payable from risk subject to the conditions set out in the comments alongside. VABB per person is limited to two procedures per year at negotiated fees. With effect from 1 July 2025, Virtual Urgent Care ("VUC") consultations is funded up to 3 consultations per family (M+) per year at 100% of the Remedi Rate from the Overall Annual Limit ("OAL"), subject to the appropriate emergency consultation and procedure codes and can be accessed through a digital platform outside of the Scheme's DSP arrangements. Consultations more than the yearly limit of 3 VUC per family and/or the available maximum family limit per year will be payable by the member. Consultations not recognised as an emergency consultation will be paid from the available IOH benefit.	the from Overall Annual Limit ("OAL").). A co-payment of 20% is applicable if a member obtains oral contraceptives from a non-DSP pharmacy. Medicine rules to apply and script can only be renewed after 23 days from the last script issued. For members who are not high risk and who are < 65 years or who are not pregnant, one influenza vaccine per person per year is payable from the IOH limit. Influenza vaccines for high-risk members and members > 65 years and/or members who are pregnant are funded from the Prevention and Screening Benefit. Clinical entry criteria are applicable. Point-of-care pathology testing is subject to meeting the Scheme's treatment guidelines and Managed Health Care criteria. Members will receive benefit in accordance with authorized "baskets of care" regarding the diagnosis, medical management and treatment of such PMB CDL and DTP related chronic diseases. If not registered then benefits will be subject to the conditions set out in paragraph 10.3, 10.4 and 10.5 of Annexures **B** and **D** to the Rules. Remedi will make payment in full to a DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except as provided for in this benefit rule and except in the involuntary circumstances described in paragraph 10.4 read with 10.3 and/or 10.5 of Annexures **B** and **D** to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit of maximum 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate.
	Benefit for out-of-hospital management and appropriate supportive treatment of specific global World Health Organisation ("WHO") recognised disease outbreaks: - COVID-19	In addition to cover contained in Annexure **D** , up to a maximum of 100% of the Remedi Rate.	Subject to the Scheme's preferred provider (where applicable), protocols and the condition and treatment meeting the Scheme's entry criteria and guidelines.	PMB requirements and Council for Medical Schemes ("CMS") guidelines prevail.

	BENEFIT	RATE	LIMITS	COMMENT
	- Monkeypox (Mpox)		Basket of care as set by the Scheme per condition.	
7.	**Optical**		Members have the option of obtaining **Optical Benefits**, subject to the above sub-limits, for services rendered by PPN and non-PPN network providers on the following conditions. 1. An annual benefit cycle. 2. Per person limit of R3 975 subject to overall family limit of R7 950 3. The following sub-limits will apply within the overall per person/family limit: Consultations A composite consultation inclusive of refraction, a glaucoma screening, vision field screening and Artificial Intelligence for the detection of diabetic retinopathy at 100% of cost for a PPN contracted network provider and up to R400 for a non-PPN network provider; <u>*and either Spectacles*</u> Frame Limit/Lens enhancements R1 350 toward the cost of a frame and/or Lens enhancements at a PPN provider per person per year. At a non PPN provider R1 350 towards a frame and/or lens enhancement per person is funded towards spectacles subject to the annual overall family limit <u>Clear lens Limit</u>: Single, Bifocal or base Multifocal lenses are funded at a PPN provider and non PPN provider as follows: • Single Vision lenses at R215 per lens; • Bifocal lenses at R460 per lens; or • Multifocal lenses at R810 per lens. • An additional R50 per lens for Branded Multifocal lenses in addition to the R810 per lens limit	The following further conditions apply to the obtaining of any optical benefits. • Payment of any claim is subject to available benefits irrespective of confirmation the Member or provider. • The spectacle lenses and contact lenses must be prescribed by an optometrist or a medical practitioner who is registered with the Health Professions Council of South Africa, to improve the patient`s visual acuity. • The contact lenses must be prescribed and dispensed by an optometrist or a medical practitioner who is registered with the Health Professions Council of South Africa, to improve the patient`s visual acuity. • Clinical Rules: Scripts less than 0.50 diopter will not be covered; No bifocal or multifocal lenses will be considered for payment for children under the age of 18. • Claims for the following conditions will only be considered for payment when motivated and approved by the PPN motivations committee: bifocals/multifocals for beneficiaries under the age of 40; Contact lenses for children under the age of 18; Composite consultations for children under the age of 5; Vertical prism less than 1 Diopter. • All clinical/prescribed information must be submitted on all claims to ensure payment. • Co-payments may be applicable on services obtained from non-preferred provider optometrists. • All claims must be submitted to PPN for adjudication and payment of benefits. • Member refunds may be applicable on services obtained from non-preferred provider optometrists without an agreement for direct payment. • Members can obtain either spectacles or contact lenses within a benefit cycle not both.

	BENEFIT	RATE	LIMITS	COMMENT
			Or Contact Lenses Contact lenses limited to the value of R2 425.	
	Refractive eye surgery Members with severely restricted vision (Including Corneal Cross Linking)	100% of the Remedi Rate	Annual sub-limit of R31 800 per person	Pre-authorisation in accordance with approved clinical protocols is required. Where pre-authorisation is not obtained, no benefits will apply.
8.	**Maternity** Limited pregnancy scans antenatal consultations and a specified range of pathology tests 	100% of the Remedi Rate	Subject to Overall Annual Limit and the requirements prescribed for PMBs the maternity benefit/basket of care includes: - 2 x 2D pregnancy scans; - 9 GP consultations at a Network GP, Midwife or Gynaecologist; - 9 x urine dipstick tests; - 2 x glucose strip tests; - HIV Elisa, Rubella, RPR and TPHA and bHCG tests as deemed clinically appropriate; - RH antigen, Haemoglobin, A B and O antigens as deemed clinically appropriate; - 1 x Nuchal Translucency (NT) and/or Non-Invasive Prenatal Test (NIPT) and T21 screening per pregnancy	The benefit allows for a defined range of services including the first two 2D ultrasound scans in gynecologists' rooms. Medical motivation is required for additional scans. NT and/or NIPT and T21 screening (Down Syndrome Screening Tests) to be made available in addition to available ultrasound scans. Clinical entry criteria will be applicable
9.	**Oncology** Consultations, visits, treatment, medication and materials used in radiotherapy and chemotherapy, including PET-CT scans if pre-authorised	Funded at the Scheme's Designated Service Providers ("DSP") up to a maximum of 100% of the Remedi Rate/Medicine Rate/ Therapeutic Remedi Reference Price List ("TRP"/"RPL"), as may be applicable and up to R410 000 per person plus a	Subject to overall annual limit and R410 000 per person at 100% of the Remedi Rate and a further R265 000 per person at 80% of the Remedi Rate, limited to an overall Oncology annual limit of R675 000 per person per year over a 12-month rolling period from date of diagnosis. Benefit subject to the requirements prescribed for PMB`s	Subject to pre-authorisation, an approved all-inclusive treatment plan and to the management of clinical risk by Discovery Health as contracted and where applicable. A co-payment of R3 400 is payable for PET-CT scans if not pre-authorised and services are not obtained at a designated service provider. Medication is funded up to 100% of the Medicine Rate/TRP/RPL as may be applicable and dispensed from

	BENEFIT	RATE	LIMITS	COMMENT
		further R265 000 per person at 80% of Remedi Rate/Medicine Rate/TRP/RPL, as may be applicable, for non-PMB treatment where OAL or thresholds are reached. PMB treatment is funded at 100% of Cost/Remedi Rate/ Medicine Rate/TRP/RPL, as may be applicable. The provisions as set out in Annexure **D** is applicable. .		the Scheme's Oncology Pharmacy Designated Service Providers as referenced in the **Glossary** of this Annexure. Sub-limit may be increased, subject to approval of the Remedi's Medical Advisory Committee, where non-PMB level of care and will be increased automatically where PMB level of care and clinically appropriate. To read Annexures **D** and **E** in conjunction with this Rule. The provisions in terms of obtaining medicines through the Remedi DSP oncology pharmacy network prevails.
10.	**Frail care and private nursing** **Sub-Acute facilities**	100% of the Remedi Rate 100% of the Remedi Rate	Unless PMB, subject to the overall annual limit with a sub-limit of R46 600 per family. **Subject to pre-authorisation.** Unlimited Subject to overall annual limit **Subject to pre-authorisation**	Subject to hospital risk management programme, prior approval of Remedi and only available as an alternative to hospitalisation. Sub-limit may be increased, subject to approval of Remedi's Medical Advisory Committee. **Where pre-authorisation is not obtained, no benefits will apply.** **Advanced Illness Benefit ("AIB") provided through the Advanced Illness Benefit Management Programme ("AIBMP") is available upon application and where pre-approved.**
11.	**Radiology and pathology** • Radiology: In hospital • Pathology: In hospital • MRI and CT scans in and out of hospital	100% of the Remedi Rate	Subject to overall annual limit and benefit confirmation for **MRI and CT scans.**	Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures **B** and **D** to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; **may be required to make co-payments to such provider for fees charged above the Remedi Rate.**

	BENEFIT	RATE	LIMITS	COMMENT
12.	**Prevention and Screening benefit** Including blood glucose, blood pressure, cholesterol and body mass index screening tests HIV, mammogram, pap smear, prostate specific antigen (PSA) test and, influenza vaccine for identified high risk members, members who are pregnant and members above the age of 65. Pneumococcal in line with latest clinical guidelines. One (1) preventative dental examination per person per year, including the oral examination, infection control, prophylaxis, polishing and fluoride of adults and children. Human Papillomavirus (HPV) vaccine for males between the ages of 11 and 21 and females between the ages of 11 and 26 years. HPV screening tests are limited to 1 x every 5 years if the member is HIV negative and one test every 3 years if the members is HIV positive. These tests are an alternative to pap smears.	100% of the Remedi Rate	Subject to Overall Annual Limit	Remedi will make payment in full, subject to the applicable limit, to a specialist DSP providing relevant health care services to a Member without such Member being liable to make any co-payment to such DSP. If such services are provided to a Member who chooses to use a non-DSP, except in the involuntary circumstances described in 10.4 read with 10.3 and/or 10.5 of Annexures **B** and **D** to the Rules, then such Member • will be liable to pay the provider; • will receive a benefit limited to 100% of the Remedi Rate; • may be required to make co-payments to such provider for fees charged above the Remedi Rate. If the member has more than 1 HPV screening test before the 5 years' period expires, if HIV negative (or before the 3 years' period expires, if HIV positive) then: • the second and sub-sequent claims during that period will be paid from the member's day-to-day acute medicine benefit, if benefits are available and where the result of the screening test is abnormal or after treatment the follow-up tests will be funded yearly until normal.
	One LDL cholesterol screening is available per high-risk beneficiary where clinically indicated at network pharmacy. HbA1c is funded from the Insured Out of Hospital benefit, where clinically appropriate. A group of age-appropriate screening tests and additional screening assessments for members 65 years and older (Senior Screening Tests). Colorectal screening limited to one fecal occult blood test or immunochemical test every 2 years per person for persons between the ages of 45 to 75 years. One colonoscopy where clinically appropriate			If the member has more than 1 HPV screening tests during the year after an abnormal HPV test result, the second and sub-sequent claims during that year will be paid from the member's day-to-day acute medicine benefit, if benefits are available.

	BENEFIT	RATE	LIMITS	COMMENT
13.	**Internal prostheses and devices** 	100% of the Remedi Rate	Subject to the Overall Annual Limit with following yearly sub-limits **per person**, unless otherwise stated: Total hip replacement: R52 300 Revision hip: R61 800 Knee replacement: R41 000 Revision knee replacement: R52 300 Total shoulder replacement: R48 100 Spinal benefit ****: **** Bare metal cardiac stents max. 3 **p.y. (each)**: ** Drug eluting cardiac stents **(each)** max. 3 **p.y.**: ** Pacemaker with Leads: R86 500 Pacemaker Biventricular: R111 500 Cardiac valves **(each)**: R57 900 Artificial eyes (prosthesis plus apparatus): R31 600 All other internal prostheses and devices **paid per person**, excluding cochlear implants: R27 300	Subject to pre-authorisation and the hospital risk management programme and the requirements prescribed for PMB`s. *Sub-limit may be increased, subject to approval of Remedi's Medical Advisory Committee. Funding of temporary and permanent Sacral nerve stimulators is specifically excluded. ** Negotiated reference price list is applicable. *** Hip and Knee Arthroplasty Procedures: The Scheme is contracted with Mediclinic as Designated Service Provider ("DSP") for these procedures. A R3 400.00 co-payment for voluntary non-DSP use will apply. The aforementioned co-payment will be waived for members who reside outside a thirty (30) kilometre radius from a DSP. ****With effect 1 January 2022, the Scheme adopted a Spinal Care Programme. Funding at network providers up to 100% of Remedi Rate/negotiated reference price and at non-network providers up to 80% of the Remedi Rate with effect from 1 January 2023.

	BENEFIT	RATE	LIMITS	COMMENT
14.	**External prostheses and appliances** (Including the external components of external prosthesis, incontinence products, etc.)	100% of the Remedi Rate	Subject to Overall Annual Limit with following sub-limits: Colostomy equipment: R32 350 **per person per year** Hearing aids: R29 900 **per person per year** Wheelchairs: R18 700 **per person per year** Oxygen appliances (Includes oxygen): R2 435 **per person per month** CGM Sensors **per person**: Up to **monthly agreed and set rates** at preferred providers Artificial limbs (below knee): R33 800 **per person per year** Artificial Limbs (above knee): R61 800 **per person per year** All other appliances, excluding Insulin Pumps: * R7 050 **per person per year**	Colostomy equipment can be obtained via Cancer Society. Oxygen benefit subject to registration for the use of oxygen on the Chronic Illness Benefit Programme managed by Discovery Health as contracted. Funding of Mirena contraceptive device payable from all other appliances, subject to pre-approval in line with Scheme clinical protocols and guidelines and provided inserted in gynaecologists' rooms. *Sub-limit may be increased, subject to approval of the Scheme's Medical Advisory Committee. CPAP devices funded from the "all other appliances" limit as available, where deemed clinically appropriate and limited to the agreed/negotiated rates with preferred providers.
	External prostheses and appliances (continued)	75% of the Remedi Rate for funding of CGM Sensor and 100% of the Remedi Rate for funding of the transmitters and readers		Point-of-care devices for point-of-care testing are funded from the "all other appliances" limit as available, where deemed clinically appropriate. With effect from 1 May 2021, Continuous Glucose Sensors which is part of the Scheme's Continuous Glucose Monitors ("CGM") benefit ("CGM"), 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 **at 100% of the Remedi Rate** and thereafter from the member's own pocket.
15.	**Paramedical services** Ambulance	100% of the Remedi Rate	Subject to utilisation of Preferred Provider, viz. ER24 Emergency Response Service.	Transfers for same event subject to medical justification. Pre-authorisation required with Preferred Provider. .

	BENEFIT	RATE	LIMITS	COMMENT
16.	**Psychiatric benefit** (Including the treatment of alcoholism and drug dependency. In hospital and in lieu of hospitalisation)	100% of the Remedi Rate	Subject to overall annual limit, limited to 21 days per year in hospital or 15 days, as well as one guided internet-based Cognitive Behavioural Treatment (iCBT) session in an out-of-hospital setting or a combination of in- and out-of-hospital as prescribed in terms of Prescribed Minimum Benefits.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted and the requirements prescribed for PMBs. Benefits may be granted for out-of-hospital consultations and/or treatment in lieu of hospitalisation only. Services and treatment for PMB conditions to be obtained from a DSP (Mental Health Network provider) contracted with the Scheme and funding per Annexure **D** will be applicable. Benefit may be increased, subject to approval of Remedi's Medical Advisory Committee.
17.	**Organ Transplants** (Including harvesting of organs, consultations/visits and post-operative anti-rejection medicines required by recipient)	PMB will be paid at 100% of Cost. Non-PMB is paid at 100% of the Remedi Rate	PMB unlimited at the DSP. Non-PMB will be subject to the Overall Annual Limit.	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted. Provisions of Annexures **B** and **D** is applicable.
18.	**Renal Failure & Dialysis** (Including all services and materials associated with the cost of acute and chronic renal dialysis including consultations/visits and medicine)	100% of the Remedi Rate	Subject to Overall Annual Limit and the requirements prescribed for PMB`s	**Subject to pre-authorisation** and the management of clinical risk by Discovery Health as contracted. Provisions of Annexures **B** and **D** is applicable.
19.	**Other Health Care Services** Chinese medicine & acupuncture, therapeutic aromatherapy, ayurveda, chiropody/podiatry, chiropractics (including x-rays), dietetics, homeopathy, iridology, naturopathy, orthoptics, osteopathy, therapeutic reflexology, therapeutic massage therapy, phytotherapy and traditional healing		Nil Benefit	

GLOSSARY / EXPLANATORY NOTES:

CDL	Chronic Disease List
DSP	A Designated Service Provider for the Prescribed Minimum Benefits - "PMBs" - selected by Remedi, being the contracted private hospitals, Clicks Pharmacies and Dis-Chem Pharmacies, Discovery Health Pharmacy Network, as well as specialists contracted by Discovery Health under Direct Payment Arrangements, General Practitioners in the GP Network, Dental Risk Company (DRC), Preferred Provider Negotiators (PPN) and the following providers for alcohol and drug dependency – The South African National Council on Alcohol and Drug Dependence (SANCA), SANCA's nominated providers and the Ramot Centre for Alcohol and Drug Dependency, as well as any other providers selected by Remedi from time to time
Direct Payment Arrangements "DPAs"	Are the specialist arrangements concluded between Discovery Health and specialist providers who agree to charge at or below a set rate for consultations and procedures and by reason thereof have also agreed that such rates shall be applicable to Remedi.
GP Network	The network of General Practitioners contracted to and through Discovery Health to provide relevant health care services to Remedi at the Remedi Rate
CDA	Chronic Drug Amount (CDA) is an amount of money that has been allocated for each medicine category each month for a specific condition.
M	Member without dependants
M+	Member plus dependants
Pb/py or Pp/py	per beneficiary per year or per person per year
Pf/py	per family per year
PMB/PMB`s	the Prescribed Minimum Benefit(s)
Pre-authorisation	the approval which has been given by the Scheme, or the Scheme`s contracted Managed Healthcare provider for relevant health services, as defined in the Act, to be provided to a beneficiary, in accordance with the protocols/treatment guidelines, accepted or determined by the Scheme.
Preferred Provider	a health care provider or group providers selected by the Scheme to provide diagnosis, treatment and care in respect of PMB or non-PMB conditions. For Chronic medicine any pharmacy charging not more than the SEP and the dispensing fee equal to that charged by the DSPs.
SAOA	South African Optometric Association
Remedi Rate	is the tariff fee / rate for the payment of relevant health services equal to the Discovery Health Rate / DH rate, as prescribed in the Guide to the Discovery Health Rate, or the fee / rate as determined by Board of Trustees in terms of any agreement between Remedi and any service provider or group of service providers
SEP	Single Exit Price
PMB Hospital Network	A Mediclinic hospital contracted to or nominated by the Scheme established for the provision of services that relates to Prescribed Minimum Benefit (PMB) conditions. See also DSP.
Mental Health Network	A defined list of Psychologists and/or Social Workers contracted or nominated by the Scheme for purposes of providing treatment to members relating to mental health conditions. See also DSP
In-Hospital GP Network	A defined list of GP and specialist authorised by the Scheme to provide in-hospital services to members as part of the Scheme's Premier Practice, Remedi Standard GP Network and Classic DPA Specialist Networks.
Hip and Knee Arthroplasty Network	Mediclinic Private Hospital Facilities as contracted for Designated Service Provider ("DSP") purposes
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 in full at MedXpress or any MedXpress Network Pharmacy, Medipost Pharmacy, Qestmed, Olsens Pharmacy,Dis-Chem's Oncology Courier Pharmacy or Southern Rx
Day Surgery Network (DSN)	A defined list of hospitals and facilities where day surgery procedures are available. Annexure **B4** has reference.

REMEDI MEDICAL AID SCHEME

ANNEXURE B4: Remedi Comprehensive, Classic and Standard benefit options Day Surgery Network Procedures Effective 1 January 2025

Save for Prescribed Minimum Benefit entitlement, a list of day surgery procedures is covered in the day surgery facilities. These healthcare services will be covered in terms of Annexures **B, B1, B2** and **B3** under the Remedi Standard, Classic and Comprehensive benefit options. A deductible amount of R7 000.00 shall be payable by the beneficiary in respect of the hospital account for elective admissions at a facility which is not in the network. A clinical exceptions process applies to all cases with complex presentations and those procedures that may require an extended length of stay. Members will be transferred to the appropriate facility where required.

The list of procedures follows:

1. Ear, Nose and Throat Procedures
   - Tonsillectomy and/or adenoidectomy
   - Repair nasal turbinates, nasal septum
   - Simple procedures for nosebleed (extensive cautery)
   - Sinus lavage
   - Scopes (nasal endoscopy, laryngoscopy)
   - Middle ear procedures (tympanoplasty, mastoidectomy, myringoplasty, myringotomy and/or grommets)

2. Gastrointestinal Procedures
   - Gastrointestinal scopes (oesophagoscopy, gastroscopy, colonoscopy, sigmoidoscopy, proctoscopy, anoscopy)
   - Anorectal procedures (treatment of haemorrhoids, fissure, fistula)

3. Urological Procedures
   - Cystoscopy
   - Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocoele vasectomy)

4. Orthopaedic Procedures
   - Arthroscopy, arthrotomy (shoulder, elbow, knee, ankle, hand, wrist, foot, temporomandibular joint), arthrodesis (hand, wrist, foot)
   - Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty)
   - Tendon and/or ligament repair, muscle debridement, fascia procedures (tenotomy, tenodesis, tenolysis, repair/reconstruction, capsulotomy, capsulectomy, synovectomy, excision tendon sheath lesion, fasciotomy, fasciectomy). Subject to individual case review.
   - Repair bunion or toe deformity
   - Treatment of simple closed fractures and/or dislocations, removal of pins and plates. Subject to individual case review

5. Gynaecological Procedures
   - Diagnostic Dilatation and Curettage
   - Endometrial ablation
   - Diagnostic Hysteroscopy
   - Colposcopy with LLETZ
   - Examination under anaesthesia
   - Diagnostic laparoscopy
   - Simple vulval and introitus procedures: Simple hymenotomo, partial hymenectomy, simple vulvectomy, excision bartholin's gland cyst
   - Vaginal, cervix and oviduct procedures: Excision vaginal septum, cyst or tumour, tubal ligation or occlusion, uterine cervix cerclage, removal cerclage suture
   - Suction curettage
   - Uterine evacuation and curettage
6. Eye Procedures
   - Corneal transplant
   - Cataract surgery
   - Treatment of glaucoma
   - Other eye procedures (removal of foreign body, conjunctival surgery (repair laceration, pterygium), glaucoma surgery, probing & repair of tear ducts, vitrectomy, retinal surgery, eyelid surgery, strabismus repair)
7. Ganglionectomy
8. Simple superficial lymphadenectomy
9. Approved Breast Procedures
   - Mastectomy for gynaecomastia
   - Lumpectomy (fibroadenoma)
10. Skin Procedures
    - Debridement
    - Removal of lesions (dependent on site and diameter)
    - Simple repair of superficial wounds
11. Biopsies: skin, subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes
12. Removal of foreign body (subcutaneous tissue, muscle, external auditory canal under general anaesthesia)
13. Hernia Procedures
    - Umbilical hernia repair
    - Inguinal hernia repair
14. Nerve Procedures
    - Neuroplasty median nerve, ulnar nerve, digital nerve of hand or foot, brachial plexus

ANNEXURE C

REMEDI MEDICAL AID SCHEME

EXCLUSIONS AND LIMITATIONS

APPLICABLE TO ALL BENEFIT OPTIONS

EXCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

1.7 Holidays for recuperative purposes.

1.8 Purchase of:

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

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

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

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

1.12 Costs for services rendered by –

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

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

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

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

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

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

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

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

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

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

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

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

2 LIMITATIONS

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

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

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

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

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REGISTERED BY ME ON
Mashilo Leboho
24/12/2021 21:22:58 (UTC+02:00)
Signed by Mashilo Leboho,
m.leboho@medicalschemes.co.za
REGISTRAR OF MEDICAL SCHEMES

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2025

PREAMBLE

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

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

- SANCA, RAMOT or Nishtara for drug and alcohol, detoxification and rehabilitation;
- Remedi Standard Option GP Network;
- Classic Direct Specialist Direct Payment Arrangements;
- Premier Specialist/GP Direct Payment Arrangements;
- KeyCare Specialist Direct Payment Arrangements;
- A list of pharmacies that entered into preferred provider arrangements with the Scheme (See Annexure **B**);
- Optical Network (Preferred Provider Negotiators – PPN);
- A list of private hospitals that entered into tariff arrangements with the Scheme;
- Dental management through the Dental Risk Company as a preferred provider for members on the Standard Option;
- ER24 as a preferred provider for emergency services;
- A list of hospitals to obtain services for Prescribed Minimum Benefits known as the PMB Hospital Network;
- An In-hospital GP and Specialist Network for services related to PMB;
- A Mental Health Network to obtain out-of-hospital services from a list of Psychiatrists and Social Workers who has entered into a preferred provider arrangement with the Scheme.
- A defined list of hospitals and facilities where day surgeries are available, known as the Day Surgery Network. Annexure **B4** has reference.

A Beneficiary will be deemed to have involuntarily obtained a service from a provider other than the abovementioned contracted network providers or DSP, if -

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

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

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

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

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

b) a Beneficiary voluntarily does not use the DSP.

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2025

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

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2025

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

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2025

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

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2025

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

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2025

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

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2025

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

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2025

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

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2025

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

Notes:

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

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

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

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

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

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

Annexure D
Remedi Medical Aid Scheme cover for Prescribed Minimum Benefits: 2025

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

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

9. In accordance with what is stated in the Scheme's main body of the rules, the Beneficiary must authorise all voluntary DTPMB hospital admissions, which admissions include, but are not limited to, Mental Illness admissions, HIV and Oncology admissions, within 48 hours of the required elective procedure/treatment. Failure to so will entitle the Scheme to apply a co-payment of R3 400.

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

REMEDI MEDICAL AID SCHEME
ANNEXURE E: Oncology Management Programme – 1 January 2025

1. In this Annexure, the following definitions apply:

1.1. **"SAOC"** means the South African Oncology Consortium Limited.

1.2. **"ICON"** means the Independent Clinical Oncology Network.

1.3. Remedi Medical Aid Scheme Oncology Basket of Care, Supportive Formulary and Protocols in respect of Prescribed Minimum Benefits means the Scheme's Baskets of Care, Formularies, preferred product list and protocols and the treatment regimens and Baskets of Care for supportive requirements –

1.3.1. as may be provided in a state/public health facility as contemplated in the Regulations; or

1.3.2. defined as treatment included as Tier 1 (**Standard, Classic and Comprehensive Options for Prescribed Minimum Benefit level of care**), Tier 2 and Tier 3 (**Classic and Comprehensive Options only for non-Prescribed Minimum Benefit level of care**) in the SAOC treatment guidelines or as essential level of care in the ICON protocols, subject to such exclusions or exceptions as may be determined by the Scheme in accordance with principles of cost-effectiveness, affordability and evidence-based medicine.

1.4. Treatment in respect of non-Prescribed Minimum Benefit includes the Scheme Oncology Baskets of Care, Formularies, preferred product list and protocols, as well as treatment regimens as outlined in the SAOC or ICON guidelines. Treatment regimens defined by SAOC or ICON are subject to such exclusions/exceptions as may be determined by the Scheme in accordance with principles of cost-effectiveness, affordability and evidence-based medicine.

2. REJECTED Registration is a prerequisite to accessing the Oncology Programme and benefits will commence on registration. If the member does not register on the programme, cover will be subject to the member's available day-to-day benefits.

3. REJECTED Any oncology-related episode (i.e. investigation and/or treatment) must be authorised and/or approved at least 48 hours prior to performing such investigation, or receiving such treatment. Failure to authorise in this manner may result in the application of a non-notification penalty equal to R3 400.00 of the total cost of the requested investigation or treatment plan.

4. REJECTED The Oncology baskets of care apply only in respect of and during the course of an active oncology episode.

5. Scope of Cover in respect of the **Standard Option** is limited to Prescribed Minimum Benefits and/or treatment within the available ICON Network. Annexure **D** has reference and claims in respect of any health service relating to an oncology episode rendered at a "in-hospital" setting shall be processed as set out in Annexure **B1**.

6. Scope of Cover in respect of the **Classic** and **Comprehensive Options** includes cover in respect of Prescribed Minimum Benefits and/or treatment within the available ICON Network. Annexure **D** has reference and claims in respect of any health service relating to an oncology episode rendered at a "in hospital" setting shall be processed as et out in Annexures **B2** or **B3**, depending on the benefit option the member is registered on.

7. Non-Prescribed Minimum Benefit (non-PMB) cover includes, benefits in respect of fees charged for chemotherapy (including facility fees), radiotherapy (including but not limited to technical and professional fees, technical planning scans, internal radiotherapy, stereotactic radiation, embolisation or chemo-embolisation), and treatment contemplated as set out in Annexures **B2** or **B3**, depending on the benefit option the member is registered on.

8. Basis of cover includes access to SAOC Tier 2 and Tier 3 treatment regimes or agreed treatment guidelines and/or protocols approved by the Scheme for members registered on the **Classic** or **Comprehensive Options**.

9. Inclusion of chemotherapy, radiotherapy, and other health care services fundable from the Oncology Management Programme will be subject to consideration of evidence-based medicine, cost-effectiveness and affordability. Health care services that are deemed by the Scheme as unaffordable and/or not cost-effective and/or lacking clinical evidence to demonstrate efficacy are excluded from cover.

10. Access to the benefit is subject to:

REJECTED

- Scheme authorisation and/or approval 48 hours before planned treatment.
- Scheme's PMB and non-PMB oncology baskets of care, formularies and/or protocols.
- Meeting Clinical Entry Criteria as specified or adopted by the Scheme.
- Peer-review by an external panel of specialists, as necessary and appropriate.
- Generic substitution and substitution or switching to a cost-effective therapeutic equivalents (drug utilisation review) and dispensed through a designated service provider.

11. Members registered on the **Comprehensive Option** oncology management programme has access to cover for a defined list of non-PMB novel and ultra-high-cost treatment and access to these medicines are managed as part of the Oncology Innovation Benefit ("OIB") and are subject to meeting clinical criteria as specified or adopted by the Scheme and peer-review as may be deemed necessary and appropriate. Treatment will be subject to the benefits as contemplated in Annexure **B2** and granted at 75% of the Scheme Rate or Therapeutic Reference Price ("TRP"), whichever is applicable. Members have access to a 25% co-payment support programme, where approved and authorised. As part of OIB, the Oncology Precision Benefit ("OPB") is available to members registered on the Comprehensive Option oncology management programme to allow funding for Next Generation Sequencing ("NGS"), a pathology test that identifies cancer genomic drivers. Funding for NGS Is paid from the Scheme's hospital benefit.

ANNEXURE E(a)
REMEDI ONCOLOGY MANAGEMENT AND TREATMENT PROGRAMME – 2025

This Annexure E (a) must be read in conjunction with Annexures E (b), B1, B2, B3 and D.

1. In this Annexure E, the following definitions apply:

1.1. **"SAOC"** means the South African Oncology Consortium Limited.

1.2. **"ICON"** means the Independent Clinical Oncology Network.

1.3. **"Remedi Medical Aid Scheme Oncology treatment guidelines in respect of benefit cover"**

1.3.1. **"Tier 1"** means 'Primary Level of Care' in the SAOC treatment guidelines, the 'Essential Level of Care' in the ICON protocols, or the corresponding treatment guideline or protocol of any other oncology network appointed by the Scheme.

1.3.2. **"Tier 2"** means 'Standard Level of Care' in the SAOC treatment guidelines, the 'Core Level of Care' in the ICON protocols or the corresponding treatment guideline or protocol of any other oncology network appointed by the Scheme.

1.3.3. **"Tier 3"** means 'Novel Treatment' in the SAOC treatment guidelines, the 'Enhanced Level of Care' in the ICON protocols or the corresponding treatment guideline or protocol of any other oncology network appointed by the Scheme.

1.4. **"Remedi Medical Aid Scheme Oncology Basket of Care, Supportive Formulary and Protocols in respect of Prescribed Minimum Benefits"** means the Scheme's Baskets of Care, Formularies, Preferred product list and Protocols and the treatment regimens and baskets of care for supportive requirements –

1.4.1. as may be provided in a state/public health facility as contemplated in the Regulations; or

1.4.2. defined as Tier 1 treatment, subject to such exclusions or exceptions as may be determined by the Scheme in accordance with principles of cost-effectiveness, affordability and evidence-based medicine.

1.5. **"Treatment in respect of non-Prescribed Minimum Benefit"** means Remedi Oncology Baskets of Care, Formularies, Preferred product list and Protocols as well as treatment regimens considered as Tier 2 or Tier 3 treatment, subject to such exclusions/exceptions as may be determined by

the Scheme in accordance with principles of cost-effectiveness, affordability and evidence-based medicine.

2. Scope of Cover is specified in the supporting Annexure.

3. Scope of Cover in respect of the **Standard Option** is limited to Prescribed Minimum Benefits or treatment within the Scheme's designated service provider (DSP) network.

4. Scope of Cover in respect of the **Classic and Comprehensive Options** is limited to Prescribed Minimum Benefits and treatment offered in the contracted or designated service provider (DSP) networks.

5. Registration is a prerequisite to accessing the basket of care of benefits available through the Oncology Programme and the enhanced basket of benefits will become available upon registration. If the member does not register on the programme, cover will be subject to the member's chosen available day-to-day benefits. The provisions of Prescribed Minimum Benefits as set out in **Annexure D** prevails.

Rejected

6. Any oncology-related episode (i.e. investigation and/or treatment) must be authorised and/or approved at least 48 hours prior to performing such investigation, or receiving such treatment. Failure to authorise in this manner may result in the application of a non-notification penalty equal to R3 400.

Rejected

7. The Oncology baskets of care apply only in respect of and during the course of an active oncology episode.

Rejected

8. In respect of all non-Prescribed Minimum Benefit Cover claims, and except for medicines covered as per the Oncology Innovation Benefit ("OIB") provisions as set out in Annexure E (b), claims will be paid at 80% of the Remedi Rate after the oncology benefit limit of the chosen benefit option has been reached. The oncology benefit limit to be reached are –

8.1. Comprehensive Option – R490 000 per 12 month rolling period per person
8.2. Classic Option – R410 000 per 12 month rolling period per person

9. In respect of any given 12-month period from the date of registration onto the Oncology Programme ("12-month cycle"), the oncology benefit limit becomes applicable as soon as the limit has been reached in respect of that 12-month cycle.

10. Claims in respect of any health service relating to an oncology episode rendered at an "in-hospital" setting shall be processed in line with the benefit rules set out in **Annexures B1, B2 and B3**.

Remedi Oncology Management and Treatment Programme - 2025

Prescribed Minimum Benefit (PMB) Cover: Applicable to all benefit options

Health Care Services Covered	Basis of Cover	Limits/Thresholds
Statutory Prescribed Minimum Benefits	As specified in **Annexure D**.	
	As per Remedi Medical Aid Scheme's oncology baskets of care, formularies and/or protocols for Prescribed Minimum Benefits. Inclusion of chemotherapy, radiotherapy, and other health care services fundable from the Oncology Management andTreatment Programme will be subject to consideration of evidence-based medicine, cost-effectiveness and affordability.	• Unlimited
	Access to the benefit is subject to: • Authorisation and/or approval 48 hours before a planned hospital admission. • Treatment must be accessed within a network of designated service providers ○ Where a member or beneficiary voluntarily uses a non-Network Provider, funding will be approved up to a maximum of 80% of the Remedi Rate and the balance will be for the member's own pocket. • Scheme's Prescribed Minimum Benefit oncology basket of care, supportive formularies and/or protocols. • Access to any treatment regimen classified as Tier 1 guidelines and/or protocols approved and/or specified by the Scheme in respect of cover • Meeting Clinical Entry Criteria as specified or adopted by the Scheme. • Subject to peer-review by a Scheme appointed external panel of specialists. • Generic substitution and substitution or switching to a cost-effective therapeutic equivalents (drug utilisation review). • Medication to be scripted and dispensed in accordance with the oncology preferred product list. Where a non-preferred product is used, funding will be approved up to a maximum of 80% of Remedi Medicine Rate or generic reference price, whichever is applicable, and the balance will be for the members own pocket. • Medication must be dispensed through a designated service provider. Where a non-network provider is used, funding will be approved up to a maximum of 80% of the Remedi Medicine Rate or generic reference price, whichever is applicable, and the balance will be for the member's own pocket.	• Co-payment only as contemplated in Regulation 8 and **Annexure D** • Co-payment of 20% for PET-CT scans where there is voluntary use of a non-DSP • Stem Cell/Bone Marrow Transplant limited to: - autologous transplant or - allogeneic bone marrow transplant with HLA matched family donor only

Remedi Oncology Management and Treatment Programme - 2025

Non-Prescribed Minimum Benefit (non-PMB) Cover: Applicable to all benefit options except Standard Option

Health Care Services Covered	Basis of Cover	Limits/Thresholds
Chemotherapy (including facility fees), Radiotherapy (including but not limited to technical and professional fees, technical planning scans, internal radiotherapy, stereotactic radiation, embolisation or chemo-embolisation), and treatment contemplated in Rule 15.18 of the Main Body of the Rules	Up to a maximum of the Remedi Rate. Up to a maximum of the Remedi Medicine Rate. **For Classic and Comprehensive benefit options** Access to SAOC treatment regimens classified as Tier 2 and Tier 3 or any other treatment guidelines and/or protocols approved and/or specified by the Scheme in respect of each plan. Inclusion of chemotherapy, radiotherapy, and other health care services fundable from the Oncology Management and Treatment Programme will be subject to consideration of evidence-based medicine, cost-effectiveness and affordability. Health care services that are deemed by the Scheme as unaffordable and/or not cost-effective and/or lacking clinical evidence to demonstrate efficacy are excluded from cover. Access to the benefit/s is subject to: • Scheme authorisation and/or approval 48 hours before planned treatment. • Scheme's non-Prescribed Minimum Benefit oncology baskets of care, formularies and/or protocols. • Meeting Clinical Entry Criteria as specified or adopted by the Scheme. • Peer-review by a Scheme appointed external panel of specialists. • Specific treatment and/or out of protocol treatments are subject to peer-review by an external panel of specialists. • Generic substitution and substitution or switching to a cost-effective therapeutic equivalents (drug utilisation review). • Medication must be dispensed through a designated service provider. Where a non-network provider is used, funding will be approved up to a maximum of 80% of the	• Accumulating to the 12-month oncology benefit limit equivalent to 100% of the Remedi Rate or generic reference price, whichever is applicable, before the oncology benefit limit is reached and 80% of the Remedi Rate or generic reference price, whichever is applicable, becomes applicable. • If beneficiaries elect PMB cover after the oncology benefit limit is reached, funding is granted at 100% of the Remedi Rate or generic reference price, whichever is applicable, with no overall limit • If beneficiaries elect to have treatment outside of the agreed network, funding is granted at 80% of the Remedi Rate or generic reference price, whichever is applicable.

REGISTERED BY ME ON
2026/04/08
REGISTRAR OF MEDICAL SCHEMES

Remedi Oncology Management and Treatment Programme - 2025		
Non-Prescribed Minimum Benefit (non-PMB) Cover: Applicable to all benefit options except Standard Option		
Health Care Services Covered	**Basis of Cover**	**Limits/Thresholds**
	Remedi Medicine Rate or generic reference price, whichever is applicable, and the balance will be for the member's own pocket. • Medication to be scripted and dispensed in accordance with the oncology preferred product list. Where a non-preferred product is used, funding will be approved up to a maximum of 80% of Remedi Medicine Rate or the generic reference price, whichever is applicable, and the balance will be for the member's own pocket.	
	Comprehensive Option: Access to cover for a defined list of non-PMB novel and ultra high-cost treatment. Access to benefit is subject to: • Meeting Clinical Criteria as specified or adopted by the Scheme. • Peer-review by a Scheme appointed external panel of specialists.	• Accumulating to the 12-month oncology benefit limit granted at 75% of the Remedi Medicine Rate or generic reference price, whichever is applicable, up to the oncology benefit limit.
Specified consultations and other healthcare services such as stomatherapy, lymphoedaema, scopes, pathology, radiology (including basic X-rays, CT and MRI Scans, isotope scans, bone scans, mammography, and other specialised scans unless otherwise specified)	**Comprehensive and Classic benefit options** • Premier Rate Providers – Up to a maximum of the Premier Rate. • Classic Direct Rate Providers – Up to a maximum of the Classic Direct Rate. All other Providers – Up to a maximum of the Remedi Rate.	• Accumulating to the 12-month oncology benefit limit equivalent to 100% of the Remedi Rate before the oncology benefit limit is reached and 80% of the Remedi Rate becomes applicable. • If beneficiaries elect PMB cover after the oncology benefit limit is reached, funding is granted at 100% of the Remedi Rate with no overall limit.
	Access to the Benefit/s is subject to: • Scheme's non-Prescribed Minimum Benefit oncology baskets of care, formularies and/or protocols. Health care services being rendered at facilities accredited under the auspices of SASMO (South African Society of Medical Oncologists) and/or SASCRO (South African Society of Radiation Oncologists).	

Remedi Oncology Management and Treatment Programme - 2025		
Non-Prescribed Minimum Benefit (non-PMB) Cover: Applicable to all benefit options except Standard Option		
Health Care Services Covered	**Basis of Cover**	**Limits/Thresholds**
Positron Emission Tomography (PET) CT Scans	Up to a maximum of the Remedi Rate. Access to benefits is subject to: • Meeting Clinical Entry Criteria as specified or adopted by the Scheme. • Peer-review by a Scheme appointed external panel of specialists. Co-payment of 20% for voluntary use of a non-Network Provider.	• Up to a maximum of 4 scans per person per rolling 12-month cycle
Prescribed Medication outside of the Scheme's supportive formulary related to the cancer (e.g. Acute Antibiotics)	• See day-to-day benefits of the relevant benefit option	
Chronic Medication for supportive care: pain, nausea, vomiting, mild depression, osteopaenia and convulsions occurring as a result of cancer and/or treatment	Up to a maximum of the Remedi Rate or generic reference price, whichever is applicable. • Scheme's non-Prescribed Minimum Benefit oncology baskets of care, formularies and protocols. • In respect of non-formulary drugs – see day-to-day benefits of the relevant benefit option. • Medication must be dispensed through a designated service provider. Where a non-network provider is used, funding will be approved up to a maximum of 80% of the Remedi Medicine Rate or generic reference price, whichever is applicable, and the balance will be for the member's own pocket. Access to the Benefit/s is subject to: • Scheme authorisation. • Meeting Clinical Entry Criteria as specified by the Scheme. • Drug Utilisation Review.	• Accumulating to the 12 month oncology benefit limit equivalent to 100% of the Remedi Rate or generic reference price, whichever is applicable, before the oncology benefit limit is reached and 80% of the Remedi Rate or generic reference price, whichever is applicable.

REGISTERED BY ME ON

2026/04/08

REGISTRAR OF MEDICAL SCHEMES

Remedi Oncology Management and Treatment Programme - 2025

Non-Prescribed Minimum Benefit (non-PMB) Cover: Applicable to all benefit options except Standard Option

Health Care Services Covered	Basis of Cover	Limits/Thresholds
Wigs	**Comprehensive Option** Paid from available Personal Medical Savings Accounts (PMSA) **Classic Option** No cover.	*Subject to provisions in **Annexure D**
REGISTERED BY ME ON 2026/04/08 REGISTRAR OF MEDICAL SCHEMES Stem Cell / Bone Marrow Transplants • Donor registration • Donor searches (including pathology) and procurement • Apheresis and cryopreservation • In-hospital work-up and procedures • Post-transplant follow-up care	**Comprehensive and Classic benefit options** • Premier Rate Providers – Up to the maximum of the Premier Rate. • In-hospital ward, radiology & pathology – Up to a maximum of the Remedi Rate. • In-hospital related accounts – Up to a maximum of 100% of the Remedi Rate. • Out-of- hospital accounts – Up to a maximum of the Remedi Rate. Access to the benefit/s is subject to**:** • Scheme authorisation and/or approval 48 hours before a planned hospital admission. • Peer-review by a Scheme appointed external panel of specialists. • Meeting Clinical Entry Criteria as specified or adopted by the Scheme. • Scheme's non-Prescribed Minimum Benefits oncology baskets of care, formularies and/or protocols. • Generic equivalent substitution where available. • Substitution by a cost-effective, affordable therapeutic equivalent alternative where available. • Medication must be dispensed through a designated service provider. Where a non-network provider is used, funding will be approved up to a maximum of 80% of the Remedi Rate, or generic reference price, whichever is applicable, and the balance will be for the member's own pocket.	**Donor registration and searches:** • limited to the agreed rate per person per transplant **Donor procurement:** • In-hospital work-up and procedures in accordance with member's chosen benefit option – **subject to Annexure D and the provisions of Annexure D** • Local procurement limited to the agreed rate • International procurement is unlimited and professional fee up to the agreed rate