POLMED®

OUR INVESTMENT OUR HEALTH OUR FUTURE

2022

BENEFITS & CONTRIBUTION GUIDE


A-Z

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Principal Officer's Foreword

The past two years have been a difficult journey with the deadly COVID-19 virus which caused panic and economic devastation worldwide. With the pandemic impacting millions of livelihoods, and families losing members, Polmed has been at the forefront ensuring that our members receive world-class medical care that included vaccination administration at the SAPS dedicated vaccination sites and NDOH sites, respectively.

Polmed vaccination drive

As of Wednesday, 31 October 2021, we have managed to vaccinate 146 033 members thus far. A total of 111 059 SAPS employees have been vaccinated, which constitutes 59% of the SAPS workforce. Considering that herd immunity is reached at 67%, Polmed is well on track and doing everything in its power to achieve this number. We continue to make treatment methods available and create ongoing awareness through organised media campaigns and wellness events.

In July 2021, we were faced with a great challenge in the supply chain of vaccines to KZN, due to the civil unrest in the province. However, once calm was restored, the Health Department managed to get the delivery process of vaccines back to normal and we were back on track with getting our members vaccinated.

I encourage all members and dependants who have not yet been vaccinated to get vaccinated as soon as possible to protect themselves, their loved ones, and the people with whom they meet. Once fully vaccinated, you will still need to wear a mask, maintain social distancing, wash your hands regularly and take other relevant safety precautions. Adhering to these standard safety measures will help slow down the infection rate until we've achieved herd immunity.

Injury-on-Duty (IOD)

I urge that every injury sustained or a disease contracted whilst on duty, should be reported to the employer (SAPS) as soon as possible. If a member is unable to register an IOD, a colleague must do so on behalf of the member in order to ensure that these claims are swiftly and correctly processed. Polmed is not held financially liable for the treatment of injuries sustained whilst on duty.

Multivitamins

The Board of Trustees approved a five-month supply of multivitamins to 180 000 of our members who were categorised as high risk. Payment for these vitamins came from the members' overall hospital risk benefit, and not their acute day-to-day benefits.

Quadruple burden of diseases

As a member of Polmed, you have access to preventative care benefits which encourage members to live healthier lives. Included in the benefit are blood pressure, diabetes and cholesterol tests. I am delighted to report that for 2022, Polmed will also be introducing a weight loss programme as well as a smoking cessation programme to further help members achieve a healthier lifestyle.

As the plan selection cycle for 2022 is about to commence, members are strongly advised to look at this *2022 Benefits and Contribution Guide* to ensure that they select a plan that best addresses their healthcare needs and that of their dependants. Members are reminded that benefit selections must be concluded before 31 December. Choosing the right plan for yourself and your family is an important decision you must make, and it ought to receive your full attention and consideration.

Wellness events

All registered Polmed beneficiaries qualify to participate at wellness events. This includes continuation members (pensioners, widows and orphans). Look out for a wellness event in your area, as prevention is always better than cure.

Network Service Providers

The following networks will be implemented from 1 January 2022:

- Dental network (during the course of 2022)
- GP and Specialist network
- Mental health network
- Oncology network
- Optical benefit management network
- Open network for emergency medical services
- Open network for oncology management
- Pharmacy network
- Renal dialysis network
- Two Anchor Hospital networks for the Aquarium plan and an open network for Marine plan members.

*Subject to CMS approval

Polmed's aim is to move away from restricted networks to open networks, so that any service provider who agrees to the Polmed tariffs and services can be included in the network.

I wish you all the best for 2022. Let's remember that the COVID-19 pandemic is not over yet, and that we must therefore continue to be vigilant to protect ourselves and our loved ones against this deadly enemy.

May all Polmed members experience good health in the year to come.

Ms Neo Khauoe
PRINCIPAL OFFICER

CONTACT DETAILS AND REGIONAL OFFICES

TEL: 0860 765 633 or 0860 POLMED
WHATSAPP: +27 60 070 2547

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

ROODEPOORT WALK-IN BRANCH

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

POSTAL ADDRESS FOR CLAIMS, MEMBERSHIP AND CONTRIBUTIONS

Polmed
Private Bag X16
Arcadia
0007

EMAIL ADDRESS FOR SUBMITTING ENQUIRIES

polmed@medscheme.co.za

REGIONAL WALK-IN BRANCHES

Refer to the map

POLMED FRAUD HOTLINE

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

POLMED WEBSITE

www.polmed.co.za

POLMED CHAT

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

Via Polmed website: Login to the Member Zone via your computer and click on the Polmed Chat widget/icon

REGIONAL OFFICES

LEPHALALE
Shop 6, Bosveld Boulevard Park,
Cnr Joe Slovo and Chris Hani Streets,
Onverwacht, Lephalale

ROODEPOORT
Shop 21 and 22, Flora Centre (Entrance 2),
Cnr Ontdekkers and Conrad Road,
Florida North, Roodepoort

RUSTENBURG
Shop 23, Lifestyle Square, Beyers Naude
Drive, Rustenburg

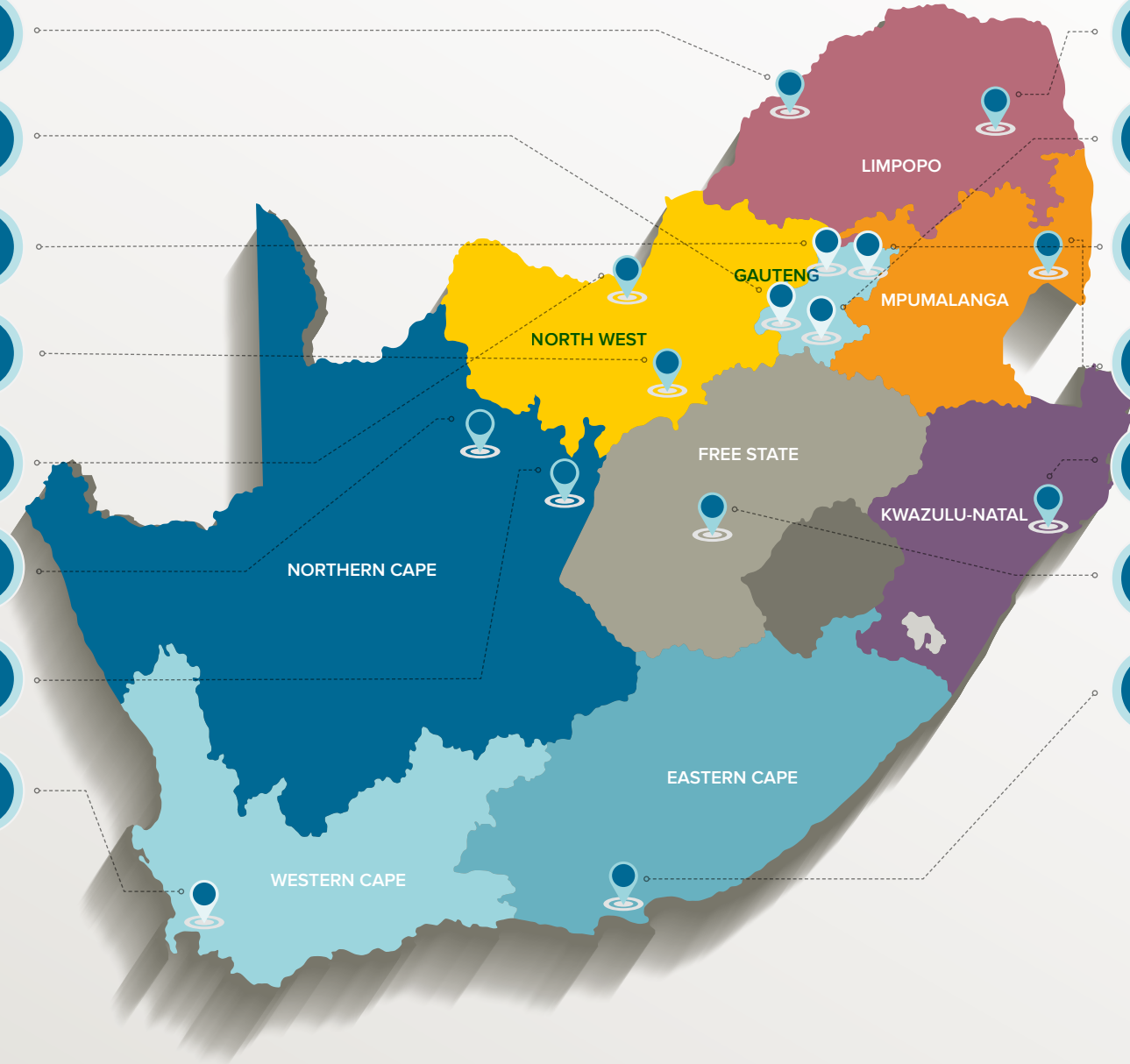
KLERKSDORP
Medicover Building, Shop 11, 22 Knowles
Street, Witkoppies, Klerksdorp

MAHIKENG
Mega City, Shop 118, Ground Floor,
East Gallery, Mahikeng

KATHU
Shop 18D Kameeldoring Plein Building,
Cnr Frikkie Meyer and Rooisand Road

KIMBERLEY
Shop 76, North Cape Mall, Royldene,
Kimberley

CAPE TOWN
Shop 6, 9 Longstreet, Cnr Long and
Waterkant Street, Cape Town



POLOKWANE
Checkers Centre, Shop 2, Ground Floor, Cnr
Hans van Rensburg and Grobler Streets,
Polokwane

VEREENIGING
Ground Floor, 36 Merriman Avenue,
Vereeniging

PRETORIA
Nedbank Plaza, Shop 17, Ground Floor, 361
Steve Biko Street, Arcadia, Pretoria

NELSPRUIT
Shop 11, City Centre Mall, Cnr Andrews Street
and Madiba Drive, Nelspruit

DURBAN
Ground Floor, 102 Stephen Dlamini Road,
Musgrave, Durban

BLOEMFONTEIN
Medical Suites 4 and 5, Middestad Medical
Suites, First Floor, Middestad Centre, Cnr Charles
and West Burger Streets, Bloemfontein

PORT ELIZABETH
Block 6, Greenacres Office Park, 2nd Avenue,
Newton Park, Port Elizabeth

ADDITIONAL SERVICE POINTS

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

Any new offices/service points will be communicated.

AREA	ADDRESS
Durban Central	SAPS – Durban Central, 255 Stalwart Simelane Street, Marine Parade, Durban
King William's Town	SAPS – King William's Town, Buffalo Road, Zwelitsha
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

POLMED®
OUR INVESTMENT OUR HEALTH OUR FUTURE

MANAGED HEALTHCARE CONTACT DETAILS

POSTAL ADDRESS
Polmed
Private Bag X16
Arcadia
0007

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

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

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

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

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

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

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

SPECIALISED DENTISTRY
TEL: 0860 765 633
FAX: 0860 104 114
EMAIL: dental.polmeddental@medscheme.co.za

IN-HOSPITAL DENTAL PROCEDURES AND SEDATION PRE-AUTHORISATION
EMAIL: polmedauths@medscheme.co.za

OUT-OF-HOSPITAL SPECIALISED DENTISTRY
EMAIL: dental.polmeddental@medscheme.co.za

HIV MANAGEMENT PROGRAMME
TEL: 0860 100 646
FAX: 0800 600 773
EMAIL: polmedhiv@medscheme.co.za
POSTAL ADDRESS: PO Box 38597
Pinelands
7430

NETWORK SERVICE PROVIDERS

To bring our members excellent medical care and price certainty, Polmed will implement several Service Provider Networks in 2022.

These Service Provider Networks can be viewed on **www.polmed.co.za**

EMERGENCY MEDICAL CARE ER24

084 124

PPN
The Optical Network Of Choice

PPN Call Centre:
0861 103 529

WHY POLMED

Polmed is a closed medical scheme that is tailored specifically for the South African Police Service (SAPS) and their dependants. This gives Polmed vital understanding and insights into your specific needs, and the ability to offer you a medical scheme that gives you what you need, when you need it.

SCHEME OVERVIEW

Polmed is registered in terms of the Medical Schemes Act 131 of 1998 and Polmed rules and benefits are approved by the Council for Medical Schemes. We don't pursue profits or try to accumulate reserves at the expense of our members. We are managed by a Board of Trustees, which prioritises the interests of our members and the Scheme's sustainability.

Half of the Trustees are elected by members, whilst half are designated by the National Police Commissioner. Our unique approach to healthcare is underpinned by the ability to support SAPS with health solutions that have a measurable impact on the health of members and, by extension, the health of the organisation.

OUR VISION AND MISSION

Vision:
"Healthy members for a safer South Africa."

Mission:
"To enable quality healthcare for SAPS members and their beneficiaries in a cost-effective manner."

YOUR GUARANTEE

As a member of Polmed, you have access to Prescribed Minimum Benefits (PMBs). PMBs are a set of defined benefits put in place to ensure that all beneficiaries have access to certain minimum healthcare services, regardless of the benefit option they have selected.

These 270 PMBs cover the most common conditions, ranging from fractured bones to various cancers, menopause management, cardiac treatment and medical emergencies. Some of them are life-threatening conditions for which cost-effective treatment would sustain and improve the member's quality of life.

PMB diagnosis, treatment and care is not limited to hospitals. Treatment can be received wherever it is most appropriate – in a clinic, an outpatient setting or even at home.

The access to diagnosis, medical or surgical management and treatment of these conditions is not limited and is paid according to specific protocols per condition.

If your doctor has diagnosed you with a chronic PMB condition, the doctor or the pharmacist needs to call us to verify if you meet the Scheme's clinical entry criteria. If you do, your chronic condition will be registered with the Scheme so that your medicine and disease management will be funded from the correct benefit category and not from your day-to-day benefits.

In addition to the 270 PMBs, you are also guaranteed treatment and medication for 26 chronic conditions. Members with these chronic conditions will need to visit their healthcare practitioner and may have to register the condition on a specialised chronic disease management programme. Some disease management programmes are obtained from a Network Service Provider. Once registered, members will be entitled to treatment, including medication according to treatment protocols and reference pricing.

POLMED WEBSITE

As this Benefit Guide is a summary of the registered Scheme Rules only, in some instances, we will refer you to the Scheme's website **www.polmed.co.za** for more information. The Scheme's website offers you a public and a member-only login area.

The public area contains:

- The full set of registered Scheme Rules;
- Information on how your Scheme works;
- Detailed information on our two plans;
- The Info Centre, containing an archive for newsletters, member communication, announcements, Polmed Rules etc. and
- All contact details and more.

You can do the following in the member login area once registered:

- View all past interactions with the Scheme;
- Upload and track your claims;
- Check your chronic benefits;
- See your hospital authorisations and events;
- Update your personal details (including your banking details);
- Change your communication preferences;
- Check your available benefits;
- Search for network providers and accredited network facilities; and
- Access the library including all forms and information about procedures and medical scheme topics, and more.

We encourage you to register on the Scheme's website and to make use of these administrative benefits.

CHOOSE THE RIGHT PLAN FOR YOU AND YOUR FAMILY

Choosing the medical aid plan that fits your needs can be tricky. Make things simpler by following these steps.

1. Analyse your family's health needs

Completing a quick personal healthcare needs analysis will help you determine what level of cover you need. If you're going to have dependants on your plan, you'll need to check that their needs are covered too. Consider how much you and your dependants have spent on medical expenses for the last year to help guide you.

Ask yourself:

- How often do you and your dependants visit the doctor?
- Do you and/or your dependants require medicine often?
- Do you and/or your dependants need to visit a specialist?
- Do you and/or your dependants need extra cover for cancer, renal dialysis, HIV, or any other condition?

2. Establish how much cover you may require

If you find that you hardly claim or have had a few medical expenses, then you may need a lower level of cover. If, however, you have had a large number of medical expenses, then you will require a higher level of cover.

3. Establish what you are able to pay towards contributions

Affordability assessment is important to ensure that you are able to continue paying your contribution without interruption.

OVERVIEW OF PLANS

BENEFITS	MARINE	AQUARIUM	CO-PAYMENTS AND COMMENTS
In-hospital benefits			
PMB hospital cover	Unlimited	Unlimited	• Subject to Polmed network on the Aquarium option • **R15 000** co-payment for admission in a non-network hospital on the Aquarium option • Negotiated network tariff • Subject to pre-authorisation • Subject to **R5 000** penalty where pre-authorisation was not obtained • Subject to managed care protocols and guidelines
Non-PMB hospital cover	Unlimited	R200 000	• **R15 000** co-payment for admission in a non-network hospital on the Aquarium option • Negotiated network tariff • Subject to pre-authorisation • Subject to **R5 000** penalty where pre-authorisation was not obtained • Subject to managed care protocols and guidelines
Anaethetist's Rate	150%	150%	
Chronic renal dialysis	Yes	Yes	• 100% agreed tariff • Subject to pre-authorisation • Subject to network • Subject to 30% co-payment when using a non-network provider
Dentistry (conservative and restorative)	Yes	Yes	• 100% Polmed rate • Subject to out-of-hospital (OOH) • Subject to dentistry sublimit • Hospital and anaesthetist costs will be reimbursed from in-hospital benefits
Emergency medical services	Yes	Yes	• Subject to authorisation within 72 hours following the incident or next day post emergency • Authorisation required for inter-hospital transfers before the event • Subject to 40% co-payment when using a non-network provider
General practitioners	Yes	Yes	• 100% of agreed tariff at network provider • 100% of Polmed rate at non-network provider
Medication (specialised drug limit) e.g. biologicals	Yes	Yes	• 100% of Polmed rate • Subject to pre-authorisation • Subject to listed sublimit
Mental health	Yes	Yes	• 100% of Polmed rate • Annual limit of 21 days in-hospital or 15 out-of-hospital sessions per beneficiary • Limited to a maximum of three day's hospitalisation if admitted by a GP or a specialist physician • Additional hospitalisation subject to motivation by the medical practitioner

BENEFITS	MARINE	AQUARIUM	CO-PAYMENTS AND COMMENTS
Oncology (chemotherapy and radiotherapy)	Yes	Yes	• 100% if agreed tariff at network provider • Subject to set limit and includes MRI/CT or PET scans • Subject to oncology formulary
Organ and tissue transplants	Yes	Yes	• 100% of agreed tariff at network provider • Subject to clinical guidelines
Pathology	Yes	Yes	Service linked to hospital pre-authorisation
Physiotherapy and dieticians	Yes	Yes	Service linked to hospital pre-authorisation. Referral required for in-hospital physiotherapy sessions
Prosthesis (internal and external)	Yes	Yes	• 100% Polmed rate • Subject to pre-authorisation • Subject to approved product list • Subject to overall prosthesis benefit limit • Subject to specific prosthesis sublimit
Radiographers	Yes	Yes	• Referral by the treating healthcare professional is required for services rendered
Refractive surgery	Yes	No benefit	• 100% Polmed rate • Subject to pre-authorisation • Procedure performed out-of-hospital and in day clinics
Social workers and registered counsellors	Yes	Yes	• A referral by the treating healthcare professional is required for services rendered. Number of consultations limited to 4 sessions in a benefit cycle
Specialists	Yes	Yes	• 100% agreed tariff at network provider • 100% Polmed rate at non-network provider

BENEFITS	MARINE	AQUARIUM	CO-PAYMENTS AND COMMENTS
Overall out-of-hospital (OOH) benefits			
Annual OOH benefits	Yes	Yes	• Subject to OOH limit, protocols and guidelines
Audiology	Yes	Yes	• Subject to OOH limit and referral
Conservative and restorative dentistry	Yes	Yes	• Subject to OOH limit and includes dentist costs for in-hospital, non-PMB procedures • Routine consultation, scaling and polishing limited to two annual check-ups per beneficiary • Oral hygiene instructions are limited to once in 12 months per beneficiary
General practitioners	Yes	Yes	• 100% agreed tariff at Network • Subject to OOH limit • Subject to listed number of consultations per family per annum • Subject to network and/or nominated general practitioner (GP)
Medication (acute)	Yes	Yes	• 100% Polmed rate at Network • Subject to the OOH limit • Subject to Polmed Formulary reference price • Subject to 20% co-payment for non-network utilisation
Medication (over-the-counter (OTC))	Yes	Yes	• 100% of Polmed rate at Network • Subject to annual sublimit • Subject to OOH limit • Subject to Polmed Formulary • Subject to 20% co-payment for non-network utilisation
Occupational and speech therapy	Yes	PMB only	• 100% Polmed rate • Subject to OOH limit • Subject to annual sublimit
Pathology	Yes	Yes	• Subject to OOH • Subject to annual pathology sublimit
Physiotherapy	Yes	Yes	• 100% of Polmed rate • Subject to OOH limit • Subject to annual physiotherapy sublimit
Psychology plus social worker	Yes	Yes	• 100% of Polmed rate • Subject to OOH limit • Subject to psychology plus social worker sublimit
Specialists	Yes	Yes	• 100% of Polmed rate at network provider • Subject to OOH limit • Subject to maximum listed number of visits/consultations per beneficiary and per family per annum • Subject to GP referral to network listed specialists • Subject to 30% co-payment if no referral is obtained where applicable

BENEFITS	MARINE	AQUARIUM	CO-PAYMENTS AND COMMENTS
Allied health services and alternative healthcare providers: biokinetics, chiropractors, chiropodists, dieticians, homeopath, naturopaths, orthoptists, osteopaths, podiatrists, reflexologists and therapeutic massage therapists	Yes	No benefit	• 100% Polmed rate • Subject to annual limit • Subject to clinical appropriateness
Appliances (medical and surgical)	Yes	Yes	• 100% Polmed rate • Subject to listed limit • Subject to referral • Subject to pre-authorisation • Subject to applicable clinical protocols and guidelines • Subject to quotations
Chronic medications	Yes	PMB only	• 100% of Polmed rate at network provider • 20% co-payment at non-network provider • Subject to formulary reference price • Subject to prior application and registration of chronic condition • PMB-CDL conditions are not subjected to limit • Extended list of chronic conditions (non-PMB) subject to listed chronic medications limit
Specialised dentistry	Yes	PMB only	• 100% Polmed rate • Subject to pre-authorisation • Subject to annual family limit • Subject to dental protocols • Subject to 5-year cycle for crown and bridges • Includes specialised dental procedures done in- and out-of-hospital • Includes metal-based dentures • Aquarium plan only PMB benefits
Maternity benefits (including home birth):	Yes	Yes	• Subject to pre-authorisation • Subject to treatment and clinical protocols and guidelines
Ultrasound scans	Yes	Yes	• Subject to listed limit • Pre-authorisation applies for extra ultrasound after 32 weeks of pregnancy

BENEFITS	MARINE	AQUARIUM	CO-PAYMENTS AND COMMENTS
Caesarean sections	Yes	Yes	• Subject to PMB • Subject to pre-authorisations • Considered in line with managed care and funding protocols • A co-payment of **R10 000** will apply for voluntary Caesarean sections
Maxillofacial	Yes	No benefit	• Subject to pre-authorisations • Shared limit with specialised dentistry
Optical	Yes	Yes	• Subject to listed limit • Each beneficiary is entitled to either spectacles or contact lenses • Subject to 24-month benefit cycle • No prorating, benefits will be calculated from benefit service date
Basic radiology	Yes	Yes	• 100% of agreed tariff • Subject to basic radiology family limit • Includes basic radiology in- and out-of-hospital • Claims for PMB first accrue towards the limit
Specialised radiology	Yes	Yes	• 100% of agreed tariff • Subject to pre-authorisation • Includes specialised radiology in- and out-of-hospital • Claims for PMB first accrue towards the limit • PMB rules apply

GENERAL GUIDELINES

How to call an ambulance

Phone ER24 on 084 124 and the emergency consultant will assist and arrange an ambulance for the patient and provide you with the authorisation.

For all accredited emergency service providers, members are required to obtain pre-authorisation for emergency medical services from the appointed service provider within 72 hours of the incident.

A 40% co-payment shall apply for unauthorised EMS services.

The service provider will be required to provide the hospital casualty and/or admission sticker, together with the patient report, when submitting an invoice to Polmed.

Hospital pre-authorisation

Authorisation is required for procedures, treatment, and hospitalisation before the event, as indicated in the benefit table, to ensure that benefits are available and correctly paid. Authorisation must be obtained by the member or dependant by calling 0860 765 633 or by your admitting doctor by calling 0860 104 111.

In case of emergency, the member, dependant or hospital should contact Polmed within 24 hours of the event or on the next business day following the event. If you do not obtain authorisation you will be liable for a co-payment of **R5 000** as stated in the benefit table.

Information required when calling for authorisation:

- Membership number
- Date of admission or procedure
- Name of patient
- Name of hospital
- Type of procedure or operation, diagnosis with CPT code and the ICD-10 code (obtainable from the doctor)
- Name of the admitting doctor or service provider and the practice number

Registration on Disease Management Programmes

Polmed has the following disease management programmes for which members and/or dependants are required to register in order to receive enhanced benefits:

- Disease Risk Management Programme for the following conditions;
  - 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 spinal conditions
  - Mental Health: Depression, Bipolar Mood Disorder, Post Traumatic Stress Disorder (PTSD) and Substance Abuse
- Maternity Programme
- Oncology Management Programme
- HIV Management Programme
- Specialised Dentistry

Chronic medicine

Chronic medicines are subject to a pharmacy network and a co-payment of 20% of costs applies for using a non-network provider.

Chronic medication benefits are subject to registration on the Chronic Medicine Management Programme. If you are diagnosed with a chronic condition (PMB or non-PMB), ask your doctor or pharmacist to register the chronic condition by calling 0860 104 111.

Chronic medicines are subject to the Polmed Formulary and generic reference pricing and the products outside the formulary may attract a 20% co-payment. Polmed will then pay for your medicine from the relevant chronic medicine benefit and not from your acute benefits.

Payment will be restricted to one month's supply.

Chronic medicines advanced supply

For an advanced supply of chronic medicine, please submit:

- A copy of your ticket and/or itinerary
- A prescription covering the period

The Scheme will only approve advanced supplies within the current benefit year. Call 0860 104 111 for further assistance.

Acute medicines

Acute medicines are subject to a pharmacy network and a co-payment of 20% of costs applies for using a non-network service provider.

Acute medicines are subject to the Polmed Formulary and generic reference pricing and the products outside the formulary may attract a 20% co-payment.

Payment will be restricted to one month's supply.

POLMED NETWORK SERVICE PROVIDERS

CATEGORY	NETWORK SERVICE PROVIDER	REMARKS
General practitioners (GP)	GP Network	Over 3 901 GPs are on the GP network
Hospital	**Acute Hospital Network for Aquarium plan members:** • Netcare and Life Healthcare with filler hospitals **Mental Health Network for Aquarium plan members:** • Life Healthcare and NHN with filler hospitals **Marine plan has an open network consisting of:** • All Clinix Hospitals • All Life Healthcare Hospitals • All Intercare Day Clinics and Sub-acute facilities • All Mediclinic Hospitals • All National Hospital Network (NHN) • All Joint Medical Holdings (JMH)	
Pharmacies	Pharmacy network	Over 2 443 pharmacies on the network, which is made up of community pharmacies, retail pharmacies and courier pharmacies
Renal network	Renal Dialysis Network	Open network with a national footprint
Oncology	Polmed Oncology Network	All accredited network oncology centres
Specialist network	All speciality disciplines	Over 3 500 specialists are on our specialist network
Optical network	Preferred Provider Negotiators (PPN)	All PPN accredited optometrists
Emergency medical services	ER24 Call Centre	An accredited emergency service provider will be sent to attend to your medical emergency
Midwife-led Care Network (midwife network)	Midwife-led Care Network	• 30% co-payment for using a non-network provider • Exception rules will apply

"HEALTHY MEMBERS FOR A SAFER SOUTH AFRICA"

PREVENTATIVE CARE BENEFITS

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 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
FULL MEDICAL EXAMINATION	
One wellness measure per year (tariff code 5550) 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 immunisations (as per the DOH guidelines) • Bone densitometry scan for members 65 years and older (once per lifetime) • Circumcision • Contraceptives (as per the DOH guidelines) • Dental screening (codes 8101, 8151 and 8102) • Flu vaccine • Glaucoma screening • HIV tests • HPV screening once every five years for females aged 21 years and older • HPV vaccine for girls aged 10-17 years • Mammogram • Pap smear • Pneumococcal vaccine • Prostate screening • Psycho-social services • Waist-to-hip ratio measurement Clinical information to be submitted to managed healthcare	Annually 100% of Polmed rate or agreed tariff where applicable Early detection screening limited to periods specified Possible indication of peptic ulcers: Members over the age of 50 years Funded from the risk pool; the benefit shall not accrue to the overall out-of-hospital limit
CHILDREN'S HEALTH	
All children's immunisations provided by the Department of Health (DOH) for children twelve (12) years and younger	As per DOH age schedule as per the Road to Health chart

FEMALE HEALTH (women and adolescent girls)	
Cervical cancer screening ICD: Z12.4 For all females aged 21-64 years old, except for those women who have had a complete hysterectomy without a residual cervix Human papilloma virus (HPV) vaccination for girls aged 10-17 years HPV screening	PAP smear test once every third year Total of two HPV vaccinations are funded Once every five years for females aged 21 years and older
Breast cancer screening ICD: Z12.3 and ICD: Z01.6 Mammogram: all women aged 40-69 years old	Once every two years, unless motivated
Contraceptives ICD: Z30	As recommended by NDOH
DENTAL HEALTH	
Consultation and topical fluoride application for children aged 0-6 years	Annually
Topical fluoride application for children aged 7-16 years	Annually
Caries risk assessment for children aged 0-14 years (Clinical information to be submitted to managed care)	Once every second year
Periodontal disease and caries risk assessment for adults 19 years of age and older (Clinical information to be submitted to managed care)	Once every second year
HIV COUNSELLING AND TESTING	
HIV counselling and pre-counselling	Annually
HCT consultation, rapid testing and post counselling	Annually
HIV testing Elisa: 3932 Confirmation test: Western Blot (payable after HCT or ELISA tests)	Annually
OTHER	
Flu vaccine	Annually
Hib titer for 60 years and older (Serology: IgM: specific antibody titer)	Annually
Prostate cancer screening For all males aged between 50 and 75 years	Annually

Glaucoma screening	Once every third year, unless motivated
Circumcision	Subject to clinical protocols
Post-trauma debriefing session Only for active principal members of SAPS, utilising the Psycho-Social Network	Four individual sessions or four group debriefing sessions per year
Weight Management Programme: 12-week exercise programme provided by BASA (Biokineticist Association of South Africa) It includes an HRA (health risk assessment), group or individual exercise sessions, and dietician and psychologist consultations	100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or Scheme Tariff One enrolment per beneficiary per annum subject to clinical protocols A separate basket to be funded from Risk
GoSmoke Free Programme is delivered by a trained nurse through HealthCraft accredited pharmacies The approach includes motivational behavioural change, clinical measures (carbon monoxide readings), follow-ups to manage relapse rates, etc	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme Tariff One enrolment per beneficiary per annum Funded from Risk as part of the Preventative healthcare benefit Nicotine Replacement Therapy to be funded from acute benefit for members enrolled on the programme

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.

POLMED PLAN:
MARINE

SCHEDULE

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2022

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

REFERENCE IN THIS ANNEXURE AND THE FOLLOWING ANNEXURES TO THE TERM:

'Polmed rate' shall mean: 2006 National Health Reference Price List (NHRPL) adjusted on annual basis with Consumer Price Index (CPI).

'Agreed tariff' shall mean: The rate negotiated by and on behalf of the Scheme with one or more providers/groups.

BENEFITS FOR THE SERVICES OUTSIDE THE REPUBLIC OF SOUTH AFRICA (RSA)

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

GENERAL RULES

APPLICATION OF CLINICAL PROTOCOLS AND FUNDING GUIDELINES

Polmed applies clinical protocols, including "best practice guidelines" as well as evidence-based medicine 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, or specialised dentistry, 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.

NETWORK SERVICE PROVIDER: OUT-OF-NETWORK RULE

Polmed has appointed healthcare providers (or a group of providers) as network service providers for diagnosis, treatment and care in respect of one or more Prescribed Minimum Benefit (PMB) conditions. Where the Scheme has appointed a network service provider and the member voluntarily chooses to use an out-of-network provider, a co-payment of up to 30% may be applied, subject to the PMBs.

Co-payments will not be applied in the following scenarios:

- In a medical emergency where the patient does not have a choice to choose the doctor or network facility.
- When the required service cannot be provided by a network doctor or facility.
- When a network provider is not available within a 50km radius from the member's residence.

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

Examples of network service providers (where applicable) are:

- Cancer (oncology) network
- General practitioner (GP) network
- Optometrist (visual) network
- Psycho-social network
- Renal (kidney) network
- Specialist network
- Pharmacy network
- Dental network

POLMED GP NETWORK (NETWORK GP PROVIDER)

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

Polmed rates for network GP provider visits are available on its website and can be accessed at **www.polmed.co.za**. These rates are reviewed annually. The co-payment to out-of-network GP providers will be calculated as being the difference between the Polmed rate for non-network GP providers and the actual rate charged by the out-of-network GP provider.

PMB rules apply for qualifying emergency consultations.

POLMED HOSPITAL NETWORK

The Polmed hospital network includes hospitals with a national footprint. Members can access the list of hospitals in the network at **www.polmed.co.za**, on their cell phones via the mobile site, via Polmed Chat or request it via the Client Service Call Centre.
All admissions (hospitals and day clinics) must be pre-authorised.

A penalty of R5 000 may be imposed if no pre-authorisation is obtained.

In case of an emergency, the Scheme must be notified within 48 hours or on the first working day after admission. Pre-authorisation will be managed under the auspices of managed healthcare. The appropriate facility must be used to perform a procedure, based on the clinical requirements, as well as the expertise of the doctor doing the procedure.

Benefits for private or semi-private rooms are excluded unless they are motivated and approved prior to admission upon the basis of clinical need.

Medicine prescribed during hospitalisation forms part of the hospital benefits.

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

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

POLMED PHARMACY NETWORK
Polmed has established an open pharmacy network for the provision of acute, chronic and over-the-counter (OTC) medication. Medicines included in Polmed's Formulary will be funded in full, subject to the availability of funds. Members who voluntarily opt to use non-formulary products, will be liable for a 20% co-payment. Polmed has agreed dispensing fees with the network pharmacies. A 20% co-payment will be levied in the event of voluntary utilisation of an Out-of-network pharmacy.

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

EMERGENCY MEDICAL SERVICES (EMS):
ER24 72-Hour Post-Authorisation Rule Subject to authorisation within 72 hours of the event, all service providers will need to get a notification number from Polmed's network service provider ER24. Co-payment of 40% of the claim shall apply where a member voluntarily uses an unauthorised service provider. Service providers will be required to provide the hospital admission/casualty sticker together with patient report forms when submitting a claim to Polmed's EMS Network Service Provider to validate delivery to a hospital.

DENTAL NETWORK
Polmed makes use of a preferred dental network for its members. By making use of the network, Polmed members will not have any out-of-pocket payments on approved conservative dental treatment up to available limits. Members can access the list of providers at **www.polmed.co.za**, on their cell phones via the mobile site, via Polmed Chat or request it via the Client Services Call Centre.

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

MEDICATION: ACUTE, OVER-THE-COUNTER (OTC) AND CHRONIC
The chronic medication benefit shall be subject to registration on the Chronic Medicine Management Programme for those conditions which are managed, and chronic medication rules will apply.

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

Pre-authorisation is required for items funded from the chronic medication benefit. Pre-authorisation is based on evidence-based medication (EBM) principles and the funding guidelines of the Scheme. Once predefined criteria are met, an authorisation will be granted for the diagnosed conditions. Beneficiaries will have access to a group (formulary) of medication appropriate for the management of their conditions or diseases for which they are registered. There is no need for a beneficiary to apply for a new authorisation if the treatment prescribed by the doctor changes and the medication is included in the condition-specific medication formulary. Updates to the authorisation will be required for newly diagnosed conditions for the beneficiary.

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

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

The 20% co-payment for medication prescribed that is not included in the Polmed Formulary can be waived via an exception management process. This process requires

a motivation from the treating service provider and will be reviewed based on the exceptional needs and clinical merits of each individual case.

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

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

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

SPECIALISED RADIOLOGY (MRI AND CT SCANS)
Pre-authorisation is required for all scans, failing which the Scheme may impose a co-payment of up to R1 000 per procedure. If these scans are not clinically indicated, the entire claim can be rejected. In the case of an emergency, the Scheme must be notified within 48 hours or on the first working day of the treatment of the patient.

SPECIALIST REFERRAL
All Polmed beneficiaries need to be referred to specialists by a general practitioner (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 or disciplines: Gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists [chronic dialysis], dental specialists, pathology, radiology and supplementary or allied health services.

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

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

CONSERVATIVE BACK AND NECK REHABILITATION PROGRAMME
Services associated with Polmed's Conservative Back and Neck Rehabilitation Programme will be funded from Hospital risk. Pre-authorisation is required to access the benefits. Spinal surgery will not be covered unless there is evidence that the patient has received conservative therapy prior to requesting surgery (PMBs apply).

LOYALTY PROGRAMME (QUARTER 2, 2022)
Polmed has introduced a wide-ranging wellness, preventative care and managed care programme which has been specifically shaped to motivate healthy living and/or behaviour change to improve member lifestyle. The gamified program uses strategic nudges to encourage members to improve their personal health score while enjoying innovative loyalty solutions. For more information, you can visit **www.polmed.co.za**.

DEFINITION OF TERMS

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

Other procedures that fall under this category are:
- Consultations
- Fluoride treatment and fissure sealants
- Non-surgical removal of teeth
- Cleaning of teeth, including non-surgical management of gum disease
- 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 more than those agreed upon with the service provider or more than what would be paid according to approved treatments. A co-payment would not be applicable in the event of a life-threatening injury or an emergency.

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

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

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

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

REGISTRATION FOR CHRONIC MEDICATION
Polmed provides for a specific list of chronic conditions that are funded from the chronic medication benefit (i.e. through a benefit that is separate from the acute medication benefit). Polmed requires members to apply for authorisation via the Chronic Medicine Management Programme to access this chronic medication benefit. Members will receive a letter by email or post indicating whether their application was successful or not. If successful, the beneficiary will be issued with a disease-specific authorisation, which will allow them access to medication included in the Polmed Formulary.

Polmed will reimburse medication intended for an approved chronic condition for up to four months from the Acute benefits. Members will be required to register such medication as Chronic during the four-month period.

SPECIALISED DENTISTRY
Specialised dentistry refers to services that are not defined as basic dentistry. These include periodontal surgery, crowns and bridges, inlays, indirect veneers, orthodontic treatment and maxillofacial surgery. All specialised dentistry services and procedures must be pre-authorised, failing which the Scheme will impose a co-payment of R500. Only maxillofacial surgery and specific periodontal surgical procedures will be considered for in-hospital treatment. Authorisation subject to clinical criteria.

GENERAL BENEFIT RULES

Benefit design	This option provides for unlimited hospitalisation paid at the prescribed tariff, as well as for out-of-hospital (day-to-day) benefits This option is intended to provide for the needs of families who have significant healthcare needs
Pre-authorisation, referrals, protocols and management by programmes	Where the benefit is subject to pre-authorisation, referral by a network service provider or general practitioner (GP), adherence to established protocols or enrolment upon a managed care programme, members' attention is drawn to the fact that there may be no benefit at all or a much-reduced benefit if the pre-authorisation, referral by a network service provider or GP, adherence to established protocols or enrolment upon a managed care programme is not complied with (a co-payment may be applied) The pre-authorisation, referral by a network service provider or GP, adherence to established protocols or enrolment upon a managed care programme is stipulated to best care for the member and his/her family and to protect the funds of the Scheme
Limits are per annum	Unless there is a specific indication to the contrary, all benefit amounts and limits are annual
Statutory Prescribed Minimum Benefits (PMBs)	There is no overall annual limit for PMBs or life-threatening emergencies
Tariff	100% of Polmed rate or agreed tariff or at cost for involuntary access to PMBs

IN-HOSPITAL BENEFITS

Annual overall in-hospital limit 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	Unlimited at network service providers Subject to PMBs, i.e. no limit in case of life-threatening emergencies or for PMB conditions or Subject to applicable tariff, i.e. 100% of Polmed rate or Agreed tariff or At cost for involuntary access to PMBs
Anaesthetists	150% of Polmed rate
Chronic renal dialysis At preferred providers	100% of agreed tariff at network service provider Polmed has established a provider network for renal dialysis Members who voluntarily opt to use a non-network provider will be liable for a 30% co-payment (PMBs apply). Pre-authorisation is required for all dialysis services

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, subject to: M0 - R5 215 M1 - R5 997 M2 - R6 779 M3 - R7 561 M4+ - R8 344 The hospital and anaesthetist's costs will be reimbursed from the in-hospital benefit
Emergency medical services (ambulance services)	Subject to Polmed Scheme rules
General practitioners (GPs)	100% of agreed tariff at network service provider 100% of Polmed rate at non-network service provider or At cost for involuntary access to PMBs
Medication (non-PMB specialist drug limit, e.g. biologicals)	100% of Polmed rate Pre-authorisation required Specialised medication sub-limit of R185 022 per family
Mental health	100% of Polmed rate or At cost for PMBs Annual limit of 21 days in-hospital or 15 out-of-hospital sessions per beneficiary Limited to a maximum of three days' hospitalisation for beneficiaries admitted by a GP or a specialist physician Additional hospitalisation to be motivated by the medical practitioner
Oncology (chemotherapy and radiotherapy) Network service provider	100% of agreed tariff at network service provider 30% co-payment for use of non-network provider Limited to R484 799 per beneficiary per annum; includes MRI/CT or PET scans related to oncology Chemotherapy and radiation limited to Oncology benefits, adherence to the Oncology Formulary and subject to medicines from network provider

Organ and tissue transplants	100% of agreed tariff at network service provider 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 and dieticians	Service will be linked to hospital pre-authorisation A referral by the treating Healthcare Professional is required for services rendered
Prosthesis (internal and external)	100% of Polmed rate or At cost for PMBs Subject to pre-authorisation and approved product list **Limited to the overall prosthesis benefit of R68 126 per beneficiary** Knee prosthesis – R56 946 Hip prosthesis – R56 946 Shoulder prosthesis – R67 896 Intraocular lens – R3 285 Aorta & peripheral arterial stent grafts – R49 279 Cardiac stents – R27 925 Cardiac pacemaker – R61 325 Spinal plates and screws – R68 126 Spinal implantable devices – R62 577 Unlisted items – R68126
Radiographers	A referral by the treating Healthcare Professional is required for services rendered
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 network service provider 100% of Polmed rate at non-network service provider or At cost for involuntary access to PMBs

Social workers and registered counsellors	A referral by the treating Healthcare Professional is required for services rendered Number of consultations limited to 4 sessions per benefit cycle

OVERALL OUT-OF-HOSPITAL BENEFITS

Annual overall out-of-hospital (OOH) limit Benefits shall not exceed the amount set out in the table PMBs shall first accrue towards the total benefit, but are not subject to a limit In appropriate cases the limit for medical appliances shall not accrue towards this limit	**Out-of-hospital benefits are subject to:** • Protocols and clinical guidelines • PMBs • The applicable tariff i.e. 100% of Polmed rate or Agreed tariff or **At cost for involuntary access to PMBs** M0 – R20 546 M1 – R25 003 M2 – R30 128 M3 – R34 549 M4+ – R37 492
Audiology	100% of Polmed rate Subject to the OOH limit **Subject to referral by the following doctors/specialists:** General practitioner (GP) Ear, nose and throat (ENT) specialist Paediatrician Physician Neurologist

Dentistry (conservative and restorative)	100% of Polmed rate **Subject to the OOH limit and includes dentist's costs for in-hospital, non-PMB procedures** M0 – R5 215 M1 – R5 997 M2 – R6 779 M3 – R7 561 M4+ – R8 344 Routine consultation, scale and polish are limited to two annual check-ups per beneficiary Oral hygiene instructions are limited to once in 12 months per beneficiary
General practitioners (GPs) Polmed has a GP network	100% of agreed tariff at network service provider or at cost for involuntary access to PMBs The limit for consultations shall accrue towards the OOH limit Subject to maximum number of visits or consultations per family M0 – 11 M1 – 16 M2 – 20 M3 – 24 M4+ – 29
Medication (acute)	100% of Polmed rate at network service provider M0 – R4 795 M1 – R8 152 M2 – R11 509 M3 – R14 866 M4+ – R18 246 Subject to the OOH limit Subject to Polmed Formulary
Medication (over-the-counter - (OTC))	100% of Polmed rate at network service provider Annual limit of R1 262 per family Subject to the OOH limit Subject to Polmed Formulary

Occupational and speech therapy	100% of Polmed rate Annual limit of R2 915 per family Subject to OOH limit
Pathology	M0 – R3 506 M1 – R5 055 M2 – R6 045 M3 – R7 445 M4+ – R9 129 The defined limit per family will apply for any pathology service done out-of-hospital
Physiotherapy	100% of Polmed rate Annual limit of R5 054 per family Subject to the OOH limit
Psychology plus social worker	% of Polmed rate Annual limit of R6 779 per family Subject to the OOH limit
Specialists Referral is not necessary for the following specialists: Gynaecologists Psychiatrists Oncologists Ophthalmologists Nephrologists (dialysis) Dental specialists Supplementary or allied health services	100% of agreed tariff at network service provider or At cost for involuntary access to PMBs The limit for consultations shall accrue towards the OOH limit Limited to 5/five visits per beneficiary or 11/eleven visits per family per annum Subject to referral by a GP (2/two specialist visits per beneficiary without GP referral allowed) R1 000 co-payment if no referral is obtained

STAND-ALONE BENEFITS

Allied health services and alternative healthcare providers Biokineticists, chiropractors, chiropodists, dieticians, homeopaths, naturopaths, orthoptists, osteopaths, podiatrists, reflexologists, therapeutic massage therapists Benefits will be paid for clinically appropriate services	100% of Polmed rate Annual limit of R2 851 per family

Appliances (medical and surgical) Members must be referred for audiology services for hearing aids to be reimbursed Pre-authorisation is required for the listed medical appliances All costs for maintenance are a Scheme exclusion Funding will be based on applicable clinical and funding protocols Quotations will be required	100% of Polmed rate	
	Hearing aids	R14 751 per hearing aid OR R29 320 per beneficiary per set Once every 3/three years
	Nebuliser	R1 399 per family Once every 4/four years
	Glucometer	R1 399 per family Once every 4/four years
	CPAP machine	R9 848 per family Once every 4/four years
	Wheelchair (non-motorised) OR Wheelchair (motorised)	R16 387 per beneficiary Once every 3/three years R55 082 per beneficiary Every 3/three years
	Medical assistive devices	Annual limit of R3 506 per family includes medical devices in-/out-of-hospital
	Consumables associated with implanted devices: • Cardiac resynchronisation therapy pacemaker battery replacement • Implantable cardiac defibrillator battery replacement	 Every 5/five years Every 5/five years
	Cochlear Implant • Cochlear implants – Unilateral subject to clinical and funding protocols • Cochlear implants – Bilateral subject to clinical and funding protocols • Cochlear implants - Maintenance or replacement of processors Subject to clinical and funding protocols	 R156 000 per beneficiary per lifetime R300 000 per beneficiary per lifetime R130 000 per beneficiary every 5 years
	Trans aortic valve insertion	R276 382 per family per year
	Implantable cardiac defibrillators	R198 161 per family per year

	Insulin delivery devices • Insulin pump device (limited to Type 1 diabetic members) • Insulin pump consumables • Continuous glucose monitoring (CGM) device • Continuous glucose monitoring (CGM) consumables	R53 681 per beneficiary per year, One device every 5/five years R21 000 per beneficiary per year R28 067 per beneficiary per year, One device every 5/five years R27 300 per beneficiary per year
	Urine catheters and consumables	Subject to three quotations and clinical protocols
	Blood transfusion	Unlimited
	Adult nappies	R1 035/month (2/two nappies per day) R1 555/month (3/three nappies per day)
Chronic medication refers to non-PMB conditions Subject to prior application and/or registration of the condition Approved PMB-CDL conditions are not subject to a limit The extended list of chronic conditions (non-PMBs) are subject to a limit	100% of medication formulary reference price **Subject to access at network service provider** M0 - R10 176 M1 - R12 197 M2 - R14 220 M3 - R16 242 M4+ - R18 264	
Dentistry (specialised) Pre-authorisation required	100% of Polmed rate or at cost for PMBs An annual limit of R14 816 per family Benefits shall not exceed the set-out limit Includes any specialised dental procedures done in-/out-of-hospital Includes metal-based dentures Excludes osseo integrated implants Subject to dental protocols (crowns and bridges 5-year cycle)	
Maternity benefits (including home birth) Pre-authorisation required Treatment protocols apply	The limit for consultations shall not accrue towards the OOH limit The benefit shall include three specialist consultations per beneficiary per pregnancy Home birth is limited to R18 428 per beneficiary per annum Annual limit of R4 981 for ultrasound scans per beneficiary; limited to 2/two 2D scans per pregnancy Benefits relating to more than 2/two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation Elective (voluntary) Caesarean sections will, subject to the PMBs, be considered in line with managed care and funding protocols. A co-payment of R10 000 will apply in all voluntary Caesarean sections (PMBs apply) except in cases where the cost of the voluntary Caesarean section falls below the applicable co-payment amount of R 10 000 Pre-authorisation is required	

Maxillofacial Pre-authorisation required	Shared limit with specialised dentistry Excludes osseo integrated implants
Optical Benefit cycle - In accordance with the below benefit sublimits, each beneficiary is entitled to either spectacles or contact lenses every 24 months from date of claiming Includes frames, lenses and eye examinations The eye examination is per beneficiary every two years (unless prior approval for clinical indication has been obtained) Benefits are not pro rata, but calculated from the benefit service date Each claim for lenses or frames must be submitted with the lens prescription	Provider Network 100% of cost for a Composite consultation, inclusive of the refraction, a glaucoma screening and visual field screening and Authenticate IT. Composite consultation fee is R668 **WITH EITHER SPECTACLES** R1 326 towards a frame and/or lens enhancement **LENSES** Either one pair of clear single vision lenses limited to R214 per lens **or** One pair of clear flat top bifocal lenses limited to R454 per lens **or** One pair of clear base multifocal lenses limited to R785 **OR CONTACT LENSES** Contact lenses to the value of R1 628 per beneficiary per annum Contact lens re-examination to a maximum cost of R250 per consultation
Optical (continued) Benefits shall not be granted for contact lenses if the beneficiary has already received a pair of spectacles in a two-year benefit cycle Contact lens re-examination can be claimed for in six-monthly intervals	**Non-Provider Network** One consultation limited to a maximum cost of R357 **WITH EITHER SPECTACLES** R995 towards a frame and/or lens enhancement Single vision lenses limited to R214 per lens **or** Bifocal lenses limited to R454 per lens **or** One pair of clear base multifocal lenses limited to R785 **OR CONTACT LENSES** Contact lenses to the value of R1 122 per beneficiary per year Contact lens re-examination to maximum cost of R250 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 R6 663 per family Includes any basic radiology done in- or out-of-hospital Claims for PMBs first accrue towards the limit
Radiology (specialised) Pre-authorisation required One (1) MRI scan Two (2) CT scans	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 Subject to a limit of 1/one scan per family per annum, except for PMBs Subject to a limit of 2/two scans per family per annum, except for PMBs

CO-PAYMENTS

General practitioner (GP)	Allows for 2/two out-of-network consultations per beneficiary, any additional consultations are funded at non-network rate
Pharmacy	20% of costs for using a non-network service provider pharmacy 20% co-payment for voluntarily using a non-formulary product
Chronic renal dialysis	Polmed has established a network service provider for renal dialysis. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply). Pre-authorisation is required for all dialysis services
Network service providers	Polmed has established a network for cancer treatment (chemo and radiation therapy). Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply)

*ANNUAL MEMBER CONTRIBUTION INCREASES ARE EFFECTIVE 1 APRIL

CONTRIBUTIONS FROM 1 APRIL 2021 UNTIL 31 MARCH 2022

1 April 2021 to 31 March 2022 (subsidised contribution)

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R6 916	396	396	99
R6 917 - R9 500	548	548	184
R9 501 - R11 607	605	605	227
R11 608 - R13 576	714	714	285
R13 577 - R15 798	832	832	330
R15 799 - R19 000	953	953	389
R19 001 - R23 319	1,050	1,050	454
R23 320 - R26 827	1,140	1,140	499
R26 828 - R31 006	1,160	1,160	509
R31 007 +	1,182	1,182	518

1 April 2021 to 31 March 2022 (excluding employer subsidy)

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R6 916	2,540	2,540	1,172
R6 917 - R9 500	2,692	2,692	1,255
R9 501 - R11 607	2,749	2,749	1,298
R11 608 - R13 576	2,859	2,859	1,357
R13 577 - R15 798	2,977	2,977	1,403
R15 799 - R19 000	3,097	3,097	1,461
R19 001 - R23 319	3,194	3,194	1,526
R23 320 - R26 827	3,285	3,285	1,572
R26 828 - R31 006	3,305	3,305	1,581
R31 007 +	3,327	3,327	1,590

CONTRIBUTIONS FROM 1 APRIL 2022 UNTIL 31 MARCH 2023

1 April 2022 to 31 March 2023 (subsidised contribution)

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R6 916	432	432	108
R6 917 - R9 500	597	597	201
R9 501 - R11 607	659	659	247
R11 608 - R13 576	778	778	311
R13 577 - R15 798	907	907	360
R15 799 - R19 000	1,039	1,039	424
R19 001 - R23 319	1,145	1,145	495
R23 320 - R26 827	1,243	1,243	544
R26 828 - R31 006	1,264	1,264	555
R31 007 - R33 393	1,288	1,288	565
R33 394 - R 41 914	1,300	1,300	570
R41 915 - R49 999	1,312	1,312	575
R50 000 +	1,324	1,324	580

1 April 2022 to 31 March 2023 (excluding employer subsidy)

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R6 916	2,683	2,683	1,235
R6 917 - R9 500	2,849	2,849	1,325
R9 501 - R11 607	2,911	2,911	1,372
R11 608 - R13 576	3,031	3,031	1,436
R13 577 - R15 798	3,159	3,159	1,486
R15 799 - R19 000	3,290	3,290	1,550
R19 001 - R23 319	3,396	3,396	1,620
R23 320 - R26 827	3,495	3,495	1,671
R26 828 - R31 006	3,517	3,517	1,680
R31 007 - R33 393	3,541	3,541	1,690
R33 394 - R 41 914	3,552	3,552	1,695
R41 915 - R49 999	3,564	3,564	1,701
R50 000 +	3,576	3,576	1,706

MARINE CHRONIC DISEASE LIST

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 erythematosus (SLE)

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

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

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

Gynaecological conditions
Endometriosis
Menopausal treatment

Haematological conditions
Haemophilia
Anaemia
Idiopathic thrombocytopenic purpura
Megaloblastic anaemia

Metabolic condition
Hyperlipidaemia

Musculoskeletal condition
Rheumatic arthritis

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

Ophthalmic condition
Glaucoma

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

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

Special category conditions
HIV/AIDS
Tuberculosis
Organ transplantation

Treatable cancers
As per PMB guidelines

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

EXTENDED CHRONIC DISEASE LIST: NON-PMB

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

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

Ear, nose and throat condition
Allergic rhinitis

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

Metabolic condition
Gout prophylaxis

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

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

Ophthalmic conditions
Dry eye or keratoconjunctivitis sicca

Psychiatric conditions
Attention deficit hyperactivity disorder (ADHD)
Post-traumatic stress disorder (PTSD)

Urological conditions
Overactive bladder syndrome

POLMED PLAN:

AQUARIUM

SCHEDULE

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2022

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

REFERENCE IN THIS ANNEXURE AND THE FOLLOWING ANNEXURES TO THE TERM:

'Polmed rate' shall mean: 2006 National Health Reference Price List (NHRPL) adjusted on annual basis with Consumer Price Index (CPI).

'Agreed tariff' shall mean: The rate negotiated by and on behalf of the Scheme with one or more providers/groups.

BENEFITS FOR THE SERVICES OUTSIDE THE REPUBLIC OF SOUTH AFRICA (RSA)

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

GENERAL RULES

APPLICATION OF CLINICAL PROTOCOLS AND FUNDING GUIDELINES

Polmed applies clinical protocols, including 'best practice guidelines' as well as evidence-based medicine 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.

NETWORK SERVICE PROVIDER: OUT-OF-NETWORK RULE

Polmed has appointed healthcare providers (or a group of providers) as network service providers for diagnosis, treatment and care in respect of one or more Prescribed Minimum Benefit (PMB) conditions. Where the Scheme has appointed a network service provider and the member voluntarily chooses to use a non-nominated or out-of-network provider, a co-payment of up to 30% may be applied, subject to the PMBs.

Co-payments will not be applied in the following scenarios:

- In a medical emergency where the patient does not have a choice to choose the doctor or network facility.
- When the required service cannot be provided by a network doctor or facility.
- When a network provider is not available within a 50km radius from the member's residence.

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

Examples of network service providers (where applicable) are:

- Cancer (oncology) network
- General practitioner (GP) network
- Optometrist (visual) network
- Psycho-social network
- Renal (kidney) network
- Specialist network
- Pharmacy network
- Dental network

POLMED GP NETWORK (NETWORK GP PROVIDER)

Members and beneficiaries are required to nominate a primary network GP. Principal members are required to nominate a secondary network GP as well. Members are allowed 3/three visits to a GP who is not nominated per annum for emergency or out-of-town situations. A 30% co-payment shall apply once the maximum out-of-non-nominated consultations are exceeded.

Polmed rates for network GP provider visits are available on its website and can be accessed at **www.polmed.co.za**. These rates are reviewed annually.
PMB rules apply for qualifying emergency consultations.

POLMED HOSPITAL NETWORK

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

All admissions (hospitals and day clinics) must be pre-authorised.

A penalty of R5 000 may be imposed if no pre-authorisation is obtained.

In case of an emergency, the Scheme must be notified within 48 hours or on the first working day after admission. Pre-authorisation will be managed under the auspices of managed healthcare. The appropriate facility must be used to perform a procedure, based on the clinical requirements, as well as the expertise of the doctor doing the procedure.

Benefits for private or semi-private rooms are excluded unless they are motivated and approved prior to admission upon the basis of clinical need.

Medicine prescribed during hospitalisation forms part of the hospital benefits.

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

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

Benefits shall also be granted if the child is stillborn.

POLMED PHARMACY NETWORK
Polmed has established an open pharmacy network for the provision of acute, chronic and over-the-counter (OTC) medication. Medicines included in Polmed's Formulary will be funded in full, subject to the availability of funds. Members who voluntarily opt to use non-formulary products, will be liable for a 20% co-payment. Polmed has agreed dispensing fees with the network pharmacies. A 20% co-payment will be levied in the event of voluntary utilisation of an out-of-network pharmacy.

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

EMERGENCY MEDICAL SERVICES (EMS): ER24

72-Hour Post-Authorisation Rule
Subject to authorisation within 72 hours of the event, all service providers will need to get a notification number from Polmed's Network Service Provider ER24. Co-payment of 40% of the claim shall apply where a member voluntarily uses an unauthorised service provider. Service providers will be required to provide the hospital admission/casualty sticker together with patient report forms when submitting a claim to Polmed's EMS network service provider to validate delivery to a hospital.

DENTAL NETWORK
Polmed makes use of a preferred dental network for its members. By making use of the network, Polmed members will not have any out-of-pocket payments on approved conservative dental treatment up to available limits. Members can access the list of providers at **www.polmed.co.za**, on their cell phones via the mobile site, via Polmed Chat or request it via the Client Services Call Centre.

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

MEDICATION: ACUTE, OVER-THE-COUNTER (OTC) AND CHRONIC
The chronic medication benefit shall be subject to registration on the Chronic Medicine Management Programme for those conditions which are managed, and chronic medication rules will apply.

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

Pre-authorisation is required for items funded from the chronic medication benefit. Pre-authorisation is based on evidence-based medication (EBM) principles and the funding guidelines of the Scheme. Once predefined criteria are met, an authorisation will be granted for the diagnosed conditions. Beneficiaries will have access to a group (formulary) of medication appropriate for the management of their conditions or diseases for which they are registered. There is no need for a beneficiary to apply for a new authorisation if the treatment prescribed by the doctor changes and the medication is included in the condition-specific medication formulary. Updates to the authorisation will be required for newly diagnosed conditions for the beneficiary.

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

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

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

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

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

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

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

SPECIALIST REFERRAL
All Polmed beneficiaries need to be referred to specialists by a nominated network general practitioner (GP). The Scheme will impose a co-payment of up to 30% 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 or disciplines: Gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists [chronic dialysis], dental specialists, pathology, radiology and supplementary or allied health services.

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

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

CONSERVATIVE BACK AND NECK REHABILITATION PROGRAMME
Services associated with Polmed's Conservative Back and Neck Rehabilitation Programme will be funded from Hospital risk. Pre-authorisation is required to access the benefits. Spinal surgery will not be covered unless there is evidence that the patient has received conservative therapy prior to requesting surgery (PMBs apply).

LOYALTY PROGRAMME
Polmed has introduced a wide-ranging wellness, preventative care and managed care programme which has been specifically shaped to motivate healthy living and/or behaviour change to improve member lifestyle. The gamified programme uses strategic nudges to encourage members to improve their personal health score while enjoying innovative loyalty solutions. For more information, you can visit **www.polmed.co.za**.

DEFINITION OF TERMS

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

Other procedures that fall under this category are:
- Consultations
- Fluoride treatment and fissure sealants
- Non-surgical removal of teeth
- Cleaning of teeth, including non-surgical management of gum disease
- 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 more than those agreed upon with the service provider or more than what would be paid according to approved treatments. A co-payment would not be applicable in the event of a life-threatening injury or an emergency.

ENROLMENT ON THE DISEASE RISK MANAGEMENT PROGRAMME
Members will be identified and contacted to enrol on the Disease Risk Management Programme. The Disease Risk Management Programme aims to ensure that members

receive health information, guidance and management of their conditions, at the same time improving compliance to treatment prescribed by the medical practitioner. Members who are registered on the programme receive a treatment plan (Care Plan), which lists authorised medical services, such as consultations, blood tests and radiological tests related to the management of their conditions.

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

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

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

REGISTRATION FOR CHRONIC MEDICATION
Polmed provides for a specific list of chronic conditions that are funded from the chronic medication benefit (i.e. through a benefit that is separate from the acute medication benefit). Polmed requires members to apply for authorisation via the Chronic Medicine Management Programme to access this chronic medication benefit. Members will receive a letter by email or post indicating whether their application was successful or not. If successful, the beneficiary will be issued with a disease-specific authorisation, which will allow them access to medication included in the Polmed Formulary.

Polmed will reimburse medication intended for an approved chronic condition for up to four months from the Acute benefits. Members will be required to register such medication as Chronic during the four-month period.

SPECIALISED DENTISTRY
Specialised dentistry refers to services that are not defined as basic dentistry. These include periodontal surgery, crowns and bridges, inlays, indirect veneers, and maxillo-facial surgery. All specialised dentistry services and procedures must be pre-authorised, failing which the Scheme will impose a co-payment of R500. Only surgical impacted teeth and children under the age of 7 requiring general anaesthesia will be considered for in-hospital treatment. Authorisation subject to clinical criteria.

GENERAL BENEFIT RULES

Benefit design	This option allows for benefits to be provided only in appointed network service provider hospitals It also provides a reasonable level of out-of-hospital (day-to-day) care This option is intended to provide for the needs of families who have little healthcare needs or whose chronic conditions are under control This option is not intended for members who require medical assistance on a regular basis, or who are concerned about having extensive access to health benefits
Pre-authorisation, referrals, protocols and management by programmes	Where the benefit is subject to pre-authorisation, referral by a network service provider (DSP) or nominated network general practitioner (GP), adherence to established protocols or enrolment upon a managed care programme. Members' attention is drawn to the fact that there may be no benefit at all or a much-reduced benefit if the pre-authorisation, referral by a network service provider or nominated network GP, adherence to established protocols or enrolment upon a managed care programme is not complied with (a co-payment may be applied) The pre-authorisation, referral by a network service provider or nominated network GP, adherence to established protocols or enrolment upon a managed care programme is stipulated to best care for the member and his/her family and to protect the funds of the Scheme
Limits are per annum	Unless there is a specific indication to the contrary, all benefit amounts and limits are annual
Statutory prescribed minimum benefits (PMBs)	There is no overall annual limit for PMBs or life-threatening emergencies
Tariff	100% of Polmed rate or agreed tariff or at cost for involuntary access to PMBs

IN-HOSPITAL BENEFITS

Annual overall in-hospital limit Subject to the Scheme's relevant managed healthcare programmes and includes the application of treatment protocols, case management and pre-authorisation R5 000 penalty may be imposed if no pre-authorisation is obtained R15 000 co-payment for admission in a non-network hospital No co-payment if the procedure is performed in a network hospital and/or a day clinic	Non-PMB admissions will be subject to an overall limit of R200 000 per family Subject to PMBs, i.e. no limit in case of life-threatening emergencies or for PMB conditions Subject to applicable tariff i.e. 100% of Polmed rate or Agreed tariff or At cost for involuntary access to PMBs
Anaesthetists	150% of Polmed rate
Chronic renal dialysis at preferred providers	100% of agreed tariff at network service provider Polmed has established a network service provider for renal dialysis. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply). Pre-authorisation is required for all dialysis services
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, subject to: M0 – R4 000 M1 – R4 500 M2 – R5 000 M3 – R5 500 M4+ – R6 000 The hospital and anaesthetist's costs will be reimbursed from the overall non-PMB limit
Emergency medical services (ambulance)	Subject to Polmed Scheme rules
General practitioners (GPs)	100% of agreed tariff at network service provider 100% of Polmed rate at non-network service provider or At cost for involuntary PMB access
Medication (Non-PMB specialist drug limit, e.g. biologicals)	100% of Polmed rate Pre-authorisation required Specialised medication sublimit of R144 139 per family

Mental health	100% of Polmed rate or At cost for PMBs Annual limit of 21 days in-hospital or 15 out-of-hospital sessions per beneficiary Limited to a maximum of three days' hospitalisation for beneficiaries admitted by a GP or a specialist physician Additional hospitalisation to be motivated by the medical practitioner
Oncology (chemotherapy and radiotherapy) Network service provider	100% of agreed tariff at network service provider 30% co-payment if non-network provider is used Limited to R271 400 per beneficiary per annum; includes MRI/CT or PET scans related to oncology Chemotherapy and radiation limited to Oncology benefits, adherence to the Oncology Formulary and subject to medicines from the Preferred Provider Network
Organ and tissue transplants	100% of agreed tariff at network service provider 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 and dieticians	Service will be linked to hospital pre-authorisation A referral by the treating Healthcare Professional is required for services rendered

Prosthesis (internal and external)	100% of Polmed rate or At cost for PMBs Subject to pre-authorisation and approved product list Limited to the overall prosthesis benefit of R64 132 per beneficiary Knee prosthesis – R54 600 Hip prosthesis – R54 600 Shoulder prosthesis – R64 132 Intraocular lens – R3 150 Aorta & peripheral arterial stent grafts – R47 250 Cardiac stents – R26 775 Cardiac pacemaker – R58 800 Spinal plates and screws – R64 132 Spinal implantable devices – R60 000 Unlisted items – R64 132
Radiographers	A referral by the treating Healthcare Professional is required for services rendered
Refractive surgery	No benefit
Specialists	100% of agreed tariff at network service provider 100% of Polmed rate for non-network service provider or At cost for involuntary PMB access
Social workers and registered counsellors	A referral by the treating Healthcare Professional is required for services rendered Consultations limited to 4 sessions in a benefit cycle

OVERALL OUT-OF-HOSPITAL BENEFITS

Annual overall out-of-hospital (OOH) limit Benefits shall not exceed the amount set out in the table PMB shall first accrue towards the total benefit, but are not subject to limit In appropriate cases the limit for medical appliances shall not accrue towards this limit Overall 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 - R 8 812 M1 - R10 677 M2 - R12 969 M3 - R13 836 M4+ - R15 855
Audiology Subject to referral by either of the following doctors/specialists: Nominated network general practitioner (GP) Ear, nose and throat (ENT) specialist Paediatrician Physician Neurologist	100% of Polmed rate Subject to the OOH limit
Dentistry (conservative and restorative)	100% of Polmed rate Subject to the OOH limit and includes dentist's costs for in-hospital, non-PMB procedures M0 – R4 000 M1 – R4 500 M2 – R5 000 M3 – R5 500 M4+ – R6 000 Routine consultation, scale and polish are limited to two annual check-ups per beneficiary Oral hygiene instructions are limited to once in 12 months per beneficiary

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 Apicetomy removal of dead tissue caused by infection Children under the age of 7 years, physically or mentally disabled patients who require general anaesthesia for dental work to be conducted Cyst removal of non-vital pulp Dentectomy Under sedation with removal of all teeth in the mouth	In all cases pre-authorisation is required A co-payment of R500 will apply if no pre-authorisation is obtained Clinical protocols apply
Nominated network general practitioners (GPs) Polmed has a GP network	100% of agreed tariff at network service provider or At cost for involuntary PMB access The limit for consultations shall accrue towards the OOH limit Subject to the use of a nominated network GP otherwise a 30% co-payment will apply to all non-nominated GP visits. Members are allowed 3/three visits to a GP who is not nominated per annum for emergency or out-of-town situations. Subject to maximum number of visits or consultations per family: M0 – 8 M1 – 12 M2 – 15 M3 – 18 M4+ – 22
Medication (acute)	100% of Polmed rate at network service provider M0 – R2 325 M1 – R3 953 M2 – R5 581 M3 – R7 209 M4 – R8 836 Subject to the OOH limit Subject to Polmed Formulary

Medication (over-the-counter - OTC)	100% of Polmed rate at network service provider Annual limit of R1 000 per family Subject to the OOH limit Shared limit with acute medication Subject to Polmed Formulary
Occupational and speech therapy	PMBs only Benefit first accrues to the OOH limit
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
Psychology plus social worker	100% of Polmed rate Annual limit of R5 000 per family Subject to the OOH limit
Specialists Referral is not necessary for the following specialists: Gynaecologists Psychiatrists Oncologists Ophthalmologists Nephrologists (dialysis) Dental specialists Supplementary or allied health services	100% of agreed tariff at network service provider or At cost for involuntary access to PMBs The limit for consultations shall accrue towards the OOH limit Limited to 4/four visits per beneficiary and 8/eight visits per family per annum Subject to referral by a nominated network GP (2/two specialist visits per beneficiary without GP referral allowed) A 30% co-payment might be applied subject to the referral rules

STAND-ALONE BENEFITS

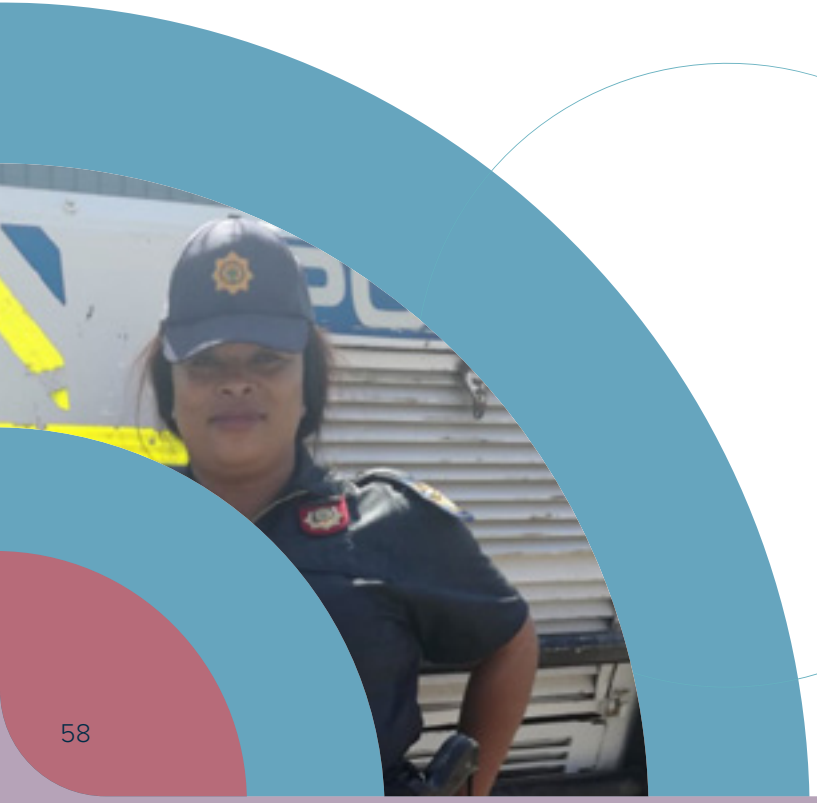
Allied health services and alternative healthcare providers Biokineticists Chiropractors Chiropodists Dieticians Homeopaths Naturopaths Orthoptists Osteopaths Podiatrists Reflexologists Therapeutic massage therapists Benefit is subject to clinically appropriate services	No benefit	
Appliances (medical and surgical) Members must be referred by an audiologist for hearing aids to be reimbursed Pre-authorisation is required for the supply of oxygen All costs for maintenance are a Scheme exclusion Funding will be based on applicable clinical and funding protocols Quotations will be required	100% of Polmed rate	
	Blood transfusions	Unlimited
	Hearing aids	R11 318 per hearing aid or R22 494 per beneficiary per set Once every 3/three years
	Nebuliser	R1 283 per family Once every 4/four years
	Glucometer	R1 283 per family Once very4/ four years
	CPAP machine	R9 168 per family Once every 4/four years
	Wheelchair (non-motorised) OR Wheelchair (motorised)	R11 983 per beneficiary Once every 3/three years R34 370 per beneficiary Once every 3/three years
	Urine catheters and consumables	Subject to three quotations and clinical protocols
	Medical assistive devices	Annual limit of R2 695 per family Includes medical devices in-/out-of-hospital
	Adult nappies	R946/month (2/two nappies per day) R1 419/month (3/three nappies per day)

Chronic medication refers to non-PMB conditions Subject to prior application and/or registration of the condition Approved PMB-CDL conditions are not subject to a limit	No benefit except for PMBs Subject to the medication reference price and Polmed Formulary
Maternity benefits (including home birth) Pre-authorisation required Treatment protocols apply	100% of agreed tariff at network service provider or 100% of Polmed rate at non-network service provider or At cost for involuntary PMB access The limit for consultations shall not accrue towards the OOH limit The benefit shall include 3/three specialist consultations per beneficiary per pregnancy
Maternity benefits (continued)	Home birth is limited to R15 138 per beneficiary per annum Annual limit of R4 038 for ultrasound scans per beneficiary; limited to 2/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 Elective (voluntary) Caesarean sections will, subject to the PMBs, be considered in line with managed care and funding protocols. A co-payment of R10 000 will apply in all voluntary Caesarean sections (PMBs apply). Pre-authorisation is required.
Optical Benefit cycle - In accordance with the below benefit sublimits, each beneficiary is entitled to either spectacles or contact lenses every 24 months from date of claiming Includes frames, lenses and eye examinations The eye examination is per beneficiary every two years (unless prior approval for clinical indication has been obtained) Benefits are not pro rata, but calculated from the benefit service date Each claim for lenses or frames must be submitted with the lens prescription	**Provider Network** 100% of cost for a Composite consultation, inclusive of the refraction, a glaucoma screening and visual field screening and Authenticate IT. Composite consultation fee is R668 **WITH EITHER SPECTACLES** R795 towards a frame and/or lens enhancement **LENSES** Either one pair of clear single vision lenses limited to R210 per lens or One pair of clear flat top bifocal lenses limited to R445 per lens or One pair of clear base multi-focal lenses limited to R445 **OR CONTACT LENSES** Contact lenses to the value of R613 per beneficiary per annum Contact lens re-examination to a maximum cost of R245 per consultation

Optical (continued) Benefits shall not be granted for contact lenses if the beneficiary has already received a pair of spectacles in a two-year benefit cycle Contact lens re-examination can be claimed for in six-monthly intervals	Non-Provider Network One consultation limited to a maximum cost of R350 **WITH EITHER SPECTACLES** R596 towards a frame and/or lens enhancement Singlevision lenses limited to R210 per lens or Bifocal lenses limited to R445 per lens or Multifocal lenses limited to R445 per lens **OR CONTACT LENSES** Contact lenses to the value of R400 per beneficiary per annum Contact lens re-examination to maximum cost of R245 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- or out-of-hospital Claims for PMBs first accrue towards the limit
Radiology (specialised) Pre-authorisation required One (1) MRI scan Two (2) CT scans	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 Subject to a limit of 1/one scan per family per annum, except for PMBs Subject to a limit of 2/two scans per family per annum, except for PMBs

CO-PAYMENTS

OUT OF NETWORK	CO-PAYMENT
General practitioner (GP)	Allows for three non-nominated network GP consultations per beneficiary, any additional consultations are funded at non-network rate and a 30% co-payment is applicable.
Hospital	R15 000
Pharmacy	20% of costs when using a non-network service provider pharmacy 20% co-payment when voluntarily using a non-formulary product
Chronic renal dialysis	Polmed has established a network service provider for renal dialysis. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply). Pre-authorisation is required for all dialysis services
Network service providers	Polmed has established a network for cancer treatment (chemo and radiation therapy). Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply).



*ANNUAL MEMBER CONTRIBUTION INCREASES ARE EFFECTIVE 1 APRIL

CONTRIBUTIONS FROM 1 APRIL 2021 UNTIL 31 MARCH 2022

1 April 2021 to 31 March 2022 (subsidised contribution)

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R6 916	95	95	41
R6 917 - R9 500	103	103	41
R9 501 - R11 607	136	136	53
R11 608 - R13 576	169	169	62
R13 577 - R15 798	200	200	72
R15 799 - R19 000	230	230	82
R19 001 - R23 319	285	285	95
R23 320 - R26 827	334	334	126
R26 828 - R31 006	354	354	134
R31 007 +	369	369	140

1 April 2021 to 31 March 2022 (excluding employer subsidy)

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R6 916	1,181	1,181	584
R6 917 - R9 500	1,190	1,190	584
R9 501 - R11 607	1,223	1,223	596
R11 608 - R13 576	1,255	1,255	606
R13 577 - R15 798	1,287	1,287	615
R15 799 - R19 000	1,316	1,316	626
R19 001 - R23 319	1,372	1,372	637
R23 320 - R26 827	1,421	1,421	669
R26 828 - R31 006	1,442	1,442	677
R31 007 +	1,457	1,457	683

CONTRIBUTIONS FROM 1 APRIL 2022 UNTIL 31 MARCH 2023

1 April 2022 to 31 March 2023 (subsidised contribution)

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R6 916	106	106	46
R6 917 - R9 500	115	115	46
R9 501 - R11 607	152	152	59
R11 608 - R13 576	189	189	69
R13 577 - R15 798	224	224	81
R15 799 - R19 000	258	258	92
R19 001 - R23 319	319	319	106
R23 320 - R26 827	374	374	141
R26 828 - R31 006	396	396	150
R31 007 - R33 393	413	413	157
R33 394 - R 41 914	417	417	158
R41 915 - R49 999	421	421	160
R50 000 +	424	424	161

1 April 2022 to 31 March 2023 (excluding employer subsidy)

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R6 916	1,247	1,247	616
R6 917 - R9 500	1,257	1,257	616
R9 501 - R11 607	1,294	1,294	630
R11 608 - R13 576	1,330	1,330	641
R13 577 - R15 798	1,365	1,365	651
R15 799 - R19 000	1,398	1,398	663
R19 001 - R23 319	1,461	1,461	676
R23 320 - R26 827	1,515	1,515	711
R26 828 - R31 006	1,539	1,539	720
R31 007 - R33 393	1,556	1,556	727
R33 394 - R 41 914	1,559	1,559	728
R41 915 - R49 999	1,563	1,563	730
R50 000 +	1,567	1,567	731

AQUARIUM CHRONIC DISEASE LIST

PRESCRIBED MINIMUM BENEFITS (PMBs); INCLUDING CHRONIC DIAGNOSIS AND TREATMENT PAIRS (DTPs)

Auto-immune disorder
Systemic lupus erythematosus (SLE)

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

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

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

Gynaecological conditions
Endometriosis
Menopausal treatment

Haematological conditions
Haemophilia
Anaemia
Idiopathic thrombocytopenic purpura
Megaloblastic anaemia

Metabolic condition
Hyperlipidaemia

Musculoskeletal condition
Rheumatic arthritis

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

Ophthalmic condition
Glaucoma

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

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

Special category conditions
HIV/AIDS
Tuberculosis
Organ transplantation

Treatable cancers
As per PMB guidelines

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

EXCLUSIONS

PRESCRIBED MINIMUM BENEFITS (PMBs)

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

GENERAL EXCLUSIONS

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

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

2. Sleep therapy;

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

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

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

6. Prenatal and/or postnatal exercises;

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

8. Accommodation in an old-age home or other institution that provides general care for the aged and/or chronically ill patients;

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

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

11. Fixed orthodontics for beneficiaries above the age of 18 years, subject to Index of Complexity, Outcome and Need (ICON);

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

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

14. Sex change operations;

15. Beneficiaries' travelling costs, except services according to the benefits in Annexure A and B;

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

17. Accommodation in spas, health or rest resorts;

18. Holidays for recuperative purposes;

19. The treatment of obesity, provided that with prior motivation the Scheme may approve benefits for the treatment of morbid obesity (outside of the weight loss program);

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

21. Any treatment as a result of surrogate pregnancy;

22. Blood pressure appliances;

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

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

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

26. 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;

27. 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;

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

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

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

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

32. Non-clinically essential or non-emergency transport via ambulance;

33. All benefits for clinical trials.

ACUTE MEDICINE 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 or devices	Thermometers, hearing aid batteries

5.06	Appliances, supplies and devices: Bandages and dressings	Cotton wool, gauze
5.07	Appliances, supplies and devices: Disposable cholesterol supplies	
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 or 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®
9.10	Vitamin and/or mineral supplements: Unregistered vitamins, mineral or food supplements	Sportron
10.01	Naturo- and homeopathic remedies/supplements: Homeopathic remedies	Weleda Natura
10.02	Naturo- and homeopathic remedies/supplements: Natural oils	Primrose oils, fish liver oil
12.00	Veterinary products	
13.00	Growth hormones	Genotropin®
14.00	Medicines where cost/benefit ratio cannot be justified	Xigris®, Zyvoxid ® Herceptin, Gleevac®,
20.00	All newly registered medication	

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

THE FOLLOWING CATEGORIES ARE NOT AVAILABLE ON ACUTE BENEFITS:

CATEGORY	DESCRIPTION	EXAMPLE
1.06	Gender or sex related: Treatment of impotence or sexual dysfunction	Viagra®, Cialis®, Caverject®
5.03	Appliances, supplies and devices: Stoma products and accessories, except where it forms	Stoma bags, adhesive paste, pouches and part of PMB-related services 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, dripsets, alcohol swabs
7.01	Treatment/prevention of substance abuse: Opoied	Revi®

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

DAY PROCEDURES (ANNEXURE D)

The following procedures will be funded from the hospital benefit if done in a doctor's rooms or day clinics. Pre-authorisation is required. If these are done in facilities other than specified above, the member may be liable for a R2 000 co-payment, except in the following cases:
a) Medical emergency
b) Doctor does not have the necessary equipment to perform the procedure
c) No day clinics nearby
d) Case is clinically complex as per Polmed protocols

PROCEDURE DESCRIPTION

- Addenoidectomy
- Ascitis or pleural tapping
- Athrocentesis
- Arthroscopy
- Arthrotomy Finger /hand/elbow/knee/toe/hip
- Aspiration/intra-articular injection of joints
- Anoscopies
- Arthrodesis of Hand/elbow/foot
- Aspiration/Injection
- Bartholin's gland drainage/excision/marsupulisation
- Biopsy of lymph node, muscle, skin, bone, breast, cervix, tangential
- Bleeding control Nasal/ any method
- Blepharoplasty
- Bone/cartilage/tendon graft
- Bronchial Lavage
- Canthopexy
- Cast application/removal
- Cataract surgery
- Cauterisation cervix/laser ablation/cornea/repair of ectropion; thermocauterisation
- Circumcision
- Closed fractures
- Colonoscopy
- Colposcopy
- Continuous nerve block infusion – sciatic nerve/femoral nerve/lumbar plexus
- Cystoscopy for diagnosis/dilatation/stent/stone removal
- Dacryocystorhinostomy/Conjunctivorhinostomy/nasolacrimal duct procedures
- Debridement nails
- Debride skin/subcutaneous tissue
- Dilatation and curettage (excluding aftercare)
- Diathermy to nose, eye and pharynx under local aneasthesia
- Dilation of anal sphincter/Haemorrhoidectomy/anal repair
- Dislocation treatment
- Drainage abscess skin/carbuncle/whitlow/hematoma/gland
- Drainage subcutaneous abscess
- Drainage of sub mucous abscess
- Endoscopy
- Excision benign lesion scalp/neck/hand/feet
- ERCP
- Excision benign/malignant lesion trunk/limbs/scalp/neck/hand/feet/genitalia
- Excision and repair of ear
- Excision and repair of eyelid/eye
- Excision of cyst, pilonidal/lactiferous/fibroadenoma
- Excision ganglion/cyst/tumour
- Excision of Meibomian cyst
- Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal or umbilicals
- Excision malignant lesion including margins, trunk, arms, legs, face, ears eyelids, nose or lips
- Fasciotomy
- Fine needle aspiration for soft tissue - all areas including breast
- Flexible nasopharyngeal-laryngoscope examination

- Gastroscopy/esophagogastroduodenoscopy
- Hymenotomy/repair of introitus/Perineoplasty/Female reproductive system repair/treatment
- Hysteroscopy
- Incision and drainage abscess/hematoma(anal/vaginal)/pilonidal cyst/foreign body, subcutaneous tissues
- Insertion Bladder Catheter
- Inject nerve block
- Inject tendon/ligament/trigger points/ganglion cyst
- Inject therapeutic Carpal tunnel e.g. local corticosteroids
- Intrapleural block
- Jaw reconstruction/relocation
- Laparoscopy diagnostic abdomen/peritoneum/omentum
- Ludwigs angina-drainage
- Myringoplasty/Tympanoplasty/Otoplasty/Ear procedures
- Myringotomy aspiration incision
- Nipple/Areola Reconstruction
- Opening of quinsy at rooms
- Orchiectomy/Male Reproductive system repair/treatment
- Paravertebral block
- Paring or cutting of benign hyperkeratotic lesion
- Proctoscopy with removal of polyps
- Procto-sigmoidoscopy/Sigmoidoscopy
- Proof puncture at rooms unilateral/bilateral
- Pyelography
- Radical nail bed removal
- Removal of foreign body
- Removal (via snare/capture) and replacement of internally dwelling ureteral stent
- Removal of implant/external fixation systems; superficial
- Repair of hypospadias complications
- Repair layer wound scalp/axillae/trunk/limbs
- Repair wound lesion scalp/hands/neck/feet
- Sclerotherapy
- Sesamoidectomy/procedures to relieve pain and inflammation
- Sinusotomy/Nasal cavity repair/treatment/control bleeding
- Tendor Repair
- Tonsillectomy - Adenoidectomy < 12 years
- Treatment by Chemo - Cryotherapy additional lesions
- Treatment of missed abortion/TOP
- Vasectomy uni/bilateral
- Vermilionectomy/Frenotomy

MEMBERSHIP

APPLICATION FOR MEMBERSHIP

NEW MEMBER APPLICATION
- Serving members
- Dependants

THIRD GENERATION CHILDREN DO NOT QUALIFY

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

DEPENDANTS ABOVE THE AGE OF 21

STUDENTS (26 YEARS AND OLDER)
- Adult unsubsidised rates even if they are still studying.

STUDENTS (21 TO 25 YEARS)
- Certificate of registration at registered tertiary learning institution – by the end of February each year.
- Copy of ID.
- Child rates apply.

FINANCIALLY DEPENDENT
- Affidavit B confirming financial dependency (21 years and above).
- Copy of ID.
- Adults unsubsidised rates apply.

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

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

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

LEGALLY ADOPTED CHILD
- Final adoption order.
- Copy of ID or birth certificate.

CONTINUATION OF MEMBERSHIP

CONTINUATION OF MEMBERSHIP (Scheme rule 6.3.1)

- Retirement (Scheme rule 6.3.1.1).
- Medically boarded (Scheme rule 6.3.1.2).
- Severance package (Scheme rule 6.3.1.4).
- Members employed under section 7 and 17C whose term of employment comes to an end.
- Death of the principal member (any dependant active at the time of the principal member's death) (Scheme rule 6.5.1).

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 and letter from Medical Board at SAPS Head Office.
- Recent bank statement or letter stamped by the bank confirming bank details.

WHAT IF BOTH PARENTS DIE?

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

Supply information of the dependant 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.
- Copies of ID documents for dependants or birth certificates in case of minor children.
- Proof of income (monthly pension of deceased that the member will receive).
- Marriage certificate or customary union certificate.
- Proof of recent bank statement or letter stamped by the bank confirming bank details is compulsory.

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.
- Widow/orphans cannot register new dependants.

GLOSSARY

Authorisation (Pre-authorisation)
Members of medical schemes are required to notify and obtain authorisation from their medical schemes before going into hospital if they are to receive non-life-threatening or hospital treatment. This is known as authorisation. Your medical scheme will supply you with prior approval in the form of an authorisation number.

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

Other procedures that fall under this category are:
- Consultations
- Fluoride treatment and fissure sealants
- Non-surgical removal of teeth
- Cleaning of teeth, including non-surgical management of gum disease
- 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 more than those agreed upon with the service provider or more than what would be paid according to approved treatments. A co-payment would not be applicable in the event of a life-threatening injury or an emergency.

Day Clinics
A day clinic offers outpatient or same day procedures, usually less complicated than those requiring hospitalisation. It is a facility which allows for a patient to be discharged on the very same day as the procedure is done.

Emergency
An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment or intervention. If the treatment or intervention is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs, or other body parts, or would place the person's life in jeopardy.

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

Generic Medicine
A medicine with the same active ingredient as original brand name medicine, usually at a lower cost.

ICD-10, NAPPI and Tariff Codes
ICD stands for International Classification of Diseases and related problems. By law, every claim that is submitted to a medical scheme, must include an ICD-10 code. Every medical condition and diagnosis have a specific code. These codes are used primarily to enable medical schemes to accurately identify the conditions for which you sought healthcare services. This coding system then ensures that your claims for specific illnesses are paid out of the correct benefit and that healthcare providers are appropriately reimbursed for the services they rendered.

NAPPI codes are unique identifiers for a given ethical, surgical, or consumable product which enables electronic transfer of information through the healthcare delivery chain. Tariff codes are used as a standard for electronic information exchange for procedure and consultation claims.

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

Network Service Provider
Network service providers are healthcare providers (doctor, pharmacist, hospital, etc.) that are a medical scheme's first choice when its members need diagnosis, treatment, or care for a PMB condition. Polmed has contracted or selected preferred providers (doctors, hospitals, health facilities, pharmacies etc.), to provide diagnosis, treatment, and care of one or more PMB conditions. This relationship often brings the benefit of negotiated, preferential rates for the members.

Pharmacist Advised Therapy (PAT)
Most common ailments can be treated effectively by medicine available from your pharmacy without a doctor's prescription. If your medical scheme option offers a PAT benefit, it means that some of these costs will be paid from the relevant benefit.

Protocols
Guidelines set for the procedures in which certain health conditions are to be diagnosed and treated.

Service Date
This can be the date on which you are discharged from hospital or the date you have received a medical service or medical supplies.

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

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CONTACT DETAILS

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