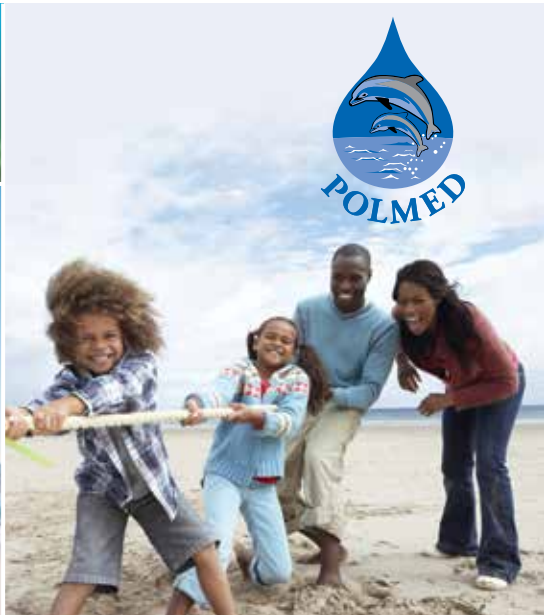
2016 GUIDE TO YOUR HEALTH

AQUARIUM & MARINE



CONTENTS

CONTENTS

BENEFIT MANAGEMENT

Keep a record of your medical claims in the table below and overleaf and keep track of your expenses to ensure you have sufficient benefits available to last you the year. Please also ensure that your claims are paid from the correct benefit category. Your medical scheme management and record-keeping efforts can also help POLMED in the fight against medical scheme fraud.

PLEASE NOTE:

All services listed under 'in hospital' will be paid from this benefit. Refer to pages 16 to 18 for Marine or to pages 52 to 54 for Aquarium.
Obtain pre-authorisation or a motivation where indicated in the benefit schedule to ensure payment of your claims.

Service date (date treated)	Name of beneficiary (main member or dependant)	Name of service provider (doctor/ pharmacy/other)	Out-of-hospital claim	Out-of-hospital claim paid by POLMED	Balance of out-of-hospital benefit	In-hospital claim	Claims for prescribed minimum benefits	In-hospital costs paid by POLMED

All services listed on pages 19 to 21 (Marine) and 55 to 57 (Aquarium) under overall out-of-hospital benefits will be paid from the amounts shown next to the member categories, e.g.:

- M0 – member with no dependants;
- M+1 – member with one dependant;
- M+2 – member with two dependants;
- M+3 – member with three dependants; and
- M+4/more – member with four or more dependants.

Example

A member with no dependants (M0) who is on Marine will have R17 978 overall out-of-hospital benefits for the year. Claims for services listed in this booklet will be paid for from this amount. Each time the benefit is accessed the cost will be deducted from the R17 978. The benefit limit amounts are different for members with one or more dependants and for members on Aquarium.

Here is another example, but this time for a member with one dependant on Marine:

- Overall out-of-hospital benefit: M+1 = R21 878, which is available at the beginning of the year
- Claim for pathology (blood test): Claim for R878 paid by POLMED
- Balance left over in overall out-of-hospital benefit after payment of the claim = R20 000

Any claims for services listed below will be deducted from the overall out-of-hospital benefit on Marine. If you are on Aquarium, please refer to page 55 to 57.

- dentistry (basic);
- general practitioner visits;
- acute medication;
- over-the-counter medication;
- audiology;
- pathology;
- physiotherapy;
- specialist consultations;
- social workers; and
- occupational and speech therapy.

BENEFIT MANAGEMENT

Service date (date treated)	Name of beneficiary (main member or dependant)	Name of service provider (doctor/ pharmacy/other)	Out-of-hospital claim	Out-of-hospital claim paid by POLMED	Balance of out-of-hospital benefit	In-hospital claim	Claims for prescribed minimum benefits	In-hospital costs paid by POLMED

ANNEXURE A1

PREVIOUSLY KNOWN AS THE HIGHER PLAN

MARINE SCHEDULE

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2016

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 below, 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) rates + inflationary figure (i.e. the 2006 base tariff increased by the inflationary amounts); and
- **'Agreed tariff'** shall mean: The rate negotiated by and on behalf of the Scheme with one or more providers/groups.

Benefits for 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.

MARINE

ANNEXURE A3

SCHEDULE OF CONTRIBUTIONS

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

Total contribution includes subsidy from employer.

CONTRIBUTION RATES HIGHER PLAN (1 April 2015 – 31 March 2016)

TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 300	1 714	1 714	798
R5 301 – R7 300	1 807	1 807	848
R7 301 – R8 900	1 841	1 841	874
R8 901 – R10 400	1 907	1 907	910
R10 401 – R12 100	1 979	1 979	937
R12 101 – R14 500	2 051	2 051	973
R14 501 – R17 800	2 109	2 109	1 012
R17 801 +	2 165	2 165	1 040

MEMBER CONTRIBUTION (SUBSIDISED CONTRIBUTION)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 300	238	238	60
R5 301 – R7 300	331	331	110
R7 301 – R8 900	365	365	136
R8 901 – R10 400	431	431	172
R10 401 – R12 100	503	503	199
R12 101 – R14 500	575	575	235
R14 501 – R17 800	633	633	274
R17 801 +	689	689	302

NOTE: Full contribution applicable to members who do not qualify for employer subsidy.

The contributions for 2016 as set out in the format required by the Registrar in Circular 48 of 2015.

CONTRIBUTION RATES MARINE (1 April 2016 – 31 March 2017)

TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 600	1 827	1 827	850
R5 601 – R7 700	1 927	1 927	904
R7 701 – R9 400	1 964	1 964	932
R9 401 – R11 000	2 035	2 035	971
R11 001 – R12 800	2 113	2 113	1 000
R12 801 – R15 400	2 191	2 191	1 039
R15 401 – R18 900	2 254	2 254	1 081
R18 901 +	2 314	2 314	1 111

MEMBER CONTRIBUTION (SUBSIDISED CONTRIBUTION)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 600	257	257	65
R5 601 – R7 700	357	357	119
R7 701 – R9 400	394	394	147
R9 401 – R11 000	465	465	186
R11 001 – R12 800	543	543	215
R12 801 – R15 400	621	621	254
R15 401 – R18 900	684	684	296
R18 901 +	744	744	326

NOTE: Full contribution applicable to members who do not qualify for employer subsidy.

GENERAL RULES

In hospital

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

In the case of 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 has to 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.

Medicine prescribed during hospitalisation forms part of the hospital benefits.

Medicine 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.

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.

Specialised radiology

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

Medication

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 medicine, 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.)

Payment in respect of over-the-counter (OTC), acute and chronic medicine, will be limited to the medicine reference price. This is the maximum allowed cost and may be based on either generic or 'formulary' reference pricing. The balance of the cost needs to be funded by the member.

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 ('basket') of medicines appropriate for the management of their particular conditions/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 medicines are included in the condition-specific medicine basket. Updates to the authorisation will be required for newly diagnosed conditions for the beneficiary. Medication that is not included in the baskets may be available through an exception management process, for which a medicine-specific authorisation may be granted; this process requires motivation from the treating service provider and will be reviewed based on the exceptional needs of the beneficiary.

The member needs to re-apply for an authorisation at least one month prior to expiry of an existing chronic medicine authorisation, failing which any claims received will not be paid from the chronic medicine benefit, but from the acute medicine benefit, if benefits exist. This only applies to authorisations that are not on-going and have an expiry date.

The Scheme shall only consider claims for medicines prescribed by a person legally entitled to prescribe medicine 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.

Specialist referral

All Polmed beneficiaries need to be referred to specialists by a general practitioner (GP). The beneficiary or the referring GP is required to obtain a referral number, which can be obtained from the Scheme. The Scheme will impose a co-payment of up to R1 000 if the member consults a specialist without the referral. 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 specialities/disciplines: Gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists [chronic dialysis], dental specialists, pathology, radiology and supplementary/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.

MARINE

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.

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 financial year.

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 alternative provider, all costs in excess of the agreed rate will be for the cost of the member and must be paid directly to the provider by the member.
You can access the list of providers at www.polmed.co.za, on your cell phone via the mobile site or request it via the Client Service Department.

Designated GP provider (network GP)

Members are allowed two visits to a 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.

Designated pharmacy network

Polmed has appointed service providers for the provision of chronic medication. The Scheme utilises the courier pharmacies as the primary service provider, with retail pharmacies providing secondary support for those members who prefer personal interaction. Where the member chooses to use an alternative provider, the member shall be liable for a co-payment of 20% of the costs that must be paid directly to the provider by the member.

You can access the list of providers at www.polmed.co.za, on your cell phone via the mobile site or request it via the Client Service Department.

- Pharmacy (medicine) designated service provider.

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.

DEFINITION OF TERMS

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 in excess of those agreed upon with the service provider or in excess of 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.

Medicine reference price

This is the reference pricing system applied by the Scheme; it may be based on either generic or 'formulary' reference pricing. This pricing system refers to the maximum price that Polmed will pay for a particular medication. Should a reference price be set for a generic or therapeutic class of medication, patients are entitled to make use of any medication within this pricing limit, but will be required to make a co-payment on medication priced above the reference pricing limit. The fundamental principle of any reference pricing system is that it does not restrict a member's choice of medicine, but instead limits the amount that will be paid for it. Accessibility of products within the reference price groups is taken into account when defining the group.

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.

Registration for chronic medication

Polmed provides for a specific list of chronic conditions that are funded from the chronic medicine 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 a letter by post or e-mail indicating whether their application was successful or not. If successful, the beneficiary will be issued with a disease-specific authorisation, which will allow access to a range of medicines that are referred to as the 'disease authorisation basket.

Enrolment on the Disease Management Programme

Members will be identified and contacted in order to enrol on the Disease Management Programme. The Disease 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

MARINE

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 that are eligible for enrolment on the programme. Members are also encouraged to register themselves on the programme.

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/fillings and replacement of missing teeth by plastic dentures.

Other procedures that fall under the category are:

- consultations
- fluoride treatment and fissure sealants
- non-surgical removal of teeth
- cleaning of teeth, including non-surgical management of gum disease
- root canal treatment.

Disclaimer: In the event of a dispute the registered rules of POLMED will apply.

MARINE BENEFIT SCHEDULE

GENERAL BENEFIT RULES	**Benefit design**	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
	Pre-authorisation, referrals, protocols and management by programmes	Where the benefit is subject to pre-authorisation, referral by a designated service provider (DSP) or general practitioner (GP), adherence to established protocols or enrolment upon 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 enrolment upon a managed 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 enrolment upon a managed care programme is stipulated in order to best care for the member and his/her family and to protect the funds of the Scheme

MARINE

GENERAL BENEFIT RULES		
	Limits are per annum	Unless there is a specific indication to the contrary all benefit amounts and limits are annual
	Statutory prescribed minimum benefits (PMBs)	There is no overall annual limit for PMBs/life-threatening emergencies
	Tariff	100% of Polmed rate or agreed tariff or at cost for involuntary access to PMBs

IN-HOSPITAL BENEFITS		
	Annual overall in-hospital limit In-hospital benefits are: Subject to the Scheme's relevant managed healthcare programmes and include the application of treatment protocols, case management and pre-authorisation; a R5 000 penalty may be imposed if no pre-authorisation is obtained Subject to PMBs, i.e. no limit in case of life-threatening emergencies or for PMB conditions Subject to applicable tariff, i.e. 100% of Polmed rate or agreed tariff or at cost for involuntary access to PMBs	Unlimited in private hospitals

IN-HOSPITAL BENEFITS		
	Dentistry (conservative and restorative)	100% of Polmed rate Dentist's costs for basic dental procedures will be reimbursed from the out-of-hospital (OOH) benefit The hospital and anaesthetist's costs will be reimbursed from the in-hospital benefit
	Emergency medical assistance Netcare 911 (082 911) is the DSP	100% of agreed tariff
	Chronic kidney dialysis National Renal Care (NRC) and Fresenius Medical Care are preferred providers	100% of agreed tariff at DSP
	Mental health	100% of Polmed rate or at cost for PMBs Annual limit of 21 days per beneficiary Limited to a maximum of three days' hospitalisation for beneficiaries admitted by a GP or a specialist physician Additional hospitalisation to be motivated by the medical practitioner
	Medication: Non-PMB specialist drug limit, e.g. biologicals	100% of Polmed rate Pre-authorisation required Specialised medicine sub-limit of R98 595 per family
	Oncology (chemotherapy and radiotherapy) Independent Clinical Oncology Network (ICON) is the DSP	100% of agreed tariff at DSP Limited to R396 630 per beneficiary per annum; includes MRI/CT or PET scans related to oncology

IN-HOSPITAL BENEFITS	**Organ and tissue transplants**	100% of agreed tariff at DSP or at cost for PMBs Subject to clinical guidelines used in State facilities Unlimited radiology and pathology for organ transplant and immunosuppressants
	Pathology	Service will be linked to hospital pre-authorisation
	Physiotherapy	Service will be linked to hospital pre-authorisation
	Prostheses (internal and external)	100% of Polmed rate or at cost for PMBs Subject to pre-authorisation and approved product list Limited to R58 300 per beneficiary
	Refractive surgery	100% of Polmed rate Subject to pre-authorisation Procedure is performed out of hospital and in day clinics
	General practitioners (GPs)	100% of agreed tariff at DSP, 100% of Polmed rate at non-DSP or at cost for involuntary access to PMBs
	Specialists Anaesthetists	100% of agreed tariff at 100% of Polmed rate at non-DSP or at cost for involuntary access to PMBs 150% of Polmed rate or at cost for PMBs

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	M0 – R17 978 M1 – R21 878 M2 – R26 362 M3 – R30 231 M4+ R32 807
	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

OVERALL OUT-OF-HOSPITAL BENEFITS		
	General practitioners (GPs) Polmed has a GP network	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/consultations per family per annum, as follows: M0 – 11 M1 – 16 M2 – 20 M3 – 24 M4 + – 29
	Medication (acute)	100% of Polmed rate Annual limit of R15 614 per family Subject to the OOH limit and the medicine reference price
	Medication (over the counter [OTC])	100% of Polmed rate Annual limit of R1 028 per family Subject to the OOH limit; shared limit with acute medication
	Audiology	100% of Polmed rate Subject to the OOH limit Subject to referral by GP, ear, nose and throat (ENT) specialist, paediatrician, physician or neurologist
	Occupational and speech therapy	100% of Polmed rate Annual limit of R2 385 per family Subject to OOH limit

OVERALL OUT-OF-HOSPITAL BENEFITS		
	Pathology	M0 – R3 000 M1 – R4 325 M2 – R5 173 M3 – R6 371 M4 + – R7 812 The defined limit per family will apply for any pathology service done out of hospital
	Physiotherapy	100% of Polmed rate Annual limit of R4 325 per family Subject to the OOH limit
	Social worker	100% of Polmed rate Annual limit of R4 325 per family Subject to the OOH limit
	Specialists Referral is not necessary for gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists (dialysis), dental specialists and supplementary/allied health services (excluding audiology services)	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 five visits per beneficiary and 11 visits per family per annum Subject to referral by a GP (two specialist visits per beneficiary without GP referral allowed) R1 000 co-payment if no referral is obtained

STAND-ALONE BENEFITS	**Allied health services and alternative healthcare providers** Includes chiropractors, biokineticists, dieticians, homeopaths, chiropodists, podiatrists, reflexologists, naturopaths, orthoptists, osteopaths and therapeutic massage therapists Benefits will be paid for clinically appropriate services	100% of Polmed rate Annual limit of R2 385 per family	
	Appliances (medical and surgical) Pre-authorisation is required for the supply of oxygen All costs for maintenance are a Scheme exclusion Members must be referred for audiology services for hearing aids to be reimbursed	100% of Polmed rate and subject to:	
		Blood transfusions	No limit
		Hearing aids	R12 624 per hearing aid or R25 090 per beneficiary per set every three years
		Nebuliser	R1 198 per family once every four years
		Glucometer	R1 198 per family once every four years
		CPAP machine	R8 427 per family once every four years
		Wheelchair (non-motorised)	R14 024 per beneficiary once every three years
		Wheelchair (motorised)	R47 138 per beneficiary once every three years
		Insulin delivery devices and urine catheters	Paid from the hospital benefit up to the mean price out of three quotations

STAND-ALONE BENEFITS	**Appliances (medical and surgical)** (continued)	Medical assistive devices	Annual limit of R3 000 per family and includes medical devices in/out of hospital
	Dentistry (specialised) Pre-authorisation required	100% of Polmed rate or at cost for PMBs An annual limit of R12 678 per family Benefits shall not exceed the set out limit and includes any specialised dental procedures done in/out of hospital Includes metal-based dentures Excludes osseointegrated implants Subject to dental protocols	
	Maternity benefits, including home birth Pre-authorisation required and treatment protocols apply	The limit for consultations shall not accrue towards the OOH limit The benefit shall include three specialist consultations per beneficiary per pregnancy Home birth is limited to R15 020 per beneficiary per annum Annual limit of R4 219 for ultrasound scans per family; limited to two 2D scans per pregnancy Benefits relating to more than two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation	
	Maxillofacial Pre-authorisation required	Shared limit with specialised dentistry Excludes osseointegrated implants	

STAND-ALONE BENEFITS

Chronic medication refers to non-PMB conditions Subject to prior application and/or registration of the condition **Approved PMB-CDL conditions do not first accrue to this limit and are not subject to a limit** Designated service providers: Courier pharmacies: Medipost and Pharmacy Direct Retail pharmacies: Clicks and MediRite	100% of medicine reference price The extended list of chronic conditions (non-PMBs) are subject to the following limits: Member with no registered dependants: Annual limit of R8 708 Member with registered dependants: Annual limit of R15 630 Subject to the medicine reference price
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 Annual contact lens limit is specified Contact lens re-examination can be claimed for in six-monthly intervals Preferred Provider Negotiators (PPN) is the preferred provider network	The benefit per beneficiary (per 24-month benefit cycle) at a PPN provider would be: One composite consultation, inclusive of refraction, tonometry and visual field screening; collection of blood pressure, glucose and cholesterol readings AND EITHER SPECTACLES A PPN frame to the value of R150 and R800 towards lens enhancements OR R950 towards the cost of any alternative frame and/or lens enhancements WITH EITHER One pair of clear Aquity single-vision or clear Aquity bifocal lenses or clear Aquity multifocal lenses

STAND-ALONE BENEFITS

Optical (continued)	OR CONTACT LENSES Contact lenses to the value of R1 510 Contact lens re-examination to a maximum cost of R210 per consultation Non-PPN provider would be: One consultation limited to a maximum cost of R325 AND EITHER SPECTACLES R950 towards a frame and/or lens enhancements WITH EITHER One pair of single-vision lenses, limited to R150 per lens, or one pair of clear flat-top bifocal lenses, limited to R325, or one pair of clear flat-top multifocal lenses, limited to R600 per lens OR CONTACT LENSES Contact lenses to the value of R1 510 Contact lens re-examination to maximum cost of R210 per consultation
Preventative care (refer to Annexure E) One wellness measure per year, including: • Blood pressure test • Body mass index test • Waist-to-hip ratio measurement • Cholesterol screening (Z13.8) • Glucose screening (Z13.1) • Healthy diet counselling (Z71.3)	100% of Polmed rate or agreed tariff where applicable Early detection screening limited to periods specified in Annexure E Funded from the risk pool; the benefit shall not accrue to the OOH limit

STAND-ALONE BENEFITS	**Preventative care (refer to Annexure E)** (continued) • Risk assessment tests: – Baby immunisation (as per the Department of Health guidelines) – Bone densitometry scan – Circumcision – Contraceptives (as per Department of Health guidelines) – Dental screening (codes 8101, 8151and 8102) – Flu vaccine – Glaucoma screening – Glucose screening – HIV tests – Mammogram – Pap smear – Pneumococcal vaccine – Prostate screening – Psycho-social services	
	Radiology (basic) i.e. black and white X-rays and soft tissue ultrasounds	100% of agreed tariff or at cost for PMBs Limited to R6 180 per family Includes any basic radiology done in/out of hospital Claims for PMBs first accrue towards the limit
	Radiology (specialised) Pre-authorisation required	100% of agreed tariff or at cost for PMBs Limited to R37 310 per family Includes any specialised radiology service done in/out of hospital Claims for PMBs first accrue towards the limit Subject to a limit of two scans per beneficiary per annum, except for PMBs

ANNEXURE A2

CO-PAYMENTS

OUT OF NETWORK	CO-PAYMENT
General practitioner (GP)	Allows for two out-of-network consultations Co-payments shall apply once maximum out-of-network consultations are exceeded
Pharmacy	20% of costs

ANNEXURE A4

MARINE: CHRONIC CONDITIONS

Prescribed minimum benefits (PMBs), including chronic diagnostic 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.

Auto-immune disorder

Systemic lupus erythematosis (SLE)

Cardiovascular conditions

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

Endocrine conditions

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

Gastro-intestinal conditions

Crohn's disease
Ulcerative colitis
Peptic ulcer disease (requires special motivation)

Gynaecological conditions

Endometriosis
Menopausal treatment

Haematological conditions

Haemophilia
Anaemia
Idiopathic thrombocytopenic purpura
Megaloblastic anaemia

Metabolic condition

Hyperlipidaemia

Musculoskeletal condition

Rheumatic arthritis

Neurological conditions

Epilepsy
Multiple sclerosis
Parkinson's disease
Cerebrovascular incident
Permanent spinal cord injuries

Ophthalmic condition

Glaucoma

Pulmonary diseases

Asthma
COPD
Bronchiectasis
Cystic fibrosis

Psychiatric conditions

Affective disorders (depression and bipolar mood disorder)
Schizophrenic disorders

Special category conditions

HIV/AIDS
Tuberculosis
Organ transplantation

Treatable cancers

As per PMB guidelines

Urological conditions

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

Extended chronic disease list: non-PMB

Chronic medication is payable from the chronic medication benefit pool, subject to the availability of funds.

Dermatological conditions

Acne (clinical photos required)
Psoriasis
Eczema
Onychomycosis (mycology report required)

Ear, nose and throat condition

Allergic rhinitis

Gastro-intestinal condition

Gastro-oesophageal reflux disease (GORD) (special motivation required)

Metabolic condition

Gout prophylaxis

Musculoskeletal conditions

Ankylosing spondylitis
Osteoarthritis
Osteoporosis
Paget's disease
Psoriatic arthritis

Neurological conditions

Alzheimer's disease
Trigeminal neuralgia
Meniere's disease
Migraine prophylaxis
Narcolepsy
Tourette's syndrome

Ophthalmic condition

Dry eye/keratoconjunctivitis sicca

Psychiatric condition

Attention deficit hyperactivity disorder (ADHD)

Urological condition

Overactive bladder syndrome

MARINE

ANNEXURE C

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 Regulations 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.

GENERAL EXCLUSIONS

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

1. 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);

2. Sleep therapy;

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

4. 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); and
   - subject to pre-authorisations and prior approval by the Scheme.

5. Charges for appointments which a member or dependant failed to keep with service providers;

6. Prenatal and/or post-natal exercises;

7. 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; for example, breast reduction, breast augmentation, otoplasty, total nose reconstruction, lipectomy, subcutaneous mastectomy, minor superficial varicose veins treatment with sclerotherapy, abdominal bowel bypass surgery, etc.;

   Members have the opportunity to lodge an appeal to POLMED's Clinical Committee, when an application for a procedure was declined;

8. Plastic and reconstructive surgery is excluded from benefits, unless previously approved by the Scheme as clinically essential and not cosmetic;

9. 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;

10. Aids for participation in sport, e.g. mouthguards;

11. Gold inlays in dentures, soft and metal base to new dentures, invisible retainers, osseo-integrated implants and bleaching of vital (living) teeth;

12. Fixed orthodontics for beneficiaries above the age of 21 years;

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

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

15. Sex change operations;

16. Bandages and plasters, unless prescribed after an operation or injury;

17. Beneficiaries' travelling costs except services according to the benefits in Annexure A/B;

18. Accounts of persons not registered with a recognised professional body constituted in terms of an Act of Parliament;

19. Accommodation in spas, health or rest resorts;

20. Holidays for recuperative purposes;

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

22. Muscular fatigue tests, except if requested by a specialist and a doctor's motivation is enclosed;

23. Any treatment as a result of surrogate pregnancy;

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

25. Non-functional prostheses used for reconstructive/restorative surgery,

excluding PMB diagnoses, provided that the Board may decide to grant the benefit in exceptional circumstances;

26. Benefits for costs of repair, maintenance, parts or accessories for the appliances or prostheses;

27. Unless otherwise indicated by the Board, costs for services rendered by any institution, not registered in terms of any law;

28. All costs in respect of sickness conditions that were specifically excluded from benefits when the member was admitted to the Scheme for twelve months from the date of coverage;

29. Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one month's supply for every such prescription or repeat thereof;

30. 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;

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

32. Nappies excluded and benefits for adult use will only be granted if previously authorised with motivation;

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

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

35. Benefits for tints and photochromic lenses;

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

ACUTE MEDICINE EXCLUSIONS

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

CATEGORY	DESCRIPTION	EXAMPLE
1.03	Gender/sex related: Treatment of female infertility	Clomid®, Profasi®, Cyclogest®
1.05	Gender/sex related: Androgens and anabolic steroids	Sustanon®
2.00	Slimming preparations:	Thinz®, Obex LA®
4.01	Patent medicines: Household remedies	Lennons
4.02	Patent medicines: Patent and products with no robust scientific evidence to support cost-effectiveness	Choats
4.03	Patent medicines: Emollients	Aqueous cream
4.04	Patent medicines: Food/nutrition	Infasoy, Ensure
4.05	Patent medicines: Soaps and cleansers	Brasivol®, Phisoac®
4.06	Patent medicines: Cosmetics	Classique
4.07	Patent medicines: Contact lens preparations	Bausch + Lomb®
4.08	Patent medicines: Patent sunscreens	Piz Buin
4.10	Patent medicines: Medicated shampoo	Denorex®, Niz shampoo
4.11	Patent medicines: Veterinary products	
5.04	Appliances, supplies and devices: Medical appliances/devices	Thermometers, hearing aid batteries
5.06	Appliances, supplies and devices: Bandages and dressings	Cotton wool, gauze

CATEGORY	DESCRIPTION	EXAMPLE
5.07	Appliances, supplies and devices: Disposable cholesterol supplies	
5.11	Appliances, supplies and devices: Incontinence products	Nappies, molipants, linen savers, except Stoma-related supplies
6.00	Diagnostic agents	Clear View pregnancy tests
8.05	Vaccines/immunoglobulins: Other immunoglobulins	Beriglobin®
9.02	Vitamin and/or mineral supplements: Multivitamins or minerals	Pharmaton SA®
9.03	Vitamin and/or mineral supplements: Geriatric vitamins and/or minerals	Gericomplex®
9.05	Vitamin and/or mineral supplements: Tonics and stimulants	Bioplus®
9.08	Vitamin and/or mineral supplements: Magnesium diet supplementation	Magnesit®
9.10	Vitamin and/or mineral supplements: Unregistered vitamins, mineral or food supplements	Sportron
10.01	Naturo- and homeopathic remedies/ supplements: Homeopathic remedies	Weleda Natura
10.02	Naturo- and homeopathic remedies/ supplements: Natural oils	Primrose oils, fish liver oil
12.00	Veterinary products	
13.00	Growth hormones	Genotropin®
14.00	Medicines where cost/benefit ratio cannot be justified	Xigris®, Zyvoxid ® Herceptin, Gleevac®,
20.00	All newly registered medicines	

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 benefits:

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

ANNEXURES

ANNEXURE D

PROCEDURES PRE-AUTHORISED UNDER AUSPICES OF MANAGED HEALTHCARE

The following elective procedures will be funded from the hospital benefit if done in a doctor's rooms and day clinics. If these are done in hospital, the member may be liable for co-payment, except in the case of emergency. If these procedures are done in a doctor's rooms, there is no need for pre-authorisation.

PROCEDURE DESCRIPTION
Additional intra-articular injection for arthritis
Ascites or pleural tapping
Aspiration of joint or intra-articular injection
Aspiration or injection
Bartholin's abscess marsupialisation
Bilateral myringotomy
Bilateral myringotomy with insertion of tube
Biopsy – nerve
Biopsy or excision of cyst or lymph node biopsy
Biopsy – muscle, skin
Bronchial lavage
Circumcision
Cone biopsy – cervix
Dilation and curettage (excluding aftercare)
Diathermy to nose or pharynx under local anaesthesia

PROCEDURE DESCRIPTION
Drainage of subcutaneous abscess – onychia, etc.
Drainage of submucous abscess
ENT endoscopy in rooms with rigid endoscope
Excision of cysts or tumours – vagina
Excision of the ganglion
Excision of lymph node for biopsy – neck or axilla
Excision of meibomian cyst
Fine-needle aspiration cytology
Fine-needle aspiration for soft tissue – all areas including breast
Flexible nasopharyngo-laryngoscope examination
Incision and drainage of peri-anal abscess
Intra-articular injection for arthritis – first joint
Intra-pleural block
Laser tonsillectomy
Limb cast

PROCEDURE DESCRIPTION
Ludwig's angina – drainage
Opening of quinsy at rooms
Plexus nerve block
Proctoscopy with removal of polyps – first time
Proof puncture at rooms – unilateral
Proof puncture uni- or bilateral under general anaesthesia
Protoscopy with removal of polyps –subsequent times
Removal of foreign body – deep fascia (except hands)
Removal of foreign body (except hands)
Removal of single nasal polyp at rooms
Retropharyngeal abscess – external approach

PROCEDURE DESCRIPTION
Retropharyngeal abscess – internal approach
Secondary suturing
Suturing of contused lacerated wounds
Tendon or ligament injection
Tonsillectomy – dissection of the tonsils
Treatment by chemo-cryotherapy – additional lesions
Treatment by chemo-cryotherapy – first lesion
Vasectomy – uni- or bilateral
Vulva and introitus – drainage of abscess
Wound debridement

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.

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.
- Payment to a hospital is subject to meeting the stipulated standards like 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 on the first working day after treatment or admission.
- An authorisation does not guarantee payment

Pre-authorisation for dentistry

It is not necessary to obtain authorisation for routine procedures, e.g. fillings or extractions. However, registration is necessary when more than four fillings and two root canal treatments are required.

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.

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.

Maxillofacial surgery

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

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 medicines within the medicine reference price or medicine 'basket(s)'.

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

- High-cost and non-effective procedures are pre-authorised at the auspices of managed healthcare.
- 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 BENEFIT 2016

All services as per specified benefit to be covered from the in-hospital benefits:

MEASURE AND ICD-10 CODES	CARE, SCREENING, TEST
FULL MEDICAL EXAMINATION	
One wellness measure per year inclusive of: ▶ Blood pressure test ▶ BMI test ▶ Waist to hip ratio measurement ▶ Consultation ▶ Cholesterol screening (Z 13.8) ▶ Glucose screening (Z 13.1) ▶ Healthy diet counselling (Z 71.3) ▶ Lipid disorder screening for age > 40 years Clinical information to be submitted to managed healthcare	Annually
CHILD HEALTH	
All child immunisation provided by the Department of Health for children six (6) years old and younger.	As per DOH age schedule as per the Road to Health chart
FEMALE HEALTH (Women and Adolescent Girls)	
Cervical cancer screening ICD: Z 12.4 For all females aged **21-64** years old, except for those women who have had a complete hysterectomy with no residual cervix	PAP smear test once every third year
Breast cancer screening ICD: Z12.3 and ICD: Z01.6 Mammogram: all women aged 40-69 years old	Once every two years, unless motivated
Contraceptives ICD: Z 30	As recommended by NDOH

MEASURE AND ICD-10 CODES	CARE, SCREENING, TEST
DENTAL HEALTH	
Consultation and topical fluoride application for children aged 0-6 years	Annually
Topical fluoride application for children aged 7-18 years	Annually
Caries risk assessment for children aged 0-14 years (Clinical information to be submitted to managed care)	Once every second year
Periodontal disease and caries risk assessment for adults 19 years of age and above (Clinical information to be submitted to managed care)	Once every second year
Measure and ICD-10	Care, screening or test
HIV COUNSELLING AND TESTING	
HIV counselling and pre-counselling	Annually
HCT consultation, rapid testing and post counselling	Annually
HIV testing Elisa: 3932 Confirmation test: Western blot (payable after HCT or ELISA tests)	Annually
OTHER	
Flu vaccine	Annually
Hib titer for 60 years and older (Serology: IgM: specific antibody titer)	Annually
Prostate cancer screening For all males aged between 50 and 75 years	Annually
Glaucoma screening	Once every third year; unless motivated
Circumcision	Subject to clinical protocols

MEASURE AND ICD-10 CODES	CARE, SCREENING, TEST
OTHER	
Post-trauma debriefing session Only for active principal members of SAPS utilising the Psych-Social Network	Four sessions per year.

DISCLAIMER:

Polmed has outlined the services that are covered under the 'preventative care benefit'. Best clinical practice dictates that the doctor should follow the best clinical management as per guidelines even when they are not specified under this benefit.

ANNEXURE B1

PREVIOUSLY KNOWN AS THE LOWER PLAN

AQUARIUM SCHEDULE

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2016

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 below, 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 NHRPL + inflationary figure (i.e. the 2006 base tariff increased by the inflationary amounts); and
- **'Agreed tariff'** shall mean: The rate negotiated by and on behalf of the Scheme with one or more providers/groups.

Benefits for 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.

AQUARIUM

ANNEXURE B3

SCHEDULE OF CONTRIBUTIONS

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

Total contribution includes subsidy from employer.

CONTRIBUTION RATES LOWER PLAN (1 April 2015 – 31 March 2016)

TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 300	806	806	400
R5 301 – R7 300	813	813	400
R7 301 – R8 900	833	833	407
R8 901 – R10 400	853	853	413
R10 401 – R12 100	873	873	419
R12 101 – R14 500	891	891	426
R14 501 – R17 800	926	926	433
R17 801 – R22 400	958	958	453
R22 401 – R25 200	989	989	481
R25 201 +	1 282	1282	609

MEMBER CONTRIBUTION (SUBSIDISED CONTRIBUTION)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 300	59	59	26
R5 301– R7 300	66	66	26
R7 301– R8 900	86	86	33
R8 901– R10 400	106	106	39
R10 401– R12 100	126	126	45
R12 101– R14 500	144	144	52
R14 501– R17 800	179	179	59
R17 801– R22 400	211	211	79
R22 401– R25 200	242	242	107
R25 201 +	535	535	235

NOTE: Full contribution applicable to members who do not qualify for employer subsidy.

The contributions for 2016 as set out in the format required by the Registrar in Circular 48 of 2015.

CONTRIBUTION RATES AQUARIUM (1 April 2016 – 31 March 2017)

TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 600	854	854	424
R5 601 – R7 700	861	861	424
R7 701 – R9 400	882	882	431
R9 401 – R11 000	902	902	437
R11 001 – R12 800	923	923	443
R12 801 – R15 400	941	941	450
R15 401 – R18 900	977	977	457
R18 901 +	1 009	1 009	478

MEMBER CONTRIBUTION (SUBSIDISED CONTRIBUTION)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 600	60	60	27
R5 601 – R7 700	67	67	27
R7 701 – R9 400	88	88	34
R9 401 – R11 000	108	108	40
R11 001 – R12 800	129	129	46
R12 801 – R15 400	147	147	53
R15 401 – R18 900	183	183	60
R18 901 +	215	215	81

NOTE: Full contribution applicable to members who do not qualify for employer subsidy.

AQUARIUM

GENERAL RULES

In hospital

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

In the case of 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 has to 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.

Medicine prescribed during hospitalisation forms part of the hospital benefits.

Medicine 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 new-born 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.

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 for non-PMB dental procedures performed in hospital will be reimbursed from the overall non-PMB benefit, subject to the availability of funds.

Specialised radiology

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

Medication

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 medicine, 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.)
Payment in respect of over-the-counter (OTC), acute and chronic medicine will be limited to the medicine reference price. This is the maximum allowed cost and may be based on either generic or 'formulary' reference pricing. The balance of the cost needs to be funded by the member.

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 ('basket') of medicines appropriate for the management of their particular conditions/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 medicines are included in the condition-specific medicine basket. Updates to the authorisation will be required for newly diagnosed conditions for the beneficiary. Medication that is not included in the baskets may be available through an exception management process, for which a medicine-specific authorisation may be granted; this process requires motivation from the treating service provider and will be reviewed based on the exceptional needs of the beneficiary.

The member needs to re-apply for an authorisation at least one month prior to expiry of an existing chronic medicine authorisation, failing which any claims reviewed will not be paid from the chronic medicine benefit, but from the acute medicine benefit if benefits exist. This only applies to authorisations that are not on-going and have an expiry date.

The Scheme shall only consider claims for medicines prescribed by a person legally entitled to prescribe medicine 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.

Specialist referral

All Polmed beneficiaries need to be referred to specialists by a general practitioner (GP). The beneficiary or the referring GP is required to obtain a referral number, which can be obtained from the Scheme. The Scheme will impose a co-payment of up to R1 000 if the member consults a specialist without the referral. 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 specialities/disciplines: Gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists [chronic dialysis], dental specialists, pathology, radiology and supplementary/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

AQUARIUM

no referral from one of the following providers: GP, ear, nose and throat (ENT) specialist, paediatrician, physician or neurologist.

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.

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 financial year.

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 alternative provider, all costs in excess of the agreed rate will be for the cost of the member and must be paid directly to the provider by the member.

You can access the list of providers at www.polmed.co.za, on your cell phone via the mobile site or request it via the Client Service Department.

Examples of designated service providers (where applicable) are:

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

Designated GP provider (network GP)

Members are allowed two visits to a 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.

Designated pharmacy network

Polmed has appointed service providers for the provision of chronic medication. The Scheme utilises the courier pharmacies as the primary service provider, with retail pharmacies providing secondary support for those members who prefer personal interaction. Where the member chooses to use an alternative provider, the member shall be liable for a co-payment of 20% of the costs that must be paid directly to the provider by the member.

You can access the list of providers at www.polmed.co.za, on your cell phone via the mobile site or request it via the Client Service Department.

- Pharmacy (medicine) DSP

DEFINITION OF TERMS

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 in excess of those agreed upon with the service provider or in excess of 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.

Medicine reference price

This is the reference pricing system applied by the Scheme; it may be derived based on either generic or 'formulary' reference pricing. This pricing system refers to the maximum price that Polmed will pay for a particular medication. Should a reference price be set for a generic or therapeutic class of medication, patients are entitled to make use of any medication within this pricing limit, but will be required to make a co-payment on medication priced above the reference pricing limit. The fundamental principle of any reference pricing system is that it does not restrict a member's choice of medicine, but instead limits the amount that will be paid for it. Accessibility of products within the reference price groups is taken into account when defining the group.

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

Registration for chronic medication

Polmed provides for a specific list of chronic conditions that are funded from the chronic medicine 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 a letter by post or e-mail indicating whether their application was successful or not. If successful, the beneficiary will be issued with a disease-specific authorisation, which will allow access to a range of medicines that are referred to as the disease authorisation basket.

Enrolment on the Disease Management Programme

Members will be identified and contacted in order to enrol on the Disease Management Programme. The Disease 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

AQUARIUM

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.

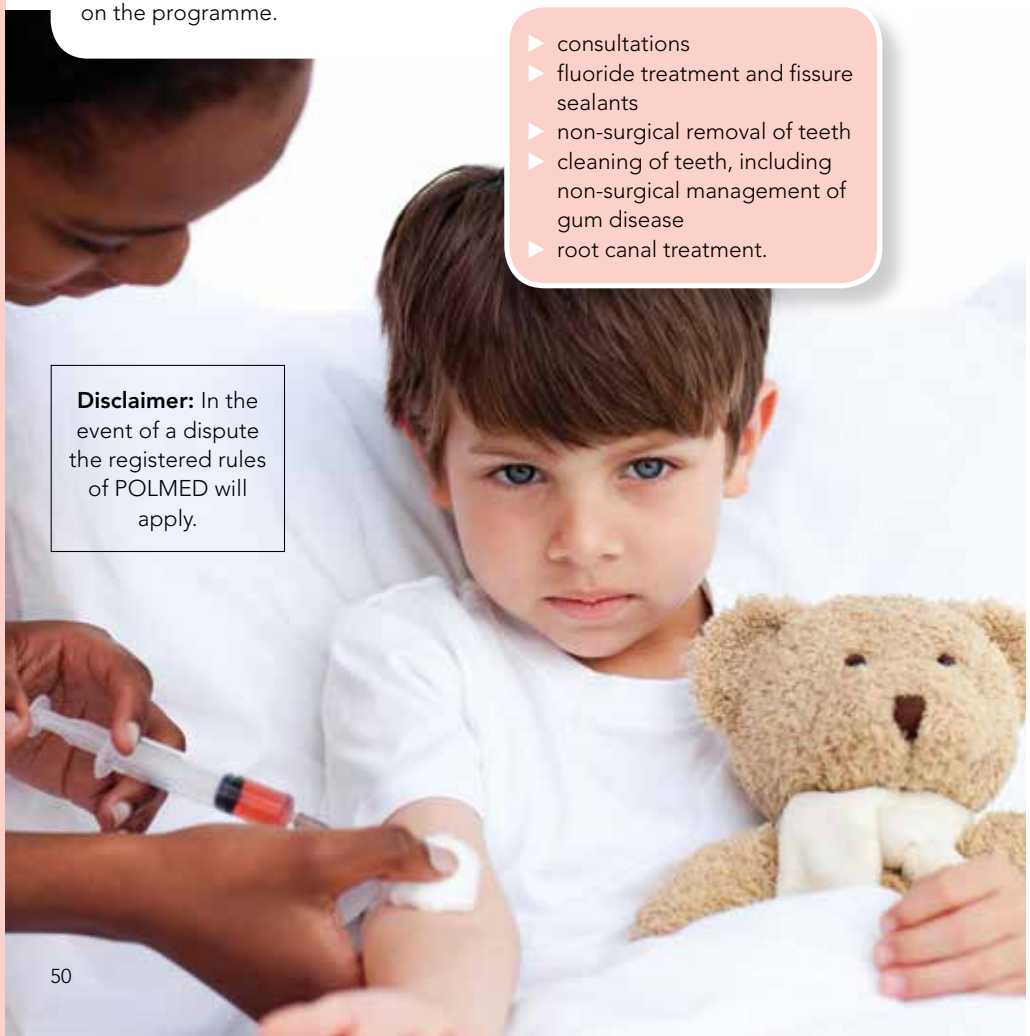
The claims data for chronic medication, consultations and hospital admissions is used to identify the members that are eligible for enrolment on the programme. Members are also encouraged to register themselves on the programme.

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/fillings and replacement of missing teeth by plastic dentures.

Other procedures that fall under the category are:

- consultations
- fluoride treatment and fissure sealants
- non-surgical removal of teeth
- cleaning of teeth, including non-surgical management of gum disease
- root canal treatment.



Disclaimer: In the event of a dispute the registered rules of POLMED will apply.

AQUARIUM BENEFIT SCHEDULE

GENERAL BENEFIT RULES		
	Benefit design	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
	Pre-authorisation, referrals, protocols and management by programmes	Where the benefit is subject to pre-authorisation, referral by a designated service provider (DSP) or general practitioner (GP), adherence to established protocols or enrolment upon 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 enrolment upon a managed 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 enrolment upon a managed care programme is stipulated in order to best care for the member and his/her family and to protect the funds of the Scheme

GENERAL BENEFIT RULES		
	Limits are per annum	Unless there is a specific indication to the contrary, all benefit amounts and limits are annual
	Statutory prescribed minimum benefits (PMBs)	There is no overall annual limit for PMBs/life-threatening emergencies
	Tariff	100% of Polmed rate or agreed tariff or at cost for involuntary access to PMBs

IN-HOSPITAL BENEFITS		
	Annual overall in-hospital limit In-hospital benefits are subject to the Scheme's relevant managed healthcare programmes and includes the application of treatment protocols, case management and pre-authorisation; a R5 000 penalty may be imposed if no pre-authorisation is obtained Subject to PMBs, i.e. no limit in case of life-threatening emergencies or for PMB conditions Subject to applicable tariff, i.e. 100% of Polmed rate or agreed tariff or at cost for involuntary access to PMBs	Non-PMB admissions will be subject to an overall limit of R200 000 per family R8 000 co-payment for admission to a non-DSP hospital No co-payment if the procedure is performed in a DSP and/or a day clinic

IN-HOSPITAL BENEFITS		
	Dentistry (conservative and restorative)	100% of Polmed rate Dentist's costs for all non-PMB procedures will be reimbursed from the out-of-hospital (OOH) benefit The hospital and anaesthetist's costs will be reimbursed from the overall non-PMB limit
	Emergency medical assistance Netcare 911 (082 911) is the DSP	100% of agreed tariff
	Chronic kidney dialysis National Renal Care (NRC) and Fresenius Medical Care are preferred providers	100% of agreed tariff at DSP
	Mental health	100% of Polmed rate or at cost for PMBs Annual limit of 21 days per beneficiary Limited to a maximum of three days' hospitalisation for beneficiaries admitted by a GP or a specialist physician Additional hospitalisation to be motivated by the medical practitioner
	Medication: Non-PMB specialist drug limit, e.g. biologicals	100% of Polmed rate Pre-authorisation required Specialised medicine sub-limit of R69 430 per family
	Oncology (chemotherapy and radiotherapy) Independent Clinical Oncology Network (ICON) is the DSP	100% of agreed tariff at DSP Limited to R231 578 per beneficiary per annum; includes MRI/CT or PET scans related to oncology

IN-HOSPITAL BENEFITS		
	Organ and tissue transplants	100% of agreed tariff at DSP or at cost for PMBs Subject to clinical guidelines used in State facilities Unlimited radiology and pathology for organ transplant and immunosuppressants
	Pathology	Service will be linked to hospital pre-authorisation
	Physiotherapy	Service will be linked to hospital pre-authorisation
	Prostheses (internal and external)	100% of Polmed rate Subject to pre-authorisation and approved product list Limited to R57 240 per beneficiary
	Refractive surgery	No benefit
	General practitioners (GPs)	100% of agreed tariff at DSP, 100% of Polmed rate at non-DSP or at cost for involuntary PMB access
	Specialists Anaesthetists	100% of agreed tariff at DSP, 100% of Polmed rate for non-DSP or at cost for involuntary PMB access 150% of Polmed rate or at cost for PMBs

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 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 PMB access	M0 – R7 865 M1 – R9 529 M2 – R11 575 M3 – R12 349 M4 + – R14 151
	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

AQUARIUM

OVERALL OUT-OF-HOSPITAL BENEFITS		
	General practitioners (GPs) POLMED has a GP network	100% of agreed tariff at DSP or at cost for involuntary PMB access The limit for consultations shall accrue towards the OOH limit Subject to maximum numbers of visits/consultations per family per annum, as follows: M0 – 8 M1 – 12 M2 – 15 M3 – 18 M4 + – 22
	Medication (acute)	100% of Polmed rate Annual limit of R8 544 per family Subject to the OOH limit and the medicine reference price
	Medication (over-the-counter [OTC])	100% of Polmed rate Annual limit of R850 per family Subject to the OOH limit; shared limit with acute medication
	Audiology	100% of Polmed rate Subject to the OOH limit Subject to referral by GP, ear, nose and throat (ENT) specialist, paediatrician, physician or neurologist
	Occupational and speech therapy	PMBs only Benefit first accrues to the OOH limit

OVERALL OUT-OF-HOSPITAL BENEFITS		
	Pathology	M0 – R2 767 M1 – R4 092 M2 – R4 950 M3 – R6 127 M4 + – R7 590 The defined limit per family will apply for any pathology service done out of hospital
	Physiotherapy	100% of Polmed rate Annual limit of R2 141 per family Subject to the OOH limit
	Social worker	100% of Polmed rate Annual limit of R2 020 per family Subject to the OOH limit
	Specialists Referral is not necessary for gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists (dialysis), dental specialists and supplementary/allied health services (excluding audiology services)	100% of agreed tariff at DSP or at cost for involuntary PMB access The limit for consultations shall accrue towards the OOH limit Limited to four visits per beneficiary and eight visits per family per annum Subject to referral by a GP (two specialist visits per beneficiary without GP referral allowed) R1 000 co-payment if no referral is obtained

AQUARIUM

STAND-ALONE BENEFITS	**Allied health services and alternative healthcare providers** Includes biokineticists, chiropractors, dieticians, homeopaths, chiropodists, podiatrists, reflexologists, naturopaths, orthoptists, osteopaths and therapeutic massage therapists Benefit is subject to clinically appropriate services	No benefit	
	Appliances (medical and surgical) Pre-authorisation is required for the supply of oxygen All costs for maintenance are a Scheme exclusion Members must be referred for audiology services for hearing aids to be reimbursed	100% of Polmed rate and subject to:	
		Blood transfusions	No limit
		Hearing aids	R10 102 per hearing aid or R20 076 per beneficiary per set every three years
		Nebuliser	R1 145 per family once every four years
		Glucometer	R1 145 per family once every four years
		CPAP machine	R8 183 per family once every four years
		Wheelchair (non-motorised)	R10 695 per beneficiary once every three years
		Wheelchair (motorised)	R30 676 per beneficiary once every three years
		Insulin delivery devices and urine catheters	Paid from the hospital benefit up to the mean price of three quotations

STAND- ALONE BENEFITS	**Appliances (medical and surgical)** (continued)	Medical assistive devices	Annual limit of R2 406 per family and includes medical devices in/out of hospital
	Dentistry (specialised) Pre-authorisation required	No benefit except for PMBs Only covers specialised dental procedures done in/out of hospital that meet PMB criteria	
	Maternity benefits, including home birth Pre-authorisation required and treatment protocols apply	100% of agreed tariff at DSP, 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 three specialist consultations per beneficiary per pregnancy Home birth is limited to R12 868 per beneficiary per annum Annual limit of R3 604 for ultrasound scans per family; limited to two 2D scans per pregnancy Benefits relating to more than two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation	
	Maxillofacial Pre-authorisation required	No benefit except for PMBs Surgical removal of impacted teeth is covered subject to overall non-PMB limit	

STAND-ALONE BENEFITS	**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 Designated service providers: Courier pharmacies: Medipost and Pharmacy Direct Retail pharmacies: Clicks and MediRite	No benefit except for PMBs Subject to the medicine reference price
	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 Annual contact lens limit is specified Contact lens re-examination can be claimed for in six-monthly intervals Preferred Provider Negotiators (PPN) is the preferred provider network	The benefit per beneficiary (per 24-month benefit cycle) at a PPN provider would be: One composite consultation, inclusive of refraction, tonometry and visual field screening; collection of blood pressure, glucose and cholesterol readings AND EITHER SPECTACLES A PPN frame to the value of R150 and R430 towards lens enhancements OR R580 towards the cost of any alternative frame and/or lens enhancements WITH EITHER One pair of clear Aquity single-vision or clear Aquity bifocal lenses or clear Aquity multifocal lenses covered up to the value of clear bifocal lens limit

STAND-ALONE BENEFITS	**Optical** (continued)	OR CONTACT LENSES Contact lenses to the value of R580 Contact lens re-examination to a maximum cost of R210 per consultation Non-PPN provider would be: One consultation limited to a maximum cost of R325 AND EITHER SPECTACLES R580 towards a frame and/or lens enhancements WITH EITHER One pair of clear Aquity single-vision lenses, limited to R150 per lens, or one pair of clear Aquity bifocal lenses, limited to R325, or multifocal clear Aquity lenses covered up to the value of clear bifocal lens limit OR CONTACT LENSES Contact lenses to the value of R580 Contact lens re-examination to a maximum cost of R210 per consultation

AQUARIUM

STAND-ALONE BENEFITS	**Preventative care (refer to Annexure E)** One wellness measure per year, including: • Blood pressure test • Body mass index test • Waist-to-hip ratio measurement • Cholesterol screening (Z13.8) • Glucose screening (Z13.1) • Healthy diet counselling (Z71.3) • Risk assessment tests: – Baby immunisation (as per the Department of Health guidelines) – Bone densitometry scan – Circumcision – Contraceptives (as per the Department of Health guidelines) – Dental screening (codes 8101, 8151 and 8102) – Flu vaccine – Glaucoma screening – HIV tests – Mammogram – Pap smear – Pneumococcal vaccine – Prostate screening – Psycho-social services	100% of Polmed rate or agreed tariff where applicable Early detection screening limited to periods specified in Annexure E Funded from the risk pool; the benefit shall not accrue to the OOH limit
	Radiology (basic) i.e. black and white X-rays and soft tissue ultrasounds	100% of agreed tariff or at cost for PMBs Limited to R4 950 per family Includes any basic radiology done in/out of hospital Claims for PMBs first accrue towards the limit

STAND-ALONE BENEFITS	**Radiology (specialised)** Pre-authorisation required	100% of agreed tariff or at cost for PMBs Limited to R34 610 per family Includes any specialised radiology service done in/out of hospital Claims for PMBs first accrue towards the limit Subject to a limit of two scans per beneficiary per annum, except for PMBs

ANNEXURE B2

CO-PAYMENTS

OUT OF NETWORK	CO-PAYMENT
General practitioner (GP)	Allows for two out-of-network consultations Co-payment shall apply once maximum out-of-network consultations are exceeded
Hospital	R8 000
Pharmacy	20% of costs

ANNEXURE B4

AQUARIUM: CHRONIC CONDITIONS

Prescribed minimum benefits (PMBs), including chronic diagnostic 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.

Auto-immune disorder

Systemic lupus erythematosis (SLE)

Cardiovascular conditions

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

Endocrine conditions

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

Gastro-intestinal conditions

Crohn's disease
Ulcerative colitis
Peptic ulcer disease (requires special motivation)

Gynaecological conditions

Endometriosis
Menopausal treatment

Haematological conditions

Haemophilia
Anaemia
Idiopathic thrombocytopenic purpura
Megaloblastic anaemia

Metabolic condition

Hyperlipidaemia

Musculoskeletal condition

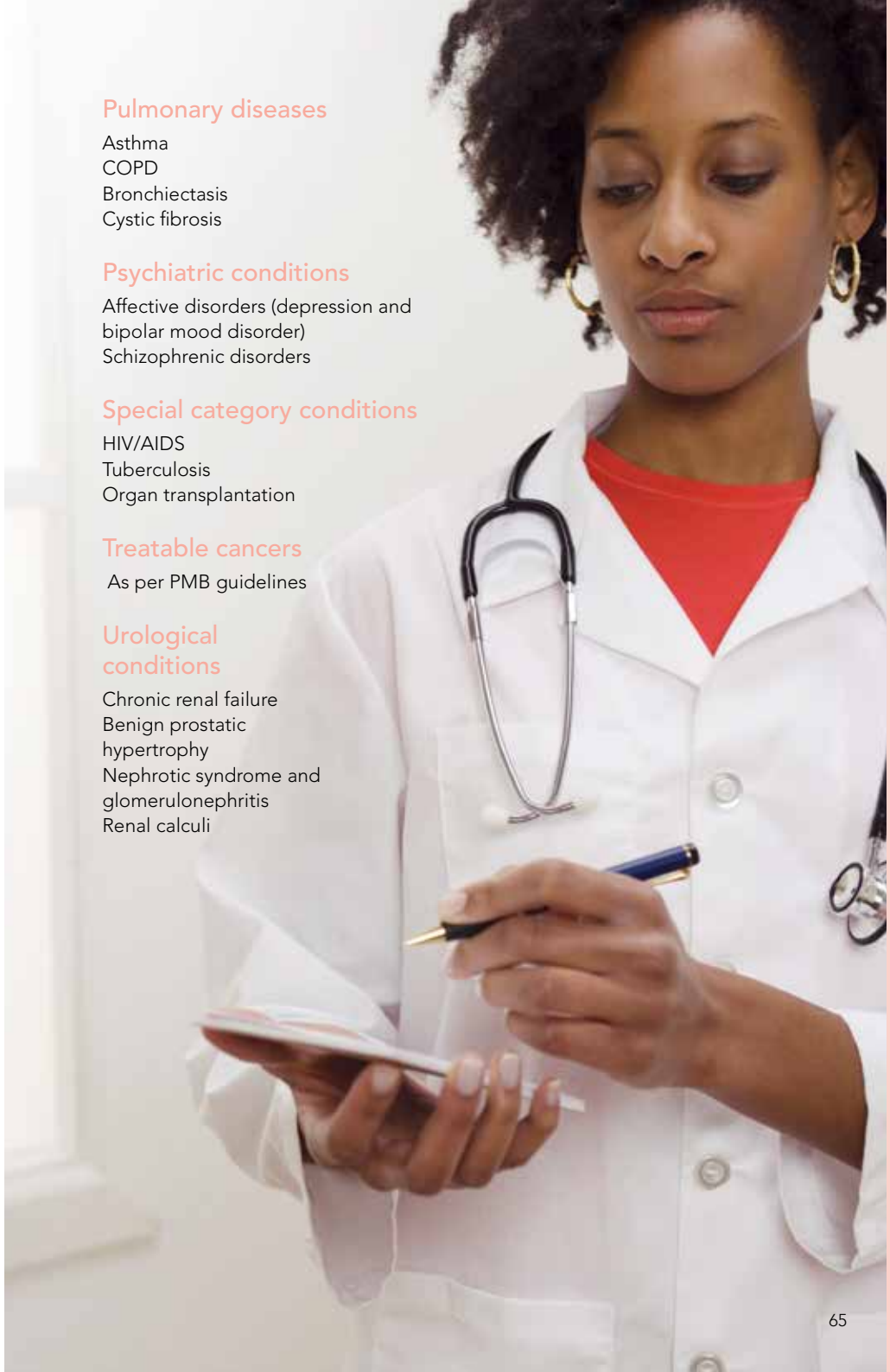
Rheumatic arthritis

Neurological conditions

Epilepsy
Multiple sclerosis
Parkinson's disease
Cerebrovascular incident
Permanent spinal cord injuries

Ophthalmic condition

Glaucoma



Pulmonary diseases

Asthma
COPD
Bronchiectasis
Cystic fibrosis

Psychiatric conditions

Affective disorders (depression and bipolar mood disorder)
Schizophrenic disorders

Special category conditions

HIV/AIDS
Tuberculosis
Organ transplantation

Treatable cancers

As per PMB guidelines

Urological conditions

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

AQUARIUM

INJURY ON DUTY (IOD)

South African Police Service (SAPS) process of submitting IOD claims for service providers

How do I claim if I'm injured on duty?

IMPORTANT CONTACT NUMBERS

SAPS IOD Human Resources Department:
012 393 2371/012 393 4106
SAPS IOD Finance Department: 012 393 1109
SAPS Medical Boards:
012 393 1475

Injury is sustained while the member is on duty

The member reports the injury to his/her Commander immediately or alternatively within 24 hours after sustaining the injury
If he/she is unable to give a report, a colleague does so on behalf of the injured member

The Commander completes a WCL2 form (employer's report), of which part B is submitted to the treating service provider

The treating service provider completes a WCL4 form (first medical report) AND/OR WCL5 form (progress/final report)

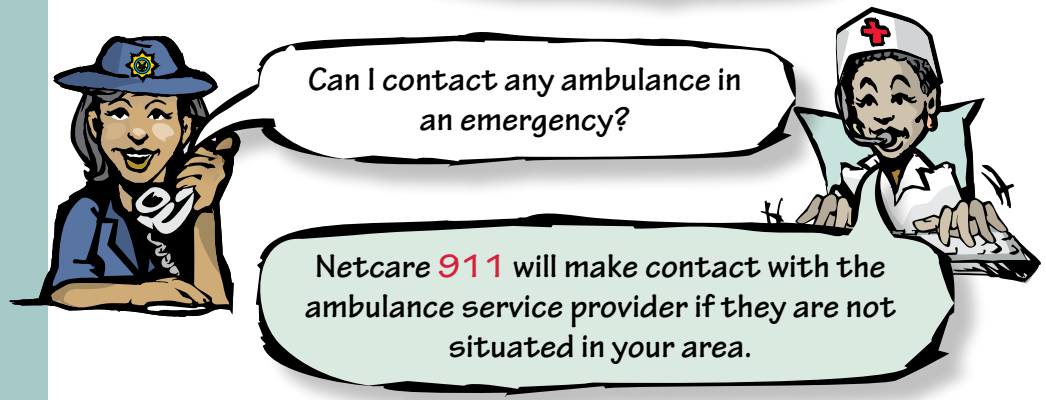
The service provider is required to attach a copy of each of the WCL2 AND WCL4 forms together with EACH account submitted to the SAPS' IOD Head Office (it is recommended that the service provider keeps copies of BOTH the WCL2 and WCL4 forms, together with the injured member's medical notes for future reference)
The SAPS' IOD Head Office will notify the service provider when the application is unsuccessful and give reasons

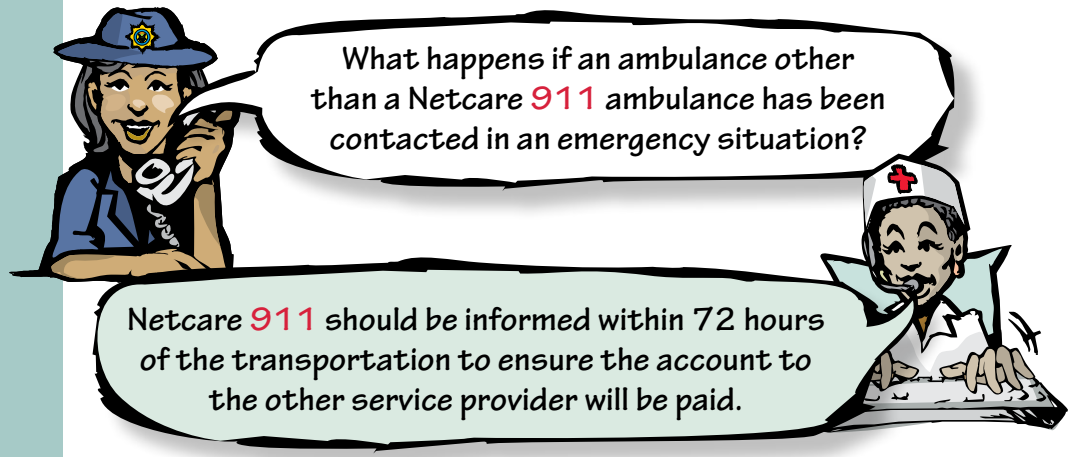
The SAPS IOD Head Office submits the service provider's account, together with the WCL2 and WCL4 forms, to the SAPS' Finance Department for payment of the account

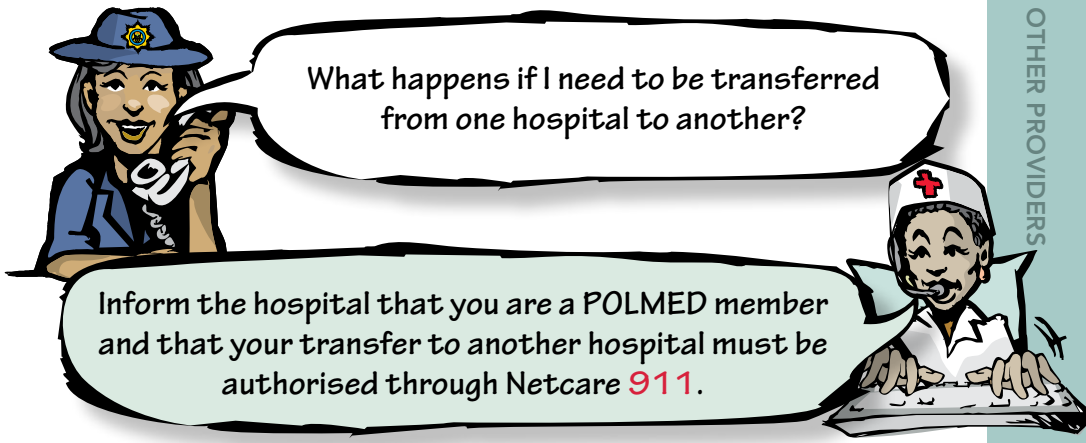
Kindly remember that the Compensation Commissioner approves benefits subject to the Compensation for Occupational Injuries and Diseases Act rules
It is essential that service providers who treat IOD patients familiarise themselves with these rules, especially in terms of the number of consultations allowed for physiotherapy and psychotherapy

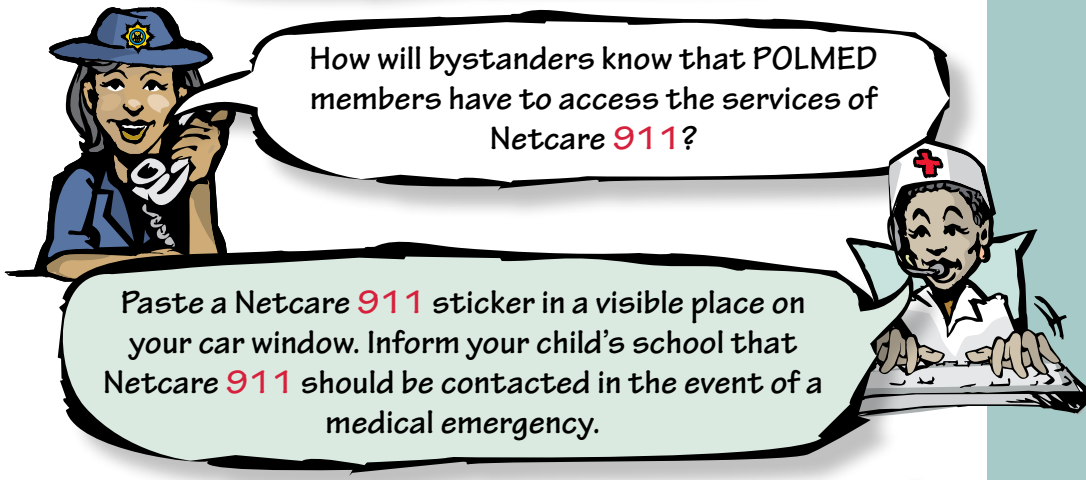
EMERGENCY MEDICAL ASSISTANCE: NETCARE 911

NETCARE 911: 082 911









IMPORTANT POINTS TO REMEMBER WHEN REPORTING AN EMERGENCY

- Remain calm and listen carefully to the questions of the call centre agent.
- Give your name and the telephone number you are calling from.
- Give a brief description of what happened and how serious the situation is.
- Give the correct address or location of the incident to assist paramedics to get to the scene.
- Do not put down the phone until the call centre agent has ended the call.

TERMINOLOGY EXPLAINED

GENERAL

AGREED TARIFF
This is the rate negotiated by and on behalf of the Scheme with one or more providers or groups.

DESIGNATED SERVICE PROVIDER (DSP)
A DSP is a healthcare provider or group of providers, i.e. doctors, pharmacies and hospitals, selected by POLMED as the preferred provider for diagnosis, treatment or care. These providers are contracted to POLMED to render quality health services to members at a tariff referred to as the POLMED rate.

EXCLUSIONS
Exclusions are conditions, services, medication and appliances that are listed in the rules of the Scheme and that are not covered by POLMED.

EX GRATIA BENEFIT
This is a benefit that you can apply for if you have exhausted a benefit before your treatment was concluded. If it is medically justified and within the criteria that is applied, consideration is given to such an application. The Scheme may, at the discretion of the Board of Trustees, grant an ex gratia payment upon written application from a member, as per the rules of the Scheme.

IN-HOSPITAL BENEFITS
The in-hospital limit provides cover for hospitalisation and certain specialised procedures performed in hospital. Under the hospitalisation benefit, hospital accounts and related costs incurred in hospital – from admission to discharge – are covered, provided that treatment is clinically appropriate and has been authorised. There are sub-limits applicable to certain categories of benefits, such as specialised radiology, oncology and prostheses, even though the treatment was obtained in hospital.

PENALTY
The rules indicate that a penalty will be payable by the member if pre-authorisation has not been obtained where indicated or required. A penalty is also applicable when a member is voluntarily admitted to a non-designated service provider hospital for an elective procedure, i.e. surgery that is scheduled in advance.

POLMED RATE
The POLMED rate refers to the rate negotiated by and on behalf of the Scheme with one or more providers or groups. This is also the rate at which POLMED will settle claims.

PRE-AUTHORISATION
Certain services or treatments require pre-authorisation by POLMED. Members must apply to the Scheme for authorisation before certain benefits can be accessed.

SUB-LIMIT
A sub-limit is a limit within a limit. It is the maximum amount that can be used for the specific benefit referred to. Benefits reflected in the benefits and contribution guide will be paid up to this amount even if you have funds available in the annual overall out-of-hospital limit.

MEMBERSHIP

BENEFICIARY
The word beneficiary is a term that includes anyone who benefits from membership of the Scheme – it can be a principal member or a person registered as a dependant of a principal member.

CONTINUATION MEMBER
This is a person who continues his/her membership of POLMED:

- after retirement;
- if he/she has been medically boarded;
- if he/she received a severance package; or
- if the principal member dies.

This excludes any person who voluntarily resigns from the South African Police Service.

CONTRIBUTION
A contribution is a monthly health insurance payment that is paid by or in respect of the member and any of his/her registered dependants.

PARTNER
A partner can be defined as a person with whom the member has a committed and serious relationship like a marriage based on mutual dependency and a shared and common household, irrespective of the gender of either party.

SERVING MEMBERS
A serving member is a member who is in the active employ of the South African Police Service.

MEDICATION

ACUTE MEDICATION
Acute medication is prescribed for a temporary illness or condition, such as flu.

GENERIC MEDICATION
Generic medication is chemically identical to its brand-name (original) equivalents. It has the same active ingredients, strength, quality, dosage and results. The only difference is that generic medication may look different and be more cost-effective than the brand-name medication. If you choose to use a brand-name medication when there is a generic medicine available, the Scheme will cover only the price of the generic medication – you will have to pay the difference between the two prices if the brand-name medication is more expensive.

MEDICINE FORMULARY
A medicine formulary is a list of prescribed, cost-effective medication that guides your doctor in the treatment of medical conditions. Medicine formularies are continuously checked and updated by medical experts to ensure that they are consistent with the latest treatment guidelines.

OVER-THE-COUNTER (OTC) MEDICATION
Over-the-counter (OTC) medication is medication that is registered by the Medicines Control Council and can be obtained from your pharmacist without a prescription. OTC medication can be obtained for conditions like colds and flu. Always consult your pharmacist for advice. Refer to the benefit guide exclusion list for medication that will not be covered.

POLMED MEDICINE REFERENCE PRICE (METREF)
The POLMED medicine reference price is the maximum amount that POLMED will pay for a particular class of medication.

Medication priced above the reference price may be substituted with a clinically appropriate alternative product (a generic or therapeutic* substitute), where applicable, that is less expensive and does not mean that you have to pay any additional costs. However, if you choose to remain on the existing, more expensive product when appropriate alternatives are available, a co-payment will apply.

** A therapeutic substitute is medication that has the same therapeutic effects as the prescribed item, but might not necessarily be an identical molecule to the item prescribed.*

PRESCRIBED MINIMUM BENEFITS (PMBs)

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 (defined in the diagnosis treatment pairs);
- and 26 chronic conditions (defined in the chronic disease list).

Medical schemes can apply managed care principles towards the payment of services for these clinical diagnoses, such as by entering mutually beneficial agreements with designated service providers to take advantage of discounts and agreed upon rates of payment.

TO TAKE OUT (TTO) MEDICATION
TTO medication is prescribed during hospitalisation and given to the patient on the day of being discharged from hospital.

CLAIMS

ICD-10 CODE
ICD-10 stands for International Classification of Diseases and Related Health Problems (10th revision). It is a list of codes for every existing ailment or condition. Your doctor and other service providers must indicate the ICD-10 code for your condition on the accounts they send to POLMED.

For example, J03.9 is the ICD-10 code for acute tonsillitis and ICD-10 code G40.9 is for epilepsy.

CO-PAYMENT
A co-payment is a portion of the cost of a medical service that you must pay to your doctor and other service providers at the point of service. This is to make up the shortfall between the amount the service provider charges and the amount that POLMED covers.

STALE CLAIMS
Accounts must be submitted within four months of the date of service – in other words within 120 days after the service was rendered. If POLMED receives your claim after this date, the claim will be considered stale (old) and the account will not be paid.

DENTISTRY

BASIC (CONSERVATIVE) DENTISTRY
Basic dentistry refers to procedures that are used mainly for the detection, prevention and treatment of oral diseases of the teeth and gums. It includes for example pain relief and sepsis, the repair of tooth structures by direct restorations/fillings and replacement of missing teeth by plastic dentures.

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

SPECIALISED DENTISTRY
Specialised dentistry refers to services that are not defined as basic (conservative) dentistry. It includes periodontal surgery, crowns and bridges, implants, inlays, indirect veneers, orthodontic treatment, removal of impacted teeth and maxillofacial surgery. It is mostly used for the replacement of lost teeth or badly damaged teeth that cannot be repaired by fillings.

PSYCHO-SOCIAL NETWORK

THE NETWORK

The network consists of a group of clinical and counselling psychologists as well as social workers that have been contracted by POLMED to offer support to serving South African Police Service (SAPS) members who are employed under the SAPS Act and registered on POLMED. All the providers on the network are in private practice, thereby ensuring confidentiality and creating a secure, private and supportive environment. A list of the network providers is available on the SAPS intranet, POLMED website or via the call centre on **0860 POLMED (0860 765 633)**.

Q What services does the network offer?

A The benefit is exclusive to the providers registered on the network and for serving SAPS members. You have a **maximum of four sessions** of which **one** is an evaluation session and **three are therapy sessions**. Should the provider identify symptoms at the initial consultation that require therapy, you have three therapy sessions. The benefit is paid from the major risk benefit and not from your day-to-day benefit. Should you require additional support/therapy you will be required to register on the Disease Risk Management Programme, where you will be provided with a care plan. Please hand a copy of the care plan to your therapist.

Q Why do you need this service and how will you benefit from it?

A Serving SAPS members need this service to equip them with coping skills to empower them to have a healthy, balanced life and to contribute positively to their emotional wellbeing. POLMED wishes to support and empower our serving members to cope more effectively with stress resulting from the nature of the jobs they are exposed to daily. By using the support offered you will add value to your home life and the communities you serve and protect in a proud and respectable way, thereby not only benefiting yourself but also everyone you come into contact with in the execution of your duties.

PROACTIVE ANNUAL CHECK-IN

- Four visits a year to a network psychologist or social worker in private practice
- All visits are confidential
- It's a check-in, not a checkup
- It's a talk about what's happening in your life; there doesn't have to be a problem
- Taking part is voluntary, through self-referral, and is encouraged

HOW TO FIND THE CLOSEST NETWORK PSYCHOLOGIST OR SOCIAL WORKER

- Call 0860 765 633
- Ask for the contact details of a provider in your area and set up an appointment

OR

- Go to www.polmed.co.za and click on Member in the top menu:

1. Choose Find a Healthcare Provider from the drop-down list
2. Choose a type of provider from the drop-down list in the first search box and type your location in the second box
3. Choose a provider from the list of search results before setting up an appointment

POSITIVE MENTAL ALERTNESS CAN SAVE YOUR LIFE
LET'S TALK

CALL 0860 765 633

DISPUTE RESOLUTION PROCESS

POLMED makes provision for members, healthcare providers and third parties to lodge complaints and disputes in cases where unfavourable outcomes were received.

Here are the channels to use as a first step to lodging a complaint or disputing a ruling:

- **Phone:** 0860 765 633
- **Fax:** 0860 104 114
- **Post:** Private Bag X16, Arcadia 0007

Alternatively, visit our Client Service Centre in your region.

If you remain dissatisfied with the outcome, put your dispute or complaint in writing. The dispute will be processed within a minimum of five working days, depending on the complexity of the enquiry.

If you are still not satisfied with the outcome, you can lodge a complaint with the Council for Medical Schemes by using the following channels:

- **Phone:** 0861 123 267 (share call from a Telkom landline) or 012 431 0500
- **E-mail:** complaints@medicalschemes.com
- **Fax:** 012 431 0608 or 012 430 7644
- **Post:** Council for Medical Schemes, Private Bag X34, Hatfield 0028

Our Investment Our Health Our Future

10/15 L4270