remedi

REMEDI
MEDICAL AID SCHEME
BENEFITS

2023

This Benefit Brochure is a summary of the benefit options and features of Remedi Medical Aid Scheme (Remedi) awaiting approval from the Council for Medical Schemes (CMS) and does not replace the Remedi Rules. In all instances, the Remedi Rules prevail. Please consult the Scheme Rules on www.yourremedi.co.za

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YOUR HEALTH. **OUR LEGACY.**

Remedi Medical Aid Scheme (Remedi) is a restricted medical scheme registered and regulated by the Council for Medical Schemes (CMS).

Our mission is to provide cost-effective healthcare benefits that meet your needs, supported by efficient administrative processes ensuring that you have peace of mind regarding major medical expenses.

Membership is open to all employees who are employed at Remgro Limited and its associated or formerly associated companies.

Remedi offers members a choice between three benefit options:

- **Remedi Comprehensive**
- **Remedi Classic**
- **Remedi Standard**

Each benefit option was designed to meet the specific needs of employees of the participating employers.

Remedi offer its members a comprehensive range of benefits, while the **Comprehensive Option** is designed to provide members with a Personal Medical Savings Account (PMSA) for benefits not covered from their hospital benefits. This benefit option also allows for additional general practitioner (GP) visits once the Insured Out-of-Hospital (IOH) and PMSA are used up for the year.

The **Classic Option** contributions are slightly lower than the **Comprehensive Option**, however, members do not have access to a PMSA and benefit limits are lower than what is available on the **Comprehensive Option**.

The **Standard Option** provides limited benefits and certain limits are only provided by Remedi's appointed designated service providers (DSPs) and within a Network. If a member visits a GP not in the Network, limited out-of-area (OOA) benefits are available.

Members of Remedi are therefore in a position to enjoy the benefits of a restricted medical scheme, while also being allowed choices that better suit them and their family. This ensures that members can enjoy the appropriate healthcare they need at an affordable price.

REMEDI KEY BENEFITS AT A GLANCE

BENEFIT OPTION	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Hospital Benefit /Overall Annual Limit (OAL) For major medical care, including in-hospital and other defined high-cost care	✓ Unlimited Overall annual limit for families	✓ R2.3 million Overall annual limit for families	✓ R675,000 Overall annual limit for families
Insured Out-of-Hospital Benefit (IOH) Specific limits apply	✓ Benefits are first paid from the IOH benefit and thereafter from available PMSA	✓ Once you reach the IOH limit, you will have to cover further expenses	✓ Certain benefits only provided by Remedi's appointed DSP and Remedi Standard Option GP Network healthcare providers
Additional GP visits Defined number of additional GP visits once IOH and PMSA used up for that year	✓	✗	✗
Personal Medical Savings Account (PMSA) For benefits not covered from the hospital benefit and when IOH benefit is used up. To allow funding for these benefits from PMSA you will need to activate the payment as part of your application request or can contact us at 0860 116 116 to assist in activating this payment for you.	✓	✗	✗
Over-the-Counter Medicine (OTC)	✓	✓	✓

Read this benefit guide to understand more about your benefit option such as:

- What to do when you need to go to a doctor or hospital
- How you are covered for preventative screening, medical conditions, medicine and treatments
- Which benefits you need to apply for to get access to
- Whether there are any limits for certain benefits

We also give you tips on how you can use technology to conveniently manage and access all the information you need through the Remedi app and the Remedi Medical Aid Scheme website at www.yourremedi.co.za

*The benefits explained in this benefit guide are provided by Remedi Medical Aid Scheme, registration number 1430, administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial service provider. This benefit guide is only a summary of the key benefits and features of Remedi awaiting approval from the Council for Medical Schemes (CMS). In all instances, Remedi rules prevail. Please consult the Scheme Rules on **www.yourremedi.co.za**. When reference is made in this brochure to 'we' in the context of benefits, members, payments or cover, it refers to Remedi. We are continually improving our communication to you. The latest version of this benefit brochure as well as detailed benefit information is available on **www.yourremedi.co.za**.*

CONTACT **DETAILS**

The Scheme's contact information through the Administrator's office is listed below:

AMBULANCE AND OTHER EMERGENCY SERVICES

- Call ER24 on 084 124

GENERAL QUERIES

- Email us at service@yourremedi.co.za or
- Phone us at 0860 116 116

WHEN TO USE SERVICE@YOURREMEDI.CO.ZA – GENERAL QUESTIONS ABOUT YOUR BENEFITS

If you need your available benefits, or used benefits visit our website www.yourremedi.co.za or access your information using the Remedi app.

You can use this email address to send us questions about claims that have already been submitted to the Scheme, and claim statements already sent to you. If you need a claim statement and want to see all claims received, visit our website www.yourremedi.co.za or access your claims history using the Remedi app.

Please see more information about how to send your claims to us and where and how to get access to the Remedi app below:

TO SEND CLAIMS

- Email us at claims@yourremedi.co.za; or
- Post it to PO Box 652509 Benmore 2010; or
- **Take a photo and submit your claim using the Remedi app which can be downloaded from the Apple iStore or Google Playstore.**

GET IT ON Google Play

Download on the App Store

Scan this QR code using your smartphone camera for more information on how to submit a claim.

OTHER SERVICES

Oncology service centre: 0860 116 116

HIVCare Programme: 0860 116 116

Internet queries: 0860 100 696

Preauthorise admission to hospital: 0860 116 116

FOR DENTAL QUERIES ON STANDARD OPTION

Dental Risk Company (DRC) call centre: 087 943 9611

General enquiries: enquiries@dentalrisk.com

Website: https://www.dentalrisk.com/

FOR OPTICAL QUERIES

Preferred Provider Negotiators (PPN) contact number: 041 065 0650

Claims: info@ppn.co.za

Website: https://www.ppn.co.za/

FOR DIABETES QUERIES

Call 0860 44 44 39 or send an email at Members_DCC@yourremedi.co.za.

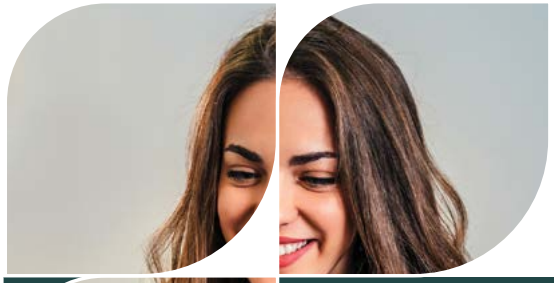
Additional information is available on our website, www.yourremedi.co.za.

REPORT FRAUD

If you would like to let us know about suspected fraud, please:

- Call our toll-free fraud hotline: 0800 004 500 (callers will remain anonymous)
- SMS 43477

Remember to include the description of the alleged fraud.



GET YOUR CLAIMS PROCESSED FASTER, SEE HOW

Scan this QR code using your smartphone camera for more information on how to submit a claim.

SUBMIT YOUR CLAIM IN 3 FAST AND EASY DIGITAL WAYS

You can submit and track your claims, benefits and medical spend in real time using our digital platforms

01

REMEDI
APP

Use your smartphone camera to take a photo of your claim and submit through the Remedi app.

If the claim has a QR code, simply scan the QR code from within the Remedi app.

02

UPLOAD
YOUR CLAIM

Scan and upload your claims on our website www.yourremedi.co.za

03

EMAIL
YOUR CLAIMS

Scan and email your claims to claims@yourremedi.co.za

Download the Remedi app today and manage your health anywhere, anytime!

GET IT ON Google Play

Download on the App Store

KEY TERMS

Throughout this benefit brochure you will find references to these terms.

Additional Disease List (ADL)	Depending on your benefit plan, and once approved on the Chronic Illness Benefit (CIB), you have cover for medicine for an additional list of life-threatening or degenerative conditions, as defined by us.
Benefit Option	The benefit option is the cover you choose to buy from Remedi. Remedi gives you a choice of three benefit options: **Remedi Comprehensive, Remedi Classic and Remedi Standard**. These benefit options are registered with the Council for Medical Schemes (CMS) in terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its regulations. The benefits as set out in the 'Rules of the Scheme' are summarised in this benefit brochure.
Benefit entry criteria	For certain illnesses, we set benefit entry criteria that you need to meet for the medical expenses to be considered for funding. This also means that we need certain details from you and your doctor before we can consider paying for the treatment.
Chronic Disease List (CDL)	A defined list of chronic conditions we cover in line with the Prescribed Minimum Benefits (PMB).
Chronic Drug Amount (CDA)	The Chronic Drug Amount (CDA) is the monthly amount that we pay up to for a medicine class. This amount depends on your benefit option. The CDA also applies to chronic medicine that is not listed on the medicine list (formulary).
Chronic Illness Benefit (CIB)	The Chronic Illness Benefit (CIB) covers you for a defined list of chronic conditions. To get access to this benefit to pay for your medicine and treatment for your chronic condition, you will need to apply for cover.
Connected Care	Connected Care is a digital platform that connects you to consult with your doctor virtually or to book your next COVID-19 vaccine/booster shot.
Co-payment	This is an amount that you need to pay towards a healthcare service. The amount can vary by the type of covered healthcare service, place of service or if the amount the service provider charges is higher than the rate we cover. If the upfront payment to a hospital (called a deductible/co-payment) is higher than the amount charged for the healthcare service, you will need to pay for the cost of the healthcare service. *For example, if you see a doctor who is not on our networks and they charge more than the Remedi Rate, Remedi will pay you for the visit at the Remedi Rate. You will then have to pay this amount to the doctor along with any charges above our rate from your own pocket.* *Another example is if you see an optician who is not on the PPN Network, Remedi will only pay your optician at the network rate and you will have to pay the difference from your own pocket. If you are on the **Comprehensive Option**, your co-payment will be paid from your available Personal Medical Savings Account. If you are on the **Standard Option**, we will pay doctors who are not on our networks directly up to the Remedi Rate and you will still be responsible to pay the amount they charged over and above our rate.*
Cover	Cover refers to the benefits (such as consultation, medicine and hospital admission) you have access to and how we pay for these healthcare services on your benefit option.
Day-to-day benefits (also referred to as Insured-Out-of-Hospital (IOH) Benefits)	You have cover for a defined set of day-to-day benefits. We set out the level of day-to-day benefits you have access to in this benefit brochure from page 21.

Designated service provider (DSP)	This is a healthcare provider (such as a doctor, specialist, allied healthcare professional, pharmacist or hospital) who we have an agreement with. The agreement we have with them is for them to provide treatment or services at a contracted rate. Visit www.yourremedi.co.za or click on 'Find a Provider' on the Remedi app to view the full list of Remedi DSPs. *For example, when you use the services of a designated service provider, we pay the provider directly at the Remedi Rate. We pay specialists who participates as a DSP at what we call the Premier, Classic Direct or Remedi Rate for claims. We also pay participating general practitioners (GPs) at the contracted GP rate for all consultations.* You will not have to pay an extra amount yourself (co-payment) to providers who take part in the Premier and Remedi network arrangements. However, you may have a co-payment for out-of-hospital visits to specialists on the Classic Direct Payment Arrangement.
Discovery Home Care	Discovery Home Care offers you quality care in the comfort of your home for healthcare services like IV infusions, wound care, post-natal care and advanced illness.
Discovery MedXpress	Discovery MedXpress is a convenient medicine ordering service, particularly for monthly medicine repeats, such as your registered chronic medicine. You can get your medicine delivered to you or collect it from participating pharmacies. Your cover depends on the type of medicine and whether you are registered on the Chronic Illness Benefit.
Emergency medical condition or medical emergencies	An emergency medical condition, also referred to as an emergency, is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical and surgical treatment. In such a case, failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy. An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency. **If you or any of the dependants on your membership visit an after-hours emergency facility at the hospital, it will only be considered as an emergency and covered as a Prescribed Minimum Benefit (PMB) if the treatment received aligns with the definition of PMB. Please note that not all treatment received at casualty units are considered part of PMB. If you are admitted to hospital from casualty, we will cover the costs of the casualty visit from your hospital benefit if we preauthorise your hospital admission. If an event occurs after hours, you must apply for authorisation on the next available working day.**
Exclusions	There are certain expenses that are not covered by Remedi. These are called exclusions.
Find a healthcare provider	'Find a healthcare provider' is a medical and provider search tool that is available on the Remedi app or our website, www.yourremedi.co.za.
Formulary (medicine list)	This is a list of preferred medicines considered by Remedi to be the most useful in-patient care. These are rated based on clinical effectiveness, safety and cost. We cover these medicines in full for the treatment of approved chronic conditions.
HealthID	HealthID is an online digital platform that gives your doctor fast, up-to-date access to your health information. Once you have given them consent, your doctor can use HealthID to access your medical history, refer you to other healthcare professionals and check your relevant test results.

Healthcare professionals who we have a payment arrangement with	Remedi has agreed rates with certain general practitioners and specialists so you can get full cover and reduce the risk of co-payments. Remedi pays these doctors and specialists directly at these agreed rates.
Hospital Benefit	The hospital benefit covers hospital costs and other accounts, like accounts from your admitting doctor, anaesthetist or any approved health care expenses, while you are in hospital. Your cover relies on your chosen benefit option's benefits (set out in this benefit guide). Examples of expenses covered are theatre and ward fees, X-rays, blood tests and the medicine you use while you are in hospital.
In-hospital GP Network	A defined list of GPs and specialists authorised by Remedi to provide in-hospital services to members as part of the Scheme's Premier Practice, Remedi Standard GP Network and Classic Designated Provider Arrangement (DPA) Specialist Networks.
Managed benefits	These benefits are managed to facilitate appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, using rules-based and clinical management-based programmes.
Medicine Rate	This is the rate we pay for medicine. It is the single exit price of medicine and includes the relevant dispensing fee.
Networks or network providers	You may need to use specific hospitals, pharmacies, doctors, specialists or allied healthcare professionals in a network. We have payment arrangements with these providers to ensure you get access to quality care at an affordable cost. By using network providers, you can avoid having to pay additional costs and deductibles yourself.
Mental Health Network	A defined list of psychologists and social workers contracted or nominated by us for purposes of providing treatment for mental health conditions to our members.
Medicine Networks	Use a pharmacy in our network to enjoy full cover and avoid co-payments when claiming for chronic medicine on the prescribed medicine list.
Oncology Pharmacy Networks	Use a pharmacy in this network to get cover aligned with the Remedi agreed medicine price list to treat cancer.
PMB network	A Mediclinic hospital contracted to or chosen by the Scheme to provide services that relate to Prescribed Minimum Benefit (PMB) conditions. Please also refer to the definition for DSP above.
Overall Annual Limit	The Scheme's Overall Annual Limit (OAL) is equivalent to the available hospital benefits as reflected on page 4 of this benefit brochure. See "Hospital Benefit /Overall Annual Limit (OAL)".

Payment arrangements	The Scheme has payment arrangements with various healthcare professionals and providers to ensure that you can get full cover with no deductibles.
Personal Medical Savings Account (PMSA)	The Personal Medical Savings Account (PMSA) is an amount that is allocated to you at the beginning of each year (or when you join the Scheme). You pay this amount back in equal portions as part of your monthly contribution. We pay some of your day-to-day or Insured Out-of-Hospital (IOH) medical expenses from the available funds allocated to the PMSA, depending on the registered Rules of the Scheme and more information is available in this benefit brochure on page 42. Any unused funds will carry over to the next year. If you leave the Scheme or change your benefit option to another benefit option without a PMSA and have used more of the funds than what you have contributed, you will need to pay the difference back to us.
Preauthorisation	You need to let Remedi know if you plan or are scheduled to be admitted to hospital. Please phone us on **0860 116 116** for preauthorisation, for us to confirm your membership and available benefits, as well as load your procedure onto your membership. Without preauthorisation, you may have a co-payment of R3,000 for each admission. **Preauthorisation is not a guarantee of payment as it only aims to confirm that the treatment that you will receive in hospital is clinically appropriate and aligned with the benefits available.** We advise our members to talk to their treating doctor so they know whether they will be responsible for out-of-pocket expenses. There are some procedures or treatments your doctor can do in their consulting rooms. For these procedures you still need to get preauthorisation for. *Examples of these are endoscopies and scans.* If you are admitted to hospital in an emergency, we must be notified as soon as possible by a family member if not possible to notify us yourself within 24 hours or the Monday following the admission if the emergency took place over the weekend. This will ensure that we authorise payment of your medical expenses. We use certain clinical policies and protocols when we decide whether to approve hospital admissions. These give us guidance about what is expected to happen when someone is treated for a specific condition and are based on scientific evidence and research.
Preferred medicine	Preferred medicine includes generic and branded medicine.
Premier Plus GP	A Premier Plus GP is a network GP who has contracted with us to provide you with coordinated care for a list of defined chronic conditions.

Prescribed Minimum Benefits (PMB)	In terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its Regulations, all medical schemes must cover the costs related to the diagnosis, treatment and care of: ■ Emergency medical conditions ■ A defined list of 271 diagnoses ■ A defined list of 27 chronic conditions (chronic disease list conditions, including HIV and AIDS). To access PMB treatment and cover, there are rules defined by the Council for Medical Schemes (CMS) that apply. These are: ■ Your medical condition must qualify for cover and be part of the defined list of PMB conditions ■ The treatment needed must match the treatments in the defined benefits ■ You must use designated service providers (DSP) in our network. This does not apply in emergencies. Where appropriate and according to the Rules of the Scheme, you may be transferred to a hospital or other service providers in our network once you have stabilised. If you do not use a DSP or refuse to be transferred to a DSP once stabilised, we will pay a portion at the Scheme Rate. In such cases, you will be responsible for the difference between what we pay and the actual cost of your treatment. More information about the Scheme Rate is available in the benefit tables provided in this benefit brochure. If your treatment doesn't meet the above criteria, we will pay according to your benefit option benefits.
Related accounts	This entails any account other than the hospital account for in-hospital care. This could include the accounts for the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology.
Relevant health services	A service as defined in the Act which is provided for in your chosen benefit option.
Remedi Rate or Scheme Rate	This is the rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services. The Remedi Rate or Scheme Rate is a rate that we negotiate with service providers. If your doctor charges more than the Remedi Rate or the contracted fee, we will pay claims at the Remedi Rate or negotiated rates. Please have a look at the 'Rate' column in the benefit tables provided in this benefit brochure, for the appropriate benefit to know when claims are paid at 100% of Remedi Rate and when at 80% of Remedi Rate, in which case you will incur a co-payment.
Service providers	A medical practitioner, dentist, pharmacist, hospital, nurse or any other person or entity who is duly registered or licensed, as may be required, to provide relevant health services.
WHO Global Outbreak Benefit	The WHO Global Outbreak Benefit provides cover for specific global disease outbreaks recognised by the World Health Organization (WHO), such as COVID-19 and Monkeypox. This benefit offers cover from a basket of care as set by Remedi for out-of-hospital management and appropriate supportive treatment as recognised in terms of Prescribed Minimum Benefit (PMB) treatment protocols.

KEY FEATURES AND BENEFITS

CANCER COVER

If you are registered on the **Comprehensive or Classic Options**, we cover your cancer treatment:

- Over a 12-month cycle
- Up to an approved annual limit per person
- At 100% of the Remedi Rate.

After the above is exhausted, we pay 80% of any additional costs up to an annual family limit, unless a PMB level of care applies. We fund a PMB level of care at 100% of the Remedi Rate (depending on the cost) at the Scheme's designated service provider (DSP) requirements.

Members registered on the **Standard Option** are covered over a 12-month cycle for Prescribed Minimum Benefit (PMB) conditions only.

Oncology medicine must be obtained from the Remedi oncology pharmacy network to make sure that you are covered in full with no co-payments when we have approved your cancer treatment.

For more information in terms of your available benefit limits and cover for cancer, please read page 32 of this benefit brochure.

COVER FOR CHRONIC MEDICINE

To obtain cover from the Chronic Illness Benefit (CIB), members need to register for cover by asking your doctor to submit your chronic medicine application to us or contact us on 0860 116 116.

On the **Comprehensive Option**, we provide you with full cover for chronic medicine on our formulary for all Chronic Disease List (CDL) conditions. You also have access to an additional list of conditions (ADL) covered up to R2,315 per person per month, including medicine for non-PMB treatment, as well as the Specialised Medicine and Bariatric Surgery Benefit of up to R210,000 per year and this benefit covers specific new high-cost medicines as well as bariatric surgery (from 2023 when approved and where clinically appropriate).

On the **Classic Option**, full cover for chronic medicine on our formulary for all Chronic Disease List (CDL) conditions are available to you. You also have access to an additional list of conditions (ADL), but your monthly and family limits for these conditions are less than what is available on the **Comprehensive Option** and members are covered up to R1,930 per person per month on this benefit option for these conditions, including medicine for non-PMB treatment.

On the **Standard Option**, cover for chronic medicine is limited to Prescribed Minimum Benefit (PMB) conditions and our formulary for all Chronic Disease List (CDL) conditions, with no access to an additional list of conditions (ADL). A co-payment of 20% is applicable if medicine is obtained from a non-DSP pharmacy.

COVER FOR HOSPITAL ADMISSIONS

You can go to any private hospital. The different benefit options will cover your admission as follows:

- There is no overall limit for hospital cover on the **Comprehensive Option**
- The **Classic Option** limits members to R2.3 million per family per year
- The **Standard Option** limits members to R675 000 per family per year.

The provisions of PMB prevails. You receive cover in hospital for GPs, specialists and other healthcare professionals who we have a payment arrangement with per your chosen benefit option's Remedi Rate for in- or out-of-hospital services. We established a network of specialists to minimise out-of-pocket expenses where members required specialist services in or out of hospital for PMB conditions. Full funding is available through a network of doctors who form part of the Scheme's Coronary Artery Disease Care Programme to manage chronic artery diseases.

COVER FOR PREGNANCY

You get comprehensive benefits for maternity that cover certain healthcare services before birth and your available cover will depend on your chosen benefit option, as well as your available Insured Out-of-Hospital (IOH) and day-to-day benefits. Please contact us as soon as your pregnancy is confirmed for us to help you activate your benefits and to assist you in understanding your benefits.

INSURED OUT-OF-HOSPITAL BENEFITS AND COMPREHENSIVE DAY-TO-DAY COVER

Depending on the benefit option of your choice, you have cover for a set of defined day-to-day benefits, that includes cover for medically appropriate GP consultations, blood tests, X-rays or medicine that is dispensed at a GP or one of our preferred provider pharmacies.

DENTISTRY AND OPTOMETRY

Basic dentistry and optometry benefits for members registered on the **Standard Option** are available through the Dental Risk Company (DRC) and Preferred Provider Negotiators (PPN).

Members registered on the **Comprehensive and Classic Options** have both basic and specialised dentistry benefits, as well as optometry benefits up to a set of annual limits at any of our PPN optical network providers.

Please consult the benefit tables and annual limits as set out in this benefit brochure to obtain more information regarding your chosen benefit option's available Insured Out-of-Hospital (IOH) and day-to-day cover.

PREVENTION AND SCREENING BENEFIT

Your Prevention and Screening Benefit covers vital tests to detect early warning signs of serious illness no matter which benefit option you are registered on.

EMERGENCY COVER

WHAT IS A MEDICAL EMERGENCY?

An emergency medical condition is the sudden and unexpected onset of a health condition that requires immediate medical or surgical treatment.

If treatment is not given in such a case would result in:

- Serious impairment to bodily functions
- Serious dysfunction of a bodily organ or part
- The person's life being placed in serious danger.

An emergency does not necessarily require a hospital admission. We may ask you or your treating provider for additional information to confirm the emergency.

WHAT DO WE PAY FOR?

We pay for all the following medical services that you may need in an emergency:

- The ambulance (or other medical transport)
- The account from the hospital
- The accounts from the doctor who admitted you to the hospital
- The anaesthetist
- Any other healthcare provider we approve.

It is important that you, a loved one or the hospital let us know about admission as soon as possible, so that we can let you know how you will be covered for the treatment you receive.

If you need HIV medicine to prevent HIV infection, mother-to-child transmission, occupational or traumatic exposure to HIV, including sexual assault, call ER24 immediately on 084 124. Treatment must start within 72 hours of exposure. Remember to get approval from us first to pay for pre-exposure (PrEP) and post-exposure prophylaxes (PEP).

If you are admitted to hospital from casualty, we will cover the costs of the casualty visit from your hospital benefit if we preauthorised your hospital admission. **You must apply for authorisation on the next available working day if the emergency event occurs after hours or over the weekend**.

COVER OUTSIDE OF SOUTH AFRICA

Cover outside of South Africa is limited to territories within the Rand-monetary area and will be covered according to the Scheme Rules and Scheme Rate. Travellers should always make sure that they get additional medical insurance cover when travelling outside the borders of South Africa. This includes Lesotho.

The Scheme does not provide international emergency evacuation services. Members must make provision in their personal capacity for international emergency evacuation services if the need arises while travelling or living outside the borders of the Republic of South Africa.

ASSISTANCE DURING OR AFTER A TRAUMATIC EVENT

You have access to dedicated assistance in the event of a traumatic incident or after a traumatic event. By calling Emergency Assist at ER24 on 084 124, you and your family have access to trauma support 24 hours a day. This service also includes access to counselling and additional benefits for trauma related to gender-based violence.

PRESCRIBED MINIMUM BENEFITS (PMB)

We established PMB Networks to prevent co-payments when you need to get services for Prescribed Minimum Benefit (PMB) conditions.

HOW DO WE COVER YOU FOR PRESCRIBED MINIMUM BENEFITS:

Prescribed Minimum Benefits are a set of minimum benefits that, by law, must be provided to all medical scheme members. The cover it gives includes the diagnosis, treatment and cost of ongoing care for a list of conditions:

- 271 diagnoses and their associated treatment
- 27 chronic conditions (chronic disease list conditions, including HIV and AIDS)
- Emergency conditions

The list of conditions is defined in the Medical Schemes Act 131 of 1998.

The 271 PMB conditions are linked to a specific diagnosis and treatment guideline known as diagnosis and treatment pairs (DTP) PMB. Many of these DTPPMB conditions are also chronic conditions, for example, depression.

If you need cover for DTPPMB conditions, you must apply for it. You can get the latest application form on the website at www.yourremedi.co.za or call 0860 116 116.

For a complete list of the DTPPMB conditions, please visit www.medicalschemes.co.za. The following DTPPMB conditions are also covered from your hospital benefit on all benefit options as long as you meet certain benefit entry criteria.

Anticoagulant therapy
Cushing's disease
Depression
Haematological disorders, like thalassaemia
Hyperthyroidism
Hypoparathyroidism
Lipidoses and other lipid storage disorders
Major psychiatric disorders, like bipolar disorder
Organ transplants
Paraplegia
Pemphigus (dermatologist must motivate)
Peripheral arteriosclerotic disease
Pituitary disorders
Quadriplegia
Stroke (cerebro-vascular accident)
Thrombocytopenic purpura
Valvular heart disease

In certain cases, we will only accept a specialist's diagnosis. Contact us to make sure how to register your PMB with us on 0860 116 116.

TO ACCESS PRESCRIBED MINIMUM BENEFITS, THERE ARE RULES THAT APPLY:

- Your medical condition must qualify for cover and be part of the list of defined Prescribed Minimum Benefit conditions.
- The treatment needed must match the treatments offered in the defined benefits.
- If you are outside of the benefit limit, you must use Designated Service Providers (DSPs) in the network to continue receiving treatment.

This does not apply in life-threatening emergencies; however, even in these cases (where appropriate and according to the Rules of the Scheme), you may be transferred to a Designated Service Provider, otherwise you would have to pay a co-payment. You will be responsible for the difference between what we pay and the actual cost of your treatment, where applicable.

IMPORTANT

Even if your doctor says your condition is a PMB, only the condition ICD-10 codes that your doctor submits to us and the relevant rules will determine whether your condition will be covered as PMB.

FUNDING MEDICATION FOR PMB CONDITIONS

The Scheme will pay 100% of the cost of the medication if you collect the medication from a Designated Service Provider (DSP). We will also cover the cost of the medication if you involuntarily obtained from a provider other than a DSP, as long as:

- The medication is included on the applicable formulary in use by the Scheme; or
- The formulary does not include a medicine that is clinically appropriate and effective for the treatment of that PMB condition.

Where medication is voluntarily collected from a provider other than a DSP, you would be responsible to pay a co payment that is equal to the difference between the cost of the medication and the cost that would have been incurred if you used the DSP.

On **Comprehensive and Classic Options**, where the formulary includes medication that is clinically appropriate and effective for the treatment of a PMB condition and the member knowingly declines the formulary medicine and chooses to use another medicine instead (that costs more than the Chronic Drug Amount (CDA) we would have paid for the formulary option) you will be responsible for the excess amounts.

On the **Standard Option**, you are registered for the Chronic Illness Benefit and the medicine is on the Remedi medicine list (formulary), we will fund the medicine in full up to the Remedi Rate for medicine or up to the lowest cost medicine of the same kind on our medicine list for the condition.

Remedi has contracted and established the following additional networks to avoid our members experiencing co-payments when getting services for Prescribed Minimum Benefit (PMB) conditions.

MENTAL HEALTH NETWORK

The Mental Health Network has been created for services from social workers, psychologists and registered counsellors in or out of hospital. The network is also applicable where services are claimed from the allied and therapeutic benefits of the Scheme and where services are accessed through the Mental Health Programme.

Members who receive services from these service providers will not have to pay an additional amount (no balance billing) as long as they received services as part of the Mental Health Network of service providers.

Where a member uses services from a non-network service provider and the provider charges above the Scheme Rate, the payment will be limited to the Scheme Rate and will be paid to the member. In these instances, members may be responsible for additional payments when settling accounts with the non-network service providers. It is therefore important to contact us to confirm whether your service provider is part of our Mental Health Network before getting services for PMB conditions.

FULL COVER WITH THE REMEDI PMB HOSPITAL NETWORK

Members have access to a PMB hospital network (consisting of Mediclinic private hospitals) to receive treatment for PMB conditions at full cover.

This means no balance billing (in other words, you won't have to pay in over and above what we pay the provider) where:

- The admitting service provider is on the Scheme's Designated Service Provider list (DSP) or GP or Specialist Network
- Services are obtained from a hospital in the PMB Hospital Network.

When you are admitted to one of these facilities, make sure that you:

- Receive treatment at the PMB Hospital Network and
- Choose a primary provider who has entered a Direct Payment Arrangement (DPA) with the Scheme.

This will ensure that we can pay all contracted providers at their contracted rate (or at cost for services received in the PMB Hospital Network). This applies to all related accounts during the admission as well.

This means that when we approve a preauthorisation for a PMB condition, we will fund the cost of the services as set out in the table below:

	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD	ADDITIONAL INFORMATION/ COMMENTS
Psychology and mental health out-of-hospital services for PMB conditions if the service provider is in the Mental Health Network	100% at agreed rate	100% at agreed rate	100% at agreed rate	No co-payments if DSP is used
Psychology and mental health out-of-hospital services for PMB conditions voluntarily obtained from a service provider who is not in the Mental Health Network	100% at a maximum of Scheme Rate	100% at a maximum of Scheme Rate	100% at a maximum of Scheme Rate	Potential co-payments if non-DSP is used
In-hospital GP services for PMB conditions if admitting GP or specialist on the network or is a DSP	100% at agreed rate	100% at agreed rate	100% at agreed rate	No co-payments if DSP is used
KeyCare GP in- and out-of-hospital services for PMB conditions if admitting GP is on the network or is a DSP	Not applicable	Not applicable	100% at agreed rate	No co-payments if DSP is used
In- and out-of-hospital services for PMB conditions voluntarily obtained from a provider who is not a DSP	100% at a maximum of Scheme Rate	100% at a maximum of Scheme Rate	100% at a maximum of Scheme Rate	Potential co-payments if non-DSP is used

IN-HOSPITAL GENERAL PRACTITIONER AND SPECIALIST NETWORK

You have access to the In-hospital General Practitioner (GP) Network.

In addition to the current Premier Practice, Remedi Standard and Classic Direct Payment Arrangement (DPA) Specialist Networks, the Scheme introduced an In-Hospital General Practitioner (GP) Network at Mediclinic hospitals for all benefit options.

If you receive in-hospital services for PMB conditions from a GP with admitting rights to a Mediclinic hospital, the GP or specialist will be paid in full (no balance billing above the agreed tariffs). We will pay in-hospital claims that are billed above the agreed tariff up to the agreed tariff – you will be responsible to pay the outstanding amount.

SUPPLIER AGREEMENTS FOR SURGICAL EQUIPMENT

The Scheme has supplier arrangements for surgical equipment including:

- Medical and surgical equipment used to induce labour
- Cardiac stents
- Oxygen appliances
- Intermittent catheters
- Breathing devices such as CPAP machines

Where members receive the above appliances from service providers who the Scheme have entered into a Preferred Payment Arrangement, the Scheme will fund the cost of the appliances up to the agreed or negotiated rate and members should have no co-payments.

Where members receive the above appliances from providers who are not DSPs, the payment will be limited up to the maximum of 100% of the Scheme Rate and limited to the annual benefit limit. In these instances, members may have co-payments and may be responsible for some of the costs of these appliances.

Please contact us at **0860 116 116** to find out the options available to you before obtaining these appliances.

NOTE: FUNDING EMERGENCY PMB CLAIMS

In case of emergencies, all approved PMB claims will be funded at cost.

Using Designated Service Providers (DSP) to minimise co-payments

Remedi has a list of designated service providers which are set out in the table below:

BENEFIT OPTION	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
SANCA, RAMOT or Nishtara for drug and alcohol, detoxification and rehabilitation	✓	✓	✓
Remedi Standard Option GP Network	✗	✗	✓
The Classic Direct Specialist Direct Payment Arrangement	✓	✓	✗
The Premier A and B Specialist Direct Payment Arrangements	✓	✓	✗
The KeyCare Specialist Direct Payment Arrangement	✗	✗	✓
Pharmacies dispensing at the Remedi Rate for medicine	✓	✓	✓
Optical management by PPN	✓	✓	✓
Private hospitals as contracted (See MaPS tool)	✓	✓	✓
Dental management by DRC	✗	✗	✓
Emergency Services (ER24)	✓	✓	✓
PMB Hospital Network at Mediclinic Hospitals	✓	✓	✓
In-Hospital GP and Specialist Network for PMB	✓	✓	✓
Out-of-Hospital Mental Health Network	✓	✓	✓
Oncology Pharmacy DSP	✓	✓	✓

Remedi is always on the lookout for healthcare providers who can give our members quality care at affordable rates. We will add more designated service providers and networks to this list as they become available.

Limits, clinical guidelines and policies apply to some healthcare services and procedures. Please check the benefit tables that sets out the benefits and limits in this benefit brochure for more information.

SCREENING AND PREVENTION

You have access to essential Screening and Prevention Benefits.

This benefit pays for certain tests that can detect early warning signs of serious illnesses. We cover various screening tests at our wellness providers, Clicks and Dis-Chem. Such screening tests include checks for blood glucose, cholesterol, HIV, as well as provide cover for a Pap smear or HPV test for cervical screening, mammograms and prostate screenings.

We make health checks available according to your age group and needs. These include:

SCREENING

For adults, this benefit covers certain tests such as blood glucose, blood pressure, cholesterol, body mass index and HIV screening at our wellness providers. We also cover a mammogram or ultrasound of the breast every year, a Pap smear once every year as an alternative to an HPV test once every 3 or 5 years depending on your HIV status.

We provide cover for a PSA test (prostate screening) each year and bowel cancer screening tests every two years for members between the ages of 45 and 75 years. Colonoscopy screening is funded up to one test every ten years for members 55 and over if performed in doctors' rooms.

The Scheme also makes one preventative dental examination per person per year available, including the oral examination, infection control, prophylaxis polishing and fluoride treatment.

SCREENING FOR SENIORS

In addition to the screening for adults, members aged 65 years and older have cover for a group of age-appropriate screening tests in our defined pharmacy network. Cover includes hearing and visual screening and falls risk assessment.

You may have cover for an additional GP consultation at a Premier Plus GP, depending on your screening test results and if you meet the Scheme's clinical entry criteria. In addition, we provide a holistic view of a member's health alongside electronic messaging on interventions. Such an email would include enrolment into disease management programmes where needed.

VACCINES FUNDED FROM YOUR SCREENING BENEFITS

You are covered for the following vaccine benefits in addition to the above screening tests:

- Pneumococcal vaccine – this is funded up to two vaccines per person per lifetime.
- Seasonal influenza vaccine – funded up to one per person per year from your hospital benefit if you are considered a high-risk member or over the age of 65. For other members, this vaccine will pay from their available day-to-day benefits.
- COVID-19 vaccine and administration costs are regarded as clinically appropriate in terms of PMB treatment or prevention. This vaccine is not funded from the screening and prevention benefits, but instead pays from your overall annual limit.
- Human Papillomavirus (HPV) vaccines – funded (if regarded as clinically appropriate) once every 3 or 5 years depending on your status.

CONNECTED CARE, VIRTUAL CONSULTATIONS AND HOME CARE SERVICES

With Remedi Medical Aid Scheme you get access to health and wellness services from the comfort of your home. Using the Connected Care platform, you can connect to doctors through virtual consultations.

VIRTUAL CONSULTATIONS

With the use of the Connected Care platform, you can schedule virtual consultations with your preferred or chosen GP **if they are registered on the platform**. These consultations will be funded from your existing day-to-day and available consultation benefits.

HOME CARE SERVICES

Some services are available in the form of 'home-based care', such as follow-up treatments after a hospital admission. These services are available through the Discovery Home Care service. You are assured of quality care in the comfort of your own home when recommended by your doctor as an alternative to hospital stay. Services include postnatal care, end-of-life care, IV infusions (drips) and wound care. These services are paid from the hospital benefit, subject to approval. Discovery Home Care is the Designated Service Provider (DSP) for administration of defined intravenous infusions. **Avoid a 20% co-payment by using Discovery Home Care for such infusions.**

POINT-OF-CARE (POC) TESTING

Members registered on certain care programmes also has access to Point-of-Care (POC) testing as a medical diagnostic test that allows for simple medical tests to be done at your bedside. Not only does it mean the shortest possible timeframes for required tests and their results to be made available to your treating doctor, but it also enhances your treating doctor's ability to record your records and results for referral and future reference purposes through HealthID.

It provides you and your treating doctor with an integrated solution keeping your medical information confidential and always protected.

Connected Care is brought to you by Discovery Health (Pty) Ltd; registration number 1997/013480/07, an authorised financial service provider and administrator of medical schemes. Discovery Home Care is a service provider. Practice 080 000 8000190. Grove Nursing Services (Pty) Ltd

INSURED OUT-OF-HOSPITAL (IOH) AND DAY-TO-DAY BENEFITS

You have access to the following day-to-day cover from your Insured Out-of-Hospital (IOH) benefit depending on the benefit option you are registered with. Some limits are subject to your Overall Annual Limit (OAL) as set out in the table below. See page 4 of this benefit guide to find out what your OAL per your chosen benefit option is.

IOH and Day-to-Day Benefits

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Annual Insured Out-of-Hospital (IOH) sublimits (day-to-day benefits)	100% of Remedi Rate or 100% of cost at DSP	**Combined family limit of:** Per principal member: R10,320 Per adult dependant: R6,090 Per child dependant: R1,720 up to a maximum of three children. If you exceed the sublimit, non-Prescribed Minimum Benefit expenses will be paid from your Personal Medical Savings Account, subject to available funds. The sublimit excludes specialised dentistry and optical claims. Facility fees will be covered where applicable.	**Combined family limit of:** Per principal member: R9,150 Per adult dependant: R5,400 Per child dependant: R1,520 up to a maximum of three children. If you exceed the sublimit, you must pay non-Prescribed Minimum Benefit expenses from your own pocket. The sub-limit includes specialised dentistry, optical claims and facility fees.	**Combined family limit of:** Per principal member: R3,010 Per adult dependant: R1,900 Per child dependant: R610 up to a maximum of three children. These sublimits are for medical specialists (excluding clinical psychologists and social workers), and emergency treatment. Includes facility fees.
GPs and specialists	100% of Remedi Rate	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit. Once depleted, it will be paid from your Personal Medical Savings Account. This benefit includes cover for a consultation with a gynaecologist for insertion of a Mirena contraceptive device, provided pre-approval was received from the Scheme in line with clinical protocols and guidelines.	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit. This benefit includes cover for a consultation with a gynaecologist for insertion of a Mirena contraceptive device, provided pre-approval was received from the Scheme in line with clinical protocols and guidelines.	Medically appropriate GP consultations and minor procedures, unlimited at member's chosen Remedi Standard Option Network GPs. The Out-of-Area (OOA) Benefit consists of three visits up to a limit of R1,975 per family. Medical specialist visits are limited to annual Insured Out-of-Hospital (IOH) sublimits. This benefit includes cover for a consultation with a gynaecologist for insertion of a Mirena contraceptive device, provided pre-approval was received from the Scheme in line with clinical protocols and guidelines.

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Network GP Benefit	100% of Remedi Rate	A defined number of extra GP consultations are paid from the hospital benefit once your Insured Out-of-Hospital benefit limits and Personal Medical Savings Account funds are exhausted. Member: Three GP visits Family: Six GP visits We will only fund visits to a Network GP from the hospital benefit, and pathology is excluded.	No benefit.	No benefit.
Acute medicine and Schedule 0, 1 and 2 medicine that can be bought over the counter without a doctor's prescription	100% of Remedi Medicine Rate	Subject to available Insured Out-of-Hospital (IOH) benefit limits and the overall annual limit. Once depleted it will be paid from your Personal Medical Savings Account. Oral contraceptives are covered up to R175 per female beneficiary per month, from the overall annual limit at preferred provider pharmacies. A co-payment of 20% is applicable if a member obtains oral contraceptives from a non-DSP pharmacy.	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit. Oral contraceptives are covered up to R175 per female beneficiary per month, from the overall annual limit at preferred provider pharmacies. A co-payment of 20% is applicable if a member obtains oral contraceptives from a non-DSP pharmacy.	*Schedule 0,1 and 2 medicine:* An over-the-counter benefit of R175 per script and R355 per person per year payable from the hospital benefit. *Acute medicine:* Subject to the Remedi Standard Option Network medicine list. Unlimited if you get the medicine from your chosen Remedi Standard Option GP. Oral contraceptives are covered up to R175 per female beneficiary per month from the overall annual limit at preferred provider pharmacies. A co-payment of 20% is applicable if a member obtains oral contraceptives from a non-DSP pharmacy.
Pathology and Radiology (excluding MRI and CT scans)	100% of Remedi Rate	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit. Once depleted, it will be paid from your PMSA.	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit.	Basic X-rays (black and white X-rays of chest, abdomen, pelvis and limbs) and limited pathology tests, subject to formulary and as referred by your Network GP, are covered at Remedi Standard Option Network healthcare providers.
Allied professionals (physiotherapy, biokinetics, occupational therapy, speech therapy, audiology, audiometry, clinical psychology and social work)	100% of Remedi Rate	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit.	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit.	No benefit.
Specialised Medicine and Bariatric Surgery Benefit	Specialised Medicine: 90% of Remedi Rate or 100% of Reference Price List Bariatric Surgery: 80% of Remedi Rate	Limited to R210,000 per person per year, subject to clinical protocols and preauthorisation.	No benefit.	No benefit.

OPTICAL BENEFITS

MAKING THE MOST OF YOUR OPTICAL BENEFITS

Remedi has a contract with the Preferred Provider Negotiators (PPN) network to make sure you get the most out of your optical benefits.

PPN can be reached as follows:

- Member Customer Care: 041 065 0650
- Claims: info@ppn.co.za
- Website: https://www.ppn.co.za

PPN charge cost-effective rates for clear lenses in return for better professional fees without compromising on professional standards or the quality of the product. Remember to tell the PPN optometrist of your Remedi membership to qualify for the negotiated rates.

Members on the **Comprehensive and Classic Options** can visit a non-PPN optometrist, but they may be charged a higher rate, which means that the full price might not be covered. If you want to avoid possible co-payments on clear lenses, make sure the optometrist you visit belongs to the PPN network.

Members on the **Standard Option** only receive benefits if services are obtained at a PPN optometrist.

On the **Comprehensive Option**, optical benefits are a separate benefit category paid from the overall annual limit.

On the **Classic Option**, you do not have a separate benefit category for optical benefits. These are paid from the available Insured Out-of-Hospital benefit, subject to the optical benefit sublimits, as well as the overall annual limit.

IMPORTANT NOTE:

Please consult the limits and benefits as set out in this benefit brochure for more information. Please note that all claims must be submitted directly to PPN for processing and payment.

Optical Benefits summarised

BENEFITS	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Optical Benefit	Subject to confirmation of benefit by the Preferred Provider Negotiators (PPN). You can choose to cover any shortfall from your available savings. All benefits are subject to the overall annual limit and the following sublimits:	Subject to confirmation of benefit by Preferred Provider Negotiators (PPN). All benefits are subject to Insured Out-of-Hospital benefit limits and the following annual sublimits:	Subject to confirmation of benefit by the Preferred Provider Negotiators (PPN). All benefits are subject to the overall annual limit and as set out below: **(Benefits are available only every 24 months)**
Beneficiary sub-limit	R3,815	R3,605	Sublimits apply as set out below.
Family sub-limit	R7,630	R7,210	Sublimits apply as set out below.
Consultations			
PPN Provider	100% of Cost A composite consultation inclusive of refraction, a glaucoma screening, visual field screening and artificial intelligence (AI) for the detection of diabetic retinopathy at PPN provider every year per person.	100% of Cost A composite consultation inclusive of refraction, a glaucoma screening, visual field screening and artificial intelligence (AI) for the detection of diabetic retinopathy at PPN provider every year per person.	100% of Cost. A composite consultation inclusive of refraction, a glaucoma screening, visual field screening and artificial intelligence (AI) for the detection of diabetic retinopathy at PPN provider every 24 months per person.
Non-PPN Provider	R380	R380	No benefit.
WITH EITHER			
Spectacles:			
Frames/lens enhancements: PPN Provider	PPN frame or lens enhancements to the value of R1,765.	PPN frame or lens enhancements to the value of R1,115.	PPN frame to the value of R315 per person every 24 months.
Frames/lens enhancements: Non PPN Provider	R1,325 towards a frame and/or lens enhancement.	R1,115 towards a frame and/or lens enhancement.	No benefit.
Clear Aquity lens limits:	Clear single-vision lenses at a PPN or non-PPN provider limited to R215 per lens.	Clear single-vision lenses at a PPN or non-PPN provider limited to R215 per lens.	Clear single-vision lenses at a PPN provider limited to R215 per lens per person every 24 months.
	Clear bifocal lenses at a PPN or non-PPN provider limited to R460 per lens.	Clear bifocal lenses at a PPN or non-PPN provider limited to R460 per lens.	Clear bifocal lenses at a PPN provider limited to R460 per lens per person every 24 months.
	Base multifocal lenses at a PPN or non-PPN provider limited to R810 per lens. An additional R50 per lens for branded multifocal lenses in addition to the R810 per lens limit.	Base multifocal lenses at a PPN or non-PPN provider limited to R810 per lens. An additional R50 per lens for branded multifocal lenses in addition to the R810 per lens limit.	Base multifocal lenses and branded multifocal lenses at a PPN provider are limited to R460 per lens per person every 24 months.
OR			
Contact lenses:			
Beneficiary sublimit	R2,440	R1,970	R615 per person every 24 months at a PPN provider.

DENTAL BENEFITS

MAKING THE MOST OF YOUR DENTAL BENEFITS

Standard Option members receive dental management from the Dental Risk Company (DRC) and you can contact them on **087 943 9611** to confirm dental benefits available on the **Standard Option.**

Certain dental procedures will require a preauthorisation and members need to contact the Remedi call centre on **0860 116 116** to confirm dental benefits available before visiting your dentist.

Summary of Remedi Dental Benefits

*The **Comprehensive Option** has a standalone benefit for specialised dentistry benefits, while **Classic Option** members' specialised dentistry is subject to the available Insured Out-of- Hospital benefit (IOH). **Comprehensive Option** members' conservative dental claims will be funded from the available Personal Medical Savings Account (PMSA) once the conservative dental benefits are used up. Members on the **Standard Option** do not have any specialised dentistry benefits available.*

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Specialised dentistry	100% of Remedi Rate	Standalone benefit Subject to the overall annual limit with the following sub-limits: Member only: R23,400 Family: R46,950 Basic dental codes are subject to available Insured Out-of-Hospital benefit. See also page 21.	Subject to available Insured Out-of-Hospital benefit. See also page 21.	No benefit.
Conservative dentistry	100% of Remedi Rate	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit. See also page 21. Once depleted it will be paid from your PMSA.	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit. See also page 21.	Basic dentistry only, such as consultations, extractions and fillings, including resin fillings; up to three surface fillings a tooth. The benefit excludes dentures and specialised dentistry. Services to be obtained from the DRC dental management preferred provider network.
Conservative dentistry under anaesthesia for patients younger than seven years	100% of Remedi Rate	Anaesthetic and hospitalisation subject to the overall annual limit. Dental claim subject to the Insured Out-of-Hospital benefit limits.		No benefit.
Preventive dentistry	100% of Remedi Rate	One preventive dental examination per person every 12 months including the oral examination, infection control, prophylaxis, polishing and fluoride of adults and children. **On the Standard Option, preventive dentistry is provided through a Network provider (DRC).**		

MATERNITY BENEFITS

*Remedi provides you with cover related to your pregnancy at **100% of the Remedi Rate** and where applicable you are covered from your available Insured Out-of-Hospital benefits (IOH).*

ANTENATAL CONSULTATIONS

For members registered on the **Comprehensive and Classic Options**, we pay for nine GP, gynaecologist or midwife antenatal consultations, which are subject to the overall annual limit.

Members registered on the **Standard Option**, are covered for nine antenatal consultations with your chosen Remedi Standard Option Network GP, midwife or gynaecologist.

ULTRASOUND SCANS AND SCREENINGS DURING PREGNANCY

Members registered on the **Comprehensive and Classic Options**, are covered for 2D ultrasound scans, and an extensive list of pregnancy-related pathology tests, as well as nine urine dipstick tests and two glucose strip tests. NT and/or NIPT and T21 screening (Down Syndrome Screening tests) are funded in addition to ultrasound scans, if deemed clinically appropriate. Your maternity benefits on the **Comprehensive and Classic Options** are subject to the overall annual limit and cover from a basket of care is aligned with PMB requirements.

Members registered on the **Standard Option**, are covered for 2D ultrasound scans performed by their chosen GP or sonographer. A specified and limited list of pregnancy-related pathology tests, as well as nine urine dipstick tests and two glucose strip tests are covered. NT and/or NIPT and T21 screening (Down Syndrome Screening tests) is funded in addition to ultrasound scans, if deemed clinically appropriate.

FLU VACCINATIONS

We pay for your flu vaccinations you may need during your pregnancy from your available day-to-day benefits.

BLOOD TESTS

On the **Comprehensive and Classic Options** we pay for a defined list of blood tests for each pregnancy from your overall annual limit and cover from a basket of care is aligned with PMB requirements. We pay for a defined list of blood tests for each pregnancy from your available radiology and pathology benefits, which is subject to the IOH benefit. On the **Standard Option** cover is limited as per PMB requirements.

The maternity benefits are subject to your overall annual limit and the provisions of Prescribed Minimum Benefits are applicable.

CHRONIC CONDITIONS AND CARE PROGRAMMES

CHRONIC BENEFITS

You have access to treatment for a list of 27 medical conditions (including HIV) set out in the list of chronic conditions known as the Chronic Disease List (CDL) and an additional list of diseases called the Additional Disease List (ADL), if registered on the **Comprehensive or Classic Options**.

The **Comprehensive Option** offers you a richer benefit for chronic conditions allowing co-payments from your Personal Medical Savings Account (PMSA), as well as a higher limit for non-PMB conditions, which is limited to R2,315 per person per month. The **Classic Option** provides cover for non-PMB chronic conditions limited to R1,930 per person per month.

The **Standard Option** does not make provision for funding of the additional list of diseases; ADL funding is limited as prescribed in terms of Prescribed Minimum Benefit (PMB) conditions.

The list of chronic conditions covered as part of the Scheme's CDL is as follows:

- **A** Addison's disease, Asthma
- **B** Bipolar mood disorder, Bronchiectasis
- **C** Cardiac failure, Cardiomyopathy, Chronic obstructive pulmonary disease (COPD), Chronic renal disease, Coronary artery disease, Crohn's disease
- **D** Diabetes insipidus, Diabetes mellitus type 1, Diabetes mellitus type 2, Dysrhythmia
- **E** Epilepsy
- **G** Glaucoma
- **H** Haemophilia, *HIV (Managed through the HIV Care programme and not covered from your chronic benefits)*, Hyperlipidaemia, Hypertension, Hypothyroidism
- **M** Multiple sclerosis
- **P** Parkinson's disease
- **R** Rheumatoid arthritis
- **S** Schizophrenia, Systemic lupus erythematosus
- **U** Ulcerative colitis

*The following list of additional chronic conditions (ADL), although not an extensive list, are examples of the additional chronic conditions covered by Remedi as part of your chronic benefits on the **Comprehensive and Classic Options:***

- **A** Ankylosing spondylitis, attention-deficit/ hyperactivity disorder (ADHD)
- **B** Behcet's disease
- **C** Cystic fibrosis
- **D** Delusional disorder, Dermatopolymyositis
- **G** Gastro-oesophageal reflux disease, Generalised anxiety disorder, Gout
- **H** Huntington's disease
- **I** Isolated growth hormone deficiency in Children < 18 years
- **M** Major depression, Motor neuron disease, Muscular dystrophy and other inherited myopathies, Myasthenia gravis
- **O** Obsessive compulsive disorder, Osteoporosis
- **P** Paget's disease, Panic disorder, Polyarthritis nodosa, Post-traumatic stress disorder, Psoriatic arthritis, Pulmonary interstitial fibrosis
- **S** Sjogren's syndrome, Systemic sclerosis
- **W** Wegener's granulomatosis

WHAT WE COVER

On the **Comprehensive and Classic Options**, we will pay your approved chronic medicine in full up to the Remedi Rate for medicine if it is on the Remedi medicine list (formulary). If your approved chronic medicine is not on the medicine list, we will pay your chronic medicine up to a set monthly Chronic Drug Amount (CDA) for each medicine category.

If you use more than one medicine in the same medicine class, where both medicines are not on the medicine list (formulary), or where one medicine is on the medicine list (formulary) and the other is not, we will pay for both medicines up to the one set monthly Chronic Drug Amount (CDA) for that medicine class.

For members on the **Standard Option**, medicine on the Remedi medicine list (formulary) will be funded in full up to the Remedi Rate for medicine. Medicine not on the Remedi medicine list (formulary) will be funded up to the Generic Reference Price (GRP), which is up to the lowest cost medicine of the same kind on our medicine list for the condition. **Members on this benefit option must get their medicine from a network pharmacy to avoid a co-payment of 20%.**

For a condition to be covered from the Chronic Illness Benefit (CIB), there are certain benefit entry criteria that the member needs to meet. If your condition is approved by CIB, the CIB will cover certain procedures, tests and consultations for the diagnosis and ongoing management of the 27 Chronic Disease List conditions in line with Prescribed Minimum Benefits.

To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 diagnosis codes. Please ask your doctor to include your ICD-10 diagnostic codes on the claims they submit and on the form that they complete when they refer you to pathologists and radiologists for tests. This will enable pathologists and radiologists to include the relevant ICD-10 diagnostic codes on the claims they submit to ensure that we pay your claims from the correct benefit.

NON-PMB CHRONIC DISEASE LIST CONDITIONS COVERED ON COMPREHENSIVE AND CLASSIC OPTIONS

On the **Comprehensive and Classic Options**, we also cover you for certain additional chronic conditions, which are not PMB. We fund approved medicine for these conditions up to specific monthly limits for each benefit option.

How to get the benefit

You must apply for the Chronic Illness Benefit (CIB) and your doctor must complete a form online or send it to us for approval to **chronicapplications@yourremedi.co.za** to qualify for this medicine funding. We need to be informed of any changes to your treatment so that we can update your chronic authorisation. **You can email the prescription for changes to your treatment plan for an approved chronic condition to chronicapplications@yourremedi.co.za. Alternatively, your doctor can submit changes to your treatment plan through HealthID if you have given consent to do so. If you do not let us know about changes to your treatment plan, we may not pay your claims from the correct benefit.**

If you are diagnosed with a new chronic condition, a new Chronic Illness Benefit application form would need to be completed.

Where and how to get your medicine

By using a pharmacy that is part of the Scheme's contracted Designated Service Providers (DSPs), you will avoid a 20% deductible for which you will be liable at point of service. **You can also order your medicine online using MedXpress to ensure that your chronic medicine is funded in full without any deductible.**

Visit **www.yourremedi.co.za** to view the detailed Chronic Illness Benefit (CIB) guide.

Summary of Care Programmes available to you

CARE PROGRAMMES

Member Care Programme

If you are diagnosed with one or more chronic conditions, you might qualify for our care programme. The programme facilitates high-quality, planned, person-centred care and chronic condition management to achieve improved outcomes. We will contact you to confirm if you qualify. The programme offers organised care to help you manage your conditions and to get the best quality healthcare.

If you are registered and take part in the programme, we will pay your treatment in full. If you choose not to take part, we will cover the hospital and related accounts up to 80% of the Scheme Rate.

Patient Care Programmes

Condition-specific care programmes for diabetes, mental health, HIV and heart conditions.

We cover condition-specific care programmes that help you to manage diabetes, mental health, HIV or heart-related medical conditions. You must be registered on these condition-specific care programmes to unlock additional benefits and services. You and your Premier Plus GP can track your progress on a personalised dashboard to identify the next steps to manage your condition optimally.

Mental health programme

Once enrolled on the programme by your network psychologist or Premier Plus GP, you have access to defined cover for the management of major depression for a period of 6 months from date of enrolment.

Enrolment on the programme unlocks cover for prescribed medicine, access to either individual or group psychotherapy sessions (virtual and face-to-face therapy) and additional GP consultations to allow for effective evaluation, tracking and monitoring of treatment. Qualifying members will also have access to a relapse-prevention programme, which includes additional cover for a defined basket of care for psychiatry consultations, counselling sessions and care coordination services.

Cardio care programme

If you are registered on the Chronic Illness Benefit (CIB) for hypertension, hyperlipidaemia or ischaemic heart disease and you are 18 years or older, you have access to a defined basket of care and an annual cardiovascular assessment, if referred by your nominated Premier Plus GP and enrolled on the Cardio Care programme.

CAD Care

Remedi also gives members access to coronary artery disease care (CAD Care). CAD Care serves as a care delivery programme, which was introduced as an alternative less invasive procedure for members, where an invasive angiogram may be necessary. The application is assessed at preauthorisation stage for identified low and intermediate risk patients. Prior to the authorisation of an invasive angiogram, a computed tomography coronary angiography (CTCA) report is necessary.

A network of doctors was established to provide members with full funding at Scheme negotiated rates, thereby limiting out-of-pocket expenses.

HIV care programme

If you are registered on the HIV programme, you are covered for the care you need, which includes additional cover for social workers. You can always be assured of confidentiality. You must see a Premier Plus GP to avoid a 20% co-payment. You also need to get your medicine from a Designated Service Provider (DSP) to avoid a 20% co-payment.

To register on the Remedi HIV Care programme:

- Telephone: **0860 116 116**
- Email: **HIV@yourremedi.co.za**

Diabetes-cardiometabolic population health management programme

The Diabetes-cardiometabolic population health management programme, is an integrated chronic care programme for members living with diabetes, as well as their related cardiometabolic conditions. The programme gives you and your Premier Plus doctor access to various tools to monitor and manage your health and to ensure you get high-quality coordinated healthcare and the best outcomes.

You and your doctor can set goals and earn rewards on your personalised condition management tool. This will help to manage your conditions and stay healthy over time.

The programme also unlocks cover for valuable healthcare services from healthcare providers like dietitians, diabetes nurse educators, diabetes coaches, podiatrists and biokineticists.

Any Remedi member registered on the Chronic Illness Benefit (CIB) for diabetes can join this programme.

The Scheme also introduced funding for Continuous Glucose Monitors (CGM) for members who need to automatically track blood glucose levels. This device gives you the ability to test your glucose level at any time and better manage your condition. When appropriately prescribed by a doctor in our network, members with type 1 diabetes have cover for continuous glucose monitoring sensors up to a monthly cover amount. Cover depends on your chosen benefit option and this benefit is currently not available on the **Standard Option**.

For more information on your cover for continuous glucose monitoring sensors please refer to the Chronic Illness Benefit formulary (medicine list) available on the Remedi website. Visit **www.yourremedi.co.za**

COVER FOR CANCER

You have comprehensive cover for cancer treatment.

If you are diagnosed with cancer and once we have approved your cancer treatment, you are covered by the Oncology Care Programme over a 12-month cycle, starting from your date of diagnosis. This means you will always have a full year's benefit no matter when in the year you are diagnosed with cancer.

All cancer-related healthcare services are covered up to 100% of the Scheme Rate limited to an annual limit per person, depending on your chosen benefit option. Thereafter we pay 80% of any additional costs limited to an overall family limit. You may use a service provider of your choice and will be covered up to 100% of Scheme Rate. However, you may be required to get your medicine from the Scheme's preferred pharmacy network providers (oncology pharmacy DSPs). You might have a co-payment if you do not use the Designated Service Provider (DSP) or if your healthcare professional charges above the Scheme Rate or if you obtain your medicine from a pharmacy outside of the Scheme's oncology pharmacy networks.

Summary of cancer/oncology benefits:

Depending on your chosen benefit option, your cancer treatment is covered as follows:

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Cancer treatment	100% of Remedi Rate up to benefit limit. Thereafter 80% of Remedi Rate if non-PMB treatment on **Comprehensive and Classic Options**	R1,070,000 per family per 12-month rolling period, of which the first R435,000 per person is covered at 100% of the Remedi Rate and the remaining R635,000 at 80% of the Remedi Rate. The requirements for Prescribed Minimum Benefits are applicable and only PMB level of care will be funded at cost or Remedi Rate through the benefit limits.	R675,000 per family per 12-month rolling period, of which the first R410,000 per person is covered at 100% of the Remedi Rate and the remaining R265,000 at 80% of the Remedi Rate. The requirements for Prescribed Minimum Benefits are applicable and only PMB level of care will be funded at cost or Remedi Rate through the benefit limits.	The requirements for Prescribed Minimum Benefits are applicable and only PMB level of care will be funded at cost or Remedi Rate through the benefit limits.

ADVANCED ILLNESS BENEFIT (AIB) FOR CANCER PATIENTS

Members with cancer have access to a comprehensive palliative care programme. This programme offers unlimited cover for approved care at home, care coordination, counselling services and supportive care for appropriate end-of-life clinical and psychologist services. You have access to a GP consultation to facilitate your palliative care treatment plan.

PRESCRIBED MINIMUM BENEFITS (PMB) FOR CANCER

Cancer treatment that is a PMB is always covered in full. On the **Standard Option**, we cover cancer treatment within the guidelines and requirements of PMBs. If you are diagnosed with cancer, you will receive cover up 100% of the Scheme Rate or cost (depending on our DSP requirements and provided the treatment you receive is at PMB level of care).

HOSPITAL COVER AND ANNUAL LIMITS

Remedi Medical Aid Scheme offer cover for hospital stays.

HOSPITAL COVER

Depending on your benefit option, your hospital benefit is limited as per below:

- For **Comprehensive Option** there is no overall limit
- For **Classic Option** there is an overall family limit of R2.3 million
- For **Standard Option** there is an overall family limit of R675,000.

If you must go to hospital, we will pay your hospital expenses up to the overall annual limit for your chosen benefit option. We pay your hospital accounts at the rate we agreed on with the hospital. This benefit covers expenses that occur while you are in hospital if you have preauthorised your admission. Examples of the expenses we cover are theatre and ward fees, X-rays, blood tests and the medicine you must take while you are in hospital. Contact us in good time before you have to go to hospital and we will confirm what you are covered for. If you do not contact us before you go, you may be responsible for some of the costs.

What is the benefit?

This benefit pays the costs when you are admitted into hospital at a general ward, not a private ward.

What we cover?

You are covered in private and public hospitals, as per your chosen benefit option and as approved by the Scheme. You have cover for both planned and emergency stays, as authorised, in hospital.

HOW TO GET THE BENEFIT?

Get your preauthorisation and confirmation first

If referred by your doctor or specialist to be admitted to hospital, contact us on 0860 116 116 at least 48 hours before you go to hospital to confirm your hospital stay and before you are admitted (this is known as preauthorisation). **If you do not confirm your admission and the costs that we would normally cover, you be responsible for a co-payment of R3,000 for the admission.**

Where to go

You have cover for planned admissions in **any** private or public hospital if treatment is preauthorised.

How we pay

We pay for planned and emergency hospital stays from your hospital benefit. We pay for services related to your hospital stay, including all healthcare professionals, services and medicines authorised by the Scheme for your hospital stay. **If you use doctors, specialists and other healthcare professionals that we have an agreement with, we will pay for these services in full at the agreed Scheme Rate. We pay up to the Scheme Rate of other healthcare professionals.**

You can avoid co-payments by:

- Going to a private hospital approved by the Scheme
- Using healthcare professionals that we have a payment arrangement with
- Contacting us on **0860 116 116** at least 48 hours before you must be admitted at hospital.

View private hospitals that the Scheme has agreed Scheme Rates with by using ‘Find a healthcare provider’ on the Remedi app.

Hospital Benefits summarised

Remedi offers hospital cover per your chosen benefit option. The table below shows how we pay for your approved hospital admissions and which procedures are covered from your hospital benefit:

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Private hospitals	100% of Remedi Rate	Subject to an unlimited overall annual limit per family. da Vinci Robotic-Assisted Prostatectomies are covered at negotiated rates where pre-approved and you may be liable for a co-payment. Cover is limited to one procedure per person.	Subject to an overall annual limit of R2,300,000 per family. da Vinci Robotic-Assisted Prostatectomies are covered at negotiated rates where pre-approved and you may be liable for a co-payment. Cover is limited to one procedure per person.	Subject to an overall annual limit of R675,000 per family. da Vinci Robotic-Assisted Prostatectomies are covered at negotiated rates where pre-approved and you may be liable for a co-payment. Cover is limited to one procedure per person.
State hospitals	100% of Remedi Rate	Limited to R600,000 per family.	Limited to R585,000 per family.	Limited to R275,000 per family.
International second-opinion services (Cleveland Clinic)	50% of cost	The cost of a second opinion consultation obtained from Cleveland Clinic, limited to one consultation per person per year, if preauthorised. Travelling costs not covered.	No benefit.	No benefit.
Overseas Treatment Benefit	80% of cost	The cost of the claim covered up to R720,000 per person per year, if preauthorised. Travelling costs not covered.	No benefit.	No benefit.
Operations, procedures and surgery		Payment will be in full to designated service providers and at 150% of the Remedi Rate if you use non-network specialists.	Payment will be in full to designated service providers and at 100% of the Remedi Rate if you use non-network specialists.	Payment will be in full to designated service providers and at 100% of the Remedi Rate if you use non-network specialists.
Ward and theatre fees	100% of Remedi Rate	Includes cover for general ward, maternity ward, theatre recovery and intensive care (ICU) unit subject to overall annual limit.		
Confinements	100% of Remedi Rate	Subject to the overall annual limit.		
Blood transfusions	100% of Remedi Rate	Subject to the overall annual limit.		
Organ transplants	100% of Remedi Rate	Subject to the overall annual limit and the requirements for Prescribed Minimum Benefits.		
Renal dialysis	100% of Remedi Rate	Subject to the overall annual limit and the requirements for Prescribed Minimum Benefits.		
Conservative dentistry under anaesthesia for patients younger than seven years	100% of Remedi Rate	Anaesthetic and hospitalisation subject to the overall annual limit. Dental claims subject to Insured Out-of-Hospital (IOH) benefit limits.		No benefit.
Refractive eye surgery	100% of Remedi Rate	Subject to clinical entry criteria, the overall annual limit and a sublimit of R31,800 a person per year. Includes funding of corneal cross-linking.	Subject to clinical entry criteria, the overall annual limit and a sub-limit of R28,400 a person per year. Includes funding for corneal cross-linking.	No benefit.
Mental health	100% of Remedi Rate	Subject to the overall annual limit, limited to 21 days a year in hospital or 15 days in- and out-of-hospital or a combination of in- and out-of-hospital per the requirements for Prescribed Minimum Benefits. Includes the treatment of alcoholism and drug dependency at SANCA, RAMOT or Nishtara. Members diagnosed for major depression by their GP will have access to enroll on the Remedi Mental Health programme as set out in more detail in this brochure on pages 16, 17 and 31.		

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Radiology and pathology	100% of Remedi Rate	Subject to the overall annual limit.		
MRI and CT scans	100% of Remedi Rate	Subject to the overall annual limit and referral by a specialist. Covers in- and out-of-hospital scans. Consumables (disposable medical items) are funded from the Insured Out-of- Hospital benefit.	Subject to the overall annual limit and referral by a specialist. Covers in- and out-of-hospital scans. Consumables (disposable medical items) are funded from the Insured Out-of- Hospital benefit.	Subject to the overall annual limit and referral by a specialist. Covers in- hospital scans only. There is no benefit for out-of- hospital scans.
Medicine given on discharge (TTOs – take out medicines)	100% of Remedi Rate	Limited to five days' supply.		
Internal prostheses and devices (These limits apply where you do not use a preferred supplier)	100% of Remedi Rate	Subject to the overall annual limit, with the following sublimits for each prosthesis: Thereafter from Personal Medical Savings Account:	Subject to the overall annual limit, with the following sublimits for each prosthesis:	Subject to the overall annual limit, with the following sublimits for each prosthesis:
Hip replacement*	per person	R55,000	R47,300	R41,700
Revision hip*	per person	R65,100	R55,800	R49,300
Knee replacement*	per person	R43,500	R37,100	R32,800
Revision knee*	per person	R55,000	R47,300	R41,700
Shoulder replacement	per person	R50,700	R43,500	R38,400
Pacemaker with leads	per person	R92,300	R78,200	R69,400
Pacemaker with biventricular	per person	R119,000	R100,800	R89,300
Cardiac valves	per valve	R61,800	R52,300	R45,200
Above knee artificial limbs	per person	R65,500	R55,800	R49,400
Below knee artificial limbs	per person	R35,500	R30,500	R27,100
Artificial eyes	per person	R33,700	R28,500	R25,400
Cochlear implants (bilateral and unilateral)	Negotiated Rates	Funded at DSP and subject to the hospital benefit, if obtained from preferred suppliers. Diagnostic work-up for cochlear implants, repairs due to breakage, loss of device, or failure of the device, as well as cochlear implant batteries funded from the available IOH, PMSA or member's own pocket, as may be applicable.	No benefit.	No benefit.
All other internal prostheses and devices	per person	R28,500	R24,600	R21,700
Sub-acute facilities	100% of Remedi Rate	Subject to the overall annual limit.	Subject to the overall annual limit.	Subject to the overall annual limit.
Frail care and private nursing as an alternative to hospitalisation	100% of Remedi Rate	Subject to the overall annual limit with a sublimit of R43,700 per person.	Subject to the overall annual limit with a sublimit of R41,650 per person.	Subject to the overall annual limit with a sublimit of R15,350 per person.
Ambulance	100% of Remedi Rate	Subject to use of ER24 emergency response service. Transfers between hospitals during an admission are subject to medical justification. **International cover excluded.**		

** To obtain from Mediclinic DSP. A R2 500.00 co-payment for voluntary non-DSP use will apply.*

Treatment performed Out-of-Hospital that we pay for from the Hospital Benefit

Remedi also cover various treatments performed out-of-hospital from our hospital benefit and these are listed below:

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
External prostheses and appliances (These limits apply where you do not use a preferred provider)	100% of Remedi Rate	Subject to the overall annual limit, with the following sublimits for each prosthesis; thereafter it is paid from PMSA:	Subject to the overall annual limit, with the following sublimits for each prosthesis:	Subject to the overall annual limit, with the following sublimits for each prosthesis:
Colostomy equipment	per person	R29,250	R29,250	R15,150
Hearing aids	per person	R27,000	R27,000	R19,500
Oxygen appliances	monthly per person	R2,200	R2,200	R2,200
Wheelchairs	per person	R20,150	R16,900	R13,400
CGM Sensors (Continuous Glucose Monitors)	Negotiated Rates	Funded up to monthly agreed rates at preferred providers if registered on the diabetes management programme and as prescribed by your Premier Practice GP. Transmitters and readers are funded from the "all other appliances" benefit limit and thereafter from the available PMSA.	Funded up to monthly agreed rates at preferred providers if registered on the diabetes management programme and as prescribed by your Premier Practice GP. Transmitters and readers are funded from the "all other appliances" benefit limit and thereafter from member's own pocket.	No benefit.
Insulin Pumps	Negotiated Rates	Subject to the overall annual limit, if approved and if registered on the diabetes management programme. Costs related to the reservoir and infusion sets are covered from the available non-PMB chronic illness benefit of R2,315 per person per month and up to a maximum of 10 of each per month.	No benefit.	No benefit.
All other external prostheses and appliances	per person	R7,600	R6,350	R3,600
		CPAP, Point-of-Care and Mirena devices, where deemed clinically appropriate are funded from the "all other external prostheses and appliances" benefit limit as available at agreed/negotiated rates.		
Trauma Recovery Extender Benefit	100% of Remedi Rate	Cover for certain out-of-hospital claims for your recovery after certain traumatic events, without using the IOH benefit. Subject to clinical entry criteria, the overall annual limit and the following sub-limits applies:		
Loss of limb	per family	R95,000	R95,000	R95,000
Private nursing	per person	R11,950	R11,950	R11,950
Prescribed medication	Member	R33,000	R15,250	R15,250
	Member + 1	R38,650	R18,000	R18,000
	Member + 2	R45,050	R21,400	R21,400
	Member + 3 or more	R51,250	R25,900	R25,900
External medical items	per person	R81,250	R36,250	R36,250
Hearing aids	per person	R29,700	R17,100	R17,100
Mental Health Benefit	per person	R28,900	R21,500	R21,500
Maintenance therapy after rehabilitation or congenital defect (mental or physical) (In- and out-of hospital)	100% of Remedi Rate	Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a conservative nature. Subject to approval of a treatment plan and the overall annual limit with a sublimit of R15,590 per family.	Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a conservative nature. Subject to approval of a treatment plan and the overall annual limit with a sublimit of R14,810 per family.	Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a conservative nature. Subject to approval of a treatment plan and the overall annual limit with a sublimit of R4,410 per family.
Rehabilitation therapy after hospitalisation	100% of Remedi Rate	Extended physiotherapy, occupational therapy, speech therapy and biokinetics. Subject to the overall annual limit and approval of a treatment plan. Treatment must start within two weeks of discharge from hospital.	Extended physiotherapy, occupational therapy, speech therapy and biokinetics. Subject to the overall annual limit and approval of a treatment plan. Treatment must start within two weeks of discharge from hospital.	Extended physiotherapy, occupational therapy, speech therapy and biokinetics. Subject to the overall annual limit, with a sub-limit of R4,410 for family and approval of a treatment plan. Treatment must start within two weeks of discharge from hospital.
Benefits for infertility	100% of Remedi Rate	Cover in line with the Prescribed Minimum Benefits requirements.		

BENEFIT UPDATES FOR 2023

Enhancing existing benefits

SPECIALISED MEDICINE BENEFIT ENHANCED TO INCLUDE COVER FOR BARIATRIC SURGERY ON THE COMPREHENSIVE OPTION

You have cover for a defined list of the latest treatments through the current Specialised Medicine Benefit. This benefit has now been enhanced for members registered on the **Comprehensive Option** to allow for bariatric surgery, where deemed clinically appropriate and pre-approved by the Scheme. We pay up to R210 000 per person per year. A deductible of up to 20% applies for bariatric surgery, if approved. The co-payment applicable for specialised medicine approved will depend on the type of medicine you obtained and will remain up to 10% of the Medicine Rate applicable.

ADVANCED ILLNESS BENEFIT ENHANCEMENT ON ALL BENEFIT OPTIONS

For the management of end-of-life care, Remedi has enhanced the Advanced Illness Benefit (AIB) for members living with advanced cancer by introducing cover for other life-limiting conditions from this benefit as well. This benefit will now allow members, **no matter which benefit option they are registered on**, to access a dedicated team of care coordinators that assist with:

- Psychosocial support
- Medical care and
- Supportive treatment such as oxygen, pain control and home-based nursing giving patients access to much needed care as required.

CORONARY ARTERY DISEASE CARE PROGRAMME (CAD CARE PROGRAMME): ENHANCEMENT ON STANDARD OPTION

The Scheme has agreed to enhance the available CAD Care programme **to introduce it to the Standard Option as well**. CAD Care serves as a care delivery programme, which was introduced for members at preauthorisation stage for low- and intermediate-risk patients where an invasive angiogram was necessary. Prior to the authorisation of an invasive angiogram, a computed tomography coronary angiography report is requested.

A network of doctors has been established to provide members with full funding at Scheme negotiated rates, thereby limiting out-of-pocket expenses.

CONTINOUS GLUCOSE MONITORING (CGM) ENHANCEMENTS: REMEDI COMPREHENSIVE AND CLASSIC OPTIONS ONLY

The **Comprehensive and Classic Options** allow members to defray medical expenditure related to Continuous Glucose Monitoring (CGM) devices. These devices use technology which helps members and their treating doctors to monitor and manage blood sugar levels. A continuous glucose monitoring sensor, which is inserted just under the skin and is left in place for several days, automatically measures blood glucose levels every 5 to 15 minutes.

For members who live with type 1 diabetes mellitus and who is registered on the Scheme's Chronic Illness Benefit (CIB) or diabetes programme we fund up to 100% of the set monthly limit if registered on the **Comprehensive Option** and up to 75% of the set monthly limit if registered on the **Classic Option**. No funding is available for members registered on the **Standard Option**.

All claims will accumulate to the monthly CGM limits which aligns with preferential rates negotiated to cover the FreeStyle Libre CGM sensor if funded at 100% of the monthly limit and any additional costs will be for the member's account.

CGM transmitters and readers are funded from the member's available external appliances benefit limits and members will need to fund a portion of the expenses out of their own pocket.

To be eligible for funding of the CGM sensors members registered on CIB for diabetes type 1 will need to:

- Obtain a device prescribed by a Premier Plus Network doctor
- Members would need to consult with their Premier Plus GP and present their medical scheme card to purchase these devices at the negotiated medical scheme rates.

ONCOLOGY PHARMACY DESIGNATED SERVICE PROVIDERS (DSP) INTRODUCTION ON ALL BENEFIT OPTIONS

Remedi has introduced an oncology pharmacy network for members to use. You need to get your approved oncology medicine on our medicine list from a DSP. Speak to your treating doctor to confirm whether they are using our DSPs for your medicine and treatment to be received in rooms or at a treatment facility.

Contact us at 0860 116 116 to obtain a list of the Remedi oncology pharmacies who are part of our Network from 2023.

Targeted benefit enhancements

IN-ROOM PROCEDURES AVAILABLE ON ALL BENEFIT OPTIONS

From 2023 you will have cover for a defined list of procedures performed in specialist rooms. Cover is up to an agreed rate, where authorised by the Scheme, from your hospital benefit.

INSULIN PUMPS AND CONSUMABLES FOR MEMBERS REGISTERED ON THE COMPREHENSIVE OPTION

Continuous subcutaneous insulin infusion (delivered via an external insulin pump) improves glucose levels for poorly controlled patients. Clinical research confirmed that members who live with diabetes and who are diagnosed as Type 1 members and who are on multiple daily doses of insulin with high HbA1C or frequent hypos show improved control and reduced insulin use. Children particularly benefit from insulin pumps with ease of insulin delivery achieving better outcomes.

From 2023 members registered on the **Comprehensive Option** will receive funding for Insulin Pumps, where clinically deemed appropriate, in line with the Scheme's approved funding guideline.

Different price points for insulin pumps with a sensor and those without a sensor exists and members will be covered from their overall annual limit for up to one insulin pump and where approved, provided the appliances are obtained from the Scheme's preferred provider, Medtronic. Reservoir and infusion sets will be covered from the available members' non-PMB Chronic Illness Benefit (CIB) of up to R2,315 per person per month and up to a maximum of 10 of each per month, provided members are registered for funding of chronic medicines. Members who are in need of a replacement of an insulin pump already previously funded by the Scheme through this benefit will need to make application through the Scheme's *ex gratia* process as set out on page 45 for funding for a second or additional insulin pumps.

Members living with type 1 diabetes and who is need of funding for these appliances are encouraged to consider the current benefit option they are registered on and to contact our contact centres at 0860 116 116 for more information with regard to this added benefit.

COCHLEAR IMPLANTS FOR MEMBERS REGISTERED ON THE COMPREHENSIVE OPTION

Cochlear implants are electronic devices that restores partial hearing to the deaf. These devices are surgically implanted in the inner ear and activated by a device worn outside the ear. Through bypassing damaged parts of the auditory system it allows the profoundly hearing impaired to receive sound.

From 2023, members registered on the **Comprehensive Option**, where deemed clinically appropriate funding will be aligned with negotiated preferred supplier prices. The following service providers are currently contracted with the Scheme:

- Southern ENT
- Medel
- Medel Distribution

Funding will be considered against a Scheme approved funding policy and diagnostic work-up for cochlear implants, repairs due to breakage, loss of device, or failure of the devices, as well as cochlear implant batteries which will be funded from the member's available IOH benefit, available PMSA or the member's own pocket.

Members who may need funding for these devices are encouraged to consider the benefit they are registered on as funding will only be available on the **Comprehensive Option** at negotiated rates up to limits deemed appropriate to fund unilateral and bilateral devices from 2023.

TAVI PROCEDURES FOR MEMBERS REGISTERED ON ALL BENEFIT OPTIONS

TAVI is an insertion of an aortic valve, using a catheter technique. Transcatheter aortic valve implantation (TAVI) treats aortic valve stenosis in patients unfit for open-heart surgery.

From 2023 members registered **on all benefit options** will receive funding for procedures per the Scheme's clinical protocol and guidelines and these procedures will be paid per the global fees negotiated from the hospital benefits.

OTHER TECHNICAL UPDATES

2023 Benefit limit changes

Day-to-day (Insured Out-of Hospital) limits were increased by 10%. Some benefit limits remained unchanged, such as the Specialised Medicine Benefit (now called the Specialised Medicine and Bariatric Surgery Benefit which is only available to members registered on the **Comprehensive Option**), as well as the Oncology limits of the **Classic Option**. *Please consult the benefit limits as set out in this benefit brochure for more details.*

YOUR CONTRIBUTIONS FOR 2023

1. Contributions as from 1 January 2023 until 31 March 2023

	REMEDI COMPREHENSIVE*			REMEDI CLASSIC			REMEDI STANDARD		
Income bands	Principal	Adult or spouse	Child**	Principal	Adult or spouse	Child**	Principal	Adult or spouse	Child**
R0 – R3,999	R3,262	R2,471	R761	R2,560	R1,819	R614	R1,595	R1,062	R323
R4,000 – R5,499	R3,443	R2,638	R810	R2,709	R1,950	R682	R1,671	R1,118	R364
R5,500 – R6,999	R3,638	R2,811	R887	R2,855	R2,076	R729	R1,752	R1,253	R450
R7,000 – R7,999	R3,827	R2,891	R967	R3,003	R2,130	R798	R1,884	R1,501	R584
R8,000 – R8,999	R4,026	R3,051	R1,011	R3,166	R2,249	R850	R1,884	R1,501	R584
R9,000 – R9,999	R4,249	R3,197	R1,062	R3,329	R2,363	R885	R1,884	R1,501	R584
R10,000 – R10,999	R4,460	R3,358	R1,156	R3,507	R2,489	R965	R1,884	R1,501	R584
R11,000+	R4,701	R3,541	R1,220	R3,685	R2,618	R999	R1,889	R1,504	R585

Savings (PMSA) portion of contributions on the **Comprehensive Option***

Income bands	Principal	Adult or spouse	Child**
R0 – R3,999	R326	R247	R76
R4,000 – R5,499	R344	R264	R81
R5,500 – R6,999	R364	R281	R89
R7,000 – R7,999	R383	R289	R97
R8,000 – R8,999	R403	R305	R101
R9,000 – R9,999	R425	R320	R106
R10,000 – R10,999	R446	R336	R116
R11,000+	R470	R354	R122

Contribution subsidies 1 January 2023 until 31 March 2023 (where applicable)

	REMEDI COMPREHENSIVE*			REMEDI CLASSIC			REMEDI STANDARD		
Income bands	Principal	Adult or spouse	Child**	Principal	Adult or spouse	Child**	Principal	Adult or spouse	Child**
R0 – R3,999	R1,929	R696	R481	R1,879	R638	R466	R1,364	R726	R218
R4,000 – R5,499	R2,044	R760	R509	R1,988	R689	R487	R1,439	R753	R250
R5,500 – R6,999	R2,146	R811	R562	R2,092	R745	R537	R1,512	R842	R309
R7,000 – R7,999	R2,271	R833	R609	R2,209	R760	R587	R1,606	R1,000	R395
R8,000 – R8,999	R2,391	R871	R634	R2,326	R794	R611	R1,606	R1,000	R395
R9,000 – R9,999	R2,510	R911	R661	R2,445	R830	R611	R1,606	R1,000	R395
R10,000 – R10,999	R2,654	R966	R714	R2,580	R883	R664	R1,606	R1,000	R395
R11,000+	R2,789	R1,019	R764	R2,715	R938	R710	R1,611	R1,003	R397

* Contributions set at a maximum of 10% are inclusive of the PMSA on the **Comprehensive Option**.

** Contribution rates for children are applied on the first three (3) children.

Contributions as from 1 April 2023 until 31 December 2023

	REMEDI COMPREHENSIVE*			REMEDI CLASSIC			REMEDI STANDARD		
Income bands	Principal	Adult or spouse	Child**	Principal	Adult or spouse	Child**	Principal	Adult or spouse	Child**
R0 – R3,999	R3,487	R2,641	R814	R2,737	R1,945	R656	R1,705	R1,135	R345
R4,000 – R5,499	R3,681	R2,820	R866	R2,896	R2,085	R729	R1,786	R1,195	R389
R5,500 – R6,999	R3,889	R3,005	R948	R3,052	R2,219	R779	R1,873	R1,339	R481
R7,000 – R7,999	R4,091	R3,090	R1,034	R3,210	R2,277	R853	R2,014	R1,605	R624
R8,000 – R8,999	R4,304	R3,262	R1,081	R3,384	R2,404	R909	R2,014	R1,605	R624
R9,000 – R9,999	R4,542	R3,418	R1,135	R3,559	R2,526	R946	R2,014	R1,605	R624
R10,000 – R10,999	R4,768	R3,590	R1,236	R3,749	R2,661	R1,032	R2,014	R1,605	R624
R11,000+	R5,025	R3,785	R1,304	R3,939	R2,799	R1,068	R2,019	R1,608	R625

Savings (PMSA) portion of contributions on the **Comprehensive Option***

Income bands	Principal	Adult or spouse	Child**
R0 – R3,999	R349	R264	R81
R4,000 – R5,499	R368	R282	R87
R5,500 – R6,999	R389	R301	R95
R7,000 – R7,999	R409	R309	R103
R8,000 – R8,999	R430	R326	R108
R9,000 – R9,999	R454	R342	R114
R10,000 – R10,999	R477	R359	R124
R11,000+	R503	R379	R130

Contribution subsidies 1 April 2023 until 31 December 2023 (where applicable)

	REMEDI COMPREHENSIVE*			REMEDI CLASSIC			REMEDI STANDARD		
Income bands	Principal	Adult or spouse	Child**	Principal	Adult or spouse	Child**	Principal	Adult or spouse	Child**
R0 – R3,999	R2,062	R744	R514	R2,009	R682	R498	R1,458	R776	R233
R4,000 – R5,499	R2,185	R812	R544	R2,125	R737	R521	R1,538	R805	R267
R5,500 – R6,999	R2,294	R867	R601	R2,236	R796	R574	R1,616	R900	R330
R7,000 – R7,999	R2,428	R890	R651	R2,361	R812	R628	R1,717	R1,069	R422
R8,000 – R8,999	R2,556	R931	R678	R2,486	R849	R653	R1,717	R1,069	R422
R9,000 – R9,999	R2,683	R974	R707	R2,614	R887	R653	R1,717	R1,069	R422
R10,000 – R10,999	R2,837	R1,033	R763	R2,758	R944	R710	R1,717	R1,069	R422
R11,000+	R2,981	R1,089	R817	R2,902	R1,003	R759	R1,722	R1,072	R424

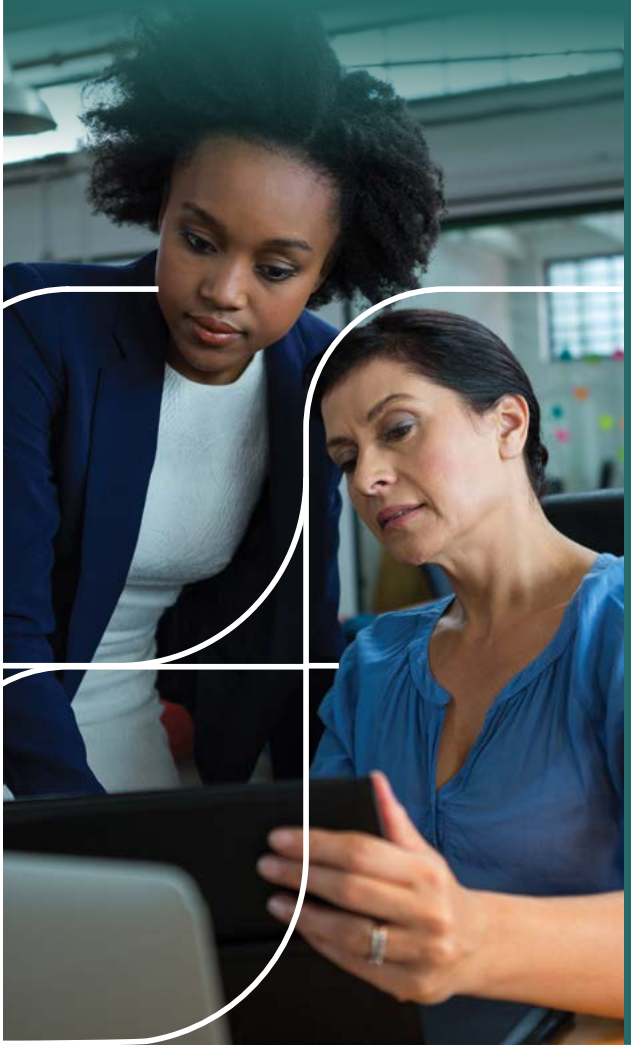
* Contributions set at a maximum of 10% are inclusive of the PMSA on the **Comprehensive Option**.

** Contribution rates for children are applied on the first three (3) children.

PERSONAL MEDICAL SAVINGS ACCOUNTS (PMSA) AVAILABLE ON THE COMPREHENSIVE OPTION

*The Personal Medical Savings Account gives members on the **Comprehensive Option** a way to save money for when they have to visit the doctor, buy medicine at the pharmacy or pay for other daily medical expenses. If you do not use all the funds in the Personal Medical Savings Account during the year, we add interest to the amount and carry it over to the next year.*

If you resign from Remedi and still have funds in your PMSA, we will transfer the money to your new medical scheme (if it has a Personal Medical Savings Account on the benefit option you choose) or refund the money to you four months after your transfer from Remedi. We follow the requirements found in the Medical Schemes Act when we refund the money to you.



WE PAY FOR THESE FROM THE INSURED OUT-OF-HOSPITAL (IOH) BENEFIT BEFORE USING FUNDS FROM THE PMSA

- GPs
- Medical specialists
- Conservative dentistry
- Prescribed acute medicine and injection material
- Physiotherapy, speech therapy, and occupational therapy
- Clinical psychologists
- Social workers
- Eye tests, spectacles or contact lenses and refractive eye surgery
- Radiology: Out-of-hospital (excluding MRI and CT scans)
- Pathology: Out-of-hospital

WE COVER THESE FROM THE PMSA ONLY

- Chiropractor, homeopath, osteopath, herbalist, naturopath or dietitian
- Condoms and some appliances not funded from available benefits, as applicable
- Preventive medicine for malaria
- Immunisations, except those covered from the Prevention and Screening Benefit

IMPORTANT NOTE:

Prescribed Minimum Benefit (PMB) treatment cannot be funded from your Personal Medical Savings Account (PMSA).

WAITING PERIODS AND CHANGING YOUR BENEFIT OPTION

MEDICAL CONDITIONS DURING A WAITING PERIOD

If we apply waiting periods because you have never belonged to a medical scheme or you have had a break in membership of more than 90 days before joining Remedi Medical Aid Scheme, you will not have access to the Prescribed Minimum Benefits (PMB) during your waiting period. This includes cover for emergency admissions. If you had a break in cover of less than 90 days before joining Remedi, you may have access to PMB during waiting periods.

IF YOU WANT TO CHANGE YOUR BENEFIT OPTION

You can change to another benefit option at the end of the year, to start from 1 January of the following year. You cannot change your benefit option during the year. To change your benefit option you would need to download the benefit change form available on the Remedi website at www.yourremedi.co.za and return to us before 16 December 2022, per the instructions provided on the form.

The benefits outlined in this brochure are a summary of Remedi Medical Aid Scheme's benefits as set out in the Remedi Scheme Rules. These benefits are reviewed every year and amended in line with the requirements of the Medical Schemes Act and take into account the requirements of the Consumer Protection Act where it relates to the business of a medical scheme. **Please visit www.yourremedi.co.za for a copy of the Scheme Rules as registered by the Council for Medical Schemes (CMS) each year.**

REMEDI EXCLUSIONS

HEALTHCARE SERVICES THAT ARE NOT COVERED ON REMEDI

Remedi Medical Aid Scheme has certain exclusions. We do not pay for certain services, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits (PMB).

THE EXCLUSION LIST INCLUDES:

A

- Appliances not part of benefit plan
  - Purchase or hire of medical or surgical appliances, such as special beds, chairs, cushions, commodes, sheepskins, waterproof sheets, bedpans, special toilet seats, adjustment or repairs of sick rooms or convalescing equipment, with the exception of the hire of oxygen cylinders where the Scheme has provided prior written approval for the purchase of these and other appliances as PMB level of care.
- Aphrodisiacs.
- Anabolic steroids.
- Artificial insemination of a person as defined in the Human Tissue Act, 1983 (At of 1983).
- Appointments not kept.
- Ante and post-natal exercise classes, mothercraft or breastfeeding instructions.

B

- Breast reductions, unless medically necessary (costs for mammoplastics)

C

- Contact lens solution, including all optical devices which are not regarded by the South African Optometric Association as clinically essential or clinically desirable, including sunglasses and spectacle cases.
- Costs for operations, medicines, treatment and procedures for cosmetic purposes.
- Consumables including bandages, cotton wool, dressings and such items.
- Costs for services rendered by persons not registered with a recognised professional body constituted in terms of any law; or any organisation, clinic, institution, nursing home or similar institution except a state or provincial hospital not registered in terms of any law.
- Costs that are more than the benefit to which a member is entitled in terms of the Scheme Rules, unless otherwise agreed to by the Board of Trustees or PMB.

D

- Diagnostic agents

E

- Erectile dysfunction treatment and associated costs.

F

- Food or nutritional supplements and patented foods, including baby foods

G

- Gold in dentures or the cost of gold as an alternative to non-precious metal in crowns, inlays and bridges
- Gender re-alignment and associated costs for personal reasons and not directly caused by or related to illness, accident or disorder.

H

- Household remedies or preparations of the type advertised to the public.
- Holidays for recuperation.

I

- Infertility treatment - unless received from a Designated Service Provider (DSP) facility or as a PMB.
- Injuries arising from professional sport, speed contests and speed trials, unless PMB.

M

- Medicine not registered with the Medicines Control Council and proprietary preparations or medicine purchased not included in a prescription from a person legally entitled to prescribe medicine.

O

- Obesity – tonics, slimming preparations used to treat or prevent obesity and dugs as advertised to the public.

S

- Sun-tan lotions, namely sunscreens and tanning agents, including cosmetics, emollients and moisturisers.
- Soaps, shampoos and other topical applications, including applicators, toiletries and beauty preparations.
- Section 21 medicines not approved and registered with the South African Medicines Control Council.

W

- War: injury or disablement due to war, invasion or civil war, except for PMB.

The above list must not be regarded as complete as we do not cover the complications or the direct or indirect expenses that arise from any of the exclusions listed here, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits.

DISCRETIONARY AND *EX GRATIA* BENEFITS

Discretionary benefits are made available to members through an Ex Gratia Policy as approved by the Board of Trustees of the Scheme.

Ex gratia is defined by the Council for Medical Schemes (CMS) as 'a discretionary benefit which a medical aid scheme may consider funding in addition to the benefits as per the registered rules of a medical scheme. Schemes are not obliged to make provision there for in the rules and members have no statutory rights thereto'. The Board of Trustees may in its absolute discretion increase the amount payable in terms of the Rules of the Scheme as an *ex gratia* award.

As *ex gratia* awards are not registered benefits, but are awarded at the discretion of the Board of Trustees, the Board has instructed the Medical Advisory Committee (MAC) who review these applications received and this committee is mandated to make decisions on behalf of the trustees and the Scheme in this regard.

Decisions taken by this committee are final and are not subject to appeal or dispute.

If you would like to apply for a discretionary benefit or grant, you can contact the Scheme's Administrator by dialing **0860 116 116** to be provided with the necessary forms and information regarding the process to follow.

COMPLAINTS AND DISPUTES

REMEDI COMPLAINTS AND DISPUTES PROCESS

Remedi Medical Aid Scheme is committed to providing you with the highest standard of service and your feedback is important to us. The following channels are available for your use and we encourage you to follow the process.

1. To reach out to us

Contact us on 0860 116 116 and speak to a consultant or email us at service@yourremedi.co.za. You will be issued with a reference number for your interaction, complaint or dispute when you contact us.

Our service times are as follows:

- 07:00 – 20:00 Monday to Friday
- 08:00 – 13:00 Saturdays
- Closed Sundays and public holidays

We'd also love to hear from you if we have exceeded your expectations.

2. To lodge a formal complaint

If you are unsatisfied with the outcome, having interacted with a consultant as set out in step 1 above, you may email your reasons for being unhappy along with your reference number to escalations@yourremedi.co.za for assistance directly from a Client Relationship Manager (CRM).

You may send your communication to the CRM at any time and will receive an automatic response of the estimated turnaround time to expect feedback by.

3. To contact the Principal Officer (PO)

If you're still not satisfied with the resolution of your issue or complaint and would like to escalate it to be investigated by the Principal Officer, you may lodge a formal dispute after following the steps above.

To escalate your issue and to lodge a formal dispute, please complete the Scheme's Dispute Form and send it with any other details you wish to bring to the attention of the Remedi PO by emailing executiveoffice@yourremedi.co.za.

Make sure that you quote the reference number you received when you first made contact with us in (following step 1 above), together with the Disputes Form to this email address to be assisted as efficiently as possible.

The disputes form is available on the Remedi website at **www.yourremedi.co.za**.

4. To contact the Council for Medical Schemes (CMS)

The Council for Medical Schemes (CMS) regulates medical schemes, including Remedi.

You can contact the CMS at any stage of the complaints process, but we encourage you to follow any of the steps above to resolve your complaint with the Scheme first before contacting the CMS directly.

If you want to contact the CMS to lodge a complaint or escalate an issue that you are unable to resolve after following the above steps, please use the below contact information of the CMS to do so.

The CMS contact details are as follows:

- Physical address: Block A, Eco-Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157
- Postal address: Private Bag X34, Hatfield, 0028 Phone number: 0861 123 267
- Fax number: 012 431 7644
- Email: complaints@medicalschemes.co.za

Read more about the Council for Medical Schemes, **www.medicalschemes.co.za**.

NOTES

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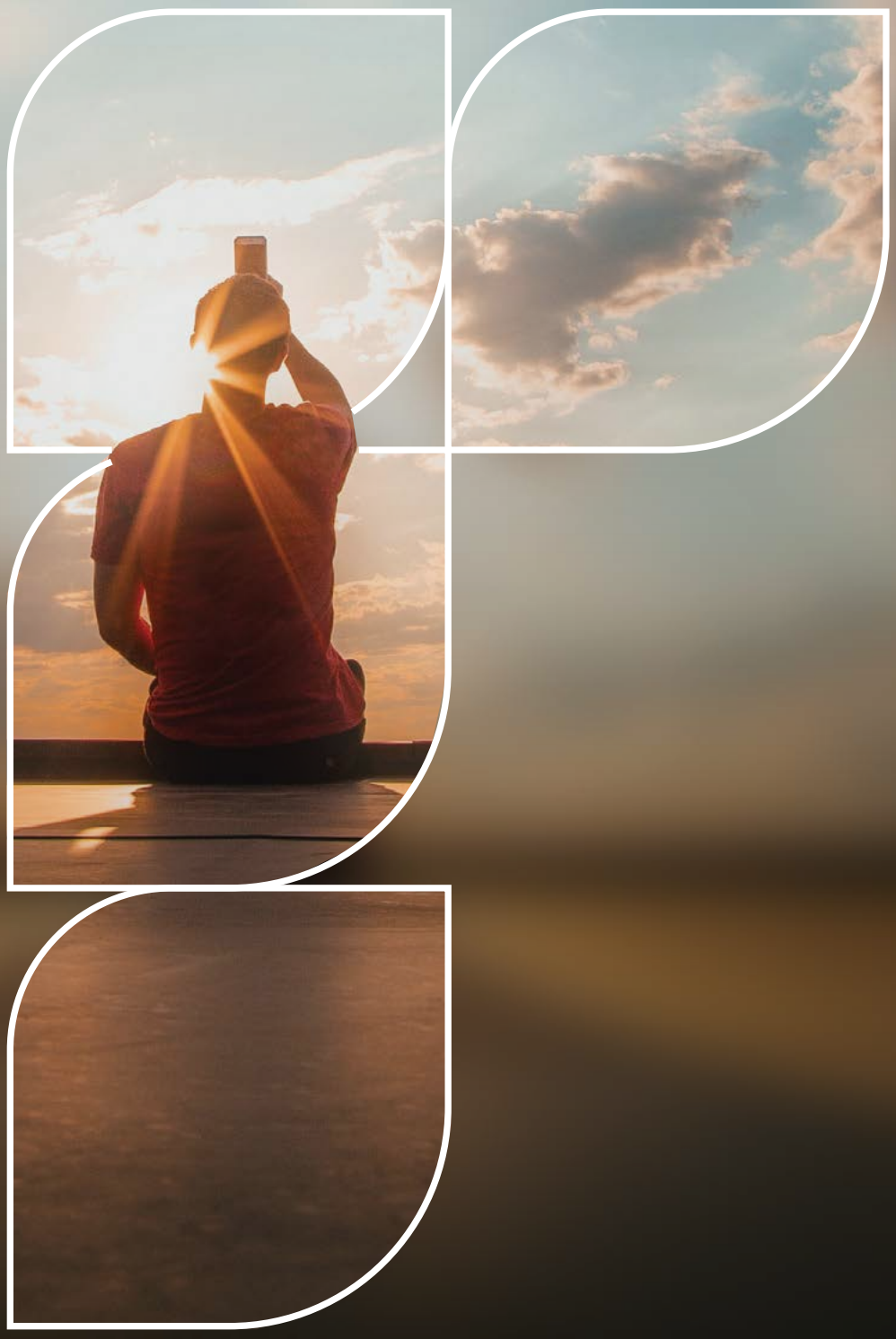

Tel 0860 116 116 | service@yourremedi.co.za | www.yourremedi.co.za

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