Retail Medical Scheme

Administered by Discovery Health

Benefit Brochure **2024**

Contact

Details

Ambulance and other emergency services

Call: 0860 999 911

Send your claims:

Email:
claims@retailmedicalscheme.co.za

Post: PO Box 652509,
Benmore, 2010 or
Postnet Suite 116,
Private Bag X19,
Milnerton,
7435

Fax: 0860 329 252

To confirm your benefits or a hospital stay

Call: 0860 101 252

To arrange approval for your chronic medicine or to register on the Oncology or HIV care programmes

Call: 0860 101 252

To arrange delivery of your chronic medicine using the MediRite Courier Service

Call: 021 983 5116

For anonymous fraud tip-offs

Fraud hotline: 0800 004 500

Extra services

Internet queries

Call: 0860 100 696

Smart Health Choices

Call: 0860 999 911
(for medical advice)

General queries

Call: 0860 101 252

Email:
service@retailmedicalscheme.co.za

Website: www.retailmedicalscheme.co.za

Contents

Please note in this brochure that specific limits may apply to the benefits reflected in the Benefit Schedules. We do not reflect these limits in the sections of the brochure where we explain how benefits work. This brochure gives you a brief outline of the Benefit Options Retail Medical Scheme offers. For more details you can visit our website, www.retailmedicalscheme.co.za.

The information in this Benefit Brochure does not replace the Scheme Rules. The registered Scheme Rules are legally binding and always take precedence.

Welcome

To Retail Medical Scheme

Retail Medical Scheme is a registered Medical Scheme and operates within the requirements of the Medical Schemes Act 1998.

The Scheme is a closed Scheme and membership is reserved for employees and pensioners of the Shoprite Group. Should you resign from the Scheme, your membership will terminate on the last day of the month in which your employment with the Group terminates.

A Board of Trustees, representing the employer and the members, governs the Scheme. These Trustees are either elected by members or appointed by the Employer to ensure the financial soundness of the Scheme and protect members' interests.

The Scheme currently holds reserves that are in excess of the required minimum solvency levels, proof of its prudent financial management.

An Outline

of what Retail Medical Scheme offers

Members have different needs, depending on their family size, financial and health circumstances

The Scheme provides a choice of two Benefit Options to meet these diverse needs. It is important to make the right choice to ensure the cover matches your healthcare funding needs.

You will have to consult the detailed benefit schedule and contribution table, to ensure your choice of Option best suits your needs. Especially if your health status changed during the past year.

Essential Option

The Essential Option provides unlimited hospital and Prescribed Minimum Benefit (PMB) cover. This Option provides limited cover for day-to-day expenses, paid for from the Scheme Risk benefits.

Essential Plus Option

The Essential Plus Option provides unlimited hospital and Prescribed Minimum Benefit (PMB) cover. You contribute to a Medical Savings Account (MSA) for all your day-to-day expenses. Once the Medical Savings Account (MSA) is exhausted and the Annual Threshold has been reached, further day-to-day cover will be provided by the Scheme from the limited Above Threshold Benefit (ATB).

Eligibility – what are the rules for joining the Scheme?

If your conditions of service makes it compulsory to join the Scheme, and you join immediately, no underwriting will be applied. However, if you are joining the Scheme voluntarily (after your date of employment) waiting periods may apply (3 months General and/or 12 months Condition Specific).

Please note

- If you intend to add your newly married spouse as a dependant, please notify the Scheme within 30 days of date of the marriage to ensure no waiting periods are applied.
- When you get divorced, your ex-spouse is no longer eligible to be a member of the Scheme. You must notify the Scheme within 30 days of the divorce being finalised.
- When they become permanently employed, your children are no longer eligible to be registered as dependants on your membership. You must let the Scheme know immediately when their employment is confirmed.

Your children are eligible to belong to the Scheme under the following conditions:

- up to their 21st birthday, your children are eligible to be registered as your dependants on your membership and they will pay contributions at child rates;
- your children who are between the ages of 21 and 25 are eligible to be registered as dependants on your membership if the following eligibility requirements are met:
  - they are financially dependent on you (we will ask you for proof of the dependency); or
  - they are full time students at a tertiary institution (we will ask you for proof of their full time studies).
- After their 21st birthday, if your children are no longer financially dependent on you, or no longer full time students, they are not eligible for membership of the Scheme. We will withdraw their membership immediately if you can no longer prove their eligibility.
- All children who are older than 25 years, are no longer eligible for membership. We will notify you in advance, and withdraw their membership at the end of the month in which they turn 25.
- All children deemed to be permanently disabled and who are older than 21 years may remain on the Scheme as adult dependants and contributions will be charged at adult rates.

  You will be required to submit proof of the disability in the form of a certificate issued by the Department of Home Affairs or an affidavit from the dependant's treating doctor, declaring the disability.

THE SCHEME ENABLES YOU TO MANAGE YOUR HEALTHCARE SPEND

Retail Medical Scheme's care programmes look after you in times of need

Cardio care programme

The Cardio Care Programme is designed to offer members for whom we have approved benefits for certain heart-related conditions the optimal care from the best service providers in a coordinated network, and to ensure the best outcomes and quality of life.

To access the programme, you need to be 18 years or older and registered on the Chronic Illness Benefit with hypertension, hyperlipidaemia and/or ischaemic heart disease. A General Practitioner (GP) in the Premier Plus GP network can enroll you onto the programme. The Cardio Care Programme is based on clinical and lifestyle guidelines.

The programme gives you and your Premier Plus GP access to various tools to monitor and manage your condition, and to ensure you have access to high-quality coordinated care. You and your GP can track your progress on a personalised dashboard, displaying your unique Cardio Care Management Score. This will help you to identify the steps you should take to manage your condition and remain healthy over time. For more information, please visit the website at www.retailmedicalscheme.co.za

Diabetes care programme

The Diabetes Care Programme is designed to offer optimal care for members with diabetes from the best service providers in a coordinated network, to ensure the best outcomes and quality of life. To access the programme, you need to be registered on the Chronic Illness Benefit with either type 1 or type 2 Diabetes. A GP in the Premier Plus GP network must enroll you onto the Programme.

The Diabetes Care Programme is based on clinical and lifestyle guidelines and gives you and your Premier Plus GP access to various tools to monitor and manage your condition. You and your GP can track your progress on a personalised dashboard displaying your unique Diabetes Management Score. This will help you to identify the steps you should take to manage your condition and remain healthy over time.

In addition to the standard treatment basket of procedures and consultations available to members registered on the Chronic Illness Benefit with Diabetes, members who join the Diabetes Care Programme will have access to an additional dietician and biokineticist consultation per year.

Disease Prevention Programme for pre-diabetic beneficiaries with cardio-metabolic risk syndrome

This programme is aimed at beneficiaries who are pre-diabetic (have not been diagnosed with diabetes), who are not registered on the Diabetes Management Programme.

Certain non-PMB and other GP-related services will be covered in a basket of care, subject to registration on the Chronic Illness Benefit and referral by the Scheme's Network GP.

The focus is to either prevent the disease from manifesting or to prevent progression of the disease.

Mental health care programme

The Mental Health Care Programme is designed to offer members diagnosed with acute or episodic Major Depression optimal care from the best service providers in a coordinated network, to ensure the best outcomes and quality of life. To access the programme, you need to be 18 years or older and diagnosed with acute or episodic Major Depression. A GP in the Premier Plus GP network can do an assessment to confirm the diagnosis and enroll you onto the programme. The programme, which will be active for 6 months from the date of enrollment, will give your Premier Plus GP access to tools to monitor and manage your condition and to ensure you have access to high-quality coordinated care. By joining the Mental Health Care Programme, you will have access to 3 GP consultations and certain first line anti-depressant therapy. You can also make use of internet-based care for Cognitive Behavioural Therapy, if supported by your treating doctor. For more information, please visit the website at www.retailmedicalscheme.co.za

HIV care programme

The HIV Care Programme offers unlimited cover for HIV- or AIDS-related illnesses. This fully inclusive programme makes sure members get personal and confidential care, including counselling and approval for anti-retroviral medicine.

On the Essential Plus Option, your Medical Savings Account will take care of day-to-day benefits. When you need more cover, the Scheme will pay claims from the Above Threshold Benefit. On the Essential Option, the Scheme pays your day-to-day medical expenses from the Out-of-Hospital Benefit, which is limited.

Home-based care programme

When you meet certain clinical criteria, and receive the services from the Scheme's Designated Service Providers (DSP), the Scheme pays for home-based care.

The programme aims to reduce re-admissions after hospitalisation, assist patients requiring certain therapeutic interventions to be discharged early, to continue treatment at home, where it is appropriate to do so.

The programme provides qualifying patients, who require inpatient acute hospital treatment, with access to care in their homes, either in lieu of hospitalisation, after early discharge, or as a continuation of care after discharge. It also includes benefits to remotely monitor and manage patients' chronic illness conditions via care coordination, coaching, virtual house calls, with escalation where necessary, and remote monitoring. Specific monitoring devices are included in the benefits for this programme.

The home-based care benefits are subject to authorisation, specific clinical entry criteria and baskets of care.

Colorectal cancer sugery and preventative care

The Scheme has identified specific Centres of Excellence for Colorectal Cancer Surgery. Patients receive very high quality care, with excellent health outcomes from the services of the surgeons operating at these facilities.

Patients undergoing colorectal cancer surgery at one of the Scheme's DSP Centres of Excellence will receive full cover for the costs of the procedure. The colorectal cancer surgery benefits are subject to authorisation, specific clinical entry criteria and baskets of care.

Members aged 45 to 75 have access to colorectal cancer screening benefits, consisting of one faecal occult blood test or one faecal immunochemical test, every two years. The Scheme will also pay for a colonoscopy, for persons found, through the testing, to be at risk.

Spinal care programme

The Scheme's Spinal Care Programme for the in- and out-of-hospital management of spinal surgery and care aims to ensure the appropriate management of back pain and spinal surgery through a focus on:

- prevention where members are at risk of developing back pain,
- out-of-hospital treatment and benefits for members who are at high risk of surgery due to severe back pain, by introducing a provider network and a basket of care for out-of-hospital related care, and
- ensuring that when surgery is the only option to manage back pain, it is performed at the best possible place of service, by the best possible surgeon to ensure the best possible outcome for the patient.

To enjoy full cover, you must make use of the services of doctors in the network and if you are undergoing surgery, the procedure must be performed in a Centre of Excellence Network facility. If your surgery requires the use of internal spinal devices, the costs will be covered in full if those are obtained from the Scheme's Preferred Suppliers of the devices.

All treatment and care must be preauthorised and are subject to clinical criteria and benefits available in a basket of care.

Oncology programme

If you have been diagnosed with cancer, you can register on the Oncology Programme and get cover in full, up to the Scheme Rate, and the applicable threshold. The threshold applies in a 12-month cycle from the month of first registration on this programme. Once your non-Prescribed Minimum Benefit treatment costs exceeds this amount, the Scheme will pay claims up to 80% of the Scheme Rate for all further treatment, and you will need to pay the balance from your own pocket. This amount could be more than 20% if your treatment cost is higher than the Scheme Rate.

Patients get support and access to reliable information on cancer and what steps to take to manage the disease. Radiology and pathology approved for your cancer treatment are also covered.

Cancer treatment that falls within the Prescribed Minimum Benefit is always covered in full, with no co-payment, providing you make use of the services of a Designated Service Provider (DSP), where relevant, and use medicine that is on the Scheme's preferred oncology medicine list. Please call us to register on the Oncology Programme.

Advanced illness benefits

The Advanced Illness Member Support Programme provides support to patients with advanced illnesses, at a time when they are trying to manage their symptoms, and understand their healthcare needs.

The Advanced Illness Benefit provides funding for the care of patients with end-of-life stage diseases and covers, amongst others, the following out-of-hospital services: GP or Specialist consultations, home-based care, Hospice nursing care, general nursing care obtained from a Discovery HomeCare provider, where available, oxygen, pain management, wound care, counseling, pathology and medicine (per defined baskets), and appropriate feeds.

Preventive screening is available on both Options

The Pharmacy or Preventive Screening Benefit covers certain screening tests from the Core Benefit only if the service of one of the Scheme's contracted providers is used. These tests include:

- Blood glucose
- Blood pressure
- Cholesterol
- Body Mass Index (BMI).

In addition to the tests listed above, beneficiaries older than 65 years have access to the Seniors Screening Benefit that provides cover for certain age-appropriate screenings and assessments. These tests are important because they allow medical conditions to be detected early, and may give you a better chance for a healthier life.

The children's Screening Benefit provides cover for certain screening tests from the Core Benefit, only at one of the Scheme's contracted providers, for children between the ages of 2 and 18 years.

These tests are:

- Body Mass Index (BMI) and counselling, if required
- Basic hearing and dental screenings
- Milestone tracking for children between 2 and 8 years old

When you, and all the qualifying beneficiaries on your membership undergo the Pharmacy and Children's screening tests, you will activate the WELLth Fund.

Additional screening tests covered by the Scheme are:

- Mammograms (once every 2 years)
- Pap smears (once every 3 years)
- Prostate Specific Antigen (PSA) tests (once every year)
- Colorectal cancer screenings (for persons between the ages of 45 and 75 years)
- HIV tests

Visit www.retailmedicalscheme.co.za to find a list of the Scheme's Designated Service Providers.

To register on one of the Scheme's managed care programmes, call 0860 101 252

Benefits

and the terms we use

Above Threshold Benefit (ATB)

The Above Threshold Benefit is a 'safety net' available on the Essential Plus Option. When your day-to-day claims all add up to the Annual Threshold, the Scheme starts paying for certain non-hospital expenses at the Scheme Rate. This benefit protects you from high expenses related to day-to-day healthcare treatment.

The Scheme adds up the day-to-day claims you send to the Scheme at the Scheme Rate, where applicable. Once your day-to-day claims reach a certain value, known as the Annual Threshold, the Scheme will pay certain day-to-day claims according to the specific benefits available on the Essential Plus Option.

The Scheme sets the Annual Threshold at the beginning of every year, based on the total number of dependants registered on your membership. The Scheme will prorate the Above Threshold Benefit if you join during the year, based on the number of months left in that year.

If a condition is listed as a Prescribed Minimum Benefit, by law all Medical Schemes must cover the medicine and certain treatment and care for the condition.

Chronic Illness Benefit (CIB)

The Chronic Illness Benefit covers approved medicine for 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions.

You must apply for cover and meet the benefit entry criteria before you can claim for this benefit.

If the Scheme has not approved your application for this benefit, these expenses will be paid from your day-to-day benefits.

The Chronic Illness Benefit application forms you have to fill in are available on the website at www.retailmedicalscheme.co.za, or you can call the Scheme on 0860 101 252 to ask for them. You and your doctor may have to give extra information for the Scheme to review your application.

How we pay for medicine authorised under the Chronic Illness Benefit

The Scheme will pay your approved medicine in full if it is on the Scheme's medicine list (formulary). If your approved medicine is not on the medicine list, the Scheme will pay your chronic medicine up to a set monthly amount, called the Chronic Drug Amount (CDA), for each medicine class. If you use more than one medicine in the same medicine class, where both medicines are not on the medicine list, or where one medicine is on the medicine list and the other is not, the Scheme will pay for both medicines up to the one monthly CDA for that medicine class.

Tests, procedures and consultations

If your PMB CDL condition is approved, the Chronic Illness Benefit will automatically open access to cover for a limited number of selected tests, procedures and/or specialist consultations for the diagnosis and ongoing management of your condition. You will also have cover for four (4) GP consultations per year, which are related to your approved PMB CDL conditions.

The number of available tests and consultations are calculated based on the number of months left in the year at the time your condition is approved. If you have cover for the same procedures or tests for more than one condition, the Scheme will pay up to the basket that gives you the most procedures or tests.

If you want to access cover from the Chronic Illness Benefit, you must apply for it. You need to complete a Chronic Illness Benefit application form with your doctor and submit it for review. You can get your latest Chronic Illness Benefit application form on the website at www.retailmedicalscheme.co.za or you can call 0860 101 252 to get one.

You must provide information to get access to the Chronic Illness Benefit

For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria that need to be met. You or your doctor may need to provide certain test results or extra information to finalise your application.

The Chronic Illness Benefit application form will give you the details as to which documents and extra information you will need to submit. Please ensure that these documents are submitted with your application. Remember, if you leave out any information, or do not provide the medical test results or documents needed with the application, cover will start from the date we receive the outstanding information.

You need to let us know when your treatment plan changes

You do not not have to complete a new Chronic Illness Benefit application form when your treating doctor changes your medicine during the management of your approved chronic condition, however, you do need to let the Scheme know when your doctor makes these changes to your treatment plan so that the Scheme can update your chronic authorisation. You can email the prescription for changes to your treatment plan for an approved chronic condition to CIB_APP_FORMS@retailmedicalscheme.co.za or fax it to 011 539 700. Alternatively, your doctor can submit changes to your treatment plan through HealthID, provided that you have given consent for them to do so. If you do not let the Scheme know about changes to your treatment plan, we may not pay your claims from the correct benefit.

Should you be diagnosed with a new chronic condition, a new Chronic Illness Benefit application form must be completed.

Prescribed Minimum Benefits (PMB)

By law all Medical Schemes in South Africa must cover a minimum set of medical treatments for certain conditions. This is true even when Scheme exclusions apply, when the Scheme has applied waiting periods in certain circumstances, or when you have reached a limit for an applicable benefit.

The PMB is a package of minimum clinical benefits that the Scheme must pay for. Your available Medical Savings Account (MSA) cannot be used to pay for these benefits.

The PMB consists of care for:

- Any life-threatening emergency medical condition;
- A defined set of 270 diagnoses, and 26 chronic conditions.

The Scheme will pay for PMB in full only if treatment is provided by, or at one of the Scheme's Designated Service Providers (DSP), except in emergencies, unless otherwise indicated.

When you have just joined the Scheme, Retail Medical Scheme will not pay for the treatment of Prescribed Minimum Benefit conditions when a general waiting period applies to your membership, or when a 12-month waiting period applies for the specific condition. If your membership was activated without waiting periods, you have cover for these conditions from day one.

Co-payments for PMB medicine will not apply when

- Your treating doctor submits an application, supported by adequate clinical information for the continuation of medicine not listed on the formulary, or a substitution of the formulary medicine (in cases where the formulary medicine would be ineffective or harmful).
- The formulary medicine is not available from the Designated Service Provider (DSP) appointed by the Scheme, or would not be provided without unreasonable delay.

Designated Service Provider for your approved chronic medicine

MediRite is the Scheme's Designated Service Provider (DSP) for acute and chronic illness medicine. You must get all your medicine from a MediRite Pharmacy.

If you do not get your Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) medicine from a MediRite Pharmacy, you will have to pay a co-payment for the difference between the Scheme Medicine Rate and any other related fee charged, directly to the pharmacy.

Please note: If there isn't a MediRite Pharmacy near your home or place of work, you will still be able to get the medicine from them as they will deliver it to an address of your choice through a courier service. Please call the MediRite call centre on 021 983 5116 to arrange this service.

Oncology medicine required for the treatment of cancer must be provided by the Scheme's Designated Provider Network pharmacies, and your doctor must prescribe medicine that is on the Scheme's preferred medicine list. If you are diagnosed with cancer and require medicine as part of your treatment plan, we will provide the information about these DSPs and the preferred medicine to you and your doctor.

You have cover for these chronic illness conditions

The Essential and Essential Plus Options provide cover for the following Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions:

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disease
- Chronic renal disease
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus type 1
- Diabetes mellitus type 2
- Dysrhythmia
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

Payment for the diagnosis and medical management of Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions

You do not pay for the diagnosis and medical management costs provided in the treatment basket. These costs are paid in accordance with the Rules of the Scheme from your Core Benefits. Unless supplied with additional information by your doctor, to be reviewed for further cover, the Scheme will pay benefits exceeding those provided for in the treatment basket from your day-to-day benefits.

The Scheme will pay in full (i.e. without any co-payments or deductibles, such as levies) for the diagnosis, treatment and ongoing care of PMB conditions, provided your treating doctor includes the correct ICD-10 diagnosis code(s) on the claim.

Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete, when they refer you to the pathologists and/or radiologists for tests. This will enable the pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit and ensure that we pay your claims from the correct benefit. If the correct ICD-10 diagnosis code(s) is not included, your claim will be treated as a day-to-day or out-of-hospital claim, and will be paid from your applicable day-to-day benefits. If you do not get the medicine from a MediRite Pharmacy, and your pharmacy charges more for the medicine, you must pay for any shortfalls.

The cost of any treatment that is not in accordance with the treatment basket may be covered from your day-to-day benefits that are paid from the Core Benefits, or you may have to pay for it, unless it is approved by DiscoveryCare, on appeal.

The following conditions or procedures will be covered on both Options based on clinical rules and the Diagnosis Treatment Pairs Minimum Benefit (DTPMB). This is not the complete list. Please ask the Scheme to confirm whether your condition is one of the DTPMB conditions, or procedures.

- Cushing's disease
- Hormone replacement therapy
- Hypoparathyroidism
- Organ transplantation
- Paraplegia
- Pectoris
- Pemphigus
- Peripheral arteriosclerotic disease
- Pituitary microadenoma
- Quadriplegia
- Stroke
- Thrombocytopaenic purpura
- Valvular heart disease

Day surgery procedures

Certain treatment or procedures will be covered in full at a Designated Service Provider (DSP) Day Surgery facility accredited by the Scheme for that purpose. When you preauthorise the procedure, the Scheme will tell you about this requirement and will help find the nearest accredited facility to you.

If your procedure or treatment is listed by the Scheme and you choose to undergo that planned procedure at a hospital or a non-accredited Day Surgery facility, you will have to pay a deductible amount directly to the hospital.

Day surgery procedures

To ensure full cover for the following treatment or procedures, you have to make use of the services of an accredited Day Surgery facility:

1. **Biopsies**

   Skin, subcutaneous tissue, soft tissue, muscle, bone, lymph, eye, mouth, throat, breast, cervix, vulva, prostate, penis, testes

2. **Breast Procedures**
   - Mastectomy for gynaecomastia
   - Lumpectomy (fibroadenoma)

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

4. **Eye procedures**
   - Cataract surgery
   - Corneal transplant
   - Treatment of glaucoma
   - Other eye procedures (removal of foreign body, conjunctival surgery (repair laceration, pterygium), glaucoma surgery, probing and repair of tear ducts, vitrectomy, retinal surgery, eyelid surgery, strabismus repair)

5. **Ganglionectomy**

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

7. **Gynaecological Procedures**
   - Colposcopy with LLETZ
   - Diagnostic Dilatation and Curettage
   - Diagnostic Hysteroscopy
   - Diagnostic laparoscopy
   - Endometrial ablation
   - Examination under anaesthesia
   - Simple vulval and introitus procedures: Simple hymenotomy, partial hymenectomy, simple vulvectomy, excision Bartholin's gland cyst
   - Suction curettage
   - Vaginal, cervix and oviduct procedures: Excision vaginal septum, cyst or tumour, tubal ligation or occlusion, uterine cervix cerclage, removal of cerclage suture
   - Uterine evacuation and curettage

8. **Nerve procedures**

   Neuroplasty median nerve, ulnar nerve, digital, nerve of hand or foot, brachial plexus

9. **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.

10. **Removal of foreign body**

    Subcutaneous tissue, muscle, external auditory canal under general anaesthesia.

11. **Simple superficial lymphadenectomy**

12. **Skin Procedures**
    - Debridement
    - Removal of lesions (dependent on site and diameter)
    - Simple repair of superficial wounds

13. **Simple hernia procedures**
    - Umbilical hernia repair
    - Inguinal hernia repair

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

When you preauthorise the procedure, the Scheme will tell you about the requirement to go to a Day Surgery facility and will help find the nearest accredited facility to you.

Designated Service Provider (DSP)

These are specific providers of healthcare services, for example hospitals, GPs and Specialists, who have agreed to provide services according to certain agreed rules. The Scheme pays these providers directly.

If you do not use the services of the Scheme's DSP

For PMB claims to be funded in full, you must use a DSP for certain services, as indicated in this brochure and your Benefit Schedule. If these providers are not used, the Scheme may apply co-payments.

You will not have to make any co-payments if you have involuntarily obtained a service (had no other choice) from a provider other than a DSP, and:

- it is an emergency, hospital admission;
- the service was not available from the DSP or would not have been provided without unreasonable delay;
- there was no DSP within a reasonable distance from your place of business or residence.

The Scheme's DSPs for the diagnosis, treatment and ongoing care costs (which may include medicine) for Prescribed Minimum Benefit (PMB) conditions are:

- Certain DSP Premier Rate Specialists and General Practitioners (GPs), who have agreed to deliver services in accordance with their Direct Payment Arrangement (DPA) with the Scheme.
- Contracted hospitals for all in-hospital treatment and care.
- Day surgery facilities in the Scheme's Day Surgery Network.
- Pharmacies in the Scheme's Oncology Medicine Network for medicine used to treat cancer.
- MediRite Pharmacies (for all acute and Chronic Illness Benefit medicine).
- National Renal Care (NRC) for care of patients requiring renal care, including dialysis.
- SANCA, RAMOT and Nishtara Lodge for all PMB benefits related to drug and alcohol detoxification and rehabilitation.
- Other service providers, as selected by the Scheme from time to time.

It is likely that the Scheme will contract with and appoint more Designated Service Providers (DSP), particularly provider networks, in its ongoing efforts to control and reduce costs for members.

Designated Service Providers (DSP)

When you use the service of a Designated Service Provider (DSP), all claims, including Prescribed Minimum Benefits (PMB) claims, are paid in full. This means you will not have any out-of-pocket expenses.

DiscoveryCare

Discovery Health (Pty) Ltd is the Scheme's contracted managed healthcare provider to manage the appropriateness and cost effective provision of healthcare services to its members. DiscoveryCare is the area in Discovery Health (Pty) Ltd that manages these initiatives on behalf of the Scheme.

Discovery 911

You have access to Discovery 911, a service that provides highly trained paramedics in response vehicles that will help you with all aspects of a medical emergency, or provide medical emergency transport.

Call **DISCOVERY911** if you need transport in a medical emergency

General Practitioner (GP) Network

This is an open network of more than 2 000 GPs and you may find information about the nearest one on www.retailmedicalscheme.co.za or by calling 0860 101 252. If you use one of these providers, you will not be liable for any co-payments as the provider will only charge the Scheme Rate. The Scheme will pay these claims in full at the amount charged, and the provider will not be allowed to ask you to make any co-payments.

If you willingly (choose to) do not use the services of a General Practitioner (GP) in the Scheme's GP Network to obtain services related to Prescribed Minimum Benefit (PMB) treatment, the Scheme will pay these claims to a maximum of 80% of the Scheme Rate only. You will have to pay the shortfall. Non-PMB claims, incurred at non-Network General Practitioners (GP), will only be paid up to 100% of the Scheme Rate.

Core benefit for hospitalisation and other expensive treatment

This benefit covers expenses incurred while you are in hospital, if the Scheme has confirmed cover for your admission. Examples of such expenses are theatre and ward fees, X-rays, blood tests and medicine given to you while you are in hospital.

If you are going to hospital for a planned procedure, you must phone the Scheme on 0860 101 252 to confirm benefits before being admitted. If it is an emergency, you must let the Scheme know as soon as you can after you are admitted, and within at least 48-hours.

If you do not confirm benefits for your admission, or let us know in an emergency, you will be responsible for 30% of the hospital and related costs.

The Scheme also pays other large cost treatment and care from the Core Benefit, such as your approved Chronic Medicine, treatment obtained out-of-hospital in lieu of hospitalisation and certain day-to-day benefits when you are pregnant.

Day-to-day claims

Day-to-day claims are expenses you incur for which you would not normally be admitted to hospital. The Scheme covers these claims through the Medical Savings Account (MSA) and the Above Threshold Benefit (ATB) on the Essential Plus Option or through the limited Out-of-Hospital Benefit on the Essential Option. Some day-to-day expenses are paid from the Core Benefits, such as the benefits offered in the Maternity Programme. Examples of day-to-day expenses include: consultations at healthcare professionals (GPs, specialists, dermatologists, homeopaths), prescribed medicine and conservative dentistry.

Medical Savings Account (MSA)

This benefit is used to pay for your day-to-day claims on the Essential Plus Option. The positive balance in the Medical Savings Account (MSA) carries over from one year to the next.

From 1 January, you have upfront access to the annual Medical Savings amount.

If you still have Medical Savings available at the end of the year, the Scheme will carry it forward and you may use those funds in the following year.

If you resign from the Scheme during the year and you have already spent more than you have contributed to the Medical Savings, you will owe the overspent amount to the Scheme, and must pay it back when your membership is withdrawn.

If you resign from the Scheme and have available funds in your Medical Savings Account (MSA), the balance will be paid to your next Scheme (if you choose an option with a Medical Savings Account), or it will be refunded to you after four months of your withdrawal from the Scheme. The Scheme follows the stipulations of the Medical Schemes Act for these refunds.

Any debt owing to the Scheme at the time of your resignation will be offset against any positive Medical Savings Account (MSA) balance before the remaining balance is either transferred or paid out.

Cancer-related PET scans

If the Scheme has approved your scan, and you have it done in our PET scan network, your claim will be paid as follows

IF YOU HAVE NOT REACHED THE ONCOLOGY THRESHOLD	IF YOU HAVE REACHED THE ONCOLOGY THRESHOLD
The Scheme pays the claims at 100% of the Scheme Rate.	The Scheme pays the claim for the PET Scan at 80% of the Scheme Rate. If the provider charges more than the Scheme Rate, you must pay the 20% co-payment and the shortfall amount.

If the Scheme has approved your scan and you have it done outside of our PET scan network the Scheme will pay your claim as follows

IF YOU HAVE NOT REACHED THE ONCOLOGY THRESHOLD	IF YOU HAVE REACHED THE ONCOLOGY THRESHOLD
The Scheme pays the claim for the PET Scan at 80% of the Scheme Rate. If the provider charges more than the Scheme Rate, you must pay the 20% co-payment and the shortfall amount.	The Scheme pays the claim for the PET Scan at 80% of the Scheme Rate. If the provider charges more than the Scheme Rate, you must pay the 20% co-payment and the shortfall amount.

You have access to local and international bone marrow searches and stem cell transplants

This benefit will be paid at the agreed rate, subject to authorisation, review and clinical criteria.

Over-the-counter (OTC) medicine

Schedule 0-2 (generic and non generic) medicine, whether prescribed or not, is also known as over-the-counter (OTC) medicine. If you buy OTC medicine and you want to claim for these from the Scheme, please make sure of the following:

- You need to get the medicine from a registered healthcare provider with a valid practice number.
- The claim needs to display a valid ICD-10 code.
- The claim needs to have a NAPPI code.

The Scheme will only pay for OTC medicine if you are on the Essential Plus Option and have available funds in the Medical Savings Account (MSA). Please remember that OTC medicine is not paid from the Above Threshold Benefit and does not add up to the Annual Threshold.

Pro-rated benefits

The Scheme calculates your benefits and limits according to the number of months left in the calendar year, if you join the Scheme during that year.

SANCA, Nishtara Lodge and RAMOT

SANCA, Nishtara Lodge and RAMOT are the Scheme's Designated Service Providers for Prescribed Minimum Benefits treatment and care related to substance abuse. The Scheme will pay in full for their services, at the negotiated rate, for all accommodation, therapeutic sessions, consultations by psychologists and psychiatrists and medicine, to manage the condition and aftercare, on both Options.

SANCA and Nishtara Lodge are organisations that address alcoholism and drug dependence through specialised treatment and services. This enhances the quality of life and restores the self respect and dignity of persons affected by alcohol and drug dependence. Ramot is a partly state-subsidised not-for-profit organisation, providing similar services.

If the services of these providers are not used, benefits are limited. Your benefit schedule provides more details.

Scheme Rate

This is how much the Scheme will pay, and is based either on a rate determined by the Scheme or a specific negotiated rate, with the healthcare professional. Unless it is indicated differently in this brochure, claims are paid at 100% of the Scheme Rate, or in the case of participating Specialists, at the Premier Rate. Participating General Practitioners (GP) are paid at the GP Network rate.

If you do not use the Scheme's Designated Service Provider (DSP) when you obtain services related to the Prescribed Minimum Benefits (PMB), your claims may be limited, or may only be paid at 80% of the Scheme Rate.

Self-payment Gap (SPG)

If you registered on the Essential Plus Option and you run out of funds in your Medical Savings Account (MSA) before you reach the Annual Threshold, you will experience a Self-payment Gap (SPG).

When you are in your SPG, you may need to pay for certain medical expenses from your own pocket, before the Scheme starts paying again. This happens when you claim from your MSA for over-the-counter medicine (which does not accumulate to your Threshold).

Your claims statement will indicate when you're likely to be in your Self-payment Gap (SPG) and have to start paying some claims.

How to get through the Self-payment Gap (SPG)

When you have used up your Medical Savings Account (MSA), but you have not yet reached your Annual Threshold, you must pay for your day-to-day healthcare expenses. Claims that do not add up to your Annual Threshold will make your Self-payment Gap (SPG) bigger.

When you are in a Self-Payment Gap (SPG), you must remember to keep sending the Scheme your claims (and the receipts of payment), so the Scheme knows when you have reached your Annual Threshold. When you reach your Annual Threshold, the Scheme will again pay for certain day-to-day claims from the Above Threshold Benefit (ATB).

Specialist Network

Approximately 80% of claims are from Premier Rate Specialists in this open network, with whom the Scheme has a Direct Payment Arrangement (DPA). You may find information about these Specialists on www.retailmedicalscheme.co.za or by calling 0860 101 252. If you use one of these providers, the Scheme will pay the claims in full at the amount charged, directly to the provider. The Specialist will not be allowed to ask you to make any payments in excess of the Scheme Rate, and you will not be liable for any co-payments.

Premier Rate Specialists are the Designated Service Providers (DSP) for Prescribed Minimum Benefit (PMB) Specialist treatment and care. If you willingly do not use the services of a Premier Rate Specialist, the Scheme will pay you to a maximum of 80% of the Scheme Rate only, and you will be liable for any co-payments. You will have to pay the provider as we will only pay the Scheme's portion directly to you.

Other claims that are not for Prescribed Minimum Benefits (PMB), incurred at Specialists who are not in the Scheme's Designated Provider (DSP) Network, will be paid to a maximum of the Scheme Rate only.

Virtual consultations

You will be able to make online appointments and book virtual consultations with your Network GP, Specialist or any other provider (where applicable). If you are registered for a chronic condition, your doctor may make a virtual housecall to discuss

What the Scheme does not cover

There are certain medical expenses the Scheme does not cover. The Scheme calls these exclusions.

The Scheme will not cover the direct or indirect consequences of the following, except as regulated in the Prescribed Minimum Benefits:

- Cosmetic procedures, for example, otoplasty for jug ears; removal of portwine stains; blepheroplasty (eyelid surgery); removal of keloid scars; hair removal; nasal reconstruction (including septoplasties, osteotomies and nasal tip surgery); and healthcare services related to gender reassignment.
- Breast reductions and implants.
- Treatment for obesity.
- Treatment for infertility, subject to Prescribed Minimum Benefits.
- Frail care.
- Experimental, unproven or unregistered treatment or practices.
- CT angiogram of the coronary vessels and CT colonoscopy.
- Alcohol and drug rehabilitation treatment, unless it is PMB-related.

The purchase of the following, unless prescribed:

- applicators, toiletries and beauty preparations;
- bandages, cotton wool and other consumable items;
- patented foods, including baby foods;
- tonics, slimming preparations and drugs;
- household and biochemical remedies;
- anabolic steroids; and
- sunscreen agents.

Unless otherwise decided by the Scheme, benefits in respect of these items, on prescription, are limited to one month's supply for every prescription or repeat thereof.

Certain costs we do not pay

- Costs of search and rescue.
- Any costs that another party is legally responsible for.
- Facility fees at casualty facilities (these are administration fees that are charged directly by the hospital or other casualty facility), unless stated differently for specific benefits.
- Costs for holidays for recuperative purposes.
- Costs in excess of the annual maximum benefits to which a member is entitled.
- Appointments not kept.
- Interest charges for late claims payments caused by members submitting claims late, or due to complaint or disputes processes.
- Costs for PMB-related healthcare services when these are received outside of South Africa.
- Costs related to services that do not meet the Scheme's clinical protocols and treatment guidelines.
- Costs related to fraudulent claims.
- Costs for healthcare services rendered during applicable waiting periods.

Always check with the Scheme

Please contact the Scheme if you have one of the conditions we exclude so the Scheme can let you know if there is any cover. In some cases, you might be covered for these conditions if they are part of Prescribed Minimum Benefits (PMB).

How to...

Use the website

Use the Smartphone App

The Discovery smartphone App puts you fully in touch with your benefits. If your mobile device is with you, so is your Scheme.

- Download the Discovery App from the App Store to your smartphone.
- Set up your own unique login (same as your login for the Scheme's website, if you are already active on the site).
- Log into the App.
- Get access to your electronic membership card, submit and track claims and get up to date information about your benefits and limits.

Add a dependant to your membership

If you want to add a dependant to an existing membership, you must complete an Additional Dependant Application Form. Please attach a copy of your dependant's identity document to the application form. You must send the completed form to your People Team for approval.

Change your Benefit Option

While you cannot make any Benefit Option changes during the year, you can do so before the end of November every year. The change will become effective on 1 January the following year. You must send the instruction to your People Team.

Please note

To make sure no underwriting will apply when you add your spouse or newborn baby to your membership, you must make sure we get the applications on time:

- New spouses: within 30 days of the date of the marriage. Common-law spouses or second and other spouses must provide the Scheme with a partner declaration or affidavit, or a traditional marriage certificate
- Your own newborn baby: within 30 days of birth of the baby.
- When you adopt a newborn baby: within 90 days of the adoption.

Claim from the Scheme

You are responsible for

- Checking your personal file with your doctor to ensure all your details are up-to-date.
- Checking all your details against your membership card, especially your membership number.
- Asking if your doctor charges the Scheme Rate or a higher rate, and negotiate with him or her to charge at the Scheme Rate.
- Sending the Scheme a detailed claim and not just a receipt, as the Scheme needs the details to process your claim.
- Ensuring your membership number, doctor's details and the practice number are clearly visible on the claim.

Note: If your doctor sends the claim electronically, you do not need to send a copy to the Scheme.

By law, each claim must contain the following information

- The surname and initials of the member.
- The surname, first name and other initials, if any, of the patient.
- The name of the Medical Scheme.
- The membership number.
- The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service.
- The relevant diagnosis and such other item code numbers that relate to such relevant health service.
- The date on which each relevant health service was rendered.
- The nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member, and the name, quantity and dosage of and net amount payable by the member in respect of the medicine.

Choose from several ways to send claims

There are various ways of sending claims to the Scheme for processing:

01 Your doctor can send the claim to the Scheme.

02 Scan (take a photo with your phone) and send your claim by email to claims@retailmedicalscheme.co.za or fax to 0860 329 252.

03 Post your claim to the Scheme by sending it to PO Box 652509, Benmore 2010 or Postnet Suite 116, Private Bag X19, Milnerton 7435

What happens after you send your claim

Once the Scheme receives your claim, it is scanned and captured on the system. The Scheme will then assess the claim and make sure all the information on the claim matches the information the Scheme has on record.

The turnaround time for processing claims is 72 hours – from the time the Scheme receives a claim to the time the Scheme processes it. It is then approved or declined for payment. Once the Scheme has made the payment, you will receive a claims notification detailing all the claims payments, or a claims statement.

How to check on the status of your claim

To see the status of your claim, you can access the website at www.retailmedicalscheme.co.za or check your claim statement. If the Scheme has your email address, you will receive a claims payment notification, that will provide you with all the information about the latest claims the Scheme has processed for you – how it was assessed against your available benefits, how it was paid and what the latest balances are – Medical Savings Account (MSA) or others.

Time limit for claims submission

You must send your claim as soon as possible. If the Scheme does not process and pay it within four months after the treatment date, your claim is no longer valid and will not be paid.

When you have questions about any of your benefits or contributions, or want to query how the Scheme has paid your claims, please call the Scheme at 0860 101 252, or email service@retailmedicalscheme.co.za. If you do not lodge a query within four months of the Scheme first informing you of how a claim was paid, your query will no longer be valid, so try and do it as soon as possible after receiving your claims notification or statement.

Note that when the Scheme pays a claim directly to you, it is your responsibility to pay the provider the full claimed amount.

Complain if you disagree with a decision about your membership or a claim

If you are not satisfied that your enquiry or complaint was resolved, email service@retailmedicalscheme.co.za or send a fax to 021 527 1923 and ask that a Team Leader or the Fund Manager look into your case. You will have to give them all the details that they ask for.

If your query is still not resolved, write to the Principal Officer of Retail Medical Scheme at service@retailmedicalscheme.co.za or Postnet Suite 116, Private Bag X19, Milnerton, 7435

Fraud and abuse

of Scheme benefits

Report fraudulent activities

It is estimated that at least 10% of the annual spend of any Medical Scheme relates to claims that were fraudulently presented for payment.

Some examples of fraud:

- Belonging to two Medical Schemes at the same time and claiming double.
- Sunglasses being billed as prescription glasses.
- Allowing your provider to claim for procedures and treatments that were not performed.
- Giving non-registered persons access to benefits through misrepresentation, for example when you give your membership card to your neighbour, who is not a Retail Medical Scheme member, to undergo treatment under your name.

Check that all transactions related to your membership are true and correct. Report any suspicions you may have immediately, by contacting Discovery's toll-free, tip-off line on 0800 004 500 or email forensics@discovery.co.za

Or you may remain anonymous if you prefer:

- SMS 43477 and include the description of the alleged fraud.
- Toll-free fax: 0800 007 788
- Email: discovery@tip-offs.com
- Post: Freepost DN298, Umhlanga Rocks 4320.

All calls or contact will be handled with the strictest confidentiality.

Any person caught committing fraud will be listed on a register and steps will be taken to recover any money you, or the Scheme, may have lost in the process.

Your responsibilities as a member

At all times, you have to:

- Provide the Scheme with information that is true and correct.
- Report any changes to your membership immediately and keep your contact details and other information provided to the Scheme updated.
- Use benefits wisely and when necessary only – this helps to contain contribution increases and ensures the Scheme can pay claims now and in the future.
- Avoid having to pay part of the claim yourself by using the services of the Scheme's Preferred or Designated Service Providers (DSP).
- Report suspected fraud immediately, whether you suspect healthcare providers or members are involved. You can report fraud anonymously.
- Pay contributions when they are due.
- Pay any outstanding debt due to the Scheme immediately when you are notified.

How we deal with fraud

The Scheme pays all claims in good faith. Ater payment has been made, claiming patterns and behaviour are properly reviewed and validated to detect unusual conduct or discrepancies. If an irregularity warrants an investigation by the Forensic Department, the relevant provider or member is always given the opportunity to respond.

If, however, it becomes clear from the investigation that someone has committed fraud, the perpetrator may face criminal or civil charges. If a healthcare professional is involved, fraudulent activity may result in the provider losing a career in healthcare, by having their required professional registration cancelled. The Scheme may also no longer pay the provider directly, or not at all. Members who are guilty of committing fraud could lose their membership of the Scheme and employees of the Administrator could face disciplinary action and be dismissed.

Protecting your

Personal Information

Personal information about you, your spouse and your dependants include information about their health, financial status, gender, age, contact numbers and addresses.

When you become a member of the Scheme, you trust us with personal information about yourself and your dependants. We are committed to protecting your right to privacy. We collect, use, share and otherwise process your personal information in line with the Protection of Personal Information Act (POPIA) to:

- Administer your benefits.
- Provide managed care services to you.
- Provide relevant information to a contracted third party who requires the information to provide a healthcare service to you.
- To analyse risks, trends, and profiles.
- To allow external health care providers to evaluate certain clinical information when you require medical treatment.

Examples of this include

- Getting your personal information from other relevant sources, including healthcare providers, contracted service providers and processing the information to assess and value a claim for medical expenses.
- Verifying with the relevant sources that your personal information is true, correct, and complete.
- Getting information from and sharing information with your employer that is relevant to your membership, with due regard for considerations of confidentiality in respect of your state of health.
- Communicating with you about any benefit or contribution changes.

If a third party, even your own spouse, asks the Scheme or Administrator for any of your personal information, we will share it with them only if:

- You have already given your consent for the disclosure of this information to that third party.
- We have a legal or contractual duty to give the information to that third party.
- We need to share it with them for risk analytical or fraud detection, prevention or recovery purposes.

You have the right to know what personal information the Scheme and Administrator holds about you.

If you wish to receive this information, please complete an 'Access Request Form', attached to the PAIA manual on the Scheme's website, and specify the information you would like to receive. We will take all reasonable steps to confirm your identity before providing details of your personal information. We are entitled to charge a fee for this service and will let you know what it is at the time of your request.

If you believe we failed to adequately protect your information, we encourage you to first follow the Scheme's internal complaints process to resolve the complaint. We explain the complaints and disputes process on the Scheme's website (www.retailmedicalscheme.co.za). If you are not satisfied after this process, you have the right to lodge a complaint with the Information Regulator.

You must give consent for someone else to act on your behalf

If you want a third party to act on your behalf, for instance when you are in hospital, you must complete a 'Permission to make information available to a third party' form, available on www.retailmedicalscheme.co.za or from the call centre at 0860 101 252.

It is advisable that you consider your position on granting such access and complete a consent form before you are no longer able to manage your own affairs. If you don't, the Scheme will not be able to disclose your personal information to a person making enquiries on your behalf, even if that person is your spouse.

Benefits 2024

CORE BENEFITS

Subject to preauthorisation

Prescribed Minimum Benefits (PMB) will be paid as per the Regulations. Emergency care and other elective PMB procedures, treatment and care, paid in full, subject to the use of Designated Service Providers (DSP) and the Scheme's protocols and clinical guidelines. If you voluntarily choose to undergo the services at non-DSP providers, claims will be paid at 80% of the Scheme Rate.

If you choose to use non-formulary medicine for Chronic Disease List (CDL) conditions, the Scheme pays up to a Chronic Drug Amount (CDA). All non-PMB benefits paid at 100% of the Scheme Rate unless otherwise stated.

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
Advanced illness benefit Out-of-hospital palliative care for patients with life-limiting conditions, including cancer. Includes hospice visits, accommodation, prescribed medicine and materials and home-based care	100% of the Scheme Rate Subject to authorisation, baskets of care and treatment meeting the Scheme's guidelines and managed care criteria. Subject to PMB	100% of the Scheme Rate Subject to authorisation, baskets of care and treatment meeting the Scheme's guidelines and managed care criteria. Subject to PMB
Advanced illness member support programme For patients with advanced illnesses, requiring support at a time when they are trying to manage their symptoms, and understand their healthcare needs	100% of the Scheme Rate Subject to authorisation and a basket of care	100% of the Scheme Rate Subject to authorisation and a basket of care
Allied and Therapeutic extender benefit	Subject to benefit entry criteria for a specific list of conditions and further subject to authorisation	Subject to benefit entry criteria for a specified list of conditions and further subject to authorisation
Assisted reproductive therapy Healthcare services, which include consultations, radiology (including ultrasound scans), pathology, embryo freezing, storage and transfer, related admission costs, related laboratory fees, supportive medicine, oocyte and sperm cryopreservation and egg donor matching fees.	Subject to PMB	Benefits in addition to PMB, limited to R128 800 per person per year. Paid up to a maximum of 75% of the Scheme Rate. Subject to the services provided by the Scheme's Preferred Provider (where applicable), protocols, the condition meeting the Scheme's entry criteria and guidelines. Cryopreservation paid for up to 5 years
Blood glucose monitoring devices		
Bluetooth enabled blood glucose monitoring devices For beneficiaries approved and registered for Diabetes on the Chronic Illness Benefit	100% of the Scheme Rate, limited to one device per beneficiary per year obtained from the Scheme's DSP	100% of the Scheme Rate, limited to one device per beneficiary per year obtained from the Scheme's DSP

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
Continuous blood glucose monitoring sensors and devices	No benefit	100% of the Scheme Rate **Sensors**: Limited to a maximum of R1 750 per patient per month, subject to a 25% co-payment. **Devices**: Limited to MSA and thereafter ATB, subject to the applicable Scheme Rate. Benefits subject to registration on the Chronic Illness Benefit for Diabetes Mellitus 1, clinical criteria, authorisation and the device obtained from a DSP pharmacy.
Chronic Illness Benefit **Chronic Medication** Access to 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions Subject to application and benefit entry criteria	Approved medicine on the Scheme's medicine list (formulary) is covered up to the Scheme Medicine Rate. Medicine that is not on the formulary is covered up to a set monthly Chronic Drug Amount (CDA)	Approved medicine on the Scheme's medicine list (formulary) is covered up to the Scheme Medicine Rate. Medicine that is not on the formulary is covered up to a set monthly Chronic Drug Amount (CDA)
PMB Baskets of Care For diagnosis, and ongoing management of approved PMB conditions	100% of Scheme Rate Limited to treatment basket according to PMB and rendered by DSP	100% of Scheme Rate Limited to treatment basket according to PMB and rendered by DSP
Circumcisions Medically necessary circumcisions performed in- and out-of-hospital (in doctor's rooms)	Paid up to 100% of the Scheme Rate Preauthorisation required if performed in-hospital Unlimited, subject to clinical rules	Paid up to 100% of the Scheme Rate Preauthorisation required if performed in-hospital Unlimited, subject to clinical rules
Cochlear and auditory brain implants	100% of the Scheme Rate Limited to R274 600 per beneficiary	100% of the Scheme Rate Limited to R274 600 per beneficiary
Colorectal cancer surgery and preventative screenings	100% of the Scheme Rate if performed by DSP Specialist at a hospital in the DSP network for the management of colorectal cancer surgery. If procedure is done by a non-DSP provider at a non-Network hospital, paid at 80% of the Scheme Rate. Colorectal cancer screening: one faecal occult blood test or one faecal immunochemical test for persons aged 45 to 75 years, per year. One colonoscopy for members found to be at risk	100% of the Scheme Rate if performed by DSP Specialist at a hospital in the DSP network for the management of colorectal cancer surgery. If procedure is done by a non-DSP provider at a non-Network hospital, paid at 80% of the Scheme Rate. Colorectal cancer screening: one faecal occult blood test or one faecal immunochemical test for persons aged 45 to 75 years, per year. One colonoscopy for members found to be at risk
Day surgery procedures network For a defined list of procedures (see page 17 of this Benefit Brochure)	100% of the Scheme Rate at a facility in the Scheme's DSP day surgery network for any procedure listed on the Scheme's defined list of procedures. A R6 650 deductible applies if the patient chooses to undergo one of the defined procedures at a non-network facility 100% for the Scheme Rate for related accounts and 100% of the Scheme Medication Rate for medicine used during the procedure Subject to authorisation and clinical criteria.	100% of the Scheme Rate at a facility in the Scheme's DSP day surgery network for any procedure listed on the Scheme's defined list of procedures. A R6 650 deductible applies if the patient chooses to undergo one of the defined procedures at a non-network facility 100% for the Scheme Rate for related accounts and 100% of the Scheme Medication Rate for medicine used during the procedure Subject to authorisation and clinical criteria.

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
Dental and oral surgery Severe life threatening infections, internal temporomandibular joint surgical procedures, cancer and certain trauma related surgery, cleft lip and palate repairs, subject to clinical entry criteria and PMBs	100% of the Scheme Rate Unlimited	100% of the Scheme Rate Unlimited
Dental – Final phase surgical dental implants For oncology-related and other specific trauma cases	100% of the Scheme Rate Unlimited	100% of the Scheme Rate Unlimited
Basic dental trauma benefit For a sudden and unanticipated impact injury because of an accident or injury to teeth and the mouth, resulting in partial or complete loss of one or more teeth that requires urgent care In- or out-of-hospital	**In-Hospital** Subject to pre-authorisation, clinical entry criteria, treatment guidelines and protocols. Members must make an upfront payment (deductible) to the hospital or Day Clinic Adult: Day Case R5 300, In-Hospital R8 300 Child < 12 years: Day Case R1 500, In-Hospital R3 250 **In- and Out-of-Hospital** Dentist and related accounts paid from the Major Medical Benefit, up to 100% of the Scheme Rate Dental appliances and prostheses, and the placement thereof, and orthodontics (surgical and non-surgical). Paid from the Major Medical Benefit, subject to a joint limit of R65 000 per person per year for treatment in- or out-of-hospital.	**In-Hospital** Subject to pre-authorisation, clinical entry criteria, treatment guidelines and protocols. Members must make an upfront payment (deductible) to the hospital or Day Clinic Adult: Day Case R5 300, In-Hospital R8 300 Child < 12 years: Day Case R1 500, In-Hospital R3 250 **In- and Out-of-Hospital** Dentist and related accounts paid from the Major Medical Benefit, up to 100% of the Scheme Rate Dental appliances and prostheses, and the placement thereof, and orthodontics (surgical and non-surgical). Paid from the Major Medical Benefit, subject to a joint limit of R65 000 per person per year for treatment in- or out-of-hospital.
Dental surgery Elective procedures, in-hospital	100% of Scheme Rate, also for Specialists and GPs with whom the Scheme has agreed rates Unlimited The following deductibles will apply: Adult: Day Case R5 300, In-Hospital R8 300 Child < 12 years: Day Case R1 500, In-Hospital R3 250	100% of Scheme Rate, also for Specialists and GPs with whom the Scheme has agreed rates Unlimited The following deductibles will apply: Adult: Day Case R5 300, In-Hospital R8 300 Child < 12 years: Day Case R1 500, In-Hospital R3 250
Doctors and allied healthcare services		
In-hospital	100% of Scheme or negotiated DSP Rate Unlimited If non-DSP is used for PMBs, benefits will be paid subject to certain limits and co-payments	100% of Scheme or negotiated DSP Rate Unlimited If non-DSP is used for PMBs, benefits will be paid subject to certain limits and co-payments
Procedures performed in doctors' rooms In lieu of hospitalisation	100% of the Scheme Rate for a defined list of surgical and other procedures performed in the doctor's rooms	100% of the Scheme Rate for a defined list of surgical and other procedures performed in the doctor's rooms

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
Second opinion specialist consultations Second opinion consultation obtained from Cleveland Clinic (America) Requested by the Scheme's Medical Review Team in consultation with the member's doctor	75% of the cost of the consultation, if obtained from the Scheme's Designated Service Provider (DSP) Subject to clinical rules and authorisation	75% of the cost of the consultation, if obtained from the Scheme's Designated Service Provider (DSP) Subject to clinical rules and authorisation
Diabetes and Cardio Care Programmes For beneficiaries who are registered on the Chronic Illness Benefit for certain CDL conditions	100% of the Scheme Rate for GP-related services covered in a treatment basket, subject to referral by the Network GP. If the services of a non-Network GP are used, a 20% co-payment will apply Paid in addition to the normal Prescribed Minimum Benefits Chronic Disease List benefits and treatment basket	100% of the Scheme Rate for GP-related services covered in a treatment basket, subject to referral by the Network GP. If the services of a non-Network GP are used, a 20% co-payment will apply Paid in addition to the normal Prescribed Minimum Benefits Chronic Disease List benefits and treatment basket
Programme to manage Cardio Metabolic Risk Syndrome	100% of the Scheme Rate for certain out-of-hospital services, managed by a Network GP, supported by Dieticians and health coaches. Subject to clinical entry criteria, treatment guidelines, protocols and preferred providers (where applicable)	100% of the Scheme Rate for certain out-of-hospital services, managed by a Network GP, supported by Dieticians and health coaches. Subject to clinical entry criteria, treatment guidelines, protocols and preferred providers (where applicable)
Drug and alcohol rehabilitation	21 days in hospital Detox limited to 3 days	21 days in hospital Detox limited to 3 days
Emergency medical evacuations and transport	100% of the Scheme Rate. Unlimited if the services of Discovery 911 is used	100% of the Scheme Rate. Unlimited if the services of Discovery 911 is used
Endoscopic procedures In hospital: gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	100% of Scheme Rate First R5 450 covered by the member Remainder of the account covered from Core Benefit	100% of Scheme Rate First R5 450 covered from the MSA/ATB, subject to the Overall ATB limit. Remainder of the account covered from Core Benefit
HIV and AIDS-related illnesses Evidence-based protocols and formularies apply Subject to the services being rendered by the Scheme's DSP	100% of the cost Unlimited Managed by the Scheme's HIV management programme. 4 GP consults as part of the basket of care services paid in full if obtained from DSP GP in the Premier Plus Network A 20% co-payment applies if services are not obtained at a DSP GP Subject to PMB	100% of the cost Unlimited Managed by the Scheme's HIV management programme. 4 GP consults as part of the basket of care services paid in full if obtained from DSP GP in the Premier Plus Network A 20% co-payment applies if services are not obtained at a DSP GP Subject to PMB
Home-based care ■ In lieu of hospitalisation ■ After early discharge ■ As a continuation of care after discharge from hospital OR ■ To remotely manage certain chronic illness conditions	100% of the Scheme Rate Unlimited Subject to authorisation or approval Subject to obtaining the services from the Scheme's DSP or Preferred Providers (where applicable), treatment guidelines and clinical and benefit entry criteria Includes benefits for home-monitoring devices for clinically appropriate chronic or acute conditions	100% of the Scheme Rate Unlimited Subject to authorisation or approval Subject to obtaining the services from the Scheme's DSP or Preferred Providers (where applicable), treatment guidelines and clinical and benefit entry criteria Includes benefits for home-monitoring devices for clinically appropriate chronic or acute conditions

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
Hospital benefit Accommodation, theatre fees, materials used, or medication for duration of hospitalisation Subject to preauthorisation	100% of Scheme Rate Unlimited Specific DSP hospitals for Psychiatric care and major joint replacement procedures. If the procedure is not performed in a DSP Hospital, a 20% co-payment applies to the hospital costs	100% of Scheme Rate Unlimited Specific DSP hospitals for Psychiatric care and major joint replacement procedures. If the procedure is not performed in a DSP Hospital, a 20% co-payment applies to the hospital costs
Hospital readmission prevention Benefits available to qualifying patients within 10 to 14 days of leaving the hospital	100% of the Scheme Rate Subject to clinical criteria, managed care guidelines, and authorisation Benefits consist of: ■ A medicine reconciliation at discharge by the treating doctor, ■ Homecare benefits in a defined basket of care, and ■ A follow-up consultation by the treating doctor	100% of the Scheme Rate Subject to clinical criteria, managed care guidelines, and authorisation Benefits consist of: ■ A medicine reconciliation at discharge by the treating doctor, ■ Homecare benefits in a defined basket of care, and ■ A follow-up consultation by the treating doctor
Influenza immunisation High risk members, who are older than 65 years, and members who are registered for the following CIB conditions: chronic obstructive pulmonary disease, Asthma, HIV and AIDS, Diabetes or Chronic renal failure	100% of the Scheme Rate Limited to one immunisation per person per year	100% of the Scheme Rate Limited to one immunisation per person per year
Internal nerve stimulators	100% of the Scheme Rate Limited to R274 600 per beneficiary	100% of the Scheme Rate Limited to R274 600 per beneficiary
Internal prostheses for major joint replacements **In-hospital**	100% of Scheme Rate for the hospital account at a network facility and for all trauma admissions, or 80% if performed at a non-network facility. Unlimited Shoulder joint prosthesis limited to R48 100 and hip/knee joint replacement prosthesis limited to R32 600 per beneficiary per prosthesis if not supplied by the Scheme's Designated Service Provider (DSP) Related accounts paid up to 100% of the Scheme Rate	100% of Scheme Rate for the hospital account at a network facility and for all trauma admissions or 80% if performed at a non-network facility. Unlimited Shoulder joint prosthesis limited to R48 100 and hip/knee joint replacement prosthesis limited to R32 600 per beneficiary per prosthesis if not supplied by the Scheme's Designated Service Provider (DSP) Related accounts paid up to 100% of the Scheme Rate
Maternity programme	100% of the Scheme Rate for medical expenses normally paid for under the Out-of-Hospital Benefit for members registered on the Maternity Programme. If not registered on the Maternity Programme, available Day-to-day Benefits apply	100% of the Scheme Rate for medical expenses normally paid for under the Out-of-Hospital Benefit for members registered on the Maternity Programme. If not registered on the Maternity Programme, available Day-to-day Benefits apply

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
Cover during pregnancy	8 antenatal Midwife, GP or Gyneacologist consultations 1 Nuchal Translucency, 1 Non-Invasive Prenatal Test (NIPT) or 1 T21 Chromosome test, subject to clinical entry criteria 2 2D Ultrasound scans (3D or 4D scans paid up to the cost of a 2D scan only) 5 pre- or post-natal classes or consultations with a registered nurse	8 antenatal Midwife, GP or Gyneacologist consultations 1 Nuchal Translucency, 1 Non-Invasive Prenatal Test (NIPT) or 1 T21 Chromosome test, subject to clinical entry criteria 2 2D Ultrasound scans (3D or 4D scans paid up to the cost of a 2D scan only) 5 pre- or post-natal classes or consultations with a registered nurse
Cover for newborn baby or toddler up to the age of two years	2 visits to a GP, Paediatrician or Ear, Nose and Throat (ENT) specialist	2 visits to a GP, Paediatrician or Ear, Nose and Throat (ENT) specialist
Cover for the mother of the newborn baby for up to 2 years after the birth	1 consultation at a GP or Gyneacologist for post-natal complications 1 nutritional assessment at a dietician 2 mental health consultations with a counsellor or psychologist 1 lactation consultation with a registered nurse or lactation specialist	1 consultation at a GP or Gyneacologist for post-natal complications 1 nutritional assessment at a dietician 2 mental health consultations with a counsellor or psychologist 1 lactation consultation with a registered nurse or lactation specialist
Medication, materials or external medical appliances (billed by the Hospital as To Take Out)	Paid from the Chronic Illness Benefit, where available, or from the Out-of-Hospital Benefit, as per the prescribed medicine or External Medical Items benefit	Paid from the Chronic Illness Benefit, where available, or from MSA/ATB, subject to the Overall Annual ATB limit, as per the prescribed medicine or External Medical Items benefit
Mental Health Care	An overall limit of 21 treatment days apply in- or out-of-hospital Limited to a maximum of 21 days in hospital treatment in a Designated Service Provider hospital. If it is not performed in a Designated Service Provider Hospital, a 20% co-payment applies to the hospital costs OR a maximum of 15 out-of-hospital sessions with a psychiatrist or psychologist	An overall limit of 21 treatment days apply in- or out-of-hospital Limited to a maximum of 21 days in hospital treatment in a Designated Service Provider hospital. If it is not performed in a Designated Service Provider Hospital, a 20% co-payment applies to the hospital costs OR a maximum of 15 out-of-hospital sessions with a psychiatrist or psychologist
Mental Care Programme For the out-of-hospital management of acute and/or episodic major depression and relapse prevention	100% of the Scheme Rate for a basket of GP-related services, subject to clinical criteria and referral by the Network GP or the treating provider for virtual Cognitive Behavioural Therapy Paid in addition to the normal Prescribed Minimum Benefits Chronic Disease List benefits and PMB baskets of care	100% of the Scheme Rate for a basket of GP-related services, subject to clinical criteria and referral by the Network GP or the treating provider for virtual Cognitive Behavioural Treatment Paid in addition to the normal Prescribed Minimum Benefits Chronic Disease List benefits and PMB baskets of care
MRI and CT scans Subject to preauthorisation	100% of Scheme Rate Unlimited	100% of Scheme Rate Unlimited

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
Oncology-related benefits Subject to authorisation and/or approval and the treatment meeting the Scheme's clinical entry criteria Includes cover for: chemo- and radiotherapy; oncologist's consultations; pathology subject to a defined list; radiology; supportive treatment; stoma therapy; terminal care; other oncology treatment and facility fees	100% of the Scheme Rate Unlimited in a 12-month cycle. All claims accumulate to a threshold of R250 000. Thereafter the benefit is paid at 80% of the Scheme Rate for all further treatment and you will need to pay the balance from your own pocket. This amount could be more than 20% if your treatment cost is higher than the Scheme Rate PMB oncology-related claims are paid with no co-payment, provided you make use of the services of a Designated Service Provider (DSP), where relevant and use medicine that is on the Scheme's preferred list. You have access to local and international bone marrow donor searches and approved stem cell harvesting and transplants subject to authorisation, clinical criteria and review. Subject to the services being rendered by a Preferred Provider. If not a limit of R1 million applies per beneficiary per year	100% of the Scheme Rate Unlimited in a 12-month cycle. All claims accumulate to a threshold of R250 000. Thereafter the benefit is paid at 80% of the Scheme Rate for all further treatment and you will need to pay the balance from your own pocket. This amount could be more than 20% if your treatment cost is higher than the Scheme Rate PMB oncology-related claims are paid with no co-payment, provided you make use of the services of a Designated Service Provider (DSP), where relevant and use medicine that is on the Scheme's preferred list. You have access to local and international bone marrow donor searches and approved stem cell harvesting and transplants subject to authorisation, clinical criteria and review. Subject to the services being rendered by a Preferred Provider. If not a limit of R1 million applies per beneficiary per year
Cancer-related PET scans Subject to using the services of Network providers and preauthorisation	The overall Oncology Threshold limit and 20% co-payment above the Threshold apply for non-PMB claims. If the services of a non-network provider are used, the claim will be paid at 80% of the Scheme Rate before and after the Oncology threshold	The overall Oncology Threshold limit and 20% co-payment above the Threshold apply for non-PMB claims. If the services of a non-network provider are used, the claim will be paid at 80% of the Scheme Rate before and after the Oncology threshold
Organ transplants Hospitalisation and harvesting of the organ, subject to preauthorisation and certain clinical entry criteria	100% of the cost Unlimited Subject to PMB	100% of the cost Unlimited Subject to PMB
Medicine for immuno-suppressive therapy	100% of the Scheme's Medicine Rate Subject to CDA	100% of the Scheme's Medicine Rate Subject to CDA
Overseas Treatment Benefit Cover for planned or elective treatment or procedures that is not available in South Africa	No Benefit	Paid at 80% of the cost, limited to R565 000 per beneficiary per year. Subject to authorisation, and members paying upfront for the treatment and claiming back from the Scheme once back in South Africa. Treatment started overseas, requiring pre- or post-treatment care, which is available in South Africa: the Scheme will only cover the portion of the treatment that was not available in South Africa. Complications from treatment received, when the member is still overseas, will be paid from the available benefit, subject to the limit.
Oxygen rental	100% of the Scheme Rate Unlimited if obtained from the Scheme's Designated Service Provider, VitalAire. If DSP is not used, claims will be paid up to the Scheme Rate only	100% of the Scheme Rate Unlimited if obtained from the Scheme's Designated Service Provider, VitalAire. If DSP is not used, claims will be paid up to the Scheme Rate only

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
Pneumococcal vaccine Persons older than 65 years and the following persons with recurrent pneumonia admissions: children under 14 and registered Chronic Illness Benefit (CIB) persons with the following CIB conditions: Asthma, Bronchiectasis, Cardiac failure, Cardiomyopathy, Chronic Obstructive Pulmonary disease (COPD), Chronic Renal Disease, Coronary Artery Disease, Diabetes (Type I and II) and HIV	Paid up to 100% of the Scheme Rate for one approved pneumococcal vaccine per qualifying person per lifetime	Paid up to 100% of the Scheme Rate for one approved pneumococcal vaccine per qualifying person per lifetime
Renal care Subject to use of the Scheme's DSP	100% of the Scheme Rate If Scheme's DSP is not used, a co-payment equal to the difference between the cost and the Scheme Rate will apply	100% of the Scheme Rate If Scheme's DSP is not used, a co-payment equal to the difference between the cost and the Scheme Rate will apply
Screening benefits		
Pharmacy Screening Benefit Blood glucose; blood pressure; cholesterol and body mass index (BMI) obtained from the Scheme's DSP	100% of the Scheme Rate Paid once per year, at the Scheme Rate, per beneficiary for a single or basket of these tests. Thereafter paid from Out-of-Hospital Benefit or by member	100% of the Scheme Rate Paid once per year, at the Scheme Rate, per beneficiary for a single or basket of these tests. Thereafter paid from MSA or ATB
Additional Screening Benefits for Seniors	Group of age-appropriate screening tests per beneficiary per year, for persons 65 years and older. One additional comprehensive screening assessment per beneficiary per year at a Network GP for at risk persons	Group of age-appropriate screening tests per beneficiary per year, for persons 65 years and older. One additional comprehensive screening assessment per beneficiary per year at a Network GP for at risk persons
Screening Benefit for children between the ages of 2 and 18 years Body mass index, including counselling if necessary, basic hearing and dental screenings and milestone tracking for children under the age of 8 years	100% of the Scheme Rate Paid once per year, at the Scheme Rate, per beneficiary for a single or basket of these tests. Thereafter paid from Out-of-Hospital Benefit or by member	100% of the Scheme Rate Paid once per year, at the Scheme Rate, per beneficiary for a single or basket of these tests. Thereafter paid from MSA or ATB
Other Screening Benefits The following screening benefits obtained from any relevant healthcare provider ■ Mammogram ■ Pap smear ■ Prostate Antigen Specific (PSA) Test Subject to PMB	100% of the Scheme Rate for the actual test codes only. Related consultations and procedures paid subject to PMB from the available Day-to-day benefits. The following annual limitations apply per beneficiary ■ 1 Mammogram every two years ■ 1 Pap smear every three years ■ 1 Prostate Antigen Test every year Subject to clinical criteria and authorisation, the Scheme pays for repeat Mammography, Pap smears, MRI breast scans, a once-off BRCA test	100% of the Scheme Rate for the actual test codes only. Related consultations and procedures paid subject to PMB from the available Day-to-day benefits. The following annual limitations apply per beneficiary ■ 1 Mammogram every two years ■ 1 Pap smear every three years ■ 1 Prostate Antigen Test every year Subject to clinical criteria and authorisation, the Scheme pays for repeat Mammography, Pap smears, MRI breast scans, a once-off BRCA test
GP consultations for mammograms and Pap smears, subject to PMBs	100% of the Scheme Rate	100% of the Scheme Rate

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
Pre-operative assessment For members undergoing one of the following planned surgical procedures: Colorectal cancer surgery, Breast cancer surgery, Prostate cancer surgery, Coronary Artery Bypass Graft (CABG) surgery, or elective hip and knee Arthroplasty	Limited to a basket of out-of-hospital care set by the Scheme, paid once per procedure. Subject to authorisation and clinical criteria	Limited to a basket of out-of-hospital care set by the Scheme, paid once per procedure. Subject to authorisation and clinical criteria
Specialty Medical technology Benefit (SMTB)	No benefit	100% of the Scheme Rate Limited to R200 000 per beneficiary with a variable co-payment up to 20%, based on the condition and the medicine prescribed
Spinal care programme In- and out-of-hospital spinal care and surgery for defined clinically appropriate procedures, which include Lumbar Fusion, Cervical Fusion, Laminectomy or Laminotomy	100% of the Scheme Rate for the hospital account at a network facility or for all trauma admissions. If the services are not obtained in a network facility, paid up to 80% of the Scheme Rate. Limited to one procedure per year Related in-hospital accounts paid up to a maximum of 100% of the Scheme Rate Spinal prostheses or devices are paid in full if obtained from the Scheme's DSP, up to 100% of the Scheme Rate. If the prosthesis or device is not obtained from DSP, limited to R27 700 for one level and R55 400 for two or more levels Out-of-hospital conservative spinal care subject to a basket of care. Subject to authorisation, treatment guidelines and clinical criteria	100% of the Scheme Rate for the hospital account at a network facility or for all trauma admissions. If the services are not obtained in a network facility, paid up to 80% of the Scheme Rate. Limited to one procedure per year Related in-hospital accounts paid up to a maximum of 100% of the Scheme Rate Spinal prostheses or devices are paid in full if obtained from the Scheme's DSP, up to 100% of the Scheme Rate. If the prosthesis or device is not obtained from DSP, limited to R27 700 for one level and R55 400 for two or more levels Out-of-hospital conservative spinal care subject to a basket of care. Subject to authorisation, treatment guidelines and clinical criteria
Statutory Prescribed Minimum Benefits (PMB)	Unlimited, subject to PMB approval Paid in full at the Scheme's Designated Service Providers or Preferred Providers If Designated Service Providers or Preferred Providers are not used, claims will be paid at the Scheme Rate and co-payments may apply	Unlimited, subject to PMB approval Paid in full at the Scheme's Designated Service Providers and Preferred Providers If Designated Service Providers or Preferred Providers are not used, claims will be paid at the Scheme Rate and co-payments may apply

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
Trauma recovery benefit Subject to clinical entry criteria and protocols Benefits for certain day-to-day care after one of the following traumatic incidents: crime-related injuries, conditions resulting from a near-drowning, poisoning and severe anaphylactic (allergic) reaction; if the trauma results in one of the following: paraplegia, quadriplegia, severe burns and external and internal head injuries or loss of limb. Allied, Therapeutic and Psychology healthcare services: chiropractors, counsellors, dietitians, homeopaths, nursing providers, occupational therapists, podiatrists, physiotherapists, social workers, psychologists, speech and hearing therapists psychometrists	100% of the Scheme Rate paid from Core Benefits to the end of the year following that in which the trauma occurred for all medical expenses normally paid for under the Out-of-Hospital Benefit, excluding cover for optometry and dentistry The following limits apply per beneficiary: Allied, Therapeutic and Psychology healthcare benefits M R 9 300 M + 1 R14 000 M + 2 R17 400 M + 3+ R20 950 Prescribed Medicine M R18 100 M + 1 R21 450 M + 2 R25 450 M + 3+ R30 950 External Medical Appliances R30 500 with a sub-limit for Hearing aids R17 000 Prosthetic limbs R98 800	100% of the Scheme Rate from the Core benefits to the end of the year following that in which the trauma occurred for all medical expenses normally paid for under MSA and ATB benefits, excluding cover for optometry, dentistry and OTC medicine The following limits apply per beneficiary: Allied, Therapeutic and Psychology healthcare benefits M R 9 300 M + 1 R14 000 M + 2 R17 400 M + 3+ R20 950 Prescribed Medicine M R18 100 M + 1 R21 450 M + 2 R25 450 M + 3+ R30 950 External Medical Appliances R30 500 with a sub-limit for Hearing aids R17 000 Prosthetic limbs R98 800
Trauma counseling Available to each beneficiary on the membership who were not directly affected by the trauma incident, to the end of the year following that in which the trauma occurred	6 psychologist or social worker counseling sessions per person	6 psychologist or social worker counseling sessions per person
World Health Organization (WHO) Outbreak Benefit		
For out-of-hospital management and appropriate supportive treatment of: 1. COVID-19, subject to Prescribed Minimum Benefits 2. MonkeyPox	Limited to a basket of care as set by the Scheme per condition. Subject to the use of the services of the Scheme's DSPs or Preferred Providers, as it may apply, protocols and the condition and treatment meeting the Scheme's entry criteria and guidelines.	Limited to a basket of care as set by the Scheme per condition. Subject to the use of the services of the Scheme's DSPs or Preferred Providers, as it may apply, protocols and the condition and treatment meeting the Scheme's entry criteria and guidelines.

Day-to-day

Benefits 2024

DAY-TO-DAY BENEFITS

Prescribed Minimum Benefits (PMB) will be paid as per the Regulations. Emergency medical care and other elective PMB procedures, treatment and care, paid in full subject to the use of Designated Service Providers (DSP) and the Scheme's protocols and clinical guidelines. Where members voluntarily choose to undergo the services at non-DSP providers, claims will be paid at 80% of the Scheme Rate.

When members choose to use non-formulary medicine for Chronic Disease List (CDL) conditions, the Scheme pays up to a Chronic Drug Amount (CDA). All non-PMB benefits paid at 100% of the Scheme Rate unless otherwise stated.

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
Out-of-Hospital Benefit	Cover for the different applicable disciplines provided as per the specific benefits listed for this Benefit Option Limited to R2 000 per beneficiary to a maximum of R4 050 per family	Cover for the different applicable disciplines provided as per the specific benefits listed for this Benefit Option, subject to MSA and limited overall Above Threshold limit
Annual Threshold	Not applicable	Annual Threshold: P R12 360 A R10 560 C R 4 920 (Maximum 3 children)
Above Threshold Benefit (ATB)	Not applicable	ATB limit: P R13 850 A R 8 400 C R 2 950 (Maximum 3 children)
Medical Savings Account (MSA)	Not applicable	All day-to-day benefits are first payable from the MSA and thereafter from the limited overall Above Threshold Benefit Limit (ATB): P R12 360 A R10 560 C R 4 920 (Maximum 3 children)
Acute medicine	Preferentially priced generic and brand medicine paid up to a maximum of 100% of the Scheme Rate Non-preferentially priced generic and brand medicine: paid up to 75% of the Scheme Rate Paid subject to the Out-of-Hospital Benefit	Preferentially priced generic and brand medicine paid up to a maximum of 100% of the Scheme Rate Non-preferentially priced generic and brand medicine: paid up to 75% of the Scheme Rate Paid from MSA and thereafter from ATB Subject to the following sub-limits (including benefits from MSA) and the overall Above Threshold Benefit Limit: M R17 100 M + 1 R20 200 M + 2 R23 950 M + 3+ R29 050

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
Allied and alternative healthcare professionals, including: ■ Biokineticists ■ Nursing agencies/ HomeCare nurses ■ Occupational therapists ■ Physiotherapists ■ Speech and hearing therapists and acousticians ■ Homeopaths ■ Registered counsellors ■ Registered nurses ■ Dieticians ■ Psychometrists ■ Social workers ■ Podiatrists ■ Chiropractors ■ Psychologists	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit Biokineticists specifically limited to 15 treatments per year, subject to available funds in the Out-of-Hospital Benefit	100% of the Scheme Rate From MSA and thereafter from ATB, subject to the following sub-limits (including benefits from MSA): M R16 550 M + 1 R22 250 M + 2 R27 200 M + 3+ R31 250 Subject to overall Above Threshold limit, except PMB Biokineticists limited to 15 treatments per year, and the limits as indicated above
Antenatal care Applies if mother is not registered on the Maternity Programme	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit	100% of the Scheme Rate From MSA and thereafter from ATB, subject to a sub-limit (including benefits from MSA) of R2 300 per beneficiary Further subject to overall Above Threshold limit
Dentistry Conservative	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit	100% of the Scheme Rate From MSA and thereafter from ATB Subject to overall Above Threshold limit
Dental devices, appliances and orthodontics (including costs for orthognathic treatment) Includes dental appliances and prostheses (fixed and removable), implant components and orthodontics (surgical and non-surgical)	No benefit	100% of the Scheme Rate From MSA and thereafter from ATB, limited to R22 800 per beneficiary Subject to overall Above Threshold limit
Endoscopic procedures Out-of-Hospital: Gastroscopy, Colonoscopy, Sigmoidoscopy and Proctoscopy	100% of Scheme Rate paid from the Core Benefit	100% of Scheme Rate paid from the Core Benefit
External medical items Including prostheses, low vision devices and wigs for alopecia	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit, except for PMBs Limited to one wig per beneficiary per year. Wigs for alopecia must be prescribed by a dermatologist	100% of the Scheme Rate From MSA and thereafter from ATB, subject to overall Above Threshold limit, except for PMBs Limited to R5 000 per wig and one wig per beneficiary per year. Wigs for alopecia must be prescribed by a dermatologist

BENEFITS	ESSENTIAL OPTION	ESSENTIAL PLUS OPTION
General Practitioners and Specialists Including psychiatrists and virtual consultations with a paediatrician for children aged 10 years and younger Subject to DSP arrangements for Specialists and GPs PMBs paid in full at DSP only	100% of the Scheme Rate or the negotiated, applicable DSP Rate. 80% of the Scheme Rate if DSPs are not used for PMB services Subject to the applicable limits in the Out-of-Hospital Benefit, except for PMBs	100% of the Scheme Rate or the negotiated, applicable DSP Rate. 80% of the Scheme Rate if DSPs are not used for PMB services Paid from MSA and thereafter from ATB Subject to overall Above Threshold limit
Optical e.g. spectacles, contact lenses, refractive surgery	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit	100% of the Scheme Rate From MSA and thereafter from ATB, subject to a sub-limit (including benefits from MSA) of R6 450 per beneficiary Subject to overall Above Threshold limit
Optometrists fees	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit	100% of the Scheme Rate From MSA and thereafter from ATB, subject to overall Above Threshold limit
Over-the-Counter Medicine Including Schedule 0,1 and 2 medicine, even if prescribed	No benefit	100% of Scheme Rate From MSA only with no accumulation to the Threshold
MRI/CT scans Out-of-Hospital	100% of the Scheme Rate Paid from the Core Benefit	100% of the Scheme Rate Paid from the Core Benefit
Radiology and Pathology (including X-Rays) and Pathology	100% of the Scheme Rate Subject to the applicable limits in the Out-of-Hospital Benefit, except for PMBs Includes payment for specific pathology tests conducted in a doctor's rooms, subject to the use of an accredited device and the submission of the test results as required by the Scheme	100% of Scheme Rate from MSA and thereafter from ATB Subject to overall Above Threshold limit, except for PMBs Includes payment for specific pathology tests conducted in a doctor's rooms, subject to the use of an accredited device and the submission of the test results as required by the Scheme

You have access to the

WELLTH *fund*

Available to all existing Retail Medical Scheme members from 1 January 2024 to 31 December 2025. New members joining after 1 January 2024 will be eligible for the benefits of the WELLTH Fund in the year of them joining the Scheme and up to the end of the next year.

General health

You have access by primary healthcare screening which include services for visual, hearing, dental and skin conditions. You also have access to one GP screening consultation per beneficiary.

Physical health

You have access to physical wellbeing screening at a dietician, chiropractor, biokinetisist and/or physiotherapist

Mental health

You have access to a mental wellness check-up to support mental wellbeing.

Women and men's health

You have access to a range of women and men's screening and prevention healthcare services. These include for example a:

- Gynaecological, prostate and/or heart consultation with your doctor
- Bone density check

Children's health

You have access to a children wellness visit which include growth and developmental milestones assessments with a occupational therapist, speech therapist and/or physiotherapist.

Medical monitoring devices

You have access to certain medical monitoring devices which helps measure for example blood pressure, cholesterol, blood sugar and respiratory.

How to get access

The WELLTH Fund is available for two benefit years, once all beneficaries who are older than 2 years complete their age-appropriate screening assessments at a provider in our Wellness Network. For new joiners, the benefit is available in the year of joining and the year thereafter.

What limits apply

The benefit is available once per beneficiary per lifetime. Qualifying healthcare services are covered up to a maximum of the Scheme Rate, subject to the overall benefit limit.

Your WELLTH Fund limit is dependant on the size and make up of your family on your membership:

- R2,500 per member and adult dependant
- R1,250 per child dependant two years and older
- Up to a maximum of R10,000 per family

The WELLTH Fund is available to all registered beneficiaries. The WELLTH Fund will not cover screening and prevention healthcare services already covered by other defined benefits.

Contributions

2024

		TOTAL CONTRIBUTIONS		
	INCOME	PRINCIPAL MEMBER	SPOUSE OR ADULT DEPENDANT	CHILD DEPENDANT
ESSENTIAL OPTION	R0 – R1 000	R1 102	R818	R414
	R1 001 – R2 500	R1 258	R824	R414
	R2 501 – R4 000	R1 340	R882	R414
	R4 001 – R6 000	R1 456	R942	R414
	R6 001 – R8 000	R1 502	R1 010	R428
	R8 001 – R10 000	R1 754	R1 184	R472
	R10 001+	R1 862	R1 336	R484

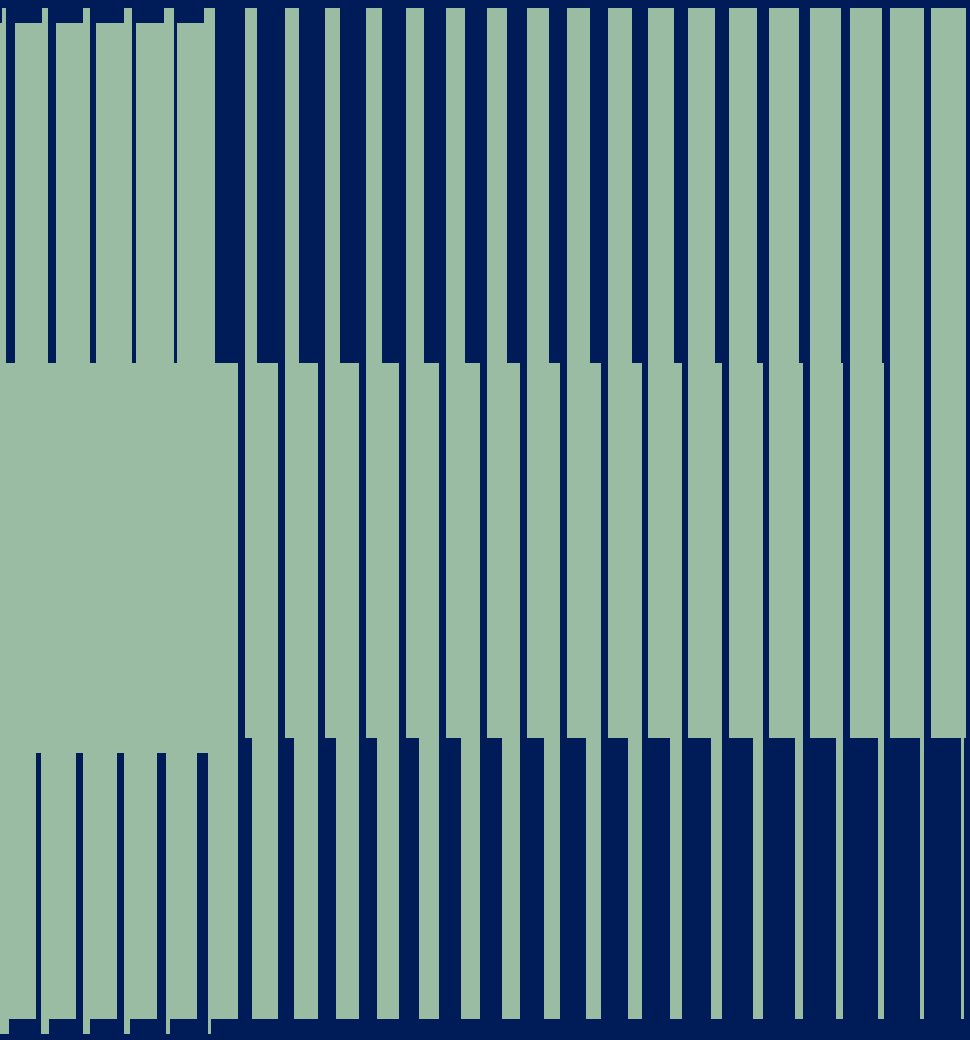
		CORE CONTRIBUTIONS			MEDICAL SAVINGS ACCOUNT (MSA) CONTRIBUTIONS			TOTAL CONTRIBUTIONS		
	INCOME	P	S/A	C	P	S/A	C	P	S/A	C
ESSENTIAL PLUS OPTION	R0 – R2 500	R3 240	R2 950	R1 334	R1 030	R880	R410	R4 270	R3 830	R1 744
	R2 501 – R4 000	R3 974	R3 368	R1 334				R5 004	R4 248	R1 744
	R4 001 – R6 000	R4 540	R3 492	R1 334				R5 570	R4 372	R1 744
	R6 001 – R8 000	R5 062	R3 618	R1 334				R6 092	R4 498	R1 744
	R8 001 – R10 000	R5 742	R3 756	R1 334				R6 772	R4 636	R1 744
	R10 001+	R6 240	R3 892	R1 334				R7 270	R4 772	R1 744

Key: P = Principal member | S = Spouse | A = Adult dependant | C = Child dependant

Note: Contributions are charged for a maximum of 3 children.

This brochure is a summary of the benefits and features of Retail Medical Scheme, pending formal approval from the Council for Medical Schemes.

Retail Medical Scheme



Service centre 0860 101 252 | service@retailmedicalscheme.co.za | www.retailmedicalscheme.co.za | Report fraud anonymously 0800 004 500

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