GENERAL RULES

APPLICATION OF CLINICAL PROTOCOLS AND FUNDING GUIDELINES

POLMED applies clinical protocols, including "Best practice guidelines" as well as evidence-based medicine principles in its funding decisions.

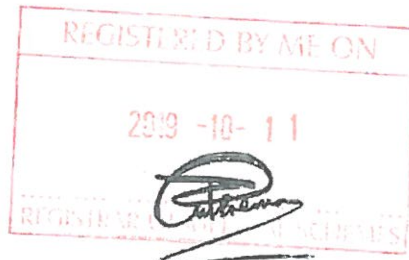
DENTAL PROCEDURES

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

DESIGNATED SERVICE PROVIDER: OUT-OF-NETWORK RULE

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

* what is the level of this copayment.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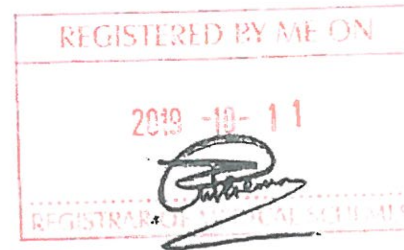
2019 -10- 11

ANNEXURE A1



MARINE SCHEDULE

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2020

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

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

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

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

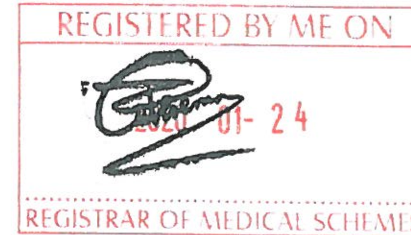
Benefits for the services outside the Republic of South Africa (RSA)

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

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

Examples of designated service providers (where applicable) are:

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



POLMED GP NETWORK (DESIGNATED GP PROVIDER)

Members are allowed two visits to a GP who is not part of the network per beneficiary per annum for emergency or out-of-town situations. Co-payments shall apply once the maximum out-of-network consultations are exceeded.
Polmed rates for designated GP provider visits are available on its website and can be accessed at www.polmed.co.za. These rates are reviewed annually. The co-payment to out of network GP providers will be calculated as being the difference between the Polmed rate for non-designated GP providers and the actual rate charged by the out of network GP provider.
PMB rule applies for qualifying emergency consultations.

POLMED HOSPITAL NETWORK (DESIGNATED HOSPITAL NETWORK)

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

All admissions (hospitals and day clinics) must be pre-authorised.
A penalty of R5 000 may be imposed if no pre-authorisation is obtained.

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

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

Medicine prescribed during hospitalisation forms part of the hospital benefits.

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

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

POLMED PHARMACY NETWORK

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

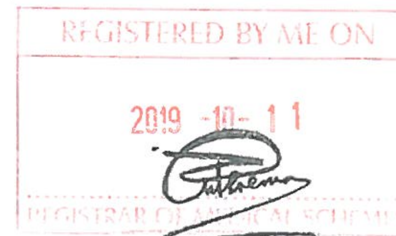
Members can access the list of providers at www.polmed.co.za, on their cell phones via the mobile site, via POLMED Chat or request it via the Client Service Call Centre.

EMERGENCY MEDICAL SERVICES (EMS): NETCARE911

72-Hour Post-Authorisation Rule

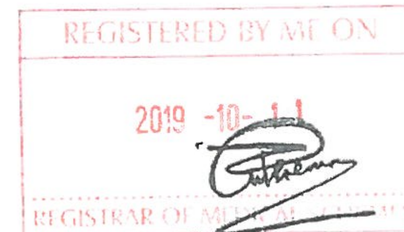
Subject to authorisation within 72 hours of the event, all service providers will need to get a notification number from POLMED's Designated Service Provider (DSP) Netcare911.

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



EX GRATIA BENEFIT

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



MEDICATION: ACUTE, OVER-THE-COUNTER (OTC) AND CHRONIC

The chronic medication benefit shall be subject to registration on the Chronic Medicine Management Programme for those conditions which are managed, and chronic medication rules will apply.

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

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

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

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

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

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

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

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PRO RATA BENEFITS

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

SPECIALISED RADIOLOGY (MRI AND CT SCANS)

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

SPECIALIST REFERRAL

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

This co-payment is not applicable to the following specialities or disciplines: Gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists [chronic dialysis], dental specialists, pathology, radiology and supplementary or allied health services.

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

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

Conservative Back and Neck rehabilitative program

Services associated with Polmed's conservative Back and Neck program will be funded from Hospital risk. Pre authorization is required to access the benefits. Spinal surgery will not be covered unless there is evidence that the patient has received conservative therapy prior to requesting surgery (PMBs apply).

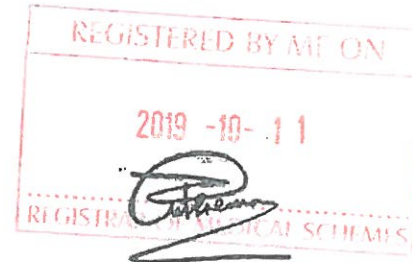
DEFINITION OF TERMS

BASIC DENTISTRY

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

Other procedures that fall under this category are:

- Consultations
- Fluoride treatment and fissure sealants
- Non-surgical removal of teeth
- Cleaning of teeth, including non-surgical management of gum disease
- Root canal treatment



CO-PAYMENT

A co-payment is an amount payable by the member to the service provider at the point of service. This includes all the costs more than those agreed upon with the service provider or more than what would be paid according to approved treatments. A co-payment would not be applicable in the event of a life-threatening injury or an emergency.

ENROLMENT ON THE DISEASE RISK MANAGEMENT PROGRAMME

Members will be identified and contacted to enrol on the Disease Risk Management Programme. The Disease Risk Management Programme aims to ensure that members receive health information, guidance and management of their conditions, at the same time improving compliance to treatment prescribed by the medical practitioner. Members who are registered on the programme receive a treatment plan (Care Plan), which lists authorised medical services, such as consultations, blood tests and radiological tests related to the management of their conditions. The claims data for chronic medication, consultations and hospital admissions is used to identify the members that are eligible for enrolment on the programme. Members are also encouraged to register themselves on the programme.

FORMULARY

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

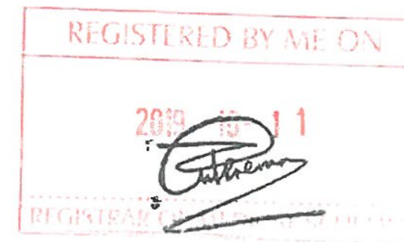
MEDICINE GENERIC REFERENCE PRICE

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

REGISTRATION FOR CHRONIC MEDICATION

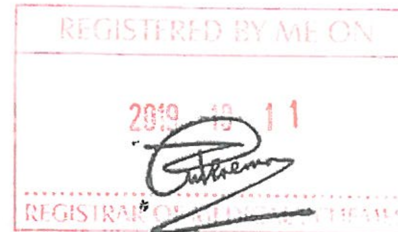
POLMED provides for a specific list of chronic conditions that are funded from the chronic medication benefit (i.e. through a benefit that is separate from the acute medication benefit). POLMED requires members to apply for authorisation via the Chronic Medicine Management Programme to access this chronic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

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



SPECIALISED DENTISTRY

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



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

* NO penalties may be imposed on a beneficiary who fails to adhere to clinical protocol!

** what is the level of this co-payment?

MARINE BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Annual overall in-hospital limit** Subject to the Scheme's relevant managed healthcare programmes and includes the application of treatment protocols, case management and pre-authorisation A R5 000 penalty may be imposed if no pre-authorisation is obtained R15 000 co-payment for voluntary admission in a non-DSP hospital	Unlimited at DSPs Subject to PMBs, i.e. no limit in case of life-threatening emergencies or for PMB conditions Subject to applicable tariff, i.e. 100% of POLMED rate **or** Agreed tariff **or** At cost for involuntary access to PMBs
	Anaesthetists	150% of POLMED rate
	Chronic Renal Dialysis **At Preferred Providers**	100% of agreed tariff at DSP POLMED has established a Preferred Provider Network for renal dialysis. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply). Pre authorization is required for all dialysis services.

MARINE BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Dentistry (conservative and restorative)**	100% of POLMED rate Dentist's costs for basic dental procedures will be reimbursed from the out-of-hospital (OOH) benefit, subject to: M0 – R5 000 M1 – R5 750 M2 – R6 500 M3 – R7 250 M4+ - R8 000 The hospital and anaesthetist's costs will be reimbursed from the in-hospital benefit
	Emergency medical services (ambulance services)	Subject to POLMED Scheme rules 100% of agreed tariffs at DSP
	General practitioners (GPs)	100% of agreed tariff at DSP 100% of POLMED rate at non-DSP **or** At cost for involuntary access to PMBs

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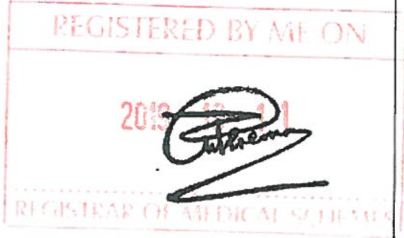
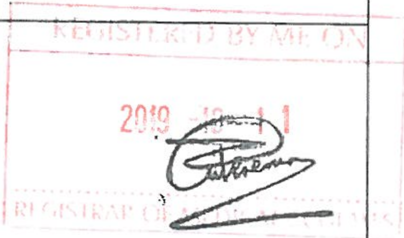
2019 -10- 11
REGISTRAR OF MEDICAL SCHEMES

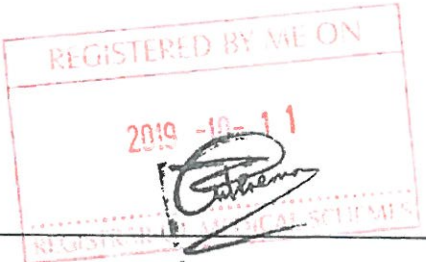
MARINE BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Medication (non-PMB specialist drug limit, e.g. biologicals)**	100% of POLMED rate Pre-authorisation required Specialised medication sub-limit of R177 402 per family
	Mental health	100% of POLMED rate **or** At cost for PMBs Annual limit of 21 days per beneficiary Limited to a maximum of three days' hospitalisation for beneficiaries admitted by a GP or a specialist physician Additional hospitalisation to be motivated by the medical practitioner



MARINE BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Oncology (chemotherapy and radiotherapy)** Independent Clinical Oncology Network (ICON) is the DSP	100% of agreed tariff at DSP Limited to R464 834 per beneficiary per annum; includes MRI/CT or PET scans related to oncology Chemotherapy and Radiation limited to Oncology benefits, adherence to the Oncology Formulary and subject to medicines from the Preferred Provider Network
	Organ and tissue transplants	100% of agreed tariff at DSP or At cost for PMBs Subject to clinical guidelines used in State facilities Unlimited radiology and pathology for organ transplant and immunosuppressant's
	Pathology	Service will be linked to hospital pre-authorisation
	Physiotherapy	Service will be linked to hospital pre-authorisation



MARINE BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Prosthesis (internal and external)**	100% of POLMED rate **or** At cost for PMBs Subject to pre-authorisation and approved product list Limited to the overall prosthesis benefit of R65 320 per beneficiary Knee Prosthesis – R54 600 Hip Prosthesis – R54 600 Shoulder Prosthesis – R65 100 Intraocular Lens – R3 150 Aorta & Peripheral Arterial Stent Grafts – R47 250 Cardiac Stents – R26 775 Cardiac Pacemaker – R58 800 Spinal plates and screws – R65 320 Spinal Implantable Devices – R60 000 Unlisted items – R65 320



MARINE BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Refractive surgery**	100% of POLMED rate Subject to pre-authorisation Procedure is performed out of hospital and in day clinics
	Specialists	100% of agreed tariff at DSP 100% of POLMED rate at non-DSP **or** At cost for involuntary access to PMBs

MARINE BENEFIT SCHEDULE		
OVERAAL OUT-OF-HOSPITAL BENEFITS	**Annual overall out-of-hospital (OOH) limit** Benefits shall not exceed the amount set out in the table PMBs shall first accrue towards the total benefit, but are not subject to a limit In appropriate cases the limit for medical appliances shall not accrue towards this limit	Out-of-hospital benefits are subject to: • protocols and clinical guidelines • PMBs • the applicable tariff i.e. 100% of POLMED rate **or** Agreed tariff **or** At cost for involuntary access to PMBs M0 – R20 143 M1 – R24 513 M2 – R29 537 M3 – R33 872 M4+ – R36 757

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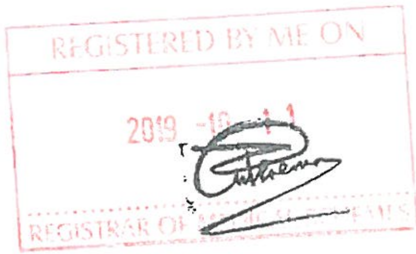
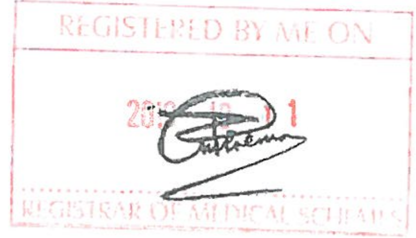
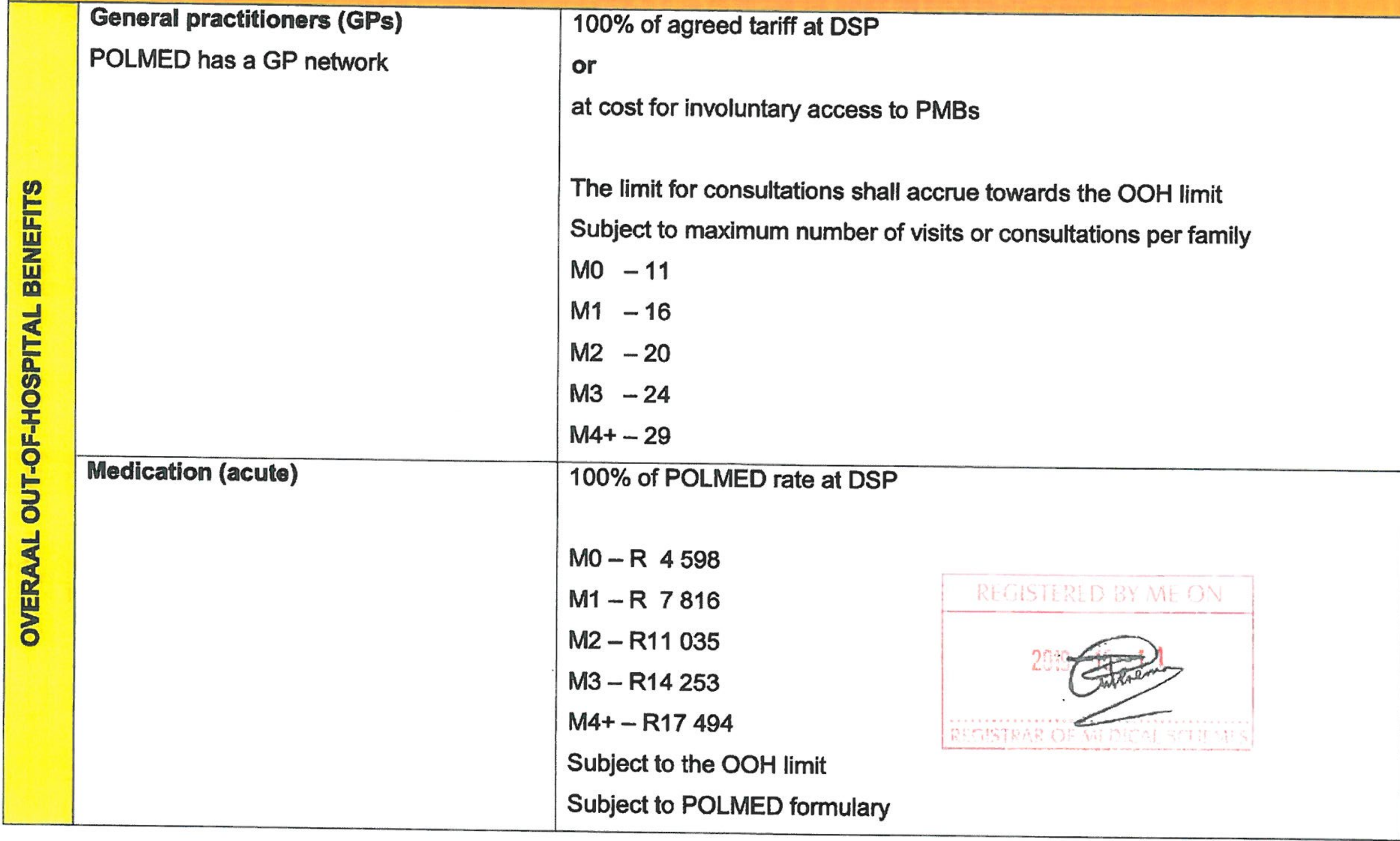
2019 -10- 1 1
REGISTRAR OF MEDICAL SCHEMES

MARINE BENEFIT SCHEDULE		
OVERAAL OUT-OF-HOSPITAL BENEFITS	**Audiology**	100% of POLMED rate Subject to the OOH limit **Subject to referral by the following doctors/specialists:** General Practitioner (GP) Ear, nose and throat (ENT) specialist Paediatrician Physician Neurologist



MARINE BENEFIT SCHEDULE		
OVERAAL OUT-OF-HOSPITAL BENEFITS	**Dentistry (conservative and restorative)**	100% of POLMED rate Subject to the OOH limit and includes dentist's costs for in-hospital, non-PMB procedures M0 – R5 000 M1 – R5 750 M2 – R6 500 M3 – R7 250 M4+ - R8 000 Routine consultation, scale and polish are limited to two annual check-ups per beneficiary Oral hygiene instructions are limited to once in 12 months per beneficiary





MARINE BENEFIT SCHEDULE		
OVERAAL OUT-OF-HOSPITAL BENEFITS	**General practitioners (GPs)** POLMED has a GP network	100% of agreed tariff at DSP **or** at cost for involuntary access to PMBs The limit for consultations shall accrue towards the OOH limit Subject to maximum number of visits or consultations per family M0 – 11 M1 – 16 M2 – 20 M3 – 24 M4+ – 29
	Medication (acute)	100% of POLMED rate at DSP M0 – R 4 598 M1 – R 7 816 M2 – R11 035 M3 – R14 253 M4+ – R17 494 Subject to the OOH limit Subject to POLMED formulary

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REGISTRAR OF MEDICAL SCHEMES

MARINE BENEFIT SCHEDULE		
OVERAAL OUT-OF-HOSPITAL BENEFITS	**Medication (over the Counter - OTC)**	100% of POLMED rate at DSP Annual limit of R1 210 per family Subject to the OOH limit Subject to POLMED formulary
	Occupational and speech therapy	100% of POLMED rate Annual limit of R2 795 per family Subject to OOH limit
	Pathology	M0 – R3 361 M1 – R4 846 M2 – R5 796 M3 – R7 138 M4+ – R8 753 The defined limit per family will apply for any pathology service done out of hospital

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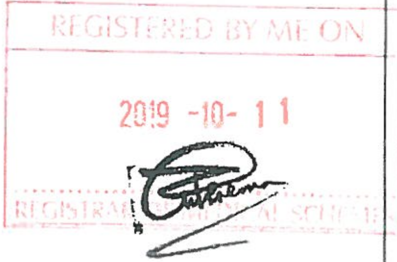
REGISTRAR OF MEDICAL SCHEMES

MARINE BENEFIT SCHEDULE		
OVERAAL OUT-OF-HOSPITAL BENEFITS	**Physiotherapy**	100% of POLMED rate Annual limit of R4 846 per family Subject to the OOH limit
	Psychology plus Social worker	100% of POLMED rate Annual limit of R6 500 per family Subject to the OOH limit
	Specialists Referral is not necessary for the following specialists: Gynaecologists Psychiatrists Oncologists Ophthalmologists Nephrologists (dialysis) Dental specialists Supplementary or allied health services	100% of agreed tariff at DSP **or** at cost for involuntary access to PMBs The limit for consultations shall accrue towards the OOH limit Limited to 5/five visits per beneficiary **or** 11/eleven visits per family per annum Subject to referral by a GP (2/two specialist visits per beneficiary without GP referral allowed) R1 000 co-payment if no referral is obtained



STAND-ALONE BENEFITS		
	Allied health services and alternative healthcare providers Biokineticists — Chiropractors Chiropodists — Dieticians Homeopaths — Naturopaths Orthoptists — Osteopaths Podiatrists Reflexologists Therapeutic massage therapists **Benefits will be paid for clinically appropriate services**	100% of POLMED rate Annual limit of R2 733 per family

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20
REGISTRAR OF MEDICAL SCHEMES

REGISTERED BY ME ON
2019 -10- 11

<table>
<tr><td rowspan="7">STAND-ALONE BENEFITS</td><td rowspan="7">Appliances (medical and surgical)

Members must be referred for audiology services for hearing aids to be reimbursed

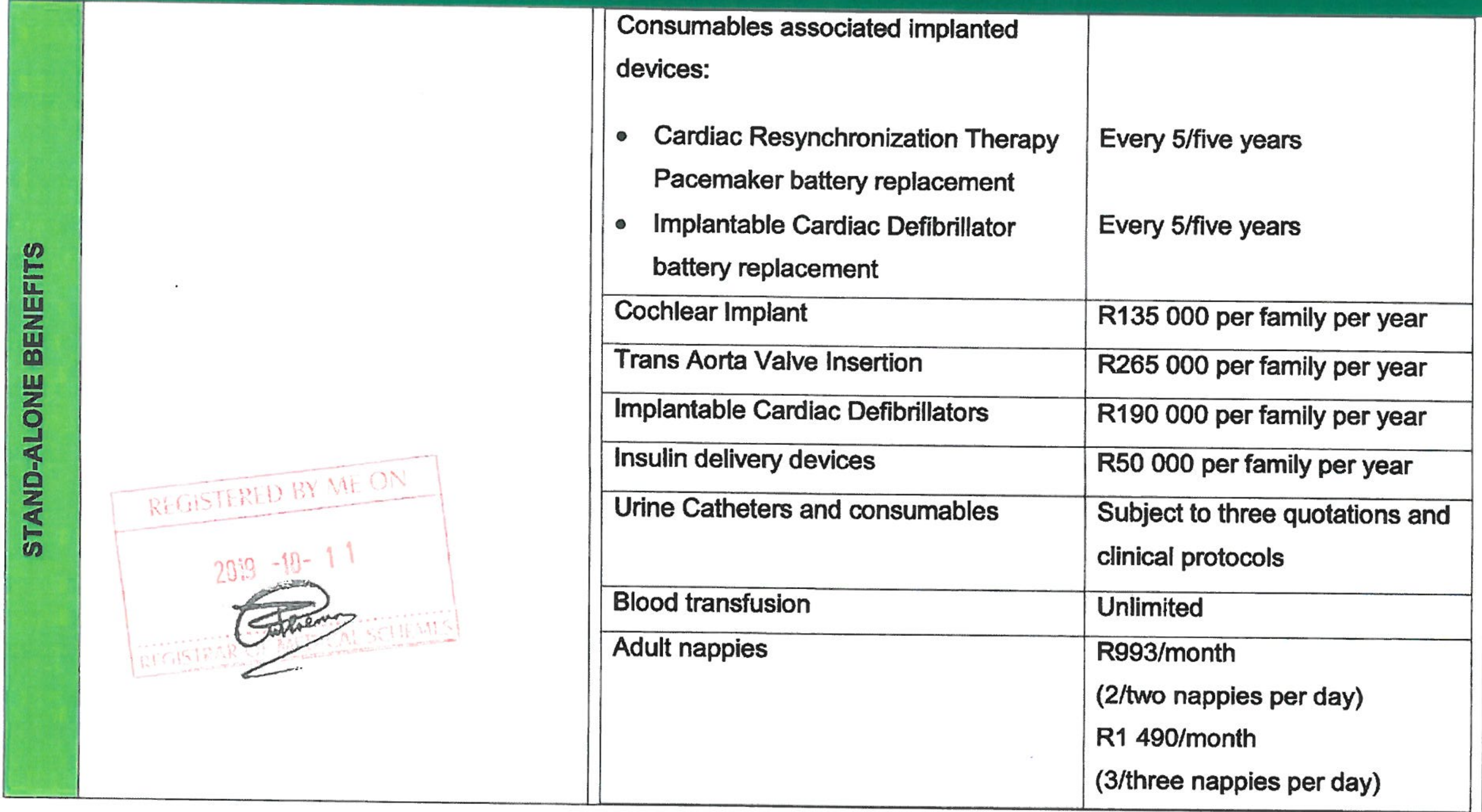
Pre-authorisation is required for the listed Medical appliances

All costs for maintenance are a Scheme exclusion

Funding will be based on applicable clinical and funding protocols

Quotations will be required</td><td colspan="2">100% of POLMED rate</td></tr>
<tr><td>Hearing aids</td><td>R14 144 per hearing aid
OR
R28 111 per beneficiary per set
Once every 3/three years</td></tr>
<tr><td>Nebuliser</td><td>R1 342 per family
Once every 4/four years</td></tr>
<tr><td>Glucometer</td><td>R1 342 per family
Once every 4/four years</td></tr>
<tr><td>CPAP machine</td><td>R9 442 per family
Once every 4/four years</td></tr>
<tr><td>Wheelchair
(non-motorised)
OR
Wheelchair (motorised)</td><td>R15 712 per beneficiary
Once every 3/three years

R52 814 per beneficiary
Every 3/three years</td></tr>
<tr><td>Medical assistive devices</td><td>Annual limit of R3 361 per family
Includes medical devices in/out of hospital</td></tr>
</table>



STAND-ALONE BENEFITS			
		Consumables associated implanted devices: • Cardiac Resynchronization Therapy Pacemaker battery replacement • Implantable Cardiac Defibrillator battery replacement	 Every 5/five years Every 5/five years
		Cochlear Implant	R135 000 per family per year
		Trans Aorta Valve Insertion	R265 000 per family per year
		Implantable Cardiac Defibrillators	R190 000 per family per year
		Insulin delivery devices	R50 000 per family per year
		Urine Catheters and consumables	Subject to three quotations and clinical protocols
		Blood transfusion	Unlimited
		Adult nappies	R993/month (2/two nappies per day) R1 490/month (3/three nappies per day)

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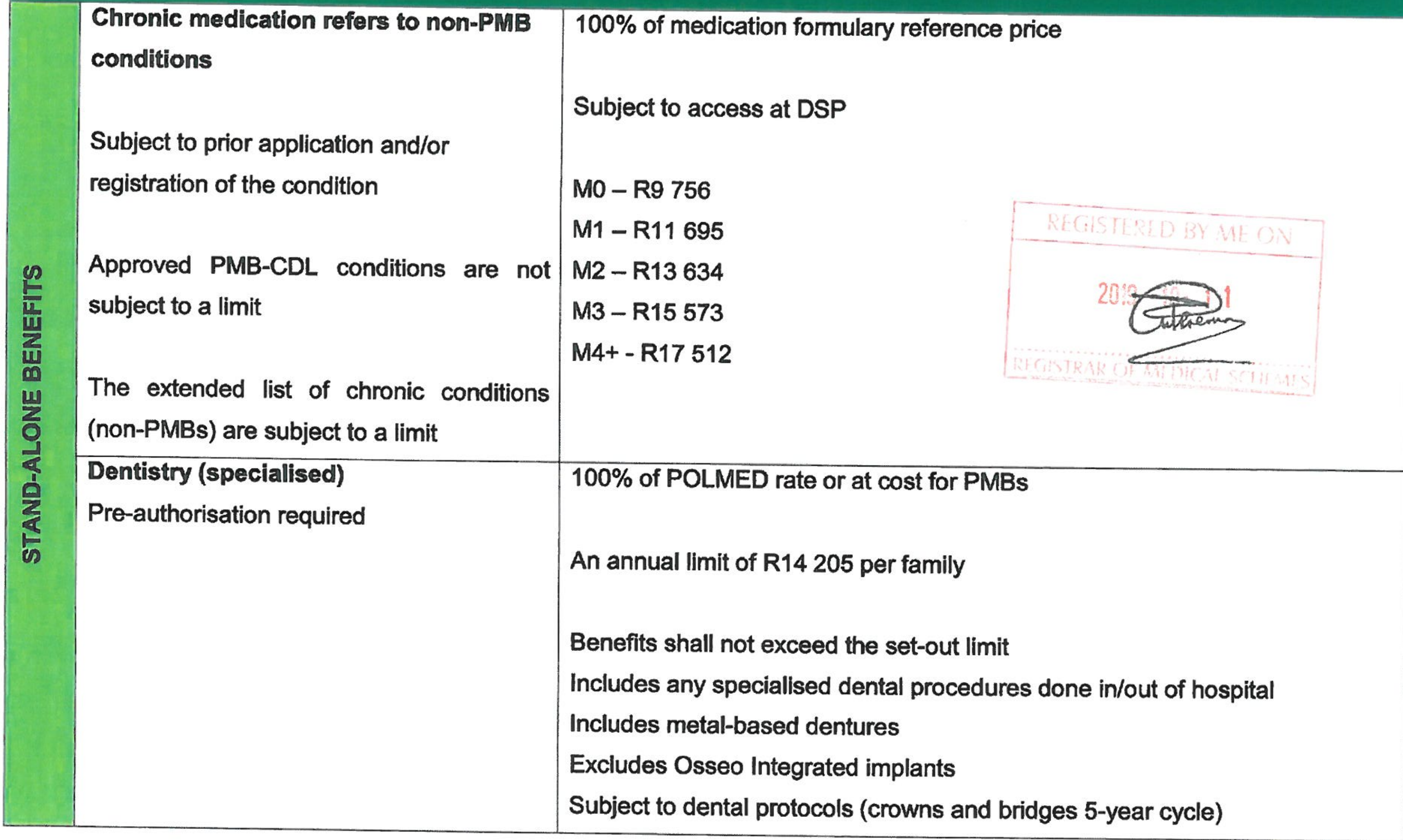
2019 -10- 11
REGISTRAR OF MEDICAL SCHEMES

MARINE BENEFIT SCHEDULE		
STAND-ALONE BENEFITS	**Chronic medication refers to non-PMB conditions** Subject to prior application and/or registration of the condition Approved PMB-CDL conditions are not subject to a limit The extended list of chronic conditions (non-PMBs) are subject to a limit	100% of medication formulary reference price Subject to access at DSP M0 – R9 756 M1 – R11 695 M2 – R13 634 M3 – R15 573 M4+ - R17 512
	Dentistry (specialised) Pre-authorisation required	100% of POLMED rate or at cost for PMBs An annual limit of R14 205 per family Benefits shall not exceed the set-out limit Includes any specialised dental procedures done in/out of hospital Includes metal-based dentures Excludes Osseo Integrated implants Subject to dental protocols (crowns and bridges 5-year cycle)



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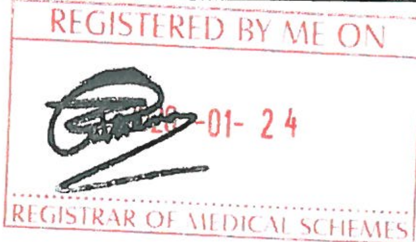
REGISTRAR OF MEDICAL SCHEMES

MARINE BENEFIT SCHEDULE		
STAND-ALONE BENEFITS	**Maternity benefits (including home birth)** Pre-authorisation required Treatment protocols apply	The limit for consultations shall not accrue towards the OOH limit The benefit shall include three specialist consultations per beneficiary per pregnancy Home birth is limited to R17 669 per beneficiary per annum Annual limit of R4 727 for ultrasound scans per beneficiary; limited to 2/two 2D scans per pregnancy Benefits relating to more than 2/two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation Elective (voluntary) Caesarean Sections will, subject to the PMBs, be considered in line with managed care and funding protocols. A co-payment of R10 000 will apply in all voluntary sections (PMBs apply) except in cases where the costs of the voluntary Caesarean section falls below the applicable co – payment amount of R 10 000. Pre-authorization is required.
	Maxillofacial Pre-authorisation required	Shared limit with specialised dentistry Excludes Osseo Integrated implants



MARINE BENEFIT SCHEDULE		
STAND-ALONE BENEFITS	**Optical** Benefit cycle - In accordance with the below benefit sub limits, each beneficiary is entitled to either spectacles or contact lenses every 24 months from date of claiming Includes frames, lenses and eye examinations The eye examination is per beneficiary every two years (unless prior approval for clinical indication has been obtained) Benefits are not pro rata, but calculated from the benefit service date Each claim for lenses or frames must be submitted with the lens prescription	**Provider Network** 100% of cost for a Composite consultation, inclusive of the refraction, a glaucoma screening and visual field screening and Authenticate IT **WITH EITHER SPECTACLES** R1 300 towards a frame and/or lens enhancement **LENSES** Either one pair of Clear single vision lenses limited to R185 per lens **or** one pair of Clear flat top bifocal lenses limited to R420 per lens **or** one pair of Clear Base multifocal lenses limited to R745 **OR CONTACT LENSES** Contact lenses to the value of R1 596 per beneficiary per annum Contact lens re-examination to a maximum cost of R245 per consultation

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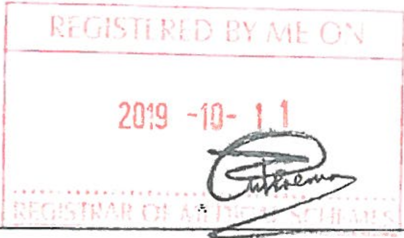
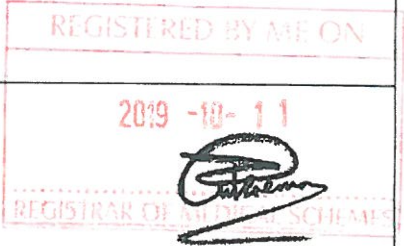
2019 -10- 11
REGISTRAR OF MEDICAL SCHEMES

MARINE BENEFIT SCHEDULE		
STAND-ALONE BENEFITS	**Optical (continue)** Benefits shall not be granted for contact lenses if the beneficiary has already received a pair of spectacles in a two-year benefit cycle Contact lens re-examination can be claimed for in sic-monthly intervals 	**Non-Provider Network** One consultation limited to a maximum cost of R330 **WITH EITHER SPECTACLES** R949 towards a frame and/or lens enhancement Single-vision lenses limited to R185 per lens **or** Bifocal lenses limited to R420 per lens **or** One pair of Clear Base multifocal lenses limited to R745 **OR CONTACT LENSES** Contact lenses to the value of R1 100 Contact lens re-examination to maximum cost of R245 per consultation

MARINE BENEFIT SCHEDULE		
STAND-ALONE BENEFITS	**Radiology (basic)** i.e. black and white X-rays and soft tissue ultrasounds	100% of agreed tariff or at cost for PMBs Limited to R6 532 per family Includes any basic radiology done in or out of hospital Claims for PMBs first accrue towards the limit
	Radiology (specialised) Pre-authorisation required One (1) MRI Scan Two (2) CT Scans	100% of agreed tariff **or** at cost for PMBs Includes any specialised radiology service done in/out of hospital Claims for PMBs first accrue towards the limit Subject to a limit of 1/one scan per family per annum, except for PMBs Subject to a limit of 2/two scans per family per annum, except for PMBs



ANNEXURE A2

CO-PAYMENTS 2020

OUT OF NETWORK	CO-PAYMENT
General practitioner (GP)	Allows for 2/two out-of-network consultations per beneficiary, any additional consultations are funded at non-network rate
Hospital	R15 000
Pharmacy	20% of costs for using a non-designated service provider pharmacy 20% co-payment for voluntarily using a non-formulary product
Chronic Renal Dialysis	POLMED has established a Preferred Provider Network for renal dialysis. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply). Pre authorization is required for all dialysis services

ANNEXURE A3

*ANNUAL MEMBER CONTRIBUTION INCREASES ARE EFFECTIVE 1 APRIL

CONTRIBUTIONS FROM 1 APRIL 2019 UNTIL 31 MARCH 2020

1 April 2019 - 31 March 2020 (subsidised contribution)

Marine	Member	Adult	Child
R0 - R6 618	R 319	R 319	R 80
R6 619 - R9 091	R 442	R 442	R 148
R9 092 - R11 107	R 488	R 488	R 183
R11 108 - R12 991	R 575	R 575	R 230
R12 992 - R15 118	R 671	R 671	R 266
R15 119 - R18 182	R 768	R 768	R 314
R18 183 - R22 315	R 846	R 846	R 366
R22 316 +	R 919	R 919	R 403

1 April 2019 - 31 March 2020 (excluding employer subsidy)

Marine	Member	Adult	Child
R0 - R6 618	R 2,204	R 2,204	R 1,023
R6 619 - R9 091	R 2,327	R 2,327	R 1,090
R9 092 - R11 107	R 2,373	R 2,373	R 1,125
R11 108 - R12 991	R 2,461	R 2,461	R 1,172
R12 992 - R15 118	R 2,557	R 2,557	R 1,209
R15 119 - R18 182	R 2,653	R 2,653	R 1,257
R18 183 - R22 315	R 2,731	R 2,731	R 1,308
R22 316 +	R 2,805	R 2,805	R 1,346

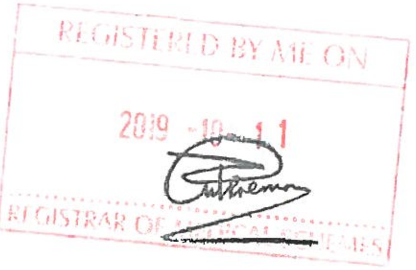
CONTRIBUTIONS FROM 1 APRIL 2020 UNTIL 31 MARCH 2021

1 April 2020 - 31 March 2021 (subsidised contribution)

Marine	Member	Adult	Child
R0 - R6 618	R 351	R 351	R 88
R6 619 - R9 091	R 486	R 486	R 163
R9 092 - R11 107	R 537	R 537	R 201
R11 108 - R12 991	R 633	R 633	R 253
R12 992 - R15 118	R 738	R 738	R 293
R15 119 - R18 182	R 845	R 845	R 345
R18 183 - R22 315	R 931	R 931	R 403
R22 316 - R25 672	R 1 011	R 1 011	R 443
R25 673 - R29 672	R 1 029	R 1 029	R 451
R29 672+	R 1 048	R 1 048	R 459

1 April 2020 - 31 March 2021 (excluding employer subsidy)

Marine	Member	Adult	Child
R0 - R6 618	R 2 366	R 2 366	R 1 096
R6 619 - R9 091	R 2 501	R 2 501	R 1 170
R9 092 - R11 107	R 2 552	R 2 552	R 1 208
R11 108 - R12 991	R 2 649	R 2 649	R 1 260
R12 992 - R15 118	R 2 754	R 2 754	R 1 301
R15 119 - R18 182	R 2 860	R 2 860	R 1 353
R18 183 - R22 315	R 2 946	R 2 946	R 1 410
R22 316 - R25 672	R 3 027	R 3 027	R 1 451
R25 673 - R29 672	R 3 045	R 3 045	R 1 459
R29 672+	R 3 064	R 3 064	R 1 467



ANNEXURE A4

MARINE: CHRONIC CONDITIONS 2020

PRESCRIBED MINIMUM BENEFITS (PMBS), INCLUDING CHRONIC DIAGNOSIS AND TREATMENT PAIRS (DTPS)

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

Auto-immune disorder

Systemic lupus erythematosus (SLE)

Cardiovascular conditions

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

Endocrine conditions

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

Gastrointestinal conditions

Crohn's disease

Ulcerative colitis

Peptic ulcer disease (requires special motivation)

Gynaecological conditions

Endometriosis

Menopausal treatment

Haematological conditions

Haemophilia

Anaemia

Idiopathic thrombocytopenic purpura

Megaloblastic anaemia

Metabolic condition

Hyperlipidaemia

Musculoskeletal condition

Rheumatic arthritis

Neurological conditions

Epilepsy

Multiple sclerosis

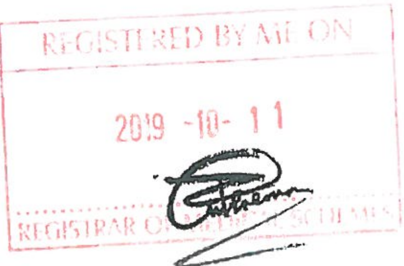
Parkinson's disease

Cerebrovascular incident

Permanent spinal cord injuries

Ophthalmic condition

Glaucoma



Pulmonary diseases

Asthma

Chronic obstructive pulmonary disease (COPD)

Bronchiectasis

Cystic fibrosis

Psychiatric conditions

Affective disorders (depression and bipolar mood disorder)

Post-traumatic stress disorder (PTSD)

Schizophrenic disorders

Special category conditions

HIV/AIDS

Tuberculosis

Organ transplantation

Treatable cancers

As per PMB guidelines

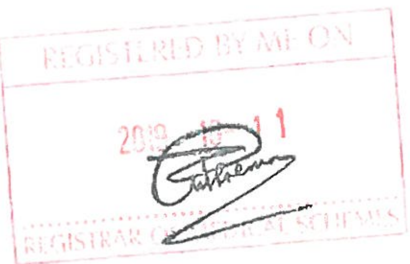
Urological conditions

Chronic renal failure

Benign prostatic hypertrophy

Nephrotic syndrome and glomerulonephritis

Renal calculi



EXTENDED CHRONIC DISEASE LIST: NON-PMB

Chronic medication for the conditions listed below is payable from the *chronic medication benefits*

Benefits are subject to the availability of funds

Dermatological conditions

Acne (clinical photos required)

Psoriasis

Eczema

Onychomycosis (mycology report required)

Ear, nose and throat condition

Allergic rhinitis

Gastrointestinal condition

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

Metabolic condition

Gout prophylaxis

Musculoskeletal conditions

Ankylosing spondylitis

Osteoarthritis

Osteoporosis

Paget's disease

Psoriatic arthritis

Neurological conditions

Alzheimer's disease

Trigeminal neuralgia

Meniere's disease

Migraine prophylaxis

Narcolepsy

Tourette's syndrome

Ophthalmic condition

Dry eye or keratoconjunctivitis sicca

Psychiatric condition

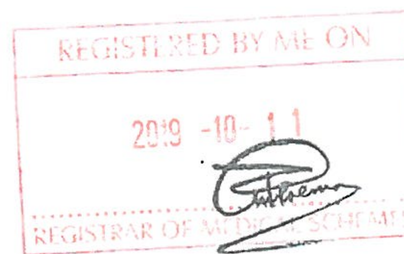
Attention deficit hyperactivity disorder (ADHD)

Post-traumatic stress disorder (PTSD)

Urological condition

Overactive bladder syndrome

ANNEXURE B1



AQUARIUM SCHEDULE

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2020

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

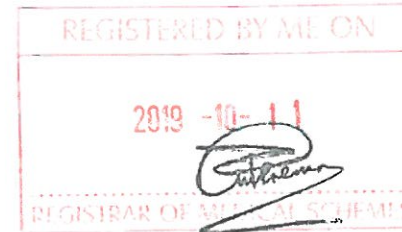
Reference in this Annexure and the following Annexures to the term:

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

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

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

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



GENERAL RULES

APPLICATION OF CLINICAL PROTOCOLS AND FUNDING GUIDELINES

POLMED applies clinical protocols, including "Best practice guidelines" as well as evidence-based medicine principles in its funding decisions.

DENTAL PROCEDURES

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

DESIGNATED SERVICE PROVIDER: OUT-OF-NETWORK RULE

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

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

Examples of designated service providers (where applicable) are:

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

POLMED GP NETWORK (DESIGNATED GP PROVIDER)

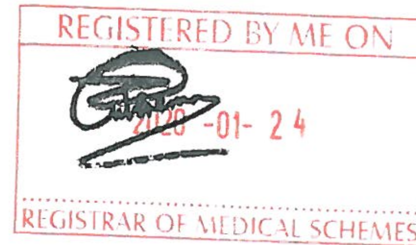
Members are allowed 2/two visits to a GP who is not part of the network per beneficiary per annum for emergency or out-of-town situations. Co-payments shall apply once the maximum out-of-network consultations are exceeded.
Polmed rates for designated GP provider visits are available on its website and can be accessed at www.polmed.co.za. These rates are reviewed annually. The co-payment to out of network GP providers will be calculated as being the difference between the Polmed rate for non-designated GP providers and the actual rate charged by the out of network GP provider.
PMB rule applies for qualifying emergency consultations.

POLMED HOSPITAL NETWORK (DESIGNATED HOSPITAL NETWORK)

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

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

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



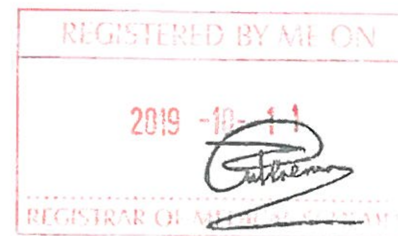
In case of an emergency, the Scheme must be notified within 48 hours or on the first working day after admission. Pre-authorisation will be managed under the auspices of managed healthcare. The appropriate facility must be used to perform a procedure, based on the clinical requirements, as well as the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

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

Medicine prescribed during hospitalisation forms part of the hospital benefits.

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

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



POLMED PHARMACY NETWORK

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

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

EMERGENCY MEDICAL SERVICES (EMS): NETCARE 911

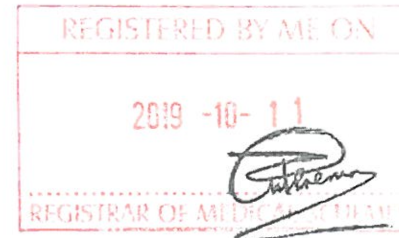
72-Hour Post-Authorisation Rule

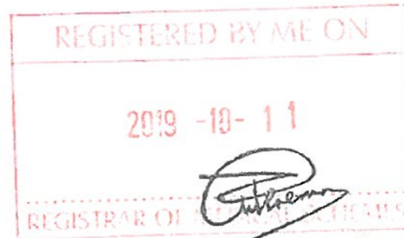
Subject to authorisation within 72 hours of the event, all service providers will need to get a notification number from POLMED's Designated Service Provider (DSP) Netcare911.

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

EX GRATIA BENEFIT

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





MEDICATION: ACUTE, OVER THE COUNTER (OTC) AND CHRONIC

The chronic medication benefit shall be subject to registration on the Chronic Medicine Management Programme for those conditions which are managed, and chronic medication rules will apply.

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

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

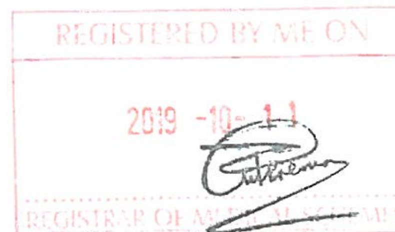
The member needs to reapply for an authorisation at least one month prior to the expiry of an existing chronic medication authorisation, failing which any claims received will not be paid from the chronic medication benefit, but from the acute medication benefit, if benefits exist. This only applies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

Payment in respect of over-the-counter (OTC), acute and chronic medication, will be subject to the medication included in the POLMED formulary. Medication is included in the POLMED formulary based on its proven clinical efficacy, as well as its costs

effectiveness. Generic reference pricing is applicable where generic equivalent medication is available. The products that are not included in the POLMED formulary will attract a 20% co-payment.

The 20% co-payment for medication prescribed that is not included in the POLMED formulary can be waived via an exception management process. This process requires a motivation from the treating service provider and will be reviewed based on the exceptional needs and clinical merits of each individual case.
The Scheme shall only consider claims for medication prescribed by a person legally entitled to prescribe medication and which is dispensed by such a person or a registered pharmacist.

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



PRO RATA BENEFITS

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

SPECIALISED RADIOLOGY (MRI AND CT SCANS)

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

SPECIALIST REFERRAL

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

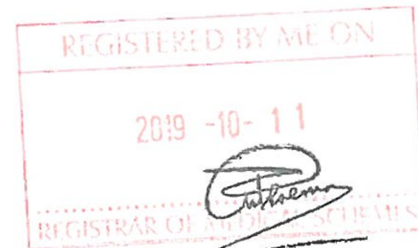
This co-payment is not applicable to the following specialities or disciplines: Gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists [chronic dialysis], dental specialists, pathology, radiology and supplementary or allied health services.

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

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

CONSERVATIVE BACK AND NECK REHABILITATIVE PROGRAM

Services associated with Polmed's conservative Back and Neck program will be funded from Hospital risk. Pre authorization is required to access the benefits. Spinal surgery will not be covered unless there is evidence that the patient has received conservative therapy prior to requesting surgery (PMBs apply).



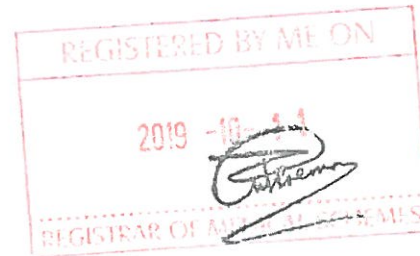
DEFINITION OF TERMS

BASIC DENTISTRY

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

Other procedures that fall under this category are:

- Consultations
- Fluoride treatment and fissure sealants
- Non-surgical removal of teeth
- Cleaning of teeth, including non-surgical management of gum disease
- Root canal treatment



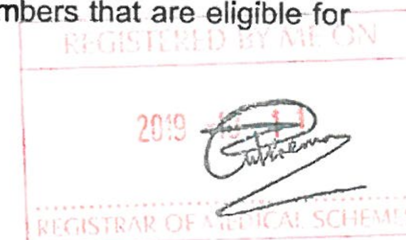
CO-PAYMENT

A co-payment is an amount payable by the member to the service provider at the point of service. This includes all the costs more than those agreed upon with the service provider or more than what would be paid according to approved treatments. A co-payment would not be applicable in the event of a life-threatening injury or an emergency.

ENROLMENT ON THE DISEASE RISK MANAGEMENT PROGRAMME

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

The claims data for chronic medication, consultations and hospital admissions is used to identify the members that are eligible for enrolment on the programme. Members are also encouraged to register themselves on the programme.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2019
REGISTRAR OF MEDICAL SCHEMES

FORMULARY

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

MEDICINE GENERIC REFERENCE PRICE

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

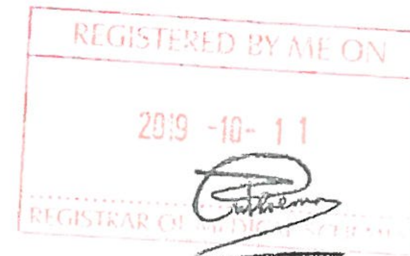
REGISTRATION FOR CHRONIC MEDICATION

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

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

SPECIALISED DENTISTRY

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



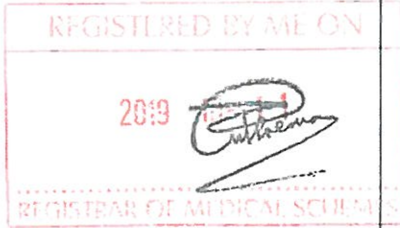
AQUARIUM BENEFIT SCHEDULE		
GENERAL BENEFIT RULES	**Benefit design**	This option provides for benefits to be provided only in appointed designated service provider (DSP) hospitals It also provides a reasonable level of out-of-hospital (day-to-day) care This option is intended to provide for the needs of families who have little healthcare needs or whose chronic conditions are under control This option is not intended for members who require medical assistance on a regular basis, or who are concerned about having extensive access to health benefits
	Pre-authorisation, referrals, protocols and management by programmes	Where the benefit is subject to pre-authorisation, referral by a designated service provider (DSP) or general practitioner (GP), adherence to established protocols or enrolment upon a managed care programme. Members' attention is drawn to the fact that there may be * no benefit at all or a much-reduced benefit if the pre-authorisation, referral by a DSP or GP, adherence to established protocols or enrolment upon a managed care programme is not complied with (a co-payment ** may be applied)

*No penalties may be imposed on a beneficiary who fails to adhere to clinical protocols.

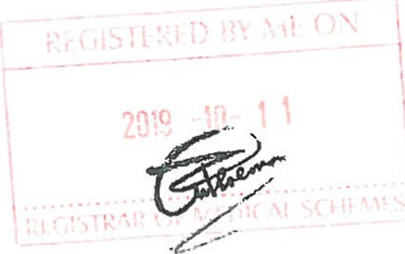
** what is the level of this co-payment?

AQUARIUM BENEFIT SCHEDULE		
GENERAL BENEFIT RULES		The pre-authorisation, referral by a DSP or GP, adherence to established protocols or enrolment upon a managed care programme is stipulated to best care for the member and his/her family and to protect the funds of the Scheme
	Limits are per annum	Unless there is a specific indication to the contrary, all benefit amounts and limits are annual
	Statutory prescribed minimum benefits (PMBs)	There is no overall annual limit for PMBs or life-threatening emergencies
	Tariff	100% of POLMED rate or agreed tariff or at cost for involuntary access to PMBs

AQUARIUM BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Annual overall in-hospital limit** Subject to the Scheme's relevant managed healthcare programmes and includes the application of treatment protocols, case management and pre-authorisation R5 000 penalty may be imposed if no pre-authorisation is obtained R15 000 co-payment for voluntary admission in a non-DSP hospital No co-payment if the procedure is performed in a DSP and/or a day clinic	Non-PMB admissions will be subject to an overall limit of R200 000 per family Subject to PMBs, i.e. no limit in case of life-threatening emergencies or for PMB conditions Subject to applicable tariff i.e. 100% of POLMED rate **or** Agreed tariff **or** At cost for involuntary access to PMBs
	Anaesthetists	150% of POLMED rate
	Chronic Renal Dialysis **At Preferred Providers**	100% of agreed tariff at DSP POLMED has established a Preferred Provider Network for renal dialysis. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply). Pre authorization is required for all dialysis services



AQUARIUM BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Dentistry (conservative and restorative)**	100% of POLMED rate Dentist's costs for all non-PMB procedures will be reimbursed from the out-of-hospital (OOH) benefit, subject to: M0 – R4 000 M1 – R4 500 M2 – R5 000 M3 – R5 500 M4+ - R6 000 The hospital and anaesthetist's costs will be reimbursed from the overall non-PMB limit
	Emergency medical services (Ambulance)	Subject to POLMED Scheme rules 100% of agreed tariff at DSP
	General practitioners (GPs)	100% of agreed tariff at DSP 100% of POLMED rate at non-DSP **or** At cost for involuntary PMB access



AQUARIUM BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Medication (Non-PMB specialist drug limit, e.g. biologicals)**	100% of POLMED rate Pre-authorisation required Specialised medication sub-limit of R144 139 per family
	Mental health	100% of POLMED rate **or** At cost for PMBs Annual limit of 21 days per beneficiary Limited to a maximum of three days' hospitalisation for beneficiaries admitted by a GP or a specialist physician Additional hospitalisation to be motivated by the medical practitioner

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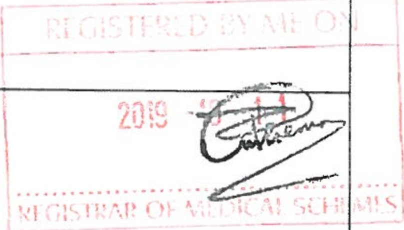
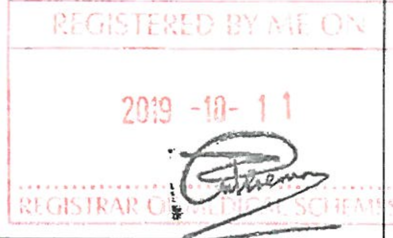
AQUARIUM BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Oncology (chemotherapy and radiotherapy)** Independent Clinical Oncology Network (ICON) is the DSP	100% of agreed tariff at DSP Limited to R271 400 per beneficiary per annum; includes MRI/CT or PET scans related to oncology Chemotherapy and Radiation limited to Oncology benefits, adherence to the Oncology Formulary and subject to medicines from the Preferred Provider Network
	Organ and tissue transplants	100% of agreed tariff at DSP **or** At cost for PMBs Subject to clinical guidelines used in State facilities Unlimited radiology and pathology for organ transplant and immunosuppressant's
	Pathology	Service will be linked to hospital pre-authorisation

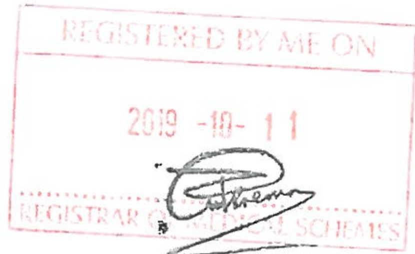


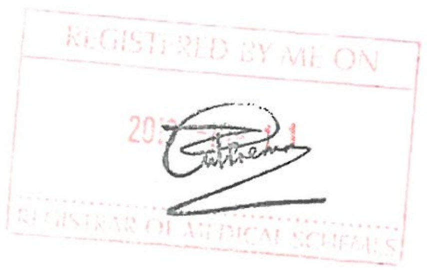
AQUARIUM BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Physiotherapy**	Service will be linked to hospital pre-authorisation
	Prosthesis (internal and external)	100% of POLMED rate **or** At cost for PMB's Subject to pre-authorisation and approved product list Limited to the overall prosthesis benefit of R64 132 per beneficiary Knee Prosthesis – R54 600 Hip Prosthesis – R54 600 Shoulder Prosthesis – R64 132 Intraocular Lens – R3 150 Aorta & Peripheral Arterial Stent Grafts – R47 250 Cardiac Stents – R26 775 Cardiac Pacemaker – R58 800 Spinal plates and screws – R64 132 Spinal Implantable Devices – R60 000 Unlisted items – R64 132

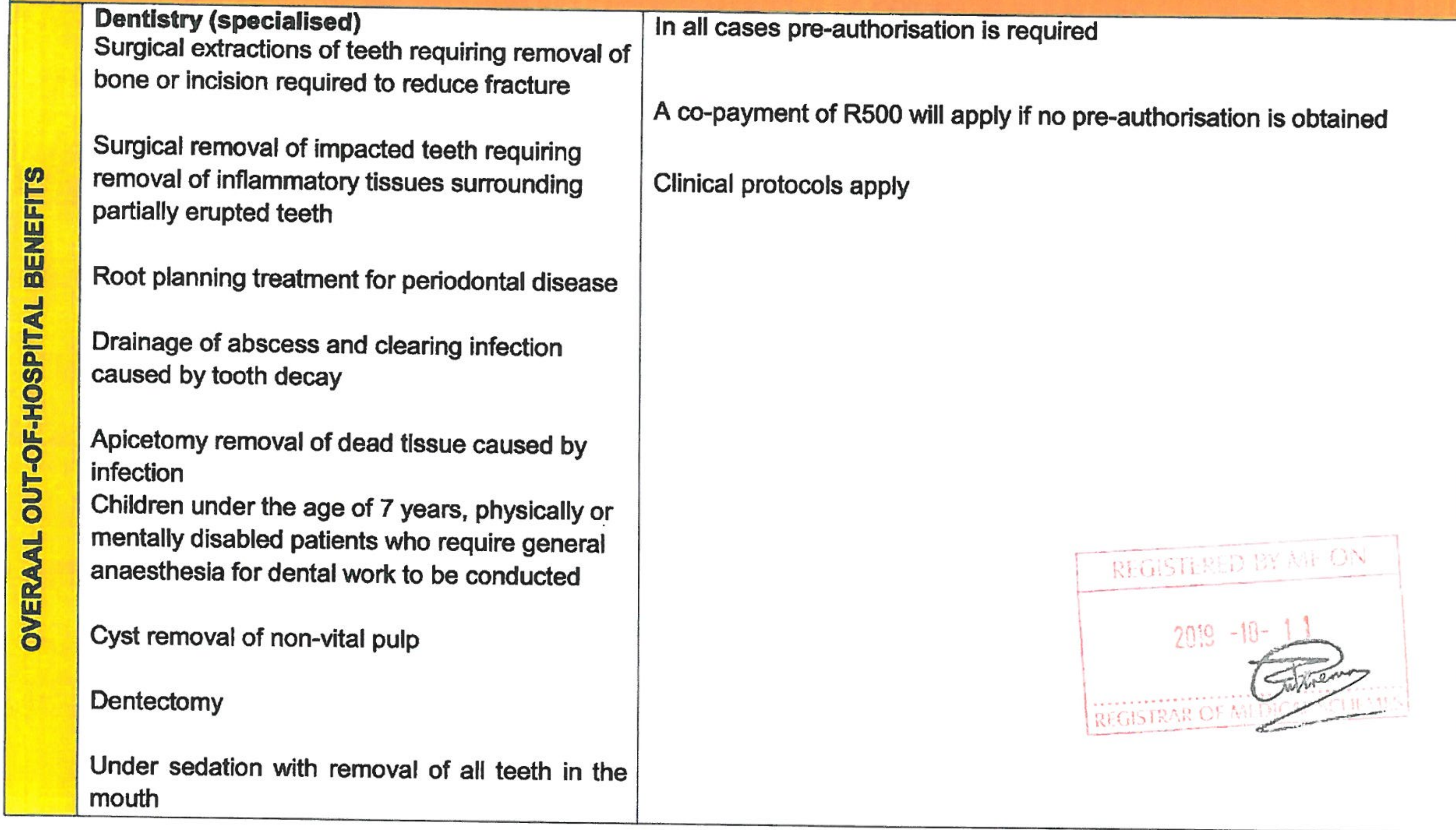


AQUARIUM BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Refractive surgery**	No benefit
	Specialists	100% of agreed tariff at DSP 100% of POLMED rate for non-DSP **or** At cost for involuntary PMB access

AQUARIUM BENEFIT SCHEDULE		
OVERAAL OUT-OF-HOSPITAL BENEFITS	**Annual overall out-of-hospital (OOH) limit** Benefits shall not exceed the amount set out in the table PMB shall first accrue towards the total benefit, but are not subject to limit In appropriate cases the limit for medical appliances shall not accrue towards this limit Overall out of hospital benefits are subject to: • Protocols and clinical guidelines • PMBs • The applicable tariff i.e. 100% of POLMED rate or agreed tariff or at cost for involuntary PMB access	M0 - R 8 812 M1 - R10 677 M2 - R12 969 M3 - R13 836 M4+ - R15 855



AQUARIUM BENEFIT SCHEDULE		
OVERAAL OUT-OF-HOSPITAL BENEFITS	**Audiology** Subject to referral by either of the following doctors/specialists: General Practitioner (GP) Ear, nose and throat (ENT) specialist Paediatrician Physician Neurologist	100% of POLMED rate Subject to the OOH limit 
	Dentistry (conservative and restorative)	100% of POLMED rate Subject to the OOH limit and includes dentist's costs for in-hospital, non-PMB procedures M0 – R4 000 M1 – R4 500 M2 – R5 000 M3 – R5 500 M4+ - R6 000 Routine consultation, scale and polish are limited to two annual check-ups per beneficiary Oral hygiene instructions are limited to once in 12 months per beneficiary



AQUARIUM BENEFIT SCHEDULE		
OVERAAL OUT-OF-HOSPITAL BENEFITS	**Dentistry (specialised)** Surgical extractions of teeth requiring removal of bone or incision required to reduce fracture Surgical removal of impacted teeth requiring removal of inflammatory tissues surrounding partially erupted teeth Root planning treatment for periodontal disease Drainage of abscess and clearing infection caused by tooth decay Apicetomy removal of dead tissue caused by infection Children under the age of 7 years, physically or mentally disabled patients who require general anaesthesia for dental work to be conducted Cyst removal of non-vital pulp Dentectomy Under sedation with removal of all teeth in the mouth	In all cases pre-authorisation is required A co-payment of R500 will apply if no pre-authorisation is obtained Clinical protocols apply

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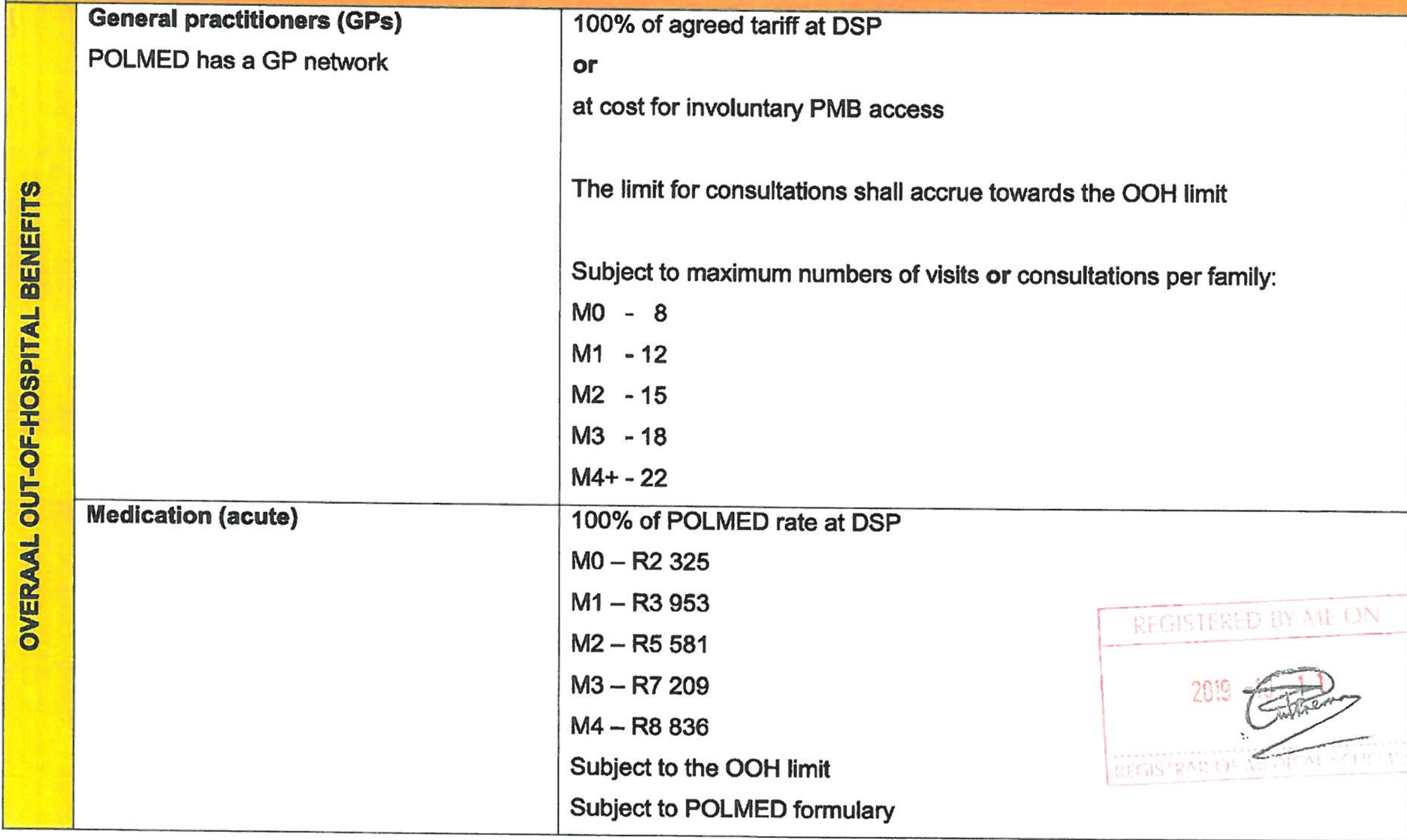

AQUARIUM BENEFIT SCHEDULE		
OVERAAL OUT-OF-HOSPITAL BENEFITS	**General practitioners (GPs)** POLMED has a GP network	100% of agreed tariff at DSP **or** at cost for involuntary PMB access The limit for consultations shall accrue towards the OOH limit Subject to maximum numbers of visits **or** consultations per family: M0 - 8 M1 - 12 M2 - 15 M3 - 18 M4+ - 22
	Medication (acute)	100% of POLMED rate at DSP M0 – R2 325 M1 – R3 953 M2 – R5 581 M3 – R7 209 M4 – R8 836 Subject to the OOH limit Subject to POLMED formulary

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AQUARIUM BENEFIT SCHEDULE		
OVERAAL OUT-OF-HOSPITAL BENEFITS	**Medication (over-the-counter - OTC)**	100% of POLMED rate at DSP Annual limit of R1 000 per family Subject to the OOH limit; Shared limit with acute medication Subject to POLMED formulary
	Occupational and speech therapy	PMBs only Benefit first accrues to the OOH limit
	Pathology	M0 - R3 100 M1 - R4 585 M2 - R5 546 M3 - R6 865 M4+ - R8 504 The defined limit per family will apply for any pathology service done out of hospital

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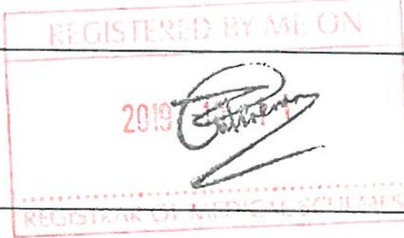
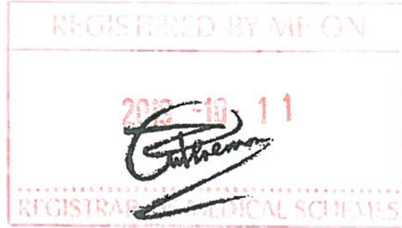
AQUARIUM BENEFIT SCHEDULE		
OVERAAL OUT-OF-HOSPITAL BENEFITS	**Physiotherapy**	100% of POLMED rate Annual limit of R2 398 per family Subject to the OOH limit
	Psychology plus Social worker	100% of POLMED rate Annual limit of R5 000 per family Subject to the OOH limit
	Specialists Referral is not necessary for the following specialists: Gynaecologists Psychiatrists Oncologists Ophthalmologists Nephrologists (dialysis) Dental specialists Supplementary or allied health services	100% of agreed tariff at DSP **or** At cost for involuntary access to PMBs The limit for consultations shall accrue towards the OOH limit Limited to 4/four visits per beneficiary and 8/eight visits per family per annum Subject to referral by a GP (2/two specialist visits per beneficiary without GP referral allowed) R1 000 co-payment if no referral is obtained



AQUARIUM BENEFIT SCHEDULE

STAND-ALONE BENEFITS		
Allied health services and alternative healthcare providers Biokineticists — Chiropractors Chiropodists — Dieticians Homeopaths — Naturopaths Orthoptists — Osteopaths Podiatrists — Reflexologists Therapeutic massage therapists **Benefit is subject to clinically appropriate services**	No benefit



STAND-ALONE BENEFITS

Appliances (medical and surgical)

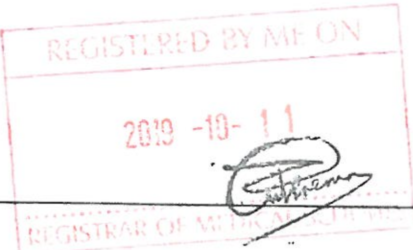
Members must be referred by an Audiologist for hearing aids to be reimbursed

Pre-authorisation is required for the supply of oxygen

All costs for maintenance are a Scheme exclusion

Funding will be based on applicable clinical and funding protocols

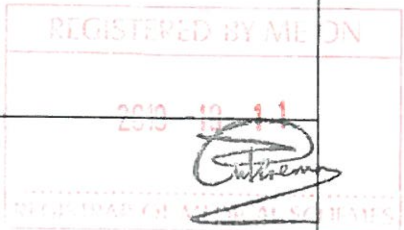
Quotations will be required



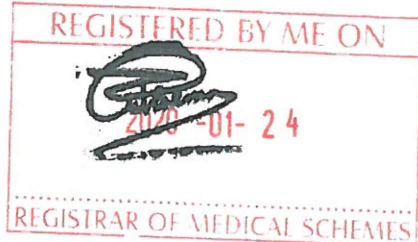
100% of POLMED rate

Blood transfusions	Unlimited
Hearing aids	R11 318 per hearing aid or R22 494 per beneficiary per set Once every 3/three years
Nebuliser	R1 283 per family Once every 4/four years
Glucometer	R1 283 per family Once very4/ four years
CPAP machine	R9 168 per family Once every 4/four years
Wheelchair (non-motorised) **OR** Wheelchair (motorised)	R11 983 per beneficiary Once every 3/three years R34 370 per beneficiary Once every 3/three years
Urine catheters and consumables	Subject to three quotations and clinical protocols
Medical assistive devices	Annual limit of R2 695 per family Includes medical devices in/out of hospital
Adult nappies	R946/month (2/two nappies per day) R1 419/month (3/three nappies per day)

AQUARIUM BENEFIT SCHEDULE		
STAND-ALONE BENEFITS	**Chronic medication refers to non-PMB conditions** Subject to prior application and/or registration of the condition Approved PMB-CDL conditions are not subject to a limit	No benefit except for PMBs Subject to the medication reference price and POLMED formulary
	Maternity benefits (including home birth) Pre-authorisation required Treatment protocols apply	100% of agreed tariff at DSP **or** 100% of POLMED rate at non-DSP **or** At cost for involuntary PMB access The limit for consultations shall not accrue towards the OOH limit The benefit shall include 3/three specialist consultations per beneficiary per pregnancy



AQUARIUM BENEFIT SCHEDULE		
STAND-ALONE BENEFITS	**Maternity Benefits (continue)**	Home birth is limited to R15 138 per beneficiary per annum Annual limit of R4 038 for ultrasound scans per beneficiary; limited to 2/two 2D scans per pregnancy Benefits relating to more than two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation Elective (voluntary) Caesarean Sections will, subject to the PMBs, be considered in line with managed care and funding protocols. A co-payment of R10 000 will apply in all voluntary Caesarean sections (PMBs apply) except in cases where the costs of the voluntary Caesarean section falls below the applicable co – payment amount of R 10 000. Pre-authorization is required.



<table>
<tr><th rowspan="2">STAND-ALONE BENEFITS</th><th>Optical</th><th>Provider Network</th></tr>
<tr><td>Benefit cycle - In accordance with the below benefit sub limits, each beneficiary is entitled to either spectacles or contact lenses every 24 months from date of claiming

Includes frames, lenses and eye examinations

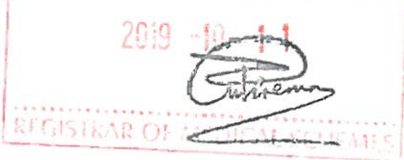
The eye examination is per beneficiary every two years (unless prior approval for clinical indication has been obtained)

Benefits are not pro rata, but calculated from the benefit service date

Each claim for lenses or frames must be submitted with the lens prescription</td><td>100% of cost for a Composite consultation, inclusive of the refraction, a glaucoma screening and visual field screening and Authenticate IT
WITH EITHER SPECTACLES
R795 towards a frame and/or lens enhancement

LENSES
Either one pair of Clear single vision lenses limited to R185 per lens
or
one pair of Clear flat top bifocal lenses limited to R420 per lens
or
one pair of Clear Base multi-focal lenses limited to R420

OR CONTACT LENSES
Contact lenses to the value of R613 per beneficiary per annum
Contact lens re-examination to a maximum cost of R245 per consultation</td></tr>
</table>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STAND-ALONE BENEFITS	Optical (continue)	Non-Provider Network
	Benefits shall not be granted for contact lenses if the beneficiary has already received a pair of spectacles in a two-year benefit cycle Contact lens re-examination can be claimed for in six-monthly intervals	One consultation limited to a maximum cost of R330 **WITH EITHER SPECTACLES** R580 towards a frame and/or lens enhancement Single-vision lenses limited to R185 per lens **or** Bifocal lenses limited to R420 per lens **or** Multifocal lenses limited to R420 per lens **OR CONTACT LENSES** Contact lenses to the value of R400 Contact lens re-examination to maximum cost of R245 per consultation

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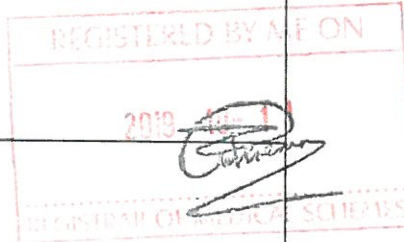
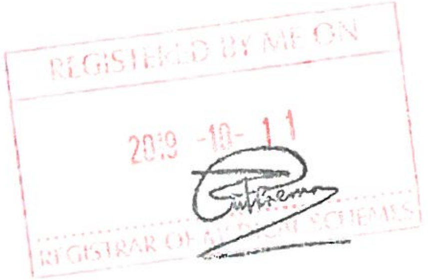
AQUARIUM BENEFIT SCHEDULE		
STAND-ALONE BENEFITS	**Radiology (basic)** i.e. black and white X-rays and soft tissue ultrasounds	100% of agreed tariff or at cost for PMBs Limited to R5 232 per family Includes any basic radiology done in or out of hospital Claims for PMBs first accrue towards the limit
	Radiology (specialised) Pre-authorisation required	100% of agreed tariff **or** At cost for PMBs Includes any specialised radiology service done in/out of hospital Claims for PMBs first accrue towards the limit
	One (1) MRI scan	Subject to a limit of 1/one scan per family per annum, except for PMBs
	Two (2) CT scans	Subject to a limit of 2/two scans per family per annum, except for PMBs



ANNEXURE B2

CO-PAYMENTS 2020

OUT OF NETWORK	CO-PAYMENT
General practitioner (GP)	Allows for two out-of-network consultations per beneficiary, any additional consultations are funded at non-network rate
Hospital	R15 000
Pharmacy	20% of costs when using a non-designated service provider pharmacy 20% co-payment when voluntarily using a non-formulary product
Chronic Renal Dialysis	POLMED has established a Preferred Provider Network for renal dialysis. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply). Pre authorization is required for all dialysis services



ANNEXURE B3

***ANNUAL MEMBER CONTRIBUTION INCREASES ARE EFFECTIVE 1 APRIL**

CONTRIBUTIONS FROM 1 APRIL 2019 UNTIL 31 MARCH 2020

1 April 2019 - 31 March 2020 (subsidised contribution)

Aquarium	Member	Adult	Child
R0 - R6 618	R 76	R 76	R 33
R6 619 - R9 091	R 83	R 83	R 33
R9 092 - R11 107	R 110	R 110	R 43
R11 108 - R12 991	R 136	R 136	R 50
R12 992 - R15 118	R 161	R 161	R 58
R15 119 - R18 182	R 185	R 185	R 66
R18 183 - R22 315	R 230	R 230	R 76
R22 316 +	R 269	R 269	R 102

1 April 2019 - 31 March 2020 (excluding employer subsidy)

Aquarium	Member	Adult	Child
R0 - R6 618	R 1,031	R 1,031	R 511
R6 619 - R9 091	R 1,039	R 1,039	R 511
R9 092 - R11 107	R 1,065	R 1,065	R 520
R11 108 - R12 991	R 1,091	R 1,091	R 528
R12 992 - R15 118	R 1,117	R 1,117	R 535
R15 119 - R18 182	R 1,140	R 1,140	R 544
R18 183 - R22 315	R 1,185	R 1,185	R 553
R22 316 +	R 1,225	R 1,225	R 579

CONTRIBUTIONS FROM 1 APRIL 2020 UNTIL 31 MARCH 2021

1 April 2020 - 31 March 2021 (subsidised contribution)

Aquarium	Member	Adult	Child
R0 - R6 618	R 84	R 84	R 36
R6 619 - R9 091	R 91	R 91	R 36
R9 092 - R11 107	R 121	R 121	R 47
R11 108 - R12 991	R 150	R 150	R 55
R12 992 - R15 118	R 177	R 177	R 64
R15 119 - R18 182	R 204	R 204	R 73
R18 183 - R22 315	R 253	R 253	R 84
R22 316 - R26 172	R 296	R 296	R 112
R26173+	R 301	R 301	R 114

1 April 2020 - 31 March 2021 (excluding employer subsidy)

Aquarium	Member	Adult	Child
R0 - R6 618	R 1 105	R 1 105	R 547
R6 619 - R9 091	R 1 113	R 1 113	R 547
R9 092 - R11 107	R 1 142	R 1 142	R 557
R11 108 - R12 991	R 1 171	R 1 171	R 566
R12 992 - R15 118	R 1 199	R 1 199	R 574
R15 119 - R18 182	R 1 225	R 1 225	R 584
R18 183 - R22 315	R 1 274	R 1 274	R 594
R22 316 - R26 172	R 1 318	R 1 318	R 622
R26173+	R 1 323	R 1 323	R 624

ANNEXURE B4

AQUARIUM: CHRONIC LIST 2020

PRESCRIBED MINIMUM BENEFITS (PMBS); INCLUDING CHRONIC DIAGNOSIS AND TREATMENT PAIRS (DTPS)

Auto-immune disorder

Systemic lupus erythematosus (SLE)

Cardiovascular conditions

Cardiac dysrhythmias

Coronary artery disease

Cardiomyopathy

Heart failure

Hypertension

Peripheral arterial disease

Thrombo embolic disease

Valvular disease

Endocrine conditions

Addison's disease

Diabetes mellitus type I

Diabetes mellitus type II

Diabetes insipidus

Hypo- and hyper-thyroidism

Cushing's disease

Hyperprolactinaemia

Polycystic ovaries

Primary hypogonadism

Gastrointestinal conditions

Crohn's disease

Ulcerative colitis

Peptic ulcer disease (requires special motivation)

Gynaecological conditions

Endometriosis

Menopausal treatment

Haematological conditions

Haemophilia

Anaemia

Idiopathic thrombocytopenic purpura

Megaloblastic anaemia

Metabolic condition

Hyperlipidaemia

Musculoskeletal condition

Rheumatic arthritis

Neurological conditions

Epilepsy

Multiple sclerosis

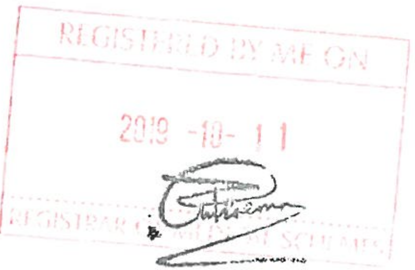
Parkinson's disease

Cerebrovascular incident

Permanent spinal cord injuries

Ophthalmic condition

Glaucoma



Pulmonary diseases

Asthma

Chronic obstructive pulmonary disease (COPD)

Bronchiectasis

Cystic fibrosis

Psychiatric conditions

Affective disorders (depression and bipolar mood disorder)

Post-traumatic stress disorder (PTSD)

Schizophrenic disorders

Special category conditions

HIV/AIDS

Tuberculosis

Organ transplantation

Treatable cancers

As per PMB guidelines

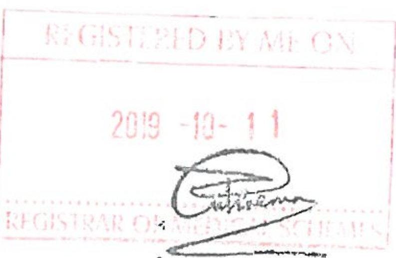
Urological conditions

Chronic renal failure

Benign prostatic hypertrophy

Nephrotic syndrome and glomerulonephritis

Renal calculi



ANNEXURE C

PRESCRIBED MINIMUM BENEFITS (PMBs) 2020

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

GENERAL EXCLUSIONS

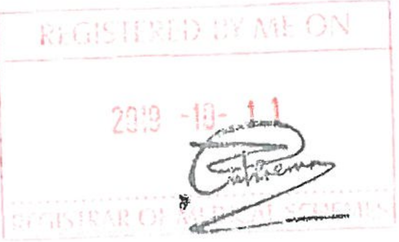
The following services/items are excluded from benefits with due regard to PMBs and will not be paid by the Scheme:

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

2. Sleep therapy;

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

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



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

6. Prenatal and/or post-natal exercises;

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

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

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

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

11. Fixed orthodontics for beneficiaries above the age of 21 years;

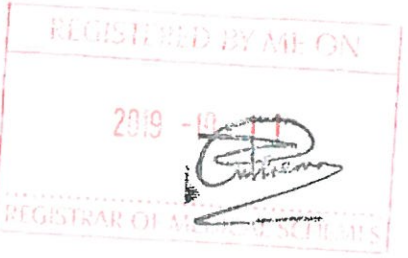
12. Any orthopaedic and medical aids that are not clinically essential, subject to PMBs;

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

14. Sex change operations;

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

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



17. Accommodation in spas, health or rest resorts;

18. Holidays for recuperative purposes;

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

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

21. Any treatment as a result of surrogate pregnancy;

22. Blood pressure appliances;

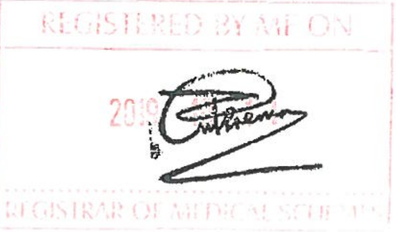
23. Non-functional prostheses used for reconstructive or restorative surgery, excluding PMB diagnoses, provided that the Board may decide to grant the benefit in exceptional circumstances;

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

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

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

27. Any health benefit not included in the list of prescribed benefits (including newly-developed interventions or technologies where the long-term safety and cost to benefit cannot be supported) shall be deemed to be excluded from the benefits;



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

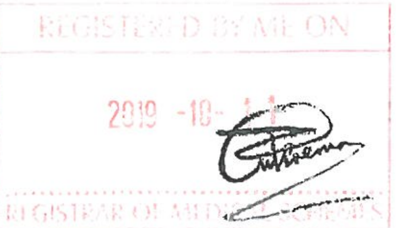
29. Benefits for organ transplant donors to recipients who are not members of the Scheme;

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

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

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

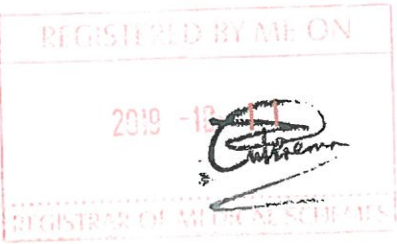
33. All benefits for Clinical trials.



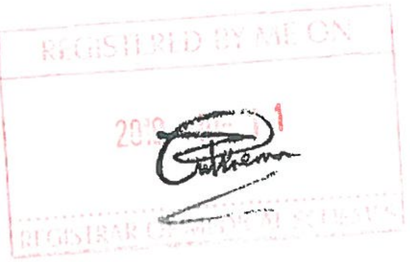
ACUTE MEDICINE EXCLUSIONS

THE FOLLOWING CATEGORIES OF MEDICATION TO BE EXCLUDED FROM ACUTE BENEFITS: SUBJECT TO PMBs

Category	Description	Example
1.03	Gender/sex related: Treatment of female infertility	Clomid®,Profasi®, Cyclogest®
1.05	Gender/sex related: Androgens and anabolic steroids	Sustanon®
2.00	Slimming preparations:	Thinz®, Obex LA®
4.01	Patent medication: Household remedies	Lennons
4.02	Patent medication: Patent and products with no robust scientific evidence to support cost-effectiveness	Choats
4.03	Patent medication: Emollients	Aqueous cream
4.04	Patent medication: Food/nutrition	Infasoy, Ensure
4.05	Patent medication: Soaps and cleansers	Brasivol®, Phisoac®
4.06	Patent medication: Cosmetics	Classique
4.07	Patent medication: Contact lens preparations	Bausch + Lomb®



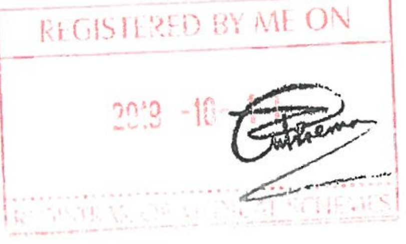
Category	Description	Example
4.08	Patent medication: Patent sunscreens	Piz Buin
4.10	Patent medication: Medicated shampoo	Denorex®, Niz shampoo
4.11	Patent medication: Veterinary products	
5.04	Appliances, supplies and devices: Medical appliances or devices	Thermometers, hearing aid batteries
5.06	Appliances, supplies and devices: Bandages and dressings	Cotton wool, gauze
5.07	Appliances, supplies and devices: Disposable cholesterol supplies	
5.11	Appliances, supplies and devices: Incontinence products	Nappies, molipants, linen savers except Stoma-related supplies
6.00	Diagnostic agents	Clear View pregnancy tests
8.05	Vaccines or immunoglobulins: Other immunoglobulins	Beriglobin®
9.02	Vitamin and/or mineral supplements: Multivitamins or minerals	Pharmaton SA®
9.03	Vitamin and/or mineral supplements: Geriatric vitamins and/or minerals	Gericomplex®
9.05	Vitamin and/or mineral supplements: Tonics and stimulants	Bioplus®



Category	Description	Example
9.08	Vitamin and/or mineral supplements: Magnesium diet supplementation	Magnesit®
9.10	Vitamin and/or mineral supplements: Unregistered vitamins, mineral or food supplements	Sportron
10.01	Naturo- and homeopathic remedies/supplements: Homeopathic remedies	Weleda Natura
10.02	Naturo- and homeopathic remedies/supplements: Natural oils	Primrose oils, fish liver oil
12.00	Veterinary products	
13.00	Growth hormones	Genotropin®
14.00	Medicines where cost/benefit ratio cannot be justified	Xigris®, Zyvoxid ® Herceptin, Gleevac®,
20.00	All newly registered medication*	

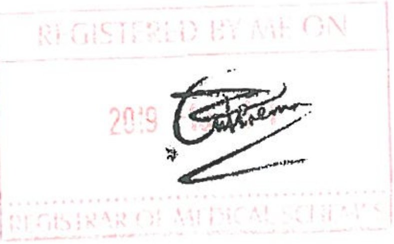
Other items and categories that can be excluded according to evidence-based medicine principles as approved by the Scheme from time to time.

* Unless they are proven to be cost-effective and affordable and also offer therapeutic role in clinical medicine



THE FOLLOWING CATEGORIES ARE NOT AVAILABLE ON ACUTE BENEFITS:

Category	Description	Example
1.06	Gender or sex related: Treatment of impotence or sexual dysfunction	Viagra®, Cialis®, Caverject®
5.03	Appliances, supplies and devices: Stoma products and accessories, except where it forms part of PMB-related services	Stoma bags, adhesive paste, pouches and accessories
5.08	Appliances, supplies and devices: Medicated dressings, except where these forms part of PMB-related services	Opsite®, Intrasite®, Tielle®, Granugel®
5.10	Appliances, supplies and devices: Surgical appliances/products for home nursing	Catheters, urine bags, butterflies, dripsets, alcohol swabs
7.01	Treatment/prevention of substance abuse: Opoied	Revia®
7.03	Treatment/prevention of substance abuse: Alcohol, except PMBs	Antabuse®, Sobrial®, Esperal implants
22.00	Immunosuppressives: Except PMBs	Azapress®, Sandimmun
23.01	Blood products: Erythropoietin, except PMBs	Eprex®, Repotin®
23.02	Blood products: Haemostatics, except PMBs	Konakion®, Factor VIII
25.01	Oxygen: Masks, regulators and oxygen	Oxygen, masks



ANNEXURE D 2020

The following procedures will be funded from the hospital benefit if done in a doctor's rooms or day clinics. Pre authorization is required. If these are done in facilities other than specified above the member may be liable for a R2 000 co-payment, except in the following cases:

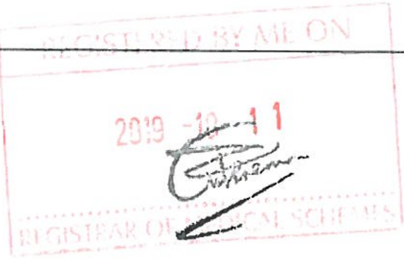
a) Medical emergency

b) Doctor does not have the necessary equipment to perform the procedure

c) No Day Clinics nearby

d) Case is clinically complex as per Polmed protocols

	PROCEDURE DESCRIPTION
	Addenoidectomy
	Ascitis or pleural tapping
	Athrocentesis
	Arthroscopy
	Arthrotomy Finger /hand/elbow/knee/toe/hip
	Aspiration/intra-articular injection of joints
	Anoscopies
	Arthrodesis of Hand/elbow/foot
	Aspiration/Injection
	Bartholin's gland darainage/excision/marsupulisation
	Biopsy of lymph node, muscle, skin, bone, breast, cervix
	Bleeding control (Nasal)
	Bronchial Lavage
	Cast application/removal



	PROCEDURE DESCRIPTION
	Cataract surgery
	Cauterisation cervix/Lazer ablation
	Circumcision
	Colonoscopy
	Continuous nerve block infusion - sciatic nerve/femoral nerve/lumbar plexus
	Cystoscopy for diagnosis/ dilatation/stent/stone removal
	Debride nails 6 or more any method
	Debride skin/subcutaneous tissue
	Dilatation and curettage (excluding aftercare)
	Diathermy to nose and pharynx under local aneasthesia
	Drainage abscess skin/carbuncle/whitlow/cyst/hematoma/gland
	Drainage subcutaneous abscess
	Drainage of sub mucous abscess
	Endoscopy
	Excision benign lesion scalp/neck/hand/feet
	Excision benign lesion trunk/limbs
	Excision ganglion/cyst/tumour
	Excision of Meibomian cyst
	Excision sweat gland axilla/inguinal simple repair
	Fine needle aspiration cytology
	Fine needle aspiration for soft tissue- all areas including breast
	Flexible nasopharyngeal-laryngoscope examination
	Gastroscopy/esophagogastroduodenoscopy

REGISTERED BY ML ON
2019 -10-
REGISTRAR OF MEDICAL COURTS

	PROCEDURE DESCRIPTION
	Incision and drainage abscess/hematoma(anal/vaginal)
	Inject nerve block
	Inject tendon/ligament/trigger points/ganglion cyst
	Inject therapeutic Carpal tunnel e.g. local corticosteroids
	Intrapleural block
	Laparoscopy diagnostic abdomen/peritoneum/omentum
	Ludwigs angina-drainage
	Myringotomy aspiration incision
	Opening of quinsy at rooms
	Proctoscopy with removal of polyps
	Proof puncture at rooms unilateral/bilateral
	Radical Nail bed removal
	Removal of Foreign body
	Repair layer wound scalp/axillae/trunk/limbs
	Repair wound lesion scalp/hands/neck/feet
	Tonsillectomy - Adenoidectomy <12YEARS
	Treatment by Chemo- Cryotherapy additional lesions
	Vasectomy uni/bilateral

ANNEXURE E

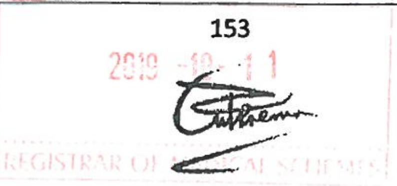
PREVENTATIVE HEALTHCARE BENEFIT 2020

This benefit allows for risk assessment tests to ensure the early detection of conditions that may be completely cured or successfully managed if treated early.

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

MEASURE AND ICD-10 CODES	CARE, SCREENING, TEST
FULL MEDICAL EXAMINATION	
One wellness measure per year (tariff code 5550) inclusive of: • **Blood pressure test** • **Body mass index (BMI) test** • **Cholesterol screening (Z13.8)** • **Consultation** • **Glucose screening (Z13.1)** • **Healthy diet counselling (Z71.3)** • **Lipid disorder screening for age > 40 years** • **Occult blood test (screening for peptic ulcer disease)** • **Risk assessment tests:** o **Baby immunisations (as per the DOH guidelines)** o **Bone densitometry scan** o **Circumcision** o **Contraceptives (as per the DOH guidelines)** o **Dental screening (codes 8101, 8151 and 8102)** o **Flu vaccine** o **Glaucoma screening** o **HIV tests** o **HPV screening once every five years for females aged 21 years and older** o **HPV vaccine for girls aged 10-17 years** o **Mammogram** o **Pap smear** o **Pneumococcal vaccine** o **Prostate screening** o **Psycho-social services** • **Waist-to-hip ratio measurement** **Clinical information to be submitted to managed healthcare**	Annually 100% of POLMED rate or agreed tariff where applicable Early detection screening limited to periods specified Possible indication of peptic ulcers: Members over the age of 50 years Funded from the risk pool; the benefit shall not accrue to the overall out-of-hospital limit REGISTERED BY ME ON 2019 REGISTRAR OF MEDICAL SCHEMES
CHILD HEALTH	
All child immunisation provided by the Department of Health (DOH) for children twelve (12) years old and younger	As per DOH age schedule as per the Road to Health chart

FEMALE HEALTH (women and adolescent girls)	
Cervical cancer screening ICD: Z12.4 For all females aged **21-64** years old, except for those women who have had a complete hysterectomy with no residual cervix	PAP smear test once every third year
Human papilloma virus (HPV) vaccination for girls aged 10-17 years	Total of two HPV vaccinations are funded
HPV screening	Once every five years to females aged 21 years and older
Breast cancer screening ICD: Z12.3 and ICD: Z01.6 Mammogram: all women aged 40-69 years old	Once every two years, unless motivated
Contraceptives ICD: Z30	As recommended by NDOH
DENTAL HEALTH	
Consultation and topical fluoride application for children aged 0-6 years	Annually
Topical fluoride application for children aged 7-18 years	Annually
Caries risk assessment for children aged 0-14 years (Clinical information to be submitted to managed care)	Once every second year
Periodontal disease and caries risk assessment for adults 19 years of age and older (Clinical information to be submitted to managed care)	Once every second year
HIV COUNSELLING AND TESTING	
HIV counselling and pre-counselling	Annually
HCT consultation, rapid testing and post counselling	Annually
HIV Testing Elisa: 3932 Confirmation test: Western Blot (payable after HCT or ELISA tests)	Annually
OTHER	
Flu vaccine	Annually
Hib titer for 60 years and older (Serology: IgM: specific antibody titer)	Annually
Prostate cancer screening For all males aged between 50 and 75 years	Annually
Glaucoma screening	Once every third year, unless motivated



Circumcision	Subject to clinical protocols
Post-trauma debriefing session Only for active principal members of SAPS, utilising the Psycho-Social Network	Four individual sessions or four group debriefing sessions per year

Disclaimer: POLMED has outlined the services that are covered under the 'preventative care benefit'. Best clinical practice dictates that the doctor should follow the best clinical management as per guidelines even when they are not specified under this benefit.