BENEFITS AND CONTRIBUTIONS GUIDE 2025

POLMED®

OUR INVESTMENT OUR HEALTH OUR FUTURE

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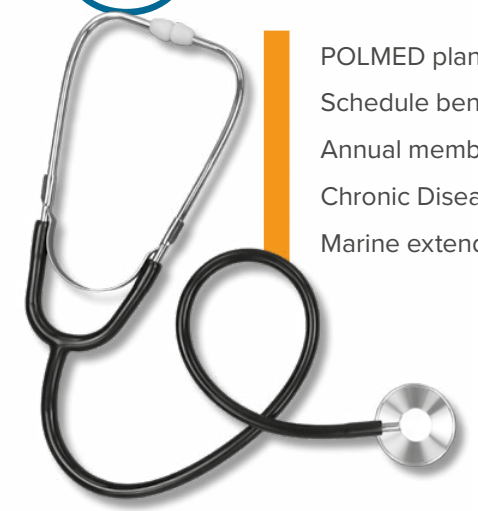


PRINCIPAL OFFICER'S FOREWORD

MS NEO KHAUOE

2024 was another challenging economic year for South Africans. However, POLMED is proud of its efforts to sustain and improve the health and wellness of Scheme members.

From January to September, the Scheme maintained a solvency ratio of 83.08%, which remains a positive performance compared to the prior year. The Scheme's resilience and financial soundness positions us to continue supporting members effectively.

Member contributions have increased by an average of 6.61% over the past five years, compared to the Scheme's medical inflation of 9%.

2025 Contribution increase for the Marine Option's lowest income band members is R21 for the main member and R5 for a child dependant. The highest income band is R67 for the main member and R30 for a child dependant. Members on the Aquarium Option in the lowest-income band will be R5 for main members, R2 for a child dependant, R43 for the highest-income band, and R16 for a child dependant.

The Scheme's current claims ratio of 97.84% year-to-date, though stable, underscores the challenge of a growing burden of disease, particularly non-communicable diseases. Our wellness and preventive care initiatives have placed our members at the centre of our strategic focus to empower our members to lead healthier lives through proactive healthcare. We remain committed to reducing the claims ratio from 97,84% to a figure below 85% by broadening our wellness and preventive care initiatives.

Our 2024 Annual General Meeting (AGM) in Thohoyandou, Limpopo, was a resounding success, marked by outstanding attendance and active engagement from our members and stakeholders. Your participation has reinforced our community spirit and shared mission. We have already begun preparations for the 2025 AGM and are dedicated to sharing logistical details with you early next year to ensure a smooth and enjoyable experience.

In 2025, POLMED will introduce a range of new preventive care benefits, including the Maternal Pertussis Booster, Down Syndrome Screening, and the Hepatitis B Vaccine for adults. The Marine Option will also feature an Obesity Care Plan, encouraging members to adopt preventive health practices. Additionally, we have expanded our chronic disease management program to cover four additional conditions—Myasthenia Gravis, Cystic Fibrosis, Neuromyelitis Optica, and Huntington's Disease—providing dedicated support under both plans. Our dental benefits have also been updated to further promote preventive care, with new exclusions and enhanced tariff options.

POLMED takes pride in having supported our members at various sporting events and marathons this year, where we provided on-site wellness support and screening services for members and beneficiaries. These events allowed us to engage directly, promoting the value of physical health and camaraderie while reinforcing our commitment to holistic wellness.

Our dedication to member support was also evident during the devastating KwaZulu-Natal tornado. In collaboration with our partners, we provided essential care packages and psychological assistance to affected members and their families. This response reflects our steadfast commitment to our members' wellbeing during challenging times.

In closing, I extend heartfelt gratitude to our members, the Board of Trustees, key stakeholders, and POLMED employees for your invaluable support and partnership throughout 2024. Together, we are building a healthier, stronger future. Thank you for your trust, and here's to a prosperous and healthy 2025.

Ms. Neo Khauoe
Principal Officer

POLMED®
OUR INVESTMENT OUR HEALTH OUR FUTURE

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)

Email address for submitting enquiries:
polmed@medscheme.co.za

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: Log in to the Member Zone via your computer and click on the POLMED Chat widget/icon

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

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

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

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 Roads

KIMBERLEY
Shop 76, North Cape Mall,
Royldene, Kimberley

WORCESTER
45 Church Street, Worcester

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

POLOKWANE
Checkers Centre,
Shop 3, Ground Floor,
Cnr Hans van Rensburg and
Grobler Streets, Polokwane

JOHANNESBURG
Mathomo Mall, 115 Main Street,
Marshalltown, 2001

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

VEREENIGING
32 Grey Ave, Vereeniging, 1930

PIETERMARITZBURG
Park Lane Shopping Centre,
Shop 32B, 12 Chief Albert Luthuli Street,
Pietermaritzburg, 3200

DURBAN
14/36 Silverton Road,
Silver Oaks Office Park,
Musgrave

BLOEMFONTEIN
Medical Suites 4 and 5,
Middestad Medical Suites,
First Floor, Middestad Mall
Corner of Charles and West Burger
Streets, Bloemfontein

EAST LONDON
Unit 5, 8 Balfour Rd, Vincent
East London

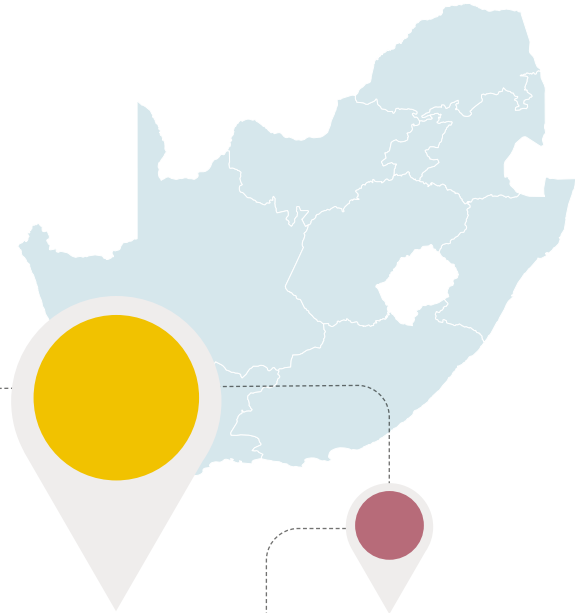
GQEBERHA
2nd Avenue, Newton Park,
78 – 84 Block 3,
Newton Park, Gqeberha

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
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 Streets, Paarl East



YOUR HEALTH IS YOUR WEALTH SO INVEST WISELY

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) PROGRAMMES
TEL: 0860 765 633

ADRM PROGRAMME
EMAIL: polmeddiseaseman@medscheme.co.za

PROLONGED CARE (HOME NURSING AND HOME OXYGEN)
EMAIL: polmedhbc@medscheme.co.za

CONSERVATIVE BACK AND NECK PROGRAMME
EMAIL: polmedcbnrp@medscheme.co.za

WEIGHT MANAGEMENT PROGRAMME
EMAIL: polmedwmp@medscheme.co.za

MENTAL HEALTH PROGRAMME
EMAIL: polpsych@medscheme.co.za

MATERNITY PROGRAMME
Email: polmedmaternity@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

AUDIOLOGY NETWORK
TEL: 010 880 6414
EMAIL: Authorisations – authorisations@hearconnect.co.za
EMAIL: Queries – polmed@hearconnect.co.za

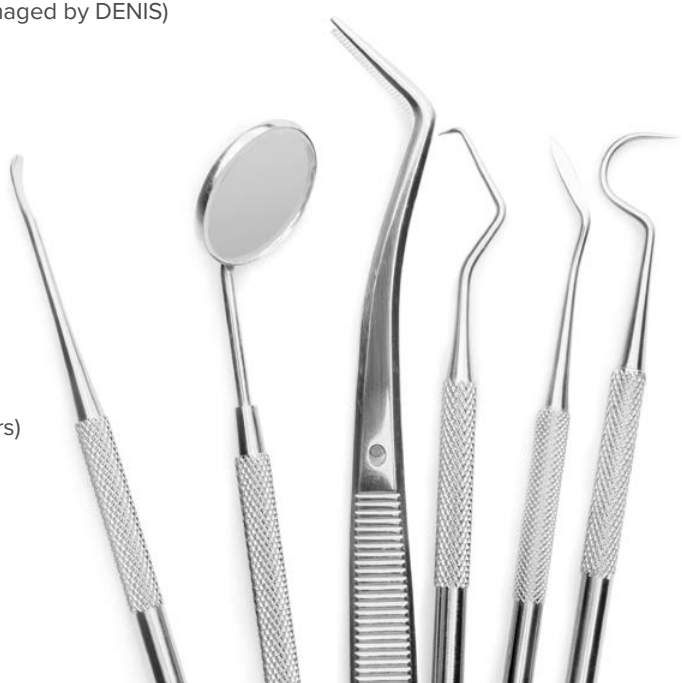
SPECIALISED DENTISTRY
TEL: 0860 765 633
FAX: 0860 104 114
EMAIL: polmedcustomerservice@denis.co.za

IN-HOSPITAL DENTAL PROCEDURES AND SEDATION PRE-AUTHORISATION
EMAIL: polmedhospitalauthorisations@denis.co.za (Managed by DENIS)

OUT-OF-HOSPITAL SPECIALISED DENTISTRY
EMAIL: polmedcustomerservice@denis.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

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



NETWORK SERVICE PROVIDERS

The POLMED Network Service Provider list has been implemented to bring our members excellent medical care and price certainty.
These Service Provider Networks can be viewed on **www.polmed.co.za**

PPN
The Optical Network Of Choice

denis

hearConnect

EMERGENCY MEDICAL CARE
ER24
084 124

- Anaesthetic Network
- Hospital Network
- General Practitioners Network
- Specialist Network
- Pharmacy Network
- Renal Dialysis Network
- Oncology Network
- Dental Network
- Audiology Network
- Psycho-Social Network

For more information about any of the above POLMED Networks please contact the POLMED Call Centre on **0860 765 633.**

WHY POLMED?

POLMED is a closed medical scheme that is tailored specifically for the South African Police Service (SAPS) members 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 under the Medical Schemes Act 131 of 1998, and its rules and benefits are authorised by the Council for Medical Schemes. Our primary focus is not on generating profits or accumulating reserves at the expense of our members' healthcare needs. The Scheme is governed by a Board of Trustees that places a priority on the wellbeing of our members and the sustainability of the Scheme.

Half of the Trustees are elected by members, whilst the other 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.

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, 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 (out-of-hospital) 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.
- All contact details and more.

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

- View all past interactions with the Scheme;
- 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 tools.

CHOOSE THE RIGHT PLAN FOR YOU AND YOUR FAMILY

Choosing a 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 will need to check that their needs are covered too. Consider how much you and your dependants have spent on medical expenses over the past 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 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

An 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 • Negotiated network tariff • Subject to pre-authorisation • Subject to **R5 000** co-payment where pre-authorisation was not obtained • Subject to managed care protocols and guidelines
Non-PMB hospital cover	Unlimited	R214 740	• An open network applies for Marine Plan • **R15 000** co-payment for admission in a non-network hospital on the Aquarium option • Scheme rates are applicable • Negotiated network tariff • Subject to pre-authorisation • Subject to **R5 000** co-payment where pre-authorisation was not obtained • Subject to managed care protocols and guidelines
Allied health services and alternative healthcare providers: Biokineticists Chiropractors Dieticians Homeopaths Naturopaths Orthoptists Osteopaths Chiropodists Reflexologists Therapeutic massage therapists	Yes	Yes	• Referral required for services rendered by all allied and auxilliary service providers in-hospital • A referral by the treating healthcare professional is required for services rendered. • Social worker and registered counselors: limit number of 4 (four) consultations in a benefit cycle
Anaesthetist's rate	Yes	Yes	• 100% agreed tariff at network provider
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

BENEFITS	MARINE	AQUARIUM	CO-PAYMENTS AND COMMENTS
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) limit • Subject to dentistry sublimit • Hospital and anaesthetist costs will be reimbursed from in-hospital benefits • Full Dental Benefit Guide can be downloaded at **www.polmed.co.za**
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 3 (three) days' hospitalisation if admitted by a GP or a specialist physician • Additional hospitalisation subject to motivation by the medical practitioner
Oncology (chemotherapy and radiotherapy)	Yes	Yes	• 100% of agreed tariff at network provider • Subject to set limit and includes MRI/CT or 2 (two) PET • Subject to oncology formulary • Subject to medicines from the preferred provider network • No specilaised drug limit for Aquarium in Oncology, limited to PMB
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
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

BENEFITS	MARINE	AQUARIUM	CO-PAYMENTS AND COMMENTS
Radiographers	Yes	Yes	• Referral by the treating healthcare professional is required for services rendered • 100% of agreed tariff • Basic radiology: Subject to basic radiology family limit, and Includes basic radiology in- and out-of-hospital • Specialised radiology: Subject to pre-authorisation; includes specialised radiology in- and out-of-hospital
Refractive surgery	Yes	No benefit	• 100% POLMED rate • Subject to pre-authorisation • Procedure performed out-of-hospital and in day clinics
Specialists	Yes	Yes	• 100% agreed tariff at network provider • 100% POLMED rate at non-network provider
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 • Subject to 20% co-payment if use out of formulary products • Co-payment will apply on the Aquarium plan for use of a non-network provider
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 • Dental network applies to Aquarium option – 30% co-payment for use of a non-network provide
General practitioners	Yes	Yes	• 100% agreed tariff at network provider • 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 provider • Subject to the OOH limit • Subject to POLMED Formulary reference price list • Subject to 20% co-payment for non-network utilisation
Medication (over-the-counter (OTC))	Yes	Yes	• 100% of POLMED rate at network provider • Subject to annual sublimit • Subject to OOH limit • Subject to POLMED Formulary • Subject to 20% co-payment for non-network utilisation

BENEFITS	MARINE	AQUARIUM	CO-PAYMENTS AND COMMENTS
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 R1 000 co-payment on Marine if no referral is obtained • Aquarium plan: 30% co-payment might be applicable subject to the referral rules
STAND-ALONE BENEFITS			
Allied health services and alternative healthcare providers: Art therapy, biokinetics, chiropractors, chiropodists, dieticians, homeopaths, naturopaths, orthoptists, osteopaths, podiatrists, reflexologists and therapeutic massage therapists	Yes	No benefit	• 100% POLMED rate • Subject to annual limit • Subject to clinical appropriateness
Maternity benefits (including home birth)	Yes	Yes	• Subject to pre-authorisation • Subject to treatment, 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
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 list • 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
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 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 subject to a 5-year cycle • Aquarium plan only PMB benefits • Full Dental Benefit Guide can be downloaded at **www.polmed.co.za**
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

Contact emergency services and the emergency 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

PLEASE NOTE:
It's important to use a network hospital or obtain a quote prior to the operation.

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
- Obesity Programme (only applicable to the Marine option)
- Oncology Management Programme
- HIV Management Programme
- Specialised Dentistry
- Weight Management Programme
- Conservative Back and Neck Rehabilitation Programme

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 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 medicine advanced supply

For an advanced supply of chronic medicine, please submit:

- Flight itinerary
- Valid prescription
- Departure date and return date
- Collection date at pharmacy

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 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
Anaesthetic Network	POLMED Anaesthetic Network	Open Network
General Practitioners (GP)	GP network	Over 3 901 GPs are on the GP network
Hospital	**Acute and mental health hospital network applicable to the Aquarium option:** • All Life Healthcare Hospitals • All Netcare Hospitals In areas where these hospitals are not well distributed, selected hospitals from other hospital groups are included. See right.	• Selected Clinix Hospitals • Selected JMH Hospitals • Selected Lenmed Hospitals • Selected Mediclinic Hospitals • Selected NHN Hospitals
Pharmacies	Pharmacy Network	Over 2 443 pharmacies on the network, which is made up of community pharmacies, retail pharmacies and courier pharmacies
Audiology Network	HearConnect Audiology Network	To be used for the authorisation of hearing aids
Dental Network	DENIS Dental Network	All DENIS contracted dentists Visit www.denis.co.za to find a network dentist
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** **084 124**	An accredited emergency service provider will be sent to attend to your medical emergency

PREVENTATIVE HEALTHCARE 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 will be covered from the in-hospital benefits and will not deplete your out-of-hospital benefits.

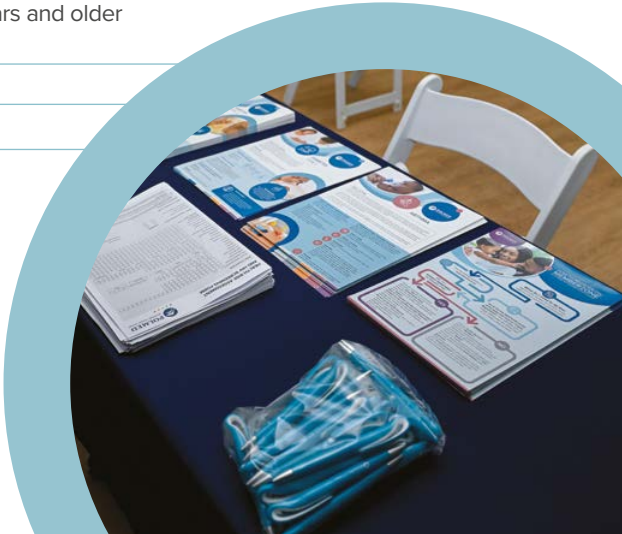
TEST		CARE, SCREENING, TEST
FULL MEDICAL EXAMINATION	TARIFF CODE	
Wellness visit	55500	**One wellness measure per year (tariff code 55500) inclusive of:** • Blood pressure test • Body mass index (BMI) test • Cholesterol screening (Z13.8) • Consultation • Glucose screening (Z13.1) • Healthy diet counselling (Z71.3) • Waist-to-hip ratio measurement

TEST	CARE, SCREENING, TEST
Prevention and screening tests	Annually 100% of POLMED rate or agreed tariff where applicable Early detection screening limited to periods specified Funded from the risk pool; the benefit shall not accrue to the overall out-of-hospital limit Inclusive of: • Occult blood test (screening for peptic ulcer disease), for members over the age of 50 years • Risk assessment tests • Baby immunisations (as per the DOH guidelines) • Bone densitometry scan for members 65 years and older (once per lifetime) • Circumcision • Hepatitis B vaccine (adults) from 18 years and older • Maternal Pertusis Booster • Colorectal Cancer Screening between 45 to 75 Years • 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 • Pap smear • Pneumococcal vaccine • Prostate screening

CHILDREN'S HEALTH	
Child immunisation Provided by the Department of Health (DOH) for children twelve (12) years old and younger	As per DOH age schedule included on the Road to Health chart
Infant hearing screening for infants up to 6 weeks of age As per guidelines of the Health Professions Council of South Africa which recommend that initial hearing screening should take place before one month of age and by no later than six weeks of age	Limited to one test in- or out-of-hospital for all infant beneficiaries
FEMALE HEALTH (WOMEN AND ADOLESCENT GIRLS)	
Cervical cancer screening ICD: Z12.4 For all women aged 21-64 years old, except for 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 5 (five) years for women aged 21 years and older
Breast cancer screening ICD: Z12.3 and ICD: Z01.6 Mammogram: all women aged 40-74 years old	Once every 2 (two) years, unless motivated
Contraceptives ICD: Z30	A contraceptive formulary applies
Maternal Pertussis Booster	Limited to 1 (one) vaccine per pregnancy in the third trimester, as part of the maternity program
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
Fissure sealants Fissure sealants for 5- to 25-year-olds	Maximum of 4 (four) per annum
Polishing (code 8155) and Prophylaxis (code 8159)	Two times a year Subject to managed care protocols
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	
Colorectal cancer screening between 45 and 75 years	Stool screening test every 2 (two) years
Hepatitis B vaccine for adults (18 years and older)	All adult beneficiaries
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 serving members of SAPS, utilising the Psycho-Social Network	4 (four) individual sessions or 4 (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, 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 1 (one) enrolment per beneficiary per annum subject to clinical protocols A separate basket to be funded from Risk Contact our Care Managers on **0860 765 633** or **polmeddiseaseman@medscheme.co.za**
GoSmokeFree 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 1 (one) enrolment per beneficiary per annum with a GoSmokeFree accredited network pharmacy 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 Book a pre-quit assessment with a GoSmokeFree advisor. Visit their website at **www.gosmokefree.co.za** for more information
Pertussis booster vaccine	Pertussis booster vaccine available to beneficiaries 7 (seven) years and older Limited to 1 vaccine per beneficiary every 10 (ten) years
Pneumococcal vaccines	Limited to one per beneficiary; every 5 (five) years
COVID-19 vaccine	COVID-19 vaccine in line with DOH protocol

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

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2025

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. It remains the responsibility of the member to acquire insurance cover when travelling outside the borders of the RSA.

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
- 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 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 in 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 with the 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 are used to identify the members eligible for enrolment in 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 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. Still, they will be required to make a co-payment on medication priced above the generic reference pricing limit. The fundamental principle of any reference pricing system is that it does not restrict a member's choice of medication but instead limits the amount that will be paid for it.

REGISTRATION FOR CHRONIC MEDICATION

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

medication benefit). POLMED requires members to apply for authorisation via the Chronic Medicine Management Programme to access this chronic medication benefit. Members will receive communication 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.

SPECIALISED DENTISTRY

Specialised dentistry refers to services that are not defined as basic dentistry. These include periodontal treatment, crowns and bridges, inlays, indirect veneers, orthodontic treatment, partial chrome cobalt frame dentures 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 removal of impacted teeth and extensive dental treatment for children younger than seven years will be considered for in-hospital treatment. Authorisation is subject to clinical criteria.

GENERAL RULES

APPLICATION OF CLINICAL PROTOCOLS AND FUNDING GUIDELINES

POLMED applies clinical protocols, including “Best practice guidelines” and evidence-based medicine principles, to 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, unless otherwise specified by the scheme rules and its annexures.

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 when 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 by requesting it via the Client Service Call Centre.

Examples of network service providers (where applicable) are:

- Anaesthetic Network
- Cancer (Oncology) Network
- General Practitioner (GP) Network
- Optometrist (Visual) Network
- Psycho-Social Network
- Renal (Kidney) Network
- Specialist Network
- Pharmacy Network
- Dental Network
- Audiology Networ

POLMED GP NETWORK (NETWORK GP PROVIDER)

Members and dependants are required to nominate a primary network GP. Principal members are required to nominate a secondary network GP as well. Members and dependants are each allowed 2 (two) visits to a GP who is not nominated per annum for emergency or out-of-town situations.

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 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 with respect to 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 of birth, Scheme rule 7.1.2 shall apply. Benefits shall also be granted if the child is stillborn. 3rd generation babies are excluded from this benefit.

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

EMERGENCY MEDICAL SERVICES (EMS): ER24 – 084 124

72-Hour Post-Authorisation Rule: Subject to authorisation within 72 hours of the event, all service providers will need to get an authorisation number from POLMED's 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 using 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**, via POLMED Chat or request it via the Client Services Call Centre.

AUDIOLOGY NETWORK

POLMED makes use of an Audiology network for its members. By using the network, POLMED members will not have any out of-pocket payments on approved audiology services up to available limits. Members can access the list of providers at **www.polmed.co.za,** via POLMED Chat or request it via the Client Services Call Centre.

ANAESTHETIC NETWORK

POLMED has established an anaesthetic network aimed at reducing beneficiaries' out-of-pocket payments.

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 Scheme's rules.

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 for OTC, acute, and chronic medications will be subject to the medication included in the POLMED formulary. Medication is included in the POLMED formulary based on its proven clinical efficacy and cost-effectiveness. Generic reference pricing is applicable where generic equivalent medication is available. 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 through 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, COVID-19 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 or can be declined, if not clinically appropriate. 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 the hearing aid if there is no referral from one of the following providers: GP, ear, nose and throat (ENT) specialist, paediatrician, physician, neurosurgeon 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 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).

WELLNESS, PREVENTATIVE CARE AND MANAGED CARE 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 programme uses strategic nudges to encourage members to improve their personal health. For more information, you can visit **www.polmed.co.za**

MATERNITY CARE PLAN

POLMED has amalgamated the current maternity benefit into a single care plan, to ease the member burden. The maternity care plan can be accessed with maternity ICD-10 codes.

OBESITY CARE PLAN

POLMED has introduced an Obesity Care Plan for qualifying members which includes 2 (two) GP consultations, specified Blood Tests, Nutritional Assessment, Psychology Assessment and a Weight Management Programme Care Plan.

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. An open network applies. Scheme rates are applicable	Unlimited at network service providers 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
Allied health services and alternative healthcare providers Chiropodists/Podiatrists Dieticians Physiotherapists Occupational therapist Social worker Counsellor/Psychologist Audiologist Speech Therapist Biokineticist	Service will be linked to hospital pre-authorisation. A referral by the treating healthcare professional is required for services rendered by all allied and auxiliary service providers. **This excludes care provided in following facilities:** • Rehabilitation • Sub-acute • Mental health step downs • Alcohol and rehabilitation Social workers and registered counsellors. Limit number of 4 (four) consultations in a benefit cycle Excluding Educational and industrial psychologist
Anaesthetists	• 100% of agreed tariff at network service provider

IN-HOSPITAL BENEFITS

Chronic renal dialysis At preferred providers	100% of agreed tariff at network service provider POLMED has established a Preferred 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) Surgical removal of impacted teeth and children under the age of 7 years requiring extensive dental treatment	100% of POLMED rate Dentist's costs for basic dental procedures will be reimbursed from the out-of-hospital (OOH) benefit, subject to: M – R6 972 M1 – R7 881 M2 – R8 633 M3 – R9 623 M4+ – R10 738 The hospital and anaesthetist's costs will be reimbursed from the in-hospital benefit Pre-authorisation required if hospitalised or use of moderate or deep sedation in the rooms
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 Pharmacy consultations limited to GP visits
Medication (non-PMB specialised drug limit, e.g. biologicals)	100% of POLMED rate Pre-authorisation required Specialised medication sub-limit of R213 778 per family
Mental health	100% of POLMED rate or At cost for PMBs Annual limit of 21 days per beneficiary in-hospital or 15 (fifteen) out-of-hospital psychotherapy sessions threshold in line with PMB benefits. Outside of threshold subject to Managed Care protocols 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 Limited to R560 145 per beneficiary per annum; includes MRI/CT or two (2) PET scans per family per year related to oncology, subject to managed care protocols **Limited to the overall oncology benefit per beneficiary:** Oncology specialised drugs (in and out of hospital) – R336 087 Chemotherapy and radiation limited to oncology benefits. Oncology specialised drugs subject to sublimit Adherence to the oncology formulary and subject to medicines from the preferred provider network

IN-HOSPITAL BENEFITS

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
Prosthesis (internal and external)	100% of POLMED rate Subject to pre–authorisation and approved product list **Limited to the overall prosthesis benefit of R87 167 per beneficiary** Knee joint prosthesis – R65 796 Below knee prosthesis – R65 796 Hip joint prosthesis – R65 796 Above knee prosthesis – R65 796 Shoulder joint prosthesis – R78 449 Intraocular lens – R3 795 Aorta and peripheral arterial stent grafts – R56 938 Cardiac stents – R32 264 Cardiac pacemaker – R70 856 Spinal plates and screws – R78 713 Spinal implantable devices – R72 303 Unlisted items – R78 713
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

OVERALL OUT-OF-HOSPTIAL BENEFTIS

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 Emergency Room (ER) visits are payable from out-of-hospital (OOH) benefit unless the member/beneficiary is admitted to the hospital on the same day	**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** M – R23 739 M1 – R28 917 M2 – R34 863 M3 – R40 046 M4+ – R43 549
Audiology	100% of POLMED rate Subject to the OOH limit Managed care protocols and hearing aid formulary apply. The products that are not included in the POLMED Formulary will attract a 20% co-payment **Subject to referral by the following doctors/specialists:** • General practitioner (GP) • Ear, nose and throat (ENT) specialist • Paediatrician • Physician • Neurologist • Neurosurgeon
Dentistry (conservative and restorative)	100% of POLMED rate **Subject to the OOH limit and includes dentist's costs for in-hospital, non-PMB procedures** M – R6 972 M1 – R7 881 M2 – R8 633 M3 – R9 623 M4+ – R10 738 Routine consultation, scale and polish are limited to 2 (two) annual check-ups per beneficiary

OVERALL OUT-OF-HOSPITAL BENEFITS

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 This benefit includes pharmacy consultation Members and dependants are each allowed 2 (two) 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, this includes PCDT Pharmacist Consultation benefit: R230 per consultation M – 11 M1 – 16 M2 – 20 M3 – 24 M4+ – 29
Medication (acute)	100% of POLMED rate at network service provider M – R5 541 M1 – R9 420 M2 – R13 297 M3 – R17 176 M4+ – R21 081 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 458 per family Subject to the OOH limit Subject to POLMED formulary Medication (Over-the-counter (OTC)) is subject to the acute sublimit
Occupational and speech therapy	100% of POLMED rate Annual limit of R3 368 per family Subject to OOH limit
Pathology	M – R4 051 M1 – R5 841 M2 – R6 985 M3 – R8 602 M4+ – R10 547 The defined limit per family will apply for any pathology service done out-of-hospital

OVERALL OUT-OF-HOSPITAL BENEFITS

Physiotherapy	100% of POLMED rate Annual limit of R5 840 per family Subject to the OOH limit
Psychologist and social worker Including marriage counselling	100% of POLMED rate Annual limit of R7 833 per family Subject to the OOH limit Marriage counselling – member will receive from psychologist or social worker Excluding educational and industrial psychology
Specialist referral: **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 • Art Therapists • Biokineticists • Dieticians • Homeopaths • Naturopaths • Orthoptists • Osteopaths • Chiropodists & Podiatrist • Reflexologists • Therapeutic Massage Therapists **Benefits will be paid for clinically appropriate services**	100% of POLMED rate Annual limit of R3 295 per family

STAND-ALONE BENEFITS

Appliances (medical and surgical) Members must be referred for audiology services for hearing aids to be reimbursed Hearing aid formulary applies. The products that are not included in the POLMED formulary will attract a 20% co-payment 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	R17 044 per hearing aid OR R33 877 per beneficiary per set Once every 3 (three) years
	Nebuliser	R1 617 per family Once every 4 (four) years
	Glucometer	R1 617 per family Once every 4 (four) years
	PAP machine	R19 127 per beneficiary Once every 4 (four) years
	Wheelchair (non-motorised) OR Wheelchair (motorised)	R26 737 per beneficiary Once every 3 (three) years R63 643 per beneficiary Every 3 (three) years
	Medical assistive devices	Annual limit of R8 254 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	 R253 091 per beneficiary per lifetime R495 179 per beneficiary per lifetime R150 205 per beneficiary every 5 (five) years
	Trans Aortic Valve Insertion	R319 336 per family per year
	Implantable Cardiac Defibrillators	R228 959 per family per year

STAND-ALONE BENEFITS

Appliances (medical and surgical)	**Insulin delivery devices**	
	Insulin pump device (limited to Type 1 diabetic members)	R81 980 per beneficiary per year One device every 5 (five) years
	Insulin pump consumables	R41 147 per beneficiary per year
	Continuous Glucose Monitoring (CGM) device	R30 855 per beneficiary per year One device every 5 (five) years
	Continuous Glucose Monitoring (CGM) consumables	R40 629 per beneficiary per year
	Urine catheters and consumables	Subject to cost effective quote and clinical protocols
	Blood transfusion	Unlimited
	Adult nappies	R1 196/month 2 (two) nappies per day) R1 797/month 3 (three) nappies per day)
	Blood pressure monitoring device • Subject to registration with chronic hypertension • Pre-authorisation required	R1 256 per family every 2 (two) years
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** M – R11 758 M1 – R14 093 M2 – R16 430 M3 – R18 766 M4+ – R21 102	
Dentistry (specialised) Pre-authorisation required	100% of POLMED rate or at cost for PMBs An annual limit of R17 118 per family Benefits shall not exceed the set-out limit Includes any specialised dental procedures done in/out of hospital Includes partial chrome cobalt dentures, orthodontics, crowns and bridge work, periodontics and maxillofacial surgery Includes Osseo Integrated implants for PMB conditions and where no alternative exists to restore function (on exception basis) Includes a second metal denture frame per beneficiary in a five-year period, where clinically appropriate PMB indicated Orthognathic and Temporo-Mandibular Joint (TMJ) surgery, with the option to refer for funding decisions where no alternative treatment options exist Subject to dental protocols (crowns and bridges five-year cycle)	

STAND-ALONE BENEFITS

Maternity benefits (including home birth) Pre-authorisation required Treatment protocols apply Benefit amalgamated into a single maternity care plan Refer to Maternity Care plan	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 R21 292 per beneficiary per annum Annual limit of R5 755 for ultrasound scans per beneficiary; 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 costs of the voluntary Caesarean section fall below the applicable co-payment amount of R10 000 Pre-authorisation is required
Maxillofacial Pre-authorisation required	Shared limit with specialised dentistry Includes Osseo Integrated implants for PMB conditions and where no alternative exists to restore function (on exception basis)
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 2 (two) years (unless prior approval for clinical indication has been obtained) Benefits are not pro rated, but calculated from the benefit service date Each claim for lenses or frames must be submitted with the lens prescription Benefits shall not be granted for contact lenses if the beneficiary has already received a pair of spectacles in a two-year benefit cycle Contact lens re-examination can be claimed for in six-monthly intervals	**PROVIDER NETWORK:** 100% of cost for a Composite consultation, inclusive of the refraction, a glaucoma screening and visual field screening and Authenticate IT. Composite consultation fee is R755. **WITH EITHER SPECTACLES**: R1 606 towards a frame and/or lens enhancement **LENSES** Either one pair of clear single vision lenses limited to R215 per lens or One pair of clear flat top bifocal lenses limited to R460 per lens or One pair of clear base multifocal lenses limited to R810 (Additional Multifocal Designer Group 1 up to R50 per lens) **OR CONTACT LENSES** Contact lenses to the value of R1 710 per beneficiary per annum. Contact lens re-examination to a maximum cost of R255 per consultation **NON-PROVIDER NETWORK** One consultation limited to a maximum cost of R400 **WITH EITHER SPECTACLES** R1 205 towards a frame and/or lens enhancement Either one pair of clear single vision lenses limited to R215 per lens or One pair of clear flat top bifocal lenses limited to R460 per lens or One pair of clear base multifocal lenses limited to R810 (Additional Multifocal Designer Group 1 up to R50 per lens) **OR CONTACT LENSES** Contact lenses to the value of R1 178 per beneficiary per year or Contact lens re-examination to a maximum cost of R255 per consultation

STAND-ALONE BENEFITS

Radiology (basic) i.e. black and white X-rays and soft tissue ultrasounds	100% of agreed tariff or at cost for PMBs Limited to R7 699 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 1 (one) MRI scan 2 (two) 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 2 (two) out-of-network consultations per beneficiary, any additional consultations are funded at non-network rate
Hospital	An open network applies. Scheme rates are applicable
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 Preferred 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
Oncology 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).
Voluntary caesarean sections	A co-payment of R10 000 will apply in all voluntary caesarean sections (PMBs apply) except in cases where the costs of the voluntary caesarean section fall below the applicable co-payment amount of R10 000

ANNUAL MEMBER CONTRIBUTIONS

CONTRIBUTIONS FROM 1 APRIL 2024 UNTIL 31 MARCH 2025

Marine member portion – 1 April 2024 to 31 March 2025

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 – R7 366	R474	R474	R118
R7 367 – R10 118	R656	R656	R221
R10 119 – R12 361	R725	R725	R272
R12 362 – R14 458	R855	R855	R341
R14 459 – R16 825	R997	R997	R396
R16 826 – R20 235	R1 142	R1 142	R466
R20 236 – R24 835	R1 258	R1 258	R544
R24 836 – R28 571	R1 366	R1 366	R598
R28 572 – R33 021	R1 390	R1 390	R610
R33 022 – R35 564	R1 417	R1 417	R621
R35 565 – R44 638	R1 443	R1 443	R632
R44 639 – R53 249	R1 470	R1 470	R644
R53 250+	R1 497	R1 497	R656

Marine full unsubsidised contribution – 1 April 2024 to 31 March 2025

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 – R7 366	R2 938	R2 938	R1 352
R7 367 – R10 118	R3 120	R3 120	R1 451
R10 119 – R12 361	R3 188	R3 188	R1 502
R12 362 – R14 458	R3 320	R3 320	R1 573
R14 459 – R16 825	R3 461	R3 461	R1 628
R16 826 – R20 235	R3 605	R3 605	R1 697
R20 236 – R24 835	R3 721	R3 721	R1 776
R24 836 – R28 571	R3 830	R3 830	R1 830
R28 572 – R33 021	R3 854	R3 854	R1 842
R33 022 – R35 564	R3 880	R3 880	R1 852
R35 565 – R44 638	R3 907	R3 907	R1 864
R44 639 – R53 249	R3 934	R3 934	R1 875
R53 250+	R3 961	R3 961	R1 888

CONTRIBUTION FROM 1 APRIL 2025 UNTIL 31 MARCH 2026

Marine member portion – 1 April 2025 to 31 March 2026

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 – R7 697	R495	R495	R123
R7 698 – R10 573	R686	R686	R231
R10 574 – R12 917	R758	R758	R284
R12 918 – R15 109	R893	R893	R356
R15 110 – R17 582	R1 042	R1 042	R414
R17 583 – R21 146	R1 193	R1 193	R487
R21 147 – R25 953	R1 315	R1 315	R568
R25 954 – R29 857	R1 427	R1 427	R625
R29 858 – R34 507	R1 453	R1 453	R637
R34 508 – R37 164	R1 481	R1 481	R649
R37 165 – R46 647	R1 508	R1 508	R660
R46 648 – R55 645	R1 536	R1 536	R673
R55 646+	R1 564	R1 564	R686

Marine full unsubsidised contributions – 1 April 2025 to 31 March 2026

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 – R7 697	R3 070	R3 070	R1 413
R7 698 – R10 573	R3 261	R3 261	R1 516
R10 574 – R12 917	R3 332	R3 332	R1 569
R12 918 – R15 109	R3 469	R3 469	R1 643
R15 110 – R17 582	R3 617	R3 617	R1 701
R17 583 – R21 146	R3 767	R3 767	R1 773
R21 147 – R25 953	R3 889	R3 889	R1 855
R25 954 – R29 857	R4 002	R4 002	R1 912
R29 858 – R34 507	R4 028	R4 028	R1 924
R34 508 – R37 164	R4 055	R4 055	R1 935
R37 165 – R46 647	R4 083	R4 083	R1 947
R46 648 – R55 645	R4 111	R4 111	R1 959
R55 646+	R4 139	R4 139	R1 973

MARINE CHRONIC DISEASE LIST

PRESCRIBED MINIMUM BENEFITS (PMBS), INCLUDING CHRONIC DIAGNOSIS AND TREATMENT PAIRS (DTPS) AND ADDITIONAL DISEASES AS DEFINED BELOW

Chronic medication is payable from chronic medication benefits once the benefit limit has been reached, PMB-related drugs will be funded from the unlimited PMB pool.

Auto-immune disorder
Systemic lupus erythematosus (SLE)
Myasthenia Gravis (MG)

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 hyperthyroidism
Cushing's disease
Hyperprolactinaemia
Polycystic ovaries
Primary hypogonadism

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

Gynaecological conditions
Endometriosis
Menopausal treatment

Haematological conditions
Haemophilia Anaemia
Idiopathic thrombocytopenic purpura
Megaloblastic anaemia

Metabolic condition
Hyperlipidaemia

Musculoskeletal condition
Rheumatic arthritis

Neurological conditions
Epilepsy
Multiple sclerosis
Parkinson's disease
Cerebrovascular incident
Permanent spinal cord injuries
Neuromyelitis Optica (NMO)
Huntington's Disease (HD)

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 condition
Overactive bladder syndrome

POLMED PLAN
AQUARIUM SCHEDULE

SCHEDULE OF BENEFITS

WITH EFFECT FROM 1 JANUARY 2025

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. It remains the responsibility of the member to acquire insurance cover when travelling outside the borders of the RSA.

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
- 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 that are eligible for enrolment 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 communication 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.

SPECIALISED DENTISTRY

Specialised dentistry refers to services that are not defined as basic dentistry. These include periodontal treatment, crowns and bridges, inlays, indirect veneers, orthodontics, partial chrome cobalt frame dentures and maxillofacial surgery.

Aquarium only makes provision for specialised dental treatment for PMB events and predefined codes as set out in the dental benefit table. All specialised dentistry services and procedures must be pre-authorised, failing which the Scheme will impose a co-payment of R500. Only removal of impacted teeth and extensive dental treatment for children younger than seven years will be considered for in-hospital treatment. Authorisation is subject to clinical criteria.

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, unless otherwise specified by the scheme rules and its annexures. 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 when 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 by requesting it via the Client Service Call Centre.

Examples of network service providers (where applicable) are:

- Anaesthetic Network
- Cancer (oncology) Network
- General Practitioner (GP) Network
- Optometrist (visual) Network
- Psycho-social Network
- Renal (kidney) Network
- Specialist Network
- Pharmacy Network
- Dental Network
- Audiology Network
- Hospital Network

POLMED GP NETWORK (NETWORK GP PROVIDER)

Members and dependants are required to nominate a primary network GP. Principal members are required to nominate a secondary network GP as well. Members and dependants are each allowed 2 (two) 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**, via POLMED Chat or request it via the Client Service Call Centre.

Failure to make use of a hospital on the POLMED network may incur a co-payment of up to R15 000. 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 new-born baby shall be regarded as part of the mother's cost for the first 90 days after birth. If the child is registered on the Scheme within 90 days from birth, Scheme rule 7.1.2 shall apply. Benefits shall also be granted if the child is stillborn.

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

EMERGENCY MEDICAL SERVICES (EMS): ER24 – 084 124

72-Hour Post-Authorisation Rule

Subject to authorisation within 72 hours of the event, all service providers will need to get a authorisation 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 Aquarium plan members. By using 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,** via POLMED Chat or request it via the Client Services Call Centre. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply).

AUDIOLOGY NETWORK

POLMED makes use of an Audiology network for its members. By making use of the network, POLMED members will not have any out-of-pocket payments on approved audiology services up to available limits. Members can access the list of providers at **www.polmed.co.za,** via POLMED chat or request it via the Client Services Call Centre. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply).

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. Approval is subject to income band.

ANAESTHETIC NETWORK

POLMED has established an anaesthetic network aimed at reducing out-of-pocket payments by beneficiaries.

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 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 through 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, COVID-19 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 (2) 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 the hearing aid if there is no referral from one of the following providers: GP, ear, nose and throat (ENT) specialist, paediatrician, physician, neurosurgeon 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 programe 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).

WELLNESS, PREVENTATIVE CARE AND MANAGED CARE 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 programme uses strategic nudges to encourage members to improve their personal health. For more information, you can visit **www.polmed.co.za**

MATERNITY CARE PLAN

POLMED has amalgamated the current maternity benefit into a single care plan, to ease the member burden. The maternity care plan can be accessed with maternity ICD-10 codes, which can be accessed at **www.polmed.co.za,** via POLMED Chat or request it via the Client Services Call Centre.

GENERAL BENEFIT RULES

Benefit	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 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 co-payment 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 R214 740 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	• 100% of agreed Tariff at Network Provider

IN-HOSPITAL BENEFITS

Allied health services and alternative healthcare providers • Chiropodist/Podiatrist • Dietician • Physiotherapist • Occupational therapist • Social worker • Counsellor/Psychologist • Audiologist • Speech therapist • Biokineticist	Service will be linked to hospital pre-authorisation. A referral by the treating Healthcare professional is required for services rendered by all allied and auxiliary service providers **This excludes care provided in the following facilities:** • Rehabilitation • Sub-acute • Mental health • Step downs • Alcohol and rehabilitation Social workers and registered counsellors. Limit number of 4 (four) consultations in a benefit cycle. Excluding Educational and industrial psychologist
Chronic renal dialysis at preferred providers	100% of agreed tariff at network service provider POLMED has established a Preferred 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) Surgical removal of impacted teeth and children under the age of 7 years requiring extensive dental treatment	100% of POLMED rate Dentist's costs for all non–PMB procedures will be reimbursed from the out–of–hospital (OOH) benefit, subject to: M – R4 984 M1 – R5 620 M2 – R6 214 M3 – R 6 821 M4+ – R7 440 The hospital and anaesthetist's costs will be reimbursed from the overall non-PMB limit Includes Osseo Integrated implants for PMB conditions and where no alternative exists to restore function (on exception basis) PMB indicated Orthognathic and Temporo-Mandibular Joint (TMJ) surgery, with the option to refer for funding decisions where no alternative treatment options exist Pre-authorisation required if hospitalised or use of moderate or deep sedation in the rooms
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

IN-HOSPITAL BENEFITS

Medication (non-PMB specialist drug limit, e.g. biologicals)	100% of POLMED rate Pre-authorisation required Specialised medication sublimit of R154 762 per family
Mental health	100% of POLMED rate or At cost for PMBs Annual limit of 21 days per beneficiary in-hospital or 15 (fifteen) out-of-hospital psychotherapy sessions threshold in line with PMB benefits. Outside of threshold subject to Managed Care protocols Limited to a maximum of 3 (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 Limited to R291 402 per beneficiary per annum; includes MRI/CT or 2 (two) PET scans per family per year related to oncology, subject to managed care protocols Oncology specialised drugs - subject to PMB Chemotherapy and radiation limited to oncology benefits. Oncology specialised drugs subject to sublimit 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
Prosthesis (internal and external)	100% of POLMED rate Subject to pre-authorisation and approved product list **Limited to the overall prosthesis benefit of R83 683 per beneficiary** Knee joint prosthesis – R58 624 Below knee prosthesis – R58 624 Hip joint prosthesis – R58 624 Above knee prosthesis – R58 624 Shoulder joint prosthesis – R68 858 Intraocular lens – R3 382 Aorta and peripheral arterial stent grafts – R50 732 Cardiac stents – R28 749 Cardiac pacemaker – R63 133 Spinal plates and screws – R68 858 Spinal implantable devices – R64 422 Unlisted items – R68 858
Radiographers	A referral by the treating healthcare professional is required for services rendered
Refractive surgery	No benefit

IN-HOSPITAL BENEFITS

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

OVERALL OUT-OF-HOSPTIAL BENEFTIS

Annual overall out-of-hospital (OOH) limit Emergency Room (ER) visits are payable from out-of-hospital (OOH) benefit unless the member/beneficiary is admitted to the hospital on the same day Benefits shall not exceed the amount set out in the table PMBs shall first accrue towards the total benefit, but are not subject to limit In appropriate cases the limit for medical appliances shall not accrue towards this limit **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	M – R9 462 M1 – R11 472 M2 – R13 936 M3 – R14 876 M4+ – R17 042
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 • Neurosurgeon • Providers on the Audiology Network must be used	100% of POLMED rate Subject to the OOH limit Managed care protocols and hearing aid formulary apply. The products that are not included in the POLMED Formulary will attract a 20% co-payment
Dentistry (conservative and restorative)	100% of POLMED rate Subject to the OOH limit and includes dentist's costs for in-hospital, non-PMB procedures M – R4 984 M1 – R5 620 M2 – R6 214 M3 – R6 821 M4+ – R7 440 Routine consultation, scale and polish are limited to two (2) annual check-ups per beneficiary Subject to the use of the dental network. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply)

OVERALL OUT-OF-HOSPITAL BENEFITS

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 planing 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. Main members are allowed to nominate 2 (two) GP's and 1 (one) dependants. Members and dependants are each allowed 2 (two) 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: M – 8 M1 – 12 M2 – 15 M3 – 18 M4+ – 22
Medication (acute)	100% of POLMED rate at network service provider M – R2 496 M1 – R4 245 M2 – R5 992 M3 – R7 740 M4+ – R9 487 Subject to the OOH limit Subject to POLMED Formulary

OVERALL OUT-OF-HOSPITAL BENEFITS

Medication (over-the-counter (OTC))	100% of POLMED rate at network service provider Annual limit of R1 074 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	M – R3 328 M1 – R4 923 M2 – R5 954 M3 – R7 371 M4+ – R9 131 The defined limit per family will apply for any pathology service done out-of-hospital
Physiotherapy	100% of POLMED rate Annual limit of R2 575 per family Subject to the OOH limit
Psychologist and social worker Including marriage counselling	100% of POLMED rate Annual limit of R5 369 per family Subject to the OOH limit Marriage counselling – member will receive from psychologist or social worker
Specialist referral: **Referral is not necessary for the following specialists:** • Gynaecologists • Psychiatrists • Oncologists • Ophthalmologists • Nephrologists (dialysis) • 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 Art Therapy, Biokineticists, Chiropractors, Chiropodists, Dieticians, Homeopaths, Naturopaths, Orthoptists, Osteopaths, Podiatrists, Reflexologists, Therapeutic Massage Therapists Benefit is subject to clinically appropriate services	No benefit

STAND-ALONE BENEFITS

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

Blood pressure monitoring device is subject to registration with chronic hypertension. Pre-authorisation required

100% of POLMED rate	
Blood transfusions	Unlimited
Hearing aids	R12 153 per hearing aid or R24 152 per beneficiary per set Once every 3 (three) years Service providers on the Audiology Network must be used
Nebuliser	R1 378 per family Once every 4 (four) years
Glucometer	R1 378 per family Once every 4 (four) years
PAP machine	R13 389 per beneficiary Once every 4 (four) years
Wheelchair (non-motorised) or Wheelchair motorised	R14 812 per beneficiary. Once every 3 (three) years R36 903 per beneficiary. Once every 3 (three) years
Urine catheters and consumables	Subject to cost-effective quote and clinical protocols
Medical assistive devices	Annual limit of R5 905 per family Includes medical devices in-/out-of-hospital
Insulin delivery devices (limited to type 1 diabetic members)	R81 980 per beneficiary. One device every 5 (five) years
Insulin pump consumables	R41 147 per beneficiary per year
Continuous Glucose Monitoring (CGM) Device	R30 855 per beneficiary. One device every 5 (five) years
Continuous Glucose Monitoring (CGM) Consumables	R40 629 per beneficiary per year
Adult nappies	R1 016/month (2 (two) nappies per day) R1 523/month (3 (three) nappies per day)
Blood pressure monitoring device • Subject to registration with chronic hypertension • Pre-authorisation required	R1 256 per family every 2 (two) years

STAND-ALONE BENEFITS

Chronic medication refers to non-PMB conditions Subject to prior application and/or registration of the condition Approved PMB CDL conditions are not subject to a limit	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 At cost for involuntary PMB access The limit for consultations shall not accrue towards the OOH limit Benefit amalgamated into a single maternity care plan Subject to Maternity Care Plan	100% of agreed tariff at network service provider or 100% of POLMED rate at non-network service provider Home birth is limited to R16 254 per beneficiary per annum Annual limit of R4 336 for ultrasound scans per beneficiary 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) except in cases where the costs of the voluntary caesarean section fall below the applicable co-payment amount of R10 000
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 2 (two) years (unless prior approval for clinical indication has been obtained) Benefits are not pro-rated, but calculated from the benefit service date Each claim for lenses or frames must be submitted with the lens prescription Screening for children 3-5 years old: • Amblyopia • Strabismus	**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 R755 **WITH EITHER SPECTACLES** R835 towards a frame and/or lens enhancement **LENSES** Either one pair of clear single vision lenses limited to R215 per lens or One pair of clear flat top bifocal lenses limited to R460 per lens or One pair of clear base multi-focal lenses limited to R460 per lens **OR CONTACT LENSES** Contact lenses to the value of R644 per beneficiary per annum Contact lens re-examination to a maximum cost of R255 per consultation

STAND-ALONE BENEFITS

Optical (continue) 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 R400 **WITH EITHER SPECTACLES** R626 towards a frame and/or lens enhancement Either one pair of clear single vision lenses limited to R215 per lens or One pair of clear flat top bifocal lenses limited to R460 per lens or One pair of clear base multifocal lenses limited to R460 per lens **OR CONTACT LENSES** Contact lenses to the value of R400 per beneficiary per annum Contact lens re-examination to a maximum cost of R255 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 617 per family Includes any basic radiology done in- or out-of-hospital Claims for PMBs first accrue towards the limit Dental X-rays covered from dental benefit Bone density for members younger than 65 years old (once in a lifetime)
Radiology (specialised) Pre-authorisation required 1 (one) MRI scan 2 (two) CT scans	100% of agreed tariff or At cost for PMBs Includes any specialised radiology service done in- or out-of-hospital Claims for PMBs first accrue towards the limit Subject to a limit of 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 2 (two) 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
Audiology network	Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply)
Chronic renal dialysis	POLMED has established a Preferred 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
Oncology 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)
Voluntary Caesarean Sections	A co-payment of R10 000 will apply in all voluntary Caesarean Sections (PMBs apply) except in cases where the costs of the voluntary Caesarean Section fall below the applicable co-payment amount of R10 000.
Dental Network Service Providers	POLMED has established a network for dental treatment. Members who voluntarily opt to use a non-network provider will be liable for a 30% co-payment (PMBs apply)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ANNUAL MEMBER CONTRIBUTIONS

CONTRIBUTIONS FROM 1 APRIL 2024 UNTIL 31 MARCH 2025

Aquarium member portion – 1 April 2024 to 31 March 2025

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 – R7 366	R117	R117	R50
R7 367 – R10 118	R127	R127	R50
R10 119 – R12 361	R168	R168	R65
R12 362 – R14 458	R208	R208	R76
R14 459 – R16 825	R246	R246	R89
R16 826 – R20 235	R283	R283	R101
R20 236 – R24 835	R351	R351	R117
R24 836 – R28 571	R411	R411	R155
R28 572 – R33 021	R436	R426	R165
R33 022 – R35 564	R454	R454	R173
R35 565 – R44 638	R493	R493	R187
R44 639 – R53 249	R499	R499	R189
R53 250+	R503	R503	R190

Aquarium full unsubsidised contributions – 1 April 2024 to 31 March 2025

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 – R7 366	R1 364	R1 364	R674
R7 367 – R10 118	R1 376	R1 376	R674
R10 119 – R12 361	R1 417	R1 417	R65
R12 362 – R14 458	R1 455	R1 455	R701
R14 459 – R16 825	R1 495	R1 495	R712
R16 826 – R20 235	R1 531	R1 531	R726
R20 236 – R24 835	R1 600	R1 600	R739
R24 836 – R28 571	R1 659	R1 659	R779
R28 572 – R33 021	R1 686	R1 686	R788
R33 022 – R35 564	R1 705	R1 705	R796
R35 565 – R44 638	R1 791	R1 791	R835
R44 639 – R53 249	R1 796	R1 796	R837
R53 250+	R1 800	R1 800	R838

CONTRIBUTIONS FROM 1 APRIL 2025 UNTIL 31 MARCH 2026

Aquarium member portion – 1 April 2025 to 31 March 2026

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 – R7 697	R122	R122	R52
R7 698 – R10 573	R133	R133	R52
R10 574 – R12 917	R176	R176	R68
R12 918 – R15 109	R217	R217	R79
R15 110 – R17 582	R257	R257	R93
R17 583 – R21 146	R296	R296	R106
R21 147 – R25 953	R367	R367	R122
R25 954 – R29 857	R429	R429	R162
R29 858 – R34 507	R456	R456	R172
R34 508 – R37 164	R474	R474	R181
R37 165 – R46 647	R535	R535	R203
R46 648 – R55 645	R541	R541	R205
R55 646+	R546	R546	R206

Aquarium full unsubsidised contributions – 1 April 2025 to 31 March 2026

INCOME BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R7 697	R1 425	R1 425	R704
R7 698 - R10 573	R1 438	R1 438	R704
R10 574 - R12 917	R1 481	R1 481	R720
R12 918 - R15 109	R1 520	R1 520	R732
R15 110 - R17 582	R1 562	R1 562	R744
R17 583 - R21 146	R1 600	R1 600	R759
R21 147 - R25 953	R1 672	R1 672	R772
R25 954 - R29 857	R1 733	R1 733	R814
R29 858 - R34 507	R1 762	R1 762	R823
R34 508 - R37 164	R1 781	R1 781	R832
R37 165 - R46 647	R1 891	R1 891	R880
R46 648 - R55 645	R1 896	R1 896	R882
R55 646+	R1 901	R1 901	R883

AQUARIUM: CHRONIC LIST

PRESCRIBED MINIMUM BENEFITS (PMBs); INCLUDING CHRONIC DIAGNOSIS AND TREATMENT PAIRS (DTPs) AND ADDITIONAL DISEASES AS DEFINED BELOW:

Auto-immune disorder
Systemic lupus erythematosus (SLE)
Myasthenia Gravis (MG)

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
Neuromyelitis Optica (NMO)

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

GENERAL 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.

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 a public hospital;
   - as defined in the 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. 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;
7. Prenatal and/or postnatal exercises;
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/full dentures including laboratory costs, invisible retainers and bleaching of vital (living) teeth;

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

12. Temporo-mandibular joint (TMJ) Benefit limited to non-surgical intervention;

13. Orthognathic (jaw correction) and other orthodontic related surgery, and any associated hospital and laboratory costs (PMB only);

14. Oral hygiene education and plaque control instruction;

15. Any orthopaedic and medical aids that are clinically essential, subject to PMBs;

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

17. Sex change operations;

18. Beneficiaries' travelling costs, except services according to the benefits in Annexure A and B of the Scheme rules;

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

20. Accommodation in spas, health or rest resorts;

21. Holidays for recuperative purposes;

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

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

24. Any treatment as a result of surrogate pregnancy;

25. 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;

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

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

28. 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;

29. 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;

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

31. Benefits for organ transplant donars to recipients who are not members of the Scheme;

32. Claims relating to the following:
    - Aptitude tests
    - IQ tests
    - School readiness
    - Questionnaires
    - Learning problems
    - Behavioural problems

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

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

35. All benefits for clinical trials;

36. Any new chemotherapeutic drug that has not convincingly demonstrated a survival advantage of more than 3 (three) months in advanced or metastatic malignancies unless pre-authorised by the managed care organisation as a cost-effective alternative to standard chemotherapy.
    36.1 Devices without Dual Power Options: The Scheme will not cover the costs associated with backup power solutions for medical devices that do not incorporate a dual power option, such as a built-in battery or equivalent functionality.
    36.2 Loadshedding-Induced Power Interruptions: The Scheme shall not be responsible for any expenses incurred for the procurement, installation, maintenance, or operation of backup power sources required solely as a consequence of loadshedding or other power supply disruptions.

37. Oral hygiene instructions (code 8151).

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 related	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	Aqueous cream
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®
9.03	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	

CATEGORY	DESCRIPTION	EXAMPLE
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 part of PMB-related services accessories	Stoma bags, adhesive paste, pouches and accessories
5.08	Appliances, supplies and devices: Medicated dressings, except where these form part of PMB-related services	Opsite®, Intrasite®, Tielle®, Granugel®
5.10	Appliances, supplies and devices: Surgical appliances/products for home nursing	Catheters, urine bags, butterflies, dripsets, alcohol swabs
7.01	Treatment/prevention of substance abuse: Opioid	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)

Day surgery procedures will be funded from the hospital benefit if done in a doctor's rooms or day clinics, subject to the relevant managed healthcare programme and subject to a defined list of procedures.

Pre-authorisation is required. If these are done in facilities other than those specified, the member may be liable for a R2 000 co-payment, except in the following cases:

- Medical emergency
- The doctor does not have the necessary equipment to perform the procedure
- No Day Clinics nearby
- The case is clinically complex as per POLMED protocols

PREVENTATIVE HEALTHCARE BENEFITS (ANNEXURE E)

PREVENTATIVE HEALTHCARE BENEFIT 2025

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.

TEST		SCREENING TEST INCLUDED
FULL MEDICAL EXAMINATION	**Tariff Code**	
Wellness visit	55500	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 **Inclusive of:** • Blood pressure test • Body mass index (BMI) test • Cholesterol screening (Z13.8) • Consultation • Glucose screening (Z13.1) • Healthy diet counselling (Z71.3) • Waist-to-hip ratio measurement Clinical information to be submitted to managed care

ANNEXURE E (Continued)

PREVENTATIVE HEALTHCARE BENEFIT 2025

TEST	SCREENING TEST INCLUDED
Risk Assessment	• Baby immunisations (as per the DOH guidelines) • Bone densitometry scan for members 65 years and older (once in a lifetime) • Circumcision • Contraceptives (as per the DOH guidelines) • Dental screening (codes 8101, 8151 and 8102) • Optical screening for lazy eye (Amblyopia) and squints (Strabismus) for children between 3-5 years of age • Flu vaccine • Glaucoma screening • HIV tests • HPV screening once every 5 (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 Clinical information to be submitted to managed care
CHILD HEALTH	
All child immunisations	Provided by the Department of Health (DOH) for children 12 (twelve) years old and younger As per DOH age schedule included on the Road to Health chart
Infant hearing screening for infants	Infants up to 6 weeks of age – as per guidelines of the Health Professional Council of South Africa which recommends that initial hearing screening should take place before one month of age and by no later than six weeks of age Limited to one test in- or out-of-hospital for all infant beneficiaries
FEMALE HEALTH (WOMEN AND ADOLESCENT GIRLS)	
Cervical cancer screening ICD: 212.4	For all females aged 21-64 years old, except for those women who have had a completehysterectomy with no 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

TEST	SCREENING TEST INCLUDED
Breast cancer screening ICD: 212.3 and ICD: 201.6	Mammogram: All women aged 40-74 years old Once every two years, unless motivated
Contraceptives ICD: 230	Contraceptive formulary applies
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
Fissure sealants for 5 to 25-year-olds	Maximum of 4 (four) per annum
Polishing (code 8155) and Prophylaxis (code 8159)	2 (two) times a year Subject to managed care protocols
HIV COUNSELLING AND TESTING	
HIV counselling and pre-counselling	Annually
HCT consultation, rapid testing and post counselling	Annually
HIV testing	Annually Elisa: 3932 Confirmation test: Western Blot (payable after HCT or Elisa tests)
OTHER	
Flu vaccine	Annually
Hib Titer for 60 years and older	Annually Serology: IgM: specific antibody Titer
Prostate cancer screening	Annually For all males aged between 50 and 75 years
Glaucoma screening	Once every third year, unless motivated
Circumcision	Subject to clinical protocols
Post-trauma debriefing session	Four individual sessions **or** four group debriefing sessions per year Only for active principal members of SAPS, utilising the Psycho-Social Network

ANNEXURE E (Continued)

PREVENTATIVE HEALTHCARE BENEFIT 2025

TEST	SCREENING TEST INCLUDED
Weight Management Programme	A 12-week exercise programme provided by BASA (Biokineticist Association of South Africa). It includes an HRA (Health Risk Assessment), group or individual exercise sessions, consultation with a dietician and psychologist 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
GoSmokeFree Programme	GoSmokeFree Programme is delivered by a trained nurse through HealthCraft accredited pharmacies. The approach includes motivational behavioural change, clinical measures (carbon monoxide readings), and follow-ups to manage relapse rates 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 with a GoSmokeFree accredited network pharmacy 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
Pertussis booster vaccine for members between 7 and 64 years	As per the World Health Organization (WHO) recommendation, countries like South Africa, using pertussis vaccine in the primary infant immunisation schedule, should consider additional boosters and maternal immunisation. Limited to 1 (one) vaccine per beneficiary every 10 years
Maternal Pertussis Booster Vaccine for pregnant females	Limited to 1 (one) vaccine per pregnancy as part of the maternity programme
COVID-19 Vaccine Benefit	Regulations stipulate that the COVID-19 vaccine is considered PMB Limited to PMB requirements
Pneumococcal Vaccine	Limited to 1 (one) vaccine per beneficiary every 5 (five) years
Colorectal Cancer screening between 45 and 75 years	Stool screening test every 2 (two) years
Hepatitis B Vaccine for adults (18 years and older)	All adult beneficiaries

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.

MEMBERSHIP

MEMBERSHIP

NEW MEMBER APPLICATION

- Serving members
- Dependants

THIRD GENERATION CHILDREN DO NOT QUALIFY (GRANDCHILDREN)

NEW MEMBER APPLICATION DOCUMENTATION REQUIRED

- Application for membership form.
- Letter of appointment or SAP96.
- Copy of ID.
- Proof of income (salary advice).
- Copy of 3 (three) months bank statements or stamped letter from the bank confirming your banking details.
- Membership certificate from previous medical aid if applicable.

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.
- Membership certificate from previous medical aid if applicable.
- Marriage certificate/Lobola letter.

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

STUDENTS 21 TO 29 YEARS OLD

- Child rates will apply for students between the age of 21 up until the age of 24 years old. From the age of 25 adult subsidised rates will apply.
- Certificate of registration at registered tertiary learning institution – by the end of February each year.
- Copy of ID.
- Adult subsidised rates apply.

FINANCIALLY DEPENDENT 21 TO 29 YEARS OLD

- Affidavit B confirming financial dependency.
- Copy of ID.
- Adult subsidised 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.

FOSTER CARE

- Proof that child has been placed under the care of the member.
- Copy of birth certificate.

PARENTS AND PARENTS-IN-LAW

- Proof of financial dependency.
- Copy of ID.
- Adult unsubsidised rates apply.

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.

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

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 Pension from GEPF
- 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

INJURY-ON-DUTY (IOD) BENEFITS

Sustained an injury while on duty and not sure what to do and what you are entitled to? Relax, because the IOD office is here for you.

How do I report injuries-on-duty?

Every employee who sustains an injury (irrespective of how minor it appears to be) or contracts a disease during the course of and as a result of the execution of official duties, should report such an injury or disease to our employer, the SAPS. IODs are regulated by COIDA (Compensation for Occupational Injuries and Diseases Act, 1993) (Act no 130 of 1993). The members must report the injury to his/her commander immediately or before reporting off duty. If he/she is unable to give a report, a colleague must do so on behalf of the injured member.

The following forms are used for injury on duty:

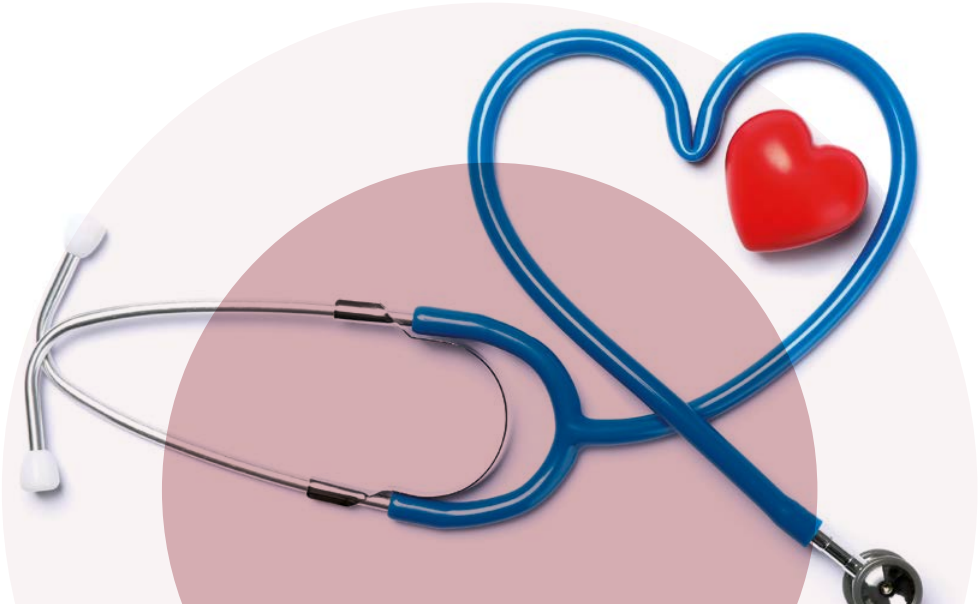
- WCL 2 (Employer's report of an accident)
- WCL 3 (Notice of an accident)
- WCL 4 (First medical report)
- WCL 5 (Progress or final medical report)
- WCL 6 (Resumption report)
- A certified copy of the injured person's ID, as well as a copy of the salary advice of the month in which the injury was sustained
- WCL 226 (Transport questionnaire) in case of MVA
- Assault report in case of assault

The following forms are used for COVID-19:

- WCL 1 (Employer's report)
- 14 Notice of an occupational disease and claim for compensation.
- WCL 22 (First medical report in respect of an occupational disease) from the treating Medical Practitioner
- WCL 26 (Progress/Final medical report in respect of an occupational disease) from the treating Medical Practitioner
- WCL 110 (COVID-19 exposure and medical questionnaire)
- Certified Copy of identity document to be attached
- Test result from Pathologist
- A certified copy of the injured member's ID, as well as a salary advice for the month in which the disease was contracted

The following forms are used for Post-Traumatic Stress Disorder:

- WCL 1//2 (Employer's report of an accident)
- WCL 3 (Notice of an accident)
- WCL 303 (First medical report)
- WCL 304 (Progress or final medical report)
- WCL 6 (Resumption report)
- Detailed Psychiatrist Report from treating doctor with brief psychiatrist rating scale, impairment rating scale and global assessment function (GAF)
- A certified copy of the injured person's ID, as well as a copy of the salary advice of the month in which the illness was contracted



What must the commander do after the IOD has been reported?

The employer (commander) must complete the WCL 2 within 24 hours, and the medical practitioner treating the employee, must complete part B of WCL 2 and attach it to the medical account. The employer reports the accident or occupational disease by submitting the WCL 2/1, WCL 4/22/303, certified copy of ID and salary advice to Head Office within 14 working days after the day of the injury, to report an IOD to the Compensation Fund (section 39 of the COIDA).

The following documents must be compiled and submitted to Head Office within THREE months after the date of the injury to determine whether the alleged injury/ disease meets the criteria for recognition as an IOD:

- SAPS 114
- The injured member's supplementary statement
- The WCL 4 (normal injury)/303 (PTSD)/22 (COVID-19) and/or medical certificate
- The on-duty statement from the commander
- The first report statement
- The witness' statement/s
- A copy of the pocketbook or diary entry
- Test results from the pathologist in case of COVID-19
- The call-up instruction for the course, if applicable
- The provincial/national sport championship call-up instruction, if applicable
- Physical fitness call-up instruction (for SAPS Act employees)
- A copy of the Occurrence Book entry

Am I still covered after my IOD claim is finalised?

Benefits are payable to the employee within the prescribed 24 months or until such time that the employee's condition becomes stabilised. The employee's right to further benefits (compensation and medical treatment) will only be revived if the claim is reopened. For this to happen, the medical service provider must submit a request for "Reopening of a Claim" on their letterhead and the online Comp Easy system or submit it manually at a Labour centre; alternatively, contact the POLMED and SAPS IOD departments.

SAPS IOD Human Resources Department:
Tel: 012 393 2848/1501/1626/1803/2941
Email address: LeonardQ@saps.gov.za/NakengDM@saps.gov.za

SAPS IOD Finance Management Services:
Tel: 012 393 2435/4461/4409
Email address: Delporth@saps.gov.za / SekoriPiet@saps.gov.za

Want to speak to us?
If you would like to speak to us, please do not hesitate to contact our Client Service Centre or send us an email.
Tel: 0860 765 633 or 0860 POLMED
Email: polmed@medscheme.co.za
Fax: 0860 104 114

POLMED Client Service Centre:
Nedbank Plaza, C/o Stanza Bopape and Steve Biko Streets,
Arcadia, 0083

Claims, Membership and Contributions:
POLMED, Private Bag X16,
Arcadia, 0007

Council for Medical Schemes:
www.medicalschemes.co.za

POLMED Fraud Hotline:
Tel: 0800 112 811
Email: fraud@medscheme.co.za

APPLICATION FOR EX GRATIA

EX GRATIA IS NOT A BENEFIT EXTENSION

Need medical care but your benefits are exhausted?

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

Ex Gratia does not pertain to the following:

- Scheme exclusions
- Stale claims (older than 120 days)
- Co-payments
- Amounts less than R1 000
- Costs relating to out-of-hospital benefits

HOW DO I APPLY FOR EX GRATIA BENEFITS?

Principal member applies for assistance.

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

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

Submit the application

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

Outcome of application communicated to member

CLAIMS PROCEDURE (SCHEME RULE 15)

Members: Submission of claims

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

Service providers: Submission of claims

Most service providers submit their claims electronically

Payment of claims

You will receive a claims statement that will advise you of the outcome of the payment process. You can also view the outcome via the Member Zone on our website at **www.polmed.co.za**

Obtain a detailed account/statement from the service provider

Submit your claims correctly

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

Email: polmedcurrentclaims@medscheme.co.za

Fax: 011 758 7660

Post: POLMED, Private Bag X16, Arcadia, 0007

Visit any POLMED regional walk-in branch

Information required to validate a claim

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

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

Member

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

Other

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

Member refunds:

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

DISPUTE/APPEAL PROCCESS

POLMED makes provision for members to lodge complaints and disputes in cases where the member is dissatisfied with the outcome of a decision from the Scheme in respect of a query. The form to complete when submitting a complaint/appeal to POLMED is available on the POLMED website under the Dispute Resolution process.

For more information and to submit your written complaint to POLMED, use the following details:
Tel: 0860 765 633
Fax: 0860 104 114
Email: polmedappeals@medscheme.co.za
Post: Private Bag X16, Arcadia 0007
Alternatively, visit our walk-in branch in your region

The dispute will be processed within a minimum of 5 (five) working days, depending on the complexity of the enquiry. The outcome of the dispute will be communicated to you.

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

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

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

MOTOR VEHICLE ACCIDENT (MVA) CLAIMS

POLMED's internal recoveries department at Medscheme will be notified when you or your dependent(s) were involved in an accident, and they will contact you to obtain additional information.

You can find the section dealing with third-party claims (which includes Road Accident Fund claims, Public Liability Claims, Assault claims and more in Section 14) of the registered POLMED Scheme rules, which forms part of your contract with POLMED.

If you plan to institute a claim against the Road Accident Fund (RAF), or any other third-party, you will be required to provide the following information:

- A short summary explaining how the accident happened;
- The contact details of the third-party involved;
- The name of the attorney firm you appointed (where applicable)
- In the event of a motor vehicle accident, you must provide the motor vehicles' registration numbers and name of the police station where the accident was reported.

Failure to lodge a claim, and/or to keep POLMED informed and to pay back money recovered in a third-party claim, constitutes a breach of your membership agreement with POLMED, as well as your employment contract with SAPS. You may be held personally liable to pay POLMED back.

You (and/or your beneficiary) will be required to sign the mandatory POLMED consent and indemnity forms, including the "Member Undertaking" to include POLMED's liability in any third-party claim, and to pay back the portion due to the medical scheme in the event of a successful recovery.

The Recovery team can refer you to a contracted Panel Attorney which offers preferential legal fees to POLMED members, in the event that you haven't appointed your own attorney.

Contact details for the POLMED Recoveries Department at Medscheme: TEL: 0800 117 222
EMAIL: polmedmvaqueries@medscheme.co.za

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.

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 has 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.

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

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, 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**.

SUSPECTED FRAUD AND WHAT TO DO

Unnecessary and fraudulent expenses are funded by you, the member, through increased contributions. You can contribute towards the fight against fraud by carefully and regularly checking your claims transactions, and making sure that you have not been involved in a fraud scam without your knowledge.

Examples of fraud scams discovered by the Scheme have been:

- A service provider putting in a claim for services that were never rendered
- A service provider performing a procedure or giving treatment that's excluded by the Scheme rules, and then charging for it under a different code
- A pharmacy providing generic medicine, but charging for the more expensive brand name

If you suspect that a service provider, colleague or any other person or organisation may be engaged in fraudulent activities against your Scheme, please contact the Fraud Hotline on **0800 11 28 11**, **SMS 33490** or email **information@whistleblowing.co.za**

This service is managed by an independent company, Tip-Offs Anonymous, and you can choose to remain anonymous.
You can also email **fraud@medscheme.co.za** to report your suspicions.

Confidentiality of your information

The Scheme would like to remind you of our confidentiality policy, which prevents unauthorised persons from obtaining and changing members' information.

Please note that the Scheme will only process changes to member details that have been furnished to the Scheme by the member or his/her representative. To ensure that your information is secure and that unauthorised callers cannot change your records, we will authenticate the identity of callers, by asking a few questions to verify your identity.

If you are disabled, aged or have a personal assistant (PA) who looks after your affairs, you can make special provision to allow that person to access your information. All that is required is a completed Letter of Authority, giving your representative (PA or family member, etc.) the authority to contact us on your behalf. Simply contact us to send you a Letter of Authority form to complete.

As your protection is our priority, should any of the above details not correspond with what we have on our system, no information will be provided to the caller.

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CONTACT DETAILS

TEL: 0860 765 633 or 0860 POLMED

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

WhatsApp: +27 60 070 2547

Email address for SUBMITTING ENQUIRIES:
polmed@medscheme.co.za

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