ANNEXURE A1

MARINE SCHEDULE

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2024

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

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

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

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

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

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

DEFINITION OF TERMS

BASIC DENTISTRY

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

Other procedures that fall under this category are:
- Consultations
- Fluoride treatment
- Non-surgical removal of teeth
- Cleaning of teeth, including non-surgical management of gum disease
- Root canal treatment

CO-PAYMENT

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

ENROLMENT ON THE DISEASE RISK MANAGEMENT PROGRAMME

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

FORMULARY

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

MEDICINE GENERIC REFERENCE PRICE

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

REGISTRATION FOR CHRONIC MEDICATION

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

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 treatment, crowns and bridges, inlays, indirect veneers, orthodontic treatment, partial chrome cobalt frame dentures and maxillofacial surgery. All specialised dentistry services and procedures must be pre-authorised, failing which the Scheme will impose a co-payment of R500. Only removal of impacted teeth and extensive dental treatment for children younger than 7 years will be considered for in-hospital treatment. Authorisation is subject to clinical criteria.

GENERAL RULES

APPLICATION OF CLINICAL PROTOCOLS AND FUNDING GUIDELINES

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

DENTAL PROCEDURES

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

NETWORK SERVICE PROVIDER: OUT-OF-NETWORK RULE

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

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

- In a medical emergency when the patient does not have a choice to choose the doctor or network facility.

- When the required service cannot be provided by a network dr or facility.
- When a network provider is not available within a 50km radius from the member's residence.

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

Examples of network service providers (where applicable) are:

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

POLMED GP NETWORK (NETWORK GP PROVIDER)

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

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

POLMED HOSPITAL NETWORK

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

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

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

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

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

Medicine prescribed during hospitalisation forms part of the hospital benefits.

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

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

POLMED PHARMACY NETWORK

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

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

EMERGENCY MEDICAL SERVICES (EMS): ER24

72-Hour Post-Authorisation Rule

Subject to authorisation within 72 hours of the event, all service providers will need to get an authorisation number from POLMED's Network Service Provider ER24.

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

DENTAL NETWORK

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

AUDIOLOGY NETWORK

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

EX GRATIA BENEFIT

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

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

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

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

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

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

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

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

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

Flu vaccines, COVID-19 vaccines, and vaccines for children under six years of age are obtainable without prescription and paid from the Preventive Care benefits.

PRO RATA BENEFITS

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

SPECIALISED RADIOLOGY (MRI AND CT SCANS)

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

SPECIALIST REFERRAL

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

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

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

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

CONSERVATIVE BACK AND NECK REHABILITATIVE PROGRAM

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

WELLNESS, PREVENTATIVE CARE AND MANAGED CARE PROGRAM

POLMED has introduced a wide-ranging wellness, preventative care and managed care program which has been specifically shaped to motivate healthy living and or behavior change to improve member lifestyle. The program uses strategic nudges to encourage members to improve their personal health. For more information, you can visit www.polmed.co.za.

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 network service provider or general practitioner (GP), adherence to established protocols or enrolment upon a managed care programme, members' attention is drawn to the fact that there may be no benefit at all or a much-reduced benefit if the pre-authorisation, referral by a network service provider or GP, adherence to established protocols or enrolment upon a managed care programme is not complied with (a co-payment may be applied) The pre-authorisation, referral by a network service provider or GP, adherence to established protocols or enrolment upon a managed care programme is stipulated to best care for the member and his/her family and to protect the funds of the Scheme
	Limits are per annum	Unless there is a specific indication to the contrary, all benefit amounts and limits are annual
	Statutory prescribed minimum benefits (PMBs)	There is no overall annual limit for PMBs or life-threatening emergencies
	Tariff	100% of POLMED rate or agreed tariff or at cost for involuntary access to PMBs

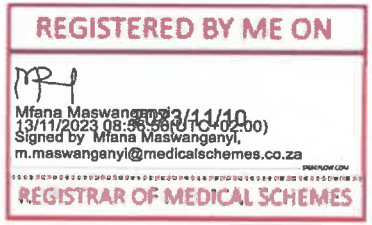
MARINE BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Annual overall in-hospital limit** Subject to the Scheme's relevant managed healthcare programmes and includes the application of treatment protocols, case management and pre-authorisation A R5 000 penalty may be imposed if no pre-authorisation is obtained An open network applies Scheme rates are applicable	Unlimited at network service providers Subject to PMBs, i.e. no limit in case of life-threatening emergencies or for PMB conditions Subject to applicable tariff, i.e. 100% of POLMED rate **or** Agreed tariff **or** At cost for involuntary access to PMBs
	Allied health services and alternative healthcare providers Chiropodists/Podiatrists Dieticians Physiotherapists Occupational therapist Social worker	Service will be linked to hospital pre-authorisation. A referral by the treating Healthcare professional is required for services rendered by all allied and auxiliary service providers. This excludes care provided in following facilities: • Rehabilitation • Sub-acute

MARINE BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	Counsellor/ Psychologist Audiologist Speech Therapist Biokineticist	• Mental health • Step downs • Alcohol and rehabilitation Social workers and registered counsellors Limit number of 4 consultations in a benefit cycle.
	Anaesthetists	150% of POLMED rate
	Chronic Renal Dialysis **At Preferred Providers**	100% of agreed tariff at network service provider POLMED has established a Preferred Provider Network for renal dialysis. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply). Pre-authorisation is required for all dialysis services.
	Dentistry (conservative and restorative)	100% of POLMED rate Dentist's costs for basic dental procedures will be reimbursed from the out-of-hospital (OOH) benefit, subject to:

MARINE BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Dentistry (conservative and restorative)** REGISTERED BY ME ON Mfana Maswanganyi 2023/11/10 13/11/2023 08:47:32(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES Surgical removal of impacted teeth and children under the age of 7 years requiring extensive dental treatment	M0 – R5 755 M1 – R6 618 M2 – R7 481 M3 – R8 344 M4+ - R9 208 The hospital and anaesthetist's costs will be reimbursed from the in-hospital benefit. Pre-authorisation required if hospitalised or use of moderate or deep sedation in the rooms
	Emergency medical services (ambulance services)	Subject to POLMED Scheme rules
	General practitioners (GPs)	100% of agreed tariff at network service provider 100% of POLMED rate at non-network service provider **or** At cost for involuntary access to PMBs
	Medication (non-PMB specialist drug limit, e.g. biologicals)	100% of POLMED rate Pre-authorisation required Specialised medication sub-limit of R204 181 per family

MARINE BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Mental health** REGISTERED BY ME ON Mfana Maswanganyi 2023/11/10 13/11/2023 08:43:15(UTC+02:00) Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za REGISTRAR OF MEDICAL SCHEMES	100% of POLMED rate **or** At cost for PMBs Annual limit of 21 days per beneficiary in-hospital or 15-out-of-hospital psychotherapy sessions threshold in line with PMB benefits. Outside of threshold subject to Managed Care protocols Limited to a maximum of three days' hospitalisation for beneficiaries admitted by a GP or a specialist physician Additional hospitalisation to be motivated by the medical practitioner
	Oncology (chemotherapy and radiotherapy) Network service provider	100% of agreed tariff at network service provider Limited to R535 000 per beneficiary per annum; includes MRI/CT or PET scans related to oncology. Limited to the overall oncology benefit per beneficiary: Oncology Specialised drugs (in and out of hospital) – R264 852

IN-HOSPITAL BENEFITS		Chemotherapy and Radiation limited to Oncology benefits. Oncology specialised drugs subject to sublimit. Adherence to the Oncology Formulary and subject to medicines from the Preferred Provider Network
	Organ and tissue transplants	100% of agreed tariff at network service provider **or** At cost for PMBs Subject to clinical guidelines used in State facilities Unlimited radiology and pathology for organ transplant and immunosuppressant's
	Pathology	Service will be linked to hospital pre-authorisation
	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 R75 180 per beneficiary Knee Joint Prosthesis – R62 842 Below Knee Prosthesis – R62 842

MARINE BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS		Hip Joint Prosthesis – R62 842 Above Knee Prosthesis – R62 842 Shoulder Joint Prosthesis – R74 927 Intraocular Lens – R3 625 Aorta & Peripheral Arterial Stent Grafts – R54 382 Cardiac Stents – R30 816 Cardiac Pacemaker – R67 675 Spinal plates and screws – R75 180 Spinal Implantable Devices – R69 057 Unlisted items – R75 180
	Radiographers	A referral by the treating Healthcare Professional is required for services rendered
	Refractive surgery	100% of POLMED rate Subject to pre-authorisation Procedure is performed out of hospital and in day clinics
	Specialists	100% of agreed tariff at network service provider 100% of POLMED rate at non-network service provider **or** At cost for involuntary access to PMBs

OVERALL OUT-OF-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 – R22 673 M1 – R27 592 M2 – R33 247 M3 – R38 126 M4+ – R41 375

MARINE BENEFIT SCHEDULE		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Audiology**	100% of POLMED rate Subject to the OOH limit Managed care protocols and hearing aid formulary apply. The products that are not included in the POLMED formulary will attract a 20% co-payment. **Subject to referral by the following doctors/specialists:** General Practitioner (GP) Ear, nose and throat (ENT) specialist Paediatrician Physician Neurologist Neurosurgeon

MARINE BENEFIT SCHEDULE		
OVERALL 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 755 M1 – R6 618 M2 – R7 481 M3 – R8 344 M4+ - R9 208 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		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Nominated network General practitioners (GPs)** POLMED has a GP network	100% of agreed tariff at network service provider **or** at cost for involuntary PMB access The limit for consultations shall accrue towards the OOH limit. Members and dependants are each allowed 2/two visits to a GP who is not nominated per annum for emergency or out-of-town situations. Subject to maximum number of visits or consultations per family M0 – 11 M1 – 16 M2 – 20 M3 – 24 M4+ – 29
	Medication (acute)	100% of POLMED rate at network service provider M0 – R5 292 M1 – R8 997 M2 – R12 700 M3 – R16 405 M4+ – R20 135 Subject to the OOH limit Subject to POLMED formulary

MARINE BENEFIT SCHEDULE		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Medication (over the Counter - OTC)**	100% of POLMED rate at network service provider Annual limit of R1 393 per family Subject to the OOH limit Subject to POLMED formulary
	Occupational and speech therapy	100% of POLMED rate Annual limit of R3 217 per family Subject to OOH limit
	Pathology	M0 – R3 869 M1 – R5 579 M2 – R6 671 M3 – R8 216 M4+ – R10 074 The defined limit per family will apply for any pathology service done out of hospital

MARINE BENEFIT SCHEDULE		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Physiotherapy**	100% of POLMED rate Annual limit of R5 578 per family Subject to the OOH limit
	Psychology plus Social Worker Including Marriage counselling	100% of POLMED rate Annual limit of R7 481 per family Subject to the OOH limit
	Specialists Referral is not necessary for the following specialists: Gynaecologists Psychiatrists Oncologists Ophthalmologists Nephrologists (dialysis) Dental specialists Supplementary or allied health services	100% of agreed tariff at network service provider **or** at cost for involuntary access to PMBs The limit for consultations shall accrue towards the OOH limit Limited to 5/five visits per beneficiary **or** 11/eleven visits per family per annum Subject to referral by a GP (2/two specialist visits per beneficiary without GP referral allowed) R1 000 co-payment if no referral is obtained

MARINE BENEFIT SCHEDULE		
STAND-ALONE BENEFITS	**Allied health services and alternative healthcare providers** Art Therapists — 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 R3 147 per family

STAND-ALONE BENEFITS

Appliances (medical and surgical)

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

Hearing aid formulary applies. The products that are not included in the POLMED formulary will attract a 20% copayment

Pre-authorisation is required for the listed Medical appliances

All costs for maintenance are a Scheme exclusion

Funding will be based on applicable clinical and funding protocols

Quotations will be required

100% of POLMED rate

Hearing aids	R16 279 per hearing aid ***OR*** R32 356 per beneficiary per set Once every 3/three years
Nebuliser	R1 544 per family Once every 4/four years
Glucometer	R1 544 per family Once every 4/four years
CPAP machine	R10 867 per family Once every 4/four years
Wheelchair (non-motorised) **OR** Wheelchair (motorised)	R18 084 per beneficiary Once every 3/three years R60 786 per beneficiary Every 3/three years
Medical assistive devices	Annual limit of R7 883 per family Includes medical devices in/out of hospital

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 Cochlear Implants – Unilateral Subject to clinical and funding protocols Cochlear Implants – Bilateral Subject to clinical and funding protocols Cochlear Implants - Maintenance or replacement of processors Subject to clinical and funding protocols	R241 730 per beneficiary per lifetime R472 950 per beneficiary per lifetime R143 462 per beneficiary every 5 years

STAND-ALONE BENEFITS		Trans Aorta Valve Insertion	R305 001 per family per year
		Implantable Cardiac Defibrillators	R218 681 per family per year
		Insulin delivery devices • Insulin Pumps Device (Limited to Type 1 diabetic members)	R78 300 per beneficiary. One device every 5/five years
		• Insulin Pumps Consumables	R39 300 per beneficiary per year
		• Continuous Glucose Monitoring (CGM) Device	R29 470 per beneficiary. One device every 5/five years
		• Continuous Glucose Monitoring (CGM) Consumables	R38 805 per beneficiary per year
		Urine Catheters and consumables	Subject to three quotations and clinical protocols
		Blood transfusion	Unlimited

STAND-ALONE BENEFITS		Adult nappies	R1 142/month (2/two nappies per day) R1 716/month (3/three nappies per day)
		Blood pressure monitoring device • Subject to registration with chronic hypertension • Pre-authorisation required	R1 200 per family every 2 years
	Chronic medication refers to non-PMB conditions Subject to prior application and/or registration of the condition Approved PMB-CDL conditions are not subject to a limit The extended list of chronic conditions (non-PMBs) are subject to a limit	100% of medication formulary reference price Subject to access at network service provider M0 – R11 230 M1 – R13 460 M2 – R15 692 M3 – R17 924 M4+ - R20 155	

MARINE BENEFIT SCHEDULE		
STAND-ALONE BENEFITS	**Dentistry (specialised)** Pre-authorisation required	100% of POLMED rate or at cost for PMBs An annual limit of R16 350 per family Benefits shall not exceed the set-out limit Includes any specialised dental procedures done in/out of hospital Includes partial chrome cobalt dentures, orthodontics, crowns and bridge work, periodontics and maxilla-facial surgery Excludes Osseo Integrated implants Subject to dental protocols (crowns and bridges 5-year cycle)
	Maternity benefits (including home birth) Pre-authorisation required Treatment protocols apply	The limit for consultations shall not accrue towards the OOH limit The benefit shall include three specialist consultations per beneficiary per pregnancy Home birth is limited to R20 336 per beneficiary per annum Annual limit of R5 497 for ultrasound scans per beneficiary; limited to 2/two 2D scans per pregnancy Benefits relating to more than 2/two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation. Elective (voluntary) Caesarean Sections will, subject to the PMBs, be considered in line with managed care and funding protocols. A co-payment of R10 000 will apply in all voluntary Caesarean sections (PMBs apply) except in cases where the costs of the voluntary Caesarean section fall below the applicable co–payment amount of R10 000. Pre-authorisation is required.

MARINE BENEFIT SCHEDULE		
STAND-ALONE BENEFITS	**Maxillofacial** Pre-authorisation required	Shared limit with specialised dentistry Excludes Osseo Integrated implants
	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	**Provider Network** 100% of cost for a Composite consultation, inclusive of the refraction, a glaucoma screening and visual field screening and Authenticate IT. Composite consultation fee is R695. **WITH EITHER SPECTACLES** R1 460 towards a frame and/or lens enhancement **LENSES** Either one pair of Clear single vision lenses limited to R215 per lens **or** one pair of Clear flat top bifocal lenses limited to R460 per lens **or** one pair of Clear Base multifocal lenses limited to R810 (Additional Multifocal Designer Group 1 up to R50 per lens) **OR CONTACT LENSES** Contact lenses to the value of R1 710 per beneficiary per annum

STAND-ALONE BENEFITS	Each claim for lenses or frames must be submitted with the lens prescription	Contact lens re-examination to a maximum cost of R255 per consultation
	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 R374 **WITH EITHER SPECTACLES** R1 043 towards a frame and/or lens enhancement Either one pair of clear Single-vision lenses limited to R215 per lens **or** One pair of clear flat top Bifocal lenses limited to R460 per lens **or** One pair of clear base Multifocal lenses limited to R810 (Additional Multifocal Designer Group 1 up to R38 per lens) **OR CONTACT LENSES** Contact lenses to the value of R1 178 per beneficiary per year Contact lens re-examination to maximum cost of R255 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 R7 353 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 A2

CO-PAYMENTS

OUT OF NETWORK	CO-PAYMENT
General practitioner (GP)	Allows for 2/two out-of-network consultations per beneficiary, any additional consultations are funded at non-network rate
Hospital	An open network applies Scheme rates are applicable
Pharmacy	20% of costs for using a non-network service provider pharmacy 20% co-payment for voluntarily using a non-formulary product
Chronic Renal Dialysis	POLMED has established a Preferred Provider Network for renal dialysis. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply). Pre-authorisation is required for all dialysis services
Oncology network service providers	POLMED has established a Network for cancer treatment (chemo and radiation therapy). Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply).

ANNEXURE A3

*ANNUAL MEMBER CONTRIBUTION INCREASES ARE EFFECTIVE 1 APRIL

CONTRIBUTIONS FROM 1 APRIL 2023 UNTIL 31 MARCH 2024

Marine member portion - 1 April 2023 to 31 March 2024

Income band	Principal Member	Adult Dependant	Child Dependant
R0 - R6 916	453	453	113
R6 917 - R9 500	627	627	211
R9 501 - R11 607	692	692	260
R11 608 - R13 576	817	817	326
R13 577 - R15 798	952	952	378
R15 799 - R19 000	1 091	1 091	445
R19 001 - R23 319	1 202	1 202	520
R23 320 - R26 827	1 305	1 305	571
R26 828 - R31 006	1328	1 328	583
R31 007 - R33 393	1 353	1 353	593
R33 394 - R 41 914	1 378	1 378	604
R41 915 - R49 999	1 404	1 404	615
R50 000 +	1 430	1 430	627

Marine full unsubsidised contributions - 1 April 2023 to 31 March 2024

Income band	Principal Member	Adult Dependant	Child Dependant
R0 - R6 916	2 806	2 806	1 291
R6 917 - R9 500	2 980	2 980	1 386
R9 501 - R11 607	3 045	3 045	1 435
R11 608 - R13 576	3 171	3 171	1 502
R13 577 - R15 798	3 306	3 306	1 555
R15 799 - R19 000	3 443	3 443	1 621
R19 001 - R23 319	3 554	3 554	1 696
R23 320 - R26 827	3 658	3 658	1 748
R26 828 - R31 006	3 681	3 681	1 759
R31 007 - R33 393	3 706	3 706	1 769
R33 394 - R 41 914	3 732	3 732	1 780
R41 915 - R49 999	3 757	3 757	1 791
R50 000 +	3 783	3 783	1 803

CONTRIBUTIONS FROM 1 APRIL 2024 UNTIL 31 MARCH 2025

Marine member portion - 1 April 2024 to 31 March 2025

Income band	Principal Member	Adult Dependant	Child Dependant
R0- R7 366	474	474	113
R7 367- R10 118	656	656	221
R10 119- R12 361	725	725	272
R12 362- R14 458	855	855	341
R14 459- R16 825	997	997	393
R16 826- R20 235	1 142	1 142	466
R20 236- R24 835	1 258	1 258	544
R24 836- R28 571	1 366	1 366	598
R28 572- R33 021	1 390	1 390	610
R33 022- R35 564	1 417	1 417	621
R35 565- R44 638	1 443	1 443	632
R44 639- R53 249	1 470	1 470	644
R53 250 +	1 497	1 497	655

Marine full unsubsidised contributions - 1 April 2024 to 31 March 2025

Income band	Principal Member	Adult Dependant	Child Dependant
R0- R7 366	2 938	2 938	1 352
R7 367- R10 118	3 120	3 120	1 451
R10 119- R12 361	3 188	3 188	1 502
R12 362- R14 458	3 320	3 320	1 573
R14 459- R16 825	3 461	3 461	1 639
R16 826- R20 235	3 605	3 605	1 697
R20 236- R24 835	3 721	3 721	1 776
R24 836- R28 571	3 830	3 830	1 830
R28 572- R33 021	3 854	3 854	1 842
R33 022- R35 564	3 880	3 880	1 852
R35 565- R44 638	3 907	3 907	1 864
R44 639- R53 249	3 934	3 934	1 875
R53 250 +	3 961	3 961	1 889

ANNEXURE A4

MARINE: CHRONIC CONDITIONS

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

Chronic medication is payable from chronic medication benefits

Once the benefit limit has been reached, PMB related drugs 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 2024

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

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

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

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

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

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

DEFINITION OF TERMS

BASIC DENTISTRY

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

Other procedures that fall under this category are:

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

CO-PAYMENT

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

ENROLMENT ON THE DISEASE RISK MANAGEMENT PROGRAMME

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

The claims data for chronic medication, consultations and hospital admissions is used to identify the members that are eligible for enrolment on the programme.

FORMULARY

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

MEDICINE GENERIC REFERENCE PRICE

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

REGISTRATION FOR CHRONIC MEDICATION

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

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 treatment, crowns and bridges, inlays, indirect veneers, orthodontics, partial chrome cobalt frame dentures and maxillofacial surgery. Aquarium only makes provision for specialised dental treatment for PMB events and predefined codes as set out in the dental benefit table. All specialised dentistry services and procedures must be pre-authorised, failing which the Scheme will impose a co-payment of R500. Only removal of impacted teeth and extensive dental treatment for children younger than 7 years will be considered for in-hospital treatment. Authorisation is subject to clinical criteria.

GENERAL RULES

APPLICATION OF CLINICAL PROTOCOLS AND FUNDING GUIDELINES

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

DENTAL PROCEDURES

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

NETWORK SERVICE PROVIDER: OUT-OF-NETWORK RULE

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

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

- In a medical emergency when the patient does not have a choice to choose the doctor or network facility.

- When the required service cannot be provided by a network dr or facility.
- When a network provider is not available within a 50km radius from the member's residence

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

Examples of network service providers (where applicable) are:

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

POLMED GP NETWORK (NETWORK GP PROVIDER)

Members and dependants are required to nominate a primary network GP. Principal members are required to nominate a secondary network GP as well. Members and dependants are each allowed 2/two visits to a GP who is not nominated per annum for emergency or out-of-town situations. A 30% co-payment shall apply once the maximum out-of-non nominated consultations are exceeded.

POLMED rates for network GP provider visits are available on its website and can be accessed at www.polmed.co.za. These rates are reviewed annually.

PMB rule applies for qualifying emergency consultations.

POLMED HOSPITAL NETWORK

The POLMED Hospital network includes hospitals with a national footprint. Members can access the list of hospitals in the network at www.polmed.co.za, via POLMED Chat or request it via the Client Service Call Centre. Failure to make use of a hospital on the POLMED network may incur a co-payment of up to R15 000.

All admissions (hospitals and day clinics) must be pre-authorised.
A penalty of R5 000 may be imposed if no pre-authorisation is obtained.
In case of an emergency, the Scheme must be notified within 48 hours or on the first working day after admission. Pre-authorisation will be managed under the auspices of managed healthcare. The appropriate facility must be used to perform a procedure, based on the clinical requirements, as well as the expertise of the doctor doing the procedure.

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

Medicine prescribed during hospitalisation forms part of the hospital benefits.

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

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

POLMED PHARMACY NETWORK

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

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

EMERGENCY MEDICAL SERVICES (EMS): ER24

72-Hour Post-Authorisation Rule

Subject to authorisation within 72 hours of the event, all service providers will need to get an authorisation number from POLMED's Network Service Provider ER24.

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

DENTAL NETWORK

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

AUDIOLOGY NETWORK

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

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

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

Flu vaccines, COVID-19 vaccines, and vaccines for children under six years of age are obtainable without prescription and paid from the Preventive Care benefits

PRO RATA BENEFITS

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

SPECIALISED RADIOLOGY (MRI AND CT SCANS)

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

SPECIALIST REFERRAL

All POLMED beneficiaries need to be referred to specialists by a nominated network general practitioner (GP). The Scheme will impose a co-payment of up to 30% if the member consults a specialist without being referred. The co-payment will be payable by the member to the specialist and is not refundable by the Scheme.
This co-payment is not applicable to the following specialities or disciplines: Gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists [chronic dialysis], dental specialists, pathology, radiology and supplementary or allied health services.

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

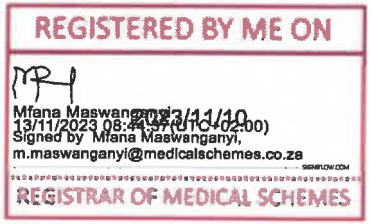
However, the Scheme will not cover the cost of the hearing aid if there is no referral from one of the following providers: GP, ear, nose and throat (ENT) specialist, paediatrician, physician, neurosurgeon or neurologist. The specialist must submit the referring GP's practice number in the claim.

CONSERVATIVE BACK AND NECK REHABILITATIVE PROGRAM

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

WELLNESS, PREVENTATIVE CARE AND MANAGED CARE PROGRAM

POLMED has introduced a wide-ranging wellness, preventative care and managed care program which has been specifically shaped to motivate healthy living and or behavior change to improve member lifestyle. The program uses strategic nudges to encourage members to improve their personal health. For more information, you can visit www.polmed.co.za.

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

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

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 admission in a non-network hospital No co-payment if the procedure is performed in a network hospital and/or a day clinic	Non-PMB admissions will be subject to an overall limit of R205 100 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
	Allied health services and alternative healthcare providers Chiropodists/Podiatrists Dieticians	Service will be linked to hospital pre-authorisation. A referral by the treating Healthcare professional is required for services rendered by all allied and auxiliary service providers.

IN-HOSPITAL BENEFITS	Physiotherapists Occupational therapist Social worker Counsellor/ Psychologist Audiologist Speech Therapist Biokineticist	This excludes care provided in following facilities: • Rehabilitation • Sub-acute • Mental health • Step downs • Alcohol and rehabilitation Social workers and registered counsellors Limit number of 4 consultations in a benefit cycle.
	Anaesthetists	150% of POLMED rate
	Chronic Renal Dialysis **At Preferred Providers**	100% of agreed tariff at network service provider POLMED has established a Preferred Provider Network for renal dialysis. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply). Pre-authorisation is required for all dialysis services
	Dentistry (conservative and restorative)	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 102

AQUARIUM BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Dentistry (conservative and restorative)** Surgical removal of impacted teeth and children under the age of 7 years requiring extensive dental treatment	M1 – R4 615 M2 – R5 128 M3 – R5 640 M4+ - R6 153 The hospital and anaesthetist's costs will be reimbursed from the overall non-PMB limit Pre-authorisation required if hospitalised or use of moderate or deep sedation in the rooms
	Emergency medical services (Ambulance)	Subject to POLMED Scheme rules
	General practitioners (GPs)	100% of agreed tariff at network service provider 100% of POLMED rate at non-network service provider **or** At cost for involuntary PMB access
	Medication (Non-PMB specialist drug limit, e.g. biologicals)	100% of POLMED rate Pre-authorisation required Specialised medication sub-limit of R147 815 per family

AQUARIUM BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Mental health**	100% of POLMED rate **or** At cost for PMBs Annual limit of 21 days per beneficiary in-hospital or 15-out-of-hospital psychotherapy sessions threshold in line with PMB benefits. Outside of threshold subject to Managed Care protocols. Limited to a maximum of three days' hospitalisation for beneficiaries admitted by a GP or a specialist physician Additional hospitalisation to be motivated by the medical practitioner
	Oncology (chemotherapy and radiotherapy) Network service provider	100% of agreed tariff at network service provider Limited to R278 321 per beneficiary per annum; includes MRI/CT or PET scans related to oncology Oncology Specialised drugs – subject to PMB Chemotherapy and Radiation limited to Oncology benefits. Oncology specialised drugs subject to sublimit. Adherence to the Oncology Formulary and subject to medicines from the Preferred Provider Network

AQUARIUM BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS	**Organ and tissue transplants**	100% of agreed tariff at network service provider **or** At cost for PMBs Subject to clinical guidelines used in State facilities Unlimited radiology and pathology for organ transplant and immunosuppressant's
	Pathology	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 R65 767 per beneficiary Knee Joint Prosthesis – R55 992 Below Knee Prosthesis – R55 992 Hip Joint Prosthesis – R55 992 Above Knee Prosthesis – R55 992

AQUARIUM BENEFIT SCHEDULE		
IN-HOSPITAL BENEFITS		Shoulder Joint Prosthesis – R65 767 Intraocular Lens – R3 230 Aorta & Peripheral Arterial Stent Grafts – R48 455 Cardiac Stents – R27 458 Cardiac Pacemaker – R60 299 Spinal plates and screws – R65 767 Spinal Implantable Devices – R61 530 Unlisted items – R65 767
	Radiographers	A referral by the treating Healthcare Professional is required for services rendered
	Refractive surgery	No benefit
	Specialists	100% of agreed tariff at network service provider 100% of POLMED rate for non-network service provider **or** At cost for involuntary PMB access

AQUARIUM BENEFIT SCHEDULE		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Annual overall out-of-hospital (OOH) limit** Benefits shall not exceed the amount set out in the table PMB shall first accrue towards the total benefit, but are not subject to limit In appropriate cases the limit for medical appliances shall not accrue towards this limit Overall out of hospital benefits are subject to: • Protocols and clinical guidelines • PMBs • The applicable tariff i.e. 100% of POLMED rate or agreed tariff or at cost for involuntary PMB access	M0 - R9 037 M1 - R10 949 M2 - R13 300 M3 - R14 189 M4+ - R16 259

AQUARIUM BENEFIT SCHEDULE		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Audiology** Subject to referral by either of the following doctors/specialists: Nominated network General Practitioner (GP) Ear, nose and throat (ENT) specialist Paediatrician Physician Neurologist Neurosurgeon	100% of POLMED rate Subject to the OOH limit Managed care protocols and hearing aid formulary apply. The products that are not included in the POLMED formulary will attract a 20% co-payment.
	Dentistry (conservative and restorative)	100% of POLMED rate Subject to the OOH limit and includes dentist's costs for in-hospital, non-PMB procedures M0 – R4 102 M1 – R4 615 M2 – R5 128 M3 – R5 640 M4+ - R6 153 Routine consultation, scale and polish are limited to two annual check-ups per beneficiary

OVERALL OUT-OF-HOSPITAL BENEFITS		Oral hygiene instructions are limited to once in 12 months per beneficiary Subject to the use of the dental network. Members who voluntarily opt to use a non-network provider, will be liable for a 30% co-payment (PMBs apply)
	Dentistry (specialised) Surgical extractions of teeth requiring removal of bone or incision required to reduce fracture Root planing treatment for periodontal disease Drainage of abscess and clearing infection caused by tooth decay 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

AQUARIUM BENEFIT SCHEDULE		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Nominated network General practitioners (GPs)** POLMED has a GP network	100% of agreed tariff at network service provider **or** at cost for involuntary PMB access The limit for consultations shall accrue towards the OOH limit Subject to the use of a nominated network GP otherwise a 30% co-payment will apply to all non-nominated GP visits. Members and dependants are each allowed 2/two visits to a GP who is not nominated per annum for emergency or out-of-town situations. Subject to maximum numbers of visits **or** consultations per family: M0 - 8 M1 - 12 M2 - 15 M3 - 18 M4+ - 22

AQUARIUM BENEFIT SCHEDULE		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Medication (acute)**	100% of POLMED rate at network service provider M0 – R2 384 M1 – R4 054 M2 – R5 723 M3 – R7 393 M4 – R9 061 Subject to the OOH limit Subject to POLMED formulary
	Medication (over-the-counter - OTC)	100% of POLMED rate at network service provider Annual limit of R1 026 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

AQUARIUM BENEFIT SCHEDULE		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Pathology**	M0 - R3 179 M1 - R4 702 M2 - R5 687 M3 - R7 040 M4+ - R8 721 The defined limit per family will apply for any pathology service done out of hospital
	Physiotherapy	100% of POLMED rate Annual limit of R2 459 per family Subject to the OOH limit
	Psychology plus Social Worker Including Marriage counselling	100% of POLMED rate Annual limit of R5 128 per family Subject to the OOH limit
	Specialists Referral is not necessary for the following specialists: Gynaecologists Psychiatrists Oncologists Ophthalmologists	100% of agreed tariff at network service provider **or** At cost for involuntary access to PMBs The limit for consultations shall accrue towards the OOH limit

AQUARIUM BENEFIT SCHEDULE		
OVERALL OUT-OF-HOSPITAL BENEFITS	Nephrologists (dialysis) Supplementary or allied health services	Limited to 4/four visits per beneficiary and 8/eight visits per family per annum Subject to referral by a nominated network GP (2/two specialist visits per beneficiary without GP referral allowed) A 30% co-payment might be applied subject to the referral rules

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
	Appliances (medical and surgical)	100% of POLMED rate Blood transfusions: Unlimited Hearing aids: R11 607 per hearing aid or R23 068 per beneficiary per set Once every 3/three years

STAND-ALONE BENEFITS

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

Hearing aid formulary applies. The products that are not included in the POLMED formulary will attract a 20% copayment

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

Nebuliser	R1 316 per family Once every 4/four years
Glucometer	R1 316 per family Once very4/ four years
CPAP machine	R9 402 per family Once every 4/four years
Wheelchair (non-motorised) **OR** Wheelchair (motorised)	R12 289 per beneficiary Once every 3/three years R35 246 per beneficiary Once every 3/three years
Urine catheters and consumables	Subject to three quotations and clinical protocols
Medical assistive devices	Annual limit of R5 640 per family Includes medical devices in/out of hospital
Insulin delivery devices • Insulin Pumps Device (Limited to Type 1 diabetic members) • Insulin Pumps Consumables • Continuous Glucose Monitoring (CGM) Device	 R78 300 per beneficiary. One device every 5/five years R39 300 per beneficiary per year R29 470 per beneficiary. One device every 5/five years

STAND-ALONE BENEFITS		• Continuous Glucose Monitoring (CGM) Consumables	R38 805 per beneficiary per year
		Adult nappies	R970/month (2/two nappies per day) R1 455/month (3/three nappies per day)
		Blood pressure monitoring device • Subject to registration with chronic hypertension • Pre-authorisation required	R1 200 per family every 2 years
	Chronic medication refers to non-PMB conditions Subject to prior application and/or registration of the condition Approved PMB-CDL conditions are not subject to a limit	No benefit except for PMBs Subject to the medication reference price and POLMED formulary	
	Maternity benefits (including home birth)	100% of agreed tariff at network service provider **or** 100% of POLMED rate at non-network service provider	

STAND-ALONE BENEFITS	Pre-authorisation required Treatment protocols apply	**or** At cost for involuntary PMB access The limit for consultations shall not accrue towards the OOH limit The benefit shall include 3/three specialist consultations per beneficiary per pregnancy
	Maternity Benefits (continue)	Home birth is limited to R15 524 per beneficiary per annum Annual limit of R4 141 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 fall below the applicable co-payment amount of R10 000. Pre-authorisation is required.

AQUARIUM BENEFIT SCHEDULE

	Optical	Provider Network
STAND-ALONE BENEFITS	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	100% of cost for a Composite consultation, inclusive of the refraction, a glaucoma screening and visual field screening and Authenticate IT. Composite consultation fee is R695. **WITH EITHER SPECTACLES** R835 towards a frame and/or lens enhancement **LENSES** Either one pair of Clear single vision lenses limited to R215 per lens **or** one pair of Clear flat top bifocal lenses limited to R460 per lens **or** one pair of Clear Base multi-focal lenses limited to R460

STAND-ALONE BENEFITS	Each claim for lenses or frames must be submitted with the lens prescription Benefits shall not be granted for contact lenses if the beneficiary has already received a pair of spectacles in a two-year benefit cycle Contact lens re-examination can be claimed for in six-monthly intervals	**OR CONTACT LENSES** Contact lenses to the value of R644 per beneficiary per annum Contact lens re-examination to a maximum cost of R255 per consultation **Non-Provider Network** One consultation limited to a maximum cost of R374 **WITH EITHER SPECTACLES** R596 towards a frame and/or lens enhancement Either one pair of clear single-vision lenses limited to R215 per lens **or** One pair of clear flat top bifocal lenses limited to R460 per lens **or** One pair of clear base multifocal lenses limited to R460 per lens **OR CONTACT LENSES** Contact lenses to the value of R400 per beneficiary per annum Contact lens re-examination to maximum cost of R255 per consultation

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 365 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

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

ANNEXURE B3

*ANNUAL MEMBER CONTRIBUTION INCREASES ARE EFFECTIVE 1 APRIL

CONTRIBUTIONS FROM 1 APRIL 2023 UNTIL 31 MARCH 2024

Aquarium member portion - 1 April 2023 to 31 March 2024

Income band	Principal Member	Adult Dependant	Child Dependant
R0 - R6 916	112	112	48
R6 917 - R9 500	121	121	48
R9 501 - R11 607	160	160	62
R11 608 - R13 576	199	199	73
R13 577 - R15 798	235	235	85
R15 799 - R19 000	270	270	96
R19 001 - R23 319	335	335	112
R23 320 - R26 827	393	393	148
R26 828 - R31 006	416	416	158
R31 007 - R33 393	434	434	165
R33 394 - R 41 914	454	454	172
R41 915 - R49 999	459	459	174
R50 000 +	463	463	175

Aquarium full unsubsidised contributions - 1 April 2023 to 31 March 2024

Income band	Principal Member	Adult Dependant	Child Dependant
R0 - R6 916	1 303	1 303	644
R6 917 - R9 500	1 314	1 314	644
R9 501 - R11 607	1 353	1 353	658
R11 608 - R13 576	1 390	1 390	670
R13 577 - R15 798	1 428	1 428	680
R15 799 - R19 000	1 462	1 462	693
R19 001 - R23 319	1 528	1 528	706
R23 320 - R26 827	1 585	1 585	744
R26 828 - R31 006	1 610	1 610	753
R31 007 - R33 393	1 628	1 628	760
R33 394 - R 41 914	1 648	1 648	768
R41 915 - R49 999	1 652	1 652	770
R50 000 +	1 656	1 656	771

CONTRIBUTIONS FROM 1 APRIL 2024 UNTIL 31 MARCH 2025

Aquarium member portion - 1 April 2024 to 31 March 2025

Income band	Principal Member	Adult Dependant	Child Dependant
R0- R7 366	117	117	50
R7 367- R10 118	127	127	50
R10 119- R12 361	168	168	65
R12 362- R14 458	208	208	76
R14 459- R16 825	246	246	89
R16 826- R20 235	283	283	101
R20 236- R24 835	351	351	117
R24 836- R28 571	411	411	155
R28 572- R33 021	436	436	165
R33 022- R35 564	454	454	173
R35 565- R44 638	493	493	187
R44 639- R53 249	499	499	189
R53 250+	503	503	190

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

Income band	Principal Member	Adult Dependant	Child Dependant
R0- R7 366	1 364	1 364	674
R7 367- R10 118	1 376	1 376	674
R10 119- R12 361	1 417	1 417	689
R12 362- R14 458	1 455	1 455	701
R14 459- R16 825	1 495	1 495	712
R16 826- R20 235	1 531	1 531	726
R20 236- R24 835	1 600	1 600	739
R24 836- R28 571	1 659	1 659	779
R28 572- R33 021	1 686	1 686	788
R33 022- R35 564	1 705	1 705	796
R35 565- R44 638	1 791	1 791	835
R44 639- R53 249	1 796	1 796	837
R53 250+	1 800	1 800	838

ANNEXURE B4

AQUARIUM: CHRONIC LIST

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

Auto-immune disorder

Systemic lupus erythematosus (SLE)

Cardiovascular conditions

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

Endocrine conditions

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

Gastrointestinal conditions

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

Gynaecological conditions

Endometriosis

Menopausal treatment

Haematological conditions

Haemophilia

Anaemia

Idiopathic thrombocytopenic purpura

Megaloblastic anaemia

Metabolic condition

Hyperlipidaemia

Musculoskeletal condition

Rheumatic arthritis

Neurological conditions

Epilepsy

Multiple sclerosis

Parkinson's disease

Cerebrovascular incident

Permanent spinal cord injuries

Ophthalmic condition

Glaucoma

Pulmonary diseases

Asthma

Chronic obstructive pulmonary disease (COPD)

Bronchiectasis

Cystic fibrosis

Psychiatric conditions

Affective disorders (depression and bipolar mood disorder)

Post-traumatic stress disorder (PTSD)

Schizophrenic disorders

Special category conditions

HIV/AIDS

Tuberculosis

Organ transplantation

Treatable cancers

As per PMB guidelines

Urological conditions

Chronic renal failure

Benign prostatic hypertrophy

Nephrotic syndrome and glomerulonephritis

Renal calculi

ANNEXURE C

PRESCRIBED MINIMUM BENEFITS (PMBs)

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

GENERAL EXCLUSIONS

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

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

2. Sleep therapy.

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

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

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

6. Prenatal and/or 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 18 years, subject to Index of Complexity, Outcome and Need (ICON).

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

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

14. Sex change operations.

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

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

17. Accommodation in spas, health or rest resorts.

18. Holidays for recuperative purposes.

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

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. 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.

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

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

25. 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.

26. 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.

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

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

29. Claims relating to the following:

- aptitude tests
- IQ tests
- school readiness
- questionnaires
- learning problems
- behavioural problems.

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

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

32. All benefits for Clinical trials.

33. Any new chemotherapeutic drug that has not convincingly demonstrated a survival advantage of more than 3 months in advanced or metastatic malignancies unless pre-authorised by the managed care organisation as a cost-effective alternative to standard chemotherapy.

ACUTE MEDICINE EXCLUSIONS

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

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

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®
9.03	Vitamin and/or mineral supplements: Geriatric vitamins and/or minerals	Gericomplex®
9.05	Vitamin and/or mineral supplements: Tonics and stimulants	Bioplus®
9.10	Vitamin and/or mineral supplements: Unregistered vitamins, mineral or food supplements	Sportron

Category	Description	Example
10.01	Naturo- and homeopathic remedies/supplements: Homeopathic remedies	Weleda Natura
10.02	Naturo- and homeopathic remedies/supplements: Natural oils	Primrose oils, fish liver oil
12.00	Veterinary products	
13.00	Growth hormones	Genotropin®
14.00	Medicines where cost/benefit ratio cannot be justified	Xigris®, Zyvoxid ® Herceptin, Gleevac®,
20.00	All newly registered medication	

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

THE FOLLOWING CATEGORIES ARE NOT AVAILABLE ON ACUTE BENEFITS:

Category	Description	Example
1.06	Gender or sex related: Treatment of impotence or sexual dysfunction	Viagra®, Cialis®, Caverject®
5.03	Appliances, supplies and devices: Stoma products and accessories, except where it forms 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

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

a) Medical emergency

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

c) No Day Clinics nearby

d) Case is clinically complex as per POLMED protocols

GYNAECOLOGY
Bartholin cyst - drainage/excision/marsupialisation
Biopsy - vulva, vagina, cervix, perineum
Cauterization of warts - all methods
Colposcopy
Diagnostic hysteroscopy
Endometrial and cervical procedures (includes dilatation and curettage, endometrial ablation, cervical cerclage, LLETZ)
Fine needle aspiration - cytology
Foreign body removal - vagina
Insertion of IUD (Intra-uterine Device)
Ovarian cyst(s) drainage
Sterilization
Laparoscopic gynaecological procedures
UROLOGY
Adult urology
Bilateral total orchidectomy for prostate cancer
Bladder biopsy (cancer and other conditions)
Bougienage for urethral stricture
Circumcision
Cystotomy with insertion of ureteric catsheter or stent
Cystourethroscopy ± urethrotomy
DJ stent removal post pyeloplasty
Foreign body removal
Hydrocelectomy for vaginal hydrocoele
Laparoscopy for ureteroneocystostomy ±cystoscopy and ureteral stent placement
Penile biopsy
Penile lesions removal - all methods

Scope and pyelogram
Second stage urethroplasty post stage 1
Testicular biopsy for infertility
Urethrocystoscopy for bladder outlet obstruction
Varicocelectomy for varicocele
Vasectomy
Cystourethroscopy Therapeutic
Paediatric urology
Circumcisions - all indications
Glandulo-cavernous shunt for priapism
Hydrocelectomy for congenital hydrocoele
Cystourethroscopy Therapeutic (continued)
Meatotomy for meatal stenosis
Orchidopexy for undescended testis
Urethrocystoscopy for urinary incontinence
ORTHOPAEDICS
Arthrocentesis
Arthrodesis - hand, wrist, elbow, foot
Arthroscopy
Aspiration/intra-articular injection of joints*
Biopsy - bone
Bunionectomy
Carpal tunnel release
Cartilage grafts
Closed fracture procedures
Foreign body removal - muscle/tendon sheath
Ganglionectomy
Grafts - bone/tendon
Implant/wire/pin insertion or removal
Injection of tendon/ligament/trigger points/ganglion cyst*
Injection therapeutic carpal tunnel*
Minor joint arthroplasty (intercarpal, carpometacarpal and metacarpophalangeal, interphalangeal joint arthroplasty)
Orthopaedic casts/spica procedures
Tenotomy - all areas
Dislocation
Contracture release
Manipulation

Capsulectomy/Capsulotomy
Ligament repair/reconstruction
Muscle transfer/release
GENERAL SURGERY
Anal procedures, including dilatations, biopsies, fissure repairs, haemorrhoidectomies
Biopsy - lymph node, muscle, skin, soft tissue
Breast biopsy/ removal of lesion(s)
Colonoscopy
Drainage of abscesses/haematomas/cysts (subcutaneous/submucosal)
Excision lipoma/cysts/tumours
Excision of sweat glands (axilla/inguinal) and simple repair
Foreign body removal
Gastroscopy/oesophagogastroduodenoscopy
Nail/nail bed related procedures
Proctoscopy and removal of polyps
Sigmoidoscopy
Wound debridement (skin/subcutaneous tissue)
Excision skin/subcutaneous tissue
Implant removal/reinsertion
Excision skin/subcutaneous tissue
Small bowel endoscopy
Fistula related procedures
Implant removal/reinsertion
Dressings under anaesthesia
Frenumectomy/frenulectomy/frenectomy
ENT SURGERY
Adenoidectomy
Antrostomy
Biopsies, including DPP (Diagnostic Proof Puncture)
ENT Endoscopy (nasal endoscopy, laryngoscopy, diagnostic and interventional)
Foreign body removal - auditory canal
Mastoidectomy
Middles ear procedures, including stapes surgery
Nasal surgery/procedures (includes control of nose bleeds, rhinoplasty, reduction of nose fracture, septoplasty, turbinectomy, nasal turbinate repair)
Oral cavity related procedures, including biopsies
Salivary gland related procedures
Sinus related surgery

Mastoidectomy
Middles ear procedures, including stapes surgery
Nasal surgery/procedures (includes control of nose bleeds, rhinoplasty, reduction of nose fracture, septoplasty, turbinectomy, nasal turbinate repair)
Oral cavity related procedures, including biopsies
Salivary gland related procedures
Sinus related surgery
Tonsillectomy
Tympanic membrane related procedures (includes myringotomy ± grommets, tympanoplasty, tympanolysis)
OPHTHALMOLOGY
Anterior and/or posterior chamber related procedures e.g., vitrectomy
Biopsy - all eye structures
Blepheroplasty
Cataract surgery
Choroid related procedures
Conjunctival procedures e.g. pterygium surgery
Fine needle aspiration - all eye structures
Foreign body removal
Intra ocular injection eg. Avastin, including Glaucoma
Iris related procedures e.g., iridectomy
Orbitotomy
Probing & repair of tear ducts
Retinal surgery
Sclera related procedures
Strabismus repair
Treatment of progressive retinopathy
Trichiasis correction (non-forceps)
Ptosis
Canthotomy
Ciliary body procedures
Cornea related procedures
Enucleation/Implant insertion/removal
PLASTIC AND RECONSTRUCTIVE SURGERY
Excision of benign lesions (scalp/neck/hands/feet/trunk/limbs)
Excision of malignant lesions and margins (face, lips, nose, ears, eyelids) ± flap
Flaps - delay/sectioning
Malignant lesions - destruction and removal via non-incision intervention

Repair wound lesions (scalp/hands/neck/feet/face)
Repair wound with layers (scalp/axillae/external genitalia/trunk/limbs)
z-plasty
NEUROSURGERY
Biopsy of spinal cord/nerve
Injection of diagnostic/therapeutic agents ± catheter/needle insertion into intrathecal space ± imaging guidance
Injection of neuolytic agents - all agents, all sites
Intraneural Injection of anaesthetic agents ± continous infusion
Electroconvulsive therapy

ANNEXURE E

PREVENTATIVE HEALTHCARE BENEFIT 2024

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

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

TEST	TARIFF CODE	SCREENING TEST INCLUDED
WELLNESS		
Wellness visit 	55500	Annually 100% of POLMED rate or agreed tariff where applicable Early detection screening limited to periods specified Possible indication of peptic ulcers: Members over the age of 50 years Funded from the risk pool; the benefit shall not accrue to the overall out-of-hospital limit Inclusive of: • Blood pressure test • Body mass index (BMI) test • Cholesterol screening (Z13.8) • Consultation • Glucose screening (Z13.1) • Healthy diet counselling (Z71.3) • Waist-to-hip ratio measurement Clinical information to be submitted to managed care
RISK ASSESSMENT		
Tests included		• Baby immunisations (as per the DOH guidelines) • Bone densitometry scan for members 65 years and older • Circumcision • Contraceptives (as per the DOH guidelines) • Dental screening (codes 8101, 8151 and 8102) • Optical screening for lazy eye (Amblyopia) and squints (Strabismus) for children between 3-5 years of age • Flu vaccine • Glaucoma screening • HIV tests

TEST	TARIFF CODE	SCREENING TEST INCLUDED
		• HPV screening once every five years for females aged 21 years and older • HPV vaccine for girls aged 10-17 years • Mammogram • Pap smear • Pneumococcal vaccine • Prostate screening • Psycho-social services Clinical information to be submitted to managed care
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 included on the Road to Health chart
Infant Hearing Screening		Infants up to 6 weeks of age - As per guidelines of the Health Professional Council of South Africa which recommends that initial hearing screening should take place before one month of age and by no later than six weeks of age Limited to one test in- or out-of-hospital for all infant beneficiaries
FEMALE HEALTH (women and adolescent girls)		
Cervical cancer screening ICD: Z12.4		For all females aged **21-64** years old, except for those women who have had a complete hysterectomy with no residual cervix Human papilloma virus (HPV) vaccination for girls aged 10-17 years HPV screening PAP smear test once every third year Total of two HPV vaccinations are funded 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 40-74 years old Once every two years, unless motivated
Contraceptives ICD: Z30		A contraceptive formulary applies
DENTAL HEALTH		

TEST	TARIFF CODE	SCREENING TEST INCLUDED
Consultation and topical fluoride application for children aged 0-6 years		Annually
Topical fluoride application for children aged 7-16 years		Annually
Caries risk assessment for children aged 0-14 years		Once every second year Clinical information to be submitted to managed care
Periodontal disease and caries risk assessment for adults 19 years of age and older		Once every second year Clinical information to be submitted to managed care
Fissure sealants for 5 to 25 year old		Maximum of four per annum
HIV COUNSELLING AND TESTING		
HIV counselling and pre-counselling		Annually
HCT consultation, rapid testing and post counselling		Annually
HIV Testing		Annually Elisa: 3932 Confirmation test: Western Blot (payable after HCT or ELISA tests)
OTHER		
Flu vaccine		Annually
Hib titer for 60 years and older		Annually Serology: IgM: specific antibody titer
Prostate cancer screening		Annually For all males aged between 50 and 75 years
Glaucoma screening		Once every third year, unless motivated
Circumcision		Subject to clinical protocols
Post-trauma debriefing session		Only for active principal members of SAPS, utilising the Psycho-Social Network Four individual sessions **or** four group debriefing sessions per year

TEST	TARIFF CODE	SCREENING TEST INCLUDED
Weight Management Program		A 12-week exercise program provided by BASA (Biokineticist Association of South Africa). It includes a HRA (Health Risk Assessment), group or individual exercise sessions, consultation with a dietician and psychologist 100% of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or Scheme Tariff One enrolment per beneficiary per annum subject to clinical protocols A separate basket to be funded from Risk
GoSmokeFree Program		GoSmokeFree Program is delivered by a trained nurse through HealthCraft accredited pharmacies. The approach includes motivational behavioural change, clinical measures (carbon monoxide readings), follow-ups to manage relapse rates 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme Tariff One enrolment per beneficiary per annum with a GoSmokeFree accredited network pharmacy Funded from Risk as part of the Preventative HealthCare benefit Nicotine Replacement Therapy to be funded from acute benefit for members enrolled on the program
Pertussis Booster Vaccine between 7 and 64 years		As per the World Health Organization (WHO) recommendation, countries, like South Africa, using pertussis vaccine in the primary infant immunisation schedule, should consider additional boosters and maternal immunisation Limited to 1 vaccine per beneficiary every 10 years
COVID-19 Vaccine Benefit		Regulations stipulate that the COVID-19 vaccine is considered PMB Limited to PMB requirements
Pneumococcal Vaccine		Limited to 1 vaccine per beneficiary every 5 years

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.