2018 GUIDE TO YOUR HEALTH

AQUARIUM & MARINE

POLMED®

OUR **INVESTMENT** OUR **HEALTH** OUR **FUTURE**

DISCLAIMERS

Scheme rules are subject to approval by the Council for Medical Schemes.

Your information will never be shared with any person without your verbal or written consent.

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CONTENTS

BENEFIT MANAGEMENT

Keep a record of your overall out-of-hospital medical claims in the table below and overleaf, and monitor benefits available for the remainder of the year:

- This tool will assist you to monitor the benefit categories from which your claims have been paid.
- This tool can be used to monitor claims for services that you did not access and will assist you to identify potential fraudulent claims.

BENEFIT DESCRIPTION (Refer to Marine or Aquarium benefit schedule to identify the 'overall out-of-hospital benefit'.)	**LIMIT**	**SUB-LIMIT**	**USED**	**AVAILABLE**
OVERALL OUT-OF-HOSPITAL (OOH) BENEFIT (Benefit amount allocated at the beginning of the year.)				
BENEFITS – SUB-LIMITS (Paid from OOH limit) (The amounts reflected in this booklet can be listed in the 'SUB-LIMIT' column and will change if/when the benefits have been accessed. This should not be added to 'OVERALL OUT-OF-HOSPITAL BENEFIT', but instead deducted to determine the balance left at any given time of the year.)				
Medication – Acute				
Medication – Over the counter				
Pathology				
Physiotherapy				
Radiology				
Social worker				
CONSULTATIONS (Paid from OOH limit)				
Consultations and visits – General practitioners (GPs)				
Consultations and visits – Specialists				
OVERALL OUT-OF-HOSPITAL (OOH) BENEFIT AVAILABLE (Amount left after claims for services listed under 'OVERALL OUT-OF-HOSPITAL BENEFIT' have been paid.)				

All services listed on pages 22 to 24 (Marine) and 62 to 64 (Aquarium) under 'overall out-of-hospital (OOH) 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 R20 143 OOH benefits for the year. Claims for services listed as sub-limits and that indicate 'Subject to OOH limit' are paid from this amount. Each time the benefit is accessed the cost will be deducted from the R20 143. 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:

- OOH benefit: M+1 = R24 513, which is available at the beginning of the year
- Claim for pathology (blood test): Claim for R878 paid by POLMED
- Balance left over in OOH benefit after payment of the claim = R23 635

Any claims for services listed below will be deducted from the OOH benefit on Marine. If you are on Aquarium, please refer to pages 62 to 64.

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

BENEFIT MANAGEMENT

BENEFIT DESCRIPTION (Refer to Marine or Aquarium benefit schedule to identify the 'overall out-of-hospital benefit'.)	**LIMIT**	**SUB-LIMIT**	**USED**	**AVAILABLE**
OVERALL OUT-OF-HOSPITAL (OOH) BENEFIT (Benefit amount allocated at the beginning of the year.)				
BENEFITS – SUB-LIMITS (Paid from OOH limit) (The amounts reflected in this booklet can be listed in the 'SUB-LIMIT' column and will change if/when the benefits have been accessed. This should not be added to 'OVERALL OUT-OF-HOSPITAL BENEFIT', but instead deducted to determine the balance left at any given time of the year.)				
Medication – Acute				
Medication – Over the counter				
Pathology				
Physiotherapy				
Radiology				
Social worker				
CONSULTATIONS (Paid from OOH limit)				
Consultations and visits – General practitioners (GPs)				
Consultations and visits – Specialists				
OVERALL OUT-OF-HOSPITAL (OOH) BENEFIT AVAILABLE (Amount left after claims for services listed under 'OVERALL OUT-OF-HOSPITAL BENEFIT' have been paid.)				

BENEFIT MANAGEMENT

MARINE SCHEDULE

ANNEXURE A1

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2018

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

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

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

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

The Scheme does not grant benefits for services rendered outside the borders of the RSA. It remains the responsibility of the member to acquire insurance cover when travelling outside the borders of the RSA.

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ANNEXURE A3

MARINE CONTRIBUTION SCHEDULE

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

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

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

TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 940	1 954	1 954	909
R5 941 – R8 160	2 060	2 060	967
R8 161 – R9 970	2 100	2 100	997
R9 971 – R11 660	2 175	2 175	1 038
R11 661 – R13 570	2 258	2 258	1 069
R13 571 – R16 320	2 341	2 341	1 111
R16 321 – R20 030	2 408	2 408	1 155
R20 031 +	2 472	2 472	1 187

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

The contributions for 2018 as set out in Circular 45 of 2017 by the Council for Medical Schemes (CMS).

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

MEMBER CONTRIBUTION (SUBSIDISED CONTRIBUTION)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R6 279	295	295	74
R6 280 – R8 625	409	409	137
R8 626 – R10 538	452	452	169
R10 539 – R12 325	532	532	213
R12 326 – R14 343	621	621	246
R14 344 – R17 250	711	711	291
R17 251 – R21 172	783	783	339
R21 173 +	851	851	373

TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R6 279	2 087	2 087	970
R6 280 – R8 625	2 201	2 201	1 033
R8 626 – R10 538	2 244	2 244	1 065
R10 539 – R12 325	2 325	2 325	1 109
R12 326 – R14 343	2 414	2 414	1 142
R14 344 – R17 250	2 503	2 503	1 188
R17 251 – R21 172	2 575	2 575	1 235
R21 173 +	2 644	2 644	1 269

MARINE

GENERAL RULES

Application of clinical protocols

POLMED applies clinical protocols, including 'best practice guidelines' and evidence-based medication (EBM) principles in its funding decisions.

Dental procedures

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

Designated GP provider *(network GP)*

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

Designated pharmacy network *(DSP for chronic medication)*

POLMED has appointed designated service providers (DSPs) for the provision of chronic medication. Medipost Pharmacy and Pharmacy Direct have been contracted as courier pharmacies to deliver chronic medication to the members' address of choice at no cost.

Clicks Pharmacy and MediRite Pharmacy are retail pharmacies that have been contracted to provide the service to members who prefer to personally collect their chronic medication

Where the member chooses to use an alternative provider for the collection of chronic medication, 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 websites of Clicks Pharmacy and MediRite Pharmacy via www.polmed.co.za and on their cellphones via the mobile site.

Designated service provider *(out-of-network rule)*

POLMED has appointed healthcare providers (or a group of providers) as DSPs for diagnosis, treatment and care in respect of one or more 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 via www.polmed.co.za, cellphone mobile site, POLMED Chat or contacting POLMED's Client Service Call Centre on 0860 765 633.

Examples of designated service providers (where applicable) are:

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

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.

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.

Medication prescribed during hospitalisation forms part of the hospital benefits. Medication prescribed during hospitalisation to take out (TTO) will be paid to a maximum of seven days' supply or a rand value equivalent to it per member 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.

Medication

Chronic 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 medication, except where the member submits proof that more than one month's supply is necessary, e.g. due to travel arrangements to foreign countries. (Travel documents must be submitted as proof.)

POLMED formulary

Payment in respect of over-the-counter (OTC), acute and chronic medication, will be subject to the medication included in the POLMED formulary. Medication is included in the POLMED formulary based on its proven clinical efficacy, as well as its cost effectiveness. The maximum reimbursed cost may be based on either a generic reference price or the inclusion of the product in the POLMED formulary. The products that are not included in the POLMED formulary will attract a 20% co-payment.

Pre-authorisation for chronic medication

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

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Members will have access to a group ('basket') of medication appropriate for the management of their particular conditions/diseases for which they are registered. There is no need for a member to apply for a new authorisation if the treatment prescribed by the doctor changes and the medication is included in the condition-specific medication basket. Updates to the authorisation will be required for newly diagnosed conditions for the member. The 20% co-payment (on medication that is not included in the POLMED formulary) can be waived via an exception management process. This process requires motivation from the treating service provider and will be reviewed based on the exceptional needs and clinical merits of each individual case.

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

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

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.

Specialised radiology

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

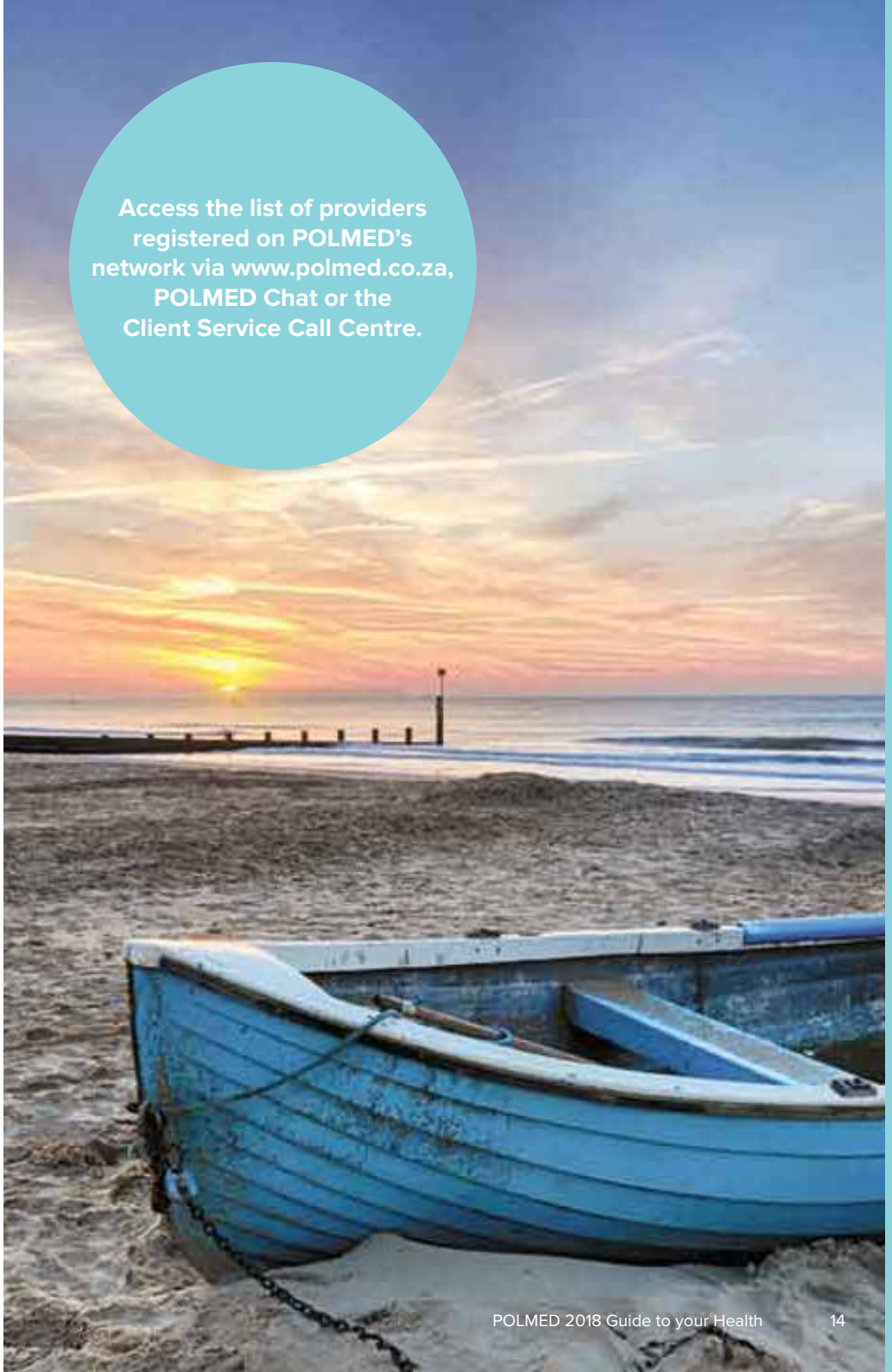
Specialist referral

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

(This co-payment is not applicable to the following 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 member per year without the requirement of a GP referral to cater for those who clinically require annual and/or bi-annual specialist visits. For example, GP referral is not required where a member has a Care Plan for a condition that lists the specialist consultation.

The Scheme will not cover the cost of the hearing aid if there is no referral from a GP or specialist. The specialist has to submit the referring GP's practice number in the claim.



DEFINITION OF TERMS

Basic dentistry

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

Other procedures that fall under this category are:

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

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.

Emergency medical services (EMS)

72-hour post-authorisation rule
Subject to authorisation within 72 hours of the event, all service providers will be required to obtain an authorisation number from POLMED's designated service provider (DSP).

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

Medication formulary

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

Medicine reference price

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

Registration for chronic medication

POLMED provides for a specific list of chronic conditions that are funded from the chronic medication benefit.

POLMED requires members to apply for authorisation via the Chronic Medicine Management Programme to access this chronic medication benefit. Members will receive communication via email, SMS or post indicating whether their application was successful or not. If successful, the member will be issued with a condition-specific authorisation, which will allow them access to medication that is referred to as the 'disease authorisation basket'.

Registration to Disease Risk Management Programme

The claims data for chronic medication, consultations and hospital admissions is used to identify the members who are eligible for registration to the Disease Risk Management Programme. The 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 Care Plan (treatment plan), which lists authorised medical services, such as consultations, blood tests and radiological tests related to the management of their conditions.

Members are also encouraged to register themselves on the Programme to ensure the payment of claims from the correct benefit category.

Specialised dentistry *(pre-authorisation required)*

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

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

MARINE

MARINE BENEFIT SCHEDULE

GENERAL BENEFIT RULES	**Benefit design**	This option provides for unlimited hospitalisation paid at the agreed tariff This option further provides for out-of-hospital benefits This option is intended to provide for the needs of families who have significant healthcare needs
	Limits are per annum	All benefit amounts and limits are annual
	Pre-authorisation, referrals, protocols and management by programmes	The pre-authorisation, referral by a designated service provider (DSP) or general practitioner (GP), adherence to established protocols or registration to a managed care programme is stipulated in order to best care for the members as well as to protect the funds of the Scheme
	Statutory prescribed minimum benefits (PMBs)	There is no overall annual limit for PMBs or life-threatening emergencies
	Tariff	100% of POLMED rate or agreed tariff or at cost for involuntary access for PMBs

IN-HOSPITAL BENEFITS		
	Anaesthetists	150% of POLMED rate or at cost for PMBs
	Annual overall in-hospital limit Subject to the Scheme's relevant managed healthcare programmes and include the application of treatment protocols, case management and pre-authorisation A R5 000 penalty may be imposed if no pre-authorisation is obtained Subject to PMBs, i.e. no limit in case of life-threatening emergencies or for PMB conditions Subject to applicable tariff, i.e. 100% of POLMED rate or agreed tariff or at cost for involuntary access for PMBs	Unlimited in private hospitals
	Chronic kidney dialysis National Renal Care (NRC) and Fresenius Medical Care are preferred providers	100% of agreed tariff at DSP
	Dentistry (conservative and restorative)	100% of POLMED rate Dentist's costs for basic dental procedures will be reimbursed from the out-of-hospital (OOH) benefit The hospital and anaesthetist's costs will be reimbursed from the in-hospital benefit
	Emergency medical services (ambulance services)	Subject to POLMED Scheme rules

IN-HOSPITAL BENEFITS		
	General practitioners (GPs)	100% of agreed tariff at DSP, 100% of POLMED rate at non-DSP or at cost for involuntary access for PMBs
	Mental health	100% of POLMED rate or at cost for PMBs Annual limit of 21 days per member Limited to a maximum of three days' hospitalisation for members admitted by a GP or a specialist physician Additional hospitalisation to be motivated by the medical practitioner
	Oncology (chemotherapy and radiotherapy) Independent Clinical Oncology Network (ICON) is the DSP	100% of agreed tariff at DSP Limited to R444 392 per member per annum; includes MRI/CT or PET scans related to oncology
	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

IN-HOSPITAL BENEFITS		
	Physiotherapy	Service will be linked to hospital pre-authorisation
	Prostheses (internal and external)	100% of POLMED rate or at cost for PMBs Subject to pre-authorisation and approved product list Limited to R65 320 per member
	Refractive surgery	100% of POLMED rate Subject to pre-authorisation Procedure is performed out of hospital and in day clinics
	Specialists	100% of agreed tariff at DSP, 100% of POLMED rate at non-DSP or at cost for involuntary access for PMBs

OVERALL OUT-OF-HOSPITAL BENEFITS		
	Annual overall out-of-hospital (OOH) limit Benefits shall not exceed the amount set out in the table PMBs shall first accrue towards the total benefit, but are not subject to a limit In appropriate cases the limit for medical appliances shall not accrue towards this limit Out-of-hospital benefits are subject to: • protocols and clinical guidelines • PMBs • the applicable tariff, i.e. 100% of POLMED rate or agreed tariff or at cost for involuntary access for PMBs	M0 – R20 143 M1 – R24 513 M2 – R29 537 M3 – R33 872 M4+ – R36 757
	Audiology	100% of POLMED rate Subject to the OOH limit Subject to referral by a GP or specialist
	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 member Oral hygiene instructions are limited to once in 12 months per member

OVERALL OUT-OF-HOSPITAL BENEFITS

General practitioners (GPs) POLMED has a GP Network	100% of agreed tariff at DSP or at cost for involuntary access for PMBs The limit for consultations shall accrue towards the OOH limit Subject to maximum number of visits/ consultations per family per annum, as follows: M0 – 11 M1 – 16 M2 – 20 M3 – 24 M4+ – 29
Medication (acute)	100% of POLMED rate Annual limit of R17 494 per family Subject to the OOH limit and the medicine reference price
Medication (over the counter [OTC])	100% of POLMED rate Annual limit of R1 152 per family Subject to the OOH limit; shared limit with acute medication
Occupational and speech therapy	100% of POLMED rate Annual limit of R2 672 per family Subject to OOH limit

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OVERALL OUT-OF-HOSPITAL BENEFITS

Pathology	M0 – R3 361 M1 – R4 846 M2 – R5 796 M3 – R7 138 M4+ – R8 753 The defined limit per family will apply for any pathology service done out of hospital
Physiotherapy	100% of POLMED rate Annual limit of R4 846 per family Subject to the OOH limit
Social worker	100% of POLMED rate Annual limit of R4 846 per family Subject to the OOH limit
Specialists Referral is not necessary for dental specialists, gynaecologists, nephrologists (dialysis), oncologists, ophthalmologists, psychiatrists and supplementary/ allied health services	100% of agreed tariff at DSP or at cost for involuntary access for PMBs The limit for consultations shall accrue towards the OOH limit Limited to five visits per member and 11 visits per family per annum Subject to referral by a GP (two specialist visits per member without GP referral applies) R1 000 co-payment if no referral is obtained

STAND-ALONE BENEFITS

Allied health services and alternative healthcare providers Includes biokineticists, chiropodists, chiropractors, dieticians, homeopaths, naturopaths, orthoptists, osteopaths, podiatrists, reflexologists and therapeutic massage therapists Benefits will be paid for clinically appropriate services	100% of POLMED rate Annual limit of R2 672 per family	
Appliances (medical and surgical) Subject to clinical protocols and pre-authorisation All costs for maintenance are a Scheme exclusion A minimum of two quotations will be required for assistive devices	100% of POLMED rate and subject to:	
	Blood transfusions	Unlimited
	CPAP machine	R9 442 per family once every four years
	Glucometer	R1 342 per family once every four years
	Hearing aids	R14 144 per hearing aid or R28 111 per member per set every three years
	Insulin delivery devices and urine catheters	Paid from the hospital benefit up to the mean price out of three quotations
	Medical assistive devices	Annual limit of R3 361 per family and includes medical devices in/out of hospital
	Nebuliser	R1 342 per family once every four years

STAND-ALONE BENEFITS

Appliances (medical and surgical) (continued)	Oxygen	Unlimited
	Wheelchair (motorised) OR Wheelchair (non-motorised)	R52 814 per member once every three years R15 712 per member once every three years
Chronic medication (non-PMB conditions) Subject to prior application and/or registration of the condition	100% of medicine reference price The extended list of chronic conditions (non-PMBs) are subject to the following limits: Member with no registered dependants: Annual limit of R9 756 Member with registered dependants: Annual limit of R17 512 Subject to the medicine reference price	
Dentistry (specialised) Pre-authorisation required	100% of POLMED rate or at cost for PMBs An annual limit of R14 205 per family Benefits shall not exceed the set out limit and includes any specialised dental procedures done in/out of hospital Includes metal-based dentures Excludes osseointegrated implants Subject to dental protocols	
Maternity benefits (including home birth) Pre-authorisation required and treatment protocols apply	The limit for consultations shall not accrue towards the OOH limit The benefit shall include three specialist consultations per member per pregnancy	

STAND-ALONE BENEFITS	
Maternity benefits (including home birth) (continued)	Home birth is limited to R16 828 per member per annum Annual limit of R4 727 for ultrasound scans per family; limited to two 2D scans per pregnancy Benefits relating to more than two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation
Maxillofacial Pre-authorisation required	Shared limit with specialised dentistry Excludes osseointegrated implants
Medication (non-PMB specialist drug limit, e.g. biologicals)	100% of POLMED rate Pre-authorisation required Specialised medication sub-limit of R169 600 per family
Optical Includes frames, lenses and eye examinations The eye examination is per member every two years (unless prior approval for clinical indication has been obtained) Benefits are not pro rata, but calculated from the benefit service date Each claim for lenses or frames must be submitted with the lens prescription Benefits shall not be granted for contact lenses if the member has already received a pair of spectacles in a two-year benefit cycle	The benefit per member (per 24-month benefit cycle) at the provider network would be: One composite consultation, inclusive of refraction, tonometry and visual field screening; collection of blood pressure, glucose and cholesterol readings **AND EITHER SPECTACLES** A frame and/or lens enhancements to the value of R1 004 **WITH EITHER** One pair of clear Aquity single-vision or clear Aquity bifocal lenses or clear Aquity multifocal lenses

STAND-ALONE BENEFITS	
Optical (continued) Annual contact lens limit is specified Contact lens re-examination can be claimed for in six-monthly intervals	**OR CONTACT LENSES** Contact lenses to the value of R1 596 Contact lens re-examination to a maximum cost of R233 per consultation The benefit at a non-provider network provider would be: One consultation limited to a maximum cost of R365 **AND EITHER SPECTACLES** R1 004 towards a frame and/or lens enhancements **WITH EITHER** One pair of single-vision lenses, limited to R174 per lens, or one pair of clear flat-top bifocal lenses, limited to R381, or one pair of clear flat-top multifocal lenses, limited to R698 per lens **OR CONTACT LENSES** Contact lenses to the value of R1 596 Contact lens re-examination to maximum cost of R233 per consultation

STAND-ALONE BENEFITS	
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 532 per family Includes any basic radiology done in/out of hospital Claims for PMBs first accrue towards the limit
Radiology (specialised) Pre-authorisation required	100% of agreed tariff or at cost for PMBs Includes any specialised radiology service done in/out of hospital Claims for PMBs first accrue towards the limit
Two (2) MRI scans	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 per member Co-payment shall apply once maximum out-of-network consultations are exceeded
Pharmacy	20% of costs for using a non-designated service provider (non-DSP) pharmacy 20% co-payment for voluntarily using a non-formulary product **Note:** A maximum co-payment of 20% applies if both the above scenarios are applicable

MARINE

ANNEXURE A4

MARINE CHRONIC CONDITIONS

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

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

Auto-immune disorder
Systemic lupus erythematosis (SLE)

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

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

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

Gynaecological conditions
Endometriosis
Menopausal treatment

Haematological conditions
Anaemia
Haemophilia
Idiopathic thrombocytopenic purpura
Megaloblastic anaemia

Metabolic condition
Hyperlipidaemia

Musculoskeletal condition
Rheumatic arthritis

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

Ophthalmic condition
Glaucoma

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

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

Special category conditions
HIV/AIDS
Organ transplantation
Tuberculosis

Treatable cancers
As per PMB guidelines

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

Extended chronic disease list: Non-PMB

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

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

Ear, nose and throat condition
Allergic rhinitis

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

Metabolic condition
Gout prophylaxis

Musculoskeletal conditions
Ankylosing spondylitis
Osteoarthritis
Osteoporosis
Paget's disease
Psoriatic arthritis

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

Ophthalmic condition
Dry eye/keratoconjunctivitis sicca

Psychiatric condition
Attention deficit hyperactivity disorder (ADHD)

Urological condition
Overactive bladder syndrome

MARINE

ANNEXURES

ANNEXURE C

ACUTE MEDICATION EXCLUSIONS

The following categories of medication 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 medication: Household remedies	Lennons
4.02	Patent medication: Patent and products with no robust scientific evidence to support cost-effectiveness	Choats
4.03	Patent medication: Emollients	Aqueous cream
4.04	Patent medication: Food/nutrition	Infasoy, Ensure
4.05	Patent medication: Soaps and cleansers	Brasivol®, Phisoac®
4.06	Patent medication: Cosmetics	Classique
4.07	Patent medication: Contact lens preparations	Bausch + Lomb®
4.08	Patent medication: Patent sunscreens	Piz Buin
4.10	Patent medication: Medicated shampoo	Denorex®, Niz shampoo
4.11	Patent medication: 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

ANNEXURES

CATEGORY	DESCRIPTION	EXAMPLE
5.07	Appliances, supplies and devices: Disposable cholesterol supplies	
5.11	Appliances, supplies and devices: Incontinence products	Nappies, molipants, linen savers, except Stoma-related supplies
6.00	Diagnostic agents	Clear View pregnancy tests
8.05	Vaccines/immunoglobulins: Other immunoglobulins	Beriglobin®
9.02	Vitamin and/or mineral supplements: Multivitamins or minerals	Pharmaton SA®
9.03	Vitamin and/or mineral supplements: Geriatric vitamins and/or minerals	Gericomplex®
9.05	Vitamin and/or mineral supplements: Tonics and stimulants	Bioplus®
9.08	Vitamin and/or mineral supplements: Magnesium diet supplementation	Magnesit®
9.10	Vitamin and/or mineral supplements: Unregistered vitamins, mineral or food supplements	Sportron
10.01	Naturo- and homeopathic remedies/ supplements: Homeopathic remedies	Weleda Natura
10.02	Naturo- and homeopathic remedies/ supplements: Natural oils	Primrose oils, fish liver oil
12.00	Veterinary products	
13.00	Growth hormones	Genotropin®

CATEGORY	DESCRIPTION	EXAMPLE
14.00	Medication where cost/benefit ratio cannot be justified	Xigris®, Zyvoxid® Herceptin, Gleevac®
20.00	All newly registered medication	

Other items and categories that can be excluded according to evidence-based medication (EBM) 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

GENERAL EXCLUSIONS

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

1. Accommodation in an old-age home or other institution that provides general care for the aged and/or chronically ill patients, unless approved by the Scheme
2. Accommodation in spas, health or rest resorts
3. Accounts of persons not registered with a recognised professional body constituted in terms of an Act of Parliament
4. Aids for participation in sport, e.g. mouthguards
5. All costs in respect of medical conditions that were specifically excluded from benefits when the member was admitted to the Scheme for 12 months from the date of coverage
6. 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
7. Any orthopaedic and medical aids that are not clinically essential, subject to PMBs
8. Any treatment as a result of surrogate pregnancy
9. Bandages and plasters, unless prescribed after an operation or an injury
10. Benefits for costs of repair, maintenance, parts or accessories for appliances or prostheses
11. Benefits for organ transplant donors to recipients who are not members of the Scheme
12. Benefits for tints and photochromic lenses
13. Blood pressure appliances: Provided that the Board may decide to grant benefits in exceptional circumstances
14. Charges for appointments that a member or dependant fails to keep with service providers
15. Claims relating to the following:
    - aptitude tests
    - IQ tests
    - school readiness
    - questionnaires
    - marriage counselling
    - learning problems
    - behavioural problems
16. Compensation for pain and suffering, loss of income, funeral expenses or claims for damages
17. Cosmetics and sunblock; sunblock may be considered for clinical reasons in albinism
18. Fixed orthodontics for members above the age of 21 years
19. Gold inlays in dentures, soft and metal base to new dentures, invisible retainers, osseointegrated implants and bleaching of vital (living) teeth
20. Holidays for recuperative purposes
21. Members' travelling costs except services according to the benefits in Annexure A and B
22. Muscular fatigue tests, except if requested by a specialist and a doctor's motivation is enclosed
23. Nappies are excluded and benefits for adult use will only be granted if previously authorised with motivation
24. Non-clinically essential or non-emergency transport via an ambulance
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. 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
27. Plastic and reconstructive surgery is excluded from benefits, unless previously approved by the Scheme as clinically essential and not cosmetic
28. Prenatal and/or post-natal exercises
29. Reports, investigations or tests for insurance purposes, admission to universities or schools, fitness tests and examinations, medical court reports, employment, emigration or immigration, etc.
30. Reversal of sterilisation procedures, provided that the Board may decide to grant benefits in exceptional circumstances
31. 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)
32. Sex change operations
33. Sleep therapy

ANNEXURES

34. 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 PMBs
    - subject to pre-authorisation and prior approval by the Scheme

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

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

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

PRESCRIBED MINIMUM BENEFITS (PMBs)

The Scheme will pay in full, without co-payment or use of deductibles, the diagnosis, treatment and care costs of the PMBs as per 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 member, the Scheme will fund the cost of the appropriate substitution treatment without a penalty to the member as required by Regulation 15H and 15I of the Act.

ANNEXURE D

PROCEDURES PRE-AUTHORISED UNDER THE AUSPICES OF MANAGED HEALTHCARE

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

PROCEDURE DESCRIPTION
Adenoidectomy
Anoscopies
Arthrocentesis
Arthrodesis of hand/elbow/foot
Arthroscopy
Arthrotomy of finger/hand/elbow/knee/toe/hip
Ascites or pleural tapping
Aspiration/injection
Aspiration/intra-articular injection of joints
Bartholin's gland drainage/excision/marsupialisation
Biopsy of lymph node/muscle/skin/bone/breast/cervix
Bleeding control (nasal)
Bronchial lavage
Cast application/removal

PROCEDURE DESCRIPTION
Cataract surgery
Cauterisation of cervix/lazer ablation
Circumcision
Colonoscopy
Colposcopy
Continuous nerve block infusion – sciatic nerve/femoral nerve/lumbar plexus
Cystoscopy for diagnosis/dilatation/stent/stone removal
Debride nails six or more – any method
Debride skin/subcutaneous tissue
Diathermy to nose and pharynx under local anaesthesia
Dilatation and curettage (excluding aftercare)
Drainage of abscess skin/carbuncle/whitlow/cyst/haematoma/gland

PROCEDURE DESCRIPTION
Drainage of subcutaneous abscess
Drainage of submucous abscess
Endoscopy
Excision benign lesion scalp/neck/ hand/feet
Excision benign lesion trunk/limbs
Excision ganglion/cyst/tumour
Excision of meibomian cyst
Excision sweat gland axilla/inguinal simple repair
Fine-needle aspiration cytology
Fine-needle aspiration for soft tissue – all areas including breast
Flexible nasopharyngo-laryngoscope examination
Gastroscopy/ esophagogastroduodenoscopy
Incision and drainage of abscess/ haematoma (anal/vaginal)
Inject nerve block
Inject tendon/ligament/trigger points/ ganglion cyst

PROCEDURE DESCRIPTION
Inject therapeutic carpal tunnel e.g. local corticosteroids
Intrapleural block
Laparoscopy diagnostic abdomen/ peritoneum/omentum
Ludwig's angina – drainage
Myringotomy aspiration incision
Opening of quinsy at rooms
Proctoscopy with removal of polyps
Proof puncture at rooms – unilateral/ bilateral
Radical nail bed removal
Removal of foreign body
Repair layer wound scalp/axillae/ trunk/limbs
Repair wound lesion scalp/hands/ neck/feet
Tonsillectomy – adenoidectomy < 12 years
Treatment by chemo-cryotherapy – additional lesions
Vasectomy – uni/bilateral

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.
- Registration is necessary when more than four fillings and two root canal treatments are required.

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 member a certain number of consultations and investigations according to clinical protocols.
- The member 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 prescribed minimum benefit (PMB) Chronic Disease List (CDL) condition and/or chronic condition if you use the medication within the medicine reference price or medication 'basket(s)'.

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.

ANNEXURES

ANNEXURE E

PREVENTATIVE HEALTHCARE BENEFIT 2018

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 as per the specified benefit to be covered from the in-hospital benefits and will not deplete your out-of-hospital benefits.

MEASURE AND ICD-10 CODES	CARE, SCREENING, TEST
CHILD HEALTH	
All child immunisation provided by the Department of Health (DOH) for children six (6) years old and younger	As per DOH age schedule as per the Road to Health chart
DENTAL HEALTH	
Caries risk assessment for children aged 0-14 years (Clinical information to be submitted to managed care)	Once every second year
Consultation and topical fluoride application for children aged 0-6 years	Annually
Periodontal disease and caries risk assessment for adults 19 years of age and older (Clinical information to be submitted to managed care)	Once every second year
Topical fluoride application for children aged 7-18 years	Annually
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
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	Pap smear test once every third year

MEASURE AND ICD-10 CODES	CARE, SCREENING, TEST
FEMALE HEALTH (women and adolescent girls)	
Human papilloma virus (HPV) screening	Once every five years for females aged 21 years and older
HPV vaccination for girls aged 10-17 years	Total of two HPV vaccinations are funded
Contraceptives ICD: Z30	As recommended by NDOH
FULL MEDICAL EXAMINATION	
One wellness measure per year inclusive of: • Blood pressure test • Body mass index (BMI) test • Cholesterol screening (Z13.8) • Consultation • Glucose screening (Z13.1) • Healthy diet counselling (Z71.3) • Lipid disorder screening for age > 40 years • Occult blood test (screening for peptic ulcer disease) • Risk assessment tests: – Baby immunisation (as per the Department of Health guidelines) – Bone densitometry scan – Circumcision – Contraceptives (as per the Department of Health guidelines) – Dental screening (codes 8101, 8151 and 8102) – Flu vaccine – Glaucoma screening – HIV tests – Human papilloma virus (HPV) screening once every five years for females aged 21 years and older – HPV vaccination for girls aged 10-17 years – Mammogram – Pap smear – Pneumococcal vaccine – Prostate screening – Psycho-social services	Annually 100% of POLMED rate or agreed tariff where applicable Early detection screening limited to periods specified Possible indication of peptic ulcers: Member over the age of 50 years Funded from the risk pool; the benefit shall not accrue to the overall out-of-hospital limit

MEASURE AND ICD-10 CODES	CARE, SCREENING, TEST
FULL MEDICAL EXAMINATION	
• Waist-to-hip ratio measurement Clinical information to be submitted to managed healthcare	
HIV COUNSELLING AND TESTING	
HCT consultation, rapid testing and post counselling	Annually
HIV counselling and pre-counselling	Annually
HIV testing Elisa: 3932 Confirmation test: Western blot (payable after HCT or ELISA tests)	Annually
OTHER	
Circumcision	Subject to clinical protocols
Flu vaccine	Annually
Glaucoma screening	Once every third year, unless motivated
Hib titer for 60 years and older (Serology: IgM: specific antibody titer)	Annually
Post-trauma debriefing session Only for active principal members of SAPS utilising the Psycho-Social Network	Four sessions per year
Prostate cancer screening For all males aged between 50 and 75 years	Annually

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 2018

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) adjusted on an annual basis with Consumer Price Index (CPI).
- **'Agreed tariff'** shall mean: The rate negotiated by and on behalf of the Scheme with one or more providers/groups.

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

The Scheme does not grant benefits for services rendered outside the borders of the RSA. It remains the responsibility of the member to acquire insurance cover when travelling outside the borders of the RSA.

AQUARIUM

ANNEXURE B3

AQUARIUM CONTRIBUTION SCHEDULE

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

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

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

TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R5 940	916	916	455
R5 941 – R8 160	923	923	455
R8 161 – R9 970	946	946	463
R9 971 – R11 660	968	968	469
R11 661 – R13 570	990	990	476
R13 571 – R16 320	1 010	1 010	483
R16 321 – R20 030	1 049	1 049	491
R20 031 +	1 083	1 083	513

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

The contributions for 2018 as set out in Circular 45 of 2017 by the Council for Medical Schemes (CMS).

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

MEMBER CONTRIBUTION (SUBSIDISED CONTRIBUTION)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R6 279	70	70	31
R6 280 – R8 625	77	77	31
R8 626 – R10 538	102	102	40
R10 539 – R12 325	126	126	46
R12 326 – R14 343	149	149	54
R14 344 – R17 250	171	171	61
R17 251 – R21 172	213	213	70
R21 173 +	249	249	94

TOTAL CONTRIBUTION (EXCLUDING EMPLOYER SUBSIDY)			
INCOME CATEGORY	MEMBER	ADULT	CHILD
R0 – R6 279	978	978	486
R6 280 – R8 625	985	985	486
R8 626 – R10 538	1 010	1 010	494
R10 539 – R12 325	1 034	1 034	501
R12 326 – R14 343	1 057	1 057	508
R14 344 – R17 250	1 079	1 079	516
R17 251 – R21 172	1 121	1 121	524
R21 173 +	1 157	1 157	548

AQUARIUM

GENERAL RULES

Application of clinical protocols

POLMED applies clinical protocols, including 'best practice guidelines' and evidence-based medication (EBM) principles in its funding decisions.

Dental procedures

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

Designated GP provider *(network GP)*

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

Designated pharmacy network *(DSP for chronic medication)*

POLMED has appointed designated service providers (DSPs) for the provision of chronic medication. Medipost Pharmacy and Pharmacy Direct have been contracted as courier pharmacies to deliver chronic medication to the members' address of choice at no cost.

Clicks Pharmacy and MediRite Pharmacy are retail pharmacies that have been contracted to provide the service to members who prefer to personally collect their chronic medication.

Where the member chooses to use an alternative provider for the collection of chronic medication, 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 websites of Clicks Pharmacy and MediRite Pharmacy via www.polmed.co.za and on their cellphones via the mobile site.

Designated service provider *(out-of-network rule)*

POLMED has appointed healthcare providers (or a group of providers) as DSPs for diagnosis, treatment and care in respect of one or more 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 via www.polmed.co.za, cellphone mobile site, POLMED Chat or contacting POLMED's Client Service Call Centre on 0860 765 633.

Examples of designated service providers (where applicable) are:

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

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.

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.

Medication prescribed during hospitalisation forms part of the hospital benefits. Medication prescribed during hospitalisation to take out (TTO) will be paid to a maximum of seven days' supply or a rand value equivalent to it per member 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.

Medication

Chronic 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 medication, except where the member submits proof that more than one month's supply is necessary, e.g. due to travel arrangements to foreign countries. (Travel documents must be submitted as proof.)

POLMED formulary

Payment in respect of over-the-counter (OTC), acute and chronic medication will be subject to the medication included in the POLMED formulary. Medication is included in the POLMED formulary based on its proven clinical efficacy, as well as its cost effectiveness. The maximum reimbursed cost may be based on either a generic reference price or the inclusion of the product in the POLMED formulary. The products that are not included in the POLMED formulary will attract a 20% co-payment.

Pre-authorisation for chronic medication

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

AQUARIUM

Members will have access to a group ('basket') of medication appropriate for the management of their particular conditions/diseases for which they are registered. There is no need for a member to apply for a new authorisation if the treatment prescribed by the doctor changes and the medication is included in the condition-specific medication basket. Updates to the authorisation will be required for newly diagnosed conditions for the member. The 20% co-payment (on medication that is not included in the POLMED formulary) can be waived via an exception management process. This process requires motivation from the treating service provider and will be reviewed based on the exceptional needs and clinical merits of each individual case.

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

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

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.

Specialised radiology

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

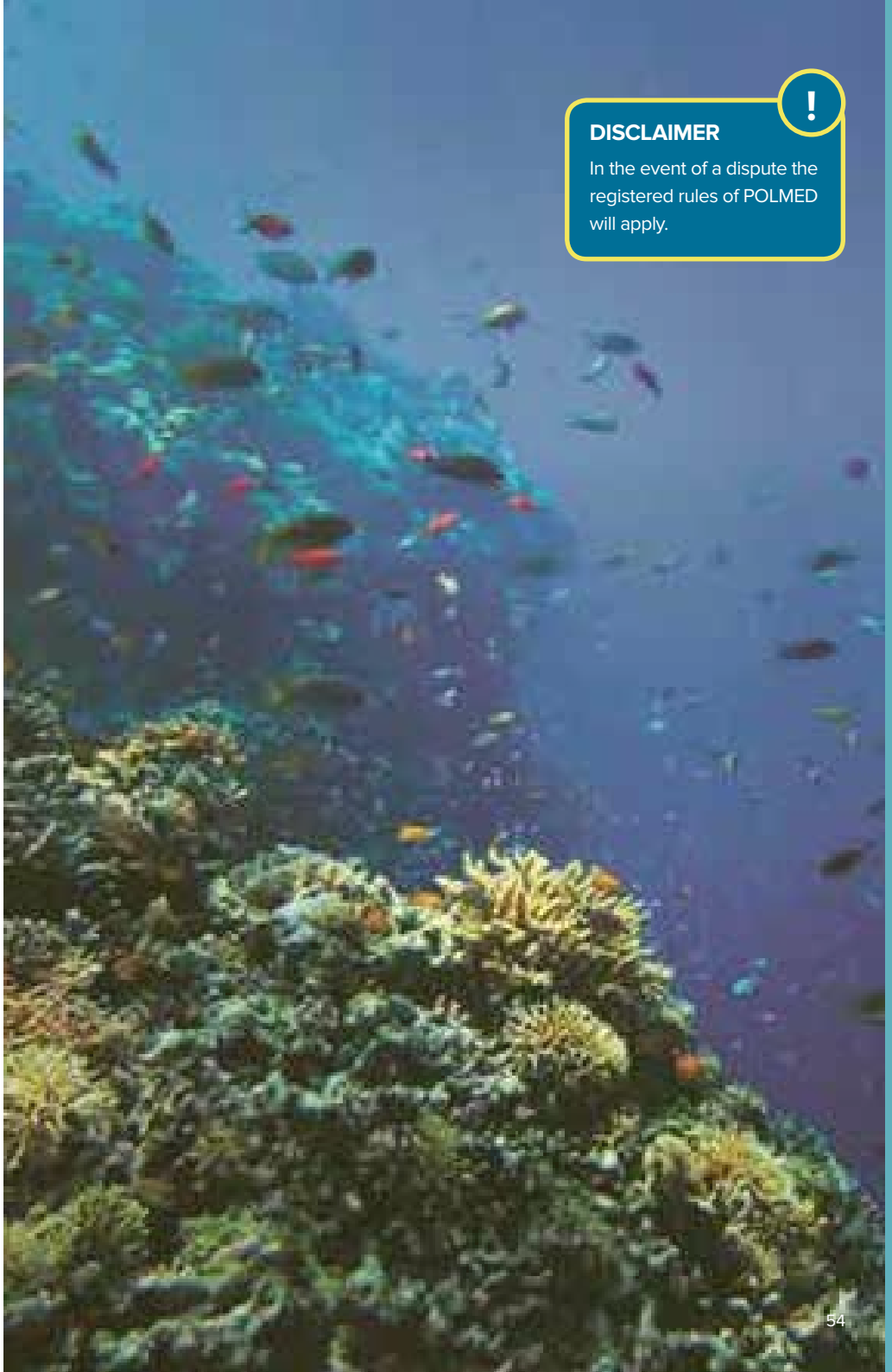
Specialist referral

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

(This co-payment is not applicable to the following 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 member per year without the requirement of a GP referral to cater for those who clinically require annual and/or bi-annual specialist visits. For example, GP referral is not required where a member has a Care Plan for a condition that lists the specialist consultation.

The Scheme will not cover the cost of the hearing aid if there is no referral from a GP or specialist. The specialist has to submit the referring GP's practice number in the claim.



DISCLAIMER

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

DEFINITION OF TERMS

Basic dentistry

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

Other procedures that fall under this category are:

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

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.

Emergency medical services (EMS)

72-hour post-authorisation rule
Subject to authorisation within 72 hours of the event, all service providers will be required to obtain an authorisation number from POLMED's designated service provider (DSP).

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

Medication formulary

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

Medicine reference price

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

Registration for chronic medication

POLMED provides for a specific list of chronic conditions that are funded from the chronic medication benefit.

POLMED requires members to apply for authorisation via the Chronic Medicine Management Programme to access this chronic medication benefit. Members will receive communication via email, SMS or post indicating whether their application was successful or not. If successful, the member will be issued with a condition-specific authorisation, which will allow them access to medication that is referred to as the 'disease authorisation basket'.

Registration to Disease Risk Management Programme

The claims data for chronic medication, consultations and hospital admissions is used to identify the members who are eligible for registration to the Disease Risk Management Programme. The 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 Care Plan (treatment plan), which lists authorised medical services, such as consultations, blood tests and radiological tests related to the management of their conditions.

Members are also encouraged to register themselves on the Programme to ensure the payment of claims from the correct benefit category.

Specialised dentistry *(pre-authorisation required)*

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

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

AQUARIUM

AQUARIUM BENEFIT SCHEDULE

GENERAL BENEFIT RULES	**Benefit design**	This option provides for benefits to be provided only in appointed designated service provider (DSP) hospitals It also provides a reasonable level of out-of-hospital care This option is intended to provide for the needs of families who have little healthcare needs or whose chronic conditions are under control This option is not intended for members who require medical assistance on a regular basis, or who are concerned about having extensive access to health benefits
	Limits are per annum	All benefit amounts and limits are annual
	Pre-authorisation, referrals, protocols and management by programmes	The pre-authorisation, referral by a DSP or general practitioner (GP), adherence to established protocols or registration to a managed care programme is stipulated in order to best care for the members as well as to protect the funds of the Scheme
	Statutory prescribed minimum benefits (PMBs)	There is no overall annual limit for PMBs or life-threatening emergencies
	Tariff	100% of POLMED rate or agreed tariff or at cost for involuntary access for PMBs

AQUARIUM

IN-HOSPITAL BENEFITS		
	Anaesthetists	150% of POLMED rate or at cost for PMBs
	Annual overall in-hospital limit 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 for 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		
	Chronic kidney dialysis National Renal Care (NRC) and Fresenius Medical Care are preferred providers	100% of agreed tariff at DSP
	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 services (ambulance services)	Subject to POLMED Scheme rules
	General practitioners (GPs)	100% of agreed tariff at DSP, 100% of POLMED rate at non-DSP or at cost for involuntary PMB access
	Mental health	100% of POLMED rate or at cost for PMBs Annual limit of 21 days per member Limited to a maximum of three days' hospitalisation for members admitted by a GP or a specialist physician Additional hospitalisation to be motivated by the medical practitioner

IN-HOSPITAL BENEFITS

Oncology (chemotherapy and radiotherapy) Independent Clinical Oncology Network (ICON) is the DSP	100% of agreed tariff at DSP Limited to R259 465 per member per annum; includes MRI/CT or PET scans related to oncology
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 R64 132 per member
Refractive surgery	No benefit
Specialists	100% of agreed tariff at DSP, 100% of POLMED rate for non-DSP or at cost for involuntary PMB access

OVERALL OUT-OF-HOSPITAL BENEFITS

Annual overall out-of-hospital (OOH) limit Benefits shall not exceed the amount set out in the table PMBs shall first accrue towards the total benefit, but are not subject to a limit In appropriate cases the limit for medical appliances shall not accrue towards this limit Out-of-hospital benefits are subject to: • protocols and clinical guidelines • PMBs • the applicable tariff, i.e. 100% of POLMED rate or agreed tariff or at cost for involuntary PMB access	M0 – R8 812 M1 – R10 677 M2 – R12 969 M3 – R13 836 M4+ – R15 855
Audiology	100% of POLMED rate Subject to the OOH limit Subject to referral by a GP or specialist
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 member Oral hygiene instructions are limited to once in 12 months per member

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 573 per family Subject to the OOH limit and the medicine reference price
Medication (over the counter [OTC])	100% of POLMED rate Annual limit of R952 per family Subject to the OOH limit; shared limit with acute medication
Occupational and speech therapy	PMBs only Benefit first accrues to the OOH limit

OVERALL OUT-OF-HOSPITAL BENEFITS

Pathology	M0 – R3 100 M1 – R4 585 M2 – R5 546 M3 – R6 865 M4+ – R8 504 The defined limit per family will apply for any pathology service done out of hospital
Physiotherapy	100% of POLMED rate Annual limit of R2 398 per family Subject to the OOH limit
Social worker	100% of POLMED rate Annual limit of R2 263 per family Subject to the OOH limit
Specialists Referral is not necessary for dental specialists, gynaecologists, nephrologists (dialysis), oncologists, ophthalmologists, psychiatrists and supplementary/ allied health 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 member and eight visits per family per annum Subject to referral by a GP (two specialist visits per member without GP referral applies) R1 000 co-payment if no referral is obtained

AQUARIUM

SPECIALISED DENTISTRY

Dentistry (specialised) Surgical extractions of teeth requiring removal of bone or incision required to reduce fracture Surgical removal of impacted teeth requiring removal of inflammatory tissues surrounding partially erupted teeth Root planning treatment for periodontal disease Drainage of abscess and clearing infection caused by tooth decay Apicoectomy – removal of dead tissue caused by infection Children under the age of seven years, physically or mentally disabled patients who require general anaesthesia for dental work to be conducted Cyst removal of non-vital pulp Odentectomy – under sedation with removal of all teeth in the mouth	In all cases pre-authorisation is required, failing which the Scheme will impose a co-payment of R500 Clinical protocols apply

STAND-ALONE BENEFITS

Allied health services and alternative healthcare providers Includes biokineticists, chiropodists, chiropractors, dieticians, homeopaths, naturopaths, orthoptists, osteopaths, podiatrists, reflexologists and therapeutic massage therapists Benefit is subject to clinically appropriate services	No benefit	
Appliances (medical and surgical) Subject to clinical protocols and pre-authorisation All costs for maintenance are a Scheme exclusion A minimum of two quotations will be required for assistive devices	100% of POLMED rate and subject to:	
	Blood transfusions	Unlimited
	CPAP machine	R9 168 per family once every four years
	Glucometer	R1 283 per family once every four years
	Hearing aids	R11 318 per hearing aid or R22 494 per member per set every three years
	Insulin delivery devices and urine catheters	Paid from the hospital benefit up to the mean price of three quotations
	Medical assistive devices	Annual limit of R2 695 per family and includes medical devices in/out of hospital
	Nebuliser	R1 283 per family once every four years
	Oxygen	Unlimited

STAND-ALONE BENEFITS

Appliances (medical and surgical) (continued)	Wheelchair (motorised) OR Wheelchair (non-motorised)	R34 370 per member once every three years R11 983 per member once every three years
Chronic medication (non-PMB medication) Subject to prior application and/or registration of the condition	No benefit except for PMBs Subject to the medicine reference price	
Maternity benefits (including home birth) Pre-authorisation required and treatment protocols apply	100% of agreed tariff at DSP, 100% of POLMED rate at non-DSP or at cost for involuntary PMB access The limit for consultations shall not accrue towards the OOH limit The benefit shall include three specialist consultations per member per pregnancy Home birth is limited to R14 417 per member per annum Annual limit of R4 038 for ultrasound scans per family; limited to two 2D scans per pregnancy Benefits relating to more than two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation	
Medication (non-PMB specialist drug limit, e.g biologicals)	100% of POLMED rate Pre-authorisation required Specialised medication sub-limit of R137 800 per family	

STAND-ALONE BENEFITS

Optical Includes frames, lenses and eye examinations The eye examination is per member every two years (unless prior approval for clinical indication has been obtained) Benefits are not pro rata, but calculated from the benefit service date Each claim for lenses or frames must be submitted with the lens prescription Benefits shall not be granted for contact lenses if the member has already received a pair of spectacles in a two-year benefit cycle Annual contact lens limit is specified Contact lens re-examination can be claimed for in six-monthly intervals	The benefit per member (per 24-month benefit cycle) at the provider network would be: One composite consultation, inclusive of refraction, tonometry and visual field screening; collection of blood pressure, glucose and cholesterol readings **AND EITHER SPECTACLES** A provider network frame or alternative frame plus enhancement to the value of R613 **WITH EITHER** One pair of clear Aquity single-vision or clear Aquity bifocal lenses or clear Aquity multifocal lenses covered up to the value of clear bifocal lens limit **OR CONTACT LENSES** Contact lenses to the value of R613 Contact lens re-examination to a maximum cost of R233 per consultation The benefit at a non-provider network provider would be: One consultation limited to a maximum cost of R365 **AND EITHER SPECTACLES** R613 towards a frame and/or lens enhancements

STAND-ALONE BENEFITS

Optical (continued)	**WITH EITHER** One pair of clear Aquity single-vision lenses, limited to R174 per lens, or one pair of clear Aquity bifocal lenses, limited to R381, or multifocal clear Aquity lenses covered up to the value of the clear bifocal lens limit **OR CONTACT LENSES** Contact lenses to the value of R613 Contact lens re-examination to a maximum cost of R233 per consultation
Radiology (basic) i.e. black and white X-rays and soft tissue ultrasounds	100% of agreed tariff or at cost for PMBs Limited to R5 232 per family Includes any basic radiology done in/out of hospital Claims for PMBs first accrue towards the limit
Radiology (specialised) Pre-authorisation required	100% of agreed tariff or at cost for PMBs Includes any specialised radiology service done in/out of hospital Claims for PMBs first accrue towards the limit
Two (2) MRI scans	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 B2

CO-PAYMENTS

OUT OF NETWORK	CO-PAYMENT
General practitioner (GP)	Allows for two out-of-network consultations Co-payment shall apply once maximum out-of-network consultations are exceeded
Hospital	R8 000
Pharmacy	20% of costs when using a non-designated service provider (non-DSP) pharmacy 20% co-payment when voluntarily using a non-formulary product **Note:** A maximum co-payment of 20% applies if both the above scenarios are applicable

AQUARIUM

ANNEXURE B4

AQUARIUM CHRONIC CONDITIONS

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

Auto-immune disorder
Systemic lupus erythematosis (SLE)

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

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

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

Gynaecological conditions
Endometriosis
Menopausal treatment

Haematological conditions
Anaemia
Haemophilia
Idiopathic thrombocytopenic purpura
Megaloblastic anaemia

Metabolic condition
Hyperlipidaemia

Musculoskeletal condition
Rheumatic arthritis

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

Ophthalmic condition
Glaucoma

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

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

Special category conditions
HIV/AIDS
Organ transplantation
Tuberculosis

Treatable cancers
As per PMB guidelines

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

AQUARIUM

ACCESS YOUR PERSONAL INFORMATION VIA OUR WEBSITE

NOTE
You must have an email address to register on Member zone.

1

WHAT DO YOU NEED TO REGISTER?

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

2

Top of the home page of www.polmed.co.za select 'Member Zone' to create an account.

3

REGISTRATION PROCESS

- On the Member zone registration page, select 'Create Account'.
- Select 'Members'.
- Type in your membership number and select 'Validate Code'.
- Follow the rest of the prompts to complete your registration.

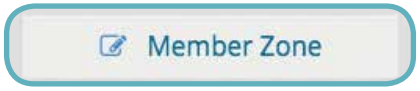
4

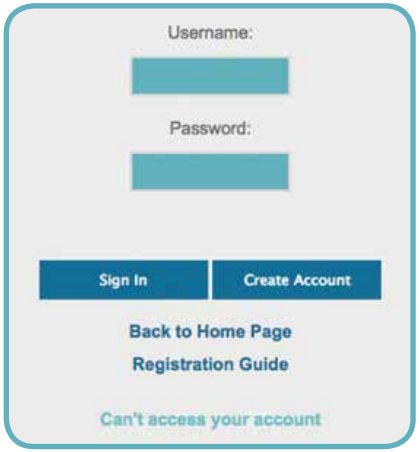
PRINCIPAL MEMBERS
When a dependant registers for access, the principal member receives an email to activate the dependant's access. The principal member needs to inform the dependant when this is done.

4

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

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





SIGN OUT
Remember to sign out when you have completed your enquiry.

WHAT CAN YOU DO ON MEMBER ZONE?

- View benefit usage and limits.
- View claims history and statements.
- Download and print your membership certificate, tax certificate and member statements (via desktop go to 'Communication Details' and via a cellphone go to 'Member Monitor' and then 'My Documents').
- View membership card details, including details of the principal member and dependants.
- View contact and address information, including the option to update information.
- View authorisations.

APPLICATION FOR EX GRATIA

NEED MEDICAL CARE BUT YOUR BENEFITS ARE EXHAUSTED?

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

EX GRATIA DOES NOT PERTAIN TO THE FOLLOWING:

- Scheme exclusions
- Stale claims (older than 120 days)
- Co-payments

HOW DO I APPLY FOR EX GRATIA BENEFITS?

Principal member applies for assistance.

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

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

SUBMIT THE APPLICATON TO:

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

Outcome of application communicated to member.

ADMINISTRATION

APPLICATION FOR MEMBERSHIP

NEW MEMBER APPLICATION

- Serving members
- Dependants

NEW MEMBER APPLICATION DOCUMENTATION REQUIRED

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

SUPPORTING DOCUMENTS REQUIRED FOR REGISTRATION OF DEPENDANTS

DEPENDANTS (SERVING MEMBERS OR CONTINUATION MEMBERS)

Only completed if the dependant was not registered when the principal member joined **POLMED:**

- **APPLICATION FOR REGISTRATION OF DEPENDANTS FORM.**
- Copy of **BIRTH CERTIFICATE** or **IDENTITY DOCUMENT.**

AVAILABILITY OF FORMS

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

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

APPLICATION SUBMISSION DETAILS

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

ADDITIONAL SUPPORTING DOCUMENTS REQUIRED FOR REGISTRATION OF DEPENDANTS

DEPENDANT BETWEEN THE AGES OF 21 AND 30

STUDENT

Certificate of registration at registered tertiary learning institution – annually.

FINANCIALLY DEPENDENT

Affidavit B confirming financial dependency (monthly income) – annually.

STEPCHILD

Affidavit D confirming child is the biological child of the member's spouse.

DISABLED CHILD OVER THE AGE OF 21

Proof of disability confirmed by a medical practitioner – annually.

CHILD BORN BEFORE OR OUT OF WEDLOCK

Affidavit A confirming member is the biological parent of the child, if the member's details do not appear on the child's birth certificate.

LEGALLY ADOPTED CHILD

Final adoption order.

APPLICATION FOR MEMBERSHIP

CONTINUATION OF MEMBERSHIP

- Death of the principal member (any dependant active at the time of the principal member's death).
- Medically boarded.
- **Retirement.**
- **Severance package.**

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

DOCUMENTS REQUIRED

- Application for continuation membership form.
- Copy of ID.
- Proof of monthly pension (IF RETIRED/MEDICALLY BOARDED).
- Proof of basic monthly salary received in the last month of service with employer (SEVERANCE PACKAGE).
- Service certificate or SAP96 and letter from Medical Board at SAPS Head Office (please indicate if related to injury on duty).

WHAT IF BOTH PARENTS DIE?

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

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

DEATH OF THE PRINCIPAL (MAIN) MEMBER

DOCUMENTS REQUIRED FROM DEPENDANTS WHO ARE REGISTERED AT THE TIME OF THE PRINCIPAL MEMBER'S DEATH

- Application for continuation membership form to be completed by remaining spouse/partner.
- Death certificate.
- Copy of cancelled ID for deceased principal member.
- Copies of ID documents for dependants.
- Proof of income (monthly pension of deceased that the member will receive).
- Marriage certificate or customary union certificate.

AVAILABILITY OF FORMS

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

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

REMEMBER

COMPLETE THE APPLICATION FOR CONTINUATION MEMBERSHIP FORM.

Submit the completed form and supporting documentation to POLMED via email, fax, by hand at your nearest POLMED regional walk-in branch or by post.

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

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

APPLICATION FOR CONTINUATION MEMBERSHIP SUBMISSION DETAILS

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

IMPORTANT

A member who resigns from SAPS, irrespective of the number of years in service, does not qualify to remain a POLMED member.

DISPUTE RESOLUTION

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

THE FIRST STEPS TO LODGING A COMPLAINT OR DISPUTING A RULING

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

Tel: 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.

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

If 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). The form to complete when submitting a complaint to the CMS is available on the CMS website.

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

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

ADMINISTRATION

FIVE EASY STEPS TO PLAN SELECTION

Understand your benefits and choose the right plan.
You must 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 via POLMED Chat.

OR

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

3 HOW WILL I KNOW MY PLAN HAS BEEN CHANGED?

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

4 WHAT IF I DO NOT INFORM POLMED?

You will remain on the same plan.

5 CAN I CHANGE MY PLAN AFTER THIS?

No, you may only change your plan at the end of each year before 31 December. You must call, complete your choice online or POLMED must receive your completed plan selection form before 31 December.

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 access to unauthorised benefits.

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

WHAT IS MEDICAL SCHEME ABUSE?

Medical scheme abuse occurs when providers supply and claim for services or products that are not medically or clinically necessary or 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 medication for unregistered members of the family.
- Buying groceries and receiving cash from healthcare providers using your POLMED membership card.
- Receiving any undue or personal benefit at the expense of POLMED.

FRAUD PREVENTION

DO

- Use your personal healthcare journal or a calendar to remember the dates of consultations and treatments.
- Monitor all your claims via SMS/email.
- Make sure healthcare providers are who they claim to be. Beware of dishonest healthcare providers who practise under false names.
- Report colleagues abusing their benefits or participating in fraud.
- 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 once?
  - 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 and you will too!
- Give out your POLMED membership number or membership card, except to POLMED staff, your doctor or other healthcare providers.
- Accept 'money, freebies or groceries' or any undue benefit in exchange for your POLMED benefits.
- Allow family members to use your membership card if they are not a registered dependant.
- Go for unnecessary treatments.

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 POLMED-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 and in the interest of national healthcare.
- Prosecute the guilty parties.

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 POLMED regional walk-in branch.

SERVICE PROVIDERS: SUBMISSION OF CLAIMS

Most service providers submit their claims electronically.

PAYMENT OF CLAIMS

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

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

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 dependant code (as it appears on the back of the POLMED membership card).
- Date of birth of patient.

Other

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

MEMBER REFUNDS

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

MEMBER QUERIES

If you have a query you may contact POLMED via:

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

NOTE:

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

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

MEMBER QUERIES (INITIAL QUERY)

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

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

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

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

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

MEMBER QUERIES ESCALATED

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

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

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

Provide the following details for POLMED to investigate your query:

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

OPERATING HOURS

The POLMED Client Service Call Centre and regional walk-in branches operate Mondays to Fridays from 7:30 to 17:00 (excluding public holidays). Regional walk-in branches also operate on Saturdays from 8:00 to 12:00.

COMPLIMENTS AND COMPLAINTS

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

ONLINE/SOCIAL MEDIA COMMENTS AND QUERIES

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

POLMED CHAT (WEEKDAYS 7:30 – 17:00)

BENEFITS OF USING THE POLMED CHAT APP

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

HOW TO ACCESS THIS APPLICATION

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

Cellphone: Download app for free via http://bit.ly/1YHAtwu or the app stores.

POLMED website: Go to www.polmed.co.za via your computer, log in to Member zone and select the POLMED Chat icon for access.

VALIDATION

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

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

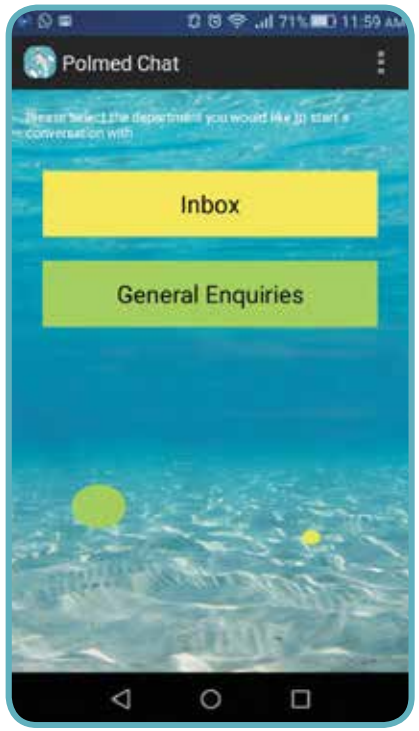
Click here to 'Validate'.

HOW DO YOU VIEW YOUR POLMED MEMBERSHIP CARD?

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

HOW DO YOU START A CHAT?

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



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

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

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

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

1. **PRESS 2** if you are a member.
2. **PRESS 2** for client services.
3. **PRESS 1** for this self-help service.

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

4. **PRESS 1** to listen to your available benefits.

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

PRESS 2 for your acute medication available benefits.

PRESS 3 for your chronic medication available benefits.

PRESS 4 for your non-surgical procedures available benefits.

PRESS 5 for your available dentistry benefits.

4. **PRESS 2** to request documents.

PRESS 1 for your membership certificate.

PRESS 2 for your tax certificate.

PRESS 3 for your member statement.

AUTHORISATION FOR APPLIANCES AND PROLONGED CARE

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.

APPLIANCES MANAGED INCLUDE:

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

CONTACT DETAILS

Email: polmedspecialcases@medscheme.co.za
Fax: 0860 104 114

DOCUMENTS REQUIRED

- Treating doctor's motivation or treatment plan with diagnosis.
- Quotation with rand value and duration of treatment.
- Member details.
- Service provider details.

Outcome sent to service provider and member.

ADDITIONAL INFORMATION REQUIRED: APPLIANCES

CPAP machines

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

Hearing aids

- Audiology report.
- Report from the referring treating doctor.
- Quotation with nappi code for hearing aid device.

PROLONGED CARE INCLUDES AUTHORISATION OF THE FOLLOWING:

- Home oxygen.
- Home nursing from registered care providers.
- Organ transplant tests (pre- and post-transplant).
- Stoma care.
- Enteral feeds.

CONTACT DETAILS

Tel: 0860 765 633 (select option for Disease Risk Management)
Email: polmedhbc@medscheme.co.za

DOCUMENTS REQUIRED

- Treating doctor's motivation or treatment plan with diagnosis.
- Quotation with rand value and duration of treatment.
- Member details.
- Service provider details.

Outcome sent to service provider and member.

ADDITIONAL INFORMATION REQUIRED: PROLONGED CARE

Home oxygen

- Letter of motivation from treating doctor with relevant diagnosis code (ICD-10).
- Quotation from supplier.
- Latest blood gases.
- Compliance reports every three months.

Home nursing

- Healthcare provider's motivation with diagnosis (ICD-10) codes.
- Assessment report from nursing service provider.
- Quotation with tariff codes and rand value per day.

CHRONIC MEDICINE MANAGEMENT

1

IMPORTANT!

If you have been diagnosed with a chronic condition, it is important to claim your medication from the chronic medication benefit and not from the acute medication benefit.

2

The chronic medication must be authorised before the prescription is handed in at the pharmacy.

3

IMPORTANT PRESCRIPTION INFORMATION

- Member details including membership number and date of birth.
- Copy of a valid chronic script – including ICD-10 code, doctor practice number/details and medication details.

?

DID YOU KNOW?

You or your treating doctor can call POLMED to obtain pre-authorisation for your chronic medication.

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

!

NOTE

Co-payments

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

Reference pricing

- Reference pricing is applied to chronic medication.
- Co-payments due to reference pricing may be avoided by using generic medication that is below the reference pricing – your pharmacist can suggest generic medication options.

POLMED 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**

Note: Notify the courier pharmacies directly about any address updates to avoid delays in the delivery of your medication.

HOSPITAL PRE-AUTHORISATION

DETAILS REQUIRED TO OBTAIN AUTHORISATION

Ensure you have the details listed below before calling POLMED for an authorisation:

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

CONTACT POLMED FOR HOSPITAL PRE-AUTHORISATION

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

AUTHORISATION

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

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

IF FURTHER INFORMATION IS REQUIRED

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

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.

MATERNITY PROGRAMME

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.

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.

REGISTRATION TO THE PROGRAMME

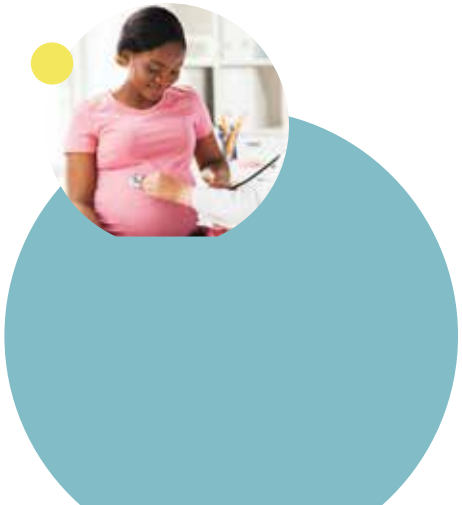
Pregnant members can contact POLMED to register to the Maternity Programme.

ADMISSION FOR DELIVERY

The member must contact POLMED on 0860 765 633 for hospital pre-authorisation.

CONTACT DETAILS

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



MENTAL HEALTH PROGRAMME (FOR ALL MEMBERS)

INTRODUCTION

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

REGISTRATION PROCESS

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

CONTACT DETAILS

Tel: 0860 765 633 between 7:30 and 17:00 from Mondays to Fridays (excluding public holidays)
Email: polpsych@medscheme.co.za

CARE PLAN

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

ONCOLOGY MANAGEMENT

CONTACT DETAILS

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

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

PRE-AUTHORISATION

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

THE FOLLOWING INFORMATION IS REQUIRED FOR AUTHORISING TREATMENT:

- Member's name and surname.
- Membership number.
- Date of birth and/or ID number.
- Treating doctor's name and practice number.
- Treatment plan from doctor.
- ICD-10 code.
- Tariff code.
- Nappi code(s) for medication.
- Date of service.
- Histology results.

AUTHORISATION

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

SUPPORT FROM POLMED CASE MANAGER

The Case Manager will:

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

PRESCRIBED MINIMUM BENEFITS

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

PMBs are a feature of the Medical Schemes Act, in terms of which medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- any emergency medical condition that requires emergency treatment
- a limited set of 270 medical conditions as defined in the Diagnosis and Treatment Pairs (DTPs)
- 26 chronic conditions as defined in the Chronic Disease List (CDL).

CHRONIC DISEASE LIST (CDL)

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

CARE PLAN

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

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

ENQUIRIES

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

PSYCHOLOGICAL BENEFITS FOR SERVING MEMBERS ONLY

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

However, POLMED has a mental health benefit for dependants and continuation members – see 'Mental Health Programme' on page 102 for more information.

BENEFIT INFORMATION

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

LOOKING FOR CONTACT DETAILS?

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

OR

Call the Client Service Call Centre on 0860 765 633 and ask for the contact details of a Psycho-Social Network provider in your area.

REGISTRATION TO DISEASE RISK MANAGEMENT (DRM) PROGRAMME

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

REGISTRATION PROCESS

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

CONTACT DETAILS

Tel: 0860 765 633 between 7:30 and 17:00 from Mondays to Fridays (excluding public holidays)
Email: polmeddiseaseman@medscheme.co.za

CARE PLAN INFORMATION

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

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

REGISTRATION TO HIV MANAGEMENT PROGRAMME

HOW DO I REGISTER TO THE POLMED HIV MANAGEMENT PROGRAMME?

THIS PROGRAMME IS STRICTLY CONFIDENTIAL.

The application form is available:

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

Submit your completed and signed application form to POLMED via:

Email: polmedhiv@medscheme.co.za
Fax: 0800 600 773
Post: PO Box 38597, Pinelands 7430

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

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

SPECIALISED DENTISTRY

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

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

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

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

PAYMENT GUIDELINES/HOSPITAL PRE-AUTHORISATION

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

PAYMENT GUIDELINES/DENTAL PROCEDURE

- 100% of POLMED rate or at cost for PMBs.
- You may be liable for the full claim or a co-payment of R500 if no pre-authorisation is obtained.

MANAGED CARE

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 2727/2941/2979

SAPS IOD Finance Department:
Tel: 012 393 1947/4409/4461

SAPS Medical Boards:
Tel: 012 393 1501/2796

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.

INJURY ON DUTY (IOD)

MOTOR VEHICLE ACCIDENT (MVA) CLAIMS

In the unfortunate event that you or your dependants are involved in a serious motor vehicle accident that requires you to receive medical attention, the following steps should be followed to ensure the efficient processing of your claims:

- POLMED will inform Alexander Forbes of your accident and their offices will contact you.
- In terms of POLMED's rules and regulations you are required to institute a claim with the Road Accident Fund.
- Alexander Forbes will request you to provide them with a letter of undertaking signed by you and an attorney. This letter confirms that both parties undertake to reimburse the Scheme for medical expenses relating to the accident in the event that the Road Accident Fund rules that you are to be reimbursed.
- The draft letter of undertaking is available from Alexander Forbes via email: possiblethirdpartyclaims@aforbes.co.za
- Alternatively, you may download the draft letter from the POLMED website:

  On www.polmed.co.za go to the home page, select the tab 'FORMS', on the drop-down list select 'Manage Care (Medical)' and then select 'Undertaking (MVA)'.
- Completed letters must be sent to Alexander Forbes via:
  Email:
  possiblethirdpartyclaims@aforbes.co.za
  Fax: 012 425 4208
- On receipt of the undertaking, the Scheme will process all accounts in accordance with the rules of the Scheme.
- On finalisation of the claim, you and your attorney must provide Alexander Forbes with the total amount equal to any advances the Scheme made in favour of you or your dependants, together with a copy of the discharge document as provided by the Road Accident Fund.
- Alexander Forbes can refer you to an attorney appointed by the Scheme who specialises in third-party claims.

For any MVA process-related queries, please contact Alexander Forbes on 012 431 9700.

MOTOR VEHICLE ACCIDENT (MVA) CLAIMS

CLIENT SERVICE CONTACT DETAILS

Roodepoort walk-in branch

Shop 21 and 22
Flora Centre (Entrance 2)
Cnr Ontdekkers & Conrad Roads
Florida North
Roodepoort

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

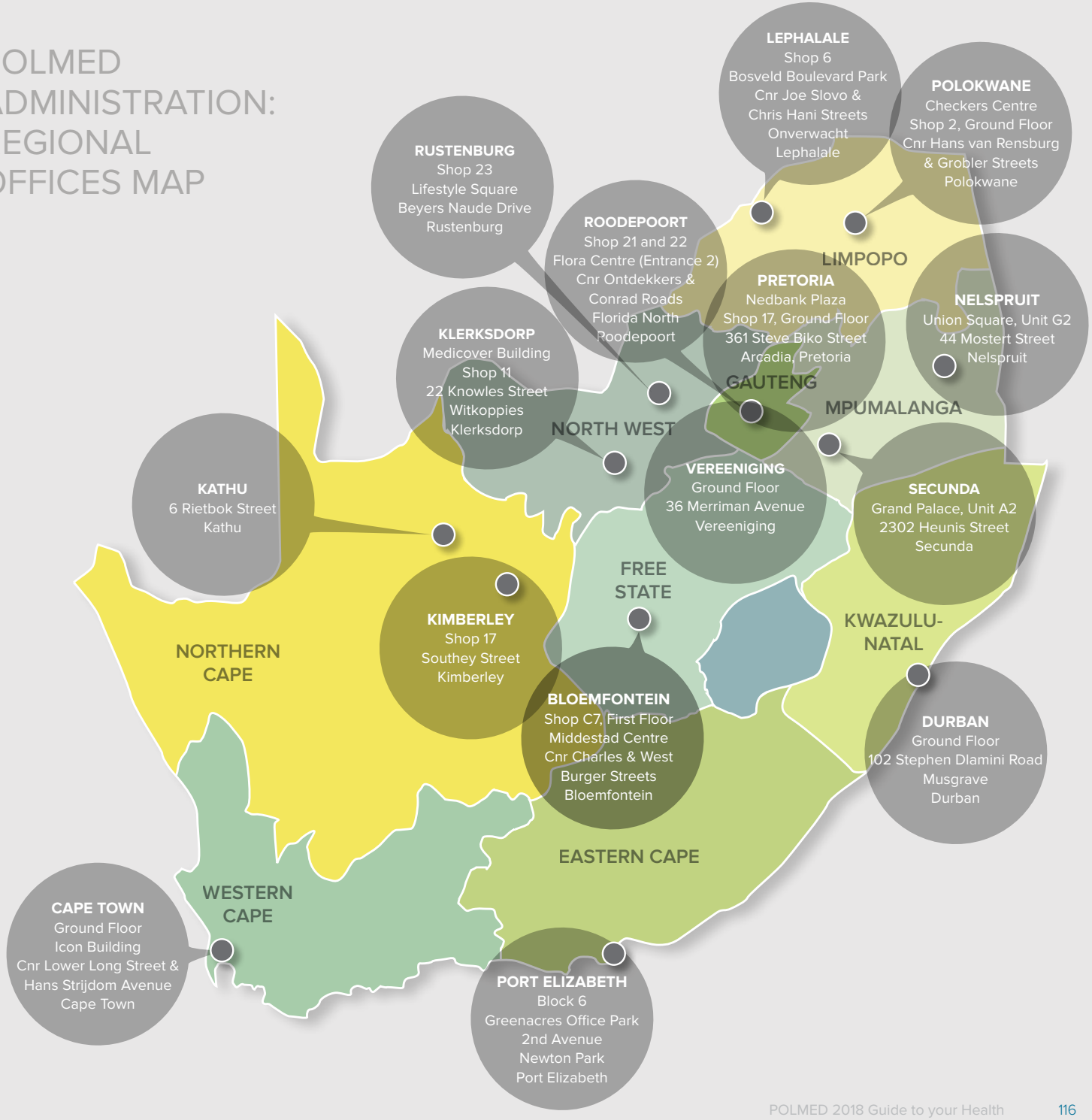
POLMED website

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.

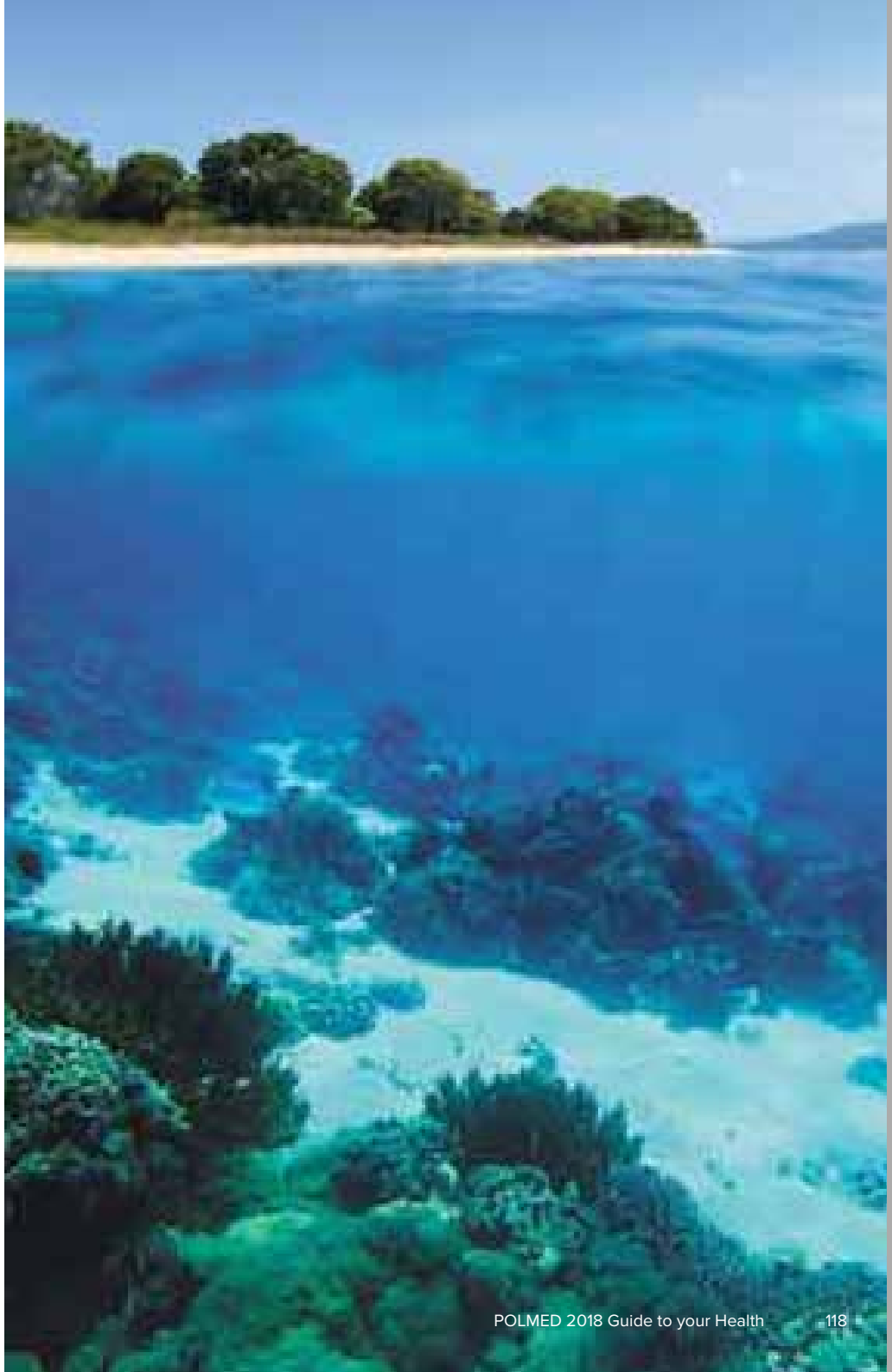
POLMED ADMINISTRATION: REGIONAL OFFICES MAP



ADDITIONAL SERVICE POINTS

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

AREA	ADDRESS
Durban central	SAPS – Durban central, 255 Stalwart Simelane Street, Marine Parade, Durban
King Williams Town	SAPS – King Williams Town, Buffalo Road, Zwelitsha
Mahikeng	SAPS – Mahikeng, 5 Tillard Street, Mahikeng
Mthatha	SAPS – Mthatha, R61 Sutherland Street, Mthatha
Pietermaritzburg	SAPS – Alexandra Road, 101 Alexandra Road, Scottsville, Pietermaritzburg
Potchefstroom	SAPS – Potchefstroom, 25 OR Tambo Street, Potchefstroom
Pretoria	Wachthuis, 231 Pretorius Street, Pretoria
Ulundi	SAPS – Ulundi, Unit A, Ingulube Street, Ulundi
Winelands (Paarl East)	SAPS – Paarl East, cnr Meacker and Van der Stel Street, Paarl East



DESIGNATED SERVICE PROVIDERS (DSPs)

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)

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

RENAL SERVICE FACILITIES

Fresenius Medical Care

Website: www.freseniusmedicalcare.com

National Renal Care
Tel: 011 726 5206
Website: www.nrc.co.za

RETAIL PHARMACIES

Clicks Pharmacy
Tel: 0860 254 257

MediRite Pharmacy
Tel: 0800 222 617

MANAGED HEALTHCARE CONTACT DETAILS

TEL	FAX	EMAIL	POST
CHRONIC MEDICINE MANAGEMENT PROGRAMME			Private Bag X16 Arcadia 0007
Members: 0860 765 633 **Providers:** 0860 104 111	0860 000 320	polmedcmm@medscheme.co.za	
DISEASE RISK MANAGEMENT (DRM) PROGRAMME			
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HOSPITAL/MRI AND CT SCAN PRE-AUTHORISATION			
Members: 0860 765 633 **Providers:** 0860 104 111	0860 104 114	polmedauths@medscheme.co.za	
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ONCOLOGY MANAGEMENT PROGRAMME			
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PRESCRIBED MINIMUM BENEFITS (PMBs)			
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SPECIALISED DENTISTRY			
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HIV MANAGEMENT PROGRAMME			
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MY CONTACTS

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Hospital

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Other _____

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