remedi

REMEDI
MEDICAL AID SCHEME
BENEFITS

2025

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

YOUR HEALTH
OUR LEGACY

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

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

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

Remedi offers members a choice between three benefit options:

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

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

Remedi offers its members a comprehensive range of benefits, while the **Comprehensive Option** is designed to provide members with a Personal Medical Savings Account (PMSA) for benefits not covered from their hospital benefits.

This benefit option also allows for extra general practitioner (GP) visits once the Insured Out-of-Hospital (IOH) and PMSA are used up for the year. The **Classic Option** contributions are slightly lower than the **Comprehensive Option**, however, members do not have access to a PMSA and benefit limits are lower than what is available on the **Comprehensive Option**.

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

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

CONTENTS

CONTACT DETAILS AND CLAIMS SUBMISSIONS

Remedi and Service Providers, contact details listed below:

AMBULANCE AND OTHER EMERGENCY SERVICES

- Call ER24 on 084 124

GENERAL QUERIES

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

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

If you need to check your benefits, or used benefits, visit our website at 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. If you need a claim statement and want to see all claims received, visit our website at 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 on page 5.

TO SEND CLAIMS

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

Download on the App Store

GET IT ON Google Play

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

The Remedi app is brought to you by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes. ˆAlexander Forbes is duly registered with the Financial Advisory Services Board and is qualified to provide financial advisory services to members in terms of the Financial Advisory and Intermediary Services Act 37 of 2002.

OTHER SERVICES

Oncology service centre:

0860 116 116

HIVCare Programme:
0860 116 116

Internet queries:
0860 100 696

Preauthorise admission to hospital: 0860 116 116

FOR DENTAL QUERIES ON STANDARD OPTION

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

General enquiries:
enquiries@dentalrisk.com

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

FOR OPTICAL QUERIES

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

Claims:
info@ppn.co.za

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

FOR DIABETES QUERIES

Call 0860 44 44 39 or tsend an email to Members_DCC@yourremedi.co.za.

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

REPORT FRAUD

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

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

Remember to include the description of the alleged fraud.

GET YOUR CLAIMS PROCESSED FASTER.

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

SUBMIT YOUR CLAIM: 3 FAST AND EASY DIGITAL WAYS

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

01

REMEDI **APP**

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

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

02

UPLOAD **YOUR CLAIM**

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

03

EMAIL **YOUR CLAIMS**

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

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

Download on the App Store

GET IT ON Google Play

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

The Remedi app is brought to you by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

COMPLAINTS AND DISPUTES PROCESS

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

1. To reach out to us

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

Our service times are as follows:

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

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

2. To lodge a formal complaint

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

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

3. To contact the Principal Officer (PO)

If you're still not satisfied with the resolution of your issue or complaint and would like to escalate it to be investigated by the Principal Officer, you may lodge a formal dispute after following steps 1 and 2.

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

Make sure that you quote the reference number you received when you first made contact with us in (following step 1), 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 steps 1 to 3 to resolve your complaint with the Scheme first before contacting the CMS directly.

If you want to contact the CMS to lodge a complaint or escalate an issue that you are unable to resolve after following steps 1 to 3, 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**.

KEY TERMS

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

Benefit Option	The benefit option is the cover you choose to buy from Remedi. Remedi gives you a choice of three benefit options: **Remedi Comprehensive, Remedi Classic and Remedi Standard**. These benefit options are registered with the Council for Medical Schemes (CMS) in terms of the Medical Schemes Act of 1998 (Act 131 of 1998) and its regulations. The benefits as set out in the 'Rules of the Scheme' are summarised in this benefit brochure.
Benefit entry criteria	For certain illnesses, we set benefit entry criteria that you need to meet for the medical expenses to be considered for payment. This also means that we need certain details from you and your doctor before we can consider paying for the treatment.
Chronic Disease List (CDL)	A defined list of chronic conditions we cover in line with the Prescribed Minimum Benefits (PMB).
Chronic Drug Amount (CDA)	The Chronic Drug Amount (CDA) is a set monthly amount that we pay up to for a medicine class. This amount depends on your benefit option. The CDA applies to chronic medicine that is not listed on the medicine list (formulary).
Chronic Illness Benefit (CIB)	The Chronic Illness Benefit (CIB) covers you for a list of chronic conditions. To get access to this benefit to pay for your medicine and treatment for your chronic condition, you will need to apply for cover.
Co-payment/Deductible	A co-payment is an amount that you need to pay towards a healthcare service where healthcare service providers charge more than the rate we cover. This amount can vary as it is dependent on the amount the healthcare service provider charges. If the amount charged is higher than the amount payable by the Scheme for the healthcare service, you will need to pay for the cost difference charged for the healthcare service and this is referred to as a "co-payment". The amount that you must pay upfront to the hospital or day clinic for specific treatments and/or procedures, is referred to as a "deductible" in this brochure. See page 46 for more information in relation to deductibles payable when not obtaining services at a Day Surgery Network facility. You will need to pay a deductible upfront while a co-payment is payable retrospectively for services received. *For example, if you see a doctor who is not on our networks and they charge more than the Remedi Rate, Remedi will pay you for the visit at the Remedi Rate. You will then have to pay this amount to the doctor along with any charges above our rate from your own pocket.* *Another example is if you see an optician who is not on the PPN Network, Remedi will only pay your optician at the network rate and you will have to pay the difference from your own pocket. If you are on the **Comprehensive Option**, your co-payment may be paid from your available Personal Medical Savings Account. If you are on the **Standard Option**, we will pay doctors who are not on our networks directly up to the Remedi Rate and you will still be responsible to pay the amount they charged over and above our rate.* *When choosing to obtain services at an acute hospital setting, instead of the Day Surgery Network facilities, where recommended, you will need to pay an upfront amount of **R7,000** at the hospital when admitted and this is referred to as a "deductible".*
Cover	Cover refers to the benefits (such as consultation, medicine and hospital admission) you have access to and how we pay for these healthcare services on your benefit option.

Day-to-day benefits (also referred to as Insured-Out-of-Hospital (IOH) Benefits)	You have cover for a defined set of day-to-day benefits. We set out the level of day-to-day benefits you have access to in this benefit brochure from page 23.
Designated service provider (DSP)	This is a healthcare provider (such as a doctor, specialist, allied healthcare professional, pharmacist or hospital) who we have an agreement with. The agreement we have with them is for them to provide treatment or services at a contracted rate. Visit www.yourremedi.co.za or click on 'Find a Provider' on the Remedi app to view the full list of Remedi DSPs. *For example, when you use the services of a designated service provider, we pay the provider directly at the Remedi Rate. We pay specialists who participate as DSPs at what we call the Premier, Classic Direct or Remedi Rate for claims. We also pay participating general practitioners (GPs) at the contracted GP rate for all consultations.* You will not have to pay an extra amount yourself (co-payment) to providers who take part in the Premier and Remedi network arrangements. However, you may have a co-payment for out-of-hospital visits to specialists on the Classic Direct Payment Arrangement.
Discovery Home Care	Discovery Home Care offers you quality care in the comfort of your home for healthcare services like IV infusions, wound care, post-natal care and advanced illness care.
Emergency medical condition or medical emergencies	An emergency medical condition, also referred to as an emergency, is the sudden and, at the time, unexpected onset of a health condition that requires immediate medical and surgical treatment. In such a case, failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy. An emergency does not necessarily require a hospital admission. We may ask you for extra information to confirm the emergency. **If you or any of the dependants on your membership visit an after-hours emergency facility at the hospital, it will only be considered as an emergency and covered as a Prescribed Minimum Benefit (PMB) if the treatment received aligns with the definition of PMB. Please note that not all treatment received at casualty units are considered part of PMB. If you are admitted to hospital from casualty, we will cover the costs of the casualty visit from your hospital benefit if we preauthorise your hospital admission. If an event occurs after hours, you must apply for authorisation on the next available working day.**
Exclusions	There are certain expenses that are not covered by Remedi. These are called exclusions.
Find a healthcare provider	'Find a healthcare provider' is a medical provider search tool that is available on the Remedi app or our website at www.yourremedi.co.za.
Formulary (medicine list)	This is a list of preferred medicines considered by Remedi to be the most useful in-patient care. These are rated based on clinical effectiveness, safety and cost. We cover these medicines in full for the treatment of approved CDL conditions.
HealthID	HealthID is an online digital platform that gives your doctor fast, up-to-date access to your health information. Once you have given them consent, your doctor can use HealthID to access your medical history, refer you to other healthcare professionals and check your relevant test results.

HealthID, Find a healthcare provider and the Remedi app are brought to you by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes. Discovery Home Care is a service provider. Practice 080 000 8000190, Grove Nursing Services (Pty) Ltd, registration number 2015/191080/07, trading as Discovery HomeCare.

Healthcare professionals who we have a payment arrangement with	Remedi has agreed rates with certain general practitioners and specialists so you can get full cover and reduce the risk of co-payments. Remedi pays these doctors and specialists directly at these agreed rates.
Hospital Benefit	The hospital benefit covers hospital costs and other accounts, like accounts from your admitting doctor, anaesthetist or any approved health care expenses, while you are in hospital. Your cover depends on your chosen benefit option's benefits (set out in this benefit guide). Examples of expenses covered are theatre and ward fees, X-rays, blood tests and the medicine you use while you are in hospital.
In-hospital GP Network	A defined list of GPs and specialists authorised by Remedi to provide in-hospital services to members as part of the Scheme's Premier Practice, Remedi Standard GP Network and Classic Designated Provider Arrangement (DPA) Specialist Networks.
Managed benefits	These benefits are managed to facilitate appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, using rules-based and clinical management-based programmes.
Medicine Rate	This is the rate we pay for medicine. It is the single exit price of medicine and includes the relevant dispensing fee.
Networks or network providers	You may need to use specific hospitals, pharmacies, doctors, specialists or allied healthcare professionals in a network. We have payment arrangements with these providers to ensure you get access to quality care at an affordable cost. By using network providers, you can avoid having to pay extra costs and deductibles yourself.
Day Surgery Network	Full cover for a defined list of procedures is available in the Remedi Day Surgery Network.
Mental Health Network	A defined list of psychologists and social workers contracted or nominated by us for purposes of providing treatment for mental health conditions to our members.
Medicine Networks	Use a pharmacy in our network to enjoy full cover and avoid co-payments when claiming for chronic medicine on the prescribed medicine list.
Oncology Pharmacy Networks	Use a pharmacy in this network to get cover aligned with the Remedi agreed medicine price list to treat cancer.
PMB network	A Mediclinic hospital contracted to or chosen by the Scheme to provide services that relate to Prescribed Minimum Benefit (PMB) conditions. Please also refer to the definition for DSP above.
Overall Annual Limit	The Scheme's overall annual limit (OAL) is equivalent to the available hospital benefits as reflected on page 12 of this benefit brochure. See 'Hospital Benefit/Overall Annual Limit (OAL)'.

Payment arrangements	The Scheme has payment arrangements with various healthcare professionals and providers to ensure that you can get full cover.
Personal Medical Savings Account (PMSA)	The Personal Medical Savings Account (PMSA) is an amount that is allocated to you at the beginning of each year (or when you join the Scheme). You pay this amount back in equal portions as part of your monthly contribution. We pay some of your day-to-day or Insured Out-of-Hospital (IOH) medical expenses from the available funds allocated to the PMSA, depending on the registered Rules of the Scheme and more information is available in this benefit brochure on page 17. Any unused funds will carry over to the next year. If you leave the Scheme or change your benefit option to another benefit option without a PMSA and have used more of the funds than what you have contributed, you will need to pay the difference back to us.
Preauthorisation	You need to let Remedi know if you plan or are scheduled to be admitted to hospital. Please phone us on **0860 116 116** for preauthorisation for us to confirm your membership and available benefits as well as load your procedure onto your membership. Without preauthorisation, you may have a co-payment of **R3,400** for each admission. **Preauthorisation is not a guarantee of payment as it only aims to confirm that the treatment that you will receive in hospital is clinically appropriate and aligned with the benefits available.** We advise our members to talk to their treating doctor so they know whether they will be responsible for out-of-pocket expenses. There are some procedures or treatments your doctor can do in their consulting rooms. You still need to get preauthorisation for these procedures. *Examples of these are endoscopies and scans.* If you are admitted to hospital in an emergency, we must be notified as soon as possible by a family member if not possible to notify us yourself within 24 hours or the Monday following the admission if the emergency took place over the weekend. This will ensure that we authorise payment of your medical expenses. We use certain clinical policies and protocols when we decide whether to approve hospital admissions. These give us guidance about what is expected to happen when someone is treated for a specific condition and are based on scientific evidence and research.
Preferred medicine	Preferred medicine includes generic and branded medicine.
Premier Plus GP	A Premier Plus GP is a network GP who has contracted with us to provide you with coordinated care for a list of defined chronic conditions.

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

KEY BENEFITS AND KEY FEATURES

BENEFIT OPTION	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Hospital Benefit/Overall Annual Limit (OAL) For major medical care, including in-hospital and other defined high-cost care	✓ Unlimited Overall annual limit for families	✓ R2,575,000 Overall annual limit for families	✓ R775,000 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
Extra GP visits Defined number of extra 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 payment for these benefits from PMSA, you will need to activate the payment as part of your application request or contact us on **0860 116 116** to assist in activating this payment for you.	✓	✗	✗
Over-the-Counter Medicine (OTC)	✓	✓	✓

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

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

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

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

KEY FEATURES

CANCER COVER

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

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

After the above is exhausted, we pay 80% of any extra costs up to a yearly limit per person, unless a PMB level of care applies. If you are registered on the **Comprehensive Option**, you may qualify for the extended cover offered by the Oncology Innovation Benefit. We pay PMB level of care at 100% of the Remedi Rate (depending on the cost) at the Scheme's designated service provider (DSP) requirements.

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

Oncology medicine must be obtained from the Remedi oncology pharmacy network to make sure that you are covered in full with no co-payments when we have approved your cancer treatment. With effect from 1 July 2025, members registered on the oncology management programme will have access to medicine management and medicine will be approved in line with the Scheme's Reference Price List and medicine lists. The reference price is set at the price of the generic equivalent or clone of a medicine and applies to all benefit options. Remedi is also contracted with the ICON Network of service providers, which means you have a wide range of service providers to support you through your cancer treatment journey. When diagnosed with cancer, you will need to register on the Oncology Care Programme and you and/or your treating doctor must contact us to register you on the programme, at which time you will receive more information of how your benefit option covers you for cancer related treatment.

From 1 January 2025, Remedi will also give cover for a defined list of innovative cancer medicine for members registered on the **Comprehensive Option**.

Payment will be subjected to the Scheme's clinical criteria. You may be liable to pay 25% of the cost of this medicine and your available oncology limits will be used to pay for medicines that form part of the new Oncology Innovation Benefit.

For more information in terms of your available benefit limits and cover for cancer, please read page 37 of this benefit brochure.

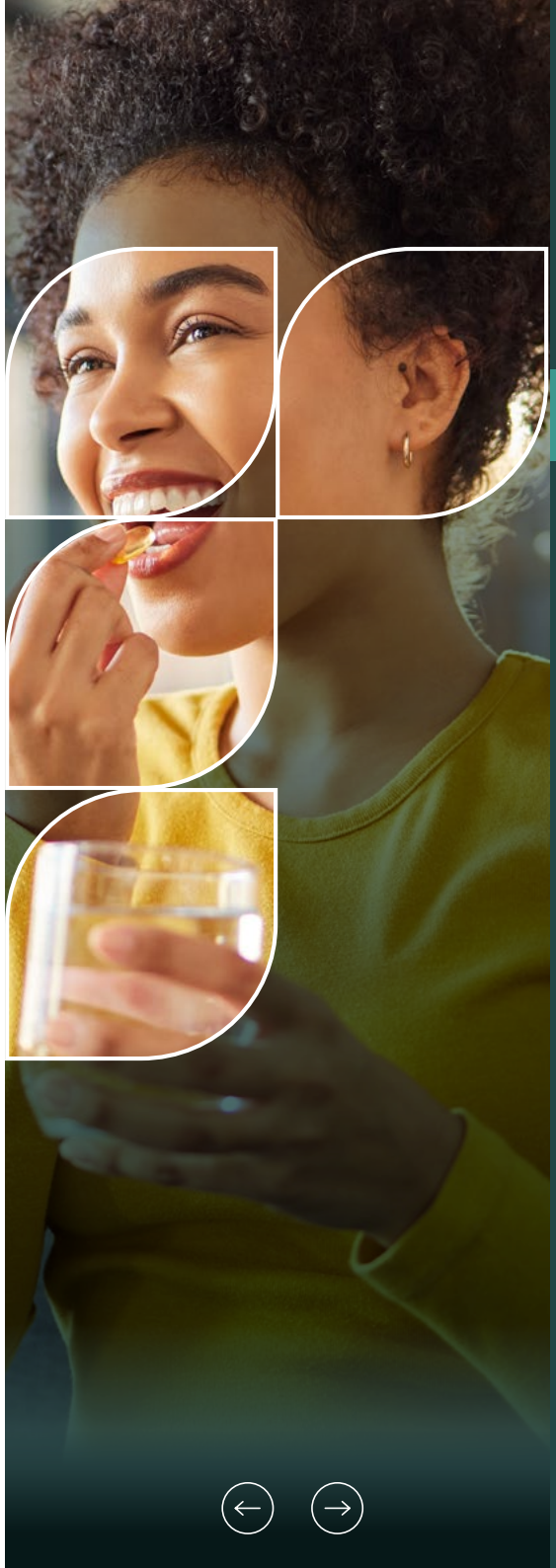
COVER FOR CHRONIC MEDICINE

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

On the **Comprehensive Option**, we provide you with full cover for chronic medicine on our medicine list for all Chronic Disease List (CDL) conditions. You also have access to an extra list of conditions (ADL) covered up to **R2,640** per person per month, including medicine for non-PMB treatment, as well as the Specialised Medicine and Bariatric Surgery Benefit of up to **R210,000** per person per year and this benefit covers specific new high-cost medicines as well as bariatric surgery.

On the **Classic Option**, full cover for chronic medicine on our medicine list for all Chronic Disease List (CDL) conditions is available to you. You also have access to an extra list of conditions (ADL), but your monthly and family limits for these conditions are less than what is available on the **Comprehensive Option** and members are covered up to **R2,200** per person per month on this benefit option for these conditions, including medicine for non-PMB treatment.

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



COVER FOR HOSPITAL ADMISSIONS

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

- There is no overall limit for hospital cover on the **Comprehensive Option**
- The **Classic Option** limits members to **R2,575,000** per family per year
- The **Standard Option** limits members to **R775,000** per family per year.

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

COVER FOR PREGNANCY

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

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

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

ADVANCED ILLNESS BENEFIT (AIB)

Members have access to a comprehensive palliative care programme. This programme offers unlimited cover for approved care at home, care coordination, counselling services and supportive care for appropriate end-of-life clinical and psychologist services. You also have access to a GP consultation to facilitate your palliative care treatment plan. From 1 January 2025, the AIB offering is enhanced with the introduction of Epilog, which will make available a digital tool to people dealing with advanced illness. With the introduction of Epilog, members will get early and personalised support based on their needs and life circumstances. Each member successfully enrolled onto the Advanced Illness Management Support Programme (AIMSP) will receive digital support at a fee paid by Remedi per each successful enrolment. This benefit is available to all members, no matter which benefit option they are registered on.

DENTISTRY AND OPTOMETRY

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

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

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

PREVENTION AND SCREENING BENEFIT

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

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

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

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

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

- GPs
- Medical specialists
- Conservative dentistry
- Prescribed acute medicine and injection material
- Physiotherapy, speech therapy, and occupational therapy
- Clinical psychologists
- Social workers
- Eye tests, spectacles or contact lenses and refractive eye surgery
- Radiology: Out-of-hospital (excluding MRI and CT scans)
- Pathology: Out-of-hospital
- Chronic medicines covered on the Additional Disease List (ADL) that are not regarded as PMB level of care

WE COVER THESE FROM THE PMSA ONLY

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

IMPORTANT NOTE:

Prescribed Minimum Benefit (PMB) treatment is not allowed to be paid from your Personal Medical Savings Account (PMSA).

EMERGENCY COVER

WHAT IS A MEDICAL EMERGENCY?

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

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

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

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

In case of an emergency dial 084 124.

EMERGENCY MEDICAL CARE ER24 084 124

WHAT DO WE PAY FOR?

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

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

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

If you need HIV medicine to prevent HIV infection, mother-to-child transmission, occupational or traumatic exposure to HIV, including sexual assault, call ER24 immediately on 084 124, to be guided to your nearest healthcare facility as treatment must start within 72 hours of exposure. Remember to get approval for treatment from Remedi by calling us on **0860 116 116** to pay for pre-exposure (PrEP) and post-exposure prophylaxes (PEP).

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

COVER OUTSIDE OF SOUTH AFRICA

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

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

ASSISTANCE DURING OR AFTER A TRAUMATIC EVENT

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

PRESCRIBED MINIMUM BENEFITS (PMB) AND DESIGNATED SERVICE PROVIDERS (DSP)

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

HOW WE COVER YOU FOR PRESCRIBED MINIMUM BENEFITS:

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

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

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

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

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

For a complete list of the DTPPMB conditions, please visit www.medicalschemes.co.za.

The following DTPPMB conditions are also covered from your hospital benefit on all benefit options as long as you meet certain benefit entry criteria.

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

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

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

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

IMPORTANT

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

PAYMENT OF MEDICATION FOR PMB CONDITIONS

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

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

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

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

On the **Standard Option**, you are registered for the Chronic Illness Benefit and if the medicine is on the Remedi medicine list, we will pay the medicine in full up to the Remedi Rate for medicine or up to the Reference Price for the condition per the specific medicine category.

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

MENTAL HEALTH NETWORK

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

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

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

FULL COVER WITH THE REMEDI PMB HOSPITAL NETWORK

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

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

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

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

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

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

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

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

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

IN-HOSPITAL GENERAL PRACTITIONER AND SPECIALIST NETWORK

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

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

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

SUPPLIER AGREEMENTS FOR SURGICAL EQUIPMENT

The Scheme has supplier arrangements for surgical equipment including:

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

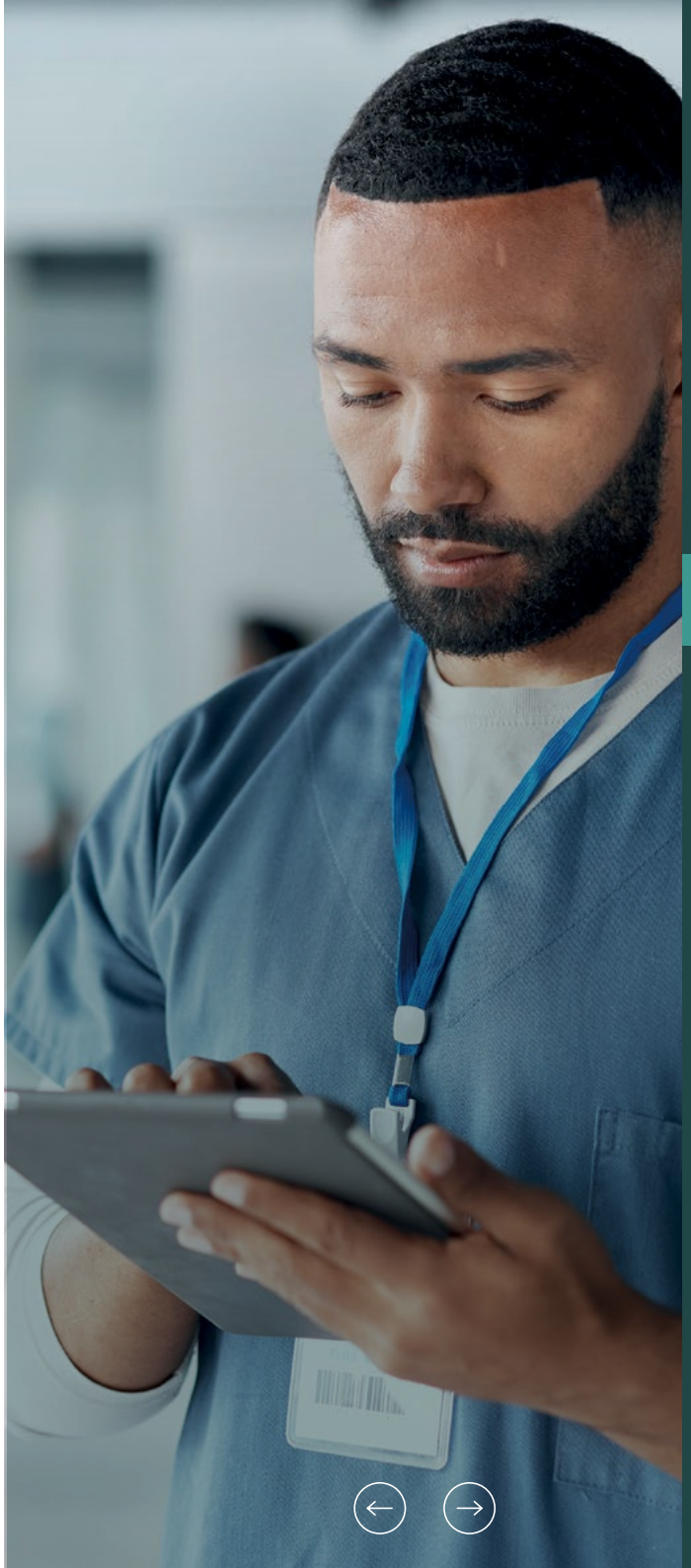
Where members receive the above appliances from service providers who the Scheme has entered into a Preferred Payment Arrangement with, the Scheme will pay the cost of the appliances up to the agreed or negotiated rate and members should have no co-payments.

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

NOTE: PAYMENT OF EMERGENCY PMB CLAIMS

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

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



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

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

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

Remedi is always on the lookout for healthcare providers who can give our members quality care at affordable rates. We will add more designated service providers and networks to this list as they become available. Limits, clinical guidelines and policies apply to some healthcare services and procedures. Please check the benefit table that sets out the benefits and limits in this benefit brochure for more information.

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

You have access to the following day-to-day cover from your Insured Out-of-Hospital (IOH) benefit depending on the benefit option you are registered with. Some limits are subject to your Overall Annual Limit (OAL) as set out in the table below. See page 12 of this benefit guide to find out what your OAL per your chosen benefit option is.

IOH and Day-to-Day Benefits

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Yearly Insured Out-of-Hospital (IOH) sublimits (day-to-day benefits) Consultations, procedures, radiology **(excluding MRI and CT scans) and pathology out-of-hospital point-of-care testing as authorised, including in the outpatient department of a hospital and inclusive of the facility fee for outpatients.**	100% of Remedi Rate or 100% of cost at DSP	**Combined family limit of:** Per principal member: R12,680 Per adult dependant: R7,480 Per child dependant: R2,110 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.	**Combined family limit of:** Per principal member: R11,240 Per adult dependant: R6,630 Per child dependant: R1,870 up to a maximum of three children. If you exceed the sub-limit, you must pay non-Prescribed Minimum Benefit expenses from your own pocket. The sub-limit includes specialised dentistry and optical claims.	**Combined family limit of:** Per principal member: R3,700 Per adult dependant: R2,330 Per child dependant: R750 up to a maximum of three children. These sub-limits are for medical specialists (excluding clinical psychologists and social workers) and casualty visits that dont lead to a hospital admission.
GPs and specialists	100% of Remedi Rate	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit. Once depleted, it will be paid from your Personal Medical Savings Account. This benefit includes cover for a consultation with a gynaecologist for insertion of a Mirena contraceptive device, provided pre-approval was received from the Scheme in line with clinical protocols and guidelines.	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit. This benefit includes cover for a consultation with a gynaecologist for insertion of a Mirena contraceptive device, provided pre-approval was received from the Scheme in line with clinical protocols and guidelines.	Medically appropriate GP consultations and minor procedures, unlimited at member's chosen Remedi Standard Option Network GPs. The Out-of-Area (OOA) Benefit consists of three visits up to a limit of R2,200 per family per year. Medical specialist visits are limited to yearly Insured Out-of-Hospital (IOH) sub-limits. This benefit includes cover for a consultation with a gynaecologist for insertion of a Mirena contraceptive device, provided pre-approval was received from the Scheme in line with clinical protocols and guidelines.

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Additional GP visits	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 pay visits to a Network GP from the hospital benefit, and pathology is excluded.	No benefit.	No benefit.
Acute medicine and Schedule 0, 1 and 2 medicine that can be bought over the counter without a doctor's prescription	100% of Remedi Medicine Rate	Subject to available Insured Out-of-Hospital (IOH) benefit limits and the overall annual limit. Once depleted, it will be paid from your Personal Medical Savings Account. Oral contraceptives are covered up to R200 per prescription per female dependant up to R2,800 per year, payable from the overall annual limit at preferred provider pharmacies. A co-payment of 20% applies if a member gets oral contraceptives from a non-DSP pharmacy. Medicine rules apply, and the medicine on the repeat prescription can only be dispensed after 23 days from when the last medicine was issued.	Subject to available Insured Out-of-Hospital (IOH) benefit limits and the overall annual limit. Oral contraceptives are covered up to R200 per prescription per female dependant up to R2,800 per year, payable from the overall annual limit at preferred provider pharmacies. A co-payment of 20% applies if a member gets oral contraceptives from a non-DSP pharmacy. Medicine rules apply, and the medicine on the repeat prescription can only be dispensed after 23 days from when the last medicine was issued.	*Schedule 0, 1 and 2 medicine:* An over-the-counter benefit of R200 per prescription and R405 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 R200 per prescription per female dependant up to R2,800 per year, payable from the overall annual limit at preferred provider pharmacies. A co-payment of 20% applies if a member gets oral contraceptives from a non-DSP pharmacy. Medicine rules apply, and the medicine on the repeat prescription can only be dispensed after 23 days from when the last medicine was issued.

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
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 a defined list and as referred by your Network GP, are covered at Remedi Standard Option Network healthcare providers.
Allied professionals (physiotherapy, biokinetics, occupational therapy, speech therapy, audiology, audiometry, clinical psychology and social work)	100% of Remedi Rate	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit.	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit.	No benefit.
Specialised Medicine and Bariatric Surgery Benefit	Specialised Medicine: 90% of Remedi Rate or 100% of Reference Price List Bariatric Surgery: 80% of Remedi Rate	Limited to R210,000 per person per year, subject to clinical protocols and preauthorisation. For bariatric surgery, a co-payment of R3,400 for failing to preauthorise will apply.	No benefit.	No benefit.

SCREENING AND PREVENTION BENEFITS

You have access to essential Screening and Prevention Benefits.

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

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

SCREENING

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

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

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

SCREENING FOR SENIORS

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

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

VACCINES PAID FROM YOUR SCREENING BENEFITS

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

- Pneumococcal vaccine – this is paid up to two vaccines per person per lifetime.
- Seasonal influenza vaccine – paid up to one per person per year from your hospital benefit if you are considered a high-risk member or over the age of 65. For other members, this vaccine will pay from their available day-to-day benefits.
- COVID-19 vaccine and administration costs are regarded as clinically appropriate in terms of PMB treatment or prevention.
- Human Papillomavirus (HPV) vaccines – paid (if regarded as clinically appropriate) once every 3 or 5 years depending on your status.

OPTICAL BENEFITS

MAKING THE MOST OF YOUR OPTICAL BENEFITS

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

PPN can be reached as follows:

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

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

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

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

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

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

IMPORTANT NOTE:

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

Optical Benefits summarised

BENEFITS	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Optical Benefit	Subject to confirmation of benefit by the Preferred Provider Negotiators (PPN). You can choose to cover any shortfall from your available savings. All benefits are subject to the overall annual limit and the following sub-limits:	Subject to confirmation of benefit by Preferred Provider Negotiators (PPN). All benefits are subject to Insured Out-of-Hospital benefit limits and the following yearly sub-limits:	Subject to confirmation of benefit by the Preferred Provider Negotiators (PPN). **(Benefits are available only every 24 months)**
Sub-limit per person	R4,225	R3,975	Sub-limits apply as set out below.
Family sub-limit	R8,450	R7,950	Sub-limits apply as set out below.
Consultations			
PPN Provider	100% of Cost A composite consultation inclusive of refraction, a glaucoma screening, visual field screening and artificial intelligence (AI) for the detection of diabetic retinopathy at PPN provider every year per person.	100% of Cost A composite consultation inclusive of refraction, a glaucoma screening, visual field screening and artificial intelligence (AI) for the detection of diabetic retinopathy at PPN provider every year per person.	100% of Cost. A composite consultation inclusive of refraction, a glaucoma screening, visual field screening and artificial intelligence (AI) for the detection of diabetic retinopathy at PPN provider every 24 months per person.
Non-PPN Provider	R400	R400	No benefit.
WITH EITHER			
Spectacles:			
Frames/lens enhancements: PPN Provider	Frame or lens enhancements to the value of R2,125.	Frame or lens enhancements to the value of R1,350.	Frame to the value of R380 per person every 24 months.
Frames/lens enhancements: Non-PPN Provider	R1,594 towards a frame and/or lens enhancement.	R1,350 towards a frame and/or lens enhancement.	No benefit.
Clear Aquity lens limits:	Clear single-vision lenses at a PPN or non-PPN provider limited to R215 per lens.	Clear single-vision lenses at a PPN or non-PPN provider limited to R215 per lens.	Clear single-vision lenses at a PPN provider limited to R215 per lens per person every 24 months.
	Clear bifocal lenses at a PPN or non-PPN provider limited to R460 per lens.	Clear bifocal lenses at a PPN or non-PPN provider limited to R460 per lens.	Clear bifocal lenses at a PPN provider limited to R460 per lens per person every 24 months.
	Base multifocal lenses at a PPN or non-PPN provider limited to R810 per lens. An extra R50 per lens for branded multifocal lenses in addition to the R810 per lens limit.	Base multifocal lenses at a PPN or non-PPN provider limited to R810 per lens. An extra R50 per lens for branded multifocal lenses in addition to the R810 per lens limit.	Base multifocal lenses at a PPN provider limited to R460 per lens per person every 24 months.
OR			
Contact lenses:			
Sub-limit per person	R2,675	R2,425	R675 per person every 24 months at a PPN provider.

DENTAL BENEFITS

MAKING THE MOST OF YOUR DENTAL BENEFITS

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

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

Summary of Remedi Dental Benefits

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

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Specialised dentistry	100% of Remedi Rate	Standalone benefit Subject to the overall annual limit with the following sub-limits: Member only: R25,900 Family: R52,000 Basic dental codes are subject to available Insured Out-of-Hospital benefit. See also page 23.	Subject to available Insured Out-of-Hospital benefit. See also page 23.	No benefit.
Conservative dentistry	100% of Remedi Rate	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit. See also page 23. Once depleted, it will be paid from your PMSA.	Subject to available Insured Out-of-Hospital benefit limits and the overall annual limit. See also page 23.	Basic dentistry only, such as consultations, extractions and fillings, including resin fillings, up to three surface fillings per tooth. The benefit excludes dentures and specialised dentistry. Services to be obtained from the DRC dental management preferred provider network.
Conservative dentistry under anaesthesia for patients younger than seven years	100% of Remedi Rate	Anaesthetic and hospitalisation subject to the overall annual limit. Dental claim subject to the Insured Out-of-Hospital benefit limits.		No benefit.
Preventive dentistry	100% of Remedi Rate	One preventive dental examination per person every 12 months including the oral examination, infection control, prophylaxis, polishing and fluoride of adults and children. On the Standard Option, preventive dentistry is provided through a Network provider (DRC).		

MATERNITY BENEFITS

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

ANTENATAL CONSULTATIONS

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

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

ULTRASOUND SCANS AND SCREENINGS DURING PREGNANCY

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

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

FLU VACCINATIONS

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

BLOOD TESTS

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

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

Please notify us as soon as your pregnancy is confirmed to unlock your maternity basket of care.

CHRONIC CONDITIONS AND CARE PROGRAMMES

CHRONIC BENEFITS

You have access to treatment for a list of 27 medical conditions (including HIV) set out in the list of chronic conditions known as the Chronic Disease List (CDL) and other non-PMB conditions, if registered on the **Comprehensive or Classic Options**.

The **Comprehensive Option** offers you a richer benefit for chronic conditions allowing co-payments from your Personal Medical Savings Account (PMSA), as well as a higher limit for non-PMB conditions, which is limited to **R2,640** per person per month. The **Classic Option** provides cover for non-PMB chronic conditions limited to **R2,200** per person per month.

The **Standard Option** does not make provision for payment of other non-PMB conditions. Payment is limited as prescribed in terms of Prescribed Minimum Benefit (PMB) conditions and members registered on this benefit option have cover for chronic conditions as per the Scheme's Chronic Disease List (CDL).

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

A Addison's disease, Asthma

B Bipolar mood disorder, Bronchiectasis

C Cardiac failure, Cardiomyopathy, Chronic obstructive pulmonary disease (COPD), Chronic renal disease, Coronary artery disease, Crohn's disease

D Diabetes insipidus, Diabetes mellitus type 1, Diabetes mellitus type 2, Dysrhythmia

E Epilepsy

G Glaucoma

H Haemophilia, *HIV (Managed through the HIV Care programme and not covered from your chronic benefits)*, Hyperlipidaemia, Hypertension, Hypothyroidism

M Multiple sclerosis

P Parkinson's disease

R Rheumatoid arthritis

S Schizophrenia, Systemic lupus erythematosus

U Ulcerative colitis

WHAT WE COVER

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

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

For members on the **Standard Option**, medicine on the Remedi medicine list (formulary) will be paid in full up to the Remedi Rate for medicine. Medicine not on the Remedi medicine list (formulary) will be paid up to the Therapeutic Reference Price (TRP) for the specific medicine category for the condition. **The TRP is the set monthly amount we will pay up to for a medicine category. This applies to medicine that is not on the medicine list (formulary). Members on this benefit option must get their medicine from a network pharmacy to avoid a co-payment of 20%.**

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

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

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

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

How to get the benefit

You must apply for the Chronic Illness Benefit (CIB) and your doctor must complete a form online or send it to us for review to **chronicapplications@yourremedi.co.za** to qualify for this medicine payment. We need to be informed of any changes to your treatment so that we can update your chronic authorisation. **You can email the prescription for changes to your treatment plan for an approved chronic condition to chronicapplications@yourremedi.co.za.**

Alternatively, your doctor can submit changes to your treatment plan through HealthID if you have given consent to do so. If you do not let us know about changes to your treatment plan, we may not pay your claims from the correct benefit.

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

Where and how to get your medicine

Members are encouraged to make use of a pharmacy that is part of the Scheme's contracted Designated Service Providers (DSPs). **You can also order your medicine online to ensure that your chronic medicine does not incur an extra deductible.**

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

NON-PMB CHRONIC CONDITIONS NOT COVERED ON COMPREHENSIVE AND CLASSIC OPTIONS

Remedi covers an additional list of chronic diseases if you are registered on the Comprehensive or Classic benefit options. The following list of non-PMB conditions are not covered:

A Acute bacterial and viral infections, Alcoholic liver cirrhosis, Alopecia, Arthralgia, Athlete's foot

B Backache

C Constipation – *unless diagnosis is Diverticular disease or as a consequence of chemotherapy,* Contraception

D Dandruff/Seborrhea, Dermatophytes, Oncomomycosis, Dermatophytic onchia, Diarrhoea, Disorders of the conjunctiva, Dysmenorrhoea/ menorrhagia, Dyspepsia, Dysuria

E Erectile Dysfunction

F Fever blisters, Fibromylgia/Myalgia, Fibrositis, Flatulence, Folate deficiency, Follicitis

H Halitosis, Headaches (non-specific), Haemorrhoids, Hirsutism, Hyperacidity/Indigestion – needs specific diagnosis (not only symptoms), Hypotension

I Insomnia – *allow for terminally ill, current members over 70 year, 6 months as withdrawal therapy, no new applications,* Irritable bowel syndrome

M Mastalgia

O Obesity, Oedema – *allow in cases of cardio-vascular conditions*, Oral and vaginal thrush/Candida

P Pain (non-specific)

R Restless legs/cramps

S Senile dementia/cognitive dysfunction – *exclude medicines such as Nootropil, Encephabol, Reactivin,* Sinusitis, Solar keratosis, Superficial fungal infections

U Unspecified cough, Urticaria

V Varicose veins

Summary of Care Programmes available to you

CARE PROGRAMMES

Member Care Programme

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

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

Patient Care Programmes

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

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

Mental health programme

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

Enrolment on the programme unlocks cover for prescribed medicine, access to either individual or group psychotherapy sessions (virtual and face-to-face therapy) and extra GP consultations to allow for effective evaluation, tracking and monitoring of treatment. Qualifying members will also have access to a relapse prevention programme, which includes extra cover for a defined basket of care for psychiatry consultations, counselling sessions and care coordination services. As part of the Scheme's mental health benefits, Remedi makes available an extra guided internet-based Cognitive Behavioural Treatment ('iCBT') session to provide increased access to mental healthcare to members, as well as providing extra support to healthcare professionals in managing depression.

Cardio Care programme

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

CAD Care

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

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

HIV Care programme

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

Contact us to register on the Remedi HIV Care programme:

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

Diabetes Care Programme

If you are registered on the Chronic Illness Benefit (CIB) for diabetes, your nominated Premier Plus GP can enrol you on the Diabetes Care Programme. The programme unlocks cover for extra glucometer strips and consultations with dietitians and biokineticists. You may also have access to a nurse educator to help you with the day-to-day management of your condition.

If registered on the Diabetes Care Programme, the Scheme also pays 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 and where deemed clinically appropriate, members with type 1 and type 2 diabetes have cover for continuous glucose monitoring sensors up to a monthly cover amount. Cover depends on your chosen benefit option and this benefit is currently not available on the **Standard Option**.

Disease Prevention Programme

If you are identified to be at risk of cardio-metabolic risk syndrome or diabetes, your nominated Premier Plus GP can enrol you on the Disease Prevention Programme. Your Premier Plus GP, dietitian and health coach will help coordinate your care. Enrolled members have access to a defined basket of care. This includes cover for consultations, certain pathology tests and medicine, where appropriate. You will also have access to health coaching sessions to help you with the day-to-day management of your condition.

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

COVER FOR CANCER

You have comprehensive cover for cancer treatment.

If you are diagnosed with cancer and once we have approved your cancer treatment, you are covered by the Oncology Care Programme over a 12-month cycle, starting from your date of diagnosis. This means you will always have a full year's benefit no matter when in the year you are diagnosed with cancer. Once you have been registered on the oncology management programme, you will have access to medicine management, and medicine will be approved in line with the Scheme's approved Reference Price Lists (RPL) and medicine lists. The reference price will be set at the price of the generic equivalent or clone of a medicine and will apply to all benefit options. This managed healthcare intervention will take effect on 1 July 2025.

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

Summary of cancer/oncology benefits:

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

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Cancer treatment	Paid at the Scheme's Designated Service Providers (DSP), up to a maximum of 100% of the Remedi Rate/Medicine Rate/Reference Price, whichever is applicable, up to benefit limit. Thereafter 80% of Remedi Rate / Medicine Rate/Reference Price whichever is applicable, if non-PMB treatment on **Comprehensive and Classic Options**	R1,195,000 per person per 12-month rolling period, of which the first R490,000 per person is covered at 100% of the Remedi Rate/Medicine Rate/Reference Price, whichever is applicable, and the remaining R705,000 at 80% of the Remedi Rate/Medicine Rate/Reference Price, whichever is applicable. The requirements for Prescribed Minimum Benefits are applicable and only PMB level of care will be paid at cost or Remedi Rate through the benefit limits.	R675,000 per person per 12-month rolling period, of which the first R410,000 per person is covered at 100% of the Remedi Rate/Medicine Rate/Reference Price, whichever is applicable, and the remaining R265,000 at 80% of the Remedi Rate/Medicine Rate/Reference Price, whichever is applicable. The requirements for Prescribed Minimum Benefits are applicable and only PMB level of care will be paid at cost or Remedi Rate through the benefit limits.	The requirements for Prescribed Minimum Benefits are applicable and only PMB level of care will be paid at cost or Remedi Rate/Medicine Rate/ Reference Price, whichever is applicable, through the benefit limits.

With effect from 1 January 2025, members registered on the Comprehensive Option will have cover for a defined list of innovative cancer medicine that meet the Scheme's criteria. You may need to pay 25% of the cost of these treatments. Payment is subject to the Scheme's clinical entry criteria.

PRESCRIBED MINIMUM BENEFITS (PMB) FOR CANCER

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

HOSPITAL AND DAY SURGERY COVER

Remedi Medical Aid Scheme offer cover for hospital stays.

HOSPITAL COVER

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

- For **Comprehensive Option**, there is no overall limit.
- For **Classic Option**, there is an overall family limit of **R2,575,000**.
- For **Standard Option**, there is an overall family limit of **R775,000**.

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

Cover for Home Care

*Discovery Home Care is a service that offers you 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 overall annual limit/hospital benefit, subject to approval. Discovery Home Care is the Designated Service Provider (DSP) for administration of defined intravenous infusions. Avoid a 20% co-payment by using Discovery Home Care for these infusions.

What is the benefit?

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

What we cover?

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

Follow-up treatment after an admission

If you qualify, you have access to a readmission prevention programme for clinically appropriate conditions. This programme gives you access to approved follow-up care and a health coaching session within 30 days after you are discharged from hospital. Cover is subject to our treatment guidelines and clinical entry criteria.

**Discovery Home Care is a service provider. Practice 080 000 8000190, Grove Nursing Services (Pty) Ltd registration number 2015/191080/07, trading as Discovery HomeCare.*

HOW TO GET THE BENEFIT?

Get your preauthorisation and confirmation first

If referred by your doctor or specialist to be admitted to hospital, contact us on **0860 116 116** at least 48 hours before you go to hospital to confirm your hospital stay and before you are admitted (this is known as preauthorisation). If you do not confirm your admission and the costs that we would normally cover, you may be responsible for a co-payment of **R3,400** for the admission.

Where to go

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

How we pay

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

You can avoid co-payments by:

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

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

The Remedi app and Find a healthcare provider are brought to you by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

Hospital Benefits summarised

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

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Private hospitals	100% of Remedi Rate	Subject to an unlimited overall annual limit per family. da Vinci Robotic-Assisted Prostatectomies are covered at 90% of negotiated rates where pre-approved and you may be liable for a co-payment. Cover is limited to one procedure per person.	Subject to an overall annual limit of R2,575,000 per family. da Vinci Robotic-Assisted Prostatectomies are covered at 90% of negotiated rates where pre-approved and you may be liable for a co-payment. Cover is limited to one procedure per person.	Subject to an overall annual limit of R775,000 per family. da Vinci Robotic-Assisted Prostatectomies are covered at 90% of negotiated rates where pre-approved and you may be liable for a co-payment. Cover is limited to one procedure per person.
State hospitals	100% of Remedi Rate	Limited to R675,000 per family.	Limited to R650,000 per family.	Limited to R305,000 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 R810,000 per person per year, if preauthorised. Travelling costs not covered.	No benefit.	No benefit.
Operations, procedures and surgery		Payment will be in full to designated service providers and at 150% of the Remedi Rate if you use non-network specialists.	Payment will be in full to designated service providers and at 100% of the Remedi Rate if you use non-network specialists.	Payment will be in full to designated service providers and at 100% of the Remedi Rate if you use non-network specialists.
Ward and theatre fees	100% of Remedi Rate	Includes cover for general ward, maternity ward, theatre recovery and intensive care (ICU) unit subject to overall annual limit.		
Confinements	100% of Remedi Rate	Subject to the overall annual limit.		
Blood transfusions	100% of Remedi Rate	Subject to the overall annual limit.		
Organ transplants	100% of Remedi Rate	Subject to the overall annual limit and the requirements for Prescribed Minimum Benefits.		
Renal dialysis	100% of Remedi Rate	Subject to the overall annual limit and the requirements for Prescribed Minimum Benefits.		
Conservative dentistry under anaesthesia for patients younger than seven years	100% of Remedi Rate	Anaesthetic and hospitalisation subject to the overall annual limit. Dental claims subject to Insured Out-of-Hospital (IOH) benefit limits.		No benefit.

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Refractive eye surgery	100% of Remedi Rate	Subject to clinical entry criteria, the overall annual limit and a sub-limit of R35,600 a person per year. Includes payment of corneal cross-linking.	Subject to clinical entry criteria, the overall annual limit and a sub-limit of R31,800 a person per year. Includes payment for corneal cross-linking.	No benefit.
Mental health	100% of Remedi Rate	Subject to the overall annual limit, limited to 21 days a year in hospital or 15 days , as well as one guided internet-based Cognitive Behavioural Treatment (iCBT) session in an out-of-hospital setting or a combination of in- and out-of-hospital as prescribed in terms of Prescribed Minimum Benefits. 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 enrol on the Remedi Mental Health programme as set out in more detail in this brochure on pages 19 and 35.		
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 paid 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 paid 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	R60,800	R52,300	R46,200
Revision hip*	per person	R72,100	R61,800	R54,500
Knee replacement*	per person	R48,100	R41,000	R36,300
Revision knee*	per person	R60,800	R52,300	R46,200
Shoulder replacement	per person	R56,100	R48,100	R42,500
Pacemaker with leads	per person	R102,200	R86,500	R76,800
Pacemaker biventricular	per person	R131,600	R111,500	R98,800
Cardiac valves	each	R68,400	R57,900	R50,000
Artifical eyes	per person	R37,300	R31,600	R28,100

**To obtain from DSP. A R3,400 co-payment for voluntary non-DSP use will apply.*

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Cochlear implants (bilateral andunilateral)	Negotiated Rates	Paid at DSP and subject to the hospital benefit, if obtained from preferred suppliers. Diagnostic work-up for cochlear implants, repairs due to breakage, loss of device, or failure of the device, as well as cochlear implant batteries paid from the available IOH, PMSA or member's own pocket, as may be applicable.	No benefit	No benefit
All other internal prostheses and devices	per person	R31,600	R27,300	R24,000
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 R48,950 per person.	Subject to the overall annual limit with a sub-limit of R46,600 per person.	Subject to the overall annual limit with a sub-limit of R17,200 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.**		

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

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

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
External prostheses and appliances (These limits apply where you do not use a preferred provider)	100% of Remedi Rate	Subject to the overall annual limit, with the following sub-limits for each prosthesis. Thereafter, it is paid from PMSA:	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	R32,350	R32,350	R16,800
Hearing aids	per person	R29,900	R29,900	R21,550
Oxygen appliances	monthly per person	R2,435	R2,435	R2,435
Wheelchairs	per person	R22,300	R18,700	R14,850
CGM Sensors (Continuous Glucose Monitors)	Negotiated Rates	Paid up to monthly agreed rates at preferred providers if registered on the diabetes management programme and as prescribed by your Premier Practice GP. Transmitters and readers are paid from the 'all other appliances' benefit limit and thereafter from the available PMSA.	Paid up to monthly agreed rates at preferred providers if registered on the diabetes management programme and as prescribed by your Premier Practice GP. Transmitters and readers are paid from the 'all other appliances' benefit limit and thereafter from member's own pocket.	No benefit.
Insulin Pumps	Negotiated Rates	Subject to the overall annual limit, if approved and if registered on the diabetes management programme. Costs related to the reservoir and infusion sets are covered up to a monthly limit R1,747 per person per month and up to a maximum of 10 of each per month.	No benefit.	No benefit.
Above knee artifical limbs	per person	R72,500	R61,800	R54,700
Below knee artificial limbs	per person	R39,300	R33,800	R30,000
All other external prostheses and appliances	per person	R8,400	R7,050	R4,000
		CPAP, Point-of-Care and Mirena devices, where deemed clinically appropriate, are paid from the 'all other external prostheses and appliances' benefit limit as available at agreed/negotiated rates.		

BENEFITS	RATE	REMEDI COMPREHENSIVE	REMEDI CLASSIC	REMEDI STANDARD
Trauma Recovery Extender Benefit	100% of Remedi Rate	Cover for certain out-of-hospital claims for your recovery after certain traumatic events, without using the IOH benefit. Subject to clinical entry criteria, the overall annual limit and the following sub-limits apply:		
Loss of limb	per family	R106,000	R106,000	R106,000
Private nursing	per person	R13,300	R13,300	R13,300
Prescribed medication	Member	R36,950	R17,100	R17,100
	Member + 1	R43,300	R20,150	R20,150
	Member + 2	R50,450	R24,000	R24,000
	Member + 3 or more	R57,400	R29,000	R29,000
External medical items	per person	R90,500	R40,500	R40,500
Hearing aids	per person	R33,000	R19,100	R19,100
Mental Health Benefit	per person	R32,200	R23,900	R23,900
Maintenance therapy after rehabilitation or congenital defect (mental or physical) (In- and out-of hospital)	100% of Remedi Rate	Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a conservative nature. Subject to approval of a treatment plan and the overall annual limit with a sublimit of R17,370 per family.	Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a conservative nature. Subject to approval of a treatment plan and the overall annual limit with a sublimit of R16,500 per family.	Extended physiotherapy, occupational therapy, speech therapy and biokinetics of a conservative nature. Subject to approval of a treatment plan and the overall annual limit with a sublimit of R4,910 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 R4,910 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.		

COVER FOR PROCEDURES IN THE DAY SURGERY NETWORK

DAY SURGERY NETWORK

We cover specific procedures that can be done in the day surgery network.

ABOUT THE BENEFIT

We cover certain planned procedures in a day surgery facility. A day surgery facility may be inside a hospital, in a clinic or at a standalone facility.

HOW TO GET THE BENEFIT?

View the list of day surgery procedures in this benefit brochure. You must contact us to get confirmation of your procedure (preauthorisation).

HOW WE PAY

We pay these services from your hospital benefit. We pay for services related to your hospital stay including all healthcare professionals' accounts, services and medicine authorised by the Scheme. If you use doctors, specialists and other healthcare professionals that we have a payment arrangement with, we will pay for these services in full up to the Scheme or negotiated rates.

WHEN YOU NEED TO PAY

If you go to a facility that is not in your benefit option's day surgery network, you will have to pay an amount of **R7,000** upfront, which is referred to as a deductible.

View all day surgery network facilities in the Remedi app.

List of procedures covered in the day surgery network

The following is a list of procedures that we cover in a day surgery:

B

BIOPSIES

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

BREAST PROCEDURES (IF APPROVED)

- Mastectomy for gynaecomastia
- Lumpectomy (fibroadenoma)

E

EAR, NOSE AND THROAT PROCEDURES

- Tonsillectomy and adenoidectomy
- Repair nasal turbinates, nasal septum
- Simple procedures for nosebleeds (extensive cautery)
- Sinus lavage
- Scopes (nasal endoscopy, laryngoscopy)
- Middle ear procedures (tympanoplasty, mastoidectomy, myringoplasty, myringotomy and/or grommets)

EYE PROCEDURES

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

G

GANGLIONECTOMY

GASTROINTESTINAL PROCEDURES

- Gastrointestinal scopes (oesophagoscopy, gastroscopy, colonoscopy, sigmoidoscopy, proctoscopy, anoscopy)
- Anorectal procedures (treatment of haemorrhoids, fissure, fistula)
- Diagnostic Dilatation and Curettage

GYNAECOLOGICAL PROCEDURES

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

N

NERVE PROCEDURES

- Neuroplasty median nerve, ulnar nerve, digital, nerve of hand or foot

O

ORTHOPAEDIC PROCEDURES

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

R

REMOVAL OF FOREIGN BODY

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

S

SIMPLE SUPERFICIAL LYMPHADENECTOMY

SKIN PROCEDURES

- Debridement
- Removal of lesions (dependent on site and diameter)
- Simple repair of superficial wounds

U

UROLOGICAL PROCEDURES

- Cystoscopy
- Male genital procedures (circumcision, repair of penis, exploration of testes and scrotum, orchiectomy, epididymectomy, excision hydrocoele, excision varicocele vasectomy)

UNCOMPLICATED HERNIA PROCEDURESS

- Umbilical hernia repair
- Ingiunal hernia repair

BENEFIT UPDATES FOR 2025

New benefits and enhancements

VIRTUAL URGENT CARE (VUC)

VUC aims to address an unmet need of members by providing 24-hour access to virtual consultations for **non-life threatening, but urgent medical needs and will reduce unnecessary and costly emergency room visits.**

During 2025 members will have access to VUC and the number of visits will depend on the benefit option that you are registered on.

For members registered on the **Comprehensive Option:**
– **Four** VUC consultations per family will be paid from your hospital benefits, if coded as an emergency.

For members registered on the **Classic Option:**
– **Three** VUC consultations per family will be paid from your hospital benefits, if coded as an emergency.

For members registered on the **Standard Option:**
– VUC will be paid from the available Out-of-Area (OOA) benefit which consists of **three** visits per family per year.

Where consultations are found not to be an emergency, the member's available Insured Out-of-Hospital (IOH) benefit will be used to pay for the consultation if the member is registered on the **Classic or Comprehensive** benefit options. For **Standard Option** members, it will be funded from the OOA benefit.

VIRTUAL PHYSICAL THERAPY (VPT)

During 2025, virtual physical therapy (VPT) will be made available to all members using the Genie Health Platform. VPT gives a cost-effective, high-quality total or partial (replacement for some musculoskeletal care sessions) alternative to in-person care. Research about VPT demonstrates increased compliance, faster recovery at lower costs and better outcomes. In partnership with Genie Health, healthcare providers use the technology-enabled platform to give evidence-based, conservative therapies for optimal care outcomes to members. Members' existing and available day-to-day benefits will be used to pay for these sessions.

Enhancing existing benefits

ADVANCED ILLNESS BENEFIT ENHANCEMENTS

The Scheme's available Advanced Illness Benefit (AIB) is enhanced with the introduction of Epilog, which will make available a digital tool to people dealing with advanced illness. With the introduction of Epilog, members will get early and personalised support based on their needs and life circumstances. Each member successfully enrolled in the Advanced Illness Management Support Programme (AIMSP) will receive digital support at a fee paid by the Scheme per each successful enrolment.

This benefit is available to all members, no matter which benefit option they are registered on.

ORAL CONTRACEPTIVES BENEFIT ENHANCEMENTS

With effect from 1 January 2025, female members will experience an enhanced oral contraceptives benefit. From 2025, oral contraceptives will be limited to R200.00 per prescription per female dependant up to R2,800.00 per year payable from the overall annual limit (OAL). A co-payment of 20% applies if a member gets oral contraceptives from a non-DSP pharmacy. Medicine rules apply, and the medicine on the repeat prescription can only be dispensed after 23 days from when the last medicine was issued.

This benefit is available to all female members no matter which benefit option they are registered on.

Please contact us on **0860 116 116** *to ensure your treatment is preauthorised and to receive more information*

ONCOLOGY ENHANCEMENTS

Members registered on all benefit options will continue to have access to their chosen benefit option's oncology benefits if they are diagnosed with cancer. Once registered on the oncology management programme, members will have access to medicine management and medicine will be approved in line with the Scheme's approved Reference Price Lists (RPL) and medicine lists. The reference price will be set at the price of the generic equivalent or clone of a medicine and will apply to all benefit options. This managed healthcare intervention will take effect on 1 July 2025.

In addition, members registered on the **Comprehensive Option** will have access to a defined list of innovative cancer medicine through the introduction of the Oncology Innovation Benefit (OIB). Medicine costs, if approved, will be paid up to 75% of the Scheme Rate from the first day of treatment (Day 1), limited to the **Comprehensive Option's** oncology benefit limits.

A co-payment support programme will be made available to help members to pay for the out-of-pocket shortfalls on medicine approved as part of this benefit on the **Comprehensive Option**.

As part of the OIB, the Oncology Precision Benefit (OPB) is introduced to cover Next Generation Sequencing (NGS), which is a pathology test that identifies cancer genomic drivers. NGS is paid from the Scheme's hospital benefit and not the oncology benefit.

In addition, the family limits have been removed and oncology benefits will be made available at a per person limit. The oncology limits for members registered on the **Classic Option** will not be increased with inflationary increases.

DISEASE PREVENTION MANAGEMENT

To proactively manage and prevent the onset of diabetes and to risk manage cardio metabolic syndrome, a Disease Prevention Management Programme will be available with effect from 1 January 2025.

CONTINUOUS GLUCOSE MONITORING (CGM) DEVICE ENHANCEMENTS

With effect from 1 January 2025, members living with type 2 diabetes who are registered on the **Classic** or **Comprehensive Options** will have access to cover for CGM devices. Members will need to be registered on the Diabetes Care Programme and clinical appropriateness will be taken into consideration.

Payment is limited to a monthly agreed rate at preferred providers and as prescribed by your Premier Practice GP. Transmitters and readers are paid from the ''all other appliances'' benefits and thereafter from the available PMSA, if you are registered on the **Comprehensive Option**. If you are registered on the **Classic Option** and you've reached your "all other appliances" benefit limits, you will need to pay the balance of the cost out of your own pocket.

OTHER TECHNICAL UPDATES

2025 Benefit limit changes

Day-to-day (Insured Out-of Hospital) limits were increased by expected inflationary increases plus an additional 5%. That is approximately 10% in total. Similarly, optical benefit limits for frames and lenses were increased by 10%. Some benefit limits remained unchanged, such as the Specialised Medicine Benefit (also called the Specialised Medicine and Bariatric Surgery Benefit, which is only available to members registered on the **Comprehensive Option**) as well as the oncology limits of the **Classic Option**.

IF YOU WANT TO CHANGE YOUR BENEFIT OPTION

You can change to another benefit option at the end of the year, to start from 1 January of the following year. You cannot change your benefit option during the year. To change your benefit option, you need to download the benefit change form available on the Remedi website at **www.yourremedi.co.za** and return it to us before 20 December 2024, per the instructions provided on the form.

The benefits outlined in this brochure are a summary of Remedi Medical Aid Scheme's benefits as set out in the Remedi Scheme Rules. These benefits are reviewed every year and amended in line with the requirements of the Medical Schemes Act and take into account the requirements of the Consumer Protection Act where it relates to the business of a medical scheme.

Please visit www.yourremedi.co.za for a copy of the Scheme Rules as registered by the Council for Medical Schemes (CMS) each year.

Please consult the benefit limits as set out in this benefit brochure for more details.

YOUR CONTRIBUTIONS FOR 2025

1. Contributions as from 1 January 2025 until 31 December 2025

	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	R3,873	R3,092	R1,042	R3,009	R2,298	R840	R1,891	R1,312	R431
R4,000 – R5,499	R4,089	R3,302	R1,110	R3,184	R2,464	R934	R1,980	R1,382	R486
R5,500 – R6,999	R4,320	R3,518	R1,214	R3,355	R2,622	R998	R2,076	R1,549	R601
R7,000 – R7,999	R4,545	R3,617	R1,324	R3,529	R2,690	R1,092	R2,233	R1,856	R778
R8,000 – R8,999	R4,781	R3,819	R1,384	R3,721	R2,840	R1,164	R2,233	R1,856	R778
R9,000 – R9,999	R5,046	R4,001	R1,454	R3,912	R2,984	R1,211	R2,233	R1,856	R778
R10,000 – R10,999	R5,296	R4,203	R1,583	R4,121	R3,144	R1,321	R2,233	R1,856	R778
R11,000+	R5,582	R4,431	R1,670	R4,330	R3,307	R1,368	R2,239	R1,860	R779

* 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.

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

Income bands	Principal	Adult or spouse	Child**
R0 – R3,999	R387	R309	R104
R4,000 – R5,499	R409	R330	R111
R5,500 – R6,999	R432	R352	R121
R7,000 – R7,999	R455	R362	R132
R8,000 – R8,999	R478	R382	R138
R9,000 – R9,999	R505	R400	R145
R10,000 – R10,999	R530	R420	R158
R11,000+	R558	R443	R167

* 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.

Contribution subsidies from 1 January 2025 until 31 December 2025 (where applicable)

	REMEDI COMPREHENSIVE*			REMEDI CLASSIC			REMEDI STANDARD		
Income bands	Principal	Adult or spouse	Child**	Principal	Adult or spouse	Child**	Principal	Adult or spouse	Child**
R0 – R3,999	R2,245	R920	R702	R2,177	R854	R666	R1,609	R903	R302
R4,000 – R5,499	R2,379	R1,004	R743	R2,303	R924	R698	R1,697	R937	R345
R5,500 – R6,999	R2,498	R1,073	R821	R2,423	R998	R762	R1,783	R1,047	R427
R7,000 – R7,999	R2,644	R1,101	R889	R2,558	R1,017	R840	R1,894	R1,244	R547
R8,000 – R8,999	R2,784	R1,152	R925	R2,694	R1,064	R874	R1,894	R1,244	R547
R9,000 – R9,999	R2,921	R1,205	R966	R2,833	R1,112	R874	R1,894	R1,244	R547
R10,000 – R10,999	R3,089	R1,277	R1,042	R2,988	R1,182	R969	R1,894	R1,244	R547
R11,000+	R3,246	R1,347	R1,115	R3,144	R1,256	R1,016	R1,900	R1,247	R548

* 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.

WAITING PERIODS, EXCLUSIONS AND DISCRETIONARY GRANTS

MEDICAL CONDITIONS DURING A WAITING PERIOD

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

REMEDI EXCLUSIONS

HEALTHCARE SERVICES THAT ARE NOT COVERED ON REMEDI

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

THE EXCLUSION LIST INCLUDES:

A

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

B

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

C

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

D

- Diagnostic agents

E

- Erectile dysfunction treatment and associated costs

F

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

G

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

H

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

I

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

M

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

O

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

S

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

W

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

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

DISCRETIONARY GRANTS

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

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

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

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

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

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