PLATINUM HEALTH

INFO GUIDE 2022

PLATINUM HEALTH

Our vision:

To provide appropriate healthcare of high quality, cost efficiently, to the satisfaction of stakeholders.

Our mission:

To practice and administer appropriate medicine of such a high standard, which optimises health care and quality of life amongst all stakeholders. To effectively manage our environment and future by becoming and remaining financially self-supporting within acceptable cost constraints set for us. To attract and retain membership through service excellence by delivering quality, appropriate, equitable healthcare. To ensure that stakeholders are consistently provided with relevant information.

Platinum Health Abbreviations

AIDS	Acquired immunodeficiency syndrome
CDL	Chronic disease list
CDRP list	Chronic disease reference price list
CMRP list	Chronic medication reference price list
CPAP	Continuous positive airway pressure
CT scan	Computed tomography scan
DSP	Designated service provider
DTP	Diagnosis and treatment pairs
GP	General practitioner
HIV	Human immunodeficiency virus
MMAP	Maximum Medical Aid Price
MRI scan	Magnetic resonance imaging scan
OAL	Overall annual limit
OTC	Over-the-counter
PAT	Pharmacist advised therapy
PB	Per beneficiary
PET scan	Positron emission tomography scan
PHRPL	Platinum Health Reference Price Listing
PMB	Prescribed minimum benefits
PMF	Per member family
RSA	Republic of South Africa
SAOA	South African Optometry Association
Scheme Tariff	NHRPL 2010 + 5%, escalated by percentage increase every benefit year
Scheme Formulary	List of medicine inclusive of all classes on a reference price
SEP	Single exit price
TRP list	Therapeutic reference price list
Medication TTO	Medication to-take-out

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WELCOME NOTE

Dear Platinum Health Member

The Platinum Health vision is to provide appropriate healthcare of high quality, cost efficiently that meets the approval of all stakeholders.

Platinum Health offers the best benefits in the Medical Scheme Industry at affordable contributions. The reason for this is because Platinum Health operates a Staff Model Health Maintenance Organisation (HMO) which means that where economically viable the Scheme appoints its own health service providers such as specialists, general practitioners (GPs), dentists, psychologists, optometrists, radiographers, physiotherapists and audiologists. Where it is not economically viable Platinum Health has appointed designated service providers (DSPs) to provide services to its members. For this reason, Plat Comprehensive and Plat Cap members located within a 50km radius of Platinum Health facilities and DSPs, are obliged to utilise the abovementioned healthcare service providers. Plat Freedom members may utilise any healthcare providers of their choice.

Platinum Health also manages its own pharmacies. All members that have chronic medical conditions must obtain chronic medicine from the Platinum Health Pharmacy in Rustenburg, which will courier medicine nationally to members. Members located within a 50km radius from Scheme-owned pharmacies and/or DSPs also have to make use of such pharmacies. In order to optimise cost efficiency, Platinum Health is a self-administered Medical Scheme, which provides managed care through its own Case Management Department. All members have to obtain authorisation for specialist referrals (excluding Plat Freedom), hospitalisation, managed-care programmes and specialised radiological investigations (MRI, CT and PET scans). If authorisation is not obtained, Platinum Health will not accept liability for payment of the accounts.

This Info Guide offers you an overview of the services Platinum Health provides, as well as the benefits you enjoy as a member and the rules and procedures which apply in each instance. I would like to call on all members to familiarise themselves with the content contained in it. The Info Guide will give members an insight as to how Platinum Health operates and also contains the contact details of all relevant departments a member may want to contact. Should you have any enquiries do not hesitate to contact any of our Client Liaison Officers who will gladly assist with any enquiries members may have.

Welcome Mboniso
Principal Officer

1. MEMBERSHIP

Platinum Health is registered as a restricted Medical Scheme. In terms of the Rules of Platinum Health Medical Scheme (PHMS), only employer groups operating in the platinum group metals (PGM) and chrome mining industries may join Platinum Health.

1.1 How to change your Medical Scheme or option within the scheme

Members may choose to switch to a different Option within the Scheme, or another Medical Scheme, during November every year. The effective date will be 1 January of the following year. Members should carefully consider the benefits, costs and implications to themselves and their dependants before exercising their choice.

Members who want to switch to another Medical Scheme must, in terms of the Platinum Health Rules, give Platinum Health one month's notice in writing. Members who wish to join Platinum Health should note that the following provisions of the Medical Scheme Act will apply when they return to Platinum Health:

- Where a member had a three-month break in Medical Scheme membership prior to applying for Platinum Health membership, a 12-month condition-specific waiting period with regards to pre-existing medical conditions (excluding PMBs) and a 3-months general waiting period may apply.
- Please note that waiting periods applicable to a member will not lapse when a member opts to change between different Options within Platinum Health. The pro-rata waiting period will be carried over to the new Option.

Can I belong to more than one Medical Scheme at the same time?

In terms of Section 28 of the Medical Schemes Act, no person is permitted to be a member of more than one Medical Scheme at the same time.

1.2 Underwriting conditions

What is a late joiner penalty?

A late joiner penalty is applied when a dependant, (who at the date of application for membership, is 35 years of age or older) and did not have coverage with one or more medical scheme, without a break in coverage that exceeds 3 months. Members are urged to supply the scheme with proof of all previous medical aid coverage to ensure this penalty is applied correctly and in terms of the formula as per Regulation Section 13 (2) and (3).

What are the types of waiting periods?

Waiting periods are periods during which beneficiaries are members, but do not qualify for benefits. In terms of Section 29A of the Medical Schemes Act there are two types of waiting periods i.e. General waiting period of up to 3 months and condition-specific waiting period of up to 12 months. Platinum Health may apply two types of waiting periods:

- **A general waiting period of up to three months from the date that you joined.** During this time, you will not be entitled to any benefits. The general waiting period can be bought out by the member agreeing to pay three months Medical Scheme contributions up-front in addition to paying the normal monthly contributions.
- **A condition-specific waiting period of up to 12 months from the date that you joined.** During this time, you will not be entitled to benefits for a particular pre-existing medical condition for which you were recommend to receive, or for which you received, medical advice, diagnosis, care or treatment (this excludes PMBs).

What are the waiting periods for specific conditions?

Should a member of Platinum Health apply to add any dependant after the initial join date of the member and the dependant for whom the application is made for membership was not a member or dependant of a Medical Scheme for a period of at least 90 days preceding the date of application:

- A general waiting period of three months and a condition specific waiting period of 12 months will apply.
- If a member or dependant did not previously belong to a Medical Scheme for a continuous period of up to 24 months, terminating less than 90 days immediately prior to the date of application:
    - A condition specific waiting period of 12 months will apply, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits (PMBs).

When do such waiting periods NOT apply?

- If a new-born is registered within 30 days from date of birth, and the join date is the date of birth.
- If you have to transfer membership because of a change of employment.
- If dependants join on the same date as the principal member.
- If the dependant is registered within 30 days of getting married and join date is the date of marriage.

1.3 Membership cards

Members and dependants will receive a membership card once registered on the Scheme. Please look after your membership card as you would with your bankcard. You may not borrow it to anyone and only you and your registered dependants may use it. Allowing anyone else to use your card is fraud and may lead to suspension and/or termination of your membership.

What information is featured on my membership card?

Your membership card contains our unique membership number and the benefit option you are on. It also shows your membership status, your dependants' code/s, the date that you registered, your card's issued date, and the date that you can start claiming benefits (if a waiting period applies). Important numbers such as the Europ Assist emergency number, Case Management and Client Liaison Call Centre numbers also feature on the card.

Where do I obtain a new or updated Medical Scheme card?

Contact the Client Liaison Call Centre or Client Liaison Officer at the sites where you work. Refer to page 67 for contact details.

Important notes on member and dependant registration

The Medical Schemes Act is very specific as to who may be permitted to become a dependant. It is important to submit applications for dependant membership at the same time and from the same date as that of the principal member, otherwise waiting periods will apply.

1.4 How to apply for membership or add a dependant

1 Visit your local Employee Walk-in Centre, HR/EB office or any Client Liaison office in your area.

2 Complete a Platinum Health application form with the following important details:

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- **Section 1:** Details of applicant
- **Section 2:** Employment details
- **Section 3:** Choice of option, Banking details, Income confirmation and Card delivery
- **Section 4:** Registration of principal member
- **Section 5:** Registration of spouse/partner
- **Section 6:** Registration of dependant
- **Section 7:** Registration of dependant
- **Section 8:** Registration of dependant
- **Section 9:** Registration of dependant
- **Section 10:** Previous membership of a medical scheme(s)
- **Section 11:** Waiving of the three-month general waiting period
- **Section 12:** Declaration

The application form must be signed by the principal member

4 **Attach the following documentation to your signed application form:**

- Copy of applicant's ID document;
- Copy of dependant's ID document;
- Copy of dependant's birth certificate;
- Copy of marriage certificate;
- Proof of income or study proof for dependants older than 21 (required annually by the end of March).
- Proof of previous medical cover.

Cards will only be issued once all the required documentation has been received.

1.5 Who qualifies as a dependant of the principal member?

	Type of Dependant	Important to note	Documentation to be submitted to the Scheme
YES	Spouse **Civil marriage**	• Principal members who get married have to add their newly wed spouses within 30 days from date of marriage, and join date is date of marriage, otherwise waiting periods may apply • A spouse who is younger than 21 years, pays adult membership contributions.	• Provide copies of: o marriage certificate o identity document o form from the Marriage Officer confirming the marriage.
	Spouse **Customary marriage**		• Lobola agreement letter OR • Letter from the Chief confirming the customary marriage • Spouse's ID document • Affidavit confirming the customary marriage
	Common-law partner, Same-sex partner and Fiancée	• A Common-law partner, Same sex partner or Fiancée who is younger than 21 years, pays adult membership contributions.	• Provide an affidavit which: o States the period of living together. o Confirms the relationship • Copy of dependant's identity document.
	Father, mother, brother or sister	• Provided that the dependant earns no more than the maximum social pension per month, of whom the member is liable for family care and support.	• Provide copies of: o A death certificate if the dependant is a widow or widower or the parents has passed on o Provide an Affidavit which states: - the relation of the dependant to the principal member - that the dependant is financially dependent on the principal member - that the dependant is unemployed and NOT registered with SARS - that the dependant has NO bank account OR has only one bank account o Copy of 3 months bank statements o ITA34 (can be obtained from SARS) o Copy of dependant's identity document
	Child/Stepchild	• Provided that the child does not earn more than the maximum social pension per month. • Refer to important notes on page 10 on when your child reach adult age (21) • Child dependants who reach 21 pays adult contributions.	• Provide copy of: o birth certificate or identity document o a member has 30 days from registration of the new-born baby to submit a birth certificate to the scheme.
	Adopted children	• Provided that the children are adopted by the principal member.	• Provide copies of: o Court order o Copy of birth certificate or identity document
NO	Ex-spouse or Ex-partner	Membership has to be terminated. Member has to give 30 day's notice to the Scheme of termination of ex-spouse or ex-partner.	Complete a change form indicating termination of ex-spouse or ex-partner and submit to Client Liaison.
	Family-in-law		
	Friend		
	Uncle or aunt, nephew or		
	niece		
	Grandparents Grandchild	If a child dependant has a baby (the member's grandchild), the baby is not a dependant of the principal member, unless the grandchild is legally adopted by the grandparent.	In such an instance the principal member must provide the following documentation to the Scheme: • Copy of identity document or birth certificate • Certified copy of court order

1.6 Registering your new-born baby

It is the responsibility of the principal member to ensure that the new-born baby is registered with the Scheme within 30 days from date of birth and the join date is date of birth, to avoid waiting periods.

Documentation needed when registering your new-born

Please take the following documentation with upon registering your baby with Platinum Health:

- Principal member's identification document.
- A registered birth certificate.
- If the baby's surname differs from the principal member's surname, an affidavit must be submitted stating the reason.
- A Hospital Confirmation/Notification document can temporarily be submitted, together with the application form, however this document is only valid for 30 days.
- As soon as the new-born baby has been registered with the Department of Home Affairs, the member is responsible to submit a copy of the birth certificate to the Scheme within 30 days of birth.
- A member has 30 days from registration of the new-born baby to submit a birth certificate to the scheme.

Where to register your new-born:

The new-born baby can be registered at any of the following:

- Employee Services Walk-in Centre at your workplace; OR
- Employee Benefits (EB) office at your workplace; OR
- Human Resources (HR) office at your workplace; OR
- Client Liaison Officer in your area; OR
- Client Liaison office situated at the Platinum Health Medical Centre (PHMC), Corner of Beyers Naudé and Heystek Streets, Rustenburg.

If your baby is still-born, or in the unfortunate event that the baby passes away shortly after birth, please note that the baby still needs to be registered with the Scheme to ensure that the costs relating to the baby's birth is covered.

We do realise that parents may go through an extremely difficult time in such instances, but we do not want you to be burdened with medical accounts etc, during such a sad time. Unfortunately, according to medical schemes rules and regulations, the baby has to be registered on the scheme.

If your baby is still-born please submit the following documentation to the scheme:

- The principal member has to complete and sign a membership application form.
- A Hospital Confirmation of stillbirth can be submitted to the Scheme or a Death Certificate

If your baby passes away shortly after birth, please submit the following documentation to the scheme:

- The principal member has to complete and sign a membership application form.
- A Hospital Confirmation can temporarily be submitted to the Scheme ((however this document is only valid for 30 days) and therefore members are urged to submit a Death Certificate within 30 days from date of death.

For more information or assistance, kindly contact the Client Liaison Call Centre on:

Tel: 014 590 1700 or 080 000 6942 OR
Email: phclientliaison@platinumhealth.co.za

1.7 If your dependant/s reach adult age (21)

If your child dependant turns 21 years of age, the Scheme Rules stipulate that you need to supply Platinum Health annually with the following documentation:

- Affidavit that confirms the dependant is financially dependent on yourself and not in receipt of remuneration of more than the maximum social pension per month, and/or
- Affidavit that confirms your dependant is studying full time/part time, with the proof of study for which the Scheme requires a copy of the registration at a recognised tertiary establishment (student cards will not be accepted).
    - If your child is studying either full –or part-time, you need to notify the Scheme of the child's new residential address. For example: if you live in Rustenburg and your child studies and resides at the North West University in Potchefstroom, you need to notify the Scheme of the child's residential address in Potchefstroom, in order for your child to enjoy benefits in the area he/she resides.

Important to note: Child dependants who reach 21 pay adult contributions.

Should your dependant not qualify for the above, kindly complete a termination form at your earliest convenience and submit to Client Liaison at email: phclientliaison@platinumhealth.co.za. For more information or assistance kindly talk to your Client Liaison Officer on site or contact the Client Liaison Call Centre on 014 590 1700 or 080 000 6942.

1.8 Just Married

Remember to *register your* spouse as your dependant

Getting married is an exciting time in one's life and whether you are married through a civil or customary marriage, it is important to remember to register your spouse with Platinum Health (PH) to ensure that your spouse enjoys the full benefits he/she deserves.

In terms of South African Law, the definition for customary marriage is: "one that is negotiated, celebrated or concluded according to any of the systems of indigenous law which exist in South Africa".

In terms of PHMS Scheme Rules, the definition of a spouse is: "The person to whom the member is married in terms of any law or custom."

CIVIL MARRIAGE	CUSTOMARY MARRIAGE
In order to register your spouse as dependant, you are required to provide the following documentation to the medical scheme within 30 days from date of marriage, and the join date is the date of marriage:	
Membership Application form Download form from the website (www.platinumhealth.co.za) or request it from Client Liaison.	**Membership Application form** Download the form from the website (www.platinumhealth.co.za) or request it from Client Liaison.
• Marriage certificate • Spouse's ID document • Form from the Marriage Officer confirming the marriage.	• Lobola agreement letter OR • Letter from the Chief confirming the customary marriage • Spouse's ID document • Affidavit confirming the customary marriage.

SUBMIT the documentation to Platinum Health via ANY of the following channels:

- Employee Services Walk-in Centre at your workplace; OR
- Employee Benefits (EB) office at your workplace; OR
- Human Resources (HR) office at your workplace; OR
- Client Liaison Officer/office in your area.

Please note if you do not register your spouse with Platinum Health within 30 days from date of marriage (and the join date is the date of marriage) and you decide to add your spouse later on, it will result in waiting periods.

For assistance, kindly contact the Client Liaison Call Centre:
Tel: 014 590 1700 or 080 000 6942 OR
Email: phclientliaison@platinumhealth.co.za
Or talk to a Client Liaison Officer in your area.

Important notes

A spouse who is younger than 21 years, pays adult membership contributions.

1.9 Retirement and Continuation (Pension) Members

What happens at retirement (55 years or older)?

You and your dependants can stay on the Scheme as continuation (pension) members. Once you have taken the decision, kindly contact the Client Liaison office to assist in completing the necessary documentation. This will ensure that you have uninterrupted membership. All continuation members pay upfront (in advance) contributions.

How do the contributions work for retirees, members who are medically boarded or continuation (pension) members?

The same contribution tables apply to all members. Continuation members need to submit proof of income (ITA34) to the scheme to ensure they are charged the correct contribution.

If the principal member passes away

If a principal member passes away, will his/her dependants who were on Platinum Health at the time of death, still be covered?

Dependants of a deceased member are entitled to remain members of Platinum Health. It is important to note that dependants need to apply with Platinum Health within 30 days of deceased member's death to ensure uninterrupted membership. The dependant who becomes the principal member, or the beneficiaries of the deceased member, will be responsible to pay the monthly medical scheme contributions.

What do dependants need to do in order to remain on the Scheme after the principal member's death?

Dependants need to complete a Membership Application form which is accessible from the Platinum Health website (www.platinumhealth.co.za) or Client Liaison offices.

The following documentation needs to be submitted with the completed Membership Application form:

- Copy of applicant's ID document
- Copy of dependant's birth certificate or ID document
- ITA34 from SARS
- Copy of deceased member's death certificate
- Copy of marriage certificate (if applicable)

Medically boarded

May I remain on the medical Scheme if I am medically boarded?

Members who are medically boarded are entitled to stay on as members of Platinum Health.

Retrenchment

Can Platinum Health terminate my membership in case of retrenchment?

In respect of ***retrenchments*** members are **not** permitted to continue being members of Platinum Health. Should employers wish to extend medical scheme membership of affected employees they can apply to the Platinum Health Board of Trustees for an extension in medical scheme membership of up to 3 months. Such application will only be considered if membership is extended to all affected employees.

Resignation

A member who resigns from the service of his employer shall on the date of such termination, cease to be a member of the scheme and all rights to benefits shall thereupon cease.

1.10 Updating personal details

Please inform Platinum Health immediately if your personal details change (for example, your address, telephone number, banking details, marital status or number of dependants). Platinum Health continuously communicates with members via SMS, email or postal mail and therefore it is imperative for members to keep their details updated.

Correct cellphone numbers will ensure that:

- Members receive authorisation numbers per SMS.
- Members receive SMS's regarding payments by the Scheme to suppliers, keeping you updated of medical expenses.
- Members receive important communication SMS's regarding:
  - Adding of dependants or termination of dependants.
  - Outstanding documentation which could lead to membership suspension.
  - Reminders of outstanding contributions.
- Members can detect any possible fraudulent claims submitted by suppliers to Platinum Health.

Correct residential and postal addresses will ensure that:

- There is no delay in DSP allocation of specialist consultations and hospital admissions. (applicable to PlatComprehensive and PlatCap)
- Members receive Scheme documentation.

Correct email address will ensure that:

- Members receive membership claims advices/statements.
- Members receive tax certificates.
- Members receive other Scheme documentation that they may have requested or which Platinum Health may distribute from time-to-time.

Incorrect banking details may lead to:

- Refunds being paid into incorrect bank account as reflected on the system.

How to update personal details

The relevant form named "Request to change membership details, Scheme Option or Card request" can be obtained from Platinum Health via any of the following channels:

1. Download the form from the Platinum Health website (www.platinumhealth.co.za)
2. Email a request to Client Liaison email address (phclientliaison@platinumhealth.co.za)
3. Phone the Client Liaison Call Centre on 014 590 1700 or 080 000 6942
4. Collect the form from Client Liaison offices in your area

Complete the form stipulating the necessary changes you wish to amend. It is important to note that the principal member needs to sign the form together with a copy of the principal member's ID document, passport or driver's license and submit back to Platinum Health either by:

Email: zzgengagementofficemembership@platinumhealth.co.za or phclientliaison@platinumhealth.co.za

OR

hand in the form at your nearest Client Liaison office

1.11 Frequently asked questions (FAQs)

Q How can I prove to Platinum Health that I was a member of another medical scheme?

A A medical scheme must, within 30 days of termination of membership, or at any time at the request of a former member, or of a dependant of a member, provide such person with a membership certificate stating the period of cover and other prescribed information.

Q May I participate in the operation of Platinum Health?

A Platinum Health Rules provide for one employer nominated trustee and one member elected trustee per constituency. The member elected trustees represent the membership of that constituency on the Platinum Health Board of Trustees. Members therefore can participate in the Scheme through their member elected trustees.

In terms of the Medical Schemes Act, an Annual General Meeting (AGM) has to be held where members approve the Board of Trustees Report, Annual Financial Statements, Appointment of Auditors and the Board of Trustees. Members may also submit a motion to be considered at the AGM.

2. PLATCOMPREHENSIVE OPTION

Benefits for 2022

Platinum Health's premium product, PlatComprehensive offers exceptional benefits, designed to meet the most demanding healthcare needs. It boasts extensive benefits such as unlimited hospitalisation at designated service provider (DSP) hospitals at 100% of the Scheme's Tariff. Going one step further in superiority, PlatComprehensive offers 100% cover of all acute and chronic medication subject to the Scheme's formulary. Healthcare services may be accessed via either a primary healthcare nurse or a general practitioner. Statutory Prescribed Minimum Benefits (PMBs), as required by the Medical Schemes Act, are covered both in-and-out of hospital at 100% of cost/negotiated Tariff. Services rendered by a public hospital or the Scheme's DSP at cost and no levy or co-payment shall apply. Subject to regulation 8(3) any services rendered by a non-DSP on a voluntary basis will be covered by the Scheme 100% of Scheme Tariff.

Service	% Benefits	Annual Limits	Conditions/Remarks
STATUTORY PRESCRIBED MINIMUM BENEFITS			
	100% of costs	Unlimited	• Services rendered by a public hospital or the Scheme's DSP at cost. No levy or co-payment shall apply.
	100% of Scheme Tariff		• Subject to regulation 8(3) any service rendered by a non-DSP on a voluntary basis will be paid at 100% of Scheme Tariff.
GENERAL PRACTITIONER SERVICES			
Consultations and visits (in-and-out of hospital)	100% of Scheme Tariff	Unlimited	• Members located within a 50km radius of Scheme DSPs are obliged to utilise scheme DSPs, subject to regulation 8(3). • Members located between 50 – 200 km radius of Scheme DSPs may utilise any GPs and will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Consultations during normal working hours: **R80** levy per patient visit will apply • Consultations after normal working hours: **R85** levy per patient visit will apply. • **Provided that the patient is referred by the Primary Health Registered Nurse, no levy shall apply.**

Service	% Benefits	Annual Limits	Conditions/Remarks
SPECIALIST SERVICES			
Consultations and visits (in-and-out of hospital)	100% of Scheme Tariff/ Negotiated rate	Unlimited	• Pre-authorisation needs to be obtained prior to consulting any specialist. • Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 - 200 km radius who elect to utilise DSPs will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Members to be referred by general practitioners or specialists and Scheme DSPs shall be utilised at all times. Subject to clinical protocol approval and regulation 8(3).
	100% of Scheme Tariff		• Pre-authorisation needs to be obtained prior to consulting any specialist. • Members located between 50 - 200km radius who elect to utilise a non-DSPs shall be deemed to have voluntary obtained services (including Psychiatric Services) in which case the scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Members to be referred by general practitioners or specialists and Scheme DSPs shall be utilised at all times. Subject to regulation 8(3).
HOSPITALISATION			
Accommodation in a general ward, high-care ward and intensive care unit	100% of Scheme Tariff/ Negotiated rate	Unlimited	• Where possible, own facilities shall be utilised. Members to be referred by general practitioners or specialists. Subject to clinical protocol approval. • No levy is applicable for hospitalisation at a DSP hospital provided that the Scheme's DSP practitioner or specialist has referred the member and that the hospitalisation is authorised. • Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 - 200km radius who elect to utilise DSPs will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Where services cannot be provided at a DSP hospital, the patient shall be referred by the Scheme for treatment at another private hospital or clinic.
Theatre fees and materials			
Ward, Theatre drugs and hospital equipment			
Medication to-take-out (TTO)	100% of Scheme Tariff	7-day supply PB, per admission	• Subject to Scheme formulary and regulation 8(3).

Service	% Benefits	Annual Limits	Conditions/Remarks
HOSPITALISATION (continued)			
Non-Designated Service Provider Hospital			
Accommodation in a general ward, high-care ward and intensive care unit Theatre fees and materials Ward, Theatre drugs and hospital equipment	100% of Scheme Tariff	**R152 818**	• Members located between 50 - 200km radius who elect to utilise non-DSPs shall be deemed to have voluntary obtained services. • Members to be referred by general practitioners or specialists. • Pre-authorisation is required, subject to clinical protocol approval and regulation 8(3).
Medication to-take-out (TTO)	100% of Scheme Tariff	7-day supply PB, per admission	• Subject to Scheme formulary and regulation 8(3).
In all instances authorisation shall be obtained prior to admission and in the event of an emergency, the Scheme shall be notified of such an emergency within one working day after admission.			
MEDICATION			
Acute	100% of Scheme formulary	Unlimited	• Members located within a 50km radius of DSPs are obliged to utilise such pharmacies, subject to regulation 8(3). • Members located outside a 50km radius of DSPs may utilise non-DSPs for medication. The Scheme shall accept liability of 100% of the therapeutic reference price (TRP) list as per the Scheme option formulary. • If a member elects to utilise a non-formulary drug, then the member is liable for 20% co-payment of SEP (single exit price) except if the medicine has been clinically motivated for and been approved by the Scheme – in which case the Scheme shall be liable for 100% of SEP. • If a member elects to utilise an original drug for which a generic drug exists on the formulary, then a co-payment (price difference between formulary drug and original drug) shall apply. • Admin fees or levies will not be covered.
PAT/OTC	100% of Scheme formulary	**R355** PB, subject to a limit of **R960** PMF	• Subject to Platinum Health network pharmacy and **R172** per event. • Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located outside a 50km radius of network provider pharmacies may utilise non-DSPs for medication. • The Scheme shall accept liability of 100% of the therapeutic reference price list as per the Scheme formulary. • Admin fees or levies will not be covered.
Chronic	100% of Scheme formulary	Unlimited for CDL conditions and additional chronic disease list	• The Scheme shall accept liability of 100% of Therapeutic Reference Price List as per the formulary. • In all instances chronic medication shall be obtained from the Scheme's DSP, subject to registration on the Chronic Medication Programme. • If a member elects to utilise a non-formulary drug, then the member is liable for 20% co-payment of SEP (single exit price) except if the medicine has been clinically motivated for and been approved by the Scheme – in which case the Scheme shall be liable for 100% of SEP. • If a member elects to utilise an original drug for which a generic drug exists on the formulary, then a co-payment (price difference between formulary drug and original drug) shall apply. Admin fees or levies will not be covered.

Service	% Benefits	Annual Limits	Conditions/Remarks
DENTAL SERVICES			
Conservative Dentistry	100% of Scheme Tariff	Unlimited	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located further than 50km radius from DSPs would be covered at 100% of Scheme Tariff, subject to regulation 8(3). • No levy for consultations. • General anaesthetic and hospitalisation for conservative dental work excluded, except in the case of trauma, patients under the age of eight years and impacted third molars.
Specialised Dentistry	85% of Scheme Tariff	**R12 332 PMF**	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located further than 50km radius from DSPs would be covered at 100% of Scheme Tariff, subject to regulation 8(3). • A 15% co-payment of the benefit limit shall apply in respect of the repair and replacement of dentures. Dentures shall be limited to one set per three consecutive years per PB. • The Scheme will accept liability for the under mentioned treatment and a 15% co-payment of the benefit limit shall apply: • Internal and External orthodontic treatment • Prosthodontics, periodontics and endodontic treatment • Crown and Bridge work • Metal Dentures • Porcelain veneers and inlays • External laboratory services
RADIOLOGY			
In-and-out of hospital	100% of Scheme Tariff/ Negotiated rate	Unlimited	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 - 200km radius who elect to utilise a DSP will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSP shall be deemed to have obtained services involuntary in which case the scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Members to be referred by a general practitioner or specialist and Scheme DSP shall be utilised at all times. • Pre-authorisation shall be obtained for all specialised radiological investigations (MRI and CT scans), subject to protocols and regulation 8(3).
	100% of Scheme Tariff	Unlimited	• Members located between 50 - 200km radius who elect to utilise a non-DSPs shall be deemed to have voluntary obtained services in which case the scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Members to be referred by a general practitioner or specialist. • Pre-authorisation shall be obtained for all specialised radiological investigations (MRI and CT scans), subject to protocols.

Service	% Benefits	Annual Limits	Conditions/Remarks
PATHOLOGY			
In-and-out of hospital	100% of Scheme Tariff/ Negotiated rate	Unlimited	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 - 200km radius who elect to utilise a DSP will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSP shall be deemed to have obtained services involuntary in which case the scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Members to be referred by a general practitioner or specialist and Scheme DSP shall be utilised at all times. • If the Scheme authorises hospitalisation at a DSP, the laboratory costs will be covered 100% of Scheme Tariff.
	100% of Scheme Tariff	Unlimited	• Members located between 50 - 200km radius who elect to utilise non-DSPs shall be deemed as have voluntary obtained services. • Members to be referred by a general practitioner or specialist, subject to regulation 8(3).
PHYSIOTHERAPY AND BIOKINETICS			
In-hospital	100% of Scheme Tariff/ Negotiated rate	Unlimited	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 - 200km radius who elect to utilise a DSP will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSP shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Members to be referred by a general practitioner or specialist. No cover for physiotherapy in mental health facilities.
	100% of Scheme Tariff	Unlimited	• Members located between 50 - 200km radius who elect to utilise non-DSPs shall be deemed as have voluntary obtained services in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Members to be referred by a general practitioner or specialist. • No cover for physiotherapy in mental health facilities.
Out-of-hospital	100% of Scheme Tariff	**R4 572** PMF	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 – 200 km radius of Scheme DSPs may utilise any provider and will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSP shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Members to be referred by a general practitioner or specialist. • No cover for physiotherapy in mental health facilities.
CHEMOTHERAPY, RADIOTHERAPY, ORGAN TRANSPLANT AND KIDNEY DIALYSIS			
	100% of Scheme Tariff	Unlimited	• Subject to referral, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).

Service	% Benefits	Annual Limits	Conditions/Remarks
EMERGENCY MEDICAL TRANSPORT (ROAD-AND-AIR)			
	100% of Scheme Tariff	Unlimited	• Subject to Scheme DSP utilisation, authorisation, clinical protocol approval and regulation 8(3).
BLOOD TRANSFUSIONS			
	100% of Scheme Tariff	Unlimited	• Subject to referral, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3). • Includes the cost of blood, blood equivalents, blood products and the transport of blood.
MEDICAL AND SURGICAL APPLIANCES			
Wheelchairs	100% of Scheme Tariff	**R7 064** PB	• Subject to referral, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3). • One every three years.
Oxygen and Cylinders		Unlimited	• Subject to referral, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).
Nebulisers and Glucometers		**R640** PB	• Subject to referral, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3). One every three years
General		**R4 001** PMF	• Subject to referral, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).
PACEMAKER, PROSTHETIC VALVES, VASCULAR PROSTHESIS AND ORTHOPAEDIC PROSTHESIS			
	100% of Scheme Tariff	Unlimited	• Subject to referral, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).
CHILD IMMUNISATION			
Childhood Immunisation Benefit	100% of Scheme Tariff	Limited to DOH Child Immunisation programme	According to the Department of Health (DOH) protocols (excludes consultation cost)
OPTOMETRY SERVICES			
Eye Examination	100% of Scheme Tariff	Combined 2-year benefit limit of **R2 675** PB	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 – 200 km radius of Scheme DSPs may utilise any provider and will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Limited to one set of spectacles or range of contact lenses per beneficiary, every 2 years from anniversary of claiming PB, up to benefit limit.
Frames, lenses, contact lenses and disposable contact lenses			
Correction of vision surgery	100% of Scheme Tariff	Unlimited	• Subject to referral, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3). • The benefit excludes excimer laser treatment.

Service	% Benefits	Annual Limits	Conditions/Remarks
AUXILIARY SERVICES			
Audiology (excluding Hearing aids), Speech therapy, Occupational therapy	100% of Scheme Tariff	Combined limit **R7 726** PMF	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 – 200 km radius of Scheme DSPs may utilise any provider and will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Subject to Scheme clinical protocol.
Hearing Aids	100% of Scheme Tariff	**R12 904** PB	• Subject to referral, authorisation, Scheme DSP utilisation and clinical protocol approval by the Scheme. • Subject to regulation 8(3). • Benefit only every three years.
CLINICAL PSYCHOLOGY (EXCLUDING SCHOLASTIC AND FORENSIC RELATED TREATMENT)			
Clinical Psychology (excluding scholastic and forensic related treatment)	100% of Scheme Tariff	**R7 726** PMF	• To be referred by a medical practitioner. • Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 - 200 km radius who elect to utilise DSPs will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3).

Contributions for 2022 - EFFECTIVE ON 1ST MARCH 2022

Beneficiary	R0 – R18 020	R18 021 – R27 325	R27 326+
Principal	R1 550	R2 236	R2 622
Adult	R1 550	R2 236	R2 622
Child	R525	R796	R911

In the event that a member's income changes during the course of a benefit year, placing the member in a higher/lower income band for contribution purposes, the member shall immediately inform the Scheme of such change and the Scheme shall effect such adjustment to the higher/lower income band from 1 January of the following benefit year except in cases of promotion and demotion wherein the Scheme shall effect such change immediately.

3. PLATCAP OPTION

Benefits for 2022

The PlatCap Option offers similar benefits to other low-cost scheme options in the market; but is significantly more affordable than other low-cost medical scheme options. GP visits are unlimited subject to PlatCap members utilising Platinum Health facilities, and/or Scheme DSPs. Certain benefits, however, have specific limits and members become responsible for medical expenses once benefit limits have been reached. Prescribed minimum benefits (PMBs), as required by the Medical Schemes Act, are covered both in-and-out of hospital at 100% of the cost/negotiated Tariff; subject to services rendered by a public hospital or the scheme's DSPs at cost and no levy or co-payment shall apply.

Service	% Benefits	Annual Limits	Conditions/Remarks
STATUTORY PRESCRIBED MINIMUM BENEFITS			
	100% of costs	Unlimited	All services rendered by a public hospital or the schemes DSP at costs. No levy or co-payment shall apply.
DAY-TO-DAY BENEFITS			
GP Consultations and visits	100% of Scheme Tariff	Unlimited	• Members located within a 50km radius of Scheme DSPs are obliged to utilise scheme DSPs, subject to regulation 8(3). • Members located between 50 – 200 km radius of Scheme DSPs may utilise any GPs and will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Consultations during normal working hours: **R80** levy per patient visit will apply • Consultations after normal working hours: **R85** levy per patient visit will apply. • **Provided that the patient is referred by the Primary Health Registered Nurse, no levy shall apply.**

Service	% Benefits	Annual Limits	Conditions/Remarks
DAY-TO-DAY BENEFITS (continue)			
Acute medication	100% of Scheme Tariff	Unlimited	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located outside a 50km radius of DSPs may utilise non-DSPs for medication. The Scheme shall accept liability of 100% of the therapeutic reference price (TRP) list as per the Plat Cap option formulary. • If a member elects to utilise a non-formulary drug, then the member is liable for 20% co-payment of SEP (single exit price) except if the medicine has been clinically motivated for and been approved by the Scheme – in which case the Scheme shall be liable for 100% of SEP. • If a member elects to utilise an original drug for which a generic drug exists on the formulary, then a co-payment (price difference between formulary drug and original drug) shall apply. • Admin fees or levies will not be covered.
PAT/OTC	100% of Scheme Tariff	**R327** PB per annum, **R642** PMF	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located outside a 50km radius of network provider pharmacies may utilise non-DSPs for medication. • The Scheme shall accept liability of 100% of the therapeutic reference price list as per the Plat Cap Option formulary. Admin fees or levies will not be covered. • Subject to Plat Cap option formulary and **R145** per event.
Specialist Consultations	100% of Scheme Tariff	3 visits or **R3 884** per beneficiary, up to 5 visits or **R5 633** per family	• Pre-authorisation needs to be obtained prior to consulting any specialist. • Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 - 200 km radius who elect to utilise non-DSPs will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Members to be referred by general practitioners or specialists and Scheme DSPs shall be utilised at all times. Subject to clinical protocol approval and regulation 8(3).
Occupational Therapy Biokinetics & Physiotherapy	100% of cost/ negotiated tariff	**R4 426 PMF**	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 – 200 km radius of Scheme DSPs may utilise any provider and will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Members to be referred by general practitioners or specialists. Subject to clinical protocol approval.

Service	% Benefits	Annual Limits	Conditions/Remarks
DAY-TO-DAY BENEFITS (continue)			
General Radiology	100% of Scheme Tariff	Unlimited	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 – 200 km radius of Scheme DSPs may utilise any provider and will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Members to be referred by general practitioners or specialists and Scheme DSPs shall be utilised at all times. Subject to clinical protocol approval. • Approved black and white X-rays and soft tissue ultrasound.
Pathology	100% of Scheme Tariff	Unlimited	• Members are obliged to utilise DSPs, subject to regulation 8(3). • Subject to referral by Scheme's DSP Medical Practitioner, clinical protocol and according to a list of approved tests.
Conservative Dentistry	100% of Scheme Tariff	One consultation PB per annum, with exception of extractions which are unlimited	• One preventative treatment PB per annum for cleaning, fillings and x-rays with exception of extractions which are unlimited. • List of approved codes, subject to Scheme DSP utilisation.
Emergency Dentistry	100% of Scheme Tariff	One-episode PB per annum	• One-episode PB for pain and sepsis only for in-or-out of network emergency dentistry per annum.
Specialised Dentistry	80% of Scheme Tariff	Dentures only One set of plastic dentures PB	• Dentures shall be limited to one set of plastic dentures per 3 consecutive years PB, applicable over age of 21 years. (20% co-payment applies). • Subject to Scheme DSP utilisation.
Optometry	100 % of Scheme Tariff	Combined 2-year benefit limit of **R1 340**. One set of spectacles per beneficiary.	• Two-year benefit from anniversary of claiming PB.
Examination			• One optometric consultation PB limited to Scheme DSP utilisation.
Frames			• Range of Scheme approved frames every 24 months. • One set of frames PB. • Subject to Scheme DSP utilisation.
Lenses			• Single vision lens. • Subject to Scheme DSP utilisation.
Contact Lenses		No benefit	
CHILD IMMUNISATION			
Child Immunisation Benefit	100% of Scheme Tariff	Limited to DOH Child Immunisation programme	According to the Department of Health (DOH) protocols (excludes consultation cost)

Service	% Benefits	Annual Limits	Conditions/Remarks
IN-AND-OUT OF HOSPITAL BENEFITS			
Maternity Care (ante and post-natal)	100 % of Scheme Tariff	Antenatal consultations are subject to the GP consultations and specialist consultation benefit	• Subject to referral by Scheme's DSP Medical Practitioner, Scheme DSP utilisation, clinical protocol approval and regulation 8(3). • Subject to registration on the Maternity Programme.
Neonatal Care	100 % of Scheme Tariff	Limited to **R54 895** per family, except PMBs	• Subject to referral by Scheme's DSP Medical Practitioner, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).
Mental Health (in-and-out of hospital)	100% of Cost/ Negotiated Tariff	PMBs only	• Subject to referral by Scheme's DSP Medical Practitioner, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3). • No cover for physiotherapy in mental health facilities.
Specialised Radiology (in-and-out of hospital)	100% of Scheme Tariff	**R14 042** per family	• Subject to referral by Scheme's DSP Medical Practitioner, authorisation, Scheme DSP utilisation and clinical protocol approval.
Emergency medical transportation	100% of Scheme Tariff	Unlimited	• Subject to Scheme DSP utilisation, authorisation, clinical protocol approval and regulation 8(3).
General medical appliances (wheelchairs and hearing aids)	100% of Scheme Tariff	**R6 573** per family	• Subject to referral by Scheme's DSP Medical Practitioner, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).
Oxygen and Cylinders	100% of Scheme Tariff	Unlimited	• Subject to referral by Scheme's DSP Medical Practitioner, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).
IN-HOSPITAL BENEFITS			
GP Consultations	100% of Scheme Tariff	Unlimited	• Subject to referral by Scheme's DSP Medical Practitioner, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).
Specialist Consultations	100% of Scheme Tariff	Unlimited	• Subject to referral by Scheme's DSP Medical Practitioner, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).
Pathology	100% of Scheme Tariff	Limited to **R32 543** per family per annum	• Subject to referral by Scheme's DSP Medical Practitioner, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).

Service	% Benefits	Annual Limits	Conditions/Remarks
IN-HOSPITAL BENEFITS (continued)			
Oncology	100% of Cost/ Negotiated Tariff	PMBs only	• Subject to referral by Scheme's DSP Medical Practitioner, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).
Organ Transplant	100% of Cost/ Negotiated Tariff	PMBs only	• Subject to referral by Scheme's DSP Medical Practitioner, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).
Renal Dialysis	100% of Cost/ Negotiated Tariff	PMBs only	• Subject to referral by Scheme's DSP Medical Practitioner, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).
Prosthesis (Internal)	100% of Cost/ Negotiated Tariff	PMBs only The following surgical procedures are not covered: Back and neck surgery, Joint replacement surgery, Caesarian sections done for non-medical reasons, Functional nasal and sinus surgery, Varicose vein surgery, Hernia repair surgery, Laparoscopic or keyhole surgery, Endoscopies and Bunion surgery	• Subject to referral by Scheme's DSP Medical Practitioner, authorisation, Scheme DSP utilisation, clinical protocol approval and regulation 8(3).
CHRONIC MEDICINE BENEFIT			
Chronic Medicine	100% of Plat Cap option formulary	Unlimited for CDL conditions	• Only CDLs covered and Prescribed Minimum Benefits (PMBs) unlimited as per Chronic Diseases Reference Price List (CDRPL). • The Scheme shall accept liability of 100% of Therapeutic Reference Price (TRP) List as per the formulary. • In all instances chronic medication shall be obtained from the Scheme's DSP, subject to registration on the Chronic Medication Programme. • If a member elects to utilise a non-formulary drug, then the member is liable for 20% co-payment of SEP (single exit price) except if the medicine has been clinically motivated for and been approved by the Scheme – in which case the Scheme shall be liable for 100% of SEP. • If a member elects to utilise an original drug for which a generic drug exists on the formulary, then a co-payment (price difference between formulary drug and original drug) shall apply. • Admin fees or levies will not be covered.

Service	% Benefits	Annual Limits	Conditions/Remarks
HOSPITALISATION			
Designated Service Provider Hospitals (100% agreed and negotiated Tariffs – unlimited)			
Accommodation in a general ward, high-care ward and intensive care unit	100% of Negotiated Tariff	Unlimited	• Where possible, own facilities shall be utilised. • No levy is applicable for hospitalisation at a DSP hospital provided that the Scheme's Medical Practitioner has referred the member and that the hospitalisation is authorised. • Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 – 200km radius who elect to utilise a non-DSP will be covered 100% of negotiated tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of negotiated tariff, subject to regulation 8(3). • Where services cannot be provided at a DSP hospital, the patient shall be referred by the Scheme for treatment at another private hospital or clinic.
Theatre fees and materials			
Ward, Theatre drugs and hospital equipment			
Medication-to-take-out (TTO)	100% of Scheme Tariff	7-day supply PB, per admission	• Subject to Plat Cap option formulary. • Admin fees or levies will not be covered.
Alternative to hospitalisation (step-down or home nursing)	100% of Scheme Tariff	Limited to **R17 263** per family per annum	• Where possible, own facilities shall be utilised. • Members are obliged to utilise DSPs, subject to regulation 8(3). • Subject to referral by Scheme's DSP Medical Practitioner, authorisation and clinical protocol approval. • Where services cannot be provided at a DSP hospital, the patient shall be referred by the Scheme for treatment at another private hospital or clinic.
Physical rehabilitation	100% of Scheme Tariff	Limited to **R61 635** per family per annum	• Where possible, own facilities shall be utilised. • Members are obliged to utilise DSPs, subject to regulation 8(3). • Subject to referral by Scheme's DSP Medical Practitioner, authorisation and clinical protocol approval. • Where services cannot be provided at a DSP hospital, the patient shall be referred by the Scheme for treatment at another private hospital or clinic.

Contributions for 2022

EFFECTIVE ON 1ST MARCH 2022

Beneficiary	R0 – R11 448	R11 449 – R17 935	R17 936+
Principal	R1 163	R1 410	R2 622
Adult	R1 163	R1 410	R2 622
Child	R475	R593	R911

In the event that a member's income changes during the course of a benefit year, placing the member in a higher/lower income band for contribution purposes, the member shall immediately inform the Scheme of such change and the Scheme shall effect such adjustment to the higher/lower income band from 1 January of the following benefit year except in cases of promotion and demotion wherein the Scheme shall effect such change immediately.

4. PLATFREEDOM OPTION

Benefits for 2022

PlatFreedom offers members complete freedom of choice to see service providers they prefer; however, members will be liable for the full cost once the limit is reached. Most benefits have limits and is subject to an Overall Annual Limit (OAL) of R1 095 150.

Hospitalisation is subject to the OAL at 100% of the lower of cost or Scheme Rate and authorisation must be obtained from the Scheme in all instances. There is a limit on Acute medication inclusive of the over-the-counter (OTC) benefit. Prescribed Minimum Benefits (PMBs), as required by the Medical Schemes Act, are covered both in-and-out of hospital at 100% of cost/negotiated Tariff; subject to services rendered by a public hospital or the scheme's DSPs at cost and no levy or co-payment shall apply.

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
Overall Annual Limit (OAL)		**R1 095 150 for a family. All limits are subject to the Overall Annual Limit (OAL)**	
ALTERNATIVE HEALTHCARE			
Homeopathic consultations and medicine only	80% of the lower of cost or Scheme Rate	**R8 496** for a family	
AMBULANCE SERVICE			
	100% if authorised by preferred provider		Subject to approval by preferred provider
APPLIANCES, EXTERNAL ACCESSORIES AND ORTHOTICS			
General medical and surgical appliances and appliance repairs	100% of the lower of cost or negotiated Scheme Rate	**R20 732** for a family (Appliances limit)	
CPAP (Continuous Positive Airway Pressure)		Subject to the Appliances limit	
Glucometers		**R1 236** for a beneficiary, included in the Appliances limit	
Peak flow meters		**R532** for a beneficiary, included in the Appliances limit	
Nebulisers		**R1 421** for a beneficiary, included in the Appliances limit	
Foot orthotics		**R5 257** for a beneficiary, included in the Appliances limit	
Keratoconus contact lenses		Subject to the Appliances limit	Authorisation required
Oxygen therapy and home ventilators		Subject to OAL	Authorisation required
Incontinence products	100% of the lower of cost or negotiated fee	Subject to OAL	Authorisation required

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS			
	100% of negotiated fee	Subject to OAL	Authorisation required
CONSULTATIONS AND VISITS - GENERAL PRACTITIONERS AND MEDICAL SPECIALISTS			
In-hospital	100% of the lower of cost or Scheme Rate	Subject to OAL. Excludes visits for alternative healthcare, dental, maternity, mental health, oncology, additional medical services and physiotherapy.	
Out-of-hospital	100% of the lower of cost or Scheme Rate	**M0: R6 156** **M1: R9 234** **M2: R12 301** **M3+: R15 389** Excludes visits for alternative healthcare, dental, maternity, mental health, oncology, additional medical services and physiotherapy.	
DENTISTRY			
Basic: Includes plastic dentures and basic dentistry performed in-hospital for children under eight (8) and for removal of impacted wisdom teeth.	100% of the lower of cost or Scheme Rate	**R15 065** for a family	Authorisation required for all dental treatment in-hospital
Advanced: Oral surgery, metal base dentures, inlays, crowns, bridges, study models, orthodontics, periodontics, prosthodontics, osseointegrated implants, orthognathic surgery and dental technician fees	100% of the lower of cost or Scheme Rate	**R15 595** for a family	Authorisation required for advanced dentistry in-hospital
HOSPITALISATION			
Accommodation in a general ward, high-care ward and intensive care unit, theatre fees, ward drugs and surgical items	100% of the lower of cost or Scheme Rate	Subject to OAL	Authorisation required
ALTERNATIVES TO HOSPITALISATION			
Physical rehabilitation facilities, hospice, nursing services and sub-acute facilities	100% of the lower of cost or Scheme Rate	**R83 292** for a family	Authorisation required
IMMUNODEFICIENCY SYNDROME (HIV/AIDS)			
	100% of cost		Authorisation required

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
INFERTILITY			
	100% of the lower of cost or negotiated fee for public hospitals	Limited to interventions and investigations as prescribed by the regulations to the Medical Scheme Act	Authorisation required
MATERNITY			
Hospital: Accommodation, theatre fees, labour ward fees, dressings, medicines and materials. **Note:** For confinement in a registered birthing unit or out-of-hospital, four (4) post-natal midwife consultations for a family each year	100% of the lower of cost or Scheme Rate	Subject to OAL	Authorisation required
Related maternity services: 12 antenatal consultations, two (2) 2D scans, pregnancy related tests and procedures	100% of the lower of cost or Scheme Rate	**R9 711** per family, 3D scan paid up to cost of 2D scan	
Amniocentesis	80% of the lower of cost or Scheme Rate	**R9 775** for a family and further limited to one test for a family each year	
MEDICINE AND INJECTION MATERIAL			
Acute medicine: including malaria prophylactics	100% of the approved price	**M0: R6 178** **M1: R10 729** **M2: R14 305** **M3+: R16 581** (Acute Medicine limit)	Refer to general Scheme exclusions
Medicine on discharge from hospital	100% of the approved price	**R553** for a beneficiary per admission, included in the Acute Medicine limit	Refer to general Scheme exclusions
Over-the-counter medicine	100% of the approved price	**R1 843** for a family; maximum **R456** per script. Included in the Acute Medicine limit	Refer to general Scheme exclusions
Chronic medicine	**Chronic Disease List conditions** Up to 100% of Scheme Rate for approved chronic medicine on the medicine list (formulary) Up to 80% of MMAP for approved chronic medicine not on the medicine list (formulary) **Additional Disease List conditions** Up to 100% of MMAP for approved chronic medicine	Subject to OAL	Authorisation required Refer to general Scheme exclusions
Contraceptive benefits: Oral, injectable, patches, rings, devices and implants	100% of approved price	Subject to OAL	Only if prescribed for contraception (not approved for skin conditions)

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
MENTAL HEALTH			
Psychiatric and psychological treatment in-hospital (including hospitalisation costs and procedures)	100% of the lower of cost or Scheme Rate	**R43 240** for a family (Mental Health limit)	Authorisation required
Rehabilitation for substance abuse	100% of the lower of cost or Scheme Rate	21 days for a person each year, included in the Mental Health limit	Authorisation required
Out-of-hospital: Consultations, visits, assessments, therapy, treatment and counselling	100% of the lower of cost or Scheme Rate	**R8 497** for a family, included in the Mental Health limit	
NON-SURGICAL PROCEDURES AND TESTS			
In-hospital	80% of the lower of cost or Scheme Rate	Subject to OAL	Authorisation required
Out-of-hospital	100% of the lower of cost or Scheme Rate	**R10 242** for a family	Authorisation required
OPTOMETRY			
Eye examination	100% of the lower of cost or SAOA Rate	One (1) examination for a beneficiary each year	
Lenses	100% of the lower of cost or SAOA Rate	Clinically essential every 2 years. Every 2 years from anniversary of claiming PB.	No benefit for lens add-ons
Frames	100% of the lower of cost or SAOA Rate	One (1) frame for a beneficiary, further limited to **R1 670** for a beneficiary, every 2 years from anniversary of claiming PB.	
Contact lenses	100% of the lower of cost or SAOA Rate	**R3 426** for a beneficiary, every 2 years (from anniversary of claiming PB) instead of spectacle lenses above.	
Readers	100% of the lower of cost or SAOA Rate	Limited to and included in the frames limit above, if obtained from a registered practice	
Refractive eye surgery	80% of the lower of cost or Scheme Rate	**R20 732** for a family	Authorisation required
ORGAN AND TISSUE TRANSPLANTS			
Harvesting of organ/s, tissue and the transplantation of them (limited to RSA)	100% of the lower of cost or Scheme Rate	**R238 941** for a family (Organ Transplant limit)	Authorisation required
Immunosuppressive medication	100% of the approved price	Included in the Organ Transplant Limit	Authorisation required
Corneal grafts. Organ harvesting not limited to RSA	100% of the lower of cost or Scheme Rate	**R31 861** for a beneficiary, included in the Organ Transplant limit	Authorisation required

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
ONCOLOGY (CANCER)			
Active treatment period. Includes approved pathology and post active treatment for 12 months	100% of the lower of cost or Scheme Rate	Subject to OAL	
Brachytherapy	100% of the lower of cost or Scheme Rate	**R56 721** for a family	Authorisation required
CHILD IMMUNISATION			
Childhood Immunisation Benefit	100% of lower of cost or Scheme Rate	According to the Department of Health protocols (excludes consultation cost)	
PATHOLOGY AND MEDICAL TECHNOLOGY			
In-hospital	100% of the lower of cost or Scheme Rate	Subject to OAL	
Out-of-hospital	100% of the lower of cost or Scheme Rate	**R10 816** for a family	
ADDITIONAL MEDICAL SERVICES			
In-hospital: Dietetics, occupational therapy, speech therapy and social workers	100% of the lower of cost or Scheme Rate	**R15 021** for a family	
Out-of-hospital: Audiology, dietetics, genetic counselling, hearing aid acoustics, occupational therapy, orthoptics, podiatry, private nurse practitioners, speech therapy and social workers	100% of the lower of cost or Scheme Rate	**R5 366** for a family	
PHYSIOTHERAPY, BIOKINETICS AND CHIROPRACTICS (EXCLUDING X-RAYS)			
In-hospital: Physiotherapy and biokinetics	100% of the lower of cost or Scheme Rate	Subject to OAL	
Out-of-hospital: Physiotherapy, biokinetics and chiropractics	100% of the lower of cost or Scheme Rate	**R9 397** for a family	
PROSTHESIS AND DEVICS (INTERNAL AND EXTERNAL)			
	100% of the authorised cost	**R65 769** for a family	Authorisation required

BENEFIT CATEGORY	RATE	LIMIT EACH YEAR	AUTHORISATION
RADIOLOGY AND RADIOGRAPHY			
In-hospital	100% of the lower of cost or Scheme Rate	Subject to OAL	
Out-of-hospital	100% of the lower of cost or Scheme Rate	**R11 856** for a family	
Specialised (in- and out-of-hospital)	100% of the lower of cost or Scheme Rate	**R22 509** for a family	Authorisation required
PET and PET-CT scans	100% of the lower of cost or Scheme Rate	One (1) for a family	Authorisation required
RENAL DIALYSIS (CHRONIC)			
	100% of the lower of cost or Scheme Rate	**R238 941** for a family	Authorisation required
SURGICAL PROCEDURES (INCLUDING MAXILLO-FACIAL SURGERY)			
	100% of the lower of cost or Scheme Rate	Subject to OAL	Authorisation required

Contributions for 2022

EFFECTIVE ON 1ST MARCH 2022

Beneficiary	R0 – R12 720	R12 721 – R18 990	R18 991 – R26 164	R26 165 – R53 067	R53 068+
Principal	R2 140	R2 736	R2 963	R3 699	R4 383
Adult	R1 679	R2 157	R2 277	R2 866	R3 481
Child	R574	R738	R796	R880	R1 030

In the event that a member's income changes during the course of a benefit year, placing the member in a higher/lower income band for contribution purposes, the member shall immediately inform the Scheme of such change and the Scheme shall effect such adjustment to the higher/lower income band from 1 January of the following benefit year except in cases of promotion and demotion wherein the Scheme shall effect such change immediately.

5. EXCLUSIONS

PRESCRIBED MINIMUM BENEFITS

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

GENERAL SCHEME EXCLUSIONS

Unless otherwise approved by the Scheme (and with the express exception of medicines or treatment approved and authorised in terms of any relevant managed healthcare programme), expenses incurred in connection with any of the following will not be paid by the scheme:

The following are excluded by the Scheme unless authorised by the Board of Trustees:

- All costs that exceed the annual or biennial limit allowed for the particular benefit set out in the Scheme Rules.
- Claims that are submitted more than four months after the date of treatment.
- Interest charges on overdue accounts, legal fees incurred as a result of delay on non-payment accounts and/or any administration fee charged by provider.
- Charges for appointments which a member or dependant fails to keep with service providers.
- Accommodation in a private room of a hospital unless clinically indicated and prescribed by a medical practitioner and authorised by the scheme.
- Accommodation in an old-age home or other institution that provides general care for the aged and /or chronically ill patients, unless approved by the Scheme.
- Accommodation and/or treatment in headache and stress-relief clinics, spas and resorts for health, slimming, recuperative or similar purposes.
- Treatment of obesity – slimming preparations and appetite suppressants, any surgical procedure to assist in weight loss.
- 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 lifesaving, life-sustaining or life-supporting: for example, breast reduction, breast augmentation, otoplasty, total nose reconstruction, lipectomy, subcutaneous mastectomy, minor superficial varicose veins treatment with sclerotherapy, abdominal bowel bypass surgery, etc.
- Reversal of sterilisation procedures.
- Sex change operations.
- 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 of disablement which impairs or threatens essential body function (the process of ageing will not be regarded as an illness or a disablement).
- Services rendered by any person who is not registered to provide health services as defined in the Medical Schemes Act and medicines that have been prescribed by someone who is not a registered health services provider.
- The purchases of bandages, syringes (other than for diabetics) and instruments, patent foods, tonics, vitamins, sunscreen agents, growth hormone, and immunisation (not part of PMB).
- General anaesthetic and hospitalisation for conservative dental work excluded, except in the case of trauma, patients under the age of eight years and impacted third molars.

- Gum guards for sport purposes, gold in dentures and the cost of gold as an alternative to non-precious metal in crowns, inlays and bridges and bleaching of teeth.
- Reports, investigations or tests for insurance purposes, admission to universities or schools, emigration or immigration, employment, legal purposes/medical court reports, annual medical surveillance, or similar services, including routine examinations.
- Pre-natal and/or post-natal exercises
- Travelling and accommodation/lodging costs, including meals as well as administration costs of a beneficiary and/or service provider.
- The cost of holiday for recuperative purposes, whether considered medically necessary or not, and travelling cost (this travelling is the patients travelling cost, not the provider).
- Prophylactic treatment – "stop" Smoke, Disulfiram treatment (Antabuse).
- The artificial insemination of a person in or outside the human body as defined in the Human Tissue Act, 1983(Act 65 of 1983) provided that, in the case of artificial insemination, the scheme's responsibility on the treatment will be:
  - As it is prescribed in the public hospital
  - As defined in the prescribed minimum benefits (PMBs), and
  - Subject to pre-authorisation and prior approval by the scheme
- Experimental unproven or unregistered treatments or practices.
- Aptitude, intelligence/IQ, and similar tests as well as the treatment of learning problems.
- Costs for evidence in a lawsuit.
- Sclerotherapy
- All costs for healthcare services if, in the opinion of the medical or dental adviser, such healthcare services are not appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition at an affordable level of service and cost.
- All costs for medicine for the treatment of chronic conditions not on the list of conditions covered, except for medicine for the treatment of an excluded chronic condition which the Scheme has specifically determined needs to be treated to achieve overall cost- effective treatment of the beneficiary.
- Alternative healthcare: (excluding PlatFreedom)
  - Homeopathic consultation and medication that have valid NAPPI codes
  - Podiatry (not part of PMB)
- Vaccinations
- Refractive eye surgery, excimer laser treatment. (excluding PlatFreedom)

6. CLAIMS & REFUNDS

Platinum Health has an agreement with designated service providers (DSP's) to submit claims directly to the Scheme in order to streamline the payment of claims. If however, a member should receive a tax invoice/account from a Medical Service Provider, the member is advised to contact Platinum Health Client Liaison to determine whether the tax invoice/account has been submitted to the Scheme. If it has not been submitted to the Scheme, the member has to ensure it is submitted within four months of date of services/supplies, to prevent it from becoming stale, resulting in non-payment.

6.1 Step-by-step guide for MEMBERS on HOW TO SUBMIT CLAIMS

01

Confirm the following details feature on the tax invoice/account:

- Tax invoice/account number
- Member's initials, surname and address
- Membership number
- Dependant code
- The date, tariff code and detail of the services/supplies provided
- Authorisation number, if the tax invoice/ account is from a specialist.
- Verify that the member or dependant did receive the service or supplies, by signing the tax invoice/account.

02

Submit claims, within four months, to the Scheme VIA any of the following channels:

Email: phclientliaison@platinumhealth.co.za
Fax: 086 591 4598
Mail: Platinum Health,
Private Bag X82081,
Rustenburg, 0300

Hand in at Client Liaison Office at your operation

03

Processing of claims received:

Claims and refunds are processed in accordance with the Medical Scheme Rules, Rates and Tariffs.

04

Payment of claims:

Payment commences after the claim is processed.

05

Member receives notification of payments VIA:

SMS notifications
Member statements with full details of payments are emailed or posted to members **(It is important for members to ensure their contact number, email & postal addresses are updated with the Scheme)**

Members can also request claims advices via the Platinum Health website (www.platinumhealth.co.za) OR contact Client Liaison on 080 000 6942 or 014 590 1700, Monday to Friday from 08:00 – 16:00 for assistance.

6.2 Step-by-step guide for MEMBERS on HOW TO REQUEST REFUNDS

Members who pay for services/supplies up-front and require a refund from Platinum Health Medical Scheme, should ensure they submit the correct refund documentation, within four months from treatment date, to the Scheme.

01 Ensure you have the correct refund documentation:

- **PROOF OF PAYMENT** such as a credit card transaction slip, a receipt of payment or a zero-balance statement from the provider indicating transactions.
- **ACCOUNT** featuring the following details:
  - Member's initials, surname and address;
  - Member's medical scheme number;
  - The date, tariff code and detail of the services/ supplies provided,
  - The name and date of birth of the patient who received the services/supplies; and
  - Platinum Health authorisation number, where applicable.
- **VERIFY** that the member or dependant did receive the service or supplies, by signing the account submitted.
- **BANK CONFIRMATION LETTER** if the member changed bank accounts OR if the member has not been refunded during the last 3 months.

02 Submit refund requests, within four months, to the Scheme VIA any of the following channels:

Email: phclientliaison@platinumhealth.co.za
Fax: 086 591 4598
Mail: Platinum Health,
Private Bag X82081,
Rustenburg, 0300

Hand in at Client Liaison Office at your operation

03 Processing of claims received:

Refund requests are processed in accordance with the Medical Scheme Rules, Rates and Tariffs.

04 Payment of refund:

Payment is made after the refund request is processed. **(It is important for members to ensure their correct banking details are updated with the Scheme.)**

05 Member receives notification of payments VIA:

SMS notifications
Member statements with full details of payments are emailed or posted to members **(It is important for members to ensure their contact number, email & postal addresses are updated with the Scheme)**

For more information or assistance, kindly contact Client Liaison on 080 000 6942 or 014 590 1700, Monday to Friday from 08:00 – 16:00.

6.3 Step-by-step guide for MEDICAL SERVICE PROVIDERS on HOW TO SUBMIT CLAIMS

01

What Medical Service Providers need to do:

Medical Service Providers are required to include the following information on all tax invoices/accounts:

- Tax invoice/account number
- Member's initials, surname and address
- The date and detail of service/supplies provided such as quantity and timeframe; as well as the tariff code for the service/supplies.
- The name and date of birth of the patient who received the service/supplies as well as patient's dependant code.
- Platinum Health authorisation number, where applicable.

02

Medical Service Providers have to submit all claims to Platinum Health, within four months of date of services/supplies either VIA:

Electronic Data Interface (EDI)
OR
Alternatively email to SuppliersRPM@platinumhealth.co.za

03

Processing of claims received:

Claims are processed in accordance with the Medical Scheme Rules, Rates and Tariffs.

04

Payment of claims:

Payment commences once claims are processed.

05

Notification of payments to Medical Service Providers

Seven days after the payment is made, a remittance advice is sent to the Medical Service Provider confirming payment made.

Medical Service Providers can also request remittance advices via the Platinum Health website (www.platinumhealth.co.za) OR by contacting the Supplier Liaison Department on 080 000 6942 or 014 590 1700, Monday to Friday, from 08:00 – 16:00.

6.4 Frequently asked questions (FAQs)

Q What is an ex-gratia payment and do I have a right to such benefits?

A It is a discretionary consideration by Platinum Health Medical Scheme, which is only made if the Scheme believes that an exceptional situation exists that warrants ex-gratia funding. It is not a benefit that the Medical Scheme has to offer, nor is it guaranteed.

- The Scheme reviews the ex-gratia application, which should be completed by the member asking for consideration.
- Only applications with complete information can be reviewed by the committee. It is your responsibility as a member to make sure that all the required information is on the application form, and attached to it, as this will be presented to the committee. Application forms can be downloaded from the Platinum Health website (www.platinumhealth.co.za) or kindly contact the Client Liaison Office for assistance. Refer to page 65 for contact details.
- Because ex-gratia is discretionary, Platinum Health Medical Scheme may decline any application without affecting its own rights in any way.
- The Scheme's decisions is final and can't be disputed or appealed against. They are not meant to replace or supplement the existing benefits of the Medical Scheme.

Q Is a provider of a healthcare service entitled to charge more than the fees determined by the Medical Scheme tariff?

A Yes. Healthcare providers are free to determine their own fees. Consequently, if an account is in excess of the fee determined by the Rules of a Medical Scheme for a particular service, the difference is the responsibility of the member.

Q What is a co-payment?

A A co-payment is a fee that members are required to pay for use of a specific benefit or if a benefit limit was reached covered by the Scheme.

Q What is the Medical Scheme rate and how is it determined?

A The Scheme used the NHRPL 2006 as a baseline on tariffs and adjusts it by Consumer Price Index (CPI) yearly.

Q What is a stale claim?

A According to the Scheme Rules, claims must reach the Scheme within four months from the treatment date. If your claim is not received within this period, it is considered stale and the Scheme will not pay for these late claims.

Q Within what time frame may I request a refund after the services provided?

A Refund requests must be submitted within four months of date of services/supplies provided.

7. CASE MANAGEMENT

7.1 Managed Care

Platinum Health operates an excellent and nationally comparable Case Management function for all patients referred to Platinum Health Medical Scheme owned facilities or outsourced providers. The Case Managers are available 24 hours a day, 7 days per week and 365 days per year. The function of Case Management is to monitor several aspects of the medical surgical treatment to ensure that the Scheme's vision of providing quality, affordable healthcare is adhered to. Case Management administers specific management programmes and authorises specialist consultations, hospital admissions and specialised radiological investigations such as MRIs, CT and PET scans.

Case Management Contact Details

Tel: 014 590 1700 or 080 000 6942

After-hours & emergencies: 082 800 8727
After-hours and emergencies contact number may not be used for general account and membership enquiries.

Fax: 086 247 9497 or 086 233 2406

Email: plathealth@platinumhealth.co.za
(specialist authorisation)
HospitalConfirmations@platinumhealth.co.za
(hospital pre-authorisation and authorisation)

Website: www.platinumhealth.co.za

7.2 Importance of obtaining authorisation

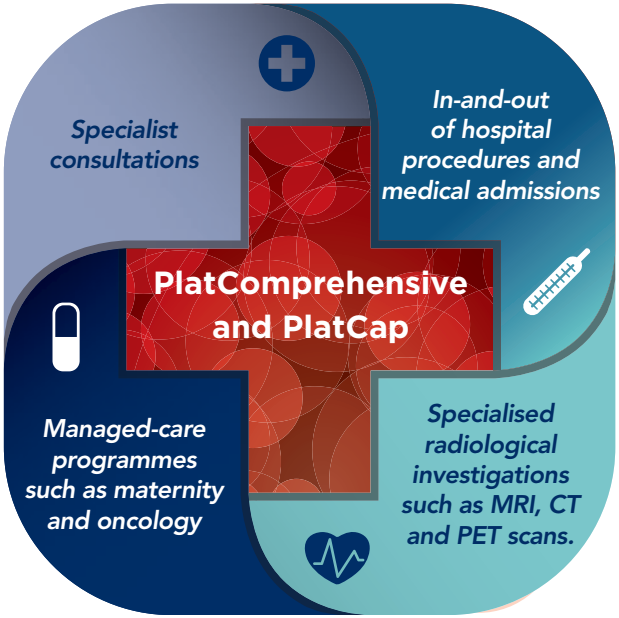
The authorisation process entails assessing the clinical necessity and appropriateness of the referral, procedure or treatment according to the Scheme's clinical protocols and guidelines, prior to the specialist visit, hospital admission or treatment.

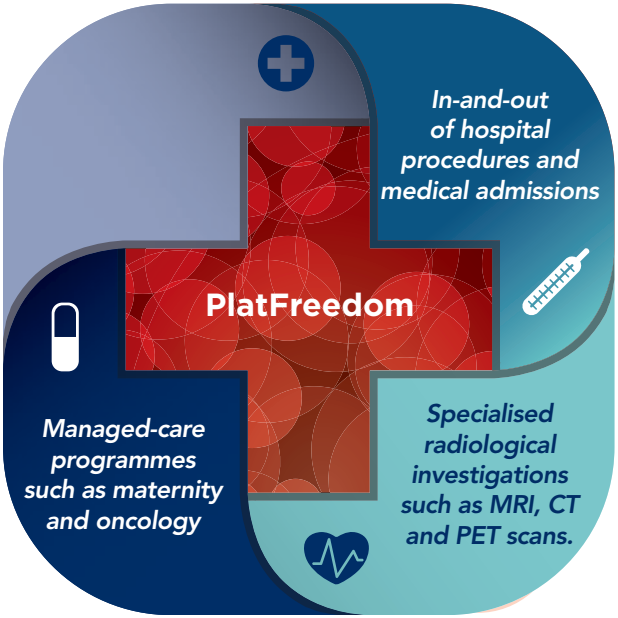
Members should also confirm their benefits prior to any of the abovementioned instances, to ensure the claim is funded from the correct benefit. Full funding is determined by availability of benefits and utilisation of designated service providers (applicable to PlatComprehensive and PlatCap Options).

Although we check if a member is eligible for treatment and that sufficient benefits are available to cover costs, an authorisation is not an automatic guarantee that claims will be paid. You are encouraged to ask for details about how much will be paid by the Scheme when requesting authorisation for non-emergency procedures such as specialist consultations, planned in-hospital procedures and medical admissions, special radiological investigations such as MRI, CT and PET scans and managed-care programmes such as maternity and oncology.

In case of emergency admissions, authorisation has to be obtained within 24-hours or on the first working day after the emergency. The member will receive confirmation of approval (authorisation) via an SMS or email. Kindly ensure to give the authorisation number to the specialist, hospital and/or treating supplier. Should authorisation be declined by the Scheme, members are advised to contact Case Management.

When is authorisation needed?





How to request authorisation from Case Management

01

Have the following information ready when phoning Case Management for authorisation:

- Membership number
- Beneficiary name and date of birth
- Date of visit/admission and proposed date of the operation
- Name of the doctor, his/her telephone number and practice number
- All the relevant procedures and associated medical diagnosis codes (your doctor can assist you with this)
  - Ask your doctor for full details of:
    - The reason for admission to hospital, or scan.
    - Applicable procedure/tariff code(s).
    - Your diagnosis and ICD-10 code if available.

Members can also request authorisation via the Platinum Health website (www.platinumhealth.co.za)
Contact Case Management for assistance if you're unsure whether any treatment requires authorisation.

02

Call Case Management on 014 590 1700 or 080 000 6942 Or alternatively email the information to:

- plathealth@platinumhealth.co.za (specialist authorisations)
- HospitalConfirmations@platinumhealth.co.za (hospital pre-authorisation and authorisation)

03

Case Management will send confirmation of approval (authorisation) to the member via an SMS or email, providing the following information:

- The unique authorisation number
- The approved dependant
- The approved supplier
- The initial approved length of stay
- The status of all the codes (whether approved or rejected in accordance with the Scheme Rules)

Frequently asked questions (FAQs)

Q If I am on holiday or away for a weekend and need to visit a GP urgently, what do I do?

A PlatComprehensive and PlatCap members may make use of any GP whilst on holiday, unless there is a Platinum Health facility or DSP GP nearby, in which case they are obliged to use such GP. PlatFreedom members may consult their GP of choice.

- The detailed DSP list is available on request from Case Management or Client Liaison 014 590 1700 or visit the Platinum Health website: www.platinumhealth.co.za.

Q If I am on holiday and I consulted a GP, where can I get my prescription filled?

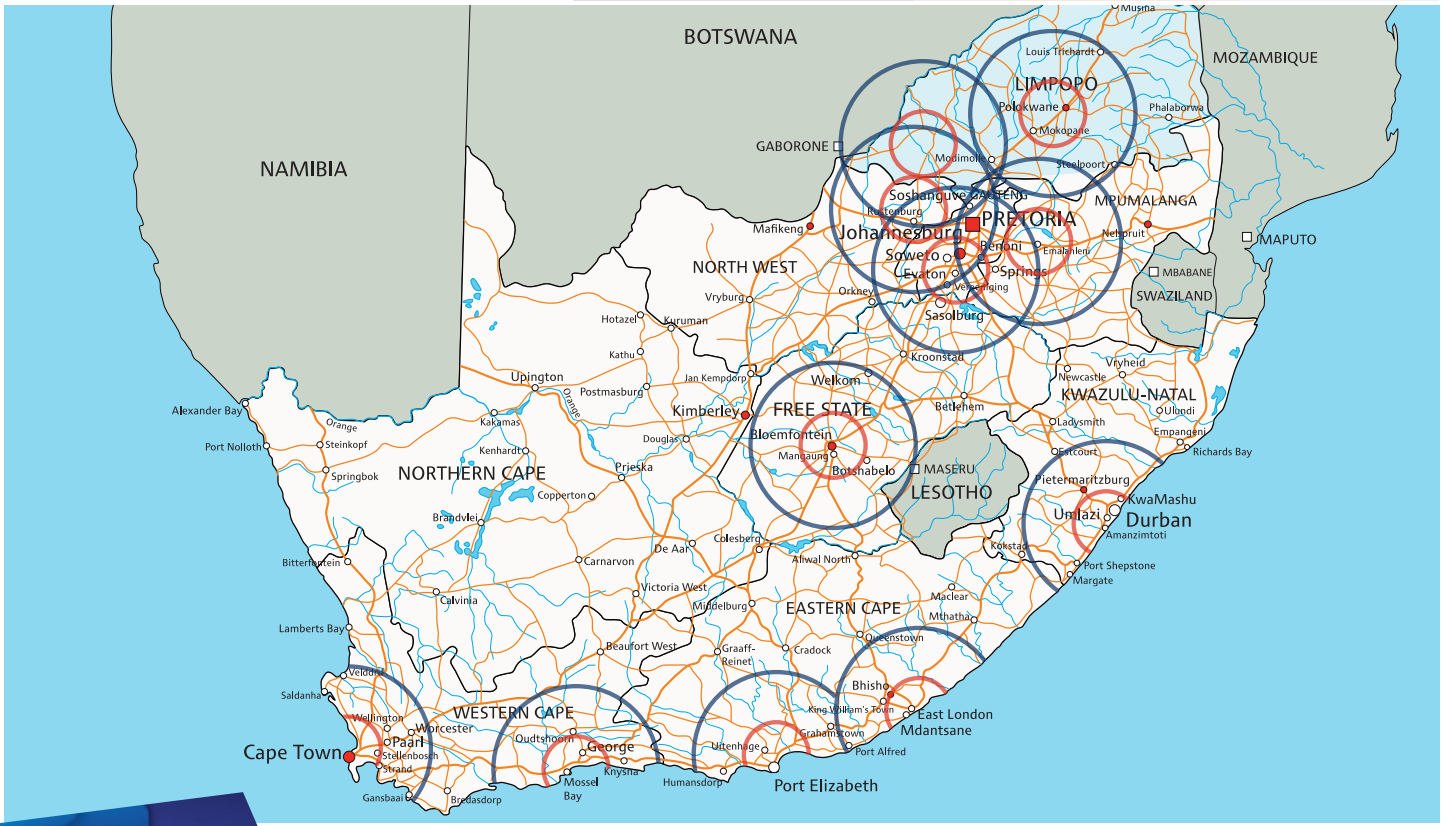
A If on holiday and you need to get your prescription filled, members are advised to utilise Clicks Medirite or Dischem pharmacies. If there is no Clicks Medirite or Dischem pharmacies nearby, the member can utilise any pharmacy available. Ask your pharmacist about generic equivalents on the PMHS formulary to avoid co-payments. Members who take chronic medication should take it with while on holiday.

7.3 Important notes on designated service providers (DSPs)

Platinum Health has established a countrywide DSP network of specialists, hospitals, radiology and pathology services. A DSP is a healthcare provider or group of providers selected by the Scheme as the preferred provider or providers to provide to its members diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions. However, members may only access these services through a GP and with authorisation from Case Management. The DSP list is available on request from Case Management or Client Liaison or can be accessed via the Platinum Health website www.platinumhealth.co.za.

This map gives an indication of the Platinum Health designated service provider network. The red circle indicates the area within 50km from the DSP, and the blue circle the area within 200km. Please note that this map is not according to geographical scale, residential postal codes determine the location. Please contact Case Management to confirm exact status.

OPTION GUIDE		
PlatComprehensive	PlatCap	PlatFreedom
• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 – 200km radius who elect to utilise a DSP will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSP shall be deemed to have obtained services involuntary in which case the scheme will cover 100% of Scheme Tariff, subject to regulation 8(3).	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs subject to regulation 8(3). • Members located between 50 – 200 km radius of Scheme DSPs may utilise any provider and will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3).	• PlatFreedom offers members complete freedom of choice to see service providers they prefer. • Benefit limits apply and members will be liable for the full cost once the overall limit is reached.



7.4 Hospital management and authorisation

Members have to obtain authorisation from Case Management for any planned hospital admission or procedure in a hospital, at least two (2) days prior to being admitted to hospital. In case of emergency admissions, authorisation has to be obtained within 24-hours or on the first working day after the emergency.

In the event of emergency treatment or admission to hospital over a weekend, public holiday or outside normal working hours, you must contact the Scheme for authorisation on the first working day after the incident.

If you do not obtain authorisation for a planned event, or fail to authorise hospital treatment on the first working day after an emergency event, your claim may be rejected for payment. Any admission or outpatient visit to a hospital, must be authorised.

If your hospital stay is longer than expected

Any additional days in hospital, multiple procedures or additional services require further authorisation or motivation. Please arrange that your doctor, the hospital case manager or a family member, inform the Scheme of the extended length of stay. If there is a clinical reason for the extended stay, the Scheme will approve the extra days. If not, the member will be responsible for the cost for the non-approved days and treatment.

Once the authorisation request has been approved, you will receive the following information:

- The unique authorisation number
- The approved dependant
- The approved supplier
- The initial length of stay
- The status of all the codes (whether approved or rejected in accordance with the Scheme Rules)

OPTION GUIDE		
PlatComprehensive	PlatCap	PlatFreedom
• Unlimited if DSP Hospitals are utilised. • 100% of Scheme Tariff. • Where possible own facilities have to be utilised. *Where services cannot be provided at a DSP hospital, the patient shall be referred by the Scheme for treatment at another private hospital or clinic.* • Members to be referred by general practitioners or specialists. Subject to clinical protocol approval and regulation 8(3). • No levy is applicable for hospitalisation at a DSP hospital provided that the Scheme's DSP practitioner or specialist has referred the member and that the hospitalisation is authorised. • Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 - 200km radius who elect to utilise DSPs will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Members located between 50 - 200km radius who elect to utilise non-DSPs shall be deemed to have voluntary obtained services. • ***Limit of R152 818* if non-DSP Hospitals are utilised. 100% of Scheme Tariff applies.** • Members to be referred by general practitioners or specialists. • Subject to clinical protocol approval and regulation 8(3).	• Unlimited if DSP Hospitals are utilised. • 100% of Scheme Tariff. • Where possible own facilities have to be utilised. *Where services cannot be provided at a DSP hospital, the patient shall be referred by the Scheme for treatment at another private hospital or clinic.* • Members to be referred by general practitioners or specialists. Subject to clinical protocol approval and regulation 8(3). • No levy is applicable for hospitalisation at a DSP hospital provided that the Scheme's Medical Practitioner has referred the member and that the hospitalisation is authorised. • Members located between 50 - 200km radius who elect to utilise non-DSP hospitals will be covered 100% of negotiated tariff, subject to regulation 8(3). • Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located between 50 - 200km radius who elect to utilise DSPs will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the Scheme will cover 100% of Scheme Tariff, subject to regulation 8(3).	• Subject to the Overall Annual Limit. • 100% of the lower of cost or Scheme Rate. • Authorisation required.

Admission process for Hospitals

	PlatComprehensive	PlatCap	PlatFreedom Option
Planned Hospital Admissions	• Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to pre-authorisation within two (2) days prior to admission. Subject to regulation 8(3). • Members located between 50 - 200km radius who elect to utilise DSPs will be covered 100% of Scheme Tariff, subject to regulation 8(3). • Members located further than 200km radius from DSPs shall be deemed to have obtained services involuntary in which case the scheme will cover 100% of Scheme Tariff, subject to regulation 8(3). • Subject to limits, benefits and clinical protocol approval.		• Members may utilise any hospital. However pre-authorisation has to be obtained from the scheme within two (2) days prior to admission. • Subject to the Overall Annual Limit (OAL), benefits and clinical protocol approval.
	• Member has to consult the GP/Specialist with a specific condition/ problem and the specialist referral process has to be followed.		• Member has to consult the GP/Specialist with a specific condition/problem.
	The GP/specialist completes a request for admission and gives it to the member. The member should use this request to obtain authorisation for the hospital admission from Case Management.		
	• The hospital authorisation request from the GP/specialist should contain the following detail: • The patient's: o Name o Date of birth o Medical Scheme number o Contact details • The hospital details and practice number • The admitting/treating GP/specialist's details and practice number • Admission date • Diagnosis • ICD 10 code(s) • Tariff code(s)/procedure code(s)		
After-hours admissions	After-hours hospital admissions should be arranged with the Case Manager on call and all related documentation to be submitted to Case Management on the first working day after the hospital admission.		
Emergency hospital admissions	Emergency admissions can be arranged telephonically between the referring GP/specialist/hospital and the responsible Case Manager, However; the documentation still needs to be finalised afterwards.		

Approved		Rejected	
PlatComprehensive/PlatCap	PlatFreedom	PlatComprehensive/PlatCap	PlatFreedom
Case Management evaluates the referring request with the assistance of the Medical Advisor and authorises the admission.		Case Management evaluates the referring request with the assistance of the Medical Advisor and rejects the hospital admission.	
Member receives an authorisation number via SMS, email, telephone or from a Platinum Health facility.	Member receives an authorisation number via SMS, email or telephone.	Member receives notification via SMS, email, telephone or from a Platinum Health facility; stating the reason why authorisation request was declined.	Member receives notification via SMS, email or telephone; stating the reason why authorisation request was declined.
Hospital authorisation request/pre-admission documents need to be send or taken to the hospital before the admission date. This is to ensure pre-admission documentation is completed and captured on the hospital system to ensure problem free admission.		Member can contact Case Management and Platinum Health facilities at their sites with regards to follow-up enquiries.	Member can contact Case Management with regards to follow-up enquiries.
Member to supply the authorisation number to the hospital.			

Admission to non-DSP Hospitals

Applicable to PlatComprehensive option

Members located within a 50km radius of DSPs are obliged to utilise such DSP Hospitals. Members located between 50-200km radius who elect to utilise non-DSPs shall be deemed to have voluntary obtained services.

Should a member choose to utilise a non-DSP hospital, the member and/or his/her dependant(s) have to bear in mind that **Platinum Health (PH) accepts liability for 100% of Scheme Tariff with a limit per member family of R152 818** per year. Members and/or dependant(s) should also note that should they utilise a non-DSP hospital, PH will only accept responsibility for 100% of Scheme Tariff for the GP, Specialists, Anaesthetist, X-rays or any other medical services/institution utilised. The member and/or dependant(s) are responsible to negotiate a better rate or discount with the hospital and/or medical service providers utilised. The principal member has to sign a letter confirming that he/she will be accepting the responsibility of utilising a non-DSP hospital.

Planned hospital admission	After-hours hospital admissions	Emergency hospital admissions
• Member has to consult the GP/Specialist with a specific condition/problem. • The GP/specialist completes a request for admission and gives it to the member. The member should use this request to obtain authorisation for the hospital admission from Case Management. • The hospital authorisation request from the GP/specialist should contain the following detail: • The patient's - Name - Date of birth - Medical Scheme number - Contact details • The hospital details and practice number • The admitting/treating GP/specialist's details and practice number • Admission date • Diagnosis • ICD 10 code(s) • Tariff code(s)/procedure(s)	After-hours hospital admissions should be arranged with the Case Manager on call and all related documentation to be submitted to Case Management on the first working day after the hospital admission.	Emergency admissions can be arranged telephonically between the referring GP/ specialist/hospital and the responsible Case Manager, however the documentation still needs to be finalised afterwards.

Approved	Rejected
• Case Management evaluates the referring request with the assistance of the Medical Advisor and authorises the admission. • Member receives an authorisation number via SMS or email or telephone. • Hospital authorisation request/pre-admission documents need to be send or taken to the hospital before the admission date. This is to ensure pre-admission documentation is completed and captured on the hospital system to ensure problem free admission. • Member to supply the authorisation number to the hospital. • Subject to clinical protocol approval.	• Case Management evaluates the referring request with the assistance of the Medical Advisor and rejects the hospital admission. • Member receives notification via SMS or email or telephone; stating the reason why authorisation request was declined. • Member can contact Case Management and Platinum Health facilities at their sites with regards to follow-up enquiries.

Submit the hospital authorisation request to Case Management via any of the following channels:

Tel: 014 590 1700 or 080 000 6942 OR

Fax: 086 247 9497 or 086 233 2406 OR

Email: HospitalConfirmations@platinumhealth.co.za (hospital pre-authorisation and authorisation) OR

Platinum Health facilities OR

Platinum Health website (www.platinumhealth.co.za) Click on the "Request authorisation function"

Important notes on payment of accounts

PlatComprehensive/PlatCap	PlatFreedom
• Platinum Health will pay providers according to scheme tariffs. Co-payment and administration levies are the responsibility of the patient. • Members who do not honour appointments will be held liable for the cost of the appointment. Therefore, it is important for members to inform Case Management of appointment date changes, in order for them to update the authorisation on the system. • If no authorisation was obtained from the scheme Platinum Health will not pay for specialist consultations, even if the member has paid cash for the consultation. Authorisation is needed for each follow-up consultation with a specialist. (Authorisation will be valid for only the date of treatment/consultation.) If the date of the specialist appointment changes after authorisation number has been issued, please inform Case Mangagement of date change so that it can be amended on the system to ensure that accounts are not rejected as a result of incorrect consultation date. • In order for diagnostic tests, procedures, admissions or other interventions to be approved, a general practitioner (GP) referral and specialist consultation authorisation needs to be obtained prior to admission. • New authorisation number has to be obtained from Case Management for follow-up visit with specialist after the patient is discharged from hospital.	• Platinum Health will pay providers according to the lower of cost or scheme rate. • Co-payments and administration levies are the responsibility of the patient. • Members who do not honour appointments will be held liable for the cost of the appointment. • Although PlatFreedom members do not need authorisation to consult a specialist, members should note there is a limit for GP/specialist consultations. • In order for diagnostic tests, procedures, admissions or other interventions to be approved, a referral from your medical practitioner must be provided to Case Management.

7.5 In case of an emergency

In case of a life-threatening emergency, members and dependants may go to the nearest medical facility. Platinum Health is contracted to Europ Assistance, providing members access to an accredited, independent network of roughly 5,000 emergency medical personnel ready to respond to all levels of medical emergencies, anywhere in South Africa.

Europ Assistance's Emergency Medical Response Service (EMS) is available 24/7/365 and is manned by medical professionals. In the event of a medical emergency, trained paramedics will assess each situation and dispatch the most appropriate medical emergency transportation via air or by road. By dialling **0861 746 548** from any cellular phone or landline, you have access to the largest national network of emergency service providers.

If possible, handle all emergencies through **Platinum Health Case Management, 082 800 8727**.

However, in some cases it may be necessary to call **Europ Assistance on 0861 746 548** directly, or someone else might call it on your behalf when you are unable to do so. As is the case for all hospital admissions, authorisation is also required.

Out of airtime and need emergency assistance? Send a "please cal me" to *130*3272*127# and Europ Assist will call you back!

europ assistance
you live we care

The Medical Schemes Act defines an emergency condition as follows:

"Emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment of bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy."

Please obtain authorisation (at the latest) on the first working day following the emergency. Members or dependants who have difficulty obtaining services should call **Case Management at 082 800 8727** (printed on Platinum Health membership cards and license disk holders); which is attended to at all times, including after-hours and on weekends.

Examples of medical emergencies:

Person lying on stretcher | Heart attack | Car crash

Examples of what are NOT medical emergencies:

Doctors appointment | Minor ailments e.g. sprained ankle or stomach ache | Booked theater cases

EUROP ASSISTANCE - CALL ME FUNCTIONALITY

In addition to the 24/7/365 branded share-call number, Europ Assistance SA offers members the ability to access services through a mobile solution, which facilitates simple, secure and convenient activation of its services. The technology offers members the ability to view the benefit information on their mobile phone and activate the service at the push of a button, initiating an immediate call back from a Contact Centre agent.

Benefits of the mobile solution include:

- Compatibility and accessibility on any mobile device;
- Convenience, cost savings and ambulance response time to the patient.

Call Me - How it works

The Call Me facility is hosted on a mobi-site which; enables a large spectrum of smartphone users to have access to Europ Assistance SA services. However, this is only possible once members have completed a quick and easy registration process.

The registration process can be completed in a few easy steps:

01 The member will receive an SMS which will contain a link to the mobi site.

02 The member have to enter their Name, Surname, ID Number as well as their Cell number. The system will then validate the user against the member database within Europ Assistance's incident management system, which will enable immediate access to services.

03 As a registered user, the member will be able to bookmark the page and place a direct link on their smartphones home page for quick future access. The Call Me facility is activated by selecting the relevant service and clicking on "Call Me." A free message will be sent to the Europ Assistance SA's telephony system, and a case manager will call the patient back within the agreed service level.

Emergencies - How it works

01

HELP REQUIRED

Member has a Medical Emergency – Requires an ambulance

02

CLIENT LOCATED

Push notification link is sent to member via SMS and once activated, the geolocation of the member is recorded

03

WITH YOU EVERY STEP OF THE WAY

Europ Assist's specialist team is with the member every step of the way

#youlivewecare

europ assistance

you live we care

PERSONAL HEALTH ADVISOR @ 24-HOUR HEALTHLINE

Personal Health Advisor is a healthcare service providing unlimited access to qualified nurses 24 hours a day.

Members benefit from:

- Emergency medical advice.
- Assessment of symptoms and referral to the most appropriate healthcare professional.
- Knowledge on all aspects of healthcare including home care remedies with scheduled follow-up assessment calls, if required.
- Explained medical terms, results of tests and information relating to medication.
- Counselling for chronic ailments and diseases to minimise the impact of these conditions on daily life.
- Access to one of the most widely searched and referenced drug and poison databases in South Africa.
- Telephonic trauma debriefing and referral to a trauma counsellor, where necessary.
- Access to a pre-recorded audio health library for information on a range of medical topics.

Terms and conditions

- Access to the service is available to validated members only.
- Based on symptom assessment, Europ Assistance SA may refer a member to a medical professional. Any costs incurred for services rendered by a medical professional are to be paid by the member.
- Symptom assessments are made based on the information provided by the member at the time of the call and can only be as accurate as the information provided by the member.

7.6 Specialist referrals and authorisations

PlatComprehensive/PlatCap members need to obtain authorisation from Case Managegment prior to consulting specialists.

PlatFreedom members don't need authorisation to visit specialists', however members still need to obtain authorisation from Case Management for in-and-out of hospital procedures and medical admissions, specialised radiological investigations such as MRI, CT and PET scans and managed care programmes such as maternity, oncology, renal dialysis etc.

Specialist referrals process for PlatComprehensive and PlatCap members: First Visit

01

General Practitioner issues a request for referral

Member has to visit GP with a specific condition or problem. The General Practitioner will refer member to a specialist.
The GP issues a request for referral and gives it to the member.
PlatComprehensive/Platcap members should use this request to obtain authorisation for the visit from Case Management.

The referral request from the GP should contain the following detail:

- The patient' name, date of birth, medical scheme number, contact details
- The specialist's details and practice number
- A detailed clinical referral letter (as well as whether or not the visit is related to an MVA or an IOD.
- The referring GP's details and practice number

02

Submit the referral letter to Case Management via any of the following channels:

Tel: 014 590 1700 or 080 000 6942 OR
Fax: 086 247 9497 or 086 233 2406 OR
Platinum Health facilities OR
Email: plathealth@platinumhealth.co.za (specialist authorisation)

Authorisation will be valid for only the date of treatment.

If a specialist referral is approved or rejected	
Approved	**Rejected**
• Case Management evaluates the request with the assistance of the Medical Advisor. • Member receives an authorisation number via SMS, email, telephone or from Platinum Health facility. • Copy of referral letter, X-rays, blood results and all related documentation to be taken with to the specialist. • Member to give authorisation number to specialist.	• Case Management evaluates the referring request with the assistance of the Medical Advisor and rejects referral. • Member's authorisation is rejected, the member will receive notification via SMS, email, telephone or from Platinum Health facility; stating the reason why authorisation request was declined. • Member can contact Case Management and Platinum Health facilities at their sites with regards to follow-up enquiries.

Members need to follow the same procedure for consultations with Paediatricians and Gynaecologists.

Follow-up Visits

Follow-up visits to specialists follow the same procedure as first visits, except that the specialist will request the follow-up visit.

01

In addition:

- Specialists will be required to write a feedback report to the referring GP to ensure that he/she has clarity on the condition/treatment of his/her patients.
- The letter requesting the follow-up visit should contain the following details:
  - The reason for the follow-up visit or frequency of visits, with a full clinical report on diagnosis and treatment, required from treating specialist.
  - The patient's:
    - Name
    - Date of birth
    - Medical Scheme number
    - Contact details
- A copy of the required documentation should be submitted to Case Management for approval prior to the follow-up visit.
- Case Management will capture the motivation/diagnosis and issue a follow-up authorisation number to the patient. This number is valid for only the date of treatment.

Follow-up visits to specialists after hospitalisation/surgery have to be authorised by Case Management.

- On discharge, the specialist will inform the member when follow-up visits are required.
- This is usually two or six weeks after discharge.
- Contact Case Management with this information for approval and an authorisation number.

New authorisation number has to be obtained from Case Management for follow-up visit with specialist after the patient is discharged from hospital.

02

Submit the referral letter to Case Management via:

Tel: 014 590 1700 or 080 000 6942 OR
Fax: 086 247 9497 or 086 233 2406 OR
Email: plathealth@platinumhealth.co.za (specialist authorisation)
Platinum Health facilities OR
Website: www.platinumhealth.co.za

If a specialist referral is approved or rejected

Approved	Rejected
• Case Management evaluates the request with the assistance of the Medical Advisor. • Member receives an authorisation number via SMS, email, telephone or from Platinum Health facility. • Copy of referral letter, X-rays, blood results and all related documentation to be taken with to the specialist. • Member to give authorisation number to specialist.	• Case Management evaluates the referring request with the assistance of the Medical Advisor and rejects referral. • If a member's authorisation is rejected, the member will receive notification via SMS, email, telephone or from Platinum Health facility; stating the reason why authorisation request was declined. • Member can contact Case Management and Platinum Health facilities at their sites with regards to follow-up enquiries.

7.7 Maternity Programme

Platinum Health offers a comprehensive ante-natal service for pregnant members and beneficiaries. This includes visits to GP's and gynaecologists; and ultrasound scans with pre-authorisation. Registration on the Maternity Programme is required for members to enjoy comprehensive benefits.

OPTION GUIDE MATERNITY BENEFIT			
	PlatComprehensive	PlatCap	PlatFreedom
Antenatal consultations	• Referral letter from GP/Specialist required to see Gynaecologist. • Authorisation required from Case Management prior to each visit.	• Subject to Specialist consultations benefit limit: 3 visits or R3 884 PB up to 5 visits or R5 633/family at DSP specialists. • Authorisation required from Case Managed for each visit.	• Subject to Maternity benefit limit of R9 711. • NO authorisation required.
Pregnancy scans	• 3 sonars per event/pregnancy. • Authorisation required from Case Management prior to scans. • Motivation letter from Obstetrician required for high-risk pregnancies. • Ultrasound scans are performed three times: at 12 and 22 weeks, and between 23 and 40 weeks. • Other sonars will be for the member's own account, if no complication is registered.	• 3 sonars per event/pregnancy. • Authorisation requried from Case Management prior to scan. • Motivational letter from Obstetrician required for high-risk pregnancies. • Ultrasound scans are performed three times: at 12 and 22 weeks, and between 23 and 40 weeks. • Other sonars will be for the member's own account, if no complication is registered.	• Two 2D scans per family for the year. • Subject to Maternity benefit limit of R9 711. • 3D & 4D scans paid up to the rate of a 2D scan only.
Amniocentesis	• 100% of Scheme Tariff	• 100% of Scheme Tariff	• 1 per family for the year. • Subject to the Amniocentesis limit of R9 775 per family. • 1 per family for the year.
Blood tests	• Lancet/Pathcare to be used.	• Lancet/Pathcare to be used.	• Paid from the Maternity Benefit limit of R9 711 per family.
Antenatal classes	• Not covered.	• Not covered.	• Not covered.
Supplements	• As per Option formulary.	• As per Option formulary.	• As per Option formulary.
Normal vaginal deliveries	• A stay of 2 days at DSP hospital. • Authorisation required from Case Management prior to hospital admission.	• A stay of 2 days at DSP hospital only. No cover for non-DSP hospitals. • Authorisation required from Case Management prior to hospital admission.	• A stay of 2 days at hospital of choice. • Authorisation required from Case Management prior to hospital admission.
Caesarean section	• A stay of 3 days at DSP hospital. • Authorisation required from Case Management prior to hospital admission.	• A stay of 3 days at DSP hospital only. No cover for non-DSP hospitals. • Authorisation required from Case Management prior to hospital admission.	• A stay of 3 days in hospital of choice. • Authorisation required from Case Management prior to hospital admission.
Circumcision	• 100% of Scheme Tariff	• 100% of Scheme Tariff	• Paid from the OAL.
Childhood Immunisation	• According to the Department of Health protocols (excludes consultation cost.)	• According to the Department of Health protocols (excludes consultation cost.)	• According to the Department of Health protocols (excludes consultation cost.) • Members may obtain services at pharmacies such as Clicks or Dischem.

7.8 Child Immunisations

Age of child	Vaccines needed	How and where it is given
At birth	BCG	Right arm
	OPV (0)	Drops by mouth
6 weeks	OPV (1)	Drops by mouth
	RV (1)	Liquid by mouth
	PCV (1)	Intramuscular Right thigh
	Hexavalent (DTaP-IPV-Hib-HBV (1)	Intramuscular Left thigh
10 weeks	Hexavalent (DTaP-IPV-Hib-HBV) (2)	Intramuscular Left thigh
14 weeks	Rotavirus (2)	Oral
	PCV (2)	Intramuscular Right thigh
	Hexavalent (DTaP-IPV-Hib-HBV) (3)	Intramuscular Left thigh
6 months	Measles (Not required if giving MMR at 12 months)	Subcutaneous Left thigh
9 months	PCV (3)	Intramuscular Right thigh
12 months	MMR	Subcutaneous Right arm
18 months	Hexavalent (DTaP-IPV-Hib-HBV) (4)	Intramuscular Left arm
6 years	DTaP-IPV	Intramuscular Left arm
12 years	TDaP-IPV	Intramuscular Left arm
Additional Vaccinations		
Girls - 9 years and older	HPV (1)	Intramuscular Non-dominant arm
	HPV (2)	

Abbreviations:

BCG	Bacilles Calmette Guerin	PCV	Pneumococcal Conjugated Vaccine
OPV	Oral Polio Vaccine	TD	Tetanus and reduced strength of Diphtheria Vaccine
RV	Rotavirus		
DTaP-IPV-Hib-HBV	Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio Vaccine and Haemophilus Influenzae Type B and Hepatitis B Combined	DTaP-IPV	Diphteria, Tetanus, Pertussis, Polio
		TDaP-IPV	Tetanus, Diphteria, Pertussis, Polio
		HPV	Human papillomavirus vaccines
MMR	Measles, Mumps, Rubella		

How does the Maternity Programme work?

01 First Visit

Visit GP to confirm pregnancy. Ante-natal screening to be done and if required patient will be referred to specialist.

02 First visit with Gynaecologist

- A referral letter from GP/specialist is required to see Gynaecologist.
- The referral letter and antenatal laboratory results need to be sent to Case Management for approval and appointment.

03 Submit the referral letter to Case Management via:

Tel: 014 590 1700 or 080 000 6942 OR
Fax: 086 247 9497 or 086 233 2406 OR
Email: plathealth@platinumhealth.co.za (specialist authorisation) OR
Platinum Health facilities OR
Website: www.platinumhealth.co.za

Authorisation will be valid for only the date of treatment.

If a specialist referral is approved or rejected

Approved	Rejected
• Case Management evaluates the request with the assistance of the Medical Advisor. • Member receives an authorisation number via SMS, email, telephone or from Platinum Health facility. • Copy of referral letter, X-rays, blood results and all related documentation to be taken with to the specialist. • Member to give authorisation number to specialist.	• Case Management evaluates the referring request with the assistance of the Medical Advisor and rejects referral. • If a member's authorisation is rejected, the member will receive notification via SMS, email, telephone or from Platinum Health facility; stating the reason why authorisation request was declined. • Member can contact Case Management and Platinum Health facilities at their sites with regards to follow-up enquiries.

Members need to follow the same procedure for consultations with Paediatricians and Gynaecologists.

Register on the Maternity Programme by completing and submitting the relevant Maternity Programme documentation to Case Management via email, fax or hand in at a Platinum Health facility.

Follow-up Visits

01

Routine specialist consultations are performed between weeks 10 and 12, and 20 and 22 gestation. From approximately week 32, the checkups will be done every two weeks, and from 36 weeks onwards, every week until delivery. If there is a need for more visits during pregnancy due to previous or present pregnancy complications, a clinical motivation letter is needed from the GP or treating specialist.

- Pregnant HIV positive ladies should receive counselling and start on a treatment regime to prevent mother-to-child transmission.

02

Member to book a bed at a hospital approved by the Scheme. Platinum Health will fund a normal maternity bed as part of the delivery. The member can ask for a private room but will have to pay the difference between the maternity room and the private room. Hospital benefit is applicable per option.

03

Pre-authorisation for bed-booking is issued by Case Management via SMS, email, telephone or Platinum Health facility.

04 Delivery

05

Register your new-born baby within 30 days from date of birth. The new-born should be registered at your Employee Services Processing Walk-in centres or HR/EB offices or at the respective Platinum Health Client Liaison offices.

The 6-weekly post-normal delivery or post C-section may not be claimed separately by the specialist.

7.9 Frequently asked questions (FAQs)

Q: If I find out I am pregnant, do I need to inform Platinum Health Medical Scheme?

A: When a member discovers that she is pregnant, she should register at Case Management on the Platinum Health Maternity Programme after consulting with a GP.

Q: Can a Medical Scheme impose a condition-specific waiting period on pregnancy?

A: If the principal member does not register his/her spouse on the Medical Scheme and she becomes pregnant; and he/she then wants to register her on the Scheme, the Scheme will not cover the pregnancy. However, the baby can be registered on the Scheme if he/she is registered within 30 days from date of birth.

Q: What is an ultrasound scan?

A: An ultrasound scan, also referred to as a sonogram, diagnostic sonography, and ultrasonography, is a device that uses high frequency sound waves to create an image of some part of the inside of the body, such as the stomach, liver, heart, tendons, muscles, joints and blood vessels. Experts say that as sound waves, rather than radiation are used, ultrasound scans are safe. Obstetric sonography is frequently used to check the baby in the womb.

Q: Do I need to get authorisation for my new-born's follow-up visits with the Paediatrician, after delivery?

A: Yes, a Paediatrician is a specialist and therefore an authorisation number should be obtained, prior to the 6-weekly follow-up visit. After the 6-week visit, the baby will have to be referred by a GP again and a separate authorisation number is needed for each visit with the Paediatrician. *Please note: If the baby was seen by the Paediatrician while still in hospital, a different authorisation number will be required for the baby than that of the mother.* *Refer to page 39 for Case Management contact details.*

7.10 Other management programmes for registration

Road Accident Fund (RAF) Programme

Platinum Health Rules provide that the expenses for which a third party is liable are excluded from benefits. It does, however, allow the Scheme to provide benefits until the third party's liability has been established, at which stage the expense will be recouped from the third party. It is in the member's interest to assist the attorney appointed by Platinum Health in lodging a third party claim.

IMPORTANT TO NOTE:

In the event of a motor vehicle accident, within the borders of South Africa, resulting in injuries and medical costs paid by the Scheme, a member or dependant shall:

- Be obliged to take all reasonable steps to recover the medical costs incurred by the Scheme from the Road Accident Fund.
- Be obliged to take all reasonable steps to recover future and subsequent medical costs incurred after date of finalisation of the third party claim from the Road Accident Fund, in terms of an Undertaking issued by the RAF to a member or dependant relating to future medical costs.
- Be obliged to provide the Scheme's attorneys with an Undertaking in terms whereof the member's attorney shall be obliged to make payment to the Scheme's attorneys of the medical expenses recovered from the Road Accident Fund, free of deduction of legal costs of the member's attorney, within 7 days upon receipt thereof, irrespective whether payment is made by way of an interim payment or final payment.
- Be obliged to reimburse the Scheme the medical costs recovered by the RAF within 7 days upon receipt thereof, irrespective whether payment is made by way of an interim payment or final payment.

The Scheme shall be entitled to terminate a member's membership or that of his/her dependants in the event that the provision of these rules are breached.

Oxygen Management Programme

Platinum Health has developed a programme to ensure that all patients who need oxygen at home are appropriately taken care of.

When prescribed by a specialist, home oxygen will be provided by our designated service provider.

Oxygen will assist in making our patients' lives more comfortable and manageable.

Cancer and Oncology Programme

The Cancer and Oncology Programme is available to members on all Scheme options. All cancer-related expenses are paid at Scheme tariffs and are subject to Scheme benefits. All members must register on the Cancer and Oncology Programme, through Case Management, as soon as a cancer diagnosis has been made. Members must forward a clinical summary of their cancer, as set out by their treating doctor, to register on the programme. This must contain the history, ICD 10 codes, the clinical findings of the doctor, as well as the test results confirming the cancer and the specific type of cancer.

Applications for chemotherapy and radiotherapy are assessed in accordance with recognised treatment protocols. All drug therapies used for the side-effects of chemotherapy and pain relief also need to be pre-authorised.

Kidney Disease Management Programme

Platinum Health proactively manages renal dialysis and kidney transplants through its Kidney Disease Management Programme. This ensures that correct renal treatment protocols are adhered to and that members get the most effective care. Should kidney failure occur, members should ensure that the specialist contacts Platinum Health Case Management to pre-authorise a treatment plan. Members who require chronic dialysis for end-stage renal disease can register on the Dialysis Programme.

Depending on clinical and other parameters, the Scheme will consider funding for peritoneal or haemodialysis. Certain medicines that are used in end-stage renal disease are only covered when the Scheme funding guidelines are met. Platinum Health has appointed Designated Service Providers (DSPs) for renal dialysis services for its members on all benefit options. Only members registered on the Dialysis Programme qualify for benefits. In order to be registered on the programme, patients must obtain a clinical summary of their condition as set out by their treating doctor. This must contain the history, ICD 10 codes and clinical findings of the doctor, as well as the test results and details on any associated disease, e.g. diabetes.

HIV Management Programme

The Platinum Health HIV Management Programme is closely integrated and interactive with employer-driven HIV/AIDS programmes. Acquired immunodeficiency syndrome (AIDS) is a chronic, potentially life-threatening condition, caused by the human immunodeficiency virus (HIV). By damaging your immune system, this virus interferes with your body's ability to fight the organisms that cause disease. HIV/AIDS is a sexually transmitted infection. It can also be spread by contact with infected blood or from mother-to-child during pregnancy or childbirth. Without medicine, it may take years before HIV weakens your immune system to the point that you have full blown AIDS. There is currently no cure for HIV/AIDS, but there is medicine available that can dramatically slow down the progression of the disease.

To qualify for benefits, a member or dependant must register on the HIV Management Programme. A member must forward a clinical summary to Platinum Health that has been obtained from the treating doctor. This summary must contain the relevant history, clinical findings, results of the HIV/AIDS diagnostic test as well as all the CD4 and viral load test results. Any additional results that have a bearing on the clinical picture, or the impact the disease has on the patient, must be forwarded. Examples of such tests include full blood count, liver function tests and specimens sent for microscopy. The programme also makes provision for blood tests to follow the course of the disease and to measure the response to treatment, medicine and anti–retrovirals, as well as medicine specifically used to fight the virus. The treatment programme covered by the Scheme is based on the HIV/AIDS funding guideline and approved treatment depends on the clinical parameters of each individual. The stage of the disease and the results of blood tests, determine what treatment will be covered and how the individual must be followed up. Cover is also provided for mother–to–child transmission in pregnancy and as post–exposure prophylaxis. Details can be obtained by contacting Platinum Health.

8. ACCESS TO MEDICINE

Platinum Health will accept 100% liability of the Scheme tariff as long as dispensing of medicine takes place according to the Platinum Health formularies and protocols. PlatComprehensive and PlatCap members are obliged to utilise DSP pharmacies for medication to avoid additional charges. Admin fees, levies and surcharges charged by non-DSP pharmacies will not be covered by Platinum Health and are for the member's own account. PlatFreedom members may utilise their Pharmacies of Choice. The Platinum Health formularies (medicine list) are well-researched and established formularies based on world best practice medicine.

8.1 PLATINUM HEALTH-OWNED PHARMACIES

Platinum Health has in-house pharmacies available at many of its facilities, which ensures that members have easy access to obtaining medicine.

Platinum Pharmacy situated at the Platinum Health Medical Centre, Rustenburg

The Chronic Medication Department is situated at the Platinum Pharmacy.

Tel: 014 590 1700

Fax Chronic prescriptions to 086 577 0274

Email orders, applications and general enquiries to:
zzgplatinumhealthchronicmedication@platinumhealth.co.za

Union Pharmacy situated at Union Hospital

Tel: 010 133 1743

Chromite Pharmacy situated at Amandelbult Hospital

Tel: 087 463 0515/087 463 0607

Norplats Pharmacy situated at Northam Medical Station

Tel: 014 784 3157

Bosveld Pharmacy, situated at the Platinum Health Medical Centre, Thabazimbi

Tel: 014 0108/0118

Iridium Pharmacy situated at the Platinum Health Medical Centre, Burgersfort

Tel: 087 463 0408/0409

For more information visit the Platinum Health website: www.platinumhealth.co.za

8.2 THE FORMULARY

A formulary is a list of safe and effective medicines, including both generic and brand name products, which are being utilised to treat certain medical conditions. The formulary has been developed by a team consisting of pharmacists and physicians from various medical specialities (Pharmaceutical and Therapeutic Committee) and is being evaluated by them on a continuous basis. Medicines on the Platinum Health formulary are based on best practice medicine, availability and quality-in-healthcare principles. The formulary is updated whenever new evidence or information pertaining to medicine becomes available.

Do formularies have any restrictions?

Most medicine formularies have associated rules to limit and restrict certain medications. The following restrictions apply to the formulary:

- PlatComprehensive and PlatCap members who choose to use a non-formulary drugs will be liable for a 20% co-payment of SEP (single exit price) except if the medicine has been clinically motivated for and been approved by the Scheme – in which case the Scheme shall be liable for 100% of SEP; and
- If PlatComprehensive and PlatCap members elect to utilise an original drug for which a generic drug exists on the formulary, then a co-payment (price difference between formulary drug and original drug) shall apply. Admin fees or levies will not be covered.

Platinum Health may allow exceptions if:

- None of the drugs in a therapeutic class listed on the formulary have been proven effective in the treatment of a specific condition of an individual; or
- The relevant prescribed medication is unavailable.

8.3 GENERIC MEDICINE

- Contains the same active ingredient,
- has the same dosage strength,
- are safe;
- are equally effective, and
- and therefore interchangeable with an original brand name product.

Generic medicine is identified by either its own brand name or its internationally approved scientific name.

8.4 ACUTE MEDICINE

Acute medicine is used to treat non-chronic conditions which implies that it is mostly for short-term use.

OPTION GUIDE - ACUTE MEDICINE

PlatComprehensive	PlatFreedom	PlatCap
• Unlimited • 100% of Scheme formulary. • Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located outside a 50km radius of DSPs may utilise non-DSPs for medication. • The Scheme shall accept liability of 100% of the therapeutic reference price list as per the Scheme formulary. • If a member elects to utilise a non-formulary drug, then the member is liable for 20% co-payment of SEP (single exit price) except if the medicine has been clinically motivated for and been approved by the Scheme – in which case the Scheme shall be liable for 100% of SEP. • If a member elects to utilise an original drug for which a generic drug exists on the formulary, then a co-payment (price difference between formulary drug and original drug) shall apply. • Admin fees or levies will not be covered.	• Acute Medicine limit: M0: R6 178 M1: R10 729 M2: R14 305 M3+: R16 581 • Including malaria prophylactics • 100% of the approved price. • Refer to general Scheme exclusions.	• Unlimited • 100% of Scheme Tariff. • Members located within a 50km radius of DSPs are obliged to utilise such DSPs, subject to regulation 8(3). • Members located outside a 50km radius of DSPs may utilise non-DSPs for medication. • The Scheme shall accept liability of 100% of the therapeutic reference price list as per the PlatCap option formulary. • If a member elects to utilise a non-formulary drug, then the member is liable for 20% co-payment of SEP (single exit price) except if the medicine has been clinically motivated for and been approved by the Scheme – in which case the Scheme shall be liable for 100% of SEP. • If a member elects to utilise an original drug for which a generic drug exists on the formulary, then a co-payment (price difference between formulary drug and original drug) shall apply. • Admin fees or levies will not be covered.

8.5 PHARMACIST ADVISED THERAPY (PAT) MEDICINE

Pharmacists are allowed by law to prescribe certain classes of medicine for minor and non-serious diseases i.e. the flu, diarrhea and headaches. The medicine that can be prescribed is restricted to schedule 0 up to schedule 2 medicine and is for a limited treatment period. PlatComprehensive and PlatCap members can obtain PAT medicine from any of the in-house or designated service provider (DSP) pharmacies. PlatFreedom members can obtain PAT medicine from their Pharmacy of Choice.

OPTION GUIDE - PAT/OTC MEDICINE		
PlatComprehensive	PlatFreedom	PlatCap
• R355 per beneficiary, subject to a limit of R960 per family. • 100% of Scheme formulary. • Subject to Platinum Health network pharmacy and R172 per event.	• R1 843 for a family; maximum R456 per script. • Included in the Acute Medicine limit. • 100% of the approved price. • Refer to general Scheme exclusions.	• R327 per beneficiary per annum, R642 PMF • 100% of Scheme Tariff • Subject to PlatCap option formulary and R145 per event.

8.6 CHRONIC MEDICINE

Chronic medication is used to treat long-term and/or recurring conditions.

Obtaining chronic medication

PlatComprehensive, PlatCap and PlatFreedom members who choose to obtain chronic medication from the Chronic Medication Department of Platinum Health, should follow these four easy steps to ensure timeous delivery of their medication:

01

Register for chronic medication approval if you are a first-time chronic medication user by requesting your doctor to complete a Chronic Illness Benefit Application form. The forms are available from the Client Liaison Officers on site during scheduled visits, or it can be downloaded from the Platinum Health website (www.platinumhealth.co.za). A separate application form is required for each family member who requires chronic medication.

02

Both the chronic illness forms (application and delivery), along with supporting documentation and a six-month prescription has to be forwarded to the Chronic Medication Department. Platinum Health staff on site at Platinum Health facilities can assist members with submitting application forms to the Chronic Medication Department.

03

The completed application form and supporting documentation has to be submitted to the Chronic Medication Department via any of the following channels:

Tel no: 014 590 1700

Email: zzgplatinumhealthchronicmedication@platinumhealth.co.za

Fax: 086 577 0274 or 014 590 1752

04

The Chronic Medication Department contacts the patient to confirm the details and arrange delivery. A courier service is available for the delivery of chronic medication to members who qualify for delivery. Members can request chronic medication to be delivered to their home, the Platinum Health Medical Facility for collection, or any other location convenient to them. Generally, three months' supply is issued.

Important to remember:

Once registered, please place follow-up medication orders at least seven working days before the current batch runs out. Orders can be placed telephonically, by email or fax, and full member and contact details must be included in all correspondence.

PlatFreedom members who choose to obtain chronic medication from their Pharmacy of Choice, should follow these steps:

Register for chronic medication approval if you are a first-time chronic medication user by requesting your doctor to complete a Chronic Illness Benefit Application form. The forms are available from the Client Liaison Officers on site during scheduled visits; or it can be downloaded from the Platinum Health website (www.platinumhealth.co.za). A separate application form is required for each family member who requires chronic medication.

The completed application form and supporting documentation has to be submitted to the Chronic Medication Department via any of the following channels:

Tel no: 014 590 1700
Email: zzgplatinumhealthchronicmedication@platinumhealth.co.za
Fax: 086 577 0274 or 014 590 1752

Upon receiving the completed Chronic Illness Benefit Application form, authorisation will be loaded on the system and the Pharmacy of Choice will be able to supply the medication to the member and submit the claim for payment to the scheme.

Please note:

- Members have to arrange collection/delivery of medication with their Pharmacy of Choice.
- Members have to place follow-up prescriptions with their Pharmacy of Choice.

OPTION GUIDE - CHRONIC MEDICINE

PlatComprehensive	PlatFreedom	PlatCap
• 27 Chronic Disease List conditions and 53 additional CDL conditions • 100% of scheme formulary. • Unlimited for CDL conditions and additional chronic disease list • In all instances, chronic medication must be obtained from the scheme's DSPs. • Platinum Health will accept liability for 100% of the therapeutic reference price list as per the formulary. • If a member elects to utilise a non-formulary drug, then the member is liable for 20% co-payment of SEP (single exit price) except if the medicine has been clinically motivated for and been approved by the Scheme – in which case the Scheme shall be liable for 100% of SEP. • If a member elects to utilise an original drug for which a generic drug exists on the formulary, then a co-payment (price difference between formulary drug and original drug) shall apply. Admin fees or levies will not be covered. • Subject to member registration on the Chronic Medication Programme.	• 27 Chronic Disease List conditions. • Chronic Disease List conditions up to 100% of scheme rate for approved chronic medicine on the medicine list. • Subject to Overall Annual Limit (OAL). • Up to 80% of Maximum Medical Aid Price (MMAP) for approved chronic medicine not on the medicine list. • Additional Disease List conditions up to 100% of MMAP for approved chronic medicine. • Subject to registration on the Chronic Medication Programme. • Authorisation required. • Refer to general Scheme exclusions.	• 27 Chronic Disease List conditions only. • Unlimited for CDL conditions. • 100% of PlatCap formulary. • In all instances chronic medication shall be obtained from the Scheme's DSP. • Only CDLs covered and PMBs unlimited as per Chronic Disease Reference Price List (CDRPL). • The Scheme shall accept liability of 100% of Therapeutic Reference Price List as per the formulary. • If a member elects to utilise a non-formulary drug, then the member is liable for 20% co-payment of SEP (single exit price) except if the medicine has been clinically motivated for and been approved by the Scheme – in which case the Scheme shall be liable for 100% of SEP. • If a member elects to utilise an original drug for which a generic drug exists on the formulary, then a co-payment (price difference between formulary drug and original drug) shall apply. Admin fees and levies will not be covered. • Subject to member registration on the Chronic Medication Programme.

8.7 PRESCRIBED MINIMUM BENEFITS (PMBs)

PMBs are a set of minimum benefits which, by law, must be provided to all members by their medical schemes. PMBs must be provided regardless of the benefit option that a member has elected. The medical scheme must pay for the costs of diagnostic tests, treatment and ongoing care.

Requirements you must meet to benefit from PMBs

There are certain requirements before you can benefit from the Prescribed Minimum Benefits. The requirements are:

- The condition must be on the list of defined PMB conditions.
- The treatment needed must match the treatments in the defined benefits on the PMB list.

Application for Prescribed Minimum Benefits (PMBs) cover

PMBs are subject to authorisation and registration on the Chronic Disease Management Programme before PMB benefits can be confirmed.

How healthcare professionals ensure payment of claims for PMBs

To ensure that claims are correctly processed, the hospital, healthcare professional and pharmacist must use specific codes (ICD-10 codes) on the account to indicate that the treatment was for a condition qualifying for Prescribed Minimum Benefits.

What are CDL PMBs?

The Council for Medical Schemes (CMS) has compiled a list of conditions, known as the Chronic Disease List (CDL), for which appropriate medicines and other treatments have been specified. Medical schemes must cover the costs of the specified treatment of CDL conditions from PMB benefits. The medical scheme may make use of clinical protocols, medicine formularies and designated service providers to manage PMB conditions. There are 27 PMBs as per the Chronic Disease List, including applicable chronic diagnosis and treatment pairs (DTP's) as indicated in regulation 29(1)(0) of the Medical Schemes Act.

The following CDL conditions are covered across all Platinum Health options, subject to authorisation:

1. Addison's disease
2. Asthma
3. Bipolar mood disorder
4. Bronchiectasis
5. Cardiac failure
6. Cardiomyopathy
7. Chronic renal disease
8. Chronic obstructive pulmonary disease (COPD)
9. Coronary artery disease
10. Crohn's disease
11. Diabetes insipidus
12. Diabetes mellitus type 1
13. Diabetes mellitus type 2
14. Dysrhythmias
15. Epilepsy
16. Glaucoma
17. Haemophilia
18. HIV/AIDS
19. Hyperlipidaemia
20. Hypertension
21. Hypothyroidism
22. Multiple sclerosis
23. Parkinson's disease
24. Rheumatoid arthritis
25. Schizophrenia
26. Systemic lupus erythematosus
27. Ulcerative colitis

What are non-CDL PMBs?

A specified list of emergencies and 270 other specified conditions (besides the conditions on the CDL), for which medical schemes must cover the costs of the diagnosis and treatment from PMB benefits. More details about PMBs can be found on the CMS website at www.medicalschemes.com/medical_schemes_pmb/index.html.

Additional Chronic Disease List (CDL) Conditions (non-PMBs)

PlatComprehensive	PlatFreedom
In addition to the 27 PMB conditions, PlatComprehensive covers the following 53 diseases, including applicable chronic DTPs as indicated in regulation 29.(1)(0) of the Medical Schemes Act.	There are further Additional Disease List conditions. There is no medicine formulary for these conditions. Cover is subject to benefit entry criteria and approval. Approved medicine for these conditions will be funded up to Maximum Medical Aid Price (MMAP).
1. Acne 2. Attention deficit and hyperactivity disorder (ADHD) 3. Allergy management 4. Alzheimer's disease 5. Anaemias 6. Ankylosing spondylitis 7. Generalised anxiety disorder (GAD) 8. Benign prostatic hypertrophy 9. Cardiac dysrhythmias 10. Cerebral palsy 11. Chronic bronchitis 12. Chronic liver disease 13. Clotting disorders 14. Cystic fibrosis 15. Deep vein thrombosis 16. Dermatitis – other 17. Endocarditis 18. Gastro-oesophageal reflux disease (GORD) 19. Gout 20. LBS/diverticular disease 21. Major depression 22. Meniere's disease 23. Menopause 24. Migraine 25. Motor neuron disease 26. Muscular dystrophy and other inherited myopathies 27. Narcolepsy 28. Neuropathies (mono and poly) 29. Obsessive compulsive disorder 30. Osteoarthritis 31. Osteoporosis 32. Paget's disease 33. Pancreatic disease 34. Plegia – hemi, para, quad 35. Parathyroid disorders 36. Peptic ulcer 37. Pituitary gland disorders 38. Peripheral vascular disease 39. Polycystic ovarian syndrome 40. Post-traumatic stress disorder 41. Prolactinoma 42. Psoriasis 43. Restless leg syndrome 44. Schizoaffective disorders 45. Scleroderma 46. Stroke 47. Thyrotoxicosis (hyperthyroidism) 48. Tourette's syndrome 49. Trigeminal neuralgia 50. Tuberculosis 51. Urinary incontinence 52. Valvular heart disease 53. Vascular dementia	1. Acne 2. Allergic Rhinitis 3. Alzheimers Disease 4. Ankylosing Spondylitis 5. Attention Deficit Hyperactivity Disorder (ADHD) 6. Bechet's disease 7. Cystic Fibrosis 8. Depression 9. Dermatomyositis 10. Eczema 11. Gastro-oesophageal Reflux Disease 12. Generalised Anxiety Disorder 13. Gout/Hyperuricaemia 14. Migraine 15. Motor Neuron Disease 16. Myasthenia Gravis 17. Obsessive Compulsive Disorder 18. Osteoarthritis 19. Osteopenia 20. Osteoporosis 21. Paget's Disease 22. Panic Disorder 23. Polyarteritis Nodosa 24. Post Traumatic Stress Disorder 25. Psoriasis 26. Pulmonary Interstitial Fibrosis 27. Sjogren's Syndrome 28. Systemic Sclerosis 29. Urinary Incontinence 30. Urticaria 31. Venous Thrombotic Disorders 32. Wegener's Granulomatosis

9. MENTAL HEALTH

9.1 What is Mental Health?

Mental health refers to our cognitive, behavioural and emotional wellbeing - it is all about how we think, feel, and behave. Mental health can affect daily life, relationships and even physical health.

Mental health also includes a person's ability to enjoy life - to attain a balance between life activities and efforts to achieve psychological resilience. It also helps determine how we handle stress, relate to others and make choices. Mental health is important at every stage of life, from childhood and adolescence through to adulthood. Over the course of your life, if you experience mental health problems; your thinking, mood, and behaviour could be affected. Early diagnosis is essential and the treatment of a mental disorder can lead to rapid recovery and substantially reduce the economic and personal costs associated with the illness.

Mental Health Services (MHS) can assist with all kinds of problems, including work stress, family problems, trauma debriefing, adjustment problems, anxiety and depressed mood, substance abuse and grief and bereavement. Our main office is situated in Rustenburg at the Platinum Health Medical Centre, 175 Beyers Naudé Avenue and the contact number is (014) 590 1700. Members can make an appointment either directly, or via a GP. The respective Human Resource Departments at the various business units may also, formally refer an employee by contacting Mental Health Services.

Therapists are also available at most Platinum Health facilities and no referral or authorisation number is required to access the service. Contact MHS or your nearest Platinum Health facility, to establish where to access the services.

Employees who qualify for the Employee Assistance Programme (EAP) may access the service via their HR Department or any Platinum Health facility. **Mental health problems are common, but it is important to note, that help is available. We offer a completely confidential service to help you improve the quality of your life.**

Important note

We offer a completely confidential service to help you improve the quality of your life.

Employee Assistance Programme (EAP) Counsellor Line 010 133 0525

At the start of the COVID-19 pandemic, Platinum Health established an Employee Assistance Programme (EAP) Counsellor Line to offer support, guidance and encouragement to all its members.

The dedicated EAP Counsellor number is manned 24 hours per day, 7 days per week and all telephone calls are private and confidential.

9.2 Frequently asked questions (FAQs)

Q What is considered a serious mental illness?

A A serious mental illness could be defined as any mental illness that causes clinically significant distress or impairment in social, occupational or other important areas of functioning and can include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD) and borderline personality disorder. All mental disorders fall along a continuum of severity.

Q What causes mental illness?

A Although the exact cause of most mental illnesses is not known, it is becoming clear through research that many of these conditions are caused by a combination of biological, psychological and environmental factors.

Q Is anyone immune to mental illness?

A Mental illnesses can affect persons of any age, race, religion or income. They do not discriminate. Although mental illnesses can affect anyone, certain conditions such as eating disorders tend to occur more often in females and other disorders such as attention deficit/hyperactivity disorder more commonly occur in children.

Q Can mental illness be prevented?

A Most mental illnesses are caused by a combination of factors and cannot be prevented.

Q Once someone has had a mental illness can they ever get better again?

A Remember, most people with mental illnesses who are diagnosed and treated, will respond well and live productive lives. Many never have the same problem again, although some will experience a return of symptoms. The important thing is that there is a range of effective treatment for just about every mental disorder.

Q How common is mental illness?

A Mental illnesses are very common; in fact, they are more common than cancer, diabetes or heart disease.

Q What are some of the warning signs of mental illness?

A Symptoms of mental disorders vary depending on the type and severity of the condition. Some general symptoms that may suggest a mental disorder include:

- **In adults:**
  - Confused thinking.
  - Long-lasting sadness and irritability.
  - Extreme highs and lows in moods.
  - Excessive fear, worrying or anxiety.
  - Social withdrawal.
  - Abuse of drugs and/or alcohol.
  - Inability to cope with daily problems and activities.
  - Changes in sleeping and/or eating habits.
  - Excessive complaints of physical problems.
  - Long-lasting negative mood, often along with poor appetite and thoughts of death.
  - Intense fear of gaining weight.
  - Frequent outbursts of anger.

- **In younger children:**
  - Changes in school performance.
  - Poor grades despite strong efforts.
  - Excessive worrying or anxiety.
  - Hyperactivity.
  - Persistent nightmares.
  - Persistent disobedience and/or aggressive behaviour.
  - Frequent temper tantrums.
  - Defying authority, skipping school, stealing or damaging property.

Q What should I do if I know someone who appears to have all of the symptoms of a serious mental disorder?

A Although this information guide cannot be substituted for professional advice, we encourage those with symptoms to talk to their family members and friends. If you know someone who is having problems, don't just think that they will snap out of it. Let them know that you care about them and there are ways this can be treated. Notify a Platinum Health mental health professional, or consult with your GP. The more you or your friends realise how many people care about them, the more likely it will be that treatment will be sought.

Q What is the difference between mental health professionals?

A **Psychiatrists** – a psychiatrist is a mental health professional who has been trained first as a medical practitioner but has then gone on to receive specialised training in mental disorders, including the more serious ones

such as schizophrenia and severe depression. They are trained and licensed to use biomedical approaches such as medications. Psychiatrists, being physicians, can arrange hospital admissions (e.g. to a psychiatric ward) and carry out physical examinations and various other types of investigative procedures such as electroencephalographs (EEG's) and brain imaging procedure scans eg. Computer assisted tomography (CAT).

- **Clinical Psychologists** – have studied psychology with the aim at understanding, treating and preventing mental problems and disorders. The educational path is a Bachelor Degree with emphasis on courses related to mental health, followed by an Honours and a Masters Degree specialising in clinical/counselling or educational psychology, which usually is two years in duration – one academic year and one year internship. A Masters Degree is the minimum standard for licensing (registration) to practice as a Clinical Psychologist.

- **Social workers** – the education of social workers differs significantly from that of other mental health professionals, in that there is much greater emphasis on the role of social factors and interventions at the social level. Otherwise social workers receive similar education with regards to recognising and treating mental health problems. The standard for licensing can be either at the bachelor or the master level. Social workers are especially knowledgeable of what mental health services are available in the community and help empower their clients to obtain such services.

Q What treatment options are available?

A Just as there are different types of medications for physical illness, different treatment options are available for individuals with mental illness, depending on the specific illness. You can ask your mental health professional about the different treatment options available.

Q What do I need to know about medications?

A The best source of information regarding medications is the pharmacist dispensing them. He/she should be able to answer questions such as:

- What is the medication supposed to do and when should it begin to take effect?
- How is the medication taken and for how long?
- What food, drinks, other medicines and activities should be avoided while taking this medication?
- What are the side-effects and what should be done if they occur?
- What do I do if a dose is missed?
- Is there any written information available about this medication?
- Is there other medication that might be appropriate? If so, why do you prefer the one you have chosen?
- How do you monitor medications and what symptoms indicate that they should be raised, lowered, or changed?

- All medications should be taken as directed. Most medicine for mental illnesses does not work when taken irregularly and extra doses can cause severe, sometimes dangerous side-effects. Many psychiatric medications begin to have a beneficial effect only after they have been taken for several weeks.

Q If a medication is prescribed to me and I begin to feel better after taking it, is it okay to stop taking it?

A It is not uncommon for people to stop taking their medication when they feel their symptoms have become controlled. Others may choose to stop their medication because of side-effects. A person may not realise that most side-effects can be effectively managed. While it may seem reasonable to stop taking the medication, the problem is that at least 50% of the time, the symptoms come back. If you or your child are taking medication, it is very important that you work together with your doctor before making decisions about any changes in your treatment.

- Another problem with stopping medication, especially if you stop it abruptly, is that you may develop withdrawal symptoms that can be very unpleasant. If you and your doctor feel a trial off your medicine is a good idea, it is necessary to slowly decrease the dosage of medications so that these symptoms don't occur.
- It is important that your doctor and pharmacist work together to make sure your medications are working safely and effectively. You should talk with them about how you are doing and whenever there are side-effects that might make you want to stop your treatment.

10. CLIENT LIAISON

The central Client Liaison Department is based in Rustenburg and serves as a Walk-in Centre where members are assisted with enquires related to:

- Membership and membership certificates
- Benefits and contributions
- Claims
- Authorisations
- Tax certificates
- Any other service-related queries

Members also have the option to be assisted by the Call Centre either via telephone or email, Monday to Friday, from 08:00 – 16:00:

Telephone: 014 590 1700 or 080 000 6942 (toll free from any Telkom landline within the borders of South Africa)

Email: phclientliaison@platinumhealth.co.za

Important note

The key function of the Client Liaison Department is to ensure that members are kept informed regarding Scheme benefits, Scheme procedures and to assist members with Scheme related enquiries.

Members are also assisted by Client Liaison staff who visit participating employers to assist members on site. This sets Platinum Health apart from any other medical scheme in South Africa. Refer to page 65 for details of Client Liaison Officers.

Client Liaison staff log all enquiries on the Medical Scheme system for record purposes. When a call is logged, the member will receive an SMS with a call log number as confirmation of the enquiries being attended too. If the enquiry is not immediately resolvable, it remains open for staff to attend to until final feedback is provided and the enquiry is closed. Once an enquiry has been resolved, members will again receive feedback via SMS.

11. BLOW THE WHISTLE ON FRAUDULENT ACTIVITIES

Fraud is escalating in the medical scheme environment and Platinum Health is vigilant in tracking trends and identifying potential fraud.

Fraud committed in terms of the medical scheme has a direct impact on its members as it could lead to increased contributions due to the financial burden placed on the scheme.

Members can report fraud via any of the following channels:

KPMG FairCall

Dial **0800 115 354** toll-free from any Telkom landline within the borders of South Africa, to report any fraudulent activities.

Email

Hotline reports may be e-mailed to hotline@kpmg.co.za

Please contact the call centre for a reference number which must appear on the report.

Web

Hotline reports may be submitted via the web by accessing the following URL or QR Code: www.thornhill.co.za/kpmgfaircallreport

KPMG FairCall is manned 24-hours a day.

You may remain anonymous.

Provide full detail in respect of the fraudulent, corrupt or unethical practice to the call operator.

- Such details may include:
  - Who is involved or doing what?
  - What has happened?
  - How is it done and how often is it done?
  - When was the incident observed, dates and times?
  - Value involved – estimated monetary value?
- Please ensure you keep your reference number in case you need to add additional information or do any follow-ups.

12. WEBSITE

Platinum Health (PH) continuously reviews communication channels in order to enhance communication between the Scheme and its members. One such communication channel is the Platinum Health website.

PH understands that our members don't always have data available to browse our website. It is for this reason that we implemented the "Free Mobile Browsing" function. This means that any website visitor using an iPad, mobile phone, laptop with 3G or any type of dongle will be able to browse our website for FREE.

When you land on the website Homepage, a pop-up message will appear - **click on the "FREE Mobile browsing" button and ENJOY!**

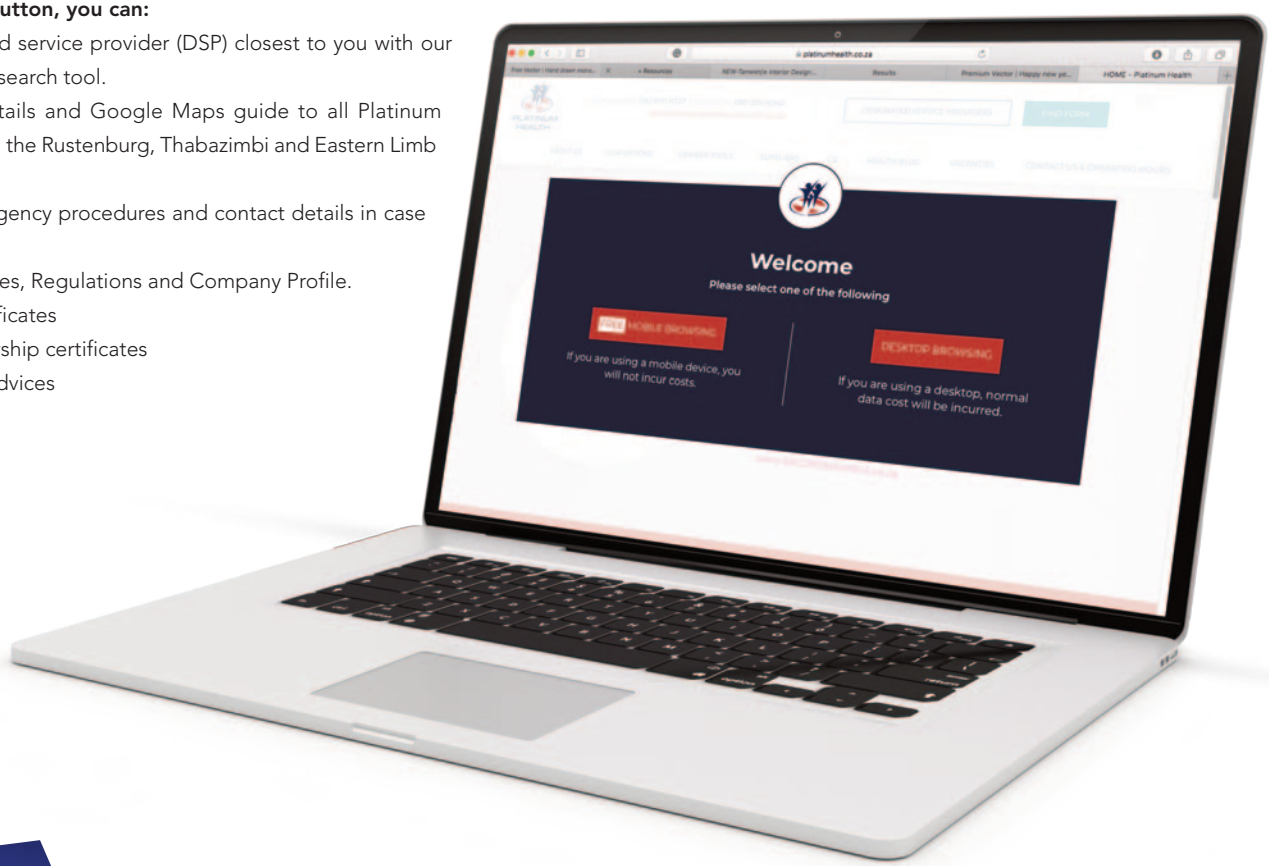
With the click of a button, you can:

- Find a designated service provider (DSP) closest to you with our easy-to-use DSP search tool.
- View contact details and Google Maps guide to all Platinum Health facilities in the Rustenburg, Thabazimbi and Eastern Limb Regions.
- Access the emergency procedures and contact details in case of need.
- View Scheme Rules, Regulations and Company Profile.
- Request tax certificates
- Request membership certificates
- Request claims advices

Register on the website

A world of information awaits at your fingertips - REGISTER on the Platinum Health website today and you will receive the latest scheme-related news, magazines and newsflashes via email.

- Request authorisation for specialist consultations, hospital admissions and specialised radiology investigations such as MRI, CT, and PET scans
- View Scheme benefits and contributions
- Download forms.
- Get the latest news on the Health blog
- Apply online for vacancies.



13. CONTACT DETAILS

Medical emergency services (ambulance): 0861 746 548 Europ Assistance After-hours Case Management: 082 800 8727

Platinum Health offers a convenient one-stop service, giving members access to a wide range of healthcare professionals and the assurance of competent case management in line with the Scheme's vision of providing quality, affordable healthcare.

An efficient administration team is ready to help you with:

- Your request for information;
- Obtaining pre-authorisation;
- Registration on a management programme;
- Claims enquiries; and
- Emergency procedures.

To ensure a quick response to your enquiry, contact Client Liaison or Case Management by calling toll free, faxing or emailing.

PLATINUM HEALTH CORPORATE OFFICE

Tel:	087 463 0660
Email:	phclientliaison@platinumhealth.co.za
Physical address:	3 Kgwebo Street, Mabe Office Park, Rustenburg, 0299
Postal address:	Private Bag X82081, Rustenburg, 0300
Office hours:	Monday to Friday 07:30 – 16:00

CASE MANAGEMENT

Tel:	014 590 1700 or 080 000 6942 (toll free)
A/H emergency:	082 800 8727
Fax:	086 233 2406 or 086 247 9497
Email:	plathealth@platinumhealth.co.za **(specialist authorisation)**
	HospitalConfirmations@platinumhealth.co.za **(hospital pre-authorisation and authorisation)**
Office hours:	Monday to Thursday 09:00 – 17:00
	Friday 09:00 – 16:00

MEMBERSHIP

Tel:	014 590 1700 or 080 000 6942 (toll free)
Email:	zzgengagementofficemembership@platinumhealth.co.za
Office hours:	Monday to Friday 08:00 – 16:00

SUPPLIER LIAISON

Tel: 014 590 1700 or 080 000 6942 (toll free)
Email: SuppliersRPM@platinumhealth.co.za
Office hours: Monday to Friday 08:00 – 16:00

CLAIMS

Tel: 014 590 1700 or 080 000 6942 (toll free)
Members submit claims electronically via zzgplatinumhealthclaims@platinumhealth.co.za
Suppliers submit claims electronically via SuppliersRPM@platinumhealth.co.za
Office hours: Monday to Friday 08:00 – 16:00

CHRONIC MEDICATION

Tel: 014 590 1700
Fax: 014 590 1752 / 086 577 0274
Email: zzgplatinumhealthchronicmedication@platinumhealth.co.za **(orders, applications and general enquiries)**
Office hours: Monday to Friday 08:30 – 16:00

CLIENT LIAISON (CUSTOMER SERVICES)

CLIENT LIAISON CALL CENTRE/ WALK-IN CENTRE
Situated at 175 Beyers Naudé Avenue, Rustenburg
Tel: 014 590 1700 or 080 000 6942 (toll free)
Fax: 086 591 4598
Email: phclientliaison@platinumhealth.co.za
Office hours: Monday to Friday 08:00 – 16:00

RUSTENBURG REGION

Tel:	083 842 0195	**Email:**	Violet.Wilson@platinumhealth.co.za
Tel:	083 791 1345	**Email:**	Masalu.Mooketsi@platinumhealth.co.za
Office hours:	Monday to Friday 07:30 – 16:00		

BOSVELD REGION (Includes Siyanda Bakgatla, Amandelbult, Northam and Thabazimbi)

Tel:	083 795 5981	**Email:**	Peggy.Lerefolo@platinumhealth.co.za
Tel:	083 719 1040	**Email:**	olga.lethoko@norplats.co.za / Olgar.Lethoko@platinumhealth.co.za
Tel:	083 455 3054	**Email**:	Itumeleng.Pheleu@platinumhealth.co.za
Office hours:	Monday to Friday 07:30 – 16:00		

EASTERN LIMB REGION

Tel:	083 455 7138	**Email:**	Kholofelo.Mzimba@platinumhealth.co.za
Tel:	083 787 8833	**Email:**	Rose.Makuwa@platinumhealth.co.za
Tel:	060 571 0870	**Email:**	Charmain.Kgoete@platinumhealth.co.za
Office hours:	Monday to Friday 07:30 – 16:00		

14. FACILITIES

14.1 RUSTENBURG REGION

PLATINUM HEALTH MEDICAL CENTRE - 014 590 1700

Corner of Beyers Naude and Heystek Streets, Rustenburg, 0299

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	014 590 1700	Monday to Friday Saturday Sunday & Public Holidays	08:00 – 18:00 08:00 – 14:00 08:00 – 12:00	
GP	014 590 1700	Monday to Friday Saturday Sunday & Public Holidays	08:00 – 18:00 08:00 – 14:00 08:00 – 12:00	
Dentistry	014 590 1700	Monday to Friday	08:00 – 16:30	
Optometry	014 590 1700	Monday to Friday	08:00 – 16:00	
Physiotherapy	014 590 1700	Monday to Friday	08:00 – 16:00	
Mental Health	014 590 1700	Monday to Friday	08:00 – 16:00	**Available on appointment only.**
Radiology	014 590 1700	Monday to Friday	08:00 – 17:00	
Pharmacy Acute	014 590 1700	Monday to Friday Saturday Sunday & Public Holidays	08:00 – 18:00 08:00 – 14:00 08:30 – 12:00	**Emergency contact number: 082 800 8727**
Pharmacy Chronic Enquiries and Ordering Chronic script refills dispensed	014 590 1700	 Monday to Friday Monday to Friday	 08:30 – 16:00 08:00 – 16:00	**(Chronic script refills are not dispensed over weekends)**

For medical emergencies after 18:00, members have to go to Peglerae ER24 situated at 102 Kock Street, Rustenburg

BAFOKENG RASIMONE PLATINUM MINE CLINIC – 014 573 1323

Boskoppies Farm, Sun City Road, Boshoek, 0301

Trauma and emergency 24 hours/day, 7 days/week

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Bafokeng Rasimone Clinic	014 573 1323	Monday to Thursday Friday	07:00 - 16:00 07:00 - 13:00	
Primary Healthcare	014 573 1498	**Available 24 hours/day, 7days/week**		
GP	014 573 1498	**GPs on call available 24 hours/day, 7 days/week**		
Radiology	014 573 1541	Monday to Thursday Friday	07:00 - 16:00 07:00 - 13:00	
Social Worker	014 573 1323	Tuesdays and Wednesdays	07:00 - 16:00	**Available on appointment only.**

MOGWASE PRIMARY HEALTHCARE CLINIC 087 463 0983

K4 NWDC Building, Mogwase 0314

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	087 463 0982	Monday to Friday Saturday	08:00 – 17:00 09:00 – 12:00	
GP *(subject to referral by PHCN)*	087 463 0981	Monday to Friday Saturday	10:00 – 12:00 14:00 – 16:00	**GP not available**

PHOKENG PRIMARY HEALTHCARE CLINIC 083 765 6397

Shop 44A, Phokeng Mall, Phokeng, 0335

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	083 765 6397	Monday to Friday Saturday	08:00 – 17:00 09:00 – 12:00	
GP *(subject to referral by PHCN)*	083 765 6397	Monday to Friday Saturday	10:00 – 12:00 14:00 – 16:00 09:00 – 12:00	

SUN VILLAGE PRIMARY HEALTHCARE CLINIC 087 463 0523

Shop No 37, Sun Village, Sun City

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	087 463 0523	Monday to Friday Saturday	08:00 – 17:00 09:00 – 12:00	
GP *(subject to referral by PHCN)*	087 463 0523	Monday to Friday Saturday	10:00 – 12:00 14:00 – 16:00 09:00 – 12:00	

14.2 BOSVELD REGION

AMANDELBULT HOSPITAL - 014 784 2828
1 Hospital Street, Tumela Mine, Chromite, 0362

Trauma and Emergency: 014 784 2828 - Available 24 hours/day, 7days/week

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Amandelbult Hospital	014 784 2828			
Primary Healthcare	087 463 0417	Monday to Friday	07:00 – 16:00	**After-hours GPs on call**
GP	087 463 0056/0086	Monday to Friday	07:00 – 16:00	
Dentistry	087 463 0415	Monday to Friday	07:30 – 16:30	
Optometry	087 463 0084	Monday to Friday	06:30 – 15:30	
Pharmacy	087 463 0607	Monday to Friday	08:00 – 16:30	
Psychologist	087 463 0414	Every 2nd Tuesday		**Available on appointment only.**
Social Worker	087 463 0414	Monday Wednesday,Thursday and Friday	07:00 – 16:00 07:30 – 13:00	**Available on appointment only.** **Available on appointment only.**

MORULENG PRIMARY HEALTHCARE CLINIC - 060 583 5390
Moruleng Mall, Shop no 43, Main Hospital Road (P50-1), Moruleng, 0318

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	060 583 5390	Monday to Friday Saturday	08:00 – 17:00 09:00 – 12:00	
GP *(subject to referral by PHCN)*	060 583 5390	Monday to Friday Saturday	10:00 – 12:00 14:00 – 16:00 10:00 – 12:00	

NORTHAM MEDICAL STATION - 014 784 3215
Farm Zondereinde 384KQ, District of Thabazimbi, Northam, 0360

Trauma and Emergency: 014 784 2396 Available 24 hours/day, 7days/week

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	014 784 3215	**Available 24 hours a day, 7 days a week**		
GP	014 784 3215	Monday to Friday	07:00 – 16:00	**After-hours GPs on call**
Pharmacy	014 784 3157	Monday to Friday	07:30 – 16:00	
OHC Department	014 784 2393/2215	Monday to Friday	06:00 – 15:00	

NORTHAM PRIMARY HEALTHCARE CLINIC - 014 133 0122/3
Next to Usave Store, Opal Street, Northam

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	014 133 0122/3	Monday to Friday Saturday	08:00 – 17:00 09:00 – 12:00	

SETARIA CLINIC - 014 784 3214

33 Merensky street, Farm Zondereinde, Setaria Village, 0383

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	014 784 3214	Monday to Friday	08:00 – 17:00	
GP	014 784 3214	Monday to Friday	08:00 – 16:00	**After-hours GPs on call**
Dentistry	014 784 3214	Monday, Tuesday, Thursday & Friday	08:00 – 17:00	
Psychologist	014 784 3214	Every 2nd Tuesday	07:30 – 16:00	**Available on appointment only.**

THABAZIMBI MEDICAL CENTRE - 014 133 0117

9 Watsonia Street, Thabazimbi, 0380

After-hours emergencies 082 881 4420

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Consulting Room	014 133 0117	Monday to Friday Saturday Sunday	08:00 – 17:00 08:00 – 12:00 11:00 – 12:00	**Emergencies only.**
Primary Healthcare	014 133 0117	Monday to Friday Saturday	08:00 – 17:00 08:00 – 12:00	
GP	014 133 0117	Monday to Friday Saturday Sunday	09:00 – 17:00 09:00 – 12:00 11:00 – 12:00	
Dentistry	014 133 0106	Monday to Friday	07:30 – 16:30	
Pharmacy	014 133 0108 / 014 133 0118	Monday to Friday Saturday Sunday and Public Holidays	08:30 – 17:30 08:30 – 12:00 11:00 – 12:00	
Optometry	014 133 0106	Tuesday and Thursday	07:30 – 16:30	
Social Worker	014 133 0106	Tuesday, Wednesday, Thursday and Friday	14:00 - 16:00	**Available on appointment only.**

UNION HOSPITAL - 010 133 1733

Hospital Street, Swartklip, 0370

OPD After-hours/Casualty 010 133 1746

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare (OPD)	010 133 1733	Monday to Friday	07:00 - 15:00	
Consulting Room	010 133 1709	Monday to Friday	07:00 - 16:00	**Booking for consulting starts at 09:00**
Pharmacy	010 133 1743	Monday to Friday	07:00 - 16:00	
Dentistry	010 133 1709	Monday to Friday	07:00 - 16:00	
Optometry	010 133 1744	Monday to Friday	07:00 - 16:00	
Psychologist	010 133 1709	Every second Tuesday		**Available on appointment only.**
Social Worker	010 133 1709	Monday to Friday	08:00 - 16:00	

14.3 EASTERN LIMB REGION

BURGERSFORT MEDICAL CENTRE - 087 463 0275

Shop no UG04, Tubatse Crossing Mall, Burgersfort

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	087 463 0275	**Available 24 hours/day, 7days/week**		
GP	087 463 0275	Monday to Friday	09:00 – 17:00	**After-hours GPs on call**
		Saturday and Sunday		**GPs on call**
Pharmacy	087 463 0408/0409	Monday to Friday	08:00 – 16:30	
Dentistry	087 463 0406	Monday to Friday	07:30 – 16:30	
Optometry	087 463 0406	Monday to Friday	08:00 – 16:30	
Psychologist	087 463 0406	Thursday		**Available on appointment only.**
Social Worker	087 463 0406	Tuesday	14:00 – 16:30	**Available on appointment only.**

JANE FURSE CLINIC – 087 463 0851

Shop 12, JPI Business Centre, Stand no 2008, Vergelegen C Section, Jane Furse Village, Sekwati, 1063

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	087 463 0851	Monday to Friday Saturday	09:00 – 17:00 09:00 – 12:00	**Closed on Public Holidays and Sundays**
GP	087 463 0851	Monday to Friday Saturday	11:00 – 13:00 15:00 – 17:00 09:00 – 12:00	
Dentistry	087 463 0851	Tuesday	09:00 – 15:00	
Optometry	087 463 0851	Tuesday	09:00 – 15:00	
Social Worker	087 463 0851	Wednesday		**Available on appointment only.**

MASHISHING (LYDENBURG) MEDICAL CENTRE – 087 463 0846

The Heads Shopping Centre, Voortrekker Street, Mashishing, 1120

Emergency number 063 257 7637

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	087 463 0846	**Available 24 hours/day, 7days/week**		
GP	087 463 0846	Monday to Friday Saturday Sunday & Public Holidays	08:00 – 18:00 08:00 – 11:00	**GPs on call**
Social Worker	087 463 0846	Wednesday		**Available on appointment only.**

MODIKWA PLATINUM MINE CLINIC - 010 133 1769

Montrose Road, Driekop, 1192

Trauma and Emergency available 24 hours/day, 7days/week

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	010 133 1766 010 133 1759	**Available 24 hours/day, 7days/week**		
GP	010 133 1769	Monday to Thursday Friday	07:30 – 15:30 07:30 – 15:30	**Thereafter trauma and emergencies only**
Social Worker	010 133 1779	Tuesday and Wednesday	07:30 – 16:30	
Rehabilitation and Functional Centre	010 133 1758	Monday to Thursday Friday	06:30 – 15:30 06:30 – 12:30	

MOKOPANE MEDICAL CENTRE - 087 463 0835

112 Thabo Mbeki Avenue, Mokopane, 0600

A fully functional Casualty Unit is available 24 hours a day, 365 days per annum.

SERVICE	CONTACT NUMBER	DAYS	HOURS	PLEASE NOTE
Primary Healthcare	087 463 0835	**Available 24 hours/day, 7days/week**		
GP	087 463 0835	Monday to Friday Saturday Sunday & Public Holidays	08:00 – 18:00 09:00 – 12:00	**GPs on call**
Psychologist	087 463 0835	Tuesday and Wednesday		**Available on appointment only.**

NOTES

PLATINUM HEALTH

Complaints and disputes

Members must first try and resolve their complaint with the Scheme and only contact
The Council for Medical Schemes if they are still in disagreement with their medical scheme.

The Council for Medical Schemes

Block A Eco Glades 2 Office Park
420 Witch-Hazel Street, Ecopark
Centurion, 0157
Telephone: 012 431 0500
Fax: 012 431 0500
Customer Care call-share number: 0861 123 267
Email: complaints@medicalschemes.com
Website: www.medicalschemes.com

DISCLAIMER

This brochure acts as a summary and does not supersede the Registered Rules of the Scheme.
All benefits in accordance with the Registered Rules of the Scheme.
Terms and conditions of membership apply as per Scheme Rules.