



2017 GUIDE TO YOUR HEALTH

AQUARIUM & MARINE



POLMED[®]

OUR INVESTMENT OUR HEALTH OUR FUTURE

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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 for 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 benefits' will be paid from this benefit. Refer to pages 19 to 21 for Marine or to pages 59 to 61 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 (principal 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 22 to 24 (Marine) and 62 to 64 (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
- M+4/more – member with four or more dependants.

Example

A member with no dependants (M0) who is on Marine will have R19 057 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 R19 057. 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 = R23 191, 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 = R22 313

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 pages 62 to 64.

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

MARINE SCHEDULE

ANNEXURE A1 SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2017

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



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



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

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



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

ANNEXURE A3

MARINE CONTRIBUTION SCHEDULE

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

Total contribution includes subsidy from employer.

CONTRIBUTION RATES MARINE 2016 (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	325

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

The contributions for 2017 as set out in the format required by the Registrar in Circular 48 of 2016.

CONTRIBUTION RATES MARINE 2017 (1 APRIL 2017 – 31 MARCH 2018)



TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)

INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 940	2 101	2 101	919
R5 941 – R8 160	2 307	2 307	1 031
R8 161 – R9 970	2 384	2 384	1 089
R9 971 – R11 660	2 530	2 530	1 169
R11 661 – R13 570	2 691	2 691	1 229
R13 571 – R16 320	2 852	2 852	1 310
R16 321 – R20 030	2 982	2 982	1 396
R20 031 +	3 106	3 106	1 458

MEMBER CONTRIBUTION (SUBSIDISED CONTRIBUTION)

INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 940	274	274	69
R5 941 – R8 160	380	380	127
R8 161 – R9 970	420	420	157
R9 971 – R11 660	495	495	198
R11 661 – R13 570	578	578	229
R13 571 – R16 320	661	661	271
R16 321 – R20 030	728	728	315
R20 031 +	792	792	347

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 will form 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 formulary. 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 reapply 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 medication benefit, but from the acute medication benefit, subject to the available benefits. This only applies to authorisations that are not ongoing 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 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. The specialist has to submit the referring GP's practice number in the claim.

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. The cut-off date for Ex Gratia applications will be the end of April in the year after the service was rendered.

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.

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

Examples of designated service providers (where applicable) are:

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

Designated GP provider (network GP)

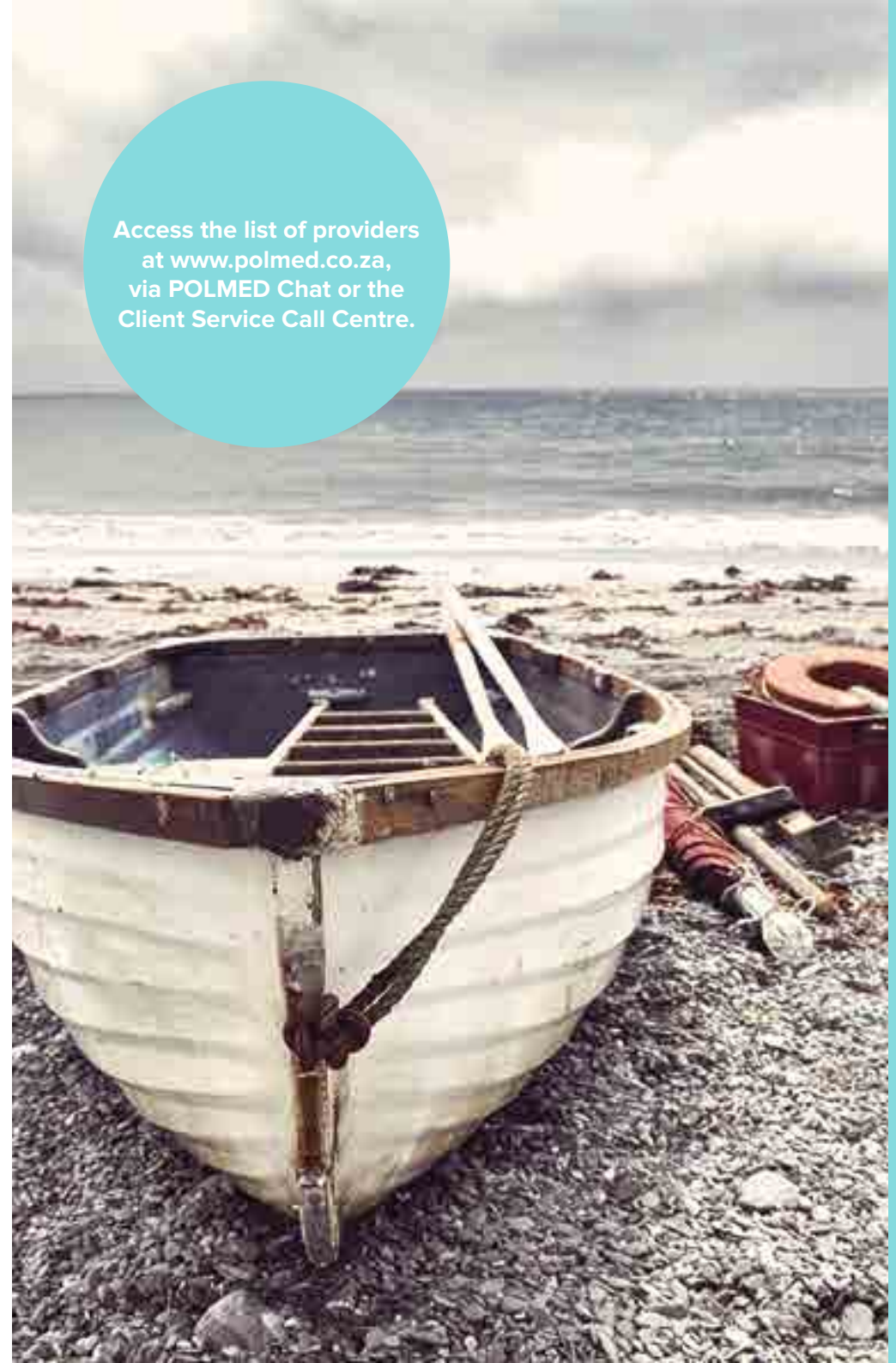
Members are allowed two visits to a GP who is not part of the network per beneficiary per annum for emergency or out-of-town situations. Co-payments shall apply once the maximum out-of-network consultations are exceeded.

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.

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DEFINITION OF TERMS

Designated service provider (DSP)

This is a list of service providers that have been contracted by POLMED to render services to its members at a negotiated tariff and/or agreed treatment protocols and/or agreed adherence to other managed care interventions.

Formulary

A formulary is a list of cost-effective, evidence-based medicines that will be reimbursed for the treatment of chronic conditions. This list is constantly reviewed and funding is subject to clinical guidelines, protocols and Scheme rules.

Generic substitution

This means substituting the chemical entity in the same dosage form for one marketed by a different company.

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, 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 medication benefit (i.e. through a benefit that is separate from the acute medication benefit). POLMED requires members to apply for authorisation via the Chronic Medicine Management Programme to access this chronic medication benefit. Members will receive a letter by email or post indicating whether their application was successful or not.

If successful, the beneficiary will be issued with a disease-specific authorisation, which will allow 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 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 this 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	<p>This option provides for unlimited hospitalisation paid at the prescribed tariff, as well as for out-of-hospital (day-to-day) benefits</p> <p>This option is intended to provide for the needs of families who have significant healthcare needs</p>
	Pre-authorisation, referrals, protocols and management by programmes	<p>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)</p> <p>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 as well as to protect the funds of the Scheme</p>

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	
<p>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</p> <p>Subject to PMBs, i.e. no limit in case of life-threatening emergencies or for PMB conditions</p> <p>Subject to applicable tariff, i.e. 100% of POLMED rate or agreed tariff or at cost for involuntary access to PMBs</p>	Unlimited in private hospitals
<p>Dentistry (conservative and restorative)</p>	<p>100% of POLMED rate</p> <p>Dentist's costs for basic dental procedures will be reimbursed from the out-of-hospital (OOH) benefit</p> <p>The hospital and anaesthetist's costs will be reimbursed from the in-hospital benefit</p>
<p>Emergency medical assistance Netcare 911 (082 911) is the DSP</p>	
<p>Chronic kidney dialysis National Renal Care (NRC) and Fresenius Medical Care are preferred providers</p>	100% of agreed tariff at DSP

IN-HOSPITAL BENEFITS	
<p>Mental health</p>	<p>100% of POLMED rate or at cost for PMBs</p> <p>Annual limit of 21 days per beneficiary</p> <p>Limited to a maximum of three days' hospitalisation for beneficiaries admitted by a GP or a specialist physician</p> <p>Additional hospitalisation to be motivated by the medical practitioner</p>
<p>Medication: Non-PMB specialist drug limit, e.g. biologicals</p>	<p>100% of POLMED rate</p> <p>Pre-authorisation required</p> <p>Specialised medicine sub-limit of R104 511 per family</p>
<p>Oncology (chemotherapy and radiotherapy) Independent Clinical Oncology Network (ICON) is the DSP</p>	<p>100% of agreed tariff at DSP</p> <p>Limited to R420 428 per beneficiary per annum; includes MRI/CT or PET scans related to oncology</p>
<p>Organ and tissue transplants</p>	<p>100% of agreed tariff at DSP or at cost for PMBs</p> <p>Subject to clinical guidelines used in State facilities</p> <p>Unlimited radiology and pathology for organ transplant and immunosuppressants</p>
<p>Pathology</p>	Service will be linked to hospital pre-authorisation
<p>Physiotherapy</p>	Service will be linked to hospital pre-authorisation

IN-HOSPITAL BENEFITS	
Prostheses (internal and external)	<p>100% of POLMED rate or at cost for PMBs</p> <p>Subject to pre-authorisation and approved product list</p> <p>Limited to R61 798 per beneficiary</p>
Refractive surgery	<p>100% of POLMED rate</p> <p>Subject to pre-authorisation</p> <p>Procedure is performed out of hospital and in day clinics</p>
General practitioners (GPs)	<p>100% of agreed tariff at DSP, 100% of POLMED rate at non-DSP or at cost for involuntary access to PMBs</p>
Specialists	<p>100% of agreed tariff at DSP, 100% of POLMED rate at non-DSP or at cost for involuntary access to PMBs</p>
Anaesthetists	<p>150% of POLMED rate or at cost for PMBs</p>



OVERALL OUT-OF-HOSPITAL BENEFITS	
<p>Annual overall out-of-hospital (OOH) limit</p> <p>Benefits shall not exceed the amount set out in the table</p> <p>PMBs shall first accrue towards the total benefit, but are not subject to a limit</p> <p>In appropriate cases the limit for medical appliances shall not accrue towards this limit</p> <p>Out-of-hospital benefits are subject to:</p> <ul style="list-style-type: none"> • 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 	<p>M0 – R19 057 M1 – R23 191 M2 – R27 944 M3 – R32 045 M4 + – R34 775</p>
<p>Dentistry (conservative and restorative)</p>	<p>100% of POLMED rate</p> <p>Subject to the OOH limit and includes dentist's costs for in-hospital, non-PMB procedures</p> <p>Routine consultation, scale and polish are limited to two annual check-ups per beneficiary</p> <p>Oral hygiene instructions are limited to once in 12 months per beneficiary</p>

OVERALL OUT-OF-HOSPITAL BENEFITS

General practitioners (GPs) POLMED has a GP Network	<p>100% of agreed tariff at DSP or at cost for involuntary access to PMBs</p> <p>The limit for consultations shall accrue towards the OOH limit</p> <p>Subject to maximum number of visits/ consultations per family per annum, as follows: M0 – 11 M1 – 16 M2 – 20 M3 – 24 M4 + – 29</p>
Medication (acute)	<p>100% of POLMED rate</p> <p>Annual limit of R16 551 per family</p> <p>Subject to the OOH limit and the medicine reference price</p>
Medication (over the counter [OTC])	<p>100% of POLMED rate</p> <p>Annual limit of R1 090 per family</p> <p>Subject to the OOH limit; shared limit with acute medication</p>
Audiology	<p>100% of POLMED rate</p> <p>Subject to the OOH limit</p> <p>Subject to referral by GP, ear, nose and throat (ENT) specialist, paediatrician, physician or neurologist</p>
Occupational and speech therapy	<p>100% of POLMED rate</p> <p>Annual limit of R2 528 per family</p> <p>Subject to OOH limit</p>

OVERALL OUT-OF-HOSPITAL BENEFITS

Pathology	<p>M0 – R3 180 M1 – R4 585 M2 – R5 483 M3 – R6 753 M4 + – R8 281</p> <p>The defined limit per family will apply for any pathology service done out of hospital</p>
Physiotherapy	<p>100% of POLMED rate</p> <p>Annual limit of R4 585 per family</p> <p>Subject to the OOH limit</p>
Social worker	<p>100% of POLMED rate</p> <p>Annual limit of R4 585 per family</p> <p>Subject to the OOH limit</p>
Specialists Referral is not necessary for gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists (dialysis), dental specialists and supplementary/ allied health services (excluding audiology services)	<p>100% of agreed tariff at DSP or at cost for involuntary access to PMBs</p> <p>The limit for consultations shall accrue towards the OOH limit</p> <p>Limited to five visits per beneficiary and 11 visits per family per annum</p> <p>Subject to referral by a GP (two specialist visits per beneficiary without GP referral allowed)</p> <p>R1 000 co-payment if no referral is obtained</p>

STAND-ALONE BENEFITS	<p>Allied health services and alternative healthcare providers Includes chiropractors, biokineticists, dieticians, homeopaths, chiropodists, podiatrists, reflexologists, naturopaths, orthoptists, osteopaths and therapeutic massage therapists</p> <p>Benefits will be paid for clinically appropriate services</p>	<p>100% of POLMED rate</p> <p>Annual limit of R2 528 per family</p> <p>Subject to the OOH limit</p>	
	<p>Appliances (medical and surgical) Pre-authorisation is required for the supply of oxygen</p> <p>All costs for maintenance are a Scheme exclusion</p> <p>Members must be referred for audiology services for hearing aids to be reimbursed</p>	<p>100% of POLMED rate and subject to:</p>	
		Blood transfusions	Unlimited
		Hearing aids	R13 381 per hearing aid or R26 595 per beneficiary per set every three years
		Nebuliser	R1 270 per family once every four years
		Glucometer	R1 270 per family once every four years
		CPAP machine	R8 933 per family once every four years
		Wheelchair (non-motorised)	R14 865 per beneficiary once every three years
		Wheelchair (motorised)	R49 966 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	<p>Appliances (medical and surgical) (continued)</p>	Medical assistive devices	Annual limit of R3 180 per family and includes medical devices in/out of hospital
	<p>Dentistry (specialised) Pre-authorisation required</p>	<p>100% of POLMED rate or at cost for PMBs</p> <p>An annual limit of R13 439 per family</p> <p>Benefits shall not exceed the set out limit and includes any specialised dental procedures done in/out of hospital</p> <p>Includes metal-based dentures</p> <p>Excludes osseointegrated implants</p> <p>Subject to dental protocols</p>	
	<p>Maternity benefits, including home birth Pre-authorisation required and treatment protocols apply</p>	<p>The limit for consultations shall not accrue towards the OOH limit</p> <p>The benefit shall include three specialist consultations per beneficiary per pregnancy</p> <p>Home birth is limited to R15 921 per beneficiary per annum</p> <p>Annual limit of R4 472 for ultrasound scans per family; limited to two 2D scans per pregnancy</p> <p>Benefits relating to more than two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation</p>	
	<p>Maxillofacial Pre-authorisation required</p>	<p>Shared limit with specialised dentistry</p> <p>Excludes osseointegrated implants</p>	

STAND-ALONE BENEFITS	<p>Chronic medication refers to non-PMB conditions Subject to prior application and/or registration of the condition</p> <p>Approved PMB-CDL conditions are not subject to a limit</p> <p>Designated service providers: Courier pharmacies: Medipost Pharmacy and Pharmacy Direct</p> <p>Retail pharmacies: Clicks Pharmacy and MediRite Pharmacy</p>	<p>100% of medicine reference price</p> <p>The extended list of chronic conditions (non-PMBs) are subject to the following limits:</p> <p>Member with no registered dependants: Annual limit of R9 230</p> <p>Member with registered dependants: Annual limit of R16 568</p> <p>Subject to the medicine reference price and formulary</p>
	<p>Optical Includes frames, lenses and eye examinations</p> <p>The eye examination is per beneficiary every two years (unless prior approval for clinical indication has been obtained)</p> <p>Benefits are not pro rata, but calculated from the benefit service date</p> <p>Each claim for lenses or frames must be submitted with the lens prescription</p> <p>Benefits shall not be granted for contact lenses if the beneficiary has already received a pair of spectacles in a two-year benefit cycle</p> <p>Annual contact lens limit is specified</p> <p>Contact lens re-examination can be claimed for in six-monthly intervals</p> <p>Preferred Provider Negotiators (PPN) is the preferred provider network</p>	<p>The benefit per beneficiary (per 24-month benefit cycle) at a PPN provider would be:</p> <p>One composite consultation, inclusive of refraction, tonometry and visual field screening; collection of blood pressure, glucose and cholesterol readings</p> <p>AND EITHER SPECTACLES</p> <p>A PPN frame or alternative frame plus lens enhancements to the value of R950</p> <p>WITH EITHER</p> <p>One pair of clear Aquity single-vision or clear Aquity bifocal lenses or clear Aquity multifocal lenses</p>

STAND-ALONE BENEFITS	<p>Optical (continued)</p>	<p>OR CONTACT LENSES</p> <p>Contact lenses to the value of R1 510</p> <p>Contact lens re-examination to a maximum cost of R220 per consultation</p> <p>Non-PPN provider would be:</p> <p>One consultation limited to a maximum cost of R345</p> <p>AND EITHER SPECTACLES</p> <p>R950 towards a frame and/or lens enhancements</p> <p>WITH EITHER</p> <p>One pair of single-vision lenses, limited to R165 per lens, or one pair of clear flat-top bifocal lenses, limited to R360, or one pair of clear flat-top multifocal lenses, limited to R660 per lens</p> <p>OR CONTACT LENSES</p> <p>Contact lenses to the value of R1 510</p> <p>Contact lens re-examination to maximum cost of R220 per consultation</p>
	<p>Preventative care (refer to Annexure E) One wellness measure per year, including:</p> <ul style="list-style-type: none"> • Blood pressure test • Body mass index test • Occult blood test • Waist-to-hip ratio measurement • Cholesterol screening (Z13.8) • Glucose screening (Z13.1) • Healthy diet counselling (Z71.3) 	<p>100% of POLMED rate or agreed tariff where applicable</p> <p>Early detection screening limited to periods specified in Annexure E</p> <p>Beneficiaries over the age of 50</p> <p>Funded from the risk pool; the benefit shall not accrue to the OOH limit</p>

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 the Department of Health guidelines)
 - Dental screening (codes 8101, 8151 and 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-authorization required

100% of agreed tariff or at cost for PMBs

Includes any specialised radiology service done in/out of hospital

Two (2) MRI

Subject to a limit of two scans per family per annum, except for PMBs

Three (3) CT scans

Subject to a limit of three scans per family 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-payment 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)



Non-PMB chronic medication is payable from chronic medication benefits. PMB-related chronic medication will be funded from the PMB pool.

Auto-immune disorder

Systemic lupus erythematosus (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

Gastrointestinal 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

Psychiatric conditions

Affective disorders (depression and bipolar mood disorder)
Schizophrenic disorders

Pulmonary diseases

Asthma
Chronic obstructive pulmonary disease (COPD)
Bronchiectasis
Cystic fibrosis

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

Gastrointestinal 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



ANNEXURES

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)
 - 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, osseointegrated 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 an 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 are 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	Lenons
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
5.07	Appliances, supplies and devices: Disposable cholesterol supplies	

CATEGORY	DESCRIPTION	EXAMPLE
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: Opioid	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

ANNEXURE D

PROCEDURES PRE-AUTHORISED UNDER THE 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 a 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	PROCEDURE DESCRIPTION
Additional intra-articular injection for arthritis	Diathermy to nose or pharynx under local anaesthesia
Ascites or pleural tapping	Drainage of subcutaneous abscess – onychia, etc.
Aspiration of joint or intra-articular injection	Drainage of submucous abscess
Aspiration or injection	Endoscopy
Bartholin's abscess marsupialisation	ENT endoscopy in rooms with rigid endoscope
Bilateral myringotomy	Excision of cysts or tumours – vagina
Bilateral myringotomy with insertion of tube	Excision of the ganglion
Biopsy – nerve	Excision of lymph node for biopsy – neck or axilla
Biopsy or excision of cyst or lymph node biopsy	Excision of meibomian cyst
Biopsy – muscle, skin	Fine-needle aspiration cytology
Bronchial lavage	Fine-needle aspiration for soft tissue – all areas including breast
Circumcision	Flexible nasopharyngo-laryngoscope examination
Colonoscopy	Incision and drainage of peri-anal abscess
Cone biopsy – cervix	
Dilation and curettage (excluding aftercare)	

PROCEDURE DESCRIPTION
Intra-articular injection for arthritis – first joint
Intra-pleural block
Laser tonsillectomy
Limb cast
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
Radical nail bed removal
Removal of foreign body – deep fascia (except hands)
Removal of foreign body (except hands)

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.

PROCEDURE DESCRIPTION
Removal of single nasal polyp at rooms
Retropharyngeal abscess – external approach
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 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 2017

This benefit allows for risk assessment tests to ensure the early detection of conditions that may be completely cured or successfully managed if treated early. All services listed under the preventative care benefit will be paid from your in-hospital benefits and will not deplete your out-of-hospital benefits. Read more about the preventative care benefit on pages 28 to 29 for Marine and page 69 for Aquarium.

MEASURE AND ICD-10 CODES	CARE, SCREENING, TEST
FULL MEDICAL EXAMINATION	
<p>One wellness measure per year inclusive of:</p> <ul style="list-style-type: none"> • Blood pressure test • Body mass index (BMI) test • Waist-to-hip ratio measurement • Consultation • Cholesterol screening (Z13.8) • Glucose screening (Z13.1) • Healthy diet counselling (Z71.3) • Lipid disorder screening for age > 40 years • Occult blood test (screening for peptic ulcer disease) <p>Clinical information to be submitted to managed healthcare</p>	<p>Annually</p> <p>Beneficiaries over the age of 50</p>
CHILD HEALTH	
<p>All child immunisation provided by the Department of Health (DOH) for children six (6) years old and younger</p>	<p>As per DOH age schedule as per the Road to Health chart</p>
FEMALE HEALTH (women and adolescent girls)	
<p>Cervical cancer screening ICD: Z12.4 For all females aged 21-64 years old, except for those women who have had a complete hysterectomy with no residual cervix</p>	<p>Pap smear test once every third year</p>

MEASURE AND ICD-10 CODES	CARE, SCREENING, TEST
FEMALE HEALTH (women and adolescent girls)	
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: Z30	As recommended by NDOH
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
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

MEASURE AND ICD-10 CODES	CARE, SCREENING, TEST
OTHER	
Glaucoma screening	Once every third year; unless motivated
Circumcision	Subject to clinical protocols
Post-trauma debriefing session Only for active principal members of SAPS utilising the Psycho-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.



AQUARIUM SCHEDULE

ANNEXURE B1

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2017

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



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



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

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



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

ANNEXURE B3

AQUARIUM CONTRIBUTION SCHEDULE

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

Total contribution includes subsidy from employer.

CONTRIBUTION RATES AQUARIUM 2016 (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.

The contributions for 2017 as set out in the format required by the Registrar in Circular 48 of 2016.

CONTRIBUTION RATES AQUARIUM 2017 (1 APRIL 2017 – 31 MARCH 2018)



TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 940	919	919	453
R5 941 – R8 160	933	933	453
R8 161 – R9 970	977	977	468
R9 971 – R11 660	1 019	1 019	480
R11 661 – R13 570	1 062	1 062	493
R13 571 – R16 320	1 100	1 100	507
R16 321 – R20 030	1 175	1 175	522
R20 031 +	1 241	1 241	565

MEMBER CONTRIBUTION (SUBSIDISED CONTRIBUTION)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 940	65	65	29
R5 941 – R8 160	72	72	29
R8 161 – R9 970	95	95	37
R9 971 – R11 660	117	117	43
R11 661 – R13 570	139	139	50
R13 571 – R16 320	159	159	57
R16 321 – R20 030	198	198	65
R20 031 +	232	232	87

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 will form 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 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 formulary. 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 reapply 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 medication benefit, but from the acute medication benefit, subject to the available benefits. This only applies to authorisations that are not ongoing 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 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. The specialist has to submit the referring GP's practice number in the claim.

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. The cut-off date for Ex Gratia applications will be the end of April in the year after the service was rendered.

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.

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

Examples of designated service providers (where applicable) are:

- cancer (oncology) network
- general practitioner (GP) network
- 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.

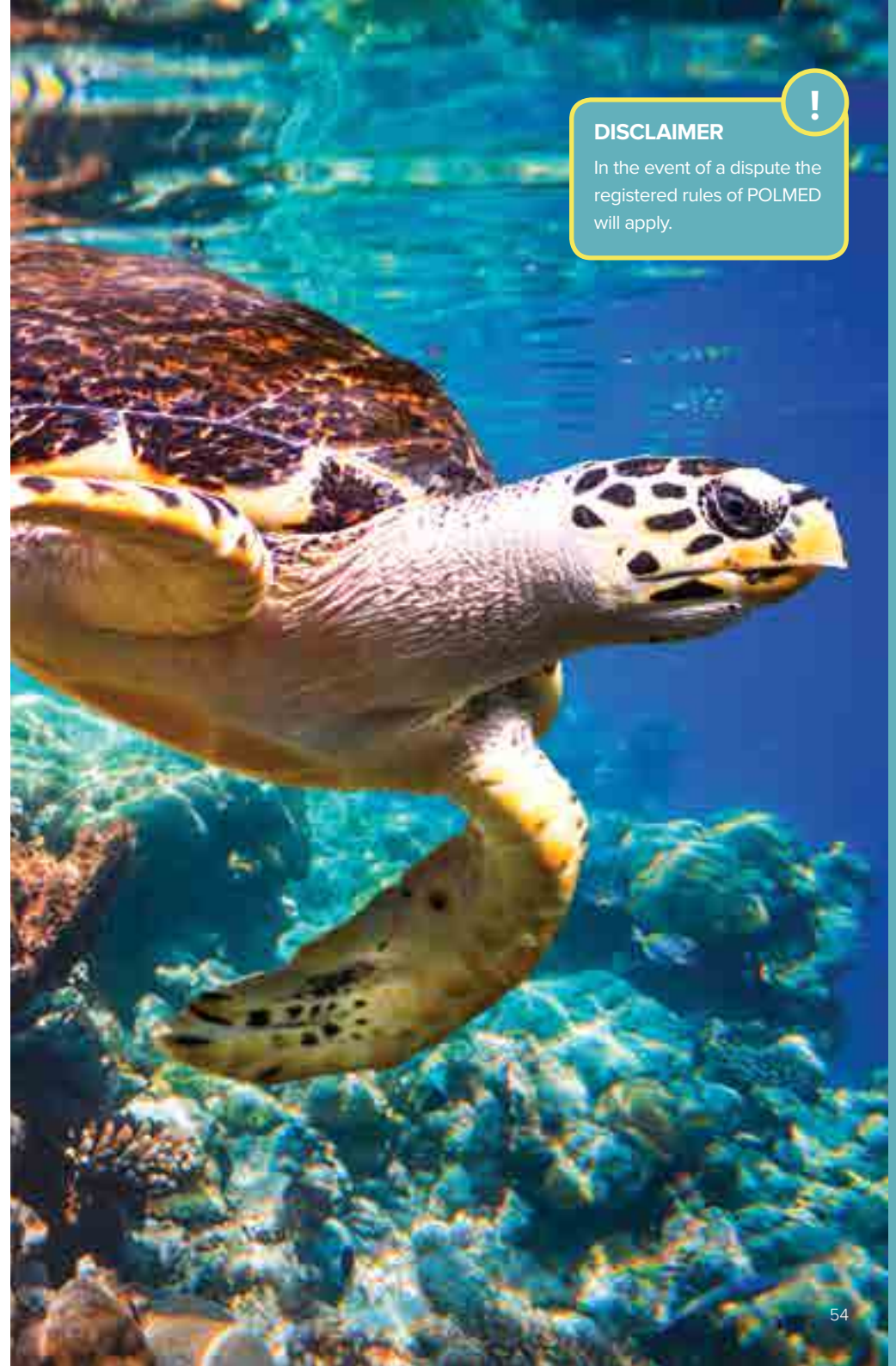
Designated pharmacy network

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.

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

DISCLAIMER

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



DEFINITION OF TERMS

Designated service provider (DSP)

This is a list of service providers that have been contracted by POLMED to render services to its members at a negotiated tariff and/or agreed treatment protocols and/or agreed adherence to other managed care interventions.

Formulary

A formulary is a list of cost-effective, evidence-based medicines that will be reimbursed for the treatment of chronic conditions. This list is constantly reviewed and funding is subject to clinical guidelines, protocols and Scheme rules.

Generic substitution

This means substituting the chemical entity in the same dosage form for one marketed from a different company.

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, 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 medication benefit (i.e. through a benefit that is separate from the acute medication benefit). POLMED requires members to apply for authorisation via the Chronic Medicine Management Programme to access this chronic medication benefit. Members will receive a letter by email or post indicating whether their application was successful or not. If successful, the beneficiary will be issued with a disease-

specific authorisation, which will allow 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 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 this 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	<p>This option provides for benefits to be provided only in appointed designated service provider (DSP) hospitals</p> <p>It also provides a reasonable level of out-of-hospital (day-to-day) care</p> <p>This option is intended to provide for the needs of families who have little healthcare needs or whose chronic conditions are under control</p> <p>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</p>
	Pre-authorization, referrals, protocols and management by programmes	<p>Where the benefit is subject to pre-authorization, 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-authorization, 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)</p> <p>The pre-authorization, 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</p>

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

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 R73 596 per family

Oncology (chemotherapy and radiotherapy)
Independent Clinical Oncology Network (ICON) is the DSP

100% of agreed tariff at DSP

Limited to R245 473 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 R60 674 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	100% of agreed tariff at DSP, 100% of POLMED rate for non-DSP or at cost for involuntary PMB access
	Anaesthetists	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	M0 – R8 337 M1 – R10 101 M2 – R12 270 M3 – R13 090 M4 + – R15 000
	Out-of-hospital benefits are subject to: <ul style="list-style-type: none"> • protocols and clinical guidelines • PMBs • the applicable tariff, i.e. 100% of POLMED rate or agreed tariff or at cost for involuntary PMB access 	
	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 PMB access The limit for consultations shall accrue towards the OOH limit Subject to maximum number 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 R9 057 per family Subject to the OOH limit and the medicine reference price
Medication (over-the-counter [OTC])	100% of POLMED rate Annual limit of R901 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 933 M1 – R4 338 M2 – R5 247 M3 – R6 495 M4 + – R8 045 The defined limit per family will apply for any pathology service done out of hospital
Physiotherapy	100% of POLMED rate Annual limit of R2 269 per family Subject to the OOH limit
Social worker	100% of POLMED rate Annual limit of R2 141 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

STAND-ALONE BENEFITS	<p>Allied health services and alternative healthcare providers Includes biokineticists, chiropractors, dieticians, homeopaths, chiropodists, podiatrists, reflexologists, naturopaths, orthoptists, osteopaths and therapeutic massage therapists</p> <p>Benefit is subject to clinically appropriate services</p>	No benefit	
	<p>Appliances (medical and surgical) Pre-authorisation is required for the supply of oxygen</p> <p>All costs for maintenance are a Scheme exclusion</p> <p>Members must be referred for audiology services for hearing aids to be reimbursed</p>	100% of POLMED rate and subject to:	
		Blood transfusions	Unlimited
		Hearing aids	R10 708 per hearing aid or R21 281 per beneficiary per set every three years
		Nebuliser	R1 214 per family once every four years
		Glucometer	R1 214 per family once every four years
		CPAP machine	R8 674 per family once every four years
		Wheelchair (non-motorised)	R11 337 per beneficiary once every three years
		Wheelchair (motorised)	R32 517 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	<p>Appliances (medical and surgical) (continued)</p>	Medical assistive devices	Annual limit of R2 550 per family and includes medical devices in/out of hospital
	<p>Dentistry (specialised) Pre-authorisation required</p>	<p>No benefit except for PMBs</p> <p>Only covers specialised dental procedures done in/out of hospital that meet PMB criteria</p>	
	<p>Maternity benefits, including home birth Pre-authorisation required and treatment protocols apply</p>	<p>100% of agreed tariff at DSP, 100% of POLMED rate at non-DSP or at cost for involuntary PMB access</p> <p>The limit for consultations shall not accrue towards the OOH limit</p> <p>The benefit shall include three specialist consultations per beneficiary per pregnancy</p> <p>Home birth is limited to R13 640 per beneficiary per annum</p> <p>Annual limit of R3 820 for ultrasound scans per family; limited to two 2D scans per pregnancy</p> <p>Benefits relating to more than two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation</p>	
	<p>Maxillofacial Pre-authorisation required</p>	<p>No benefit except for PMBs</p> <p>Surgical removal of impacted teeth is covered subject to overall non-PMB limit</p>	

STAND-ALONE BENEFITS	<p>Chronic medication refers to non-PMB conditions Subject to prior application and/or registration of the condition</p> <p>Approved PMB-CDL conditions are not subject to a limit</p> <p>Designated service providers: Courier pharmacies: Medipost Pharmacy and Pharmacy Direct</p> <p>Retail pharmacies: Clicks Pharmacy and MediRite Pharmacy</p>	<p>No benefit except for PMBs</p> <p>Subject to the medicine reference price</p>
	<p>Optical Includes frames, lenses and eye examinations</p> <p>The eye examination is per beneficiary every two years (unless prior approval for clinical indication has been obtained)</p> <p>Benefits are not pro rata, but calculated from the benefit service date</p> <p>Each claim for lenses or frames must be submitted with the lens prescription</p> <p>Benefits shall not be granted for contact lenses if the beneficiary has already received a pair of spectacles in a two-year benefit cycle</p> <p>Annual contact lens limit is specified</p> <p>Contact lens re-examination can be claimed for in six-monthly intervals</p> <p>Preferred Provider Negotiators (PPN) is the preferred provider network</p>	<p>The benefit per beneficiary (per 24-month benefit cycle) at a PPN provider would be:</p> <p>One composite consultation, inclusive of refraction, tonometry and visual field screening; collection of blood pressure, glucose and cholesterol readings</p> <p>AND EITHER SPECTACLES</p> <p>A PPN frame or alternative frame plus enhancement to the value of R580</p> <p>WITH EITHER</p> <p>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</p>

STAND-ALONE BENEFITS	<p>Optical (continued)</p>	<p>OR CONTACT LENSES</p> <p>Contact lenses to the value of R580</p> <p>Contact lens re-examination to a maximum cost of R220 per consultation</p> <p>Non-PPN provider would be:</p> <p>One consultation limited to a maximum cost of R345</p> <p>AND EITHER SPECTACLES</p> <p>R580 towards a frame and/or lens enhancements</p> <p>WITH EITHER</p> <p>One pair of clear Aquity single-vision lenses, limited to R165 per lens, or one pair of clear Aquity bifocal lenses, limited to R360, or multifocal clear Aquity lenses covered up to the value of clear bifocal lens limit</p> <p>OR CONTACT LENSES</p> <p>Contact lenses to the value of R580</p> <p>Contact lens re-examination to a maximum cost of R220 per consultation</p>
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STAND-ALONE BENEFITS

<p>Preventative care (refer to Annexure E) One wellness measure per year, including:</p> <ul style="list-style-type: none"> • Blood pressure test • Body mass index test • Waist-to-hip ratio measurement • Cholesterol screening (Z13.8) • Glucose screening (Z13.1) • Occult blood test • Healthy diet counselling (Z71.3) • Risk assessment tests: <ul style="list-style-type: none"> - 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 	<p>100% of POLMED rate or agreed tariff where applicable</p> <p>Early detection screening limited to periods specified in Annexure E</p> <p>Funded from the risk pool; the benefit shall not accrue to the OOH limit</p> <p>Beneficiaries over the age of 50</p>
<p>Radiology (basic) i.e. black and white X-rays and soft tissue ultrasounds</p>	<p>100% of agreed tariff or at cost for PMBs</p> <p>Limited to R4 950 per family</p> <p>Includes any basic radiology done in/out of hospital</p> <p>Claims for PMBs first accrue towards the limit</p>

<p>STAND-ALONE BENEFITS</p>	<p>Radiology (specialised) Pre-authorization required</p>	<p>100% of agreed tariff or at cost for PMBs</p> <p>Includes any specialised radiology service done in/out of hospital</p> <p>Claims for PMBs first accrue towards the limit</p>
	<p>Two (2) MRI</p>	<p>Subject to a limit of two scans per family per annum, except for PMBs</p>
	<p>Three (3) CT scans</p>	<p>Subject to a limit of three scans per family per annum, except for PMBs</p>

ANNEXURE B2 CO-PAYMENTS

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



ANNEXURE B4

AQUARIUM CHRONIC LIST

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 PMB pool.

Auto-immune disorder

Systemic lupus erythematosus (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

Gastrointestinal 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

Psychiatric conditions

Affective disorders (depression and bipolar mood disorder)
Schizophrenic disorders

Pulmonary diseases

Asthma
Chronic obstructive pulmonary disease (COPD)
Bronchiectasis
Cystic fibrosis

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



24-HOUR SELF-HELP SERVICE PROCESS

CALL 0860 765 633

An interactive voice recording will prompt you to choose an option.

Choose 2 for member and 1 when prompted for the self-help service.

Remember: You would need your membership number to access your information.



YOUR STEP-BY-STEP GUIDE TO ACCESS THE 24-HOUR SELF-HELP SERVICE

PRESS 1 to listen to your available benefits. You then have a choice between the following:

- Press 1 - general practitioner (GP) and specialist consultations
- Press 2 - acute medication
- Press 3 - chronic medication
- Press 4 - non-surgical procedures
- Press 5 - dentistry

PRESS 2 to request documents. You then have a choice between the following:

- Press 1 - your membership certificate
- Press 2 - your tax certificate
- Press 3 - your member statement

PRESS 3 to request a membership card.

POLMED CHAT

POLMED Chat allows members to send and receive short text messages directly with POLMED Client Service Call Centre Consultants in real time. This application helps to ensure that our members can communicate effectively and efficiently with these Consultants.

HOW TO ACCESS THIS APPLICATION
 You can use POLMED Chat via the Internet on a computer or your mobile device:
Via a mobile device: It is available to download free as an app via <http://bit.ly/1YHAtwu> or from the Android, Apple Appstore and Windows Phone Store platforms.
Via the POLMED website: Go to the POLMED website at www.polmed.co.za via your computer, log in to the Member zone and select the POLMED Chat widget/icon for access.

BENEFITS OF USING THE POLMED CHAT APPLICATION
 There are numerous benefits such as:

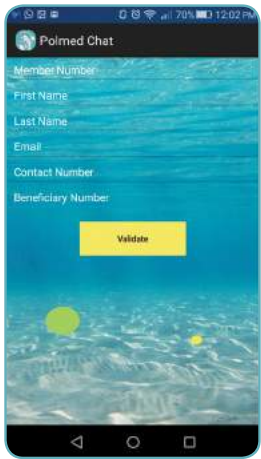
- It's less costly than a phone call.
- You will receive feedback faster in comparison to an email.
- You can chat online to a person, rather than an automated system.
- You can be anywhere and discuss personal details without anyone listening – this further promotes confidentiality.

WHAT CAN YOU DO WITH THIS APPLICATION?
 POLMED Chat enables you to:

- Clarify simple enquiries without having to call the Client Service Call Centre or send emails.
- Ask benefit and/or claims-related questions.
- Attach documentation to your message and forward it directly to a Consultant.
- Request an electronic version of your POLMED membership card.

DO YOU NEED TO DO ANYTHING THE FIRST TIME THAT YOU WANT TO USE POLMED CHAT?
 Upon opening this functionality for the first time, you would need to type in your POLMED details in the respective fields and select 'Validate'. The fields include:

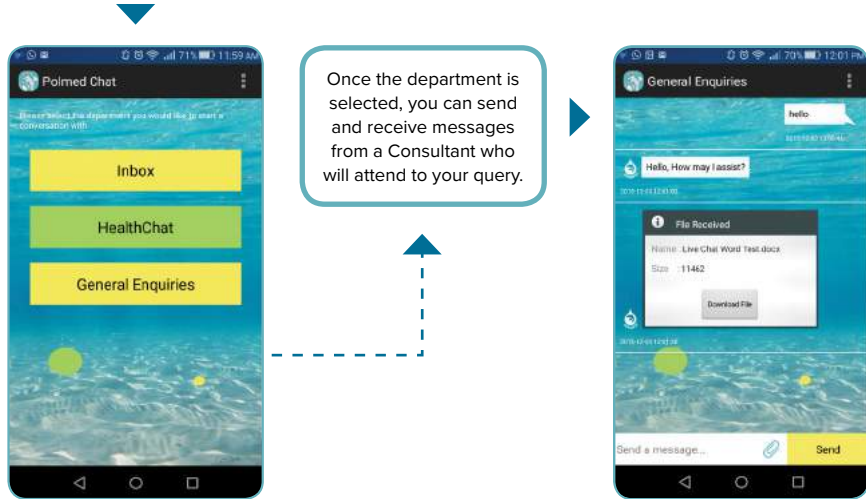
- Membership number
- First name
- Last name
- Email address
- Cellphone number
- Beneficiary number



OPERATING HOURS
 These Consultants are available during office hours (from 7:30 to 17:00 on Mondays to Fridays, excluding public holidays) to assist you.

NOTE
 If you have validated the application and then open the application again in future, the verification process would automatically use the previous details entered.

HOW DO YOU START A CHAT?
 When the validation is successful, you can proceed to chat. Depending on your query, you would select the department that is most relevant. For example, select 'General Enquiries' and then type a message on that page.



HOW DO YOU VIEW YOUR POLMED MEMBERSHIP CARD?
 From the department screen you would access the menu button and then select 'Member Card'. Your membership card would then display.

MORE INFORMATION
 For more information and assistance contact the POLMED Client Service Call Centre on 0860 765 633. Alternatively, go to the POLMED website at www.polmed.co.za and select 'MEMBERS', 'Online Tools', and then 'POLMED Chat Guide' for a comprehensive guide.

HOW TO REGISTER ON MEMBER ZONE

WHAT DO YOU NEED TO REGISTER ON MEMBER ZONE?

You need the following for registration:

- POLMED membership number
- ID number
- Email address
- A username
- A password

Visit the POLMED website at www.polmed.co.za.

Go to the top of the home page and select 'Member'. This will take you to a page where you can create an account for Member zone.

MEMBER ZONE REGISTRATION PROCESS

- Select 'Create Account'.
- Select 'Members'.
- Type in your membership number and select 'Validate Code'.
- Confirm or choose from the list of members to indicate your status and name, and then choose 'Select'.
- Validate your account with either your ID number, email address or cellphone number and then select 'Use'.
- Type in the details, including your email address and a password.
- Read through the terms and conditions, and then select 'Create Account' to complete the registration process.
- **Note:** If you are a beneficiary, the principal member will receive an email to activate your access.

MEMBER ZONE FEATURES

Access useful membership and Scheme-related information and also update certain membership details such as the following:

- View benefit usage and limits.
- View claims history and statements.
- View contribution information (via desktop only – available via mobile soon).
- View your communication profile (via desktop only – available via mobile soon).
- Access your tax certificate.
- View your membership card.
- Access your membership certificate.
- View authorisations.
- View your and your dependants' personal information, including banking details (via desktop only – available via mobile soon).
- View your contact and address information, including the option to update your information (via desktop only – available via mobile soon).
- View queries, including previous correspondence (via desktop only – available via mobile soon).
- Access Health Portal (via desktop only – available via mobile soon).
- Access Scheme documents (via desktop only – available via mobile soon).

Member zone landing page



SIGN OUT

Remember to sign out when you have completed your enquiry.

FIVE EASY STEPS TO PLAN SELECTION

! Understand your benefits and choose the right plan. You should inform us before 31 December.

1 HOW DO I CHOOSE A PLAN?

Read and understand the new benefits and choose the plan that will address your needs.

2 HOW DO I INFORM POLMED?

Complete the plan selection form and email, fax or post it to us or, alternatively, you can hand it in at any of the walk-in branches.

OR

Submit your choice online at www.polmed.co.za.

OR

Contact the Client Service Call Centre on 0860 765 633 and speak to a Consultant during office hours.



3 HOW WILL I KNOW MY PLAN HAS BEEN CHANGED?

You will receive a communication from POLMED to confirm the change.

4 WHAT IF I DO NOT INFORM POLMED?

You will remain on the same plan.

5 CAN I CHANGE MY PLAN AFTER THIS?

No, you may only change your plan at the end of each year.

WHY DO I HAVE TO CHANGE MY PLAN EVERY YEAR?
 The Scheme's benefits and contributions are changed every year. It is important that you understand the benefits of a specific plan before you make your selection. You must ensure that the plan you choose will address your healthcare needs.

CAN I CHANGE MY PLAN IN THE MIDDLE OF THE YEAR?
 You can only change your plan once a year and it is therefore important that you make the right choice and ensure that you inform POLMED. The plan selection form must be completed and signed before posting, faxing, emailing or the hand delivery of it to POLMED.

WHEN WILL THE NEW CONTRIBUTIONS COME INTO EFFECT IF I REMAIN ON THE SAME PLAN?
 The annual increase in contributions is effective on 1 April each year.

WHAT HAPPENS WHEN I CHANGE MY PLAN?
 The new contribution will be based on the plan selected and deducted from 1 January. New membership cards will be issued for the new plan.

DOCUMENTS REQUIRED WHEN APPLYING FOR MEMBERSHIP

MEMBERS/ADULT DEPENDANTS

SERVING MEMBER

Documents needed:

- Application for membership form
- Letter of appointment
- Copy of ID
- Proof of income (salary advice)
- Copy of most recent bank statement or stamped letter from the bank confirming your banking details

SPOUSE

Documents needed:

- Application for registration of dependants form
- Copy of ID
- Copy of marriage certificate or customary union certificate
- Membership certificate from previous medical scheme, if it is applicable

PARTNER

Documents needed:

- Application for registration of dependants form
- Copy of ID
- Three affidavits (one from a member, a partner and a witness) confirming co-habitation and financial dependency on principal member – annually
- Membership certificate from previous medical scheme, if it is applicable

BIOLOGICAL PARENTS/ PARENTS-IN-LAW

Documents needed:

- Application for registration of dependants form
- Copy of ID
- Proof of monthly income
- Affidavit confirming financial dependency
- Membership certificate from previous medical scheme, if it is applicable

HOW TO OBTAIN FORMS

POLMED website: Go to www.polmed.co.za, select 'FORMS', from the drop-down list select 'Administration (Membership)' and then select the relevant form required.

Client Service Call Centre: 0860 765 633

Email: polmed@medscheme.co.za

REMEMBER

For new members or dependants an application form must be completed and the necessary documentation attached to it.

CHILDREN

BIOLOGICAL CHILD

Documents needed for child born before or out of wedlock:

- Application for registration of dependants form
- Copy of birth certificate
- Affidavit confirming member is the biological parent of the child

LEGALLY ADOPTED CHILD

Documents needed:

- Application for registration of dependants form
- Copy of birth certificate/ID
- Final adoption order

STEPCHILD

Documents needed:

- Application for registration of dependants form
- Copy of birth certificate/ID
- Affidavit confirming child is the biological child of the member's spouse

DEPENDANT BETWEEN THE AGES OF 21 AND 30

Documents needed:

- Application for registration of dependants form
- Copy of ID

Student:

- Certificate of registration at registered tertiary learning institution – annually

Financially dependent:

- Affidavit confirming financial dependency (monthly income) – annually

DISABLED CHILD OVER THE AGE OF 21

Documents needed:

- Application for registration of dependants form
- Copy of ID
- Proof of disability supplied by a medical practitioner – annually

APPLICATION FOR CONTINUATION OF MEMBERSHIP

REMEMBER

Any changes that affect your membership status should be reported to POLMED within 30 days.
A new membership card will be posted to you.
Please provide your correct address details.

WHAT IF BOTH PARENTS DIE?

The youngest child becomes the principal member when both parents die.

WHAT SHOULD BE DONE IF THE PRINCIPAL MEMBER DIES?

Complete the application for continuation membership form and email, fax or post it via one of the following methods together with the requested additional documents:

Email: polmedmembership@medscheme.co.za
Fax: 0861 888 110
Post: Private Bag X16, Arcadia 0007

HOW TO OBTAIN THE APPLICATION FORM

POLMED website: Go to www.polmed.co.za, select 'FORMS', from the drop-down list select 'Administration (Membership)' and then 'Application for Continuation Membership'.

Client Service Call Centre: 0860 765 633
Email: polmed@medscheme.co.za

ADDITIONAL DOCUMENTS NEEDED MAY INCLUDE:

- Copy of ID/birth certificate
- Marriage certificate or customary union certificate
- Death certificate of the late principal member
- Proof of pension
- Information of guardian for minor orphans

WHAT DO I DO WHEN I RETIRE?

RESIGNATION

You cannot remain a POLMED member if you resign as an employee of SAPS.

WHAT TO DO WHEN YOU RETIRE FROM SAPS

Inform the Scheme within 90 days in writing with the reason and date of your resignation, being either:
Medically boarded or pensioned.

IF MEDICALLY BOARDED

Documents needed:

- Application for continuation membership form
- Copy of ID
- Proof of monthly pension
- Service certificate and letter from Medical Board at SAPS Head Office – please indicate if related to injury on duty

IF PENSIONED

Documents needed:

- Application for continuation membership form
- Copy of ID
- Proof of monthly income
- Service certificate



HOW TO SUBMIT A CLAIM

MEMBERS: SUBMISSION OF CLAIMS

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

Obtain a detailed account/statement from the service provider.

SUBMIT YOUR CLAIMS CORRECTLY

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

Email: polmedcurrentclaims@medscheme.co.za

Fax: 011 758 7660

Post: POLMED
Private Bag X16
Arcadia
0007

OR

Visit any of our regional walk-in branches.

SERVICE PROVIDERS: SUBMISSION OF CLAIMS

Most service providers submit their claims electronically.

PAYMENT OF CLAIMS

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

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



WHAT INFORMATION MUST A CLAIM CONTAIN?

Service provider

- Name and practice number
- Referring doctor's practice number
- In the case of a group practice, group practice number and the name of the practitioner who provided the service

Member

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

Other

- Date of service
- Account/reference number
- Tariff code(s) – this is a code that refers to the pricing of a medical service/product
- ICD-10 code(s)
- Cost of each treatment, item or procedure
- In respect of medicine claims, the name, quantity, dosage and net amount payable by the member should be provided
- Proof of payment (receipt or bank deposit) – if you paid for the service

APPLICATION FOR EX GRATIA BENEFITS PROCESS

NEED MEDICAL CARE BUT YOUR BENEFITS ARE EXHAUSTED?

- Ex Gratia is used in very special cases for financial assistance towards medical expenses incurred by a member to maintain health and prevent substantial mental or physical suffering. It is, however, not an additional or an extension of a benefit.
- The rate of reimbursement will be between 80% and 100% of the POLMED rate.
- The cut-off date for the submission of applications is the end of April of the following year.

HOW DO I APPLY FOR EX GRATIA BENEFITS?

Principal member applies for assistance when benefits are exhausted.

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

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

EX GRATIA DOES NOT PERTAIN TO THE FOLLOWING:

- Scheme exclusions.
- Stale claims (older than 120 days).
- Co-payments of any sort.

RETURN THE COMPLETED FORM BY:

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

POLMED receives detailed application.

Captures information. The application for Ex Gratia is submitted to the Clinical Committee to clinically evaluate the application and make a decision. This may take up to a month.

Outcome of application communicated to member.

Claims are settled in accordance with the decision made.

NOTE

- The Ex Gratia authorisation letter must be attached to the form when it is submitted to POLMED for the claim.
- Claims can be submitted via email to us at: polmedcurrentclaims@medscheme.co.za



THIRD PARTY CONSENT

WHAT IS THIRD PARTY CONSENT?

Third party consent is when you consent to:

- giving another person or entity access to your personal information with the Scheme
- another person updating your personal information (biographical only) with the Scheme.

WHO IS A THIRD PARTY?

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

WHY IS THIRD PARTY CONSENT IMPORTANT?

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

WHERE DO I GET A THIRD PARTY MEMBER CONSENT FORM?

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

HOW DO I SUBMIT A COMPLETED CONSENT FORM?

Email it to polmed@medscheme.co.za.

OR

Fax it to 0860 104 114.

OR

Hand deliver it to any regional walk-in branch.



HEALTHCARE FRAUD IS REAL: FRAUD AWARENESS

FACT

The healthcare sector is defrauded of billions every year. Together we can fight fraud, as failure to do so could result in increased member contributions. Every rand lost through fraud means:

- there is someone who could be sick and not get the treatment they need or die
- the depletion of benefits for real emergencies.

WHAT IS MEDICAL SCHEME FRAUD?

Fraud occurs when an individual or organisation deliberately deceives others in order to gain unauthorised benefits.

Medical scheme fraud generally involves deliberately billing for services that were not received or billing for services at a higher rate than is actually justified.

WHAT IS MEDICAL SCHEME ABUSE?

Medical scheme abuse occurs when providers supply services or products that are not medically necessary or that do not meet professional standards.

FRAUD PROTECTION TIPS

Protect yourself from medical scheme fraud and abuse: Treat your membership card like your bank card – keep it safe at all times.

Detect medical scheme fraud and abuse: Use your personal healthcare journal or calendar and review your POLMED claims statements. Check for services you did not receive and services not ordered by your doctor.

CONTACT DETAILS

POLMED fraud hotline: 0800 112 811
Email: fraud@medscheme.co.za

EXAMPLES OF FRAUD AND ABUSE

- Billing for services and supplies that were not rendered.
- Billing for equipment not delivered.
- 'Up coding' – improper coding to obtain a higher payment.
- Unnecessary or excessive X-rays and lab tests.
- Claims for services that are not medically necessary, e.g. gold teeth, slimming products, etc.
- Using another person's medical scheme membership card to obtain medical services, supplies or equipment.
- Forging the doctor's prescription to obtain medicine for unregistered members of the family.
- Buying groceries and receiving cash from healthcare providers using your POLMED membership card.

FRAUD PREVENTION

DO

- Use your personal healthcare journal or a calendar to remember the dates of consultations.
- Monitor all your claims via SMS/email.
- Make sure healthcare providers are who they claim to be. Beware of bogus healthcare providers who practice under false names.
- Review your POLMED claims statement and answer the following questions:
 - Did you receive services from the listed healthcare providers?
 - Did the doctor order this service, product or test?
 - Were you billed for the same service more than one time?
 - Is the charge or service related to your condition or treatment?
 - Did you already pay cash and then notice the healthcare provider also submitted a claim to POLMED?

DON'T

- Collude with healthcare providers – they always get caught!
- Give out your POLMED membership number or membership card, except to POLMED staff, your doctor or other healthcare providers.
- Accept 'money, freebies or groceries' in exchange for your Scheme benefits.
- Allow family members to use your membership card if they are not a registered dependant.

RULES PERTAINING TO FRAUD

If actual or potential fraud and misconduct are uncovered, a comprehensive and objective investigation will be conducted and the following will serve as guidelines:

- Stop claims' payments to healthcare provider.
- Place healthcare provider on indirect payment (stop payment to provider).
- Make detailed findings to the Scheme-appointed external investigators.
- Suspend or terminate the membership of the member and submit a detailed report to employer.
- Report healthcare provider to the Health Professions Council of South Africa (HPCSA).
- Initiate civil proceedings against member and/or healthcare provider.
- Initiate criminal proceedings against member/healthcare provider, which is a good deterrent.

MEMBER QUERIES PROCESS

If you have a query and would like to speak to a Client Service Call Centre Consultant, contact POLMED via **TELEPHONE** on 0860 765 633.

Alternatively send your query/application via **FAX** to 0860 104 114 or send it via **EMAIL** to polmed@medscheme.co.za.

Note: The Administrator has five (5) working days to respond to and resolve your initial enquiry. **ALWAYS OBTAIN A REFERENCE NUMBER AND NAME OF THE AGENT.**

It is extremely important that you follow the correct process in order for us to assist you.

MEMBER QUERIES (INITIAL QUERY)

ADMIN/MANAGED CARE (CLINICAL)/GENERAL QUERIES

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

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

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

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

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

MEMBER QUERIES ESCALATED

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

The query received at POLMED will be investigated and feedback will be provided to the member within a minimum of five (5) working days. The number of days depends on the complexity of the enquiry i.e. more information required from the member/provider to resolve the query.

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

Provide the following details for POLMED to investigate your query:

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

OPERATING HOURS

The POLMED Client Service Call Centre and Regional Offices operate Mondays to Fridays from 7:30 to 17:00 (excluding public holidays).



ADDITIONAL POLMED CONTACT DETAILS

- **CHRONIC MEDICINE MANAGEMENT REGISTRATION:**
polmedcmm@medscheme.co.za
- **AMBULATORY PRESCRIBED MINIMUM BENEFIT (aPMB) REGISTRATION:**
polmedapmb@medscheme.co.za
- **HOSPITAL PRE-AUTHORISATION:**
polmedauths@medscheme.co.za
- **POLMED CHAT (VIA MOBILE DEVICE):**
Download the free POLMED Chat app on your mobile device: <http://bit.ly/1YHAtwu>
- **POLMED CHAT (VIA POLMED WEBSITE ON YOUR COMPUTER):**
Log in to the Member zone and click on the POLMED Chat widget/icon

COMPLIMENTS

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

ONLINE/SOCIAL MEDIA COMMENTS AND QUERIES

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

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

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.

WHAT ARE THE STEPS TO USE AS A FIRST STEP TO LODGING A COMPLAINT OR DISPUTE A RULING?

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

Alternatively, visit our walk-in branch 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 the appeals and disputes process does not solve your query or you remain dissatisfied with the outcome/service experience, you may also lodge a complaint with the Council for Medical Schemes (CMS) in one of the following ways:

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

The CMS will inform POLMED of the complaint received. POLMED will engage with the Administrator to investigate the complaint. Thereafter POLMED will provide feedback to the CMS within the timeline indicated by the CMS. The CMS will then inform the member of the outcome of the investigation.

AMBULATORY PRESCRIBED MINIMUM BENEFIT (aPMB) CARE PLAN MANAGEMENT

Ambulatory prescribed minimum benefit (aPMB) Care Plans give members access to out-of-hospital benefits for specific PMB Chronic Disease List (CDL) conditions. These Care Plans are for services that are likely to be needed by members to manage their conditions, such as doctor consultations, radiology and pathology tests.

CHRONIC DISEASE LIST (CDL)

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy disease
- Chronic obstructive pulmonary disorder
- Chronic renal disease
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus type I
- Diabetes mellitus type II
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

PAYMENT GUIDELINES

Provide a copy of the Care Plan letter to your treating doctor. Your doctor needs to submit the relevant ICD-10 and tariff codes to ensure payment.

HOW DO I ACCESS MY BENEFITS FOR MY PMB CDL CONDITION?

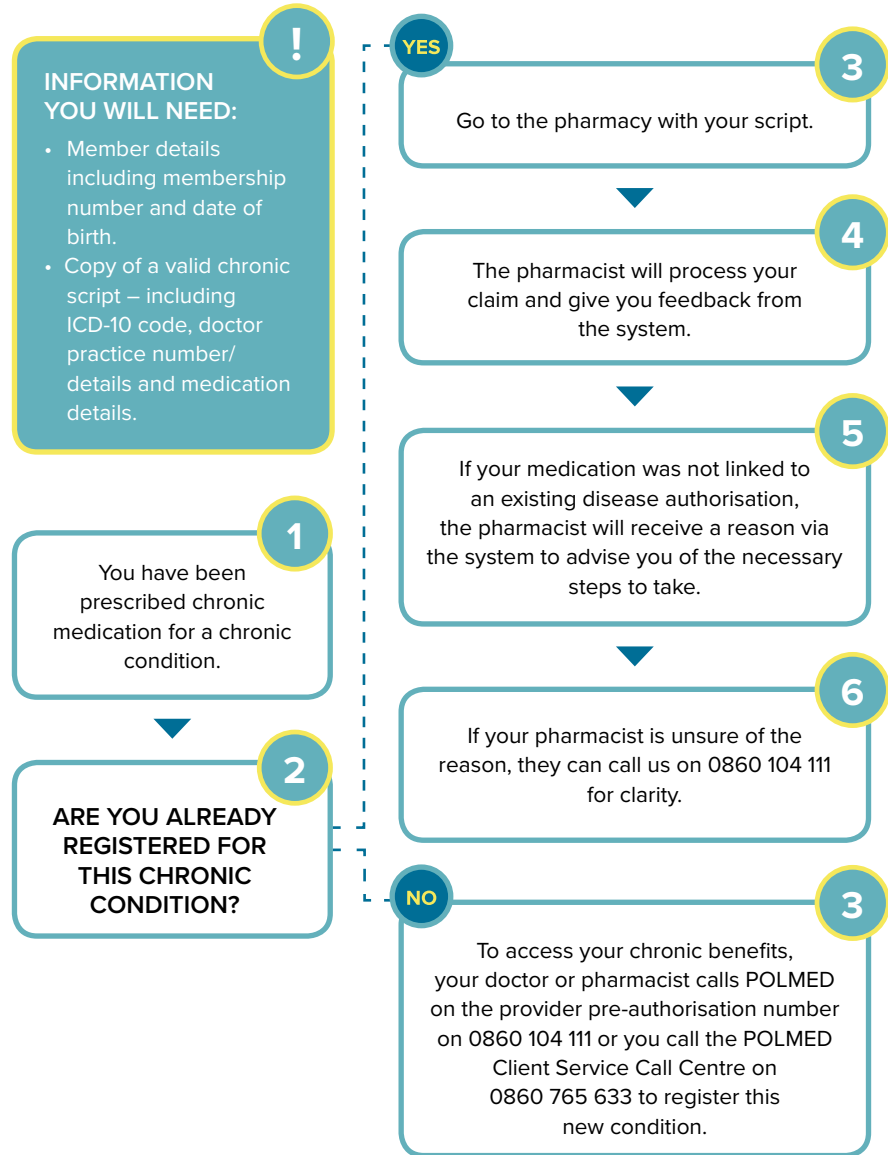
PMB Care Plan benefits are mostly triggered by the registration of medication for the PMB condition. Upon registering your medication on chronic, a Care Plan will be generated for you.

A Care Plan letter is issued by email or post and gives details in respect of services that can be claimed from PMBs.

CONTACT DETAILS

For required changes or additions to the Care Plan, contact POLMED via:
Tel: 0860 765 633
Fax: 0860 000 320
Email: polmedapmb@medscheme.co.za

HOW TO COLLECT CHRONIC MEDICATION WITH DISEASE AUTHORISATIONS



NOTE

- If you obtain your medication from a non-designated service provider (DSP), you will have a 20% co-payment.
- Medication formularies and reference pricing are applied to chronic medication.
- Ensure your doctor prescribes items on your medication formulary to avoid a 20% co-payment.
- Reference pricing co-payments may be avoided by using generic medication that is below the reference pricing – your pharmacist can suggest generic medication options.

COLLECTION/DELIVERY OF MEDICATION
Choose one of POLMED's DSP pharmacies:

- **courier pharmacies**
 - **Pharmacy Direct**
Tel: 0860 027 800 or
Fax: 0866 114 000/1/2/3
 - **Medipost Pharmacy**
Tel: 012 426 4000 or
Fax: 0866 823 317 or 0866 567 623
- **retail pharmacies**
 - **Clicks Pharmacy**
 - **MediRite Pharmacy**

PRE-APPROVED MEDICATION BASKET

If you have been approved for a chronic condition, you will have access to a list of pre-approved medications called a BASKET – this means that if your doctor changes/prescribes new medication for the condition authorised, you may already have access to it.

DECLINED MEDICATION

If your medication was declined, you may need a motivation, additional test results, or an alternative medication – you will receive a letter with the details. Discuss the reason your medication was declined with your doctor.



DISEASE RISK MANAGEMENT (DRM) PROGRAMME

POLMED is committed to giving you the best solutions to manage your health. This is why we take pride in offering you a DRM Programme.

The DRM Programme aims to assist you with improving your long-term health by managing your chronic conditions.

Your information will **never** be shared with any third party without your written consent.

CONTACT DETAILS

Tel: 0860 765 633

Email: polmeddiseaseman@medscheme.co.za

DISEASES MANAGED ON THE DRM PROGRAMME

- **Respiratory:** Asthma and chronic obstructive pulmonary disease (COPD)
- **Cardiac:** Hyperlipidaemia, high blood pressure, heart failure, coronary artery disease and dysrhythmia
- **Metabolic:** Diabetes
- **Spinal:** Cervical and lumbar conditions
- **Psychiatric:** Depression, bipolar mood disorder, post-traumatic stress disorder (PTSD) and substance abuse

WHEN AND HOW DO I JOIN THE PROGRAMME?

Members are identified based on their claims for chronic medication, consultations and hospital admissions.

Members who are eligible for enrolment are then contacted to join the programme.

ALTERNATIVELY

If POLMED is unable to contact the identified members, we will leave a message for the members to contact us.

TELEPHONIC FOLLOW-UP BY CASE MANAGER, WHO WILL:

- provide health support, information and guidance to improve the understanding and management of your condition
- assist in getting authorisation for appropriate healthcare services
- set goals to improve your health by liaising with your service providers.

NEED HELP MANAGING YOUR CONDITION?

Your Case Manager can be contacted for assistance with the management of your condition.

PAYMENT GUIDELINES

- The services on the Care Plan will be paid from your in-hospital benefits.
- Your doctor needs to submit the relevant ICD-10 and tariff codes to ensure payment.

DENTAL PRE-AUTHORISATION PROCESS



INFORMATION NEEDED

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

NOTE

If this information is not provided, we may not be able to authorise the procedure.

IN-HOSPITAL DENTAL PROCEDURES – PRE-AUTHORISATION

Tel: 0860 765 633

Fax: 0860 104 114

Email: polmedauths@medscheme.co.za

OUT-OF-HOSPITAL SPECIALISED DENTISTRY IN DOCTORS' ROOMS

Call 0860 765 633 or email dental.polmeddental@medscheme.co.za to confirm available benefits and, if required, complete pre-authorisation.

Assess the appropriateness of the procedures.

Pre-authorisation is granted or denied.

IF GRANTED

Communicate outcome to member and provider.

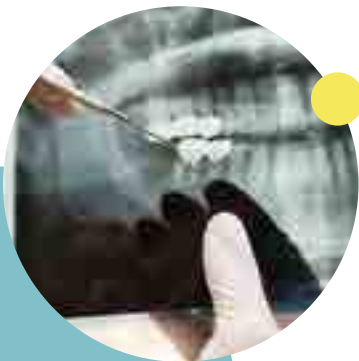
IF DENIED

Feedback provided to treating provider and member by fax or email.

Receive and process claims according to authorisation.

PAYMENT GUIDELINES

- A co-payment of R5 000 applies if no pre-authorisation is obtained for in-hospital dental procedures.
- A co-payment of R500 may apply for out-of-hospital specialised dentistry procedures if no pre-authorisation is obtained e.g. crowns, bridges and orthodontic treatment.
- The POLMED payment rules will apply to dental procedures done in hospital and out of hospital.
- Clinical protocols and guidelines apply.
- Dentists will be reimbursed from out-of-hospital benefits.



HIV MANAGEMENT PROGRAMME ENROLMENT PROCESS



HOW DO I ENROL ON THE POLMED HIV MANAGEMENT PROGRAMME?

Obtain the HIV/AIDS enrolment form.

Application form is available from 0860 100 646, at www.polmed.co.za (go to 'FORMS', select 'Manage Care (Medical)', and then 'HIV Application') or from any regional walk-in branch.

Application form is completed and signed by treating doctor and member; return enrolment form by fax to 0800 600 773, email to polmedhiv@medscheme.co.za or post to PO Box 38597, Pinelands 7430.

Application assessed based on clinical protocols.

NOTE

- The programme is strictly confidential
- The services on the programme will be paid from your in-hospital benefits.

Authorisation of HIV treatment.

Treating doctor and member receive authorisation letter and treatment plan.

COLLECTION/DELIVERY OF MEDICATION
Choose one of POLMED's DSP pharmacies:

- **courier pharmacies**
 - Pharmacy Direct
Tel: 0860 027 800 or
Fax: 0866 114 000/1/2/3
 - Medipost Pharmacy
Tel: 012 426 4000 or
Fax: 0866 889 867
- **retail pharmacies**
 - Clicks Pharmacy
 - MediRite Pharmacy

WHAT HAPPENS IF YOU DON'T USE A DSP FOR CHRONIC MEDS?

If you choose to obtain your chronic medication from a supplier that is not a designated service provider (DSP) pharmacy, you will be liable for a 20% co-payment.

DO YOU NEED HELP?

A Case Manager can be contacted on 0860 100 646 if you require help with the management of your condition.

MENTAL HEALTH PROGRAMME PROCESS

INTRODUCTION

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

The programme aims to collaborate with you, your doctor and, where appropriate, other healthcare providers to assist in improving your mental health and wellbeing.

ENROLMENT PROCESS

- POLMED will automatically identify members eligible for enrolment on the programme through claims for admissions, chronic medication, etc.
- You or your healthcare provider may also request enrolment onto the programme through any of the following channels:

Tel: 0860 765 633

Email: polpsych@medscheme.co.za

Enrolment is subject to clinical criteria assessed during a telephonic conversation with the Care Manager.

CONTACT DETAILS

Tel: 0860 765 633 (follow the voice prompts) between 7:30 and 17:00 from Mondays to Fridays (excluding public holidays)

Email: polpsych@medscheme.co.za

Website: www.polmed.co.za



WHAT CAN I EXPECT FROM THE PROGRAMME?

MENTAL HEALTH CARE PLAN

You will receive a Mental Health Care Plan listing the care/services you have access to in order to manage your condition. The authorised services will be paid from your overall in-hospital benefit and not from your overall out-of-hospital (day-to-day) benefit.

ADVICE AND SUPPORT

- You will receive advice and support from a Care Manager, who is a qualified professional.
- The Care Manager will phone you at agreed times and ask you questions about your health, provide advice and support, and share information with your doctor, if you agree to this.
- All your information will be treated confidentially.

If the information you provide indicates that you need to see your doctor, your Care Manager will advise you to make an appointment, or assist you in making an appointment with your doctor. You will also receive a checklist to help remind you of the relevant things to discuss with your doctor.

Your Care Manager will assist in connecting you with other healthcare providers you may need to help manage your mental health. They may include a psychologist, social worker, or community-based organisations of your choice.

ADDITIONAL ASSISTANCE

You will also be assisted with:

- obtaining authorisations for appropriate healthcare services
- any queries related to any other chronic condition(s)
- information on how to access medical, dietary and nutritional information using the POLMED Health Portal
- information on preventative care and available benefits.

PSYCHO-SOCIAL NETWORK PROCESS

As a serving South African Police Service (SAPS) member, you have no doubt encountered stressful situations in your work environment. With the POLMED Psycho-Social Network, help is at hand.

WHAT IS THE PURPOSE OF THE NETWORK?

The Psycho-Social Network consists of a group of clinical and counselling psychologists, as well as social workers contracted by POLMED to offer support to **servicing SAPS members** who are employed under the SAPS Act and registered on POLMED.

Through this service, POLMED wishes to support and empower our servicing members to cope more effectively with stress resulting from the nature of the jobs they are exposed to daily.

HOW DOES THIS SERVICE BENEFIT YOU?

- It allows proactive 'check-ins' consisting of four visits a year to a network psychologist or social worker in private practice.
- It empowers you to manage your stressors and assists you in leading a healthy, balanced life which will contribute positively to your emotional and social wellbeing.
- All visits are confidential and take place in a private, secure and supportive environment
- 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).



BENEFIT INFORMATION

- This service is for serving SAPS members only; not dependants.
- The consultations will be paid from the major risk benefit and not from your overall out-of-hospital (day-to-day) benefit.
- You will be allowed a maximum of four sessions a year, where the first is an evaluation session. Should symptoms be identified at this initial consultation that require therapy, you will then have three therapy sessions.
- Should you require additional support/therapy, you may make use of your standard Scheme benefits, or you may be enrolled on the Mental Health Programme where you will be provided with a Care Plan.
(Note: Enrolment on the Mental Health Programme is subject to clinical criteria assessed during a telephonic conversation with a Care Manager.)

HOW CAN YOU FIND THE CLOSEST NETWORK PSYCHOLOGIST OR SOCIAL WORKER?

POLMED encourages you to make use of the Psycho-Social Network.

To find a Psycho-Social Network provider near you:

- Access the list of providers on the SAPS intranet.
- OR**
- Call the **POLMED Client Service Call Centre** on 0860 765 633 and ask for the contact details of a Network provider in your area.
- OR**
- Go to the **POLMED website** at www.polmed.co.za and search for a Network provider from the drop-down list.

MATERNITY PROGRAMME PROCESS



The aim of the POLMED Maternity Programme is to provide the expectant mother with additional benefits, support, education and advice through all stages of the pregnancy, confinement and postnatal period.

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

ENROLMENT ONTO THE MATERNITY PROGRAMME
 When a member is identified as being pregnant, she is automatically enrolled onto the programme.

A Care Manager, who is a qualified midwife, will be assigned to a member identified with:

- Previous admissions to hospital for pregnancy-related conditions.
- Co-morbidities including depression, asthma, diabetes, hypothyroidism, epilepsy, hypertension, etc.
- Being pregnant at an age younger or older than the norm.
- A high number of previous pregnancies.
- Previous pregnancy complications.

Prior to delivery or for any maternity-related admission to hospital, the member must call the POLMED Client Service Call Centre on 0860 765 633 and follow the voice prompts for hospital authorisations in order to obtain pre-authorisation.

HOW IS A MEMBER IDENTIFIED FOR ENROLMENT?
 The eligible member is identified for enrolment based on:

- pregnancy-related claims
- the member calling the POLMED Client Service Call Centre for enrolment onto the programme
- a referral from a healthcare provider.

WHAT WILL THE CARE MANAGER DO?
 The Care Manager will contact the member telephonically and provide additional support and services.

THE FOLLOWING INFORMATION MUST BE AT HAND WHEN YOU CALL FOR HOSPITAL PRE-AUTHORISATION:

- Membership number.
- Name or practice number where you are being admitted.
- Name of patient.
- Date of birth.
- Name or practice number of treating doctor.
- Diagnosis and/or method of delivery.

WHAT BENEFITS ARE AVAILABLE?
 The enrolled member receives a welcome letter that outlines the benefits available and other useful information, such as:

- The maternity treatment Care Plan.
- The authorisation of certain pregnancy vitamins and minerals as approved by the Scheme for a period of six months.
- Details about hospitalisation for the birth.
- Midwifery services for a home birth.
- A pamphlet describing the changes that the mother and baby experience during each trimester.
- Details about accessing the POLMED Health Portal.

WHAT MUST I DO WHEN I NEED TO BE ADMITTED TO HOSPITAL?

NO BENEFIT WILL BE PAID IF:

- pre-authorisation was not obtained
- the pre-authorisation request was denied.

FAILURE TO OBTAIN HOSPITAL PRE-AUTHORISATION
 Members failing to obtain pre-authorisation for hospital admissions will be subject to a penalty of R5 000 per admission to hospital.

AQUARIUM PLAN: ARE THERE CO-PAYMENTS FOR NON-DSP HOSPITALS?
 A co-payment of R8 000 will be payable by the member if admitted to a non-designated service provider (DSP) hospital.

AWARENESS ABOUT HIV/AIDS
 It's important for a member to discuss HIV testing with the treating doctor during early pregnancy, as HIV can be passed from mother to baby during pregnancy, birth and breast feeding. Testing will help to ensure that the necessary preventative measures can be taken to protect the baby and reduce the possibility of transmission.
 The POLMED HIV Management Programme assists members living with HIV/AIDS and confidentiality is maintained at all times. For more information a member can contact the programme on 0860 100 646 or email polmedhiv@medscheme.co.za for assistance from an HIV Case Manager.

IN-HOSPITAL PRE-AUTHORISATION PROCESS

HOW TO OBTAIN IN-HOSPITAL PRE-AUTHORISATION

Your doctor or the hospital calls POLMED on the provider pre-authorisation number on 0860 104 111 or you call the POLMED Client Service Call Centre on 0860 765 633 to obtain authorisation prior to any hospital admission.

OUR OPERATOR WILL ASK FOR THE FOLLOWING DETAILS:

- ID number
- Membership number
- Name of patient
- Date of birth
- Name of hospital/practice number
- Name of service provider (i.e. doctor, specialist, etc.) and his/her practice number
- The diagnosis (ICD-10) code
- The procedure to be performed (CPT4 or tariff code)
- The date of admission
- The name and telephone number of the caller
- Whether or not the treating doctor charges medical scheme rates

EMERGENCY HOSPITALISATION PROCESS

Please note that in case of an emergency, the member or the hospital should contact POLMED within 24 hours of the event or on the next working day. A penalty of R5 000 may be imposed if no pre-authorisation is obtained.

IF PRE-AUTHORISATION IS GRANTED

An authorisation number is given to the caller and immediately faxed/emailed to the hospital and your treating provider. You are notified of the decision and are required to liaise with your doctor if you are uncertain about anything. A penalty of R5 000 may be imposed if no pre-authorisation is obtained.

PRIOR TO YOUR ADMISSION

We notify your doctor and update our records for future reference.

Our professional nursing Case Managers liaise with the hospital staff to ensure that you receive appropriate treatment.

IF FURTHER INFORMATION IS REQUIRED

- The admission request/procedure is queried with the hospital.
- A letter of motivation is requested from your doctor.
- Your doctor's motivation is referred to our medical advisor for consideration and will be finalised within 48 hours, excluding weekends.
- Our medical advisor grants or denies pre-authorisation.

IF PRE-AUTHORISATION IS DENIED

You, your doctor or the hospital is informed that pre-authorisation has been denied. Your doctor can appeal by submitting a clinical motivation.



ONCOLOGY MANAGEMENT PROCESS



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

A member or registered dependant who has been diagnosed with cancer and requires treatment must inform POLMED.

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

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

The treatment plan that is received from the treating doctor is assessed.

TREATMENT GRANTED
 If within protocols and guidelines.

TREATMENT DENIED
 The member and doctor informed of reasons for rejection.

Authorisation submitted to service provider.

ONCOLOGY DSP

- The designated service provider (DSP) is the Independent Clinical Oncology Network (ICON).
- Should your condition be managed by a non-ICON doctor, a co-payment will apply.

UPON EACH NEW REGISTRATION AN ONCOLOGY CASE MANAGER CONTACTS THE MEMBER TO:

- help the member understand the processes to be followed
- explain the benefits available
- provide other support and information.

PAYMENT GUIDELINES
 Authorisation is for cancer-related treatment and diagnosis only. Claims that are not related to cancer will be paid from out-of-hospital or specific benefits, as it applies.



APPLIANCE APPLICATION PROCESS

IMPORTANT APPLIANCES BENEFIT NOTES

- Authorisation must be obtained before appliances can be issued.
- Any repairs to or maintenance of appliances are not covered.
- The appliance will not be replaced if it is lost or stolen.
- Other appliances not listed in the rules will be funded from the overall out-of-hospital benefits.

APPLIANCES MANAGED INCLUDE:

- Hearing aids
- Nebulisers
- CPAP machines
- Wheelchairs (motorised and non-motorised)
- Insulin delivery devices
- Urine catheters
- Stoma bags
- Adult nappies
- Home oxygen

PLAN LIMITS

Refer to pages 25 to 26 for Marine limits and pages 65 to 66 for Aquarium limits.

Member/registered service provider sends application (doctor's prescription or motivation) to POLMED using the following details:

For all requests except home oxygen:

Email: polmedspecialcases@medscheme.co.za

Fax: 0860 104 114

For home oxygen requests:

Email: polmedhbc@medscheme.co.za

The following documents are required:

- Treating doctor's motivation
- Quotation

Request assessment of clinical appropriateness.

Authorisation emailed to service provider and letter posted to member.

ADDITIONAL INFORMATION REQUIRED

CPAP machines

- Polysomnogram (sleep study); in case of anomalies also tritration studies

Hearing aids

- Audiology report
- Report from the referring treating doctor

Home oxygen

- Letter of motivation from treating doctor with relevant diagnosis code (ICD-10)
- Quotation from supplier
- Latest blood gasses

AUDIOLOGY TEST REFERRAL REQUIRED

The Scheme will not cover the cost of audiology tests if there has not been a referral from a GP/ear, nose and throat (ENT) specialist, paediatrician, physician or neurologist.

INJURY ON DUTY (IOD)

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

IMPORTANT CONTACT NUMBERS

SAPS IOD Human Resources Department:

Tel: 012 393 2371/012 393 4106

SAPS IOD Finance Department:

Tel: 012 393 2673/1083/4461

SAPS Medical Boards:

Tel: 012 393 1475

HOW DO I CLAIM IF I'M INJURED ON DUTY?

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 Head Office will notify the service provider when the application is unsuccessful and give reasons.

The 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.

BENEFIT GUIDELINES

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

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

Call Netcare 911 on 082 911.

**CAN I CONTACT ANY AMBULANCE IN
AN EMERGENCY?**

Netcare 911 will make contact with the ambulance service provider if they are not situated in your area.

**WHAT HAPPENS IF AN AMBULANCE OTHER THAN A
NETCARE 911 AMBULANCE HAS BEEN
CONTACTED IN AN EMERGENCY SITUATION?**

Netcare 911 should be informed within 72 hours of the transportation to ensure the account to the other service provider will be paid.

**NETCARE 911:
082 911**



**WHAT HAPPENS IF I NEED TO BE
TRANSFERRED FROM ONE HOSPITAL
TO ANOTHER?**

Inform the hospital that you are a POLMED member and that your transfer to another hospital must be authorised through Netcare 911.

**HOW WILL BYSTANDERS KNOW THAT
POLMED MEMBERS HAVE TO ACCESS
THE SERVICES OF NETCARE 911?**

Paste a Netcare 911 sticker in a visible place on your car window. Inform your child's school that Netcare 911 should be contacted in the event of a medical emergency.

**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.



FIVE STEPS TO MORE COST-EFFECTIVE EYE CARE

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

FIVE QUICK STEPS TO SIMPLIFYING YOUR OPTICAL EXPERIENCE:

1

BENEFITS ENQUIRY

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

2

FIND AN OPTOMETRIST

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

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

CO-PAYMENTS

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

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

3

4

ADDITIONAL BENEFITS

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

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

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

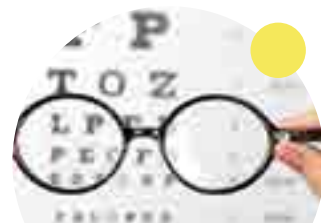
Note: You do not require a referral by a general practitioner prior to a consultation with an Ophthalmologist.

5

FIGHTING FRAUD

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

How can you contribute? Report any fraudulent or suspicious activities to optimumfraud@ppn.co.za or 0861 103 529. Confidentiality is assured at all times.



FREQUENTLY ASKED QUESTIONS

MEMBERSHIP

Q: How will I know if my application for membership has been received?

A: An SMS confirmation will be sent to the cellphone number on the application form.

Q: When will I receive a POLMED membership card?

A: Your membership card will be posted to you immediately after we've activated your membership.

Q: Who may use my membership card?

A: Only the principal member and the dependants indicated on the membership card may use it.

Q: Who may I register as my dependants?

A: You may register any of the following as your dependants, provided you are liable for their family care and support, and they are not members or dependants on another medical scheme:

- Your spouse.
- Your life partner – whether the same or opposite gender.
- Your children – whether natural, stepchildren, adopted or foster children (child dependants may remain registered as your dependants up to the age of 30).
- Your father and/or mother.
- Your mother-in-law or father-in-law.

Q: What should I do if the principal member passes away?

A: Please inform POLMED as soon as possible. If the deceased member's dependants wish to remain on POLMED, a fully completed and signed application for continuation membership form – including the documentation listed on page 83 – must be submitted to POLMED. Please call our Client Service Call Centre on 0860 765 633 for any further information.

Q: Can I change my benefit plan during the year?

A: No. You can only change your benefit plan at the end of each year to take effect on 1 January the following year.

Q: How do I change my banking details?

A: Please inform POLMED in writing and provide a copy of your most recent bank statement or stamped letter from the bank confirming your banking details. You may email the information to polmedmembership@medscheme.co.za or fax it to 0861 888 110. You should never send your banking details via SMS or give it to someone over the telephone.

Q: How will my contributions be paid to POLMED?

A: Active members will pay via Persal deductions at the end of each month and continuation members will pay via a debit order from their bank on or before the third day of each month.

Q: When will the POLMED contributions be increased?

A: If you change your benefit plan, the change in contribution will be from 1 January. Contributions are increased annually on 1 April.

EX GRATIA**Q: Is it possible to apply for additional benefits if my out-of-hospital benefits have been depleted?**

A: Yes, you can apply for Ex Gratia benefits. Please note that this benefit is not an extension of the out-of-hospital benefit and is subject to an approval process to determine clinical appropriateness.

Q: How long does it take to get a response for Ex Gratia?

A: It may take up to a month once the Clinical Committee has made a decision.

Q: What is the cut-off date for the submission of Ex Gratia applications?

A: The cut-off date for the submission of applications is the end of April of the following year.

CLIENT SERVICES**Q: My claims statement indicates that I have benefits available for physiotherapy, but the account was rejected because the benefit is depleted.**

A: Physiotherapy benefits are subject to the overall out-of-hospital benefit. If there are no funds left in your overall out-of-hospital benefit, you will not be able to claim from any of the benefit categories.

Q: How long do I have to submit claims to POLMED after receiving treatment?

A: All claims must be submitted to POLMED by no later than the last day of the fourth month following the month in which the service was rendered, i.e. within 120 days of the date of service.

Q: How often during the month does POLMED pay claims to service providers, i.e. doctors, pharmacies, etc.?

A: POLMED pays claims twice per month.

Q: How often during the month does POLMED make refunds to members?

A: POLMED pays refunds to members four times per month.

CHRONIC MEDICINE MANAGEMENT PROGRAMME**Q: What if my application for chronic medication has been declined?**

A: You will receive correspondence stating the reason that certain medication items have not been approved. It is important that you review the reasons for the decline and request your doctor or service provider to submit the information required so that the Scheme may reconsider the decision. A copy of the correspondence after the reassessment of your application will be sent to your prescribing doctor.

Q: Is original or brand-name medication more effective than generic medication?

A: Generic medication may not have the same name as the brand-name medication or look and taste the same because of the choice of inactive ingredients, such as colouring, binding and flavouring, but by law the active ingredients in the generic and the brand-name medication must be exactly the same.

Q: What does POLMED consider to be chronic medication?

A: Chronic medication is used to treat chronic diseases; that is, long-term treatment (three months or longer) of a chronic condition that meets the following requirements:

- The medication is used to treat and prevent a serious medical condition.
- The medication is used for an uninterrupted period of three months or longer.
- The medication is used to sustain life and delay the progress of a disease.
- The medication is the accepted treatment, according to POLMED's medicine formulary.

If you suffer from a chronic illness, read more about chronic medication and how to apply for the programme on pages 97 to 98.

PRESCRIBED MINIMUM BENEFITS (PMBs)**Q: Are all emergency visits to emergency units treated as PMBs?**

A: Not necessarily – only emergencies that meet the definition of an emergency medical condition/PMB, as defined in the Medical Schemes Act, no 131 of 1998, are treated as PMBs.

Q: How will I know if it is a possible PMB-related condition/injury?

- A:** Emergency medical conditions are subject to the following:
- The onset of the health condition must be sudden and unexpected.
 - It must require immediate medical or surgical treatment.
 - Failure to provide such treatment would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy.
 - It must be certified as such by a medical practitioner.
 - The correct ICD-10 code must reflect on the accounts submitted.

Any visit to an emergency room or emergency medical unit that does not qualify as a PMB will be covered under your overall out-of-hospital benefits available for GP consultations. Emergency units at most hospitals are separate practices from the hospital and members may be required to pay an administration fee or pay upfront and claim it back from the Scheme.

For more information, please refer to the conditions listed as PMBs on the Marine Plan on pages 31 to 32 and the Aquarium Plan on pages 71 to 72.

HOSPITAL RISK MANAGEMENT

Q: What will happen if I do not obtain authorisation for my admission to hospital?

A: If you don't obtain pre-authorisation for your hospital admission, you will have to pay a penalty. Emergency admissions must be registered on the first working day following the admission. This can be done by the member, a relative, the hospital or the attending doctor.

Q: What if I am hospitalised after-hours for a medical emergency?

A: You will still need to obtain authorisation for your admission. Simply contact POLMED on the first working day following your admission. Read more about how to do this on pages 111 to 112.

Q: Is pre-authorisation a guarantee of payment?

A: Pre-authorisation for hospital admission refers to the clinical appropriateness of the admission, medical necessity and to the length of stay. It is not a guarantee of payment. Always refer to this POLMED Guide to your Health booklet for the limits that may apply per benefit.

STAND-ALONE BENEFITS

Q: What will happen if I do not obtain pre-authorisation for specialised radiology?

A: Pre-authorisation is required for all scans. If pre-authorisation is not obtained for specialised radiology, the procedure may not be authorised and you will be liable for the costs of the procedure. Alternatively, if a late authorisation is

obtained the Scheme may impose a co-payment up to R1 000 per procedure. Emergency specialised radiology must be authorised on the first working day following the procedure. This can be done by the member, a relative, the hospital or the attending doctor.

Q: How will specialised dentistry be covered for members on the Marine Plan when performed in hospital?

A: If specialised dentistry is pre-authorised to be performed in hospital, the costs of the dental specialists will be reimbursed from the dentistry (specialised) benefit. The hospital and anaesthetist's costs will be reimbursed from the in-hospital benefit.

POLMED GENERAL PRACTITIONER (GP) NETWORK

Q: I have used the number of GP consultations I am entitled to, but I still have overall out-of-hospital (day-to-day) benefits available. Can I visit my GP again?

A: No. Unfortunately you cannot increase your GP consultation limit, as it is a set limit.

Q: How can I find out if my GP is registered on the POLMED GP Network?

A: Please visit the POLMED website at www.polmed.co.za (via your computer or mobile device) and select the 'Search For a Provider' tab on the home page. Alternatively, contact the Client Service Call Centre on 0860 765 633.

Q: May I visit a GP outside the Network?

A: If you choose to visit a GP outside the Network, you will be liable for a co-payment on the doctor's consultation if the cost of the consultation is higher than the cost the Network GP would have charged.

POLMED SPECIALIST NETWORK

Q: What are the benefits of this Network?

A: Specialists who have signed up to the Network have agreed to limit their fees to the POLMED rate for both in- and out-of-hospital services, without compromising on quality of care.

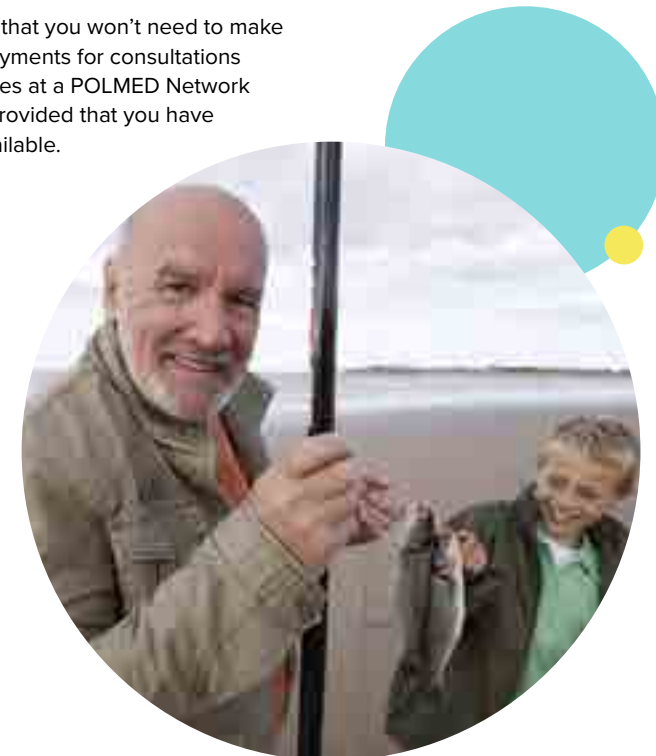
This means that you won't need to make personal payments for consultations or procedures at a POLMED Network specialist, provided that you have benefits available.

Q: How can I find out if my specialist is registered on the Network?

A: Please visit the POLMED website at www.polmed.co.za (via your computer or mobile device) and select the 'Search For a Provider' tab on the home page. Alternatively, contact the Client Service Call Centre on 0860 765 633.

Q: May I visit a specialist outside the Network?

A: If you choose to visit a specialist outside the Network, you will be liable for a co-payment if the cost of the specialist's account is higher than the cost the Network specialist would have charged.



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-DSP 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 the principal member dies (orphans and widows only).

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 medication 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

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 exclusion list in this Guide to your Health booklet for medication that will not be covered.

POLMED reference price

The POLMED 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 as defined in the Chronic Disease List (CDL).

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.

Ambulatory prescribed minimum benefit (aPMB) Care Plans

Ambulatory prescribed minimum benefit (aPMB) Care Plans give members access to out-of-hospital benefits for specific PMB Chronic Disease List (CDL) conditions. These Care Plans are for services that are likely to be needed by members to manage their conditions, such as doctor consultations, radiology and pathology tests.

To take out (TTO) medication

TTO medication is prescribed during hospitalisation and given to the patient on the day of being discharged from the 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, 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.

CONTACT DETAILS

Pretoria walk-in branch

Nedbank Plaza, Shop 17
361 Steve Biko Street
Arcadia, Pretoria
0083

Tel: 0860 765 633 or 0860 POLMED

Fax: 0860 104 114

Fax: 0861 888 110 (Membership-related
correspondence)

Fax: 011 758 7660 (New claims)

**Postal address for claims,
membership and contributions**

POLMED
Private Bag X16
Arcadia
0007

**Email address for submitting
enquiries**

polmed@medscheme.co.za

Regional walk-in branches

Refer to the grey bullets on the map.

POLMED fraud hotline

Tel: 0800 112 811

Email: fraud@medscheme.co.za

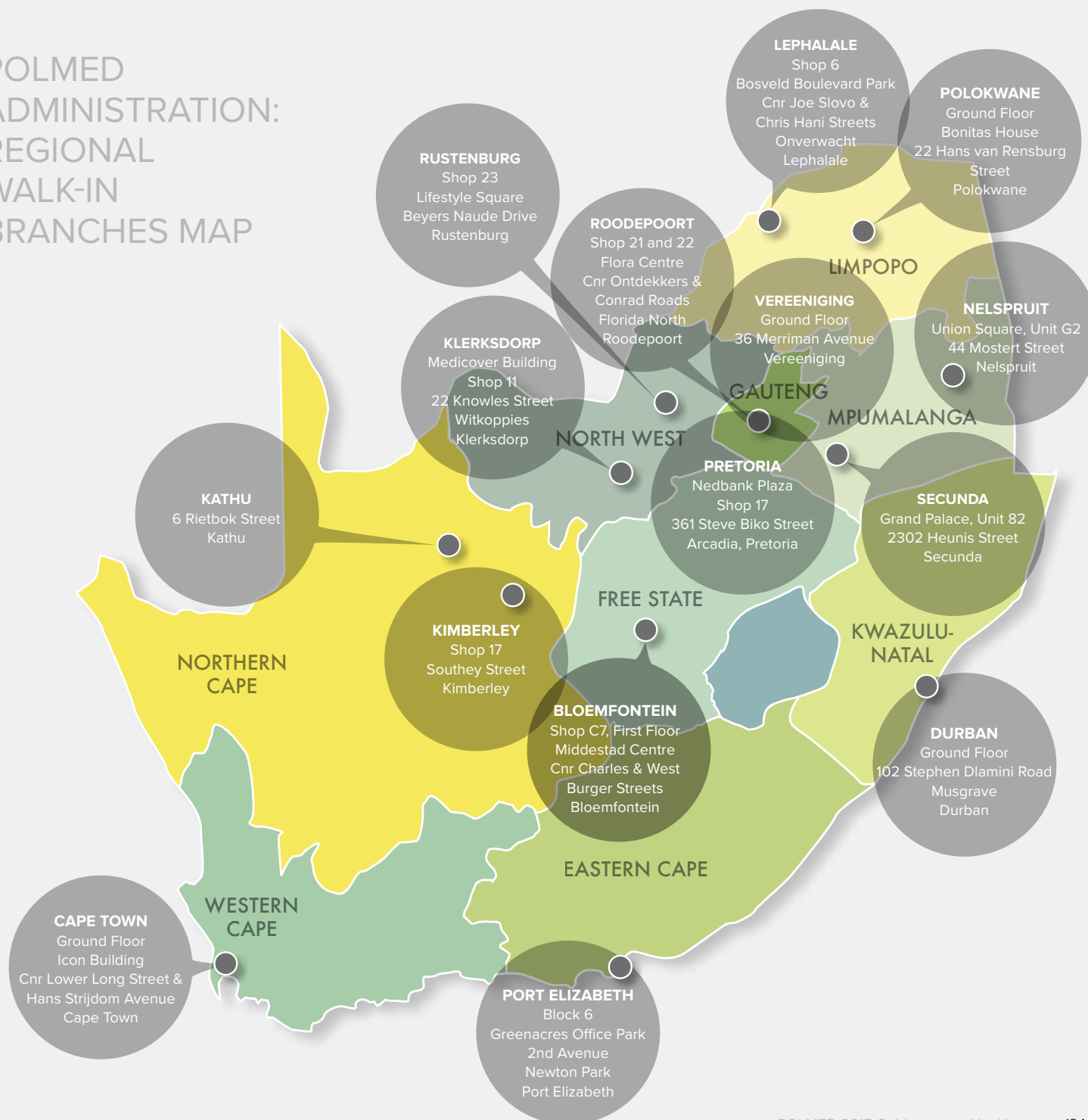
POLMED website

www.polmed.co.za

POLMED Chat

Via mobile device: Download the free app
via <http://bit.ly/1YHAtwu> or from various
app stores.

Via POLMED website: Log in to the
Member zone via your computer and click
on the POLMED Chat widget/icon.

POLMED
ADMINISTRATION:
REGIONAL
WALK-IN
BRANCHES MAP

MANAGED HEALTHCARE CONTACT DETAILS

TEL	FAX	EMAIL	POST
AMBULATORY PRESCRIBED MINIMUM BENEFIT (aPMB) PROGRAMME (CARE PLANS)			
0860 765 633		polmedapmb@medscheme.co.za	
CHRONIC MEDICINE MANAGEMENT PROGRAMME			
0860 765 633	0860 000 320	polmedcmm@medscheme.co.za	
DENTAL PRE-AUTHORISATION			
0860 765 633	0860 104 114	In-hospital dental procedures and sedation pre-authorisation: polmedauths@medscheme.co.za Out-of-hospital specialised dentistry: dental.polmeddental@medscheme.co.za	
DISEASE RISK MANAGEMENT PROGRAMME			
0860 765 633		DRM Programme: polmeddiseaseman@medscheme.co.za Prolonged Care Programme: polmedhbc@medscheme.co.za	Private Bag X16 Arcadia 0007
HOSPITAL/MRI AND CT SCAN PRE-AUTHORISATION			
Members: 0860 765 633 Providers: 0860 104 111	0860 104 114	PolmedAuths@medscheme.co.za	
MATERNITY PROGRAMME			
0860 765 633		polmedmaternity@medscheme.co.za	
MENTAL HEALTH PROGRAMME			
0860 765 633		polpsych@medscheme.co.za	
ONCOLOGY MANAGEMENT PROGRAMME			
0860 765 633	0860 000 340	polmedonco@medscheme.co.za	
HIV MANAGEMENT PROGRAMME			
0860 100 646	0800 600 773	polmedhiv@medscheme.co.za	PO Box 38597 Pinelands 7430

DESIGNATED SERVICE PROVIDERS (DSPs)

RETAIL PHARMACIES	
 Clicks Pharmacy Tel: 0860 254 257	 MediRite Pharmacy Tel: 0800 222 617
COURIER PHARMACIES	
 Medipost Pharmacy Tel: 012 426 4000 Fax – HIV medication: 0866 889 867 Fax – Chronic medication: 0866 823 317/0866 567 623 Email: mhealth@medipost.co.za or polmed@medipost.co.za	 Pharmacy Direct Tel: 0860 027 800 Fax: 0866 114 000/1/2/3 Email: care@pharmacydirect.co.za or polmed@pharmacydirect.co.za
ONCOLOGY (CANCER)	EMERGENCY MEDICAL ASSISTANCE
 Independent Clinical Oncology Network (ICON) Tel: 021 944 3750	 Netcare 911 Tel: 082 911
RENAL SERVICE FACILITIES	
 Fresenius Medical Care Website: www.polmed.co.za	 National Renal Care Tel: 011 726 5206 Website: www.nrc.co.za
PREFERRED PROVIDER NEGOTIATORS (PPN) – THE PREFERRED PROVIDER NETWORK	
 Preferred Provider Negotiators Tel: 0861 103 529	

MY CONTACTS

Doctor**Dentist****Hospital****DSP pharmacy****Other** _____**Other** _____**Other** _____**Other** _____**Other** _____**Other** _____



POLMED