Annexure

MEDSCHEME DOCTOR NETWORK AGREEMENT FOR THE MEDSCHEME INTEGRATED CHRONIC CARE FAMILY PRACTITIONER NETWORK for 2026

1. Application

This Annexure sets out the arrangements for Participating Doctors to take part in the Medscheme Integrated Chronic Care Family Practitioner Network and is applicable to Qualifying Beneficiaries of participating Medscheme client schemes.

2. Participating Medical Schemes

This Annexure shall be applicable to all Medscheme client medical schemes that are participants in the Integrated Chronic Care Model.

From 1 January 2026, the following medical schemes and their respective qualifying beneficiaries were included:

- Bonitas Medical Fund;
- Fedhealth Medical Scheme;
- AECI Medical Aid Society.
- SAMWUMED

In the event that there is an additional medical scheme for which Medscheme provides relevant managed healthcare services and where the medical scheme has given Medscheme its mandate to participate in this Integrated Chronic Care Model, Participating Doctors will be duly notified in writing. The agreement as set out in this Annexure will automatically apply to additional medical schemes which agree to participate in the Network without the necessity of an additional addendum.

3. Interpretation

In this Agreement and in the annexures to this Agreement:

3.1 Clause headings are for convenience and are not to be used in its interpretation.

3.2 The following expressions bear the meanings assigned to them below and cognate expressions bear corresponding meanings:

3.3 “Agreement - means this Medscheme Integrated Chronic Care Family Practitioner Network Agreement including the applicable annexures;

3.4 “Medical Practitioner” - means Medical Practitioner as defined in the Health Professions Act no. 56 of 1974 as amended;

3.5 “Medscheme Integrated Chronic Care Family Practitioner Network” – means the contractual arrangement between Medscheme and the Participating Family Practitioner;

3.6 “Pre-authorisation” – means the authorisation by or on behalf of Medscheme where application has been made by or on behalf of a Member to obtain relevant health services for which authorisation is necessary in terms of the Rules to

authorise the relevant health services. This authorisation does not provide benefit reservation or guaranteed payment of the claim;

3.7 "Scheme Rate" - means the tariffs as determined by the Rules of the relevant Scheme.

3.8 **"Care Coordination"** means the deliberate organisation of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services. Organising care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

3.9 **"Benefit Basket**" means a list of health care benefits (e.g. consults, pathology tests, imaging) that is funded from the scheme risk pool for patients with Prescribed Minimum Benefit conditions or conditions endorsed by the participating Schemes for enhanced benefits;

3.9.1 **"Gaps in care"** means process and/or outcome measures that fall short of process and outcomes measure targets, in a given population, as defined from time to time;

3.9.2 **"Participating Beneficiary"** means a Qualifying Beneficiary, which includes all Beneficiaries who have been registered to the Chronic Disease Risk Management Programs for the following any of the following 2 Chronic Conditions:
a. Hypertension
b. Diabetes Mellitus

3.9.3 **"Participating Doctor"** means Medical Practitioners who have signed the Agreement to participate in the Medscheme IPA Doctor Network;

4. Reimbursement of Participating Doctors

4.1 All Participating Doctors will be entitled to claim a prolonged consultation fee which will be reimbursed at contracted tariff rate, making use of the dedicated prolonged consult tariff code as indicated within Annexure 1' and limited to 1 prolonged consultation per Participating Beneficiary per annum.

4.2 All Participating Doctors will be entitled to claim a Telemedicine, or Virtual Care fee which will be reimbursed at prevailing Scheme Network FP consultation rate in respect of each participating medical scheme, and making use of tariff code 0130 as indicated in within Annexure 1' and limited to 1 Telemedicine consultations per Participating Beneficiary per annum.

4.3 Above highlighted care benefits to be in addition to the consultations included within the Chronic Condition Prescribed Minimum Benefits.

4.4 In the event of the Participating Beneficiary's Benefit Basket considered to have inadequate benefits to allow for providing the appropriate care based on the Participating Beneficiary's clinical requirements, the Participating Doctor are permitted to motivate for an additional consultation to ensure optimal care.

4.5 Standard fee-for-service and enhanced reimbursement fees based on the REPI[2] profiling tool will continue where applicable for normal consultations (enhanced fees do not apply to prolonged consults and the coordination fee).

4.6 To qualify for the reimbursement as set out in (4.1), (4.2) and (4.4) above the Participating Doctor agrees to adhere to the conditions of participation as described in paragraph (5) below.

5. Conditions of participation

To participate in these Scheme specific arrangements, the Participating Doctor agrees to abide by the following criteria:

5.1 General Criteria

5.1.1 To adhere to the terms of the main Medscheme IPA Doctor Network Agreement to which this is an annexure and expansion;

5.1.2 To participate in and adhere to the terms of the participating Schemes' Doctor Network Arrangement which is an annexure to the main Medscheme IPA Doctor Network Agreement;

5.1.3 To function as a Designated Service Provider for Prescribed Minimum Benefits and as a preferred primary care provider to the Schemes' Beneficiaries;

5.1.4 To charge for the Relevant Health Services according to the agreed rates as per clause 4 and not to levy any co-payments;

5.1.5 To adhere to the specialist referral management process where applicable whereby an automated authorization number is obtained from Medscheme prior to the Beneficiary being referred to a specialist.

5.2 Participation in the Scheme's Integrated Chronic Care Family Practitioner Network

5.2.1 In relation to the clinical care to be provided to Participating Beneficiaries, and to whom the Participating Doctor is regarded as the primary care coordinator, he/she agrees to:

5.2.1.1 Make reasonable effort to ensure that each Participating Beneficiary receives consistent, high-quality chronic disease care, applying principles of good clinical governance and appropriate and ongoing care coordination, including shared decision-making and counselling, as well as disease education.

5.2.1.2 Make reasonable efforts to ensure that each Participating Beneficiary is consulted at least annually for a prolonged consultation.

5.2.1.3 Demonstrate reasonable efforts to ensure Beneficiary compliance to the management. This would include proactively communicating with the Participating Beneficiary to assist in scheduling follow up appointments, investigations and educational sessions.

5.2.1.4 Follow up on missed visits and address gaps in care and to be the custodian of the primary care responsibility and care coordination outside of only face-to-face consultations.

5.3 **Clinical Governance criteria**

The Participating Doctor agrees to adhere to the clinical governance criteria listed below:

5.3.1 **Clinical risk management criteria**

5.3.1.1 To participate in online and face-to-face Continuing Professional Development as outlined by the HPCSA.

5.3.1.2 To agree to participate in the peer mentorship process where indicated and as outlined in the Scheme's Doctor Network Manual.

5.3.1.3 To agree that the peer mentorship process can be implemented on the basis of quality, risk adjusted cost and clinical alerts, as determined by REPI^2, being outside the normal distribution range for peers, with the purpose of improving care to Participating Beneficiaries.

5.3.2 **Clinical effectiveness and clinical practice**

5.3.2.1 To regularly perform self-review of the performance of the practice against a clinical quality and cost effectiveness monitoring tool (such as the REPI^2 profiling tool which requires a quarterly profile review).

5.3.2.2 Where the clinical quality and cost effectiveness monitoring demonstrate adverse findings, the Participating Doctor must demonstrate that reasonable measures have been taken to analyse, understand and where indicated, put in processes to address these findings.

5.3.2.3 To ensure accurate diagnostic coding as determined by the most recent ICD 10 coding rules.

5.3.3 **Ethical criteria**

5.3.3.1 To confirm that he/she has not been found guilty of medical scheme fraud nor that he/she is under investigation by the Medscheme special investigation unit.

6. Proviso

From time to time, it may be necessary to make minor changes to the methodology in this arrangement. Unless these changes have a material effect on the outcome of this arrangement Medscheme reserves the right to make these changes without necessarily adding an addendum to the main Medscheme IPA Doctor Network Agreement.

…… Signature of the Doctor	
…… Full names of signatory	…… Capacity of signatory
…… Date	…… Place

ANNEXURE 1 – ICC BENEFIT BASKET, TARIFF CODES AND RATE OF PAYMENTS

Each Participating Beneficiary will have access to the following care events annually.

Integrated Chronic Care Program Benefit Basket			
Benefit	**Tariff Code**	**Amount per Year**	**Cost per event**
ICC Prolonged Consultation	07347	1	Per Participating Scheme Rate
ICC Virtual Consultation	0130	1	Per Participating Scheme Rate
Chronic Consultations from PMB Benefit Basket	0190	2	Per Participating Scheme Rate
Additional Chronic Consultation per Motivation and Authorization	0190	1	Per Participating Scheme Rate

Notes

- Above references the full Benefit Basket all Participating Beneficiaries have access to.
- The 'Chronic Consultations from PMB Benefit Basket' refers to the benefits which the Participating Beneficiaries already have access to within their Chronic Condition aPMB level Benefit Basket, and is not an additional benefit included within ICC.
- Participating Beneficiaries will not have access to above ICC Benefits if they choose to seek care at the Doctor who is not contracted to the ICC Network.

The following Rates of Payment will apply.

Integrated Chronic Care Program (ICC) Benefit Basket			
Benefit	**Tariff Code**	**Amount per year**	**Tariff Rate (2026)**
ICC 30-minute prolonged consultation	07347	1	Bonitas Medical Fund: **R 1054.78**
			Fedhealth Medical Scheme: **R 1,046.65**
			AECI Medical Aid Society: **R 1,056.83**
			Samwumed Medical Fund **R 1054.78**
ICC virtual consultation	0130	1	Per participating scheme rate
Chronic consultations already in place, paid from the aPMB Benefit Basket	0190	2	Per participating scheme rate
Additional chronic consultation upon motivation and authorisation	0190	1 (Upon motivation and authorisation)	Per participating scheme rate