REMEDI

Administered by Discovery Health

REMEDI MEDICAL AID SCHEME

BENEFITS 2022

This Benefit Brochure is a summary of the benefits and features of Remedi Medical Aid Scheme, pending formal approval from the Council for Medical Schemes and does not replace the Remedi Rules. The registered Remedi Rules are legally binding and always take precedence.

WELCOME TO REMEDI

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.

The Scheme offers members three Benefit Options to choose from. Each Benefit Option was designed to meet the specific needs of employees of the participating employers.

Remedi's **Comprehensive Option** provides members with a Personal Medical Savings Account (PMSA) for benefits not covered from your Hospital Benefits. This 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). 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 at an affordable price.

QUICK CONTACT **REFERENCES**

For ambulance and other emergency services

Call **ER24** on **084 124**

General queries

service@yourremedi.co.za
Call centre **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 **claims@yourremedi.co.za**
Fax it to **0860 329 252**
Drop off your claim in any blue Discovery Health claims box, or post it to PO Box 652509 Benmore 2010 or take a photo and submit your claim using the Remedi App. The Remedi App can be downloaded at the Apple iStore and Google Playstore.

Other services

Oncology service centre **0860 116 116**
HIV*Care* Programme **0860 116 116**
Internet queries **0860 100 696**

For Dental queries on Standard

Dental Risk Company (DRC) call centre **087 943 9611**
General enquiries **enquiries@dentalrisk.com**
Website **https://www.dentalrisk.com/**

For Optical queries

Preferred Provider Network (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 to **Members_DCC@yourremedi.co.za**
Additional information is available on our website **www.yourremedi.co.za**

Preauthorisation

Contact us on **0860 116 116**

Report fraud

If you even slightly suspect someone of committing fraud, report all information to the Discovery fraud hotline: **forensics@yourremedi.co.za** directly.
You may remain anonymous if you prefer:
Toll-free phone **0800 004 500**
SMS **43477** and include the description of the alleged fraud.
Toll-free fax **0800 007 788**
Email **discovery@tip-offs.com**
Post **Freepost DN298, Umhlanga Rocks 4320**

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QUICK A TO Z

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.
Benefit entry criteria	For certain illnesses, we set benefit entry criteria that you need to meet in order 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.
Co-payment	This is the amount you may be asked to pay in addition to what we pay to cover your medical expenses. For example, if you see a non-network doctor who charges more than the Remedi Rate, Remedi will pay you for the visit at the Remedi Rate and you will have to pay the extra amount 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 or, if you are on the Comprehensive Option, from your available Personal Medical Savings Account. We will pay non-network doctors directly up to the Remedi Rate, if you are on the Standard Option. Read more: Preauthorisation on page 8.
Designated service provider (DSP)	This is a doctor, specialist or other healthcare provider Remedi has reached an agreement with about payment and rates for the purpose of Prescribed Minimum Benefits (PMB). When you use the services of a designated service provider, we pay the provider directly at the Remedi Rate. We pay participating specialists at the Premier, Classic Direct or Remedi Rate for claims. We also pay participating general practitioners at the contracted GP rate for all consultations. You will not have to pay extra from your own pocket for providers who participate in the Premier and Remedi network arrangements, but may have a co-payment for out-of-hospital visits to specialists on the Classic Direct Payment Arrangement.
Exclusions	There are certain expenses that are not covered by Remedi. These are called exclusions. They are listed on page 20 of this Benefit Brochure.
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 your expenses for serious illness and high-cost care while you are in hospital, if we have confirmed you have cover for your admission. 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 the Scheme 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.
Medical emergencies	This is a condition that develops quickly, or occurs from an accident, and you need immediate medical treatment or an operation. In a medical emergency, your life could be in danger if you are not treated, or you could lose a limb or organ. Not all urgent medical treatment falls within the definition of PMB. If you or any members of your family visit an after hours emergency facility at the hospital, it will only be considered as an emergency and covered as a PMB if the doctor diagnoses the condition as a PMB.

QUICK A TO Z (continued)

Mental Health Network	A defined list of Psychiatrists, Psychologists, Registered Counselors and/or Social Workers contracted or nominated by the Scheme for purposes of providing treatment to members relating to mental health conditions. See also DSP
PMB Network	A Mediclinic hospital contracted to or nominated by the Scheme established for the provision of services that relates to Prescribed Minimum Benefit (PMB) conditions. See also DSP.
Preauthorisation	You have to let us know if you plan to be admitted to hospital. Please phone us on **0860 116 116** for preauthorisation, so we can confirm your membership and available benefits. Without preauthorisation, you may have to make a co-payment of R1 000 for each admission. **Preauthorisation is not a guarantee of payment as it only aims to confirm that the treatment to be received in hospital is clinically appropriate and aligned with the benefits available.** We advise members to talk to their treating doctor so they know whether or not they will be responsible for out of pocket expenses, when they preauthorise their treatment. There are some procedures or treatments your doctor can do in their rooms. For these procedures you also have to get preauthorisation. Examples of these are endoscopies and scans. If you are admitted to hospital in an emergency, Remedi must be notified as soon as possible so that we can 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. They are based on scientific evidence and research. Read more: Preauthorisation on page 8.
Prescribed Minimum Benefits (PMB)	These are a list or a set of defined benefits determined in the Medical Schemes Act, that all medical schemes have to give to their members. Read more: PMB and DTPPMB on page 15.
Related accounts	This type of account is separate from the hospital account when you are admitted to hospital. Related accounts include the accounts from doctors or other healthcare professionals, such as the anaesthetist accounts and for pathology or radiology tests when you are treated in hospital.
Remedi Rate	This is the Rate at which we pay for your medical claims. The Remedi Rate is based on specific rates that we negotiate with healthcare service providers. Unless we state differently in this Benefit Brochure, we pay for claims at 100% of the Remedi Rate or negotiated contracted fees. If your doctor charges more than the Remedi Rate or negotiated fees, we will pay available benefits to you at the Remedi Rate or negotiated rates and you will have to pay the healthcare provider. We will pay your service provider directly, up to 100% of the Remedi Rate, even if they charge more than the negotiated Rate, if you are on the Standard Option.

REMEDI **BENEFIT UPDATES FOR 2022**

Targeted benefit enhancements

SPINAL CARE CENTRE OF EXCELLENCE

This benefit enhancement consists of a spinal surgery component for members needing spinal surgery, and a conservative care programme for those with severe back pain, but when surgery can be prevented through out-of-hospital care. For more information please see page 13 of this Benefit Brochure.

POINT-OF-CARE (POC) TESTING

These tests consist of medical diagnostic tests that allows for simple medical tests to be done at the patient's bedside. The Scheme has adopted a POC strategy to ensure the shortest possible timeframes for required tests and their results, allowing:

- Direct integration with approved POC devices used for select tests associated with the management of members registered on Care Programmes and you will be able to access this benefit through the Connected Care Platform (See page 12 of the Benefit Brochure); and
- Reimbursement of these POC tests where the results have been received by a defined integrated solution to protect member confidentiality and personal information, as well as to allow for analysis and recording as part of the member's record into the HealthID platform of the Scheme.

HOSPITAL RE-ADMISSIONS MANAGEMENT

This benefit aims to achieve improvements in readmission rates through a 'home health initiative'. Home health ensures that when patients, who are considered to be at high risk of readmission, are discharged from acute care, they do not suffer a relapse or deterioration that may require readmission to hospital. For more information please see page 12 of the Benefit Brochure.

MEMBER CARE PROGRAMME

This customised, outpatient programme helps members who have complex medical needs. The programme is offered on all benefit options as an extra benefit and more information is available on page 13 of the Benefit Brochure.

Enhancing existing benefits

MENTAL HEALTH RELAPSE PROGRAMME

The Scheme makes available a Mental Health Programme to members registered on all benefit options and the Mental Health Relapse Prevention Programme is an enhancement of this existing programme. The programme aims to reduce the risk of chronicity of Major Depression and to prevent multiple admissions to hospital for depression related illnesses. For more information regarding the Scheme's Mental Health Programme please see pages 11 and 16 of the Benefit Brochure.

LONG COVID BASKET OF CARE

As part of the Prescribed Minimum Benefits (PMB), the Scheme is introducing a basket of care for those diagnosed with 'Long COVID' without affecting day-to-day benefits. For more information regarding the Scheme's World Health Organization (WHO) global outbreak benefit see page 13 of the Benefit Brochure.

Other technical updates

CHRONIC ILLNESS BENEFIT

From 2022 formulary and Chronic Drug Amount changes will be applied and you can read more about your chronic illness benefits on page 9 of the Benefit Brochure.

2022 BENEFIT LIMIT CHANGES

Limits were increased on average by 4.5%. Some benefit limits remained unchanged, such as the Specialised Medicine Benefit. Please consult the benefit limits as set out from pages 13 and 25 of this Benefit Brochure for more details.

OPERATIONS, HOSPITAL VISITS AND PREAUTHORISATION

EMERGENCY SERVICES BY ER24

In a medical emergency, you can call ER24 on 084 124, at any time of the day or night, to get authorisation for emergency transportation.

Highly-qualified emergency personnel from ER24 manage the service. They will send an ambulance or helicopter, if medically necessary, when you've been in an accident or other emergency. This emergency medical transport is covered by your Hospital Benefit, if medically justified, whether you are admitted to hospital or not, only if you get authorisation from ER24.

Otherwise, go straight to the emergency room yourself – but get someone to call us within 24 hours if you are admitted to hospital. Your emergency treatment in-hospital will be covered according to your Option's benefits.

YOU HAVE EMERGENCY COVER

There are times when you may not have access to cover on your Benefit Option, for example, when you have run out of benefits or you reach a benefit limit or when you are in a waiting period.

If you are covered for Prescribed Minimum Benefits, you will still be covered for a life-threatening emergency. Please remember that not all emergencies are part of your Prescribed Minimum Benefits and you need to use designated service providers to receive payment in full.

COVER FOR GOING TO EMERGENCY ROOMS

If you visit the emergency rooms at any hospital, and are admitted to hospital from there, we will cover the costs of the visit from your Hospital Benefit, if you have phoned us for authorisation within 24 hours of being admitted.

If you go to the emergency rooms but you are not admitted to hospital, we will pay the cost of the visit from your Insured Out-of-Hospital Benefit. We also cover the facility fee in some instances.

INTERNATIONAL EMERGENCY EVACUATION SERVICES

It is important to note that the Scheme does not make provision for international emergency evacuation services. Members are required to 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.

If you need an operation or hospital treatment

For planned hospital stays, you have to call us for preauthorisation at least 48 hours before going to hospital. Remedi covers you for planned hospitalisation up to the overall annual limit for your 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 have to take while you are in hospital.

Hospital visits and preauthorisation

Before you go to hospital for a planned procedure, remember to get authorisation first. You have to:

- Visit your doctor so that he or she can decide if it is necessary for you to be admitted to hospital.
- Find out which doctor is going to admit you to hospital. Sometimes, your own doctor will refer you to another doctor or specialist.
- Choose the hospital you want to be admitted to, but remember that not all procedures are done in all hospitals. Your doctor can advise you on this.
- Phone us to find out how we cover healthcare professionals, like anaesthetists, so that you can reduce the risk of a co-payment.
- Preauthorise your hospital admission by calling us on **0860 116 116** at least 48 hours before you go to hospital. We will give you information that is relevant to how we will pay for your hospital stay. **If you do not confirm your admission and the costs that we would normally cover, you may have to make a co-payment of R1 000 for the admission.**

Remember, the Hospital Benefit only covers you for admission to a general ward, not a private ward.

CHRONIC ILLNESS BENEFIT **(CIB),** ADVANCED ILLNESS BENEFIT **(AIB)** AND CANCER TREATMENT

Remedi provides cover for chronic illness, an advanced illness benefit, cancer treatment, home care and more. Details of the specific benefit provided on each Option can be found by visiting the Remedi website, www.yourremedi.co.za.

Chronic Illness Benefit (CIB) and cover for your chronic conditions

You have cover for approved medicine for the 26 Prescribed Minimum Benefits (PMB) Chronic Disease List (CDL) conditions. We need to approve your application before we cover your condition from the Chronic Illness Benefit (CIB). The latest Chronic Illness Benefit application form can be found by visiting the Remedi website, **www.yourremedi.co.za.**

Medicine cover for approved Chronic Disease List (CDL) conditions

On the Remedi Classic and Comprehensive Benefit 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 Remedi 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 Option must obtain their medicine from a network pharmacy to avoid a co-payment of 20%.**

For a condition to be covered from the Chronic Illness Benefit, 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 26 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 code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete, when they refer you to pathologists and radiologists for tests. This will enable pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit to ensure that we pay your claims from the correct benefit.

YOU NEED TO LET US KNOW WHEN YOUR TREATMENT PLAN CHANGES

You do not not have to complete a new Chronic Illness Benefit application form when your treating doctor changes your medicine during the management of your approved chronic condition, however, you do need to let us know when your doctor makes these 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, provided that 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.

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

Non-PMB chronic disease list conditions covered on Remedi Comprehensive and Classic Options

On the Remedi Comprehensive and Remedi 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 option.

Cancer treatment

If you're diagnosed with cancer, we cover you from the Remedi Oncology Programme once we have approved your cancer treatment. Your cancer treatment costs are limited up to the benefit limit of your chosen Option, unless your treating doctor prescribes PMB level of care and treatment. Once your benefit limit has been reached, only 80% of the Remedi Rate will be covered and you must therefore consult with your treating doctor to determine the most cost effective treatment available to ensure your co-payments are limited.

Your Oncology Benefit is made available to you over a 12 month rolling period from date of diagnosis.

All cancer-related healthcare services are covered up to 100% of the Remedi Rate where PMB level of care and treatment is prescribed and you will continue to receive cover in addition to the benefit limits made available if your treatment is aligned with PMB level of care. Please visit the Remedi website, **www.yourremedi.co.za** and access the applicable disease management section to obtain more information about the cover you will receive in the unfortunate event that you are diagnosed with cancer or contact us on **0860 116 116** for more information or assistance.

CHRONIC ILLNESS BENEFIT **(CIB),** ADVANCED ILLNESS BENEFIT **(AIB)** AND CANCER TREATMENT

Advanced Illness Benefit

End-of-life care for members diagnosed with oncology-related conditions are funded from the unlimited Advanced Illness Benefit (AIB) and members have access to a comprehensive palliative care programme on all Options. This programme offers unlimited cover for approved care in the comfort of your home, with minimum disruption to your normal routine and family life. The palliative care is provided by a multidisciplinary team, including trained doctors and nurses, in partnership with the Hospice Palliative Care Association of South Africa. To register, your doctor needs to complete the Advanced Illness Benefit application form and email it to **AIB@yourremedi.co.za**

End-of-life care for members who require frail care nursing for other conditions continues to be funded from the frailcare and nursing benefits as set out in this Brochure from page 24.

REMEDI PATIENT MANAGEMENT PROGRAMMES

Remedi Cardio Care

The Cardio Care Programme is designed to offer our members care for certain approved heart-related conditions. Optimal care is received from the best service providers in a coordinated network, to ensure the best outcomes and quality of life. To access the programme, you need to be 18 years or older and registered on the Chronic Illness Benefit (CIB) with hypertension, hyperlipidaemia and/or ischaemic heart disease. A General Practitioner (GP) in the Premier Plus GP network can enroll you onto the programme. The Cardio Care Programme is based on clinical and lifestyle guidelines. The programme gives you and your Premier Plus GP access to various tools to monitor and manage your condition and to ensure you have access to high-quality coordinated care. You and your GP can track your progress on a personalised dashboard displaying your unique Cardio Care Management Score. This will help you to identify the steps you should take to manage your condition and remain healthy over time. For more information, please visit the Remedi website, **www.yourremedi.co.za.**

Remedi Diabetes-cardiometabolic population health management

The Diabetes-cardiometabolic population health management Programme, is an integrated chronic care Programme for members living with diabetes, as well as their related cardiometabolic condition(s). 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 condition(s) and stay healthy over time.

The programme also unlocks cover for valuable healthcare services from healthcare providers like dietitians, 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 the 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**

Remedi HIV Care

The HIV Care Programme, together with your Premier Plus GP, will help you actively manage your condition. The programme gives you and your Premier Plus GP access to various tools to monitor and manage your condition and to ensure you get high-quality coordinated healthcare and the best outcomes.

A Premier Plus GP is a network GP who has contracted with us to provide you with high quality healthcare for your condition.

When you register for our HIV Care Programme and choose a Premier Plus GP to manage your condition, you are covered for the care you need, which includes additional cover for social workers.

To register on the Remedi HIV Care Programme:

Call us on **0860 116 116**
email: **HIV@yourremedi.co.za**

Remedi Mental Health Care

The Mental Health Care Programme is designed to offer our members diagnosed with acute or episodic major depression the optimal care from the best service providers in a coordinated network. This is to ensure the best outcomes and quality of life for members diagnosed with major depression. A GP in the Premier Plus GP network can do the assessment to confirm the diagnosis and enroll you onto the programme. The programme, which will be active for 6 months from the date of enrollment, will give your Premier Plus GP access to tools to monitor and manage your condition and to ensure you have access to high-quality coordinated care. By joining the Mental Health Care Programme, you will have access to 3 GP consultations and certain first line anti-depressant therapy.

From 2022, qualifying members will also have access to a relapse prevention programme, which includes additional cover for a defined basket of care for psychiatry consultations, counseling sessions and care coordination services.

For more information, please visit the website at **www.yourremedi.co.za.**

YOUR ACCESS TO **CONNECTED CARE** AND **HOME CARE BENEFITS**

Remedi aims to enable members to receive healthcare whenever they need it and introduced Connected Care in 2021.

Connected Care for members at home

Using the Connected Care Platform, you can connect to doctors through virtual consultations like never before, from the comfort of your home.

As part of the enhancements for 2022, members will receive funding for point-of-care devices from their available "other external prostheses and appliances" benefits depending on their chosen benefit option. These devices will allow members to do point-of-care testing to track and manage their chronic conditions from home. The tests will be funded from your available pathology benefit per your chosen benefit option.

Re-admission benefit: Home-based care for follow-up treatment after an admission

Clinically appropriate conditions such as chronic obstructive pulmonary disease, chronic cardiac failure, ischaemic heart disease and pneumonia have access to enhanced home-based care once discharged from hospital. If you meet the clinical entry criteria you have cover for bedside medicine reconciliation prior to admission discharge, a follow-up consultation with a GP or specialist, and a defined basket of supportive care at home that includes a face-to-face consultation and virtual consultations with a Discovery Home Care nurse.

Home care benefit

This benefit is a service offering that provides you with quality care in the comfort of your own home when recommended by your doctor as an alternative to a hospital stay. Services include postnatal care, end-of-life care, IV infusions (drips) and wound care. These services are paid from the Hospital Benefits, subject to approval and provided to you through Discovery Home Care as a designated service provider (DSP) for administration of defined intravenous infusions. Avoid a 20% co-payment by using Discovery Home Care for these infusions.

EXTRA BENEFITS

As a member of Remedi, you get the following extra benefits to enhance your cover.

ALL BENEFIT OPTIONS:

Spinal care programme

For conservative spinal treatment out-of-hospital you have access to a defined basket of care which includes cover for virtual and face-to-face consultations with an appropriately registered allied healthcare professional.

Prosthetic devices used in spinal surgery is covered in full if you get your prosthesis from our preferred suppliers. If you do not use a preferred supplier, your benefit option's internal prosthesis benefit limits will be applicable.

You have full cover for approved spinal surgery admissions if you use a provider in our spinal surgery network. Planned admissions are funded up to 100% of the Scheme Rate for the hospital account.

Claims related to traumatic events

The Trauma Recover Extender Benefit extends your cover for out-of-hospital claims related to certain traumatic events. Claims are paid from the Trauma Recovery Extender Benefit for the rest of the year in which the trauma occurred, as well as the year after the event occurred. You need to apply for this benefit if you experience:

- Crime-related injuries
- Quadriplegia
- Conditions resulting from a near drowning
- Severe anaphylactic (allergic) reaction
- Poisoning
- Severe burns
- Paraplegia
- External and internal head injuries

Member care programme

As part of an enhanced service offering to Remedi members, Remedi is introducing a member care programme in 2022 as a customised, outpatient programme to assist those members who have complex medical needs. The programme facilitates high-quality, planned, person-centred care and chronic condition management to achieve improved outcomes. Members that qualify for the programme are identified via a risk intelligence tool and the member care team. The team will contact members proactively to offer voluntary enrolment if they meet the clinical criteria.

WHO global outbreak benefit

You have cover up to 100% of the Scheme Rate for relevant healthcare services, as well as a defined basket of care for out-of-hospital healthcare services, related to the global World Health Organisation (WHO) recognized disease outbreaks such as COVID-19. This does not affect your day-to-day benefits, where applicable, and in line with Prescribed Minimum Benefits (PMB).

This defined basket of care includes cover for the vaccine, screening consultations, testing, out-of-hospital management and appropriate supportive treatment as long as the treatment meets our benefit entry criteria. In-hospital treatment for approved COVID-19 admission is covered from the Hospital Benefit and in accordance with PMB.

As part of the Prescribed Minimum Benefits (PMB), the Scheme is introducing a basket of care for those diagnosed with 'Long COVID' from 2022, and funding for Long COVID will not impact your day-to-day benefits. Long COVID is diagnosed when symptoms of acute COVID-19 disease persist beyond 21 days after a confirmatory test. The benefit is activated for a period of 6 months from the date of diagnosis by the treating healthcare provider.

COMPREHENSIVE OPTION EXTRA BENEFITS:

Specialised medicine benefit

You have cover for a defined list of the latest treatments through the Specialised Medicine Benefit. We pay up to R210 000 per person per year. A co-payment of up to 10% may be applicable depending on the medicine that is prescribed by your treating doctor.

International second opinion services

Through your specialist, you have access to second opinion services from Cleveland Clinic for life-threatening and life-changing conditions. We cover 50% for the cost of the second opinion service.

Overseas treatment benefit

You have cover for treatment not available in South Africa. The treatment must be provided by a recognized professional and is paid up to a limit of R680 000 per person. You will need to pay and claim back from us when you return to South Africa. A co-payment of 20% applies.

HOW TO USE YOUR **PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA)**

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 Personal Medical Savings Account, we will transfer the money to your new medical scheme (if it has a Personal Medical Savings Account on the Option you choose) or refund the money to you four months after transfer. We follow the requirements found in the Medical Schemes Act when we refund the money to you.

WE PAY FOR THESE FROM THE 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.

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

HOW TO ACCESS YOUR **OPTICAL AND DENTAL 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 Benefit.

- 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 he or she may charge 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 sub-limits, as well as the overall annual limit.

Making the most of your dental benefits

Remedi 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.

Members on the Classic and Comprehensive Options have access to conservative Dental Benefits which is subject to the available Insured Out-of-Hospital Benefit limits and the overall annual limit. Comprehensive members' conservative dental claims will be funded from the available Personal Medical Savings Account (PMSA) once the conservative Dental Benefits are used up.

The Comprehensive Option makes specialised dentistry Benefits available to members, while Classic members' specialised dentistry is subject to the available Insured Out-of-Hospital Benefit. Members on the Standard Option do not have any specialised dentistry benefits available.

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.

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.

PRESCRIBED MINIMUM BENEFITS (PMB) AND DIAGNOSIS AND TREATMENT PAIRS (DTPPMB)

What are Prescribed Minimum Benefits?

The Prescribed Minimum Benefits (PMB) are a set of defined benefits determined by the Medical Schemes Act, that all medical schemes have to give to their members. This compulsory cover is designed to:

- Make sure all medical scheme members can get access to the same level of care, no matter which Benefit Option they are on
- Give medical scheme members access to healthcare that they can afford
- Help people to stay healthy.

All medical schemes have to cover the costs related to the diagnosis, treatment and care of emergency medical conditions, a limited set of medical conditions and certain chronic conditions. As part of this, we cover you for a list of 270 PMB conditions that are linked to a specific diagnosis and treatment guideline known as Diagnosis and Treatment Pairs PMB. Many of these DTPPMB 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, subject to 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 (psychiatrist must motivate)
Organ transplants
Paraplegia
Pemphigus (dermatologist must motivate)
Peripheral arteriosclerotic disease
Pituitary disorders
Quadriplegia
Stroke (cerebro-vascular accident)
Thrombocytopenic purpura
Valvular heart disease

It is important to note that even if your doctor says it is a PMB, only the condition ICD-10 codes that your doctor submits, and the rules will determine whether it is covered as PMB or not.

Funding of Medication for PMB conditions

The Scheme will pay 100% of the Cost of the medication, **if the medication is obtained from a Designated Service Provider (DSP)** or if involuntarily obtained from a provider other than a DSP, further provided that:

- 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 obtained from a provider other than a DSP, a co-payment equal to the difference between the actual Cost of the medication and the Cost that would have been incurred had the DSP been used would be applied.

On Remedi 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, for any amount in excess of the Chronic Drug Amount (CDA), which is applicable for that condition, the member will be liable for the excess amounts. On the Remedi Standard Option, if the member is registered for the Chronic Illness Benefit and the medicine is on the Remedi medicine list (formulary), funding will be 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.

PRESCRIBED MINIMUM BENEFIT (PMB) NETWORKS

Remedi has contracted and established the following additional Networks with effect from 1 January 2022 in an effort to avoid co-payments being experienced by members when obtaining services for Prescribed Minimum Benefit (PMB) conditions.

Mental health network

The Scheme identified a gap in options available to members to obtain full cover for mental health treatment from allied providers such as social workers, psychologists and registered counsellors.

The Mental Health Network has been created for these providers and applies across all Options with effect from 1 January 2022 where these providers bill for treatment i.e. Out-of-Hospital (OOH) benefits and in-hospital related accounts.The Network is also applicable where services are claimed from the allied and therapeutic benefits of the Scheme and where services are obtained via the Mental Health Programme available on both Options

Members who obtain services from these providers will experience no balance billing, provided they obtained services as part of the Mental Health Network of Service Providers. Where a member obtain services from a non-network provider and the provider charge above the Scheme Rate, the payment will be limited to Scheme Rate **and will be paid to the member.** In such instances members may be liable for additional payments when settling accounts with the non-network Service Providers and it is therefore important to contact us to confirm whether your preferred Service Provider is part of the Mental Health Network of the Scheme before obtaining services for PMB conditions to ensure that your account is paid in full.

Implementation of a PMB hospital network and a PMB in hospital full cover model

Members on Remedi have access to the Remedi PMB Hospital Network, consisting of **Mediclinic private hospitals** to obtain services for PMB at **full cover.** That means no more balance billing for members where the admitting service provider is on the Scheme's Designated Service Provider list (DSP) or GP/Specialist Network and services are obtained from a Hospital in the PMB Hospital Network.

Once you have been admitted to one of these facilities and if you

- obtained services at the PMB Hospital Network and
- selected a primary provider who has entered into a Direct Payment Arrangement (DPA) with the Scheme for your particular chosen Option, i.e. admitting doctor is on the Option's DPA

then all contracted providers will be reimbursed at their contracted rate or at Cost for services obtained in the Mediclinic hospital as referred by your admitting doctor. This applies to all related accounts during the admission as well.

Therefore, where a pre-authorisation is obtained for a potential PMB, the Scheme will fund the Cost of the services obtained as set out in the table below:

PRESCRIBED MINIMUM BENEFIT (PMB) NETWORKS (continued)

	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 is on the Network/DSP	100% at agreed rate	100% at agreed rate	100% at agreed rate	No co-payments if DSP is used
KeyCare GP in & out-of-hospital services for PMB conditions if admitting GP is on the Network/DSP	Not applicable	Not applicable	100% at agreed rate	No co-payments if DSP is used
In & out-of-hospital services for PMB conditions voluntarily obtained from a non-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 GP network

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

Should you obtain in-hospital services for PMB Conditions from a GP with admitting rights to a Mediclinic hospital, the GP or Specialist will be reimbursed in full **with no balance billing above the agreed tariffs.** In-Hospital claims billed above the agreed tariff will be paid up to the agreed tariff and the difference will be for the member's account.

Note: Funding of emergency PMB claims

In case of emergencies, all approved PMB claims will fund at Cost.

DESIGNATED SERVICE PROVIDERS (DSP)

Here is a list of Remedi's designated service providers for the diagnosis, treatment and ongoing care costs (which may include medicine) for Prescribed Minimum Benefit conditions:

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	✓	✓	✓

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.

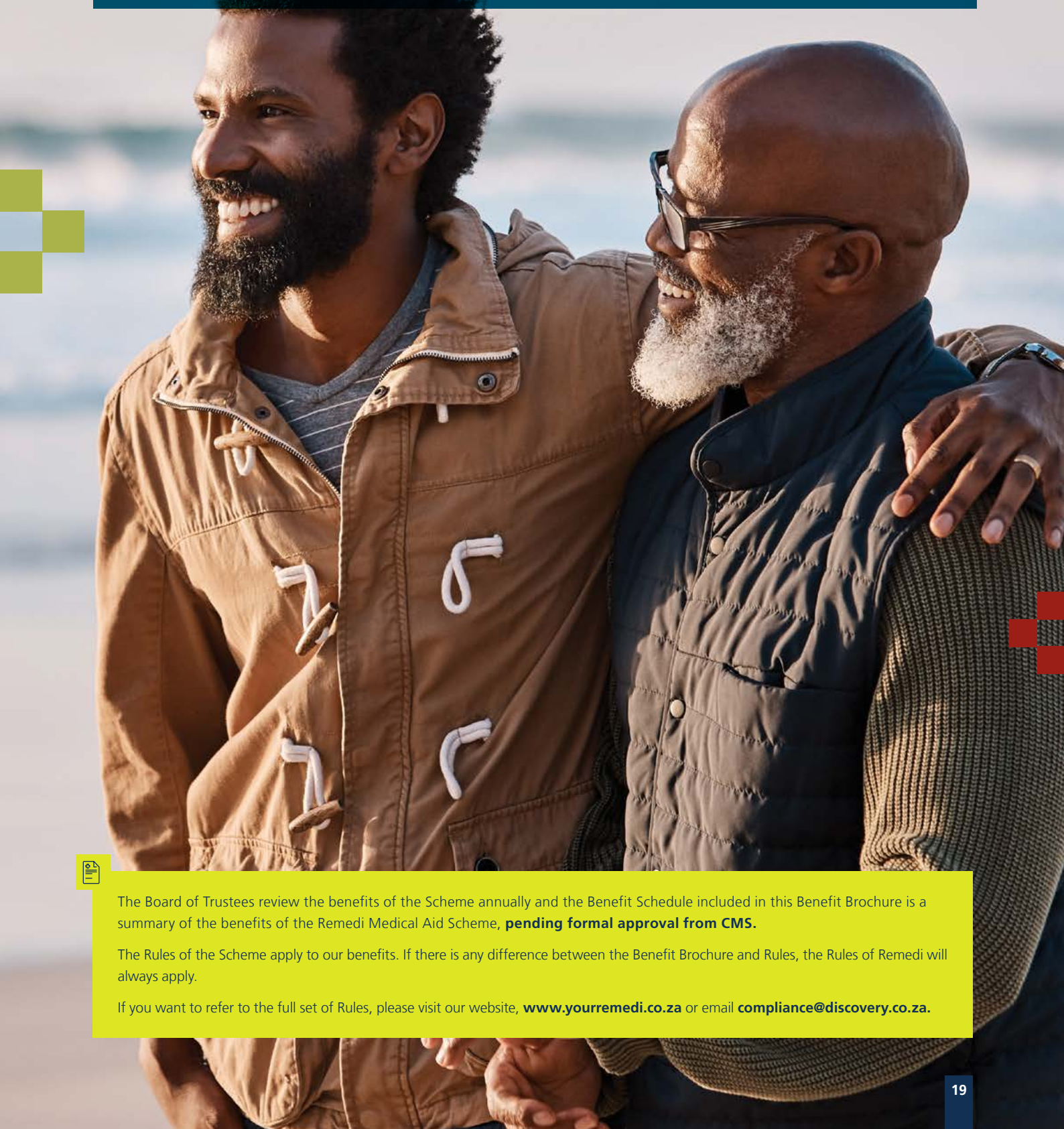
Limits, clinical guidelines and policies apply to some healthcare services and procedures. Please check the Benefit Option tables with benefits and limits in this Benefit Brochure for more information.

EX GRATIA POLICY

Ex gratia is defined by the Council for Medical Schemes (CMS) as 'a discretionary benefit which a medical aid scheme may consider to fund in addition to the benefits as per the registered Rules of a medical scheme. Schemes are not obliged to make provision therefore 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 appointed a Medical Advisory Committee (MAC) who review *ex gratia* applications and this Committee is tasked to act on behalf of the Board in making decisions in this regard, guided by an approved *ex gratia* Policy and Mandate.



The Board of Trustees review the benefits of the Scheme annually and the Benefit Schedule included in this Benefit Brochure is a summary of the benefits of the Remedi Medical Aid Scheme, **pending formal approval from CMS.**

The Rules of the Scheme apply to our benefits. If there is any difference between the Benefit Brochure and Rules, the Rules of Remedi will always apply.

If you want to refer to the full set of Rules, please visit our website, **www.yourremedi.co.za** or email **compliance@discovery.co.za.**

EXCLUSIONS, WHERE TO OBTAIN THE REMEDI **RULES** AND HOW TO MAKE BENEFIT OPTION CHANGES

Remedi does not cover the following exclusions

Remedi will not cover the following procedures or the direct or indirect medical consequences of the following events, except if it is required by law as stated under the Prescribed Minimum Benefits. The following is a list of costs not covered by the Scheme:

- All costs in respect of injuries arising from professional sport, speed contests and speed trials, unless PMB.
- All costs for operations, medicines, treatment and procedures for cosmetic purposes.
- All costs for Mammoplastics, i.e. Breast Reductions, unless medically necessary.
- All costs for the treatment of infertility, except for PMB.
- The artificial insemination of a person as defined in the Human Tissue Act, 1983 (Act of 1983).
- Holidays for recuperative purposes.
- Purchase of:
  - Medicines not registered with the Medicines Control Council and proprietary preparations;
  - Applicators, toiletries, beauty preparations, soaps, shampoos and other topical applications;
  - Cosmetics, emollients and moisturizers, including sun-tan lotions namely; sunscreens and tanning agents;
  - Bandages, cotton wool, dressings and other consumable items;
  - Food/nutritional supplements and patented foods, including baby foods;
  - Tonics, slimming preparations used to treat or prevent obesity and drugs as advertised to the public; and
  - Household and biochemical remedies;
  - Diagnostic agents;
  - Aphrodisiacs;
  - Anabolic steroids;
  - Household remedies or preparations of the type advertised to the public.
- The purchase of medicines not included in a prescription from a person legally entitled to prescribe medicine.
- Unless PMB, all 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.
- Charges for appointments which a member or dependant of a member fails to keep.
- 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.
- All costs related to the treatment of erectile dysfunction, unless approved by the Scheme.
- All costs related to gender re-alignment for personal reasons and not directly caused by or related to illness, accident or disorder.
- Section 21 medicines not approved and registered with the South African Medicines Control Council.
- All costs for use of gold in dentures or the cost of gold as an alternative to non-precious metal in crowns, inlays and bridges.
- All optical devices which are not regarded by the South African Optometric Association as clinically essential or clinically desirable, including sunglasses and spectacle cases or solution kits for contact lenses.
- Appliances: the purchase or hire of special beds, chairs, cushions, commodes, sheepskin, waterproof sheets for beds, bedpans, special toilet seats or repairs of or adjustments to sick room or convalescing equipment, with the exception of the hire of oxygen cylinders where the Scheme has provided prior written approval for the purchase of these and other appliances as PMB level of care.
- Motherhood: charges for ante- and post-natal exercise classes, mothercraft or breastfeeding instructions.
- War: injury or disablement fur to war, invasion or civil war, except for PMB.

If you want to change your Benefit Option
You can change to another Remedi 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.

It is advisable to consult the Rules of the Scheme available on the website **www.yourremedi.co.za** to obtain a detailed list of the exclusions of the Scheme at all times.

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 on **service@yourremedi.co.za**. You will be issued with a reference number for your interaction/complaint/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

   Have we exceeded your expectations?
   We'd also love to hear from you.

2. **To lodge a formal complaint**
   If you are unsatisfied with the outcome, having interacted with a consultant as set out in Step 1, 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 auto response of the estimated turn-around time to expect feedback by.

3. **To contact the Principal Officer (PO)**
   If you're still not satisfied with the resolution of your issue/complaint and wish 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 mailing **executiveoffice@yourremedi.co.za.**
   You must ensure that you quote the reference number you received when you first made contact with us in Step 1, 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.

   Should you wish to contact the CMS to lodge a complaint or to 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.**

REMEDI **KEY BENEFITS** AT A GLANCE

Our three Benefit Options provide you with peace of mind, and a wide range of cover and stability.

BENEFIT OPTION	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Hospital Benefit For major medical care, including in-hospital and other defined high-cost care	✓ Unlimited Overall annual limit for families	✓ R 2.150 million Overall annual limit for families	✓ R625 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)	✓	✓	✓

YOUR BENEFITS FOR 2022

1. 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 Prostatectomy at negotiated rates where pre-approved	Subject to an overall annual limit of R2 150 000 per family Da Vinci Robotic Assisted Prostatectomy at 100% of Remedi Rate provided pre-approved and limited to R113 000 per person per year	Subject to an overall annual limit of R625 000 per family Da Vinci Robotic Assisted Prostatectomy at 100% of Remedi Rate provided pre-approved and limited to R113 000 per person per year
State hospitals	100% of Remedi Rate	Limited to R565 000 per family	Limited to R550 000 per family	Limited to R260 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 R680 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 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 claim subject to Insured Out-of-Hospital Benefit limits		No benefit
Refractive eye surgery	100% of Remedi Rate	Subject to clinical entry criteria, the overall annual limit and a sub-limit of R29 900 a person each year. Includes funding of corneal cross-linking	Subject to clinical entry criteria, the overall annual limit and a sub-limit of R26 700 a person each 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 and 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 Care Programme as set out in more detail in this Brochure on pages 7, 11 and 16.		

YOUR BENEFITS FOR 2022

1. Hospital Benefit (continued)

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 sub-limits for each prosthesis: Thereafter from Personal Medical Savings Account:	Subject to the overall annual limit, with the following sub-limits for each prosthesis:	Subject to the overall annual limit, with the following sub-limits for each prosthesis:
▪ Hip replacement	per person	R51 900	R44 600	R39 300
▪ Revision hip	per person	R61 400	R52 600	R46 500
▪ Knee replacement	per person	R41 000	R35 000	R30 900
▪ Revision knee	per person	R51 900	R44 600	R39 300
▪ Shoulder replacement	per person	R47 800	R41 000	R36 200
▪ Pacemaker with leads	per person	R87 100	R73 800	R65 500
▪ Pacemaker with biventricular	per person	R112 300	R95 100	R84 200
▪ Cardiac valves	each	R58 300	R49 300	R42 600
▪ Above knee artifical limbs	per person	R61 800	R52 600	R46 600
▪ Below knee artificial limbs	per person	R33 500	R28 800	R25 600
▪ Artificial eyes	per person	R31 800	R26 900	R24 000
▪ All other internal prostheses and devices	per person	R26 900	R23 200	R20 500
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 sub-limit of R41 050 per person	Subject to the overall annual limit with a sub-limit of R39 100 per person	Subject to the overall annual limit with a sub-limit of R14 400 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**		

2. Managed Benefits

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Chronic medicine for Prescribed Minimum Benefits	100% of Remedi Medicine Rate	If registered for Chronic Illness Benefit and the medicine is on the Remedi medicine list (formulary) funding will be in full. You must also get the medicine from a network pharmacy We pay for non-formulary medicine (medicine not found on our medicine list) up to the Chronic Drug Amount for a registered medicine class. Co-payments may not be funded from available funds in your Personal Medical Savings Account	If registered for Chronic Illness Benefit and the medicine is on the Remedi medicine list (formulary) funding will be in full. You must also get the medicine from a network pharmacy We pay for non-formulary medicine (medicine not found on our medicine list) up to the Chronic Drug Amount for a registered medicine class	If registered for Chronic Illness Benefit and the medicine is on the Remedi medicine list (formulary), funding will be 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. **To avoid a co-payment of 20%, you must also get the medicine from a network pharmacy.**
Chronic medicine for Non-Prescribed Minimum Benefit conditions	100% of Remedi Medicine Rate	Subject to benefit entry criteria and Remedi's list of excluded conditions	Subject to benefit entry criteria and Remedi's list of excluded conditions	Benefit not applicable
		Limited to R2 185 per month per person Subject to registration on the Chronic Illness Benefit	Limited to R1 820 per month per person Subject to registration on the Chronic Illness Benefit	
Specialised Medicine Benefit	90% of Remedi Rate	Limited to R210 000 per person per year, subject to clinical protocols and preauthorisation	No benefit	No benefit
HIVCare Management Programme	100% of Remedi Rate	Subject to clinical protocols If you are registered on the programme you can obtain services for treatment from your Premier Practice GP and gain access to one social worker consultation in addition to the benefits available in the 'baskets of care'		
Diabetes – cardiometabolic Health Care Programme	100% of Remedi Rate	We cover condition-specific care programmes that help you to manage your diabetes or heart-related medical conditions. You have to be registered on these condition-specific care programmes to unlock additional benefits and services. You can read more about these programmes on page 11.		
		Subject to clinical protocols If you are registered on the programme you can obtain services for treatment from your Premier Practice Doctor and gain access to diabetes coaches and dietitians. You also have access to dedicated care navigators to guide you through your benefits and assist you to finding services. Annual podiatry and ophthalmologist screenings, as well as diabetes related pathology are included in the programme.		

YOUR BENEFITS FOR 2022

2. Managed Benefits (continued)

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 010 000 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 R600 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/ 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/ Remedi Rate through the benefit limits	R235 000 per family per 12 month rolling period, and further limited to R235 000 per person is covered at 100% of the Remedi Rate. The requirements for Prescribed Minimum Benefits are applicable and only PMB level of care will be funded at cost/Remedi Rate through the benefit limits
Advanced Illness Benefit		Advanced Illness Benefit (AIB). Members with advanced cancer and who are registered on the programme will receive enhanced funding and delivery of optimal palliative care. Once authorised, access to AIB is granted on a voluntarily basis subject to clinical entry criteria. The benefit is made available to members that require end-of-life management in a palliative care setting.		
Maternity Management Benefit	100% of Remedi Rate	Includes two 2D scans, an extensive list of pregnancy-related pathology tests and nine antenatal consultations with a gynaecologist or midwife (limited to your IOH) or your GP, as well as nine urine dipstick tests and two glucose strip tests. One Down Syndrome test, as clinically appropriate.		Includes two 2D scans performed by your chosen GP or Sonographer. A specified range of pregnancy-related pathology tests and nine antenatal consultations with your chosen Standard Option Network GP, midwife or gynaecologist, as well as nine urine dipstick tests and two glucose strip tests are included with this benefit. One Down Syndrome test per pregnancy, as clinically appropriate.
		Subject to overall annual limit and the Prescribed Minimum Benefit requirements		
Optical Benefit		Subject to confirmation of benefit by the Preferred Provider Network (PPN) You can choose to cover any shortfall from your available savings. All benefits are subject to the overall annual limit and the following sub-limits:	Subject to confirmation of benefit by Preferred Provider Network (PPN) All benefits are subject to Insured Out-of-Hospital Benefit limits and the following annual sub-limits:	Subject to confirmation of benefit by the Preferred Provider Network (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 595	R3 385	Sub-limits apply
Family sub-limit		R7 190	R6 770	Sub-limits apply
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 twenty four months** per person
Non PPN Provider		R365	R365	No benefit

YOUR BENEFITS FOR 2022

2. Managed Benefits (continued)

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
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 twenty four 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 provider and Non PPN provider limited to R210 per lens	Clear Single vision lenses at a PPN provider and Non PPN provider limited to R210 per lens	Clear Single vision lenses at a PPN provider limited to R210 per lens per person **every twenty four months**
		Clear Bifocal lenses at a PPN provider and Non PPN provider limited to R445 per lens	Clear Bifocal lenses at a PPN provider and Non PPN provider limited to R445 per lens	Clear Bifocal lenses at a PPN provider limited to R445 per lens per person **every twenty four months**
		Base Multifocal lenses at a PPN provider and a Non PPN provider limited to R770 per lens	Base Multifocal lenses at a PPN provider and a Non PPN provider limited to R770 per lens	Base Multifocal lenses at a PPN provider limited to R445 per lens per person **every twenty four months**
OR				
Contact Lenses:				
Beneficiary sub-limit		R2 390	R1 930	R595 per person **every twenty four months** at a PPN Provider

3. Treatment performed out-of-hospital that we pay for from the Hospital Benefit

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: R21 950 ▪ Family: R44 000 Basic dental codes are subject to available Insured Out-of-Hospital Benefit	Subject to available Insured Out-of-Hospital Benefit	No benefit
External prostheses and appliances (These limits apply where you do not use a preferred supplier)	100% of Remedi Rate	Subject to the overall annual limit, with the following sub-limits for each prosthesis: thereafter from Personal Medical Savings Account	Subject to the overall annual limit, with the following sub-limits for each prosthesis:	Subject to the overall annual limit, with the following sub-limits for each prosthesis:
▪ Colostomy equipment	per person	R27 600	R27 600	R14 300
▪ Hearing aids	per person	R25 450	R25 450	R18 400

YOUR BENEFITS FOR 2022

3. Treatment performed out-of-hospital that we pay for from the Hospital Benefit (continued)

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
▪ Oxygen appliances (monthly limit)	per person	R2 075	R2 075	R2 075
▪ Wheelchairs	per person	R19 000	R15 950	R12 650
▪ All other external prostheses and appliances	per person	R7 150	R6 000	R3 400
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 Insured Out-of-Hospital Benefit. Subject to clinical entry criteria, the overall annual limit and the following sub-limits:		
▪ Loss of limb	per family	R89 000	R89 000	R89 000
▪ Private nursing	per person	R11 200	R11 200	R11 200
▪ Prescribed medication	Member	R31 000	R14 300	R14 300
	Member + 1	R36 300	R16 900	R16 900
	Member + 2	R42 300	R20 100	R20 100
	Member + 3 or more	R48 100	R24 300	R24 300
▪ External medical items	per person	R76 250	R34 000	R34 000
▪ Hearing aids	per person	R27 900	R16 100	R16 100
▪ Mental Health Benefit	per person	R27 100	R20 200	R20 200
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 sub-limit of R14 610 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 sub-limit of R13 880 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 sub-limit of R4 130 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 130 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		

4. Insured Out-of-Hospital Benefit

The following day-to-day benefits are paid from the Hospital Benefit and are subject to available Insured Out-of-Hospital Benefit limits and the overall annual limit for each Option.

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Annual IOH sub-limits	100% of Remedi Rate or 100% of cost at DSP	**Combined family limit of:** Per Principal Member: R9 380 Per Adult Dependant: R5 540 Per Child Dependant: R1 560 up to a maximum of three children. If you exceed the sub-limit, non-Prescribed Minimum Benefit expenses will be paid from your Personal Medical Savings Account, subject to available funds. The sub-limit excludes specialised dentistry and optical claims. Facility fees will be covered where applicable	**Combined family limit of:** Per Principal Member: R8 320 Per Adult Dependant: R4 910 Per Child Dependant: R1 380 up to a maximum of three children. If you exceed the sub-limit, you have to 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: R2 740 Per Adult Dependant: R1 730 Per Child Dependant: R550 up to a maximum of three children. These sub-limits 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 obtained 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 obtained 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 850** per family. Medical specialist visits are limited to annual IOH sub-limits. This benefit includes cover for a consultation with a gynaecologist for insertion of a Mirena contraceptive device, provided pre-approval was obtained from the Scheme in line with clinical protocols and guidelines
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

4. Insured Out-of-Hospital Benefit (continued)

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
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 R165 per female beneficiary per month, from the overall annual limit at preferred provider pharmacies.	Subject to available Insured Out-of-Hospital Benefit limits and the overall annual limit. Oral contraceptives are covered up to R165 per female beneficiary per month, from overall annual limit at preferred provider pharmacies.	Schedule 0,1 and 2 medicine: An over the counter benefit of R165 per script and R335 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 R165 per female beneficiary per month from overall annual limit at preferred provider pharmacies.
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
Conservative dentistry	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 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
Specialised dentistry	100% of Remedi Rate	Standalone benefit. Not funded from the Insured Out-of-Hospital Benefit See detailed benefits in item 3 above. This will be covered from your PMSA once the specialised dentistry limit is depleted	Subject to available Insured Out-of-Hospital Benefit limits and the overall annual limit	No benefit
Optical Benefit	100% of Remedi Rate	Standalone benefit. Not funded from the Insured Out-of-Hospital Benefit. See also under item 2	Subject to available Insured Out-of-Hospital Benefit limits and the overall annual limit. See also under item 2	Benefit only available through the Preferred Provider Network (PPN). See also under item 2
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

5. Personal Medical Savings Account

On the Comprehensive Option, certain non-Prescribed Minimum Benefit medical costs that are more than the available benefit may be funded from the Personal Medical Savings Account. You must give a yearly instruction for this. This benefit is not available on the Classic and Standard Options.

BENEFITS	RATE	REMEDI COMPREHENSIVE
Other healthcare services, which include: chiropractic treatment, dietetics, homeopathy, or herbalists, preventive medicine for malaria. Immunisations, except influenza and pneumococcal vaccines where clinically indicated, and Human Papillomavirus (HPV) vaccines which are funded from the Preventive and Screening Benefit	100% of cost	Payment will only be made from the Personal Medical Savings Account subject to available funds

6. Summary of Remedi Dental Benefits

The Comprehensive Option has a standalone benefit for Specialised Dentistry Benefits, while Classic members' specialised dentistry is subject to the available Insured Out-of-Hospital Benefit (IOH). Members on the Standard Option do not have any specialised dentistry benefits available. Conservative dentistry is funded from the IOH on Comprehensive Option before it will pay from your Personal Medical Savings Account.

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: R21 950 ▪ Family: R44 000 Basic dental codes are subject to available Insured Out-of-Hospital Benefit	Subject to available Insured Out-of-Hospital Benefit. See also under item 4	No benefit
Conservative dentistry	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. See also under item 4	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)**		

7. Preventive and Screening Benefit

The following tests are paid from the Hospital Benefit and are subject to the overall annual limit for each Option. Consultations and extra tests are covered from available Insured Out-of-Hospital Benefit limits.

TESTS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Screening Benefit	100% of Remedi Rate	Includes the following screening tests at a designated service provider. **Consultations and extra tests are covered from available Insured Out-of-Hospital Benefit limits. Clinical entry criteria will be applied.**		
▪ Random blood glucose		One test each year per person		
▪ Blood pressure		One test each year per person		
▪ Body mass index (BMI)		One test each year per person		
▪ Random cholesterol		One test each year per person		
▪ HIV test		Unlimited number of tests		
▪ HPV test		1 test every 5 years if the member is HIV negative and once every 3 years if the member is HIV positive. The test is an alternative to pap smear tests.		
▪ Mammogram		One test each year per female beneficiary		
▪ Pap smear		One test each year per female beneficiary as an alternative to HPV tests		
▪ Prostate-specific antigen (PSA)		One test each year per male beneficiary		
▪ Colonoscopy		One test every 10 years per person. Only for members over the age of 55 if performed in the doctors rooms		
▪ Flu vaccination		One vaccination each year per person paid from your Hospital Benefit for high-risk members and members over the age of 65. The vaccine will be paid from day-to-day limits for other members.		
▪ Pneumococcal vaccine		One vaccination per person each year for high-risk members if clinically appropriate		
▪ Preventive dentistry		One preventive dental examination per person every 12 months including the oral examination, infection control, prophylaxis, polishing and fluoride of adults and children. **On Standard Option preventive dentistry is provided through a designated service provider (DRC).**		
▪ Human Papillomavirus (HPV) vaccines		One vaccine per male dependant between the ages of 11 and 21 and one vaccine per female dependant between the ages of 11 and 26, as clinically appropriate per year		
▪ Colorectal Screening		1 Faecal Occult Blood Test/Faecal Immunochemical Test every 2 years for members 45-75 years of age. Colonoscopy Screening for high-risk members or where a positive stool test.		

Members with high glucose readings are given the more clinically robust HbA1c test. The test is available at network pharmacies and HbA1c will be funded from your available day-to-day and pathology benefit limits and limited to one test per person per year.

YOUR CONTRIBUTIONS FOR 2022

1. Contributions as from 1 January 2022 until 30 June 2022

	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 023	R2 290	R705	R2 373	R1 686	R569	R1 478	R984	R299
R4 000 – R5 499	R3 191	R2 445	R751	R2 511	R1 807	R632	R1 549	R1 036	R337
R5 500 – R6 999	R3 372	R2 605	R822	R2 646	R1 924	R676	R1 624	R1 161	R417
R7 000 – R7 999	R3 547	R2 679	R896	R2 783	R1 974	R740	R1 746	R1 391	R541
R8 000 – R8 999	R3 731	R2 828	R937	R2 934	R2 084	R788	R1 746	R1 391	R541
R9 000 – R9 999	R3 938	R2 963	R984	R3 085	R2 190	R820	R1 746	R1 391	R541
R10 000 – R10 999	R4 133	R3 112	R1 071	R3 250	R2 307	R894	R1 746	R1 391	R541
R11 000+	R4 357	R3 282	R1 131	R3 415	R2 426	R926	R1 751	R1 394	R542

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

INCOME BANDS	**Principal**	**Adult or spouse**	**Child****
R0 – R3 999	R302	R229	R71
R4 000 – R5 499	R319	R245	R75
R5 500 – R6 999	R337	R261	R82
R7 000 – R7 999	R355	R268	R90
R8 000 – R8 999	R373	R283	R94
R9 000 – R9 999	R394	R296	R98
R10 000 – R10 999	R413	R311	R107
R11 000+	R436	R328	R113

Contribution subsidies 1 January 2022 until 30 June 2022 (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 788	R645	R446	R1 741	R591	R432	R1 264	R673	R202
R4 000 – R5 499	R1 894	R704	R472	R1 842	R638	R451	R1 334	R698	R232
R5 500 – R6 999	R1 989	R752	R521	R1 939	R690	R498	R1 401	R780	R286
R7 000 – R7 999	R2 105	R772	R564	R2 047	R704	R544	R1 488	R927	R366
R8 000 – R8 999	R2 216	R807	R588	R2 156	R736	R566	R1 488	R927	R366
R9 000 – R9 999	R2 326	R844	R613	R2 266	R769	R566	R1 488	R927	R366
R10 000 – R10 999	R2 460	R895	R662	R2 391	R818	R615	R1 488	R927	R366
R11 000+	R2 585	R944	R708	R2 516	R869	R658	R1 493	R930	R368

* 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.

YOUR CONTRIBUTIONS FOR 2022

2. Contributions as from 1 July 2022 until 31 December 2022

	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 July 2022 until 31 December 2022 (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.

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