CONTACT DETAILS AND REGIONAL OFFICES

TEL: 0860 765 633 or 0860 POLMED

FAX: 0860 104 114
FAX: 0861 888 110 (Membership-related correspondence)
FAX: 011 758 7660 (New claims)

ROODEPOORT WALK-IN BRANCH
Shop 21 and 22
Flora Centre (Entrance 2)
Cnr Ontdekkers & Conrad Roads
Florida North
Roodepoort

POSTAL ADDRESS FOR CLAIMS, MEMBERSHIP AND CONTRIBUTIONS
POLMED
Private Bag X16
Arcadia
0007

EMAIL ADDRESS FOR SUBMITTING ENQUIRIES
polmed@medscheme.co.za

REGIONAL WALK-IN BRANCHES
Refer to the map.

POLMED FRAUD HOTLINE
TEL: 0800 112 811
EMAIL: fraud@medscheme.co.za

POLMED WEBSITE
www.polmed.co.za

POLMED CHAT
Via mobile device: Download the free app via http://bit.ly/1YHAtwu or from various app stores.
Via POLMED website: Log in to the Member zone via your computer and click on the POLMED Chat widget/icon.
ADDITIONAL SERVICE POINTS

NOTE: Please refer to the notices at police stations or South African Police Service (SAPS) buildings for details about dates and times that assistance is offered at these additional service points.

Any new offices/service points will be communicated.

<table>
<thead>
<tr>
<th>AREA</th>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durban central</td>
<td>SAPS – Durban central, 255 Stalwart Simelane Street, Marine Parade, Durban</td>
</tr>
<tr>
<td>King Williams Town</td>
<td>SAPS – King Williams Town, Buffalo Road, Zwelitsha</td>
</tr>
<tr>
<td>Mthatha</td>
<td>SAPS – Mthatha, R61 Sutherland Street, Mthatha</td>
</tr>
<tr>
<td>Pietermaritzburg</td>
<td>SAPS – Alexandra Road, 101 Alexandra Road, Scottsville, Pietermaritzburg</td>
</tr>
<tr>
<td>Potchefstroom</td>
<td>SAPS – Potchefstroom, 25 OR Tambo Street, Potchefstroom</td>
</tr>
<tr>
<td>Pretoria</td>
<td>Wachthuis, 231 Pretorius Street, Pretoria</td>
</tr>
<tr>
<td>Ulundi</td>
<td>SAPS – Ulundi, Unit A, Ingulube Street, Ulundi</td>
</tr>
<tr>
<td>Winelands (Paarl East)</td>
<td>SAPS – Paarl East, cnr Meacker and Van der Stel Street, Paarl East</td>
</tr>
</tbody>
</table>
MANAGED HEALTHCARE
CONTACT DETAILS

POSTAL ADDRESS
POLMED
Private Bag X16
Arcadia
0007

CHRONIC MEDICINE MANAGEMENT PROGRAMME
TEL: 0860 765 633 (members) or 0860 104 111 (providers)
FAX: 0860 000 320
EMAIL: polmedcm@medscheme.co.za

DISEASE RISK MANAGEMENT (DRM) PROGRAMME
TEL: 0860 765 633
EMAIL:
polmedseaman@medscheme.co.za
(ADR Programme)
EMAIL: polmedhbc@medscheme.co.za
(Prolonged Care Programme)

HOSPITAL/MRI AND CT SCAN PRE-AUTHORISATION
TEL: 0860 765 633 (members) or 0860 104 111 (providers)
FAX: 0860 104 114
EMAIL: polmedauths@medscheme.co.za

MATERNITY PROGRAMME
TEL: 0860 765 633
EMAIL: polmedmaternity@medscheme.co.za

MENTAL HEALTH PROGRAMME
TEL: 0860 765 633
EMAIL: polpsych@medscheme.co.za

ONCOLOGY MANAGEMENT PROGRAMME
TEL: 0860 765 633
FAX: 0860 000 340
EMAIL: polmedonco@medscheme.co.za

PRESCRIBED MINIMUM BENEFITS (PMBs)
TEL: 0860 765 633
EMAIL: polmedapmb@medscheme.co.za

SPECIALISED DENTISTRY
TEL: 0860 765 633
FAX: 0860 104 114

In-hospital dental procedures and sedation pre-authorisation:
EMAIL: polmedauths@medscheme.co.za

Out-of-hospital specialised dentistry:
EMAIL: dental.polmeddental@medscheme.co.za

HIV MANAGEMENT PROGRAMME
TEL: 0860 100 646
FAX: 0800 600 773
EMAIL: polmedhiv@medscheme.co.za

POSTAL ADDRESS: PO Box 38597
Pinelands
7430

DESIGNATED SERVICE PROVIDERS (DSPs)

EMERGENCY MEDICAL SERVICES

Netcare 911
Tel: 082 911

EYE CARE (OPTOMETRY)

Preferred Provider Negotiators
Tel: 0861 103 529

MOTOR VEHICLE ACCIDENT (MVA) CLAIMS

Batsumi
Tel: 012 431 9700/0861 303 303/0860 303 303

ONCOLOGY (CANCER)

Independent Clinical Oncology Network (ICON)
Tel: 021 944 3750

RENAI SERVICE FACILITIES

Fresenius Medical Care
Website: www.freseniusmedicalcare.com

National Renal Care
Tel: 011 726 5206
Website: www.nrc.co.za
ANNEXURE A3
MARINE CONTRIBUTION SCHEDULE

The contributions for 2018 as set out in the format required by the Registrar in Circular 45 of 2017.

The monthly contributions are payable by or on behalf of the member per registered member.

ANNUAL MEMBER CONTRIBUTION INCREASES ARE EFFECTIVE 1 APRIL

**CONTRIBUTION RATES MARINE 2018 (1 APRIL 2018 – 31 MARCH 2019)**

<table>
<thead>
<tr>
<th>INCOME CATEGORY</th>
<th>MEMBER</th>
<th>ADULT</th>
<th>CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>R0 – R6 279</td>
<td>295</td>
<td>295</td>
<td>74</td>
</tr>
<tr>
<td>R6 280 – R8 625</td>
<td>409</td>
<td>409</td>
<td>137</td>
</tr>
<tr>
<td>R8 626 – R10 538</td>
<td>452</td>
<td>452</td>
<td>169</td>
</tr>
<tr>
<td>R10 539 – R12 325</td>
<td>532</td>
<td>532</td>
<td>213</td>
</tr>
<tr>
<td>R12 326 – R14 343</td>
<td>621</td>
<td>621</td>
<td>246</td>
</tr>
<tr>
<td>R14 344 – R17 250</td>
<td>711</td>
<td>711</td>
<td>291</td>
</tr>
<tr>
<td>R17 251 – R21 172</td>
<td>783</td>
<td>783</td>
<td>339</td>
</tr>
<tr>
<td>R21 173 +</td>
<td>851</td>
<td>851</td>
<td>373</td>
</tr>
</tbody>
</table>

**TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)**

**NOTE**: Total contribution applicable to members who do not qualify for employer subsidy, e.g. parents.

<table>
<thead>
<tr>
<th>INCOME CATEGORY</th>
<th>MEMBER</th>
<th>ADULT</th>
<th>CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>R0 – R6 279</td>
<td>2 087</td>
<td>2 087</td>
<td>970</td>
</tr>
<tr>
<td>R6 280 – R8 625</td>
<td>2 201</td>
<td>2 201</td>
<td>1 033</td>
</tr>
<tr>
<td>R8 626 – R10 538</td>
<td>2 244</td>
<td>2 244</td>
<td>1 065</td>
</tr>
<tr>
<td>R10 539 – R12 325</td>
<td>2 325</td>
<td>2 325</td>
<td>1 109</td>
</tr>
<tr>
<td>R12 326 – R14 343</td>
<td>2 414</td>
<td>2 414</td>
<td>1 142</td>
</tr>
<tr>
<td>R14 344 – R17 250</td>
<td>2 503</td>
<td>2 503</td>
<td>1 188</td>
</tr>
<tr>
<td>R17 251 – R21 172</td>
<td>2 575</td>
<td>2 575</td>
<td>1 235</td>
</tr>
<tr>
<td>R21 173 +</td>
<td>2 644</td>
<td>2 644</td>
<td>1 269</td>
</tr>
</tbody>
</table>

The contributions for 2019 as set out in the format required by the Registrar in Circular 33 of 2018.

**CONTRIBUTION RATES MARINE 2019 (1 APRIL 2019 – 31 MARCH 2020)**

<table>
<thead>
<tr>
<th>INCOME CATEGORY</th>
<th>MEMBER</th>
<th>ADULT</th>
<th>CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>R0 – R6 618</td>
<td>319</td>
<td>319</td>
<td>80</td>
</tr>
<tr>
<td>R6 619 – R9 091</td>
<td>442</td>
<td>442</td>
<td>148</td>
</tr>
<tr>
<td>R9 092 – R11 107</td>
<td>488</td>
<td>488</td>
<td>183</td>
</tr>
<tr>
<td>R11 108 – R12 991</td>
<td>575</td>
<td>575</td>
<td>230</td>
</tr>
<tr>
<td>R12 992 – R15 118</td>
<td>671</td>
<td>671</td>
<td>266</td>
</tr>
<tr>
<td>R15 119 – R18 182</td>
<td>768</td>
<td>768</td>
<td>314</td>
</tr>
<tr>
<td>R18 183 – R22 315</td>
<td>846</td>
<td>846</td>
<td>366</td>
</tr>
<tr>
<td>R22 316 +</td>
<td>919</td>
<td>919</td>
<td>403</td>
</tr>
</tbody>
</table>

**TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)**

**NOTE**: Total contribution applicable to members who do not qualify for employer subsidy, e.g. parents.

<table>
<thead>
<tr>
<th>INCOME CATEGORY</th>
<th>MEMBER</th>
<th>ADULT</th>
<th>CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>R0 – R6 618</td>
<td>2 204</td>
<td>2 204</td>
<td>1 023</td>
</tr>
<tr>
<td>R6 619 – R9 091</td>
<td>2 373</td>
<td>2 373</td>
<td>1 125</td>
</tr>
<tr>
<td>R9 092 – R11 107</td>
<td>2 461</td>
<td>2 461</td>
<td>1 172</td>
</tr>
<tr>
<td>R11 108 – R12 991</td>
<td>2 557</td>
<td>2 557</td>
<td>1 209</td>
</tr>
<tr>
<td>R12 992 – R15 118</td>
<td>2 653</td>
<td>2 653</td>
<td>1 257</td>
</tr>
<tr>
<td>R15 119 – R18 182</td>
<td>2 731</td>
<td>2 731</td>
<td>1 308</td>
</tr>
<tr>
<td>R18 183 – R22 315</td>
<td>2 805</td>
<td>2 805</td>
<td>1 346</td>
</tr>
</tbody>
</table>
ANNEXURE A1

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2019

Subject to the provisions contained in these rules, including all Annexures, members making monthly contributions at the rates specified in Annexure A3 shall be entitled to the benefits as set out herein, with due regard to the provisions in the Act and Regulations in respect of prescribed minimum benefits (PMBs).

Reference in this Annexure and the following Annexures to the term:

- ‘POLMED rate’ shall mean: 2006 National Health Reference Price List (NHRPL) adjusted on an annual basis with Consumer Price Index (CPI).
- ‘Agreed tariff’ shall mean: The rate negotiated by and on behalf of the Scheme with one or more providers/groups.

Benefits for the services outside the Republic of South Africa (RSA)

The Scheme does not grant benefits for services rendered outside the borders of the RSA. A claim for such services will, however, be considered if the benefit category and limitations applicable in the RSA can be determined. The benefit will be paid according to the POLMED rate. However, it remains the responsibility of the member to acquire insurance cover when travelling outside the borders of the RSA.
GENERAL RULES

APPLICATION OF CLINICAL PROTOCOLS AND FUNDING GUIDELINES

POLMED applies clinical protocols, including ‘best practice guidelines’ as well as evidence-based medicine (EBM) principles in its funding decisions.

DENTAL PROCEDURES

All dental procedures performed in hospital require pre-authorisation. The dentist’s costs for procedures that are normally done in a doctor’s rooms, when performed in hospital, shall be reimbursed from the out-of-hospital (OOH) benefit, subject to the availability of funds. The hospital and anaesthetist’s costs, if the procedure is pre-authorised, will be reimbursed from the in-hospital benefit.

DESIGNATED SERVICE PROVIDER: OUT-OF-NETWORK RULE

POLMED has appointed healthcare providers (or a group of providers) as designated service providers (DSPs) for diagnosis, treatment and care in respect of one or more prescribed minimum benefit (PMB) conditions. The Scheme has appointed a DSP and the member voluntarily chooses to use an out-of-network provider, all costs higher than the Scheme rate will be for the cost of the member and must be paid directly to the provider by the member.

Members can access the list of providers at www.polmed.co.za, on their cellphones via the mobile site, via POLMED Chat or request it via the Client Service Call Centre.

EMERGENCY MEDICAL SERVICES (EMS): NETCARE 911

72-hour post-authorisation rule
Subject to authorisation within 72 hours of the event, all service providers will need to get an authorisation number from POLMED’s DSP.

Co-payment of 40% of the claim shall apply where a member voluntarily uses an unauthorised service provider (non-DSP). Service providers will be required to provide the hospital admission/casualty sticker together with patient report forms when submitting a claim to POLMED’s EMS DSP to validate delivery to a hospital.

EX GRATIA BENEFIT

The Scheme may, at the discretion of the Board of Trustees, grant an Ex Gratia payment upon written application from members as per the rules of the Scheme.

MEDICATION: ACUTE, OVER THE COUNTER (OTC) AND CHRONIC

The chronic medication benefit shall be subject to registration on the Chronic Medicine Management Programme for those conditions which are managed, and chronic medication rules will apply.

Payment will be restricted to one month’s supply in all cases for acute and chronic medication, except where the member submits proof that more than one month’s supply is necessary, e.g. due to travel arrangements to foreign countries. (Travel documents must be submitted as proof)

Pre-authorisation is required for items funded from the chronic medication benefit. Pre-authorisation is based on evidence-based medicine (EBM) principles and the funding guidelines of the Scheme. Once predefined criteria are met, an authorisation will be granted for the diagnosed conditions.

Beneficiaries will have access to a group (formulary) of medication appropriate for the management of their conditions or diseases for which they are registered. There is no need for a beneficiary to apply for a new authorisation if the treatment prescribed by the doctor changes and the medication is included in the condition-specific medication formulary. Updates to the authorisation will be required for newly diagnosed conditions for the beneficiary.

The beneficiary needs to reapply for an authorisation at least one month prior to the expiry of an existing chronic medication authorisation, failing which any claims received will not be paid from the chronic medication benefit, but from the acute medication benefit, if benefits exist. This only applies to authorisations that are not ongoing and have an expiry date.

Payment in respect of over-the-counter (OTC), acute and chronic medication, will be subject to the medication included in the POLMED formulary. Medication is included in the POLMED formulary based on its proven clinical efficacy, as well as its cost effectiveness. Generic reference pricing is applicable where generic equivalent medication is available. The products that are not included in the POLMED formulary will attract a 20% co-payment.

The 20% co-payment for medication prescribed that is not included in the POLMED formulary can be waived via an exception management process. This process requires a motivation from the treating service provider and will be reviewed based on the exceptional needs and clinical merits of each individual case.

The Scheme shall only consider claims for medication prescribed by a person legally entitled to prescribe medication and which is dispensed by such a person or a registered pharmacist.

Flu vaccines and vaccines for children under six years of age are obtainable without prescription and paid from the preventative care benefits.

POLMED GP NETWORK (DESIGNATED GP PROVIDER)

Members are allowed two visits to a general practitioner (GP) who is not part of the network per beneficiary per annum for emergency or out-of-town situations. Co-payments shall apply once the maximum out-of-network consultations are exceeded. PMB rule applies for qualifying emergency consultations.

POLMED HOSPITAL NETWORK (DESIGNATED HOSPITAL NETWORK)

The POLMED Hospital DSP includes hospitals with a national footprint. Members can access the list of hospitals linked to the network.
in the network at www.polmed.co.za, on their cellphones via the mobile site, via POLMED Chat or request it via the Client Service Call Centre.

All admissions (hospitals and day clinics) must be pre-authorised. A penalty of R5 000 may be imposed if no pre-authorisation is obtained.

In the case of an emergency, the Scheme must be notified within 48 hours or on the first working day after admission.

Pre-authorisation will be managed under the auspices of managed healthcare. The appropriate facility must be used to perform a procedure, based on the clinical requirements, as well as the expertise of the doctor doing the procedure. Benefits for private or semi-private rooms are excluded unless they are motivated and approved prior to admission upon the basis of clinical need.

Medication prescribed during hospitalisation forms part of the hospital benefits. Medication prescribed during hospitalisation to take out (TTO) will be paid to a maximum of seven days’ supply or a rand value equivalent to it per beneficiary per admission, except for anticoagulants post-surgery and oncology medication, which will be subject to the relevant managed healthcare programme.

MATERNITY: The costs incurred in respect of a newborn baby shall be regarded as part of the mother’s cost for the first 90 days after birth. If the child is registered on the Scheme within 90 days from birth, Scheme rule 7.1.2 shall apply. Benefits shall also be granted if the child is stillborn.

POLMED PHARMACY NETWORK

POLMED has established an open pharmacy network for the provision of acute, chronic and over-the-counter (OTC) medication. Medication included in POLMED’s formulary will be funded in full, subject to the availability of funds. Members who voluntarily opt to use non-formulary products will be liable for a 20% co-payment. POLMED has agreed dispensing fees with the network pharmacies. A 20% co-payment will be levied in the event of voluntary utilisation of an out-of-network pharmacy. Members can access the list of providers at www.polmed.co.za, on their cellphones via the mobile site, via POLMED Chat or request it via the Client Service Call Centre.

PRO RATA BENEFITS

The maximum annual benefits referred to in this schedule shall be calculated from 1 January to 31 December each year, based on the services rendered during that year and shall be subject to pro rata apportionment calculated from the member’s date of admission to the Scheme to the end of that budget year.

SPECIALISED RADIOLOGY (MRI AND CT SCANS)

Pre-authorisation is required for all scans, failing which the Scheme may impose a co-payment of up to R1 000 per procedure. In the case of an emergency the Scheme must be notified within 48 hours or on the first working day of the treatment of the patient.

SPECIALIST REFERRAL

All POLMED beneficiaries need to be referred to specialists by a GP. The Scheme will impose a co-payment of up to R1 000 if the member consults a specialist without being referred. The co-payment will be payable by the member to the specialist and is not refundable by the Scheme.

This co-payment is not applicable to the following specialties or disciplines: Gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists (chronic dialysis), dental specialists, pathology, radiology and supplementary or allied health services.

The Scheme will allow two specialist visits per beneficiary per year without the requirement of a GP referral to cater for those who clinically require annual and/or bi-annual specialist visits.

However, the Scheme will not cover the cost of the hearing aid if there is no referral from one of the following providers: GP, ear, nose and throat (ENT) specialist, paediatrician, physician or neurologist. The specialist must submit the referring GP’s practice number in the claim.
DEFINITION OF TERMS

BASIC DENTISTRY
Basic dentistry refers to procedures that are used mainly for the detection, prevention and treatment of oral diseases of the teeth and gums. These include the alleviation of pain and sepsis, the repair of tooth structures by direct restorations or fillings and the replacement of missing teeth by plastic dentures.

Other procedures that fall under this category are:
- cleaning of teeth, including non-surgical management of gum disease
- consultations
- fluoride treatment and fissure sealants
- non-surgical removal of teeth
- root canal treatment.

MEDICINE GENERIC REFERENCE PRICE
This is the reference pricing system applied by the Scheme based on generic reference pricing or the inclusion of a product in the medication ‘formulary’. This pricing system refers to the maximum price that POLMED will pay for a generic medication. Should a reference price be set for a generic medication, patients are entitled to make use of any generically equivalent medication within this pricing limit but will be required to make a co-payment on medication priced above the generic reference pricing limit. The fundamental principle of any reference pricing system is that it does not restrict a member’s choice of medication, but instead limits the amount that will be paid for it.

REGISTRATION FOR CHRONIC MEDICATION
POLMED provides for a specific list of chronic conditions that are funded from the chronic medication benefit (i.e. through a benefit that is separate from the acute medication benefit).

POLMED requires members to apply for authorisation via the Chronic Medicine Management Programme to access this chronic medication benefit. Members will receive communication via email, SMS or post indicating whether their application was successful or not. If successful, the beneficiary will be issued with a disease-specific authorisation, which will allow them access to medication included in the POLMED formulary.

POLMED will reimburse medication intended for an approved chronic condition for up to four months from the acute medication benefit. Members will be required to register such medication as chronic during the four-month period.

REGISTRATION TO DISEASE RISK MANAGEMENT PROGRAMME
Members will be identified and contacted to register to the Disease Risk Management Programme. The Disease Risk Management Programme aims to ensure that members receive health information, guidance and management of their conditions, at the same time improving compliance to treatment prescribed by the medical practitioner. Members who are registered on the Programme receive a treatment plan (Care Plan) which lists authorised medical services, such as consultations, blood tests and radiological tests related to the management of their conditions.

SPECIALISED DENTISTRY
Specialised dentistry refers to services that are not defined as basic dentistry. These include periodontal surgery, crowns and bridges, implant procedures, inlays, indirect veneers, orthodontic treatment and maxillofacial surgery. All specialised dentistry services and procedures must be pre-authorised, failing which the Scheme will impose a co-payment of R500.

DISCLAIMER
In the event of a dispute, the registered rules of POLMED will apply.
## GENERAL BENEFIT RULES

### Benefit design

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit design</td>
<td>This option provides for unlimited hospitalisation paid at the prescribed tariff, as well as for out-of-hospital (day-to-day) benefits. This option is intended to provide for the needs of families who have significant healthcare needs.</td>
</tr>
</tbody>
</table>

### Limits are per annum

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits are per annum</td>
<td>Unless there is a specific indication to the contrary, all benefit amounts and limits are annual.</td>
</tr>
</tbody>
</table>

### Pre-authorisation, referrals, protocols and management by programmes

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-authorisation, referrals, protocols and management by programmes</td>
<td>Where the benefit is subject to pre-authorisation, referral by a designated service provider (DSP) or general practitioner (GP), adherence to established protocols or registration to a managed care programme, members’ attention is drawn to the fact that there may be no benefit at all or a much-reduced benefit if the pre-authorisation, referral by a DSP or GP, adherence to established protocols or registration to a management care programme is not complied with (a co-payment may be applied). The pre-authorisation, referral by a DSP or GP, adherence to established protocols or registration to a managed care programme is stipulated to best care for the member and his/her family and to protect the funds of the Scheme.</td>
</tr>
</tbody>
</table>

### Statutory prescribed minimum benefits (PMBs)

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory prescribed minimum benefits (PMBs)</td>
<td>There is no overall annual limit for PMBs or life-threatening emergencies.</td>
</tr>
</tbody>
</table>

### Tariff

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tariff</td>
<td>100% of POLMED rate or Agreed tariff or At cost for involuntary access to PMBs</td>
</tr>
<tr>
<td>DESCRIPTION</td>
<td>BENEFIT</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Anaesthetists</td>
<td>150% of POLMED rate</td>
</tr>
<tr>
<td>Annual overall in-hospital limit</td>
<td>Subject to the Scheme’s relevant managed healthcare programmes and includes the application of treatment protocols, case management and pre-authorisation</td>
</tr>
<tr>
<td></td>
<td>A R5 000 penalty may be imposed if no pre-authorisation is obtained</td>
</tr>
<tr>
<td></td>
<td>R8 000 co-payment for admission to a non-DSP hospital</td>
</tr>
<tr>
<td>Chronic kidney dialysis</td>
<td>Preferred providers: National Renal Care (NRC) Fresenius Medical Care</td>
</tr>
<tr>
<td></td>
<td>100% of agreed tariff at DSP</td>
</tr>
<tr>
<td>Dentistry (conservative and restorative)</td>
<td>100% of POLMED rate</td>
</tr>
<tr>
<td></td>
<td>Dentist’s costs for basic dental procedures will be reimbursed from the out-of-hospital (OOH) benefit</td>
</tr>
<tr>
<td></td>
<td>The hospital and anaesthetist’s costs will be reimbursed from the in-hospital benefit</td>
</tr>
<tr>
<td>Emergency medical services (ambulance services)</td>
<td>Subject to POLMED Scheme rules</td>
</tr>
<tr>
<td><strong>DESCRIPTION</strong></td>
<td><strong>BENEFIT</strong></td>
</tr>
<tr>
<td>General practitioners (GPs)</td>
<td>100% of agreed tariff at DSP</td>
</tr>
<tr>
<td></td>
<td>100% of POLMED rate at non-DSP or At cost for involuntary access to PMBs</td>
</tr>
<tr>
<td>Medication (non-PMB specialist drug limit, e.g. biologics)</td>
<td>100% of POLMED rate</td>
</tr>
<tr>
<td></td>
<td>Pre-authorisation required</td>
</tr>
<tr>
<td></td>
<td>Specialised medication sub-limit of R177 402 per family</td>
</tr>
<tr>
<td>Mental health</td>
<td>100% of POLMED rate or At cost for PMBs</td>
</tr>
<tr>
<td></td>
<td>Annual limit of 21 days per beneficiary</td>
</tr>
<tr>
<td></td>
<td>Limited to a maximum of three days’ hospitalisation for beneficiaries admitted by a GP or a specialist physician</td>
</tr>
<tr>
<td></td>
<td>Additional hospitalisation to be motivated by the medical practitioner</td>
</tr>
<tr>
<td>Oncology (chemotherapy and radiotherapy) Independent Clinical Oncology Network (ICON) is the DSP</td>
<td>100% of agreed tariff at DSP</td>
</tr>
<tr>
<td></td>
<td>Limited to R464 834 per beneficiary per annum; includes MRI/CT or PET scans related to oncology</td>
</tr>
<tr>
<td>Organ and tissue transplants</td>
<td>100% of agreed tariff at DSP</td>
</tr>
<tr>
<td></td>
<td>At cost for PMBs</td>
</tr>
<tr>
<td></td>
<td>Subject to clinical guidelines used in State facilities</td>
</tr>
<tr>
<td></td>
<td>Unlimited radiology and pathology for organ transplant and immunosuppressants</td>
</tr>
<tr>
<td>Pathology</td>
<td>Service will be linked to hospital pre-authorisation</td>
</tr>
</tbody>
</table>
### OVERALL OUT-OF-HOSPITAL BENEFITS

**Annual overall out-of-hospital (OOH) limit**

Benefits shall not exceed the amount set out in the table.

PMBs shall first accrue towards the total benefit, but are not subject to a limit.

In appropriate cases the limit for medical appliances shall not accrue towards this limit.

Out-of-hospital benefits are subject to:

- protocols and clinical guidelines
- PMBs
- the applicable tariff, i.e. 100% of POLMED rate or agreed tariff or at cost for involuntary access to PMBs

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0</td>
<td>R20 143</td>
</tr>
<tr>
<td>M1</td>
<td>R24 513</td>
</tr>
<tr>
<td>M2</td>
<td>R29 537</td>
</tr>
<tr>
<td>M3</td>
<td>R33 872</td>
</tr>
<tr>
<td>M4+</td>
<td>R36 757</td>
</tr>
</tbody>
</table>

### IN-HOSPITAL BENEFITS

**Physiotherapy**

Service will be linked to hospital pre-authorisation.

**Prostheses (internal and external)**

- 100% of POLMED rate
- At cost for PMBs

Subject to pre-authorisation and approved product list.

Limited to R65 320 per beneficiary.

**RefRACTive surgery**

- 100% of POLMED rate

Subject to pre-authorisation.

Procedure is performed out of hospital and in day clinics.

**Specialists**

- 100% of agreed tariff at DSP
- 100% of POLMED rate at non-DSP

At cost for involuntary access to PMBs.

### Dentistry (conservative and restorative)

100% of POLMED rate

Subject to the OOH limit and includes dentist’s costs for in-hospital, non-PMB procedures.

Routine consultation, scale and polish are limited to two annual check-ups per beneficiary.

Oral hygiene instructions are limited to once in 12 months per beneficiary.

100% of POLMED rate

Subject to referral by either of the following doctors/specialists:

- Ear, nose and throat (ENT) specialist
- General practitioner (GP)
- Neurologist
- Paediatrician
- Physician

100% of POLMED rate

Subject to the OOH limit.

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology</td>
<td>100% of POLMED rate</td>
</tr>
<tr>
<td>Dentistry</td>
<td>100% of POLMED rate</td>
</tr>
</tbody>
</table>

Subject to the OOH limit and includes dentist’s costs for in-hospital, non-PMB procedures.

Routine consultation, scale and polish are limited to two annual check-ups per beneficiary.

Oral hygiene instructions are limited to once in 12 months per beneficiary.
<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioners (GPs) POLMED has a GP Network</td>
<td>100% of agreed tariff at DSP or At cost for involuntary access to PMBs The limit for consultations shall accrue towards the OOH limit Subject to maximum number of visits or consultations per family M0 – 11 M1 – 16 M2 – 20 M3 – 24 M4+ – 29</td>
</tr>
<tr>
<td>Medication (acute)</td>
<td>100% of POLMED rate at DSP M0 – R4 598 M1 – R7 816 M2 – R11 035 M3 – R14 253 M4+ – R17 494 Subject to the OOH limit Subject to the POLMED formulary</td>
</tr>
<tr>
<td>Medication (over the counter [OTC])</td>
<td>100% of POLMED rate at DSP Annual limit of R1 152 per family Subject to the OOH limit Shared limit with acute medication Subject to the POLMED formulary</td>
</tr>
<tr>
<td>Occupational and speech therapy</td>
<td>100% of POLMED rate Annual limit of R2 795 per family Subject to the OOH limit</td>
</tr>
<tr>
<td>Pathology</td>
<td>M0 – R3 361 M1 – R4 846 M2 – R5 796 M3 – R7 138 M4+ – R8 753 The defined limit per family will apply for any pathology service done out of hospital</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>100% of POLMED rate Annual limit of R4 846 per family Subject to the OOH limit</td>
</tr>
<tr>
<td>Social worker</td>
<td>100% of POLMED rate Annual limit of R4 957 per family Subject to the OOH limit</td>
</tr>
<tr>
<td>Specialists Referral is not necessary for the following specialists: - Dental specialists - Gynaecologists - Nephrologists (dialysis) - Oncologists - Ophthalmologists - Psychiatrists - Supplementary or allied health services</td>
<td>100% of agreed tariff at DSP or At cost for involuntary access to PMBs The limit for consultations shall accrue towards the OOH limit Limited to 5/five visits per beneficiary or 1/eleven visits per family per annum Subject to referral by a GP (2/two specialist visits per beneficiary without GP referral allowed) R1 000 co-payment if no referral is obtained</td>
</tr>
</tbody>
</table>
### STAND-ALONE BENEFITS

**Allied health services and alternative healthcare providers**
- Biokineticists
- Chiropodists
- Chiropractors
- Homeopaths
- Naturopaths
- Orthoptists
- Osteopaths
- Podiatrists
- Reflexologists
- Therapeutic massage therapists

Benefits will be paid for clinically appropriate services

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of POLMED rate</td>
<td></td>
</tr>
<tr>
<td>Annual limit of R2 733 per family</td>
<td></td>
</tr>
</tbody>
</table>

**Appliances (medical and surgical)**
- Members must be referred for audiology services for hearing aids to be reimbursed
- Pre-authorisation is required for the listed medical appliances
- All costs for maintenance are a Scheme exclusion
- Funding will be based on applicable clinical and funding protocols
- Quotations will be required

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult nappies</td>
<td>R946/month (2/two nappies per day)</td>
</tr>
<tr>
<td></td>
<td>R1 419/month (3/three nappies per day)</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Cochlear implant</td>
<td></td>
</tr>
<tr>
<td>Consumables associated implanted devices:</td>
<td>Every 5/five years</td>
</tr>
<tr>
<td>• Cardiac resynchronisation therapy pacemaker battery replacement</td>
<td></td>
</tr>
<tr>
<td>• Implantable cardiac defibrillator battery replacement</td>
<td></td>
</tr>
<tr>
<td>CPAP machine</td>
<td>R9 442 per family</td>
</tr>
<tr>
<td></td>
<td>Once every 4/four years</td>
</tr>
</tbody>
</table>

### Staff Benefits

**Appliances (medical and surgical) (continued)**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucometer</td>
<td>R1 342 per family</td>
</tr>
<tr>
<td></td>
<td>Once every 4/four years</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>R14 144 per hearing aid or R28 111 per beneficiary per set</td>
</tr>
<tr>
<td></td>
<td>Once every 3/three years</td>
</tr>
<tr>
<td>Implantable cardiac defibrillator</td>
<td></td>
</tr>
<tr>
<td>Insulin delivery devices</td>
<td></td>
</tr>
<tr>
<td>Urine catheters and consumables</td>
<td></td>
</tr>
<tr>
<td>Medical assistive devices</td>
<td>Annual limit of R3 361 per family</td>
</tr>
<tr>
<td></td>
<td>Includes medical devices in/out of hospital</td>
</tr>
<tr>
<td>Nebuliser</td>
<td>R1 342 per family</td>
</tr>
<tr>
<td></td>
<td>Once every 4/four years</td>
</tr>
<tr>
<td>Transcatheter aortic valve insertion (TAVI)</td>
<td></td>
</tr>
<tr>
<td>Wheelchair (motorised)</td>
<td>R52 814 per beneficiary</td>
</tr>
<tr>
<td></td>
<td>Once every 3/three years</td>
</tr>
<tr>
<td>Wheelchair (non-motorised)</td>
<td>R15 712 per beneficiary</td>
</tr>
<tr>
<td></td>
<td>Once every 3/three years</td>
</tr>
</tbody>
</table>
## STAND-ALONE BENEFITS

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chronic medication</strong>&lt;br&gt;refers to non-PMB conditions&lt;br&gt;Subject to prior application and/or registration of the condition&lt;br&gt;Approved PMB CDL conditions are not subject to a limit&lt;br&gt;The extended list of chronic conditions (non-PMBs) are subject to a limit</td>
<td>100% of medication formulary reference price&lt;br&gt;Subject to access at DSP&lt;br&gt;Approved PMB CDL conditions are not subject to a limit&lt;br&gt;The extended list of chronic conditions (non-PMBs) are subject to a limit</td>
</tr>
<tr>
<td><strong>Dentistry (specialised)</strong>&lt;br&gt;Pre-authorisation required</td>
<td>100% of POLMED rate&lt;br&gt;or&lt;br&gt;At cost for PMBs&lt;br&gt;An annual limit of R14 205 per family&lt;br&gt;Benefits shall not exceed the set out limit&lt;br&gt;Includes any specialised dental procedures done in/out of hospital&lt;br&gt;Includes metal-based dentures&lt;br&gt;Excludes osseointegrated implants&lt;br&gt;Subject to dental protocols</td>
</tr>
<tr>
<td><strong>Maternity benefits (including home birth)</strong>&lt;br&gt;Pre-authorisation required&lt;br&gt;Treatment protocols apply</td>
<td>The limit for consultations shall not accrue towards the OOH limit&lt;br&gt;The benefit shall include three specialist consultations per beneficiary per pregnancy&lt;br&gt;Home birth is limited to R16 828 per beneficiary per annum&lt;br&gt;Annual limit of R4 727 for ultrasound scans per beneficiary; limited to 2/two 2D scans per pregnancy&lt;br&gt;Benefits relating to more than 2/two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation</td>
</tr>
</tbody>
</table>

## MAXILLOFACIAL

- Pre-authorisation required
- Shared limit with specialised dentistry
- Excludes osseointegrated implants

## OPTICAL

- Includes frames, lenses and eye examinations
- The eye examination is per beneficiary every two years (unless prior approval for clinical indication has been obtained)
- Benefits are not pro rata, but calculated from the benefit service date
- Each claim for lenses or frames must be submitted with the lens prescription
- Benefits shall not be granted for contact lenses if the beneficiary has already received a pair of spectacles in a two-year benefit cycle
- Contact lens re-examination can be claimed for in six-monthly intervals

## PROVIDER NETWORK

- 100% of cost for a composite consultation, inclusive of the refraction, a glaucoma screening and visual field screening, Authenticate IT and biometric readings
- **WITH EITHER SPECTACLES**
  - R1 300 towards a frame and/or lens enhancements
- **LENSES**
  - Either one pair of clear single-vision lenses or one pair of clear flat-top bifocal lenses or one pair of clear base multifocal lenses
- **OR CONTACT LENSES**
  - Contact lenses to the value of R1 596 annually
  - Contact lens re-examination to a maximum cost of R233 per consultation

## NON-PROVIDER NETWORK

- One consultation limited to a maximum cost of R300
- **WITH EITHER SPECTACLES**
  - R910 towards a frame and/or lens enhancements
  - Single-vision lenses limited to R175 per lens or
  - Bifocal lenses limited to R410 per lens or
  - Multifocal lenses limited to R710 per lens
- **OR CONTACT LENSES**
  - Contact lenses to the value of R1 000 annually
  - Contact lens re-examination to a maximum cost of R233 per consultation
## Co-payments

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology (basic) i.e. black and white X-rays and soft tissue ultrasounds</td>
<td>100% of agreed tariff or At cost for PMBs Limited to R6 532 per family Includes any basic radiology done in or out of hospital Claims for PMBs first accrue towards the limit</td>
</tr>
<tr>
<td>Radiology (specialised) Pre-authorisation required</td>
<td>100% of agreed tariff or At cost for PMBs Includes any specialised radiology service done in or out of hospital Claims for PMBs first accrue towards the limit Subject to a limit of 2/two scans per family per annum, except for PMBs</td>
</tr>
<tr>
<td>2/two MRI scans</td>
<td></td>
</tr>
<tr>
<td>3/three CT scans</td>
<td></td>
</tr>
</tbody>
</table>

## Annexure A2

### Co-Payments

<table>
<thead>
<tr>
<th>Out of Network</th>
<th>Co-Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner (GP)</td>
<td>Allows for 2/two out-of-network consultations per beneficiary Co-payments shall apply once maximum out-of-network consultations are exceeded</td>
</tr>
<tr>
<td>Hospital</td>
<td>R8 000</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>20% of costs for using a non-designated service provider (non-DSP) pharmacy 20% co-payment for voluntarily using a non-formulary product</td>
</tr>
</tbody>
</table>
ANNEXURE A4

MARINE: CHRONIC CONDITIONS

Prescribed minimum benefits (PMBs), including chronic Diagnosis and Treatment Pairs (DTPs)

Chronic medication is payable from chronic medication benefits. Once the benefit limit has been reached, it will be funded from the unlimited PMB pool.

Autoimmune disorder
- Systemic lupus erythematosus (SLE)

Cardiovascular conditions
- Cardiac dysrhythmias
- Cardiomyopathy
- Coronary artery disease
- Heart failure
- Hypertension
- Peripheral arterial disease
- Thromboembolic disease
- Valvular disease

Endocrine conditions
- Addison’s disease
- Cushing’s disease
- Diabetes insipidus
- Diabetes mellitus type I
- Diabetes mellitus type II
- Hyperprolactinaemia
- Hypo- and hyperthyroidism
- Polycystic ovaries
- Primary hypogonadism

Gastrointestinal conditions
- Crohn’s disease
- Peptic ulcer disease (requires special motivation)
- Ulcerative colitis

Gynaecological conditions
- Endometriosis
- Menopausal treatment

Haematological conditions
- Anaemia
- Haemophilia
- Idiopathic thrombocytopenic purpura
- Megaloblastic anaemia

Metabolic condition
- Hyperlipidaemia

Musculoskeletal condition
- Rheumatic arthritis

Neurological conditions
- Cerebrovascular incident
- Epilepsy
- Multiple sclerosis
- Parkinson’s disease
- Permanent spinal cord injuries

Ophthalmic condition
- Glaucoma

Psychiatric conditions
- Affective disorders (depression and bipolar mood disorder)
- Post-traumatic stress disorder (PTSD)
- Schizophrenic disorders

Pulmonary diseases
- Asthma
- Bronchiectasis
- Chronic obstructive pulmonary disease (COPD)
- Cystic fibrosis

Special category conditions
- HIV/AIDS
- Organ transplantation
- Tuberculosis

Treatable cancers
- As per PMB guidelines

Urological conditions
- Benign prostatic hypertrophy
- Chronic renal failure
- Nephrotic syndrome and glomerulonephritis
- Renal calculi

Extended chronic disease list: Non-PMB

Chronic medication for the conditions listed below is payable from the chronic medication benefit. Benefits subject to the availability of funds.

Dermatological conditions
- Acne (clinical photos required)
- Eczema
- Onychomycosis (mycology report required)
- Psoriasis

Ear, nose and throat condition
- Allergic rhinitis

Gastrointestinal condition
- Gastro-oesophageal reflux disease (GORD) (special motivation required)
- Gout prophylaxis

Metabolic condition
- Ankylosing spondylitis
- Osteoarthritis
- Osteoporosis
- Paget’s disease
- Psoriatic arthritis

Neurological conditions
- Alzheimer’s disease
- Migraine prophylaxis
- Narcolepsy
- Tourette’s syndrome
- Trigeminal neuralgia

Ophthalmic condition
- Dry eye or keratoconjunctivitis sicca

Psychiatric condition
- Attention deficit hyperactivity disorder (ADHD)

Urological condition
- Overactive bladder syndrome
## ANNEXURE C

### ACUTE MEDICATION EXCLUSIONS

The following categories of medication to be excluded from acute medication benefits:

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.03</td>
<td>Gender/sex related: Treatment of female infertility</td>
<td>Clomid®, Profasi®, Cyclogest®</td>
</tr>
<tr>
<td>1.05</td>
<td>Gender/sex related: Androgens and anabolic steroids</td>
<td>Sustanon®</td>
</tr>
<tr>
<td>2.00</td>
<td>Slimming preparations</td>
<td>Thinz®, Obex LA®</td>
</tr>
<tr>
<td>4.01</td>
<td>Patent medication: Household remedies</td>
<td>Lennons</td>
</tr>
<tr>
<td>4.02</td>
<td>Patent medication: Patent and products with no robust scientific evidence to support cost-effectiveness</td>
<td>Choats</td>
</tr>
<tr>
<td>4.03</td>
<td>Patent medication: Emollients</td>
<td>Aqueous cream</td>
</tr>
<tr>
<td>4.04</td>
<td>Patent medication: Food/nutrition</td>
<td>Infasoy, Ensure</td>
</tr>
<tr>
<td>4.05</td>
<td>Patent medication: Soaps and cleansers</td>
<td>Brasivolt®, Phisoac®</td>
</tr>
<tr>
<td>4.06</td>
<td>Patent medication: Cosmetics</td>
<td>Classique</td>
</tr>
<tr>
<td>4.07</td>
<td>Patent medication: Contact lens preparations</td>
<td>Bausch + Lomb®</td>
</tr>
<tr>
<td>4.08</td>
<td>Patent medication: Patent sunscreens</td>
<td>Piz Buin</td>
</tr>
<tr>
<td>4.10</td>
<td>Patent medication: Medicated shampoo</td>
<td>Denorex®, Niz shampoo</td>
</tr>
<tr>
<td>4.11</td>
<td>Patent medication: Veterinary products</td>
<td></td>
</tr>
<tr>
<td>5.04</td>
<td>Appliances, supplies and devices: Medical appliances or devices</td>
<td>Thermometers, hearing aid batteries</td>
</tr>
<tr>
<td>5.06</td>
<td>Appliances, supplies and devices: Bandages and dressings</td>
<td>Cotton wool, gauze</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>DESCRIPTION</td>
<td>EXAMPLE</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>---------</td>
</tr>
<tr>
<td>5.07</td>
<td>Appliances, supplies and devices: Disposable cholesterol supplies</td>
<td>Nappies, molipants, linen savers, except Stoma-related supplies</td>
</tr>
<tr>
<td>5.11</td>
<td>Appliances, supplies and devices: Incontinence products</td>
<td>Xigris®, Zyvoxid® Herceptin, Gleevac®</td>
</tr>
<tr>
<td>6.00</td>
<td>Diagnostic agents</td>
<td>Clear View pregnancy tests</td>
</tr>
<tr>
<td>8.05</td>
<td>Vaccines or immunoglobulins: Other immunoglobulins</td>
<td>Beriglobin®</td>
</tr>
<tr>
<td>9.02</td>
<td>Vitamin and/or mineral supplements: Multivitamins or minerals</td>
<td>Pharmaton SA®</td>
</tr>
<tr>
<td>9.03</td>
<td>Vitamin and/or mineral supplements: Geriatric vitamins and/or minerals</td>
<td>Gericomplex®</td>
</tr>
<tr>
<td>9.05</td>
<td>Vitamin and/or mineral supplements: Tonics and stimulants</td>
<td>Bioplus®</td>
</tr>
<tr>
<td>9.08</td>
<td>Vitamin and/or mineral supplements: Magnesium diet supplementation</td>
<td>Magnesit®</td>
</tr>
<tr>
<td>9.10</td>
<td>Vitamin and/or mineral supplements: Unregistered vitamins, mineral or food supplements</td>
<td>Sportron</td>
</tr>
<tr>
<td>10.01</td>
<td>Naturo- and homeopathic remedies/ supplements: Homeopathic remedies</td>
<td>Weleda Natura</td>
</tr>
<tr>
<td>10.02</td>
<td>Naturo- and homeopathic remedies/ supplements: Natural oils</td>
<td>Primrose oils, fish liver oil</td>
</tr>
<tr>
<td>12.00</td>
<td>Veterinary products</td>
<td></td>
</tr>
<tr>
<td>13.00</td>
<td>Growth hormones</td>
<td>Genotropin®</td>
</tr>
</tbody>
</table>

Other items and categories that can be excluded according to evidence-based medicine principles as approved by the Scheme from time to time.

The following categories are not available on acute medication benefits:

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.06</td>
<td>Gender/sex related: Treatment of impotence/sexual dysfunction</td>
<td>Viagra®, Cialis®, Caverject®</td>
</tr>
<tr>
<td>5.03</td>
<td>Appliances, supplies and devices: Stoma products and accessories, except where it forms part of PMB-related services</td>
<td>Stoma bags, adhesive paste, pouches and accessories</td>
</tr>
<tr>
<td>5.08</td>
<td>Appliances, supplies and devices: Medicated dressings, except where these form part of PMB-related services</td>
<td>Opsite®, Intrasite®, Tielle®, Granugel®</td>
</tr>
<tr>
<td>5.10</td>
<td>Appliances, supplies and devices: Surgical appliances/products for home nursing</td>
<td>Catheters, urine bags, butterflies, drip sets, alcohol swabs</td>
</tr>
<tr>
<td>7.01</td>
<td>Treatment/prevention of substance abuse: Opioid</td>
<td>Revia®</td>
</tr>
<tr>
<td>7.03</td>
<td>Treatment/prevention of substance abuse: Alcohol, except PMBs</td>
<td>Antabuse®, Sobriall®, Esperal implants</td>
</tr>
<tr>
<td>22.00</td>
<td>Immunosuppressives: Except PMBs</td>
<td>Azapress®, Sandimun</td>
</tr>
<tr>
<td>23.01</td>
<td>Blood products: Erythropoietin, except PMBs</td>
<td>Eprex®, Repotin®</td>
</tr>
<tr>
<td>23.02</td>
<td>Blood products: Haemostatics, except PMBs</td>
<td>Konakion®, Factor VIII</td>
</tr>
<tr>
<td>25.01</td>
<td>Oxygen: Masks, regulators and oxygen</td>
<td>Oxygen, masks</td>
</tr>
</tbody>
</table>
GENERAL EXCLUSIONS

The following services/items are excluded from benefits with due regard to prescribed minimum benefits (PMBs) and will not be paid by the Scheme:

1. Accommodation in an old-age home or other institution that provides general care for the aged and/or chronically ill patients, unless approved by the Scheme

2. Accommodation in spas, health or rest resorts

3. Accounts of providers not registered with a recognised professional body constituted in terms of an Act of Parliament

4. Aids for participation in sport, e.g. mouthguards

5. Any health benefit not included in the list of prescribed benefits (including newly developed interventions or technologies where the long-term safety and cost to benefit cannot be supported) shall be deemed to be excluded from the benefits

6. Any orthopaedic and medical aids that are not clinically essential, subject to PMBs

7. Any treatment as a result of surrogate pregnancy

8. Beneficiaries’ travelling costs, except services according to the benefits in Annexure A and B

9. Benefits for costs of repair, maintenance, parts or accessories for appliances or prostheses

10. Benefits for organ transplant donors to recipients who are not members of the Scheme

11. Blood pressure appliances: Provided that the Board may decide to grant benefits in exceptional circumstances

12. Charges for appointments that a member or dependant fails to keep with service providers

13. Claims relating to the following:
   - aptitude tests
   - IQ tests
   - school readiness
   - questionnaires
   - marriage counselling
   - learning problems
   - behavioural problems

14. Compensation for pain and suffering, loss of income, funeral expenses or claims for damages

15. Cosmetics and sunblock; sunblock may be considered for clinical reasons in albinism

16. Fixed orthodontics for beneficiaries above the age of 21 years

17. Gold inlays in dentures, soft and metal base to new dentures, invisible retainers, osseointegrated implants and bleaching of vital (living) teeth

18. Holidays for recuperative purposes

19. Muscular fatigue tests, except if requested by a specialist and a doctor’s motivation is enclosed

20. Non-clinically essential or non-emergency transport via an ambulance

21. Non-functional prostheses used for reconstructive or restorative surgery, excluding PMB diagnoses, provided that the Board may decide to grant the benefit in exceptional circumstances

22. Operations, treatments and procedures, by choice, for cosmetic purposes where no pathological substance exists which proves the necessity of the procedure, and/or which is not life-saving, life-sustaining or life-supporting

23. Prenatal and/or post-natal exercises

24. Reports, investigations or tests for insurance purposes, admission to universities or schools, fitness tests and examinations, medical court reports, employment, emigration or immigration, etc.

25. Reversal of sterilisation procedures, provided that the Board may decide to grant benefits in exceptional circumstances

26. Services not mentioned in the benefits as well as services which, in the opinion of the Scheme, are not aimed at the treatment of an actual or supposed illness or disablement which impairs or threatens essential body functions (the process of ageing will not be regarded as an illness or a disablement)

27. Sex change operations

28. Sleep therapy

29. The artificial insemination of a person in or outside the human body as defined in the Human Tissue Act, 1983 (Act 65 of 1983) provided that, in the case of artificial insemination, the Scheme’s responsibility on the treatment will be:
   - as it is prescribed in the public hospital
   - as defined in the prescribed minimum benefits (PMBs)
   - subject to pre-authorisation and prior approval by the Scheme

30. The treatment of obesity, provided that with prior motivation the Scheme may approve benefits for the treatment of morbid obesity

31. Unless otherwise decided by the Board, benefits in respect of medication obtained on a prescription is limited to one month’s supply for every such prescription or repeat thereof

32. Unless otherwise indicated by the Board, costs for services rendered by any institution not registered in terms of any law.
**PRESCRIBED MINIMUM BENEFITS (PMBs)**

The Scheme will pay in full, without co-payment or use of deductibles, the diagnosis, treatment and care costs of the PMBs as per Regulation 8 of the Act. Furthermore, where a protocol or a formulary drug preferred by the Scheme has been ineffective or would cause harm to a beneficiary, the Scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by Regulation 15H and 15I of the Act.

**ANNEXURE D**

**PROCEDURES PRE-AUTHORISED UNDER THE Auspices OF MANAGED HEALTHCARE**

The following elective procedures will be funded from the hospital benefits if done in the doctor’s rooms and/or day clinics and as a day procedure in an acute hospital. If these procedures are done in the doctor’s rooms, there is no need for pre-authorisation. Pre-authorisation is required when procedures are done in the day clinic or in hospital. A R1 000 co-payment will be levied when the length of stay for an Annexure D procedure is voluntarily extended beyond the agreed day rate period.

<table>
<thead>
<tr>
<th>PROCEDURE DESCRIPTION</th>
<th>PROCEDURE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenoidectomy</td>
<td>Cataract surgery</td>
</tr>
<tr>
<td>Anoscopies</td>
<td>Cauterisation of cervix/lazer ablation</td>
</tr>
<tr>
<td>Arthrocentesis</td>
<td>Circumcision</td>
</tr>
<tr>
<td>Arthrodesis of hand/elbow/foot</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td>Arthroscopy</td>
<td>Colposcopy</td>
</tr>
<tr>
<td>Arthrotomy of finger/hand/elbow/knee/toe/hip</td>
<td>Continuous nerve block infusion – sciatic nerve/femoral nerve/lumbar plexus</td>
</tr>
<tr>
<td>Ascites or pleural tapping</td>
<td>Cystoscopy for diagnosis/dilatation/stent/stone removal</td>
</tr>
<tr>
<td>Aspiration/injection</td>
<td>Debride nails six or more – any method</td>
</tr>
<tr>
<td>Aspiration/intra-articular injection of joints</td>
<td>Debride skin/subcutaneous tissue</td>
</tr>
<tr>
<td>Bartholin’s gland drainage/excision/marsupialisation</td>
<td>Diathermy to nose and pharynx under local anaesthesia</td>
</tr>
<tr>
<td>Biopsy of lymph node/muscle/skin/bone/breast/cervix</td>
<td>Dilatation and curettage (excluding aftercare)</td>
</tr>
<tr>
<td>Bleeding control (nasal)</td>
<td>Drainage of abscess skin/carbuncle/whitlow/cyst/haematoma/gland</td>
</tr>
<tr>
<td>Bronchial lavage</td>
<td></td>
</tr>
<tr>
<td>Cast application/removal</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROCEDURE DESCRIPTION</th>
<th>PROCEDURE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical colpotomy</td>
<td></td>
</tr>
<tr>
<td>Colposcopy for diagnosis/therapy/freeze</td>
<td></td>
</tr>
<tr>
<td>Colposcopy</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td></td>
</tr>
<tr>
<td>Colposcopy</td>
<td></td>
</tr>
<tr>
<td>Continuous nerve block infusion – sciatic nerve/femoral nerve/lumbar plexus</td>
<td>Cystoscopy for diagnosis/dilatation/stent/stone removal</td>
</tr>
<tr>
<td>Cystoscopy for diagnosis/dilatation/stent/stone removal</td>
<td>Debride nails six or more – any method</td>
</tr>
<tr>
<td>Debride nails six or more – any method</td>
<td>Debride skin/subcutaneous tissue</td>
</tr>
<tr>
<td>Debride skin/subcutaneous tissue</td>
<td>Diathermy to nose and pharynx under local anaesthesia</td>
</tr>
<tr>
<td>Debride skin/subcutaneous tissue</td>
<td>Dilatation and curettage (excluding aftercare)</td>
</tr>
<tr>
<td>Debride skin/subcutaneous tissue</td>
<td>Drainage of abscess skin/carbuncle/whitlow/cyst/haematoma/gland</td>
</tr>
<tr>
<td>Debride skin/subcutaneous tissue</td>
<td></td>
</tr>
<tr>
<td>Debride skin/subcutaneous tissue</td>
<td></td>
</tr>
</tbody>
</table>
Basic dentistry

- The Scheme must authorise dental procedures that require general anaesthesia.
- Procedures done under general anaesthesia are only permitted for children under the age of seven years or in the case of the surgical removal of impacted wisdom teeth.

Maxillofacial surgery

All procedures performed by a maxillofacial surgeon in hospital must be authorised.

Pre-authorisation for hospitalisation

All elective/scheduled hospital admissions must be pre-authorised and where indicated, a hospital network will apply.

- You may obtain a hospital authorisation number by phoning the Hospital Risk Management Programme Department.
- Payment to a hospital is subject to meeting the stipulated standards such as pre-authorisation, clinical necessity, appropriate treatment, benefit limits and prescribed minimum benefits (PMBs).
- If you are admitted to an intensive care unit (ICU) or high care (HC) ward, the hospital is required to motivate your continued accommodation in either of these facilities every 72 hours.
- You may be liable for a co-payment, except in the case of an emergency:
  - if your option stipulates that you use a hospital network
  - if you have not obtained pre-authorisation.
- In the case of an emergency the Scheme must be notified within 48 hours or first working day after treatment or admission.
- An authorisation does not guarantee payment.

Pre-authorisation for PMB CDL/chronic condition

- The Disease Risk Management (DRM) Care Plan Programme will grant each registered beneficiary a certain number of consultations and investigations according to clinical protocols.
- The beneficiary is notified about these benefits at the beginning of each calendar year or shortly after being diagnosed with the condition.
- No co-payment applies for the treatment of a PMB CDL and/or chronic condition if you use the medication within the medicine reference price or medication formulary.

Pre-authorisation of high-cost or non-effective procedures

High-cost and non-effective procedures are pre-authorised at the auspices of managed healthcare.

Pre-authorisation policies and procedures

Where applicable, pre-authorisation must be obtained for clinical services and will be subject to benefit limits. Managed healthcare may require a clinical motivation for certain services and is subject to clinical protocols.

Specialised dentistry

- All specialised dentistry services and procedures must be pre-authorised.
- If any of the procedures involve hospitalisation, the member must obtain a pre-authorisation number via the managed healthcare organisation.
- Where there is an alternative option of treatment, the Scheme might limit the benefit to the price of the open procedure.
ANNEXURE E
PREVENTATIVE HEALTHCARE BENEFITS 2019

These benefits allow for risk assessment tests to ensure the early detection of conditions that may be completely cured or successfully managed if treated early. All services as per the specified benefit to be covered from the in-hospital benefits and will not deplete your out-of-hospital benefits.

<table>
<thead>
<tr>
<th>MEASURE AND ICD-10 CODES</th>
<th>CARE, SCREENING, TEST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHILD HEALTH</strong></td>
<td></td>
</tr>
<tr>
<td>All child immunisation provided by the Department of Health (DOH) for children twelve (12) years old and younger</td>
<td>As per DOH age schedule as per the Road to Health chart</td>
</tr>
<tr>
<td><strong>DENTAL HEALTH</strong></td>
<td></td>
</tr>
<tr>
<td>Caries risk assessment for children aged 0-14 years (Clinical information to be submitted to managed care)</td>
<td>Once every second year</td>
</tr>
<tr>
<td>Consultation and topical fluoride application for children aged 0-6 years</td>
<td>Annually</td>
</tr>
<tr>
<td>Periodontal disease and caries risk assessment for adults 19 years of age and older (Clinical information to be submitted to managed care)</td>
<td>Once every second year</td>
</tr>
<tr>
<td>Topical fluoride application for children aged 7-18 years</td>
<td>Annually</td>
</tr>
<tr>
<td><strong>FEMALE HEALTH (women and adolescent girls)</strong></td>
<td></td>
</tr>
<tr>
<td>Breast cancer screening ICD: Z12.3 and ICD: Z01.6 Mammogram: all women aged 40-69 years old</td>
<td>Once every two years, unless motivated</td>
</tr>
<tr>
<td>Cervical cancer screening ICD: Z12.4 For all females aged 21-64 years old, except for those women who have had a complete hysterectomy with no residual cervix</td>
<td>Pap smear test once every third year</td>
</tr>
</tbody>
</table>
### Female Health (Women and Adolescent Girls)

<table>
<thead>
<tr>
<th>Measure and ICD-10 Codes</th>
<th>Care, Screening, Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human papilloma virus (HPV) screening</td>
<td>Once every five years for females aged 21 years and older</td>
</tr>
<tr>
<td>HPV vaccination for girls aged 10-17 years</td>
<td>Total of two HPV vaccinations are funded</td>
</tr>
<tr>
<td>Contraceptives ICD: Z30</td>
<td>As recommended by NDOH</td>
</tr>
</tbody>
</table>

#### Full Medical Examination

<table>
<thead>
<tr>
<th>Measure and ICD-10 Codes</th>
<th>Care, Screening, Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>One wellness measure per year (tariff code 5550) inclusive of:</td>
<td>Annually</td>
</tr>
<tr>
<td>- Blood pressure test</td>
<td>100% of POLMED rate or agreed tariff where applicable</td>
</tr>
<tr>
<td>- Body mass index (BMI) test</td>
<td>Early detection screening limited to periods specified</td>
</tr>
<tr>
<td>- Cholesterol screening (Z13.8)</td>
<td>Possible indication of peptic ulcers: Members over the age of 50 years</td>
</tr>
<tr>
<td>- Consultation</td>
<td>Funded from the risk pool; the benefit shall not accrue to the overall out-of-hospital limit</td>
</tr>
<tr>
<td>- Glucose screening (Z13.1)</td>
<td></td>
</tr>
<tr>
<td>- Healthy diet counselling (Z71.3)</td>
<td></td>
</tr>
<tr>
<td>- Lipid disorder screening for age &gt; 40 years</td>
<td></td>
</tr>
<tr>
<td>- Occult blood test (screening for peptic ulcer disease)</td>
<td></td>
</tr>
<tr>
<td>- Risk assessment tests:</td>
<td></td>
</tr>
<tr>
<td>- Baby immunisations (as per the DOH guidelines)</td>
<td></td>
</tr>
<tr>
<td>- Bone densitometry scan</td>
<td></td>
</tr>
<tr>
<td>- Circumcision</td>
<td></td>
</tr>
<tr>
<td>- Contraceptives (as per the DOH guidelines)</td>
<td></td>
</tr>
<tr>
<td>- Dental screening (codes 8101, 8151 and 8102)</td>
<td></td>
</tr>
<tr>
<td>- Flu vaccine</td>
<td></td>
</tr>
<tr>
<td>- Glaucoma screening</td>
<td></td>
</tr>
<tr>
<td>- HIV tests</td>
<td></td>
</tr>
<tr>
<td>- HPV screening once every five years for females aged 21 years and older</td>
<td></td>
</tr>
<tr>
<td>- HPV vaccination for girls aged 10-17 years</td>
<td></td>
</tr>
<tr>
<td>- Mammogram</td>
<td></td>
</tr>
<tr>
<td>- Pap smear</td>
<td></td>
</tr>
<tr>
<td>- Pneumococcal vaccine</td>
<td></td>
</tr>
<tr>
<td>- Prostate screening</td>
<td></td>
</tr>
<tr>
<td>- Psycho-social services</td>
<td></td>
</tr>
</tbody>
</table>

### HIV Counselling and Testing

<table>
<thead>
<tr>
<th>Measure and ICD-10 Codes</th>
<th>Care, Screening, Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCT consultation, rapid testing and post counselling</td>
<td>Annually</td>
</tr>
<tr>
<td>HIV counselling and pre-counselling</td>
<td>Annually</td>
</tr>
<tr>
<td>HIV testing</td>
<td></td>
</tr>
<tr>
<td>Elisa: 3932</td>
<td></td>
</tr>
<tr>
<td>Confirmation test: Western blot</td>
<td>(payable after HCT or ELISA tests)</td>
</tr>
</tbody>
</table>

#### Other

<table>
<thead>
<tr>
<th>Measure and ICD-10 Codes</th>
<th>Care, Screening, Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circumcision</td>
<td>Subject to clinical protocols</td>
</tr>
<tr>
<td>Flu vaccine</td>
<td>Annually</td>
</tr>
<tr>
<td>Glaucoma screening</td>
<td>Once every third year, unless motivated</td>
</tr>
<tr>
<td>Hib titer for 60 years and older</td>
<td>Annually</td>
</tr>
<tr>
<td>(Serology: IgM: specific antibody titer)</td>
<td></td>
</tr>
<tr>
<td>Post-trauma debriefing session</td>
<td>Four sessions per year</td>
</tr>
<tr>
<td>Only for active principal members of SAPS utilising the Psycho-Social Network</td>
<td></td>
</tr>
<tr>
<td>Prostate cancer screening</td>
<td>Annually</td>
</tr>
<tr>
<td>For all males aged between 50 and 75 years</td>
<td></td>
</tr>
</tbody>
</table>

### Disclaimer

POLMED has outlined the services that are covered under the ‘preventative care benefits’. Best clinical practice dictates that the doctor should follow the best clinical management as per guidelines even when they are not specified under these benefits.
ANNEXURE B3

AQUARIUM CONTRIBUTION SCHEDULE

The contributions for 2018 as set out in the format required by the Registrar in Circular 45 of 2017.

The monthly contributions are payable by or on behalf of the member per registered member.

ANNUAL MEMBER CONTRIBUTION INCREASES ARE EFFECTIVE 1 APRIL

CONTRIBUTION RATES AQUARIUM 2018 (1 APRIL 2018 – 31 MARCH 2019)

<table>
<thead>
<tr>
<th>INCOME CATEGORY</th>
<th>MEMBER</th>
<th>ADULT</th>
<th>CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>R0 – R6 279</td>
<td>70</td>
<td>70</td>
<td>31</td>
</tr>
<tr>
<td>R6 280 – R8 625</td>
<td>77</td>
<td>77</td>
<td>31</td>
</tr>
<tr>
<td>R8 626 – R10 538</td>
<td>102</td>
<td>102</td>
<td>40</td>
</tr>
<tr>
<td>R10 539 – R12 325</td>
<td>126</td>
<td>126</td>
<td>46</td>
</tr>
<tr>
<td>R12 326 – R14 343</td>
<td>149</td>
<td>149</td>
<td>54</td>
</tr>
<tr>
<td>R14 344 – R17 250</td>
<td>171</td>
<td>171</td>
<td>61</td>
</tr>
<tr>
<td>R17 251 – R21 172</td>
<td>213</td>
<td>213</td>
<td>70</td>
</tr>
<tr>
<td>R21 173 +</td>
<td>249</td>
<td>249</td>
<td>94</td>
</tr>
</tbody>
</table>

TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)

<table>
<thead>
<tr>
<th>INCOME CATEGORY</th>
<th>MEMBER</th>
<th>ADULT</th>
<th>CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>R0 – R6 279</td>
<td>978</td>
<td>978</td>
<td>486</td>
</tr>
<tr>
<td>R6 280 – R8 625</td>
<td>985</td>
<td>985</td>
<td>486</td>
</tr>
<tr>
<td>R8 626 – R10 538</td>
<td>1 010</td>
<td>1 010</td>
<td>494</td>
</tr>
<tr>
<td>R10 539 – R12 325</td>
<td>1 034</td>
<td>1 034</td>
<td>501</td>
</tr>
<tr>
<td>R12 326 – R14 343</td>
<td>1 057</td>
<td>1 057</td>
<td>508</td>
</tr>
<tr>
<td>R14 344 – R17 250</td>
<td>1 079</td>
<td>1 079</td>
<td>516</td>
</tr>
<tr>
<td>R17 251 – R21 172</td>
<td>1 121</td>
<td>1 121</td>
<td>524</td>
</tr>
<tr>
<td>R21 173 +</td>
<td>1 157</td>
<td>1 157</td>
<td>548</td>
</tr>
</tbody>
</table>

NOTE: Total contribution applicable to members who do not qualify for employer subsidy, e.g. parents.

CONTRIBUTION RATES AQUARIUM 2019 (1 APRIL 2019 – 31 MARCH 2020)

<table>
<thead>
<tr>
<th>INCOME CATEGORY</th>
<th>MEMBER</th>
<th>ADULT</th>
<th>CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>R0 – R6 618</td>
<td>76</td>
<td>76</td>
<td>33</td>
</tr>
<tr>
<td>R6 619 – R9 091</td>
<td>83</td>
<td>83</td>
<td>33</td>
</tr>
<tr>
<td>R9 092 – R11 107</td>
<td>110</td>
<td>110</td>
<td>43</td>
</tr>
<tr>
<td>R11 108 – R12 991</td>
<td>136</td>
<td>136</td>
<td>50</td>
</tr>
<tr>
<td>R12 992 – R15 118</td>
<td>161</td>
<td>161</td>
<td>58</td>
</tr>
<tr>
<td>R15 119 – R18 182</td>
<td>185</td>
<td>185</td>
<td>66</td>
</tr>
<tr>
<td>R18 183 – R22 315</td>
<td>230</td>
<td>230</td>
<td>76</td>
</tr>
<tr>
<td>R22 316 +</td>
<td>269</td>
<td>269</td>
<td>102</td>
</tr>
</tbody>
</table>

TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)

<table>
<thead>
<tr>
<th>INCOME CATEGORY</th>
<th>MEMBER</th>
<th>ADULT</th>
<th>CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>R0 – R6 618</td>
<td>1 031</td>
<td>1 031</td>
<td>511</td>
</tr>
<tr>
<td>R6 619 – R9 091</td>
<td>1 039</td>
<td>1 039</td>
<td>511</td>
</tr>
<tr>
<td>R9 092 – R11 107</td>
<td>1 065</td>
<td>1 065</td>
<td>520</td>
</tr>
<tr>
<td>R11 108 – R12 991</td>
<td>1 091</td>
<td>1 091</td>
<td>528</td>
</tr>
<tr>
<td>R12 992 – R15 118</td>
<td>1 117</td>
<td>1 117</td>
<td>535</td>
</tr>
<tr>
<td>R15 119 – R18 182</td>
<td>1 140</td>
<td>1 140</td>
<td>544</td>
</tr>
<tr>
<td>R18 183 – R22 315</td>
<td>1 185</td>
<td>1 185</td>
<td>553</td>
</tr>
<tr>
<td>R22 316 +</td>
<td>1 225</td>
<td>1 225</td>
<td>579</td>
</tr>
</tbody>
</table>

NOTE: Total contribution applicable to members who do not qualify for employer subsidy, e.g. parents.
ANNEXURE B1

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2019

Subject to the provisions contained in these rules, including all Annexures, members making monthly contributions at the rates specified in Annexure B3 shall be entitled to the benefits as set out herein, with due regard to the provisions in the Act and Regulations in respect of prescribed minimum benefits (PMBs).

- ‘POLMED rate’ shall mean: 2006 National Health Reference Price List (NHRPL) adjusted on an annual basis with Consumer Price Index (CPI).
- ‘Agreed tariff’ shall mean: The rate negotiated by and on behalf of the Scheme with one or more providers/groups.

Reference in this Annexure and the following Annexures to the term:

Benefits for the services outside the Republic of South Africa (RSA)

The Scheme does not grant benefits for services rendered outside the borders of the RSA. A claim for such services will, however, be considered if the benefit category and limitations applicable in the RSA can be determined. The benefit will be paid according to the POLMED rate. However, it remains the responsibility of the member to acquire insurance cover when travelling outside the borders of the RSA.
GENERAL RULES

APPLICATION OF CLINICAL PROTOCOLS AND FUNDING GUIDELINES

POLMED applies clinical protocols, including ‘best practice guidelines’ as well as evidence-based medicine (EBM) principles in its funding decisions.

DENTAL PROCEDURES

All dental procedures performed in hospital require pre-authorisation. The dentist’s costs for procedures that are normally done in a doctor’s rooms, when performed in hospital, shall be reimbursed from the out-of-hospital (OOH) benefit, subject to the availability of funds. The hospital and anaesthetist’s costs, if the procedure is pre-authorised, will be reimbursed from the in-hospital benefit.

DESIGNATED SERVICE PROVIDER: OUT-OF-NETWORK RULE

POLMED has appointed healthcare providers (or a group of providers) as designated service providers (DSPs) for diagnosis, treatment and care in respect of one or more prescribed minimum benefit (PMB) conditions. Where the Scheme has appointed a DSP and the member voluntarily chooses to use an out-of-network provider, all costs higher than the Scheme rate will be for the cost of the member and must be paid directly to the provider by the member.

Members can access the list of providers at www.polmed.co.za, on their cellphones via the mobile site, via POLMED Chat or request it via the Client Service Call Centre.

Examples of designated service providers (where applicable) are:

- cancer (oncology) network
- general practitioner (GP) network
- optometrist (visual) network
- psycho-social network
- renal (kidney) network
- specialist network.

EMERGENCY MEDICAL SERVICES (EMS): NETCARE 911

72-hour post-authorisation rule
Subject to authorisation within 72 hours of the event, all service providers will need to get an authorisation number from POLMED’s DSP.

Co-payment of 40% of the claim shall apply where a member voluntarily uses an unauthorised service provider (non-DSP). Service providers will be required to provide the hospital admission/casualty sticker together with patient report forms when submitting a claim to POLMED’s EMS DSP to validate delivery to a hospital.

EX GRATIA BENEFIT

The Scheme may, at the discretion of the Board of Trustees, grant an Ex Gratia payment upon written application from members as per the rules of the Scheme.

MEDICATION: ACUTE, OVER THE COUNTER (OTC) AND CHRONIC

The chronic medication benefit shall be subject to registration on the Chronic Medicine Management Programme for those conditions which are managed, and chronic medication rules will apply.

Payment will be restricted to one month’s supply in all cases for acute and chronic medication, except where the member submits proof that more than one month’s supply is necessary, e.g. due to travel arrangements to foreign countries. (Travel documents must be submitted as proof)

Pre-authorisation is required for items funded from the chronic medication benefit. Pre-authorisation is based on evidence-based medicine (EBM) principles and the funding guidelines of the Scheme. Once predefined criteria are met, an authorisation will be granted for the diagnosed conditions.

Beneficiaries will have access to a group (formulary) of medication appropriate for the management of their conditions or diseases for which they are registered. There is no need for a beneficiary to apply for a new authorisation if the treatment prescribed by the doctor changes and the medication is included in the condition-specific medication formulary. Updates to the authorisation will be required for newly diagnosed conditions for the beneficiary.

The beneficiary needs to reapply for an authorisation at least one month prior to the expiry of an existing chronic medication authorisation, failing which any claims received will not be paid from the chronic medication benefit, but from the acute medication benefit, if benefits exist. This only applies to authorisations that are not ongoing and have an expiry date.

Payment in respect of over-the-counter (OTC), acute and chronic medication, will be subject to the medication included in the POLMED formulary. Medication is included in the POLMED formulary based on its proven clinical efficacy, as well as its cost effectiveness. Generic reference pricing is applicable where generic equivalent medication is available. The products that are not included in the POLMED formulary will attract a 20% co-payment.

The 20% co-payment for medication prescribed that is not included in the POLMED formulary can be waived via an exception management process. This process requires a motivation from the treating service provider and will be reviewed based on the exceptional needs and clinical merits of each individual case.

The Scheme shall only consider claims for medication prescribed by a person legally entitled to prescribe medication and which is dispensed by such a person or a registered pharmacist.

Flu vaccines and vaccines for children under six years of age are obtainable without prescription and paid from the preventative care benefits.

POLMED GP NETWORK (DESIGNATED GP PROVIDER)

Members are allowed two visits to a general practitioner (GP) who is not part of the network per beneficiary per annum for emergency or out-of-town situations. Co-payments shall apply once the maximum out-of-network consultations are exceeded. PMB rule applies for qualifying emergency consultations.

POLMED HOSPITAL NETWORK (DESIGNATED HOSPITAL NETWORK)

The POLMED Hospital DSP includes hospitals with a national footprint. Members can access the list of hospitals in the network at www.polmed.co.za, on their cellphones via the mobile site, via
AQUARIUM

POLMED Chat or request it via the Client Service Call Centre.

All admissions (hospitals and day clinics) must be pre-authorised. A penalty of R5 000 may be imposed if no pre-authorisation is obtained.

In the case of an emergency, the Scheme must be notified within 48 hours or on the first working day after admission.

Pre-authorisation will be managed under the auspices of managed healthcare. The appropriate facility must be used to perform a procedure, based on the clinical requirements, as well as the expertise of the doctor doing the procedure. Benefits for private or semi-private rooms are excluded unless they are motivated and approved prior to admission upon the basis of clinical need.

Medication prescribed during hospitalisation forms part of the hospital benefits. Medication prescribed during hospitalisation to take out (TTO) will be paid to a maximum of seven days’ supply or a rand value equivalent to it per beneficiary per admission, except for anticoagulants post-surgery and oncology medication, which will be subject to the relevant managed healthcare programme.

MATERNITY: The costs incurred in respect of a newborn baby shall be regarded as part of the mother’s cost for the first 90 days after birth. If the child is registered on the Scheme within 90 days from birth, Scheme rule 7.1.2 shall apply. Benefits shall also be granted if the child is stillborn.

POLMED PHARMACY NETWORK

POLMED has established an open pharmacy network for the provision of acute, chronic and over-the-counter (OTC) medication. Medication included in POLMED’s formulary will be funded in full, subject to the availability of funds.

Members who voluntarily opt to use non-formulary products will be liable for a 20% co-payment. POLMED has agreed dispensing fees with the network pharmacies. A 20% co-payment will be levied in the event of voluntary utilisation of an out-of-network pharmacy. Members can access the list of providers at www.polmed.co.za, on their cellphones via the mobile site, via POLMED Chat or request it via the Client Service Call Centre.

PRO RATA BENEFITS

The maximum annual benefits referred to in this schedule shall be calculated from 1 January to 31 December each year, based on the services rendered during that year and shall be subject to pro rata apportionment calculated from the member’s date of admission to the Scheme to the end of that budget year.

SPECIALISED RADIOLOGY (MRI AND CT SCANS)

Pre-authorisation is required for all scans, failing which the Scheme may impose a co-payment of up to R1 000 per procedure. In the case of an emergency the Scheme must be notified within 48 hours or on the first working day of the treatment of the patient.

SPECIALIST REFERRAL

All POLMED beneficiaries need to be referred to specialists by a GP. The Scheme will impose a co-payment of up to R1 000 if the member consults a specialist without being referred. The co-payment will be payable by the member to the specialist and is not refundable by the Scheme.

This co-payment is not applicable to the following specialties or disciplines: Gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists (chronic dialysis), dental specialists, pathology, radiology and supplementary or allied health services.

The Scheme will allow two specialist visits per beneficiary per year without the requirement of a GP referral to cater for those who clinically require annual and/or bi-annual specialist visits.

However, the Scheme will not cover the cost of the hearing aid if there is no referral from one of the following providers: GP, ear, nose and throat (ENT) specialist, paediatrician, physician or neurologist. The specialist must submit the referring GP’s practice number in the claim.

POLMED has agreed dispensing fees with the network pharmacies. A 20% co-payment will be levied in the event of voluntary utilisation of an out-of-network pharmacy. Members can access the list of providers at www.polmed.co.za, on their cellphones via the mobile site, via POLMED Chat or request it via the Client Service Call Centre.

DISCLAIMER

In the event of a dispute, the registered rules of POLMED will apply.
DEFINITION OF TERMS

BASIC DENTISTRY
Basic dentistry refers to procedures that are used mainly for the detection, prevention and treatment of oral diseases of the teeth and gums. These include the alleviation of pain and sepsis, the repair of tooth structures by direct restorations or fillings and the replacement of missing teeth by plastic dentures.

MEDICINE GENERIC REFERENCE PRICE
This is the reference pricing system applied by the Scheme based on generic reference pricing or the inclusion of a product in the medication ‘formulary’. This pricing system refers to the maximum price that POLMED will pay for a generic medication. Should a reference price be set for a generic medication, patients are entitled to make use of any generically equivalent medication within this pricing limit but will be required to make a co-payment on medication priced above the generic reference pricing limit. The fundamental principle of any reference pricing system is that it does not restrict a member’s choice of medication, but instead limits the amount that will be paid for it.

REGISTRATION FOR CHRONIC MEDICATION
POLMED provides for a specific list of chronic conditions that are funded from the chronic medication benefit (i.e. through a benefit that is separate from the acute medication benefit).

POLMED requires members to apply for authorisation via the Chronic Medicine Management Programme to access this chronic medication benefit. Members will receive communication via email, SMS or post indicating whether their application was successful or not. If successful, the beneficiary will be issued with a disease-specific authorisation, which will allow them access to medication included in the POLMED formulary.

CO-PAYMENT
A co-payment is an amount payable by the member to the service provider at the point of service. This includes all the costs more than those agreed upon with the service provider or more than what would be paid according to approved treatments. A co-payment would not be applicable in the event of a life-threatening injury or an emergency.

FORMULARY
A formulary is a list of cost-effective, evidence-based medication for the treatment of acute and chronic conditions.

POLMED will reimburse medication intended for an approved chronic condition for up to four months from the acute medication benefit. Members will be required to register such medication as chronic during the four-month period.

REGISTRATION TO DISEASE RISK MANAGEMENT PROGRAMME
Members will be identified and contacted to register to the Disease Risk Management Programme. The Disease Risk Management Programme aims to ensure that members receive health information, guidance and management of their conditions, at the same time improving compliance to treatment prescribed by the medical practitioner. Members who are registered on the Programme receive a treatment plan (Care Plan) which lists authorised medical services, such as consultations, blood tests and radiological tests related to the management of their conditions.

The claims data for chronic medication, consultations and hospital admissions is used to identify the members who are eligible for registration to the Programme. Members are also encouraged to register themselves on the Programme.

SPECIALISED DENTISTRY
Specialised dentistry refers to services that are not defined as basic dentistry. These include periodontal surgery, crowns and bridges, inlays, indirect veneers and maxillofacial surgery.

All specialised dentistry services and procedures must be pre-authorised, failing which the Scheme will impose a co-payment of R500.

DISCLAIMER
In the event of a dispute, the registered rules of POLMED will apply.
BENEFIT SCHEDULE

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit design</td>
<td>This option provides for benefits to be provided only in appointed designated service provider (DSP) hospitals. It also provides a reasonable level of out-of-hospital (day-to-day) care. This option is intended to provide for the needs of families who have little healthcare needs or whose chronic conditions are under control. This option is not intended for members who require medical assistance on a regular basis, or who are concerned about having extensive access to health benefits.</td>
</tr>
<tr>
<td>Limits are per annum</td>
<td>Unless there is a specific indication to the contrary, all benefit amounts and limits are annual.</td>
</tr>
<tr>
<td>Pre-authorisation, referrals, protocols and management by programmes</td>
<td>Where the benefit is subject to pre-authorisation, referral by a designated service provider (DSP) or general practitioner (GP), adherence to established protocols or registration to a managed care programme, members’ attention is drawn to the fact that there may be no benefit at all or a much-reduced benefit if the pre-authorisation, referral by a DSP or GP, adherence to established protocols or registration to a management care programme is not complied with (a co-payment may be applied). The pre-authorisation, referral by a DSP or GP, adherence to established protocols or registration to a managed care programme is stipulated to best care for the member and his/her family and to protect the funds of the Scheme.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory prescribed minimum benefits (PMBs)</td>
<td>There is no overall annual limit for PMBs or life-threatening emergencies.</td>
</tr>
<tr>
<td>Tariff</td>
<td>100% of POLMED rate or agreed tariff or at cost for involuntary access to PMBs.</td>
</tr>
</tbody>
</table>
## IN-HOSPITAL BENEFITS

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetists</td>
<td>150% of POLMED rate</td>
</tr>
<tr>
<td>Annual overall in-hospital limit</td>
<td>Non-PMB admissions will be subject to an overall limit of R200 000 per family</td>
</tr>
<tr>
<td></td>
<td>Subject to the Scheme’s relevant managed healthcare programmes and includes the application of treatment protocols, case management and pre-authorisation</td>
</tr>
<tr>
<td></td>
<td>Subject to PMBs, i.e. no limit in case of life-threatening emergencies or for PMB conditions</td>
</tr>
<tr>
<td></td>
<td>Subject to applicable tariff, i.e. 100% of POLMED rate or Agreed tariff or At cost for involuntary access to PMBs</td>
</tr>
<tr>
<td>A R5 000 penalty may be imposed if no pre-authorisation is obtained</td>
<td></td>
</tr>
<tr>
<td>R8 000 co-payment for admission to a non-DSP hospital</td>
<td></td>
</tr>
<tr>
<td>No co-payment if the procedure is performed in a DSP and/or a day clinic</td>
<td></td>
</tr>
</tbody>
</table>

### Chronic kidney dialysis
**Preferred providers:**
- National Renal Care (NRC)
- Fresenius Medical Care

### Dentistry (conservative and restorative)

### Emergency medical services (ambulance services)

### General practitioners (GPs)

### Medication (non-PMB specialist drug limit, e.g. biologicals)

### Mental health
<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology (chemotherapy and radiotherapy)</td>
<td>100% of agreed tariff at DSP</td>
</tr>
<tr>
<td>Independent Clinical Oncology Network (ICON)</td>
<td>Limited to R271 400 per beneficiary per annum; includes MRI/CT or PET</td>
</tr>
<tr>
<td></td>
<td>scans related to oncology</td>
</tr>
<tr>
<td>Organ and tissue transplants</td>
<td>100% of agreed tariff at DSP</td>
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<tr>
<td></td>
<td>or</td>
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<tr>
<td></td>
<td>At cost for PMBs</td>
</tr>
<tr>
<td></td>
<td>Subject to clinical guidelines used in State facilities</td>
</tr>
<tr>
<td></td>
<td>Unlimited radiology and pathology for organ transplant and immunosuppressants</td>
</tr>
<tr>
<td>Pathology</td>
<td>Service will be linked to hospital pre-authorisation</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Service will be linked to hospital pre-authorisation</td>
</tr>
<tr>
<td>Prostheses (internal and external)</td>
<td>100% of POLMED rate</td>
</tr>
<tr>
<td></td>
<td>or</td>
</tr>
<tr>
<td></td>
<td>At cost for PMBs</td>
</tr>
<tr>
<td></td>
<td>Subject to pre-authorisation and approved product list</td>
</tr>
<tr>
<td></td>
<td>Limited to R64 132 per beneficiary</td>
</tr>
<tr>
<td>Refractive surgery</td>
<td>No benefit</td>
</tr>
<tr>
<td>Specialists</td>
<td>100% of agreed tariff at DSP</td>
</tr>
<tr>
<td></td>
<td>100% of POLMED rate</td>
</tr>
<tr>
<td></td>
<td>or</td>
</tr>
<tr>
<td></td>
<td>At cost for involuntary PMB access</td>
</tr>
</tbody>
</table>

**OVERALL OUT-OF-HOSPITAL BENEFITS**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual overall out-of-hospital (OOH) limit</td>
<td>M0 – R8 812</td>
</tr>
<tr>
<td>Benefits shall not exceed the amount set out in</td>
<td></td>
</tr>
<tr>
<td>the table</td>
<td></td>
</tr>
<tr>
<td>PMBs shall first accrue towards the total benefit, but are not subject to a limit</td>
<td></td>
</tr>
<tr>
<td>In appropriate cases the limit for medical appliances shall not accrue towards this limit</td>
<td></td>
</tr>
<tr>
<td>Overall out-of-hospital benefits are subject to:</td>
<td></td>
</tr>
<tr>
<td>• protocols and clinical guidelines</td>
<td></td>
</tr>
<tr>
<td>• PMBs</td>
<td></td>
</tr>
<tr>
<td>• the applicable tariff, i.e. 100% of POLMED rate or agreed tariff or at cost for involuntary PMB access</td>
<td></td>
</tr>
<tr>
<td>Audiology</td>
<td>100% of POLMED rate</td>
</tr>
<tr>
<td>Subject to referral by either of the following doctors/specialists:</td>
<td></td>
</tr>
<tr>
<td>• Ear, nose and throat (ENT) specialist</td>
<td></td>
</tr>
<tr>
<td>• General practitioner (GP)</td>
<td></td>
</tr>
<tr>
<td>• Paediatrician</td>
<td></td>
</tr>
<tr>
<td>• Physician</td>
<td></td>
</tr>
<tr>
<td>• Neurologist</td>
<td></td>
</tr>
<tr>
<td>Dentistry (conservative and restorative)</td>
<td>100% of POLMED rate</td>
</tr>
<tr>
<td>Subject to the OOH limit</td>
<td></td>
</tr>
<tr>
<td>Subject to the OOH limit and includes dentist’s costs for in-hospital, non-PMB procedures</td>
<td></td>
</tr>
<tr>
<td>Routine consultation, scale and polish are limited to two annual check-ups per beneficiary</td>
<td></td>
</tr>
<tr>
<td>Oral hygiene instructions are limited to once in 12 months per beneficiary</td>
<td></td>
</tr>
<tr>
<td>DESCRIPTION</td>
<td>BENEFIT</td>
</tr>
<tr>
<td>-------------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Dentistry (specialised)</strong>&lt;br&gt;Surgical extractions of teeth requiring removal of bone or incision required to reduce fracture&lt;br&gt;Surgical removal of impacted teeth requiring removal of inflammatory tissues surrounding partially erupted teeth&lt;br&gt;Root planning treatment for periodontal disease&lt;br&gt;Drainage of abscess and clearing infection caused by tooth decay&lt;br&gt;Apicoectomy – removal of dead tissue caused by infection&lt;br&gt;Children under the age of seven years, physically or mentally disabled patients who require general anaesthesia for dental work to be conducted&lt;br&gt;Cyst removal of non-vital pulp&lt;br&gt;Odontectomy – under sedation with removal of all teeth in the mouth</td>
<td>In all cases pre-authorisation is required&lt;br&gt;A co-payment of R500 will apply if no pre-authorisation is obtained&lt;br&gt;Clinical protocols apply</td>
</tr>
<tr>
<td><strong>General practitioners (GPs)</strong>&lt;br&gt;POLMED has a GP Network</td>
<td>100% of agreed tariff at DSP&lt;br&gt;At cost for involuntary PMB access&lt;br&gt;The limit for consultations shall accrue towards the OOH limit&lt;br&gt;Subject to maximum number of visits or consultations per family: &lt;br&gt;M0 – 8&lt;br&gt;M1 – 12&lt;br&gt;M2 – 15&lt;br&gt;M3 – 18&lt;br&gt;M4+ – 22</td>
</tr>
</tbody>
</table>

### OVERALL OUT-OF-HOSPITAL BENEFITS

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Medication (acute)</strong>&lt;br&gt;100% of POLMED rate at DSP&lt;br&gt;M0 – R2 325&lt;br&gt;M1 – R3 953&lt;br&gt;M2 – R5 581&lt;br&gt;M3 – R7 209&lt;br&gt;M4+ – R8 836&lt;br&gt;Subject to the OOH limit&lt;br&gt;Subject to the POLMED formulary</td>
<td></td>
</tr>
<tr>
<td><strong>Medication (over the counter [OTC])</strong>&lt;br&gt;100% of POLMED rate at DSP&lt;br&gt;Annual limit of R952 per family&lt;br&gt;Subject to the OOH limit&lt;br&gt;Shared limit with acute medication&lt;br&gt;Subject to the POLMED formulary</td>
<td>healthcare services and their respective costs, including medications for acute and over the counter use, as well as other services like general practitioners, physiotherapy, and dental procedures. Each service has specific benefits and limitations as outlined in the table.</td>
</tr>
<tr>
<td>DESCRIPTION</td>
<td>BENEFIT</td>
</tr>
<tr>
<td>-------------</td>
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</tr>
<tr>
<td>Social worker</td>
<td>100% of POLMED rate</td>
</tr>
<tr>
<td></td>
<td>Annual limit of R2 315 per family</td>
</tr>
<tr>
<td></td>
<td>Subject to the OOH limit</td>
</tr>
<tr>
<td>Specialists</td>
<td>100% of agreed tariff at DSP or At cost for involuntary access to PMBs</td>
</tr>
<tr>
<td>Referral is not necessary for the following specialists:</td>
<td>The limit for consultations shall accrue towards the OOH limit</td>
</tr>
<tr>
<td>· Dental specialists</td>
<td>Limited to 4/four visits per beneficiary or 8/eight visits per family per annum</td>
</tr>
<tr>
<td>· Gynaecologists</td>
<td>Subject to referral by a GP (2/two specialist visits per beneficiary without GP referral allowed)</td>
</tr>
<tr>
<td>· Nephrologists (dialysis)</td>
<td>R1 000 co-payment if no referral is obtained</td>
</tr>
<tr>
<td>· Oncologists</td>
<td></td>
</tr>
<tr>
<td>· Ophthalmologists</td>
<td></td>
</tr>
<tr>
<td>· Psychiatrists</td>
<td></td>
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<tr>
<td>· Supplementary or allied health services</td>
<td></td>
</tr>
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<tr>
<td>· Ophthalmologists</td>
<td></td>
</tr>
<tr>
<td>· Psychiatrists</td>
<td></td>
</tr>
<tr>
<td>· Supplementary or allied health services</td>
<td></td>
</tr>
</tbody>
</table>

### STAND-ALONE BENEFITS

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appliances (medical and surgical)</td>
<td>Members must be referred by an audiologist for hearing aids to be reimbursed</td>
</tr>
<tr>
<td></td>
<td>Pre-authorisation is required for the supply of oxygen</td>
</tr>
<tr>
<td></td>
<td>All costs for maintenance are a Scheme exclusion</td>
</tr>
<tr>
<td></td>
<td>Funding will be based on applicable clinical and funding protocols</td>
</tr>
<tr>
<td></td>
<td>Quotations will be required</td>
</tr>
<tr>
<td>Blood transfusions</td>
<td>Unlimited</td>
</tr>
<tr>
<td>CPAP machine</td>
<td>R9 168 per family</td>
</tr>
<tr>
<td></td>
<td>Once every 4/four years</td>
</tr>
<tr>
<td>Glucometer</td>
<td>R1 283 per family</td>
</tr>
<tr>
<td></td>
<td>Once every 4/four years</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>R11 318 per hearing aid or R22 494 per beneficiary per set</td>
</tr>
<tr>
<td></td>
<td>Once every 3/three years</td>
</tr>
<tr>
<td>Insulin delivery devices</td>
<td>Paid from the hospital benefit up to the mean price of three quotations</td>
</tr>
<tr>
<td>Urine catheters</td>
<td></td>
</tr>
</tbody>
</table>

## Allied health services and alternative healthcare providers
- Biokineticists
- Chiropractors
- Homeopaths
- Orthoptists
- Podiatrists
- Therapeutic massage therapists
- Alternative healthcare providers
- Biokineticists
- Chiropodists
- Chiropractors
- Dieticians
- Homeopaths
- Naturopaths
- Osteopaths
- Reflexologists

### Benefit is subject to clinically appropriate services

**Apparatus (medical and surgical)**
- Members must be referred by an audiologist for hearing aids to be reimbursed
- Pre-authorisation is required for the supply of oxygen
- All costs for maintenance are a Scheme exclusion
- Funding will be based on applicable clinical and funding protocols
- Quotations will be required

### Appliances (medical and surgical)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult nappies</td>
<td>R946/month (2/two nappies per day)</td>
</tr>
<tr>
<td></td>
<td>R1 419/month (3/three nappies per day)</td>
</tr>
<tr>
<td>Blood transfusions</td>
<td>Unlimited</td>
</tr>
<tr>
<td>CPAP machine</td>
<td>R1 000 co-payment if no referral is obtained</td>
</tr>
<tr>
<td>Glucometer</td>
<td>R1 000 co-payment if no referral is obtained</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>R11 318 per hearing aid or R22 494 per beneficiary per set</td>
</tr>
<tr>
<td>Insulin delivery devices</td>
<td>Paid from the hospital benefit up to the mean price of three quotations</td>
</tr>
<tr>
<td>Urine catheters</td>
<td>Paid from the hospital benefit up to the mean price of three quotations</td>
</tr>
<tr>
<td>DESCRIPTION</td>
<td>BENEFIT</td>
</tr>
<tr>
<td>-------------</td>
<td>---------</td>
</tr>
<tr>
<td>Appliances (medical and surgical) (continued)</td>
<td>Medical assistive devices</td>
</tr>
<tr>
<td>Nebuliser</td>
<td>R1 283 per family Once every 4/four years</td>
</tr>
<tr>
<td>Wheelchair (motorised)</td>
<td>OR Wheelchair (non-motorised)</td>
</tr>
</tbody>
</table>

**Chronic medication refers to non-PMB conditions**
Subject to prior application and/or registration of the condition
Approved PMB CDL conditions are not subject to a limit

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity benefits (including home birth) Pre-authorisation required Treatment protocols apply</td>
<td>100% of agreed tariff at DSP or 100% of POLMED rate at non-DSP or At cost for involuntary PMB access The limit for consultations shall not accrue towards the OOH limit The benefit shall include 3/three specialist consultations per beneficiary per pregnancy Home birth is limited to R14 417 per beneficiary per annum</td>
</tr>
<tr>
<td>Optical Includes frames, lenses and eye examinations</td>
<td>PROVIDER NETWORK 100% of cost for a composite consultation, inclusive of the refraction, a glaucoma screening and visual field screening, Authenticate IT and biometric readings WITH EITHER SPECTACLES R795 towards a frame and/or lens enhancements LENSES Either one pair of clear single-vision lenses or one pair of clear flat-top bifocal lenses. Clear base multifocal lenses covered up to the bifocal lens limit. OR CONTACT LENSES Contact lenses to the value of R613 annually Contact lens re-examination can be claimed for in six-monthly intervals</td>
</tr>
</tbody>
</table>

Benefits relating to more than 2/two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation

Benefits are not pro rata, but calculated from the benefit service date
Each claim for lenses or frames must be submitted with the lens prescription Benefits shall not be granted for contact lenses if the beneficiary has already received a pair of spectacles in a two-year benefit cycle
**STAND-ALONE BENEFITS**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
</table>
| Optical (continued) | NON-PROVIDER NETWORK  
One consultation limited to a maximum cost of R300  
WITH EITHER SPECTACLES  
R557 towards a frame and/or lens enhancements  
Single-vision lenses limited to R175 per lens  
or  
Bifocal lenses limited to R410 per lens  
or  
Multifocal lenses limited to R410 per lens  
OR CONTACT LENSES  
Contact lenses to the value of R400 annually  
Contact lens re-examination to maximum cost of R233 per consultation |

| Radiology (basic) | 100% of agreed tariff  
or  
At cost for PMBs  
Limited to R5 232 per family  
Includes any basic radiology done in or out of hospital  
Claims for PMBs first accrue towards the limit |

| Radiology (specialised) | 100% of agreed tariff  
or  
At cost for PMBs  
Includes any specialised radiology service done in/out of hospital  
Claims for PMBs first accrue towards the limit |

| 2/two MRI scans | Subject to a limit of 2/two scans per family per annum, except for PMBs |

| 3/three CT scans | Subject to a limit of 3/three scans per family per annum, except for PMBs |

**ANNEXURE B2**

**CO-PAYMENTS**

<table>
<thead>
<tr>
<th>OUT OF NETWORK</th>
<th>CO-PAYMENT</th>
</tr>
</thead>
</table>
| General practitioner (GP) | Allows for 2/two out-of-network consultations  
Co-payment shall apply once maximum out-of-network consultations are exceeded |
| Hospital | R8 000 |
| Pharmacy | 20% of costs when using a non-designated service provider (non-DSP) pharmacy  
20% co-payment when voluntarily using a non-formulary product |
ANNEXURE B4
AQUARIUM: CHRONIC CONDITIONS

Prescribed minimum benefits (PMBs), including chronic Diagnosis and Treatment Pairs (DTPs)

Auto-immune disorder
Systemic lupus erythematosus (SLE)

Cardiovascular conditions
Cardiac dysrhythmias
Cardiomyopathy
Coronary artery disease
Heart failure
Hypertension
Peripheral arterial disease
Thromboembolic disease
Valvular disease

Endocrine conditions
Addison’s disease
Cushing’s disease
Diabetes insipidus
Diabetes mellitus type I
Diabetes mellitus type II
Hyperprolactinaemia
Hypo- and hyperthyroidism
Polycystic ovaries
Primary hypogonadism

Gastrointestinal conditions
Crohn’s disease
Peptic ulcer disease (requires special motivation)
Ulcerative colitis

Gynaecological conditions
Endometriosis
Menopausal treatment

Haematological conditions
Anaemia
Haemophilia
Idiopathic thrombocytopenic purpura
Megaloblastic anaemia

Metabolic condition
Hyperlipidaemia

Musculoskeletal condition
Rheumatoid arthritis

Neurological conditions
Cerebrovascular incident
Epilepsy
Multiple sclerosis
Parkinson’s disease
Permanent spinal cord injuries

Ophthalmic condition
Glaucoma

Psychiatric conditions
Affective disorders (depression and bipolar mood disorder)
Post-traumatic stress disorder (PTSD)
Schizophrenic disorders

Pulmonary diseases
Asthma
Bronchiectasis
Chronic obstructive pulmonary disease (COPD)
Cystic fibrosis

Special category conditions
HIV/AIDS
Organ transplantation
Tuberculosis

Treatable cancers
As per PMB guidelines

Urological conditions
Benign prostatic hypertrophy
Chronic renal failure
Nephrotic syndrome and glomerulonephritis
Renal calculi
APPLICATION FOR EX GRATIA

NEED MEDICAL CARE BUT YOUR BENEFITS ARE EXHAUSTED?
• The Board shall not authorise payment for services other than those provided for in the Scheme rules but may, in its absolute discretion, upon written request by a member, authorise an Ex Gratia payment in respect of a benefit, upon proof that undue hardship would otherwise be imposed upon a member.
• The cut-off date for the submission of applications is the end of April of the following year.

EX GRATIA DOES NOT PERTAIN TO THE FOLLOWING:
• Scheme exclusions
• Stale claims (older than 120 days)
• Co-payments
• Amounts less than R1 000
• Costs relating to out-of-hospital benefits

HOW DO I APPLY FOR EX GRATIA BENEFITS?
Principal member applies for assistance.

Call 0860 765 633 for the Ex Gratia application or download it from www.polmed.co.za (go to ‘FORMS’, from the drop-down list select ‘CLAIMS’, and then ‘Application for Ex Gratia’).

Form must be completed and signed by member/patient and doctor (include motivation from treating doctor). Attach outstanding claims to the Ex Gratia application.

SUBMIT THE APPLICATION:
Email: polmedexgratia@medscheme.co.za
Fax: 0860 104 114
Post: Ex Gratia Department: POLMED
Private Bag X16
Arcadia
0007

Outcome of application communicated to member.

EX GRATIA IS NOT A BENEFIT EXTENSION!
APPLICATION FOR MEMBERSHIP

NEW MEMBER APPLICATION
• Serving members
• Dependents

NEW MEMBER APPLICATION DOCUMENTATION REQUIRED
• Application for membership form.
• Letter of appointment or SAP96.
• Copy of ID.
• Proof of income (salary advice).
• Copy of most recent bank statement or stamped letter from the bank confirming your banking details.

APPLICATION SUBMISSION DETAILS
• Email: polmedmembership@medscheme.co.za
• Fax: 0861 888 110
• Post: Private Bag X16, Arcadia 0007
• Hand in at any POLMED regional walk-in branch near you.

APPLICATION FOR MEMBERSHIP

THIRD GENERATION CHILDREN DO NOT QUALIFY

SUPPORTING DOCUMENTS REQUIRED FOR REGISTRATION OF DEPENDANTS

DEPENDANTS (SERVING MEMBERS OR CONTINUATION MEMBERS)
Only completed if the dependant was not registered when the principal member joined POLMED:
• APPLICATION FOR REGISTRATION OF DEPENDANTS FORM.
• Copy of BIRTH CERTIFICATE or IDENTITY DOCUMENT.

AVAILABILITY OF FORMS
POLMED WEBSITE: On www.polmed.co.za go to the home page, select the tab marked ‘FORMS’, on the drop-down list select ‘Administration (Membership)’ and then select the form required.
Call the Client Service Call Centre on 0860 765 633 to request the form.

APPLICATION SUBMISSION DETAILS
• Email: polmedmembership@medscheme.co.za
• Fax: 0861 888 110
• Post: Private Bag X16, Arcadia 0007
• Hand in at any POLMED regional walk-in branch near you.

ADDITIONAL SUPPORTING DOCUMENTS REQUIRED FOR REGISTRATION OF DEPENDANTS

DEPENDANT BETWEEN THE AGES OF 21 AND 30 STUDENT
• Certificate of registration at registered tertiary learning institution – by the end of February each year.
• Copy of ID.
FINANCIALLY DEPENDENT
• Affidavit B confirming financial dependency (unless informed otherwise).
• Copy of ID.

STEPCHILD
• Affidavit D confirming child is the biological child of the member’s spouse.
• Copy of ID or birth certificate.

DISABLED CHILD OVER THE AGE OF 21
• Proof of disability confirmed by a medical practitioner – annually.
• Copy of ID.

CHILD BORN BEFORE OR OUT OF WEDLOCK
• Affidavit A confirming member is the biological parent of the child, if the member’s details do not appear on the child’s birth certificate.
• Copy of ID or birth certificate.

LEGALLY ADOPTED CHILD
• Final adoption order.
• Copy of ID or birth certificate.
CLAIMS PROCEDURE (Scheme rule 15)

MEMBERS: SUBMISSION OF CLAIMS

- Claims must be submitted within 120 days of the service date. Claims received after this period will be rejected as stale.
- Copies of accounts will be accepted for processing or payment.
- In cases where the service provider charges above POLMED rates, you will be responsible for payment of the balance of the claim directly to the provider.

SERVICE PROVIDERS: SUBMISSION OF CLAIMS

Most service providers submit their claims electronically.

PAYMENT OF CLAIMS

You will receive a claims statement that will advise you of the outcome of the payment process.

You can also view the outcome via the Member zone on our website at www.polmed.co.za.

SUBMIT YOUR CLAIMS CORRECTLY

There are various ways of submitting claims to POLMED for processing:

Email: polmedcurrentclaims@medscheme.co.za
Fax: 011 758 7660
Post: POLMED
Private Bag X16
Arcadia
0007

OR

Visit any POLMED regional walk-in branch.

INFORMATION REQUIRED TO VALIDATE A CLAIM

Healthcare provider (e.g. doctor, specialist etc.)

- Name and practice number.
- Referring doctor’s practice number (for specialist claim).
- In the case of a group practice, group practice number and the name of the practitioner who provided the service.

Member

- Membership number.
- Scheme name and benefit plan (Marine or Aquarium).
- Main member’s initials and surname.
- The patient’s name, other initials and surname (if it is not the principal member), as well as the dependant code (as it appears on the back of the POLMED membership card).
- Date of birth of patient.

Other

- Date of service.
- Account/reference number.
- Tariff/Nappi/procedure code(s) – this is a code that refers to the pricing of a medical service/product.
- ICD-10 code(s).
- Cost of each treatment, item or procedure.
- In respect of medication claims, the name, quantity, dosage and net amount payable by the member should be provided.

MEMBER REFUNDS

If you paid for a service directly and want to request a member refund, you need to submit your proof of payment (receipt or bank deposit slip) together with the service provider’s account that displays a zero balance for the claim.
CONTINUATION OF MEMBERSHIP

CONTINUATION OF MEMBERSHIP (Scheme rule 6.3.1)
• Death of the principal member (any dependant active at the time of the principal member’s death) (Scheme rule 6.5.1).
• Hawks (Scheme rule 6.3.1.5).
• Medically boarded (Scheme rule 6.3.1.2).
• Retirement (Scheme rule 6.3.1.1).
• Severance package (Scheme rule 6.3.1.4).

Imagine the Scheme within 90 days in writing with the reason and date of your last day of service, being either: Medically boarded, retirement or severance package.

DOCUMENTS REQUIRED
• Application for continuation membership form.
• Copy of ID.
• Proof of monthly pension (if retired/medically boarded).
• Service certificate or SAP96 and letter from Medical Board at SAPS Head Office (please indicate if related to injury on duty).

WHAT IF BOTH PARENTS DIE?
The youngest child becomes the principal member when both parents die.

Supply information of the guardian in the case of minor orphans.

DEATH OF THE PRINCIPAL (MAIN) MEMBER

DOCUMENTS REQUIRED FROM DEPENDANTS WHO ARE REGISTERED AT THE TIME OF THE PRINCIPAL MEMBER’S DEATH
• Application for continuation membership form to be completed by remaining spouse/partner.
• Death certificate.
• Copy of cancelled ID for deceased principal member.
• Copies of ID documents for dependants.
• Proof of income (monthly pension of deceased that the member will receive).
• Marriage certificate or customary union certificate.

APPLICATION FOR CONTINUATION MEMBERSHIP SUBMISSION DETAILS
• Email: polmedmembership@medscheme.co.za
• Fax: 0861 888 110
• Post: Private Bag X16, Arcadia 0007
• Hand in at any POLMED regional walk-in branch near you.

AVAILABILITY OF FORMS
POLMED WEBSITE: On www.polmed.co.za go to the home page, select the tab marked ‘FORMS’, on the drop-down list select ‘Administration (Membership)’ and then select the form required.

Call the Client Service Call Centre on 0860 765 633 to request the form.

REMEMBER
COMPLETE THE APPLICATION FOR CONTINUATION MEMBERSHIP FORM.
Submit the completed form and supporting documentation to POLMED via email, fax, by hand at your nearest POLMED regional walk-in branch or by post.

Ensure POLMED has your correct postal address details for delivery of your new membership card, which is issued when your membership status changes.

Any changes that affect your membership status should be reported to POLMED within 30 days.

IMPORTANT
A member who resigns from SAPS, irrespective of the number of years in service, does not qualify to remain a POLMED member.
FIVE EASY STEPS TO PLAN SELECTION

1. HOW DO I CHOOSE A PLAN?
   - Read and understand the new benefits and choose the plan that will address your needs.

2. HOW DO I INFORM POLMED?
   - Complete the plan selection form and email, fax or post it to us or, alternatively, you can hand it in at any of the walk-in branches.
   - OR
   - Submit your choice online at www.polmed.co.za or via POLMED Chat.
   - OR
   - Call the Client Service Call Centre on 0860 765 633 and speak to a Consultant during office hours.

3. HOW WILL I KNOW MY PLAN HAS BEEN CHANGED?
   - You will receive a communication from POLMED to confirm the change.

4. WHAT IF I DO NOT INFORM POLMED?
   - You will remain on the same plan.

5. CAN I CHANGE MY PLAN AFTER THIS?
   - No, you may only change your plan at the end of each year before 31 December. You must call, complete your choice online or POLMED must receive your completed plan selection form before 31 December.
MEMBER QUERIES (INITIAL QUERIES)

If you have a query you may contact POLMED via:

- **TELEPHONE** on 0860 765 633
- **FAX** on 0860 104 114
- **EMAIL** at polmed@medscheme.co.za
- **POLMED CHAT.**

**NOTE:**
- The Administrator has five (5) working days to respond to your query.
- Always obtain a reference number and name of the agent.
- It is extremely important that you follow the correct query process in order for us to assist you:
  - **CHRONIC MEDICINE MANAGEMENT REGISTRATION:**
    polmedcmmm@medscheme.co.za
  - **PRESCRIBED MINIMUM BENEFIT (PMB) REGISTRATION:**
    polmedapmb@medscheme.co.za
  - **HOSPITAL PRE-AUTHORISATION:**
    polmedauths@medscheme.co.za

POLMED has an agreement with the Administrator whereby we monitor their level of service offered to members. If the formal processes are not followed, it is impossible to monitor or measure these service levels.

OPERATING HOURS

The POLMED Client Service Call Centre and regional walk-in branches operate Mondays to Fridays from 8:30 to 17:00 (excluding public holidays). Regional walk-in branches also operate on Saturdays from 8:00 to 12:00.

COMPLIMENTS AND COMPLAINTS

If you want to submit a compliment or complaint about a positive or negative experience that you had with the Scheme, simply send an email to polmed@medscheme.co.za and include the details of your experience together with the name of the agent who assisted you.

ONLINE/SOCIAL MEDIA COMMENTS AND QUERIES

The Protection of Personal Information (POPI) Act prohibits the Scheme from disclosing any member’s personal information to third parties without a member’s consent. It is for this reason that POLMED cannot communicate with you via any social media platform such as Facebook, Twitter and Instagram or any other social medium.

MEMBER QUERIES (INITIAL QUERY)

These are queries you raise with the Administrator when you initially experience a problem with or require information with regard to a medical scheme-related matter.

A reference number will automatically be supplied to you when you submit your query via email. Remember to also obtain a reference number when you report any matter to the Client Service Call Centre.

Submit your query to the Administrator at: polmed@medscheme.co.za

Provide the following information for the Administrator to investigate your query:

- Membership number
- Patient name and surname
- Dependant code (e.g. 01 – refer to the back of your membership card)
- Date of service
- Name of provider
- Practice number of the provider
- Details of enquiry that may further assist POLMED to investigate the matter
- Supporting documents, i.e. invoice/invoice/statement/medication or medical procedure declined

MEMBER QUERIES ESCALATED

These are queries that serve as a follow up to your first query after you have not received satisfactory feedback/service.

The query received at POLMED will be investigated and feedback will be provided to the member within a minimum of five (5) working days.

Send an email to POLMED at: polmedhouse@medscheme.co.za

Provide the following details for POLMED to investigate your query:

- Membership number
- Patient name and surname
- Dependant code (e.g. 01 – refer to the back of your membership card)
- Reference number obtained from the Administrator (you should have requested this when the initial query was raised)
- Date of initial query
- Details of the enquiry that may further assist POLMED to investigate the matter
MEMBER ESCALATED QUERIES

POLMED makes provision for members to lodge complaints and disputes in cases where the member is dissatisfied with the outcome of a decision from the Scheme in respect of a query.

The form to complete when submitting a complaint/appeal to POLMED is available on the POLMED website under the Dispute Resolution process.

For more information and to submit your written complaint to POLMED, use the following details:

Tel: 0860 765 633
Fax: 0860 104 114
Email: polmedescalations@medscheme.co.za
Post: Private Bag X16
Arcadia
0007

Alternatively, visit our walk-in branch in your region.

The dispute will be processed within a minimum of five working days, depending on the complexity of the enquiry. The outcome of the dispute will be communicated to you.

If your query is not resolved or you remain dissatisfied with the outcome/service experience, you may also lodge a complaint with the Council for Medical Schemes (CMS). The form to complete when submitting a complaint to the CMS is available on the CMS website.

Tel: 0861 123 267 (share call from a Telkom landline) or 012 431 0500
Fax: 086 673 2466
Email: complaints@medicalschemes.com
Post: Council for Medical Schemes, Private Bag X34, Hatfield 0028
Website: www.medicalschemes.com

The CMS will inform POLMED of the complaint received. POLMED will engage with the Administrator to investigate the complaint. Thereafter POLMED will provide feedback to the CMS within the timeline indicated by the CMS. The CMS will then inform you of the outcome of the investigation.
NO MORE QUEUES: ACCESS YOUR INFORMATION VIA OUR WEBSITE – IN THE COMFORT OF YOUR HOME, OFFICE OR WHILST ON HOLIDAY

NOTE:
• You can access the POLMED website via your cellphone.
• Serving members can also access the POLMED website via the SAPS intranet.
• You must have an email address to register on Member zone.

WHAT DO YOU NEED TO REGISTER?
• POLMED membership number
• ID number
• Cellphone number
• Email address
• A username
• A password

REGISTRATION PROCESS
• On the Member zone registration page, select ‘Create Account’.
• Select ‘Members’.
• Type in your membership number and select ‘Validate Code’.
• Follow the rest of the prompts to complete your registration.

PRINCIPAL MEMBERS
When a dependant registers for access, the principal member receives an email to activate the dependant’s access. The principal member needs to inform the dependant when this is done.

DEPENDANTS
When a dependant registers for access, the principal member needs to activate the dependant’s access and must inform the dependant when this step is done.

DID YOU KNOW?
You can download and print your membership certificate, tax certificate and member statement via Member zone instead of calling the Client Service Call Centre or visiting a regional walk-in branch.

WHAT CAN YOU DO ON MEMBER ZONE?
• View benefit usage and limits.
• View claims history and statements.
• Download and print your membership certificate, tax certificate and member statements (via desktop go to ‘Communication Details’ and via a cellphone go to ‘Member Monitor’ and then ‘My Documents’).
• View membership card details, including details of the principal member and dependants.
• View contact and address information, including the option to update information.
• View authorisations.

SIGN OUT
Remember to sign out when you have completed your enquiry.
**POLMED CHAT (WEEKDAYS ONLY)**

**BENEFITS OF USING THE POLMED CHAT APP**

POLMED Chat allows you to send and receive short text messages directly with Client Service Call Centre Consultants in real time and is less costly than a phone call.

**HOW TO ACCESS THIS APPLICATION**

You can use POLMED Chat via your cellphone or the Internet on a computer:

- **Cellphone:** Download app for free via http://bit.ly/1YHAtwu or the app stores.
- **POLMED website:** Go to www.polmed.co.za via your computer, log in to Member zone and select the POLMED Chat icon for access.

**VALIDATION**

Upon opening this app for the first time, you need to type in your POLMED details and select ‘Validate’. The fields include:

- Membership number
- First name
- Last name
- Email address
- Cellphone number
- Beneficiary number

Click here to ‘Validate’.

**HOW DO YOU VIEW YOUR POLMED MEMBERSHIP CARD?**

Select the menu button to open the list of menu options, and then select ‘Member Card’. Your membership card will then display. You can share it with your dependants or service providers.

**HOW DO YOU START A CHAT?**

When the validation is successful, you can proceed to chat. Select the department that is most relevant. For example, select ‘General Enquiries’ and type a message on that page.

Once the department is selected, you can send and receive messages from a Consultant who will attend to your query.
THIRD PARTY CONSENT

WHAT IS THIRD PARTY CONSENT?

Third party consent is when you consent to:
• giving another person or entity access to your personal information with the Scheme
• another person updating your personal information (biographical only) with the Scheme.

WHO IS A THIRD PARTY?

This is the person, such as a spouse, partner or close family member, or entity, such as an employer, that you give access to your personal information. You can specify the kind of information they will have access to, such as financial or medical information, in the third party member consent form.

WHERE DO I GET A THIRD PARTY MEMBER CONSENT FORM?

• Via the POLMED website. Go to www.polmed.co.za, select ‘FORMS’, ‘POPI Act’ and then ‘Third Party Consent’.
• Call us on 0860 765 633.
• Visit any regional walk-in branch.

HOW DO I SUBMIT A COMPLETED CONSENT FORM?

Email it to polmed@medscheme.co.za.
Fax it to 0860 104 114.
Hand deliver it to any regional walk-in branch.

WHY IS THIRD PARTY CONSENT IMPORTANT?

In this way we restrict any third party from gaining access to and updating your personal information without prior, written consent. We respect your privacy and exercise strict governance practices to keep your personal information private and confidential.

Third party consent is for persons 18 years and older.
YOUR STEP-BY-STEP GUIDE TO THE 24-HOUR TELEPHONIC SELF-HELP SERVICE

Call the Client Service Call Centre on 0860 765 633 and follow the voice prompts for guidance in order to access the self-help service.

1. PRESS 2 if you are a member.

2. PRESS 2 for client services.

3. PRESS 1 for this self-help service.

4. PRESS 2 to request documents.

PRESS 1 to listen to your available benefits.

PRESS 1 for your general practitioner (GP) and specialist consultation available benefits.

PRESS 2 for your acute medication available benefits.

PRESS 3 for your chronic medication available benefits.

PRESS 4 for your non-surgical procedures available benefits.

PRESS 5 for your available dentistry benefits.

PRESS 1 for your membership certificate.

PRESS 2 for your tax certificate.

PRESS 3 for your member statement.

This service gives you the option to access information without speaking to a Consultant.

You will be requested to enter your membership number to access this service and obtain your information.
COMPLAINTS AND DISPUTE RESOLUTION

1. Request for review of funding decision
2. Motivation/application received by Administrator
3. Clinical protocols, Scheme rules and EBM principles are applied
4. Decision made
   - Approved
   - Declined
5. Member/provider notified
6. Treatment/procedure undertaken
7. Account paid according to Scheme rules

Written appeals considered by POLMED Principal Officer

- Declined
- Approved
- Member/provider notified about the decision in writing
- Member/provider notified about the decision in writing
- Member/provider accepts the PO's decision
- Member/provider appeals the PO's decision
- Treatment/procedure undertaken
- Account paid according to Scheme rules

Written appeal referred to PO for referral to Complaints and Dispute Resolution Committee.
The form to complete when submitting a complaint/appeal to POLMED is available on the POLMED website under the Dispute Resolution process.
HOSPITAL PRE-AUTHORISATION

DETAILS REQUIRED TO OBTAIN AUTHORISATION
Ensure you have the details listed below before calling POLMED for an authorisation:
- ID number.
- Membership number.
- Name of patient.
- Date of birth.
- Name of hospital/practice number.
- Name of service provider (i.e. doctor, specialist, etc.) and practice number.
- The diagnosis (ICD-10) code.
- The procedure to be performed (CPT4 or tariff code).
- The date of admission.
- The name and telephone number of the caller.
- Whether or not the treating doctor charges medical scheme rates.

CONTACT POLMED FOR HOSPITAL PRE-AUTHORISATION
Your admitting doctor must contact POLMED on 0860 104 111 to obtain pre-authorisation. Alternatively, you (if you have all the details) may contact POLMED on 0860 765 633 to obtain pre-authorisation.

AUTHORISATION
An authorisation number is given to the caller and immediately faxed or emailed to the hospital and your treating provider. A penalty of R5 000 may be imposed if no pre-authorisation is obtained.

Should you require confirmation of the tariff amounts that will be paid per tariff code, call the Client Service Call Centre on 0860 765 633 or email polmed@medscheme.co.za.

IF FURTHER INFORMATION IS REQUIRED
- The admission request/procedure is queried with the hospital.
- A letter of motivation is requested from your doctor.
- POLMED may require additional information prior to approval of the procedure and will contact the treating doctor to obtain this.

R8 000 co-payment will be applied for admission to a non-network hospital, applicable to both the Marine and Aquarium plans. Visit the POLMED website at www.polmed.co.za to access the list of hospitals in the network.

EMERGENCY HOSPITALISATION PROCESS
Please note that in case of an emergency, the member or the hospital should contact POLMED within 24 hours of the event or on the next working day. A penalty of R5 000 may be imposed if no pre-authorisation is obtained.
The aim of the POLMED Maternity Programme is to provide the expectant mother with additional benefits, support, education and advice through all stages of the pregnancy, confinement and postnatal period.

REGISTRATION TO THE PROGRAMME
Pregnant members can contact POLMED to register to the Maternity Programme.

CONTACT DETAILS
Tel: 0860 765 633
Email: polmedmaternity@medscheme.co.za

THE FOLLOWING INFORMATION MUST BE AT HAND WHEN YOU CALL FOR HOSPITAL PRE-AUTHORISATION:
• Membership number.
• Name or practice number where you are being admitted.
• Name of patient.
• Date of birth.
• Name or practice number of treating doctor.
• Diagnosis (ICD-10 code) and/or method of delivery
• Clinical motivation may be requested for a C-section.

ADMISSION FOR DELIVERY
The member must contact POLMED on 0860 765 633 for hospital pre-authorisation.
IMPORTANT!
If you have been diagnosed with a chronic condition, it is important that your medication be authorised before your prescription is handed in at the pharmacy.

INFORMATION REQUIRED WHEN APPLYING FOR CHRONIC AUTHORISATION:

- Member details including membership number and date of birth.
- A valid chronic prescription containing the following information:
  - Diagnosis: Valid ICD-10 code.
  - Date: The date on the prescription should not be older than 6 months from date of issue by the service provider.
  - Doctor’s details: Practice name, practice number, telephone number, address and signature.
  - Patient’s details: Full name and surname.
  - Medication: Name, dosage, quantity, directions for use.
  - Duration of treatment: How long the prescription is valid for, e.g. repeat for 6 months.
- You may also have to attach or upload your test results. It all depends on your condition.

DID YOU KNOW?
You or your treating doctor or pharmacist can call POLMED to obtain pre-authorisation for your chronic medication.

Treating doctor/pharmacist: Call 0860 104 111
Member: Call 0860 765 633

NOTE
Co-payments
- Ensure your doctor prescribes items on the medication formulary to avoid a 20% co-payment.
- If you obtain your medication from a non-designated service provider (non-DSP), you will have a 20% co-payment.
- If both the above scenarios are applicable, a maximum co-payment of 20% applies.

Generic reference pricing
- Generic reference pricing is applicable where generic equivalent medication is available.
- Co-payments due to reference pricing may be avoided by using generic medication that is below the reference pricing – your pharmacist can suggest generic medication options.
MENTAL HEALTH PROGRAMME (FOR ALL MEMBERS)

INTRODUCTION
POLMED's Mental Health Programme offers support to members and their registered dependants diagnosed with conditions such as depression, bipolar mood disorder, post-traumatic stress disorder, schizophrenia, and alcohol and substance abuse.

REGISTRATION PROCESS
You or your treating doctor may contact POLMED to register you to the Programme.

CONTACT DETAILS
Tel: 0860 765 633 weekdays only (excluding public holidays)
Email: polpsych@medscheme.co.za

CARE PLAN
Once registered, you will receive a Care Plan listing the care/services you have access to in order to manage your condition. The authorised services will be paid from your overall in-hospital benefit and not from your overall out-of-hospital (day-to-day) benefit.
ONCOLOGY MANAGEMENT

CONTACT DETAILS
Tel: 0860 765 633
Fax: 0860 000 340
Email: polmedonco@medscheme.co.za
Post: POLMED, Private Bag X16, Arcadia 0007

Independent Clinical Oncology Network (ICON) is the designated service provider (DSP).

PRE-AUTHORISATION
Pre-authorisation is required for all oncology treatment and procedures.

THE FOLLOWING INFORMATION IS REQUIRED FOR AUTHORISING TREATMENT:
- Member’s name and surname.
- Membership number.
- Date of birth and/or ID number.
- Treating doctor’s name and practice number.
- Treatment plan from doctor.
- ICD-10 code.
- Tariff code.
- Nappi code(s) for medication.
- Date of service.
- Histology results.

AUTHORISATION
Once registered, you and your treating doctor will receive an authorisation for treatment of your condition.

SUPPORT FROM POLMED CASE MANAGER
The Case Manager will:
- help the member understand the processes to be followed
- explain the benefits available
- provide other support and information.
PRESCRIBED MINIMUM BENEFITS

Prescribed minimum benefits (PMBs) are a set of benefits that are meant to ensure that all medical scheme members have access to certain minimum health services, regardless of their benefit option. The aim is to provide members with continuous care to improve their health and well-being, and to make healthcare more affordable.

PMBs are a feature of the Medical Schemes Act, in terms of which medical schemes have to cover the costs related to the diagnosis, treatment and care of:
- any emergency medical condition that requires emergency treatment
- a limited set of 270 medical conditions as defined in the Diagnosis and Treatment Pairs (DTPs)
- 26 chronic conditions as defined in the Chronic Disease List (CDL).

CHRONIC DISEASE LIST (CDL)
- Addison’s disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy disease
- Chronic obstructive pulmonary disorder
- Chronic renal disease
- Coronary artery disease
- Crohn’s disease
- Diabetes insipidus
- Diabetes mellitus type I and II
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- HIV/AIDS
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson’s disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

CARE PLAN
You and your treating doctor will receive a Care Plan for treatment of your condition. Your doctor needs to submit the relevant ICD-10 and tariff codes when submitting claims.

The Care Plan is sent via email or post and contains details in respect of services that can be claimed from the PMB benefit.

ENQUIRIES
Tel: 0860 765 633
Fax: 0860 000 320
Email: polmedapmb@medscheme.co.za

PSYCHOLOGICAL BENEFITS FOR SERVING MEMBERS ONLY

POLMED has established a Psycho-Social Network that consists of clinical psychologists and social workers. This benefit excludes dependants and continuation members.

However, POLMED has a mental health benefit for dependants and continuation members – see ‘Mental Health Programme’ on page 105 for more information.

BENEFIT INFORMATION
- This service is for serving SAPS members only; not dependants.
- The consultations will be paid from the Psycho-Social benefit irrespective of your available overall out-of-hospital (day-to-day) benefit.
- You will be allowed a maximum of four sessions a year, where the first is an evaluation session. Should symptoms be identified at this initial consultation that require therapy, you will then have three therapy sessions.
- Should you require additional support/therapy, you may use your standard Scheme benefits.

LOOKING FOR CONTACT DETAILS?

Visit the POLMED website at www.polmed.co.za and use the provider search tool at the top of the home page to search for a Network PSYCHOLOGIST or SOCIAL WORKER.

Call the Client Service Call Centre on 0860 765 633 and ask for the contact details of a Psycho-Social Network provider in your area.
REGISTRATION TO DISEASE RISK MANAGEMENT (DRM) PROGRAMME

The DRM Programme is aimed at assisting you to manage your chronic condition and, in the long term, improve your health.

REGISTRATION PROCESS
You or your treating doctor may contact POLMED to be registered to the Programme as soon as you have been diagnosed with a chronic condition.

CONTACT DETAILS
Tel: 0860 765 633 weekdays only (excluding public holidays)
Email: polmeddiseaseman@medscheme.co.za

DISEASES MANAGED ON THE DRM PROGRAMME
- Respiratory: Asthma and chronic obstructive pulmonary disease (COPD)
- Cardiac: Hyperlipidaemia, high blood pressure, heart failure, coronary artery disease and dysrhythmia
- Metabolic: Diabetes
- Spinal: Cervical and lumbar conditions
- Mental health: Depression, bipolar mood disorder, post-traumatic stress disorder (PTSD) and substance abuse

CARE PLAN INFORMATION
Once registered, you and your treating doctor will receive a Care Plan that will reflect the services, ICD-10 codes and tariff codes. The information that appears on the Care Plan must be used when the claim is submitted to ensure correct payment of your claims.

REGISTRATION TO HIV MANAGEMENT PROGRAMME

HOW DO I REGISTER TO THE POLMED HIV MANAGEMENT PROGRAMME?

This Programme is strictly confidential.

The application form is available:
- via the POLMED website at www.polmed.co.za (go to ‘FORMS’, select ‘Manage Care (Medical)’, and then ‘HIV Application’)
- by contacting the HIV Management Call Centre at 0860 100 646
- from any POLMED regional walk-in branch.

Submit your completed and signed application form to POLMED via:
Email: polmedhiv@medscheme.co.za
Fax: 0800 600 773
Post: PO Box 38597, Pinelands 7430

A COUNSELLOR CAN BE CONTACTED ON 0860 100 646 IF YOU REQUIRE HELP WITH THE MANAGEMENT OF YOUR CONDITION.

You and your treating doctor will receive the authorisation and Care Plan.
SPECIALISED DENTISTRY

ALL SPECIALISED DENTISTRY IS SUBJECT TO PRE-AUTHORISATION.

Submit the following information to dental.polmeddental@medscheme.co.za in order to obtain authorisation:

• Full diagnosis of the condition.
• Treatment plan (tariff codes and ICD-10 codes).
• Clinical motivation.
• Teeth numbers.
• Laboratory codes (where applicable).
• Clear X-rays.

AQUARIUM PLAN:
Refer to the dentistry (specialised) benefit for the list of procedures covered. Clinical protocols apply.

IN-HOSPITAL DENTAL PROCEDURES – CONTACT DETAILS FOR PRE-AUTHORISATION

Tel: 0860 765 633
Fax: 0860 104 114
Email: polmedauths@medscheme.co.za

PAYMENT GUIDELINES/HOSPITAL PRE-AUTHORISATION

• 100% of POLMED rate or at cost for prescribed minimum benefits (PMBs).
• You may be liable for the full claim or a co-payment of R5 000 if no pre-authorisation is obtained.

PAYMENT GUIDELINES/DENTAL PROCEDURE

• 100% of POLMED rate or at cost for PMBs.
• You may be liable for the full claim or a co-payment of R500 if no pre-authorisation is obtained.
EMERGENCY MEDICAL SERVICES (EMS): NETCARE 911

**WHO CAN I CALL IN THE EVENT OF A MEDICAL EMERGENCY?**

Members/service providers must call Netcare 911 on 082 911.

**72-HOUR POST-AUTHORISATION RULE**

Subject to authorisation within 72 hours of the event, all accredited service providers will need to get an authorisation number from Netcare 911.

Co-payment of 40% of the claim shall apply where a member voluntarily uses an unauthorised service provider. Service providers will be required to provide the hospital admission/casualty sticker together with patient report forms when submitting a claim to POLMED’s EMS DSP to validate delivery to a hospital.

**NETCARE 911:**

082 911

Co-payment of 40% of the claim shall apply where a member voluntarily uses an unauthorised service provider. Service providers will be required to provide the hospital admission/casualty sticker together with patient report forms when submitting a claim to POLMED’s EMS DSP to validate delivery to a hospital.
FIVE STEPS TO MORE COST-EFFECTIVE EYE CARE

**POLMED** has contracted eye care network Preferred Provider Negotiators (PPN) to provide consultations, clear spectacle lenses as well as frame and lens enhancements. PPN Optometrists have agreed to charge cost-effective rates for clear lenses in return for better professional fees. This has resulted in cost-effective pricing with no compromise on professional standards or the quality of products.

**BENEFITS ENQUIRY**
Should you be unsure if you have benefits available or when it will become available, you can either contact the dedicated PPN Customer Care Line on 0861 103 529 or register to use the ‘member dashboard’ by visiting the PPN website at www.ppn.co.za.

**FIND AN OPTOMETRIST**
To maximise your benefits, we recommend that you consult a PPN Optometrist. PPN is the largest optical network in South Africa, with over 2 600 Optometrists currently contracted to the network. To locate a PPN Optometrist in your area, please contact their Customer Care Line or visit their website.

You may visit an Optometrist that is not on the network, but the account will be paid at the PPN rate. If the Optometrist charges more than the PPN rate, you will be liable for a co-payment.

**CO-PAYMENTS**
Please visit a PPN Optometrist to avoid co-payments. PPN Optometrists charge PPN rates, which are up to 75% lower than the rates charged by Optometrists outside the PPN network for certain lens prescriptions.

Ask your Optometrist to provide you with spectacles within your optical benefit limit. If you are not happy with the price of the spectacles, ask for a written quotation and email it to PPN at management@ppn.co.za for their opinion and advice.

**ADDITIONAL BENEFITS**
Any additional optometric benefit requests should be sent to PPN at ppnmotivations@ppn.co.za, together with a quotation and motivation letter. It will be forwarded to their Motivations Committee for their opinion and input.

Should surgery be required to treat an eye condition, e.g. glaucoma, POLMED will issue the pre-authorisation. The treating specialist or hospital contacts POLMED on the provider pre-authorisation number on 0860 104 111 or you call the POLMED Client Service Call Centre on 0860 765 633 to obtain authorisation prior to hospital admission.

For more information about benefits relating to ophthalmology or specialists, please contact the POLMED Client Service Call Centre on 0860 765 633.

**Note:** You do not require a referral by a general practitioner prior to a consultation with an Ophthalmologist.

**FIGHTING FRAUD**
Fraud is one of the major contributing factors to our rising healthcare costs. PPN would like to put your mind at ease and can assure you that the PPN Forensic Audit Unit initiates campaigns that detect occurrences of fraudulent activities, investigates them and creates prevention mechanisms to deter these fraudulent acts from occurring.

How can you contribute? Report any fraudulent or suspicious activities to optimumfraud@ppn.co.za or 0861 103 529. Confidentiality is assured at all times.
MOTOR VEHICLE ACCIDENT (MVA) CLAIMS

POLMED will inform Batsumi Claims Management Solutions (Batsumi) of your accident and their office will contact you to verify the details of the incident.

You, together with your personal attorney, will be required to complete an Accident Report and an Indemnity Form. [This form confirms that you undertake to lodge a claim against the Road Accident Fund (RAF) and reimburse POLMED the total amount recovered from the RAF at finalisation of the claim.]

In the event that you do not have a personal attorney, Batsumi can refer you or your dependant to a network of attorneys that specialise in third-party claims to assist you with your claim.

The completed forms are to be sent to Batsumi at the following email address: possiblethirdpartyclaims@batsumicare.com or fax to 012 425 4208.

Batsumi will continue to update your claims and liaise with your attorneys to ensure that all medical-related claims are included and are submitted to the RAF.

On finalisation of the claim, you and your attorney must reimburse POLMED the total amount recovered from the RAF in respect of all medical costs incurred on behalf of yourself or your dependants.

Failure to lodge a claim against the RAF by a member may result in the member being liable to the Scheme.
### MY CONTACTS

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