ALLIANCE-MIDMED MEDICAL SCHEME

ANNEXURE C - EXCLUSIONS

(with effect from 1 January 2020)

1. PRESCRIBED MINIMUM BENEFITS

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

2. LIMITATION AND RESTRICTION OF BENEFITS

2.1 In cases of illness of a protracted nature, the Scheme shall have the right to insist upon a member or dependant of a member consulting any particular specialist the Scheme may nominate in consultation with the attending practitioner.

2.2 The Scheme may require a second opinion in respect of proposed treatment or medication which may result in a claim for benefits and for that purpose the relevant beneficiary shall consult a dental or medical practitioner nominated by the Scheme and at the cost of the Scheme. In the event that the second opinion proposes different treatment or medication to the first, the Scheme may in its discretion require that the second opinion proposals be followed.

2.3 In cases where a specialist is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme may, at its discretion, be limited to the amount that would have been paid to the general practitioner for the same service.

2.4 Unless otherwise decided by the Scheme, benefits in respect of medicines obtained on a prescription are limited to one month's supply (or to the nearest unbroken pack) for every such prescription or repeat thereof.

2.5 If the Scheme does not have funding guidelines or protocols in respect of benefits for services and supplies referred to in Annexure B, beneficiaries will only qualify for benefits in respect of those services and supplies if the Scheme's Medical Advisor acknowledges it as medically necessary, and then subject to such conditions as the Scheme's Medical Advisor may impose. "Medically necessary" refers to services or supplies that meet all the following requirements:

2.5.1 it is required to restore normal function of an affected limb, organ, or system;

2.5.2 no alternative exists that has a better outcome, is more cost-effective, or has a lower risk;

2.5.3 it is accepted as optimal and necessary for the specific condition, and at an appropriate level to render safe and adequate care;

2.5.4 it is not rendered for the convenience of the relevant beneficiary or service provider;

2.5.5 outcome studies are available and acceptable to the Scheme in respect of such services or supplies. All benefits are subject to evidence based clinical policies and protocols. With regards to new technology the Scheme reserves the right to evaluate the technology prior to making a decision.

2.6 No benefits are payable in respect of any new medical service or supply or appliance, including any newly registered medicine, or new indications for existing medicines, until such time that the Scheme is satisfied, through the submission of clinical data or other relevant information, in regard to the following aspects relating to that service or supply:

2.6.1 therapeutic role in clinical medicine;

2.6.2 cost-efficiency / affordability;

2.6.3 value relative to existing services or supplies;

2.6.4 establishment by the contracted drug utilization review company of the role of that service or supply in drug therapy.

2.7 In the event that:

2.7.1 the treatment of a chronic sickness condition becomes necessary; or

2.7.2 a disease or a condition (including pregnancy) requires specialized or intensive treatment; or

2.7.3 the treatment of any disease or condition becomes of a protracted nature or requires extended medication;

and such treatment is given in a private hospital, any applicable health management programme may evaluate the case and, having regard to the aforementioned diseases or conditions in question, if it should determine that any annual benefit limits available to the beneficiary receiving such treatment, as set out in paragraph D4 of Annexure B, are likely to be exceeded in the course of the year, it may require or advise the transfer of that beneficiary to a public hospital or other designated provider facility where appropriate care is available or it may require the use of a specific service provider, or it may require or advise the application of a limited drug formulary, or all such transfer and restricted drug formulary in order to conserve or maximise efficient utilisation of available benefits.

2.8 In the event that the applicable health management programme has taken a decision in terms of paragraph 2.7 above, the following conditions shall apply:

2.8.1 in respect of PMB conditions, no hospital benefit limit shall apply provided treatment is given at a public hospital or designated provider facility. If for any reason the beneficiary receives treatment at a private hospital or other non-designated provider facility, the Scheme shall only pay for such treatment at the rate stipulated or agreed for appropriate treatment in the public hospital or designated provider facility;

2.8.2 in respect of non-PMB conditions, after having been advised to move to a public hospital or designated provider facility or to accept a limited drug formulary, or both, in order to conserve available benefits, the member may elect on behalf of himself or his beneficiary, to remain in the private hospital, or remain on the full drug formulary available, or both, in which event the Scheme shall pay up to the benefit limit stipulated in paragraph D4 of Annexure B, where after the member shall be responsible for payment, direct to the private hospital, for any further treatment in such hospital, or payment direct to the supplier for further medication;

2.8.3 if the beneficiary is moved to a public hospital or designated provider facility in terms of this paragraph 2.8, such beneficiary shall only be entitled to the services that are normally, or by agreement with the Scheme, available at such hospital or facility,

2.8.4 any costs incurred over and above the stipulated benefit (excluding PMB conditions) shall be the member's responsibility irrespective of where treatment is procured.

3. BENEFITS EXCLUDED

General exclusions mentioned in this paragraph are not affected by any specific exclusions. Unless otherwise decided by the Scheme (and with the express exception of medicines or treatment approved and authorised in terms of any health implication to the Scheme), expenses incurred in connection with any of the following will not be paid by the Scheme.

3.1 all costs that exceed the annual or biennial or time-specific maximum allowed for the particular category as set out in Annexure B, for the benefits to which the member is entitled in terms of the rules;

3.2 all costs for operations, medicines, treatments and procedures for cosmetic purposes or for personal reasons and not directly caused by or related to illness, accident or disease (not applicable to costs associated with circumcisions).

3.3 if, in the opinion of the Medical Advisor, the health care service in respect of which a claim is made, is not appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition at an affordable level of service and cost;

3.4 all costs for treatment, if the efficacy and safety of such treatment cannot be proved;

3.5 injuries or conditions willfully self-inflicted or injuries sustained while voluntarily participating in a riot, civil commotion, war, invasion, act of foreign enemy, hostilities whether war is declared or not, and civil war; or injuries arising from professional sport, speed contests and speed trials except for PMB cases. (The arrangement is as follows: the scheme will be paying up to R10 000 without denying benefits or requiring any additional authorizations).

3.6 it is recorded that the relationship between the Scheme and its members shall at all times be deemed to be one of the utmost good faith. The member therefore acknowledges and agrees that, notwithstanding anything to the contrary, or not specifically set out in the rules or Annexures of the Scheme, the member is under a duty of care to disclose all and any information or matters to the Scheme, which may in any manner impact upon or effect a decision or discretion which vests in the Scheme, concerning such member or his claim;

3.7 the Scheme shall not be liable for the payment of any costs incurred by a member, which arose or may have arisen, as a result of the actions or omissions of another party. The Scheme will however pay any costs incurred by the member in terms of the rules, arising from the actions or omissions of any other party up to a maximum of R10 000 without denying benefits or requiring any additional authorizations. The member shall:

3.7.1 be liable to repay to the Scheme all amounts paid by the Scheme and recovered by or on behalf of the member from the party responsible to compensate such member, free of any legal costs or deductions that may have been incurred in the recovery of such amount;

3.7.2 ensure that, prior to the settlement of any claim instituted against such other party, all the amounts set out above and paid by the Scheme, are included in such claim and form part of any settlement amount, whether globular or separately;

3.7.3 disclose to the Scheme, alternatively, instruct his legal representative to disclose to the Scheme, the full extent of any compensation awarded in respect of past and future medical expenses from any and all sources;

3.7.4 sign all documentation as may be required by the Scheme to obtain copies of all such information not in the Scheme's possession, relating to the member's medical accounts and records from the relevant practitioners and/or medical institutions;

3.7.5 sign all such documentation as may be required by the Scheme, to proceed with a claim in the member's name to recover any amounts expended by the Scheme, subject to the Scheme indemnifying the member against any costs which may arise as a result of the institution of such claim, if the Scheme is satisfied that a valid claim exists and the member elects not to proceed with it;

3.7.6 be deemed to be liable to repay all amounts expended by the Scheme, as above, in the event of the member's claim being finalized and paid in circumstances where no specific or separate award is made for the payment of medical or hospital expenses incurred;

3.7.7 either personally or through his legal representative keep the Scheme informed, whether called upon by the Scheme to do so or not, as to the ongoing progress of his claim;

3.7.8 when requested by the Scheme, whether prior to or subsequent to the Scheme effecting any payments as referred to above, provide the Scheme with a written undertaking signed by both the member and his legal representative so as to give full effect to what is contained in paragraphs 3.6 and 3.7.1 to 3.7.7 above;

3.8 should a member's claim referred to in paragraph 3.7 against the party liable for his injuries not be successful, alternatively, only be partially successful, then in such event the member shall be entitled to such benefits or portion of benefits in respect of which his claim has been unsuccessful as would have applied, should no claim have been possible *ab initio*, irrespective of the lapse of time.

3.9 all costs for services rendered by:

3.9.1 persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or

3.9.2 any institution, nursing home or similar institution, except a state or provincial hospital, not registered in terms of any law;

3.10 abdominoplasties (including the repair of divarication of the abdominal muscles);

3.1 accommodation and services provided in a geriatric hospital, old age home, frail care facility or the like (unless specifically provided for in Annexure B);

3.12 anabolic steroids, immune-stimulants and growth hormones

3.13 appointments which a beneficiary fails to keep;

3.14 appliances, devices and procedures not scientifically proven or appropriate

3.15 arch supports;

3.16 autopsies;

3.17 back rests and chair seats;

3.18 bandages and dressings except medicated dressings or related to a specific injury;

3.19 beds and mattresses;

3.20 bilateral gynaecomastia in beneficiaries under the age of 18 years;

3.21 blepharoplasties;

3.22 breast augmentation;

3.23 breast reconstruction (unless mastectomy is pre-authorised),

3.24 breast reductions;

3.25 contact lens solutions;

3.26 Mirena devices for contraception purposes unless specifically motivated and clinical evidence provided to support a clinical need.

3.27 cosmetic preparations, emollients, moisturizers, medicated or otherwise, soaps, scrubs and other cleansers, sun screening and sun tanning preparations, medicated shampoos and conditioners;

3.28 dental procedures or devices which are not regarded by the medical and dental advisor/s as clinically essential or clinically desirable; and all costs for;

3.28.1 anaesthetics in respect of dental services;

3.28.1.1 general anaesthetics and hospitalisation for dental work.

3.28.2 in-hospital dental work for members older than 6 (six) years.

3.28.2 Oral Hygiene

3.28.2.1 Oral hygiene instruction;

3.28.2.2 Oral hygiene evaluation;

3.28.2.3 Professionally applied adult fluoride for beneficiaries 13 years and older;

3.28.2.4 Dental bleaching;

3.28.2.5 Nutritional and tobacco counselling;

3.28.2.6 Cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl) and ointments;

3.28.2.7 Fissure sealants on patients 16 years and older.

3.28.3 Fillings

3.28.3.1 Fillings to restore teeth damaged due to toothbrush abrasion, attrition, erosion and fluorosis;

3.28.3.2 Resin bonding for restorations that are charged as a separate procedure to the restoration;

3.28.3.3 Gold foil restorations;

3.28.3.4 The polishing of restorations;

3.28.3.5 Ozone therapy;

3.28.4 In-hospital dentistry.

3.28.4 **Root Canal**

3.28.4.1 Root canal therapy on primary (milk) teeth and wisdom teeth (3rd molars);

3.28.4.2 Direct and indirect pulp capping procedures.

3.28.5 **Maxillo Facial Surgery**

3.28.5.1 Orthognathic (jaw correction) surgery and any related hospital cost, and the associated laboratory costs;

3.28.5.2 Sinus lifts;

3.28.5.3 Bone augmentations;

3.28.5.4 Bone and tissue regeneration procedures;

3.28.5.5 The cost of bone regeneration material;

3.28.5.6 The auto-transplantation of teeth;

3.28.5.7 The closure of an oral-antral opening (currently code 8909) when claimed during the same visit with impacted teeth (currently codes 8941, 8943 and 8945).

3.28.6 Dentures

3.28.6.1 Diagnostic dentures and associated laboratory costs;

3.28.6.2 Snoring appliances and associated laboratory costs;

3.28.6.3 High impact acrylic;

3.28.6.4 The cost of gold, precious metal, semi-precious metal and platinum foil;

3.28.6.5 Laboratory delivery fees;

3.28.6.6 Provisional dentures and associated laboratory costs;

3.28.6.7 The metal base to full dentures and associated laboratory costs.

3.28.6.8 The clinical fee of denture repairs, denture tooth replacements and the addition of a soft base to new dentures. (The laboratory fee will be covered at the Scheme Dental Tariff where managed care protocols apply).

3.28.6.9 The laboratory cost associated with mouth guards. (The clinical fee will be covered at the Scheme Dental Tariff where managed care protocols apply).

3.28.7 Crown and bridge

3.28.7.1 Crown and bridge procedures for cosmetic reasons and associated laboratory costs;

3.28.7.2 Occlusal rehabilitations and associated laboratory costs;

3.28.7.3 Provisional crowns and associated laboratory costs;

3.28.7.4 Porcelain veneers and inlays or onlays and associated laboratory costs;

3.28.7.5 Emergency crowns that are not placed for the immediate protection in tooth injury and associated laboratory costs;

3.28.7.6 The cost of gold, precious metal, semi-precious metal and platinum foil;

3.28.7.7 Laboratory delivery fees;

3.28.7.8 Crowns or crown retainers on wisdom teeth (3rd molars);

3.28.7.9 Pontics on 2nd molars, where the third molar is a retainer;

3.28.7.10 Crown and bridge procedure where there is no extensive tooth structure loss and associated laboratory costs;

3.28.7.11 Dental Implants and associated laboratory costs.

3.28.8 Orthodontics

3.28.8.1 Orthodontic re-treatment and any related Laboratory costs;

3.28.8.2 Orthognathic (jaw correction) and other orthodontic related surgery and any related Hospital and Laboratory costs;

3.28.8.3 Cost of invisible retainer material;

3.28.8.4 Laboratory delivery fees;

3.28.8.5 Orthodontic treatment over the age of 18 years;

3.28.8.6 Orthodontic treatment for cosmetic reasons and associated laboratory costs.

3.28.9 Periodontics

3.28.9.1 Surgical periodontics which includes gingivectomies, periodontal flap surgery tissue grafting and the hemisection of a tooth

3.28.9.2 Perio chip placement

3.28.10 Additional Dental exclusions

3.28.10.1 Electrognathographic recordings, pantographic recordings and other such electronic analyses;

3.28.10.2 Dental testimony including Dento-legal fees;

3.28.10.3 Caries susceptibility and microbiological tests;

3.28.10.4 Pulp tests;

3.28.10.5 Cost of Mineral Trioxide;

3.28.10.6 Special report;

3.28.10.7 Treatment plan completed (currently code 8120);

3.28.10.8 Enamel microabrasion;

3.28.10.9 Behaviour management;

3.28.10.10 Intramuscular or subcutaneous injection;

3.28.10.11 Procedures that are defined as unusual circumstances and procedures that are defined as unlisted procedures;

3.28.10.12 Appointments not kept;

3.28.10.13 electric toothbrushes.

3.29 diagnostic kits, agents and appliances unless otherwise stated

3.30 erectile dysfunction and loss of libido

3.31 food and nutritional supplements including baby food and special milk preparations other than pre-authorised baby formula for babies born to mothers who are HIV positive.

3.32 gender re-alignment for personal reasons and not directly caused by or related to illness, accident or disease

3.33 genioplasties as an isolated procedure

3.34 headaches: oral appliances specified for the treatment of headaches

3.35 herbal and homeopathic preparations (unless provided for under the homeopathic benefit)

3.36 Hirsutism (except for PMB)

3.37 holidays for recuperative purposes

3.38 Humidifiers, unless prescribed by a medical practitioner.

3.39 hyperbaric oxygen therapy except for anaerobic life threatening infections

3.40 infertility (unless a PMB or specifically provided for in Annexure B)

3.41 ionizers and air purifiers

3.42 keloid surgery, except for burns and functional impairment

3.43 medical, surgical and orthopaedic appliances, devices and products, including oxygen hire or purchase and attachments (unless a PMB or specifically provided for in Annexure B)

3.44 medication in respect of Gauchers: Imiglucerase or other glucocerebrosidase enzyme therapy

3.45 medicines not included in a prescription from a medical practitioner or another healthcare professional legally entitled to prescribe such medicines (except for schedule 0, 1 and 2 medicines supplied by a registered pharmacist)

3.46 medicines used specifically to treat infertility; except for PMB

3.47 medicines for the treatment of alcohol and drug addiction (unless a PMB or specifically provided for)

3.48 medicines not authorised by the contracted medicine programmes

3.49 medicines not approved by the Medicine Control Council

3.50 nasal scans (full) ordered by general practitioners

3.51 nuclear or radio-active material or waste: all costs for medical treatment as a result of exposure

3.52 obesity

3.53 optical devices which are not regarded by the Optometry Benefit Management Programme as clinically essential or clinically desirable

3.54 organ donations to any person other than to a member or dependant of a member

3.55 orthopaedic shoes and boots

3.56 otoplasties

3.57 pain relieving machines, e.g. TENS, APS, etc.

3.58 patent medicines, household remedies and propriety preparations and preparations not otherwise classified

3.59 Positron Emission Tomography (PET) unless a specific motivation has been provided and authorization given in terms of the oncology management programme

3.60 refractive surgery for less severe (in the opinion of Scheme's Medical Adviser) refractive errors

3.61 revision of scars

3.62 rhinoplasties (unless a medical necessity)

3.63 smoking cessation and anti-smoking preparations

3.64 sphygmomanometers (blood pressure apparatus)

3.65 stethoscopes

3.66 telephone consultations

3.67 topical preparations

3.68 traveling expenses incurred by members and their registered dependants

3.69 uvulo palatal pharyngoplasty (UPPP and LAUP)

3.70 veterinary products

3.71 minerals and tonics other than iron and folic acid

3.72 biological drugs unless part of a Disease Management Programme and subject to Clinical Protocols

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