ANNEXURE B1

LOWER PLAN SCHEDULE

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2015

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.

Reference in this Annexure and the following Annexures to the "POLMED rate" shall mean:	2006 NHRPL plus inflationary figure (i.e. the 2006 base tariff increased by the inflationary amounts)
Reference in this Annexure and the following Annexures to the "agreed tariff" shall mean:	The rate negotiated by and on behalf of the Scheme with one or more providers/groups

GENERAL RULES

In hospital

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

In the case of emergency, the Scheme must be notified within 48 hours/first working day after admission.

Pre-authorisation will be managed under the auspices of managed healthcare. The **appropriate facility has to 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 be taken out (TTO) will be paid to a maximum of seven days' supply.

Maternity: The costs incurred in respect of a newborn baby shall be regarded as part of the mother's cost for the first 90 days after birth. If the child is registered on the Scheme within 90 days from birth, Scheme Rule 7.1.2 shall apply.

Benefits shall also be granted if the child is stillborn.

Dental procedures

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

Specialised radiology

Pre-authorisation is required for all scans, failing which the Scheme will impose a co-payment of R1 000 per procedure. In case of emergency the Scheme must be notified within 24 hours/first working day of the treatment of the patient.

Medication

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

Payment will be restricted to one month's supply in all cases for acute and chronic medicine, 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.)

Payment in respect of over-the-counter (OTC), acute and chronic medicine will be limited to the POLMED medicine reference price (MetRef); this is the maximum allowed cost which may be based on either generic or therapeutic reference pricing. The balance of the cost needs to be funded by the member.

Pre-authorisation is required for items funded from the chronic medication benefit. Pre-authorisation is based on evidence-based medicine (EBM) principles and the funding guidelines of the Scheme. Once predefined criteria are met, beneficiaries may claim from a group ("basket") of medicines appropriate for the management of a particular condition/disease for which they are registered. Changes for products included in a medicine basket may not require reapplication. In addition, medication that may not be included in the "basket(s)" may be available through an exception management process, for which product-specific pre-authorisation may be granted, a process requiring motivation from the treating service provider.

The member needs to re-apply at least six weeks prior to expiry of the existing chronic medication authorisation.

The Scheme shall only consider claims for medicines obtained on the written prescription of a person legally entitled to prescribe medicine and dispensed by such person or a registered pharmacist.

Flu and baby vaccines are obtainable without prescription.

Specialist referral

All POLMED beneficiaries need to be referred by a general practitioner (GP) to a specialist. The Scheme will impose a co-payment up to R1 000 if the specialist does not reflect the referring general practitioner on the specialist account. 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/disciplines: Gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists [chronic dialysis], dental specialists, pathology, radiology and supplementary/allied health services.) However, the Scheme will not cover the cost of audiology tests if there is no referral from the GP, ear, nose and throat (ENT) specialist, paediatrician, physician or neurologist.

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.

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.

Pro rata benefits

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 admission date of the member to the Scheme to the end of that financial year.

Designated service provider (out-of-network rule)

POLMED has appointed healthcare

LOWER PLAN

providers (or a group of providers) as designated service providers (DSPs) for diagnosis, treatment and care in respect of one or more prescribed minimum benefit (PMB) condition. Where the Scheme has appointed a DSP and the member voluntarily chooses to use an alternative provider, all costs in excess of those agreed with the DSP will be for the cost of the member and paid directly to the provider by the member.

Examples of designated service providers (where applicable) are:

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

Please access the list of the providers at www.polmed.co.za, on your cellphone via the mobi site or on request via the Client Service Department.

Designated GP provider (network GP)

Members are allowed two visits out of a network (i.e. to a GP who is not part of the network) for emergency or out-of-town situations.

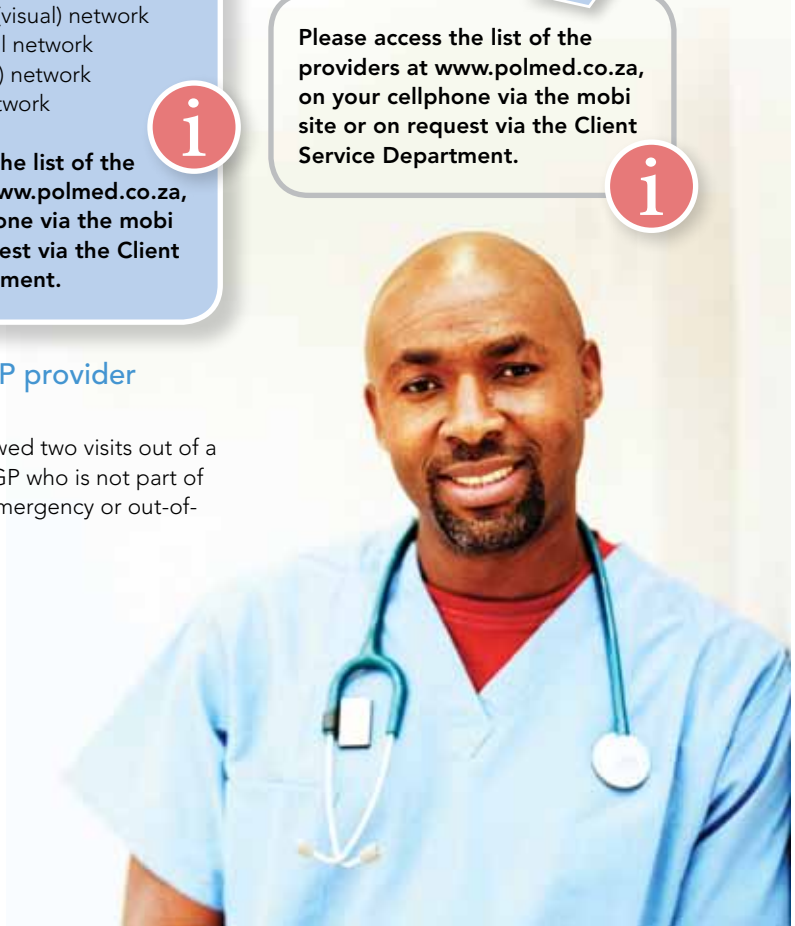
Designated pharmacy network

POLMED has appointed service provider(s) for the provision of chronic medication.

The Scheme utilises the courier pharmacy service as the primary service provider, with retail pharmacies providing secondary support for those members who prefer personal interaction. Where the member chooses to use an alternative provider, the member shall be liable for a co-payment of 20% of the costs paid directly to the provider by the member.

- DSP pharmacy

Please access the list of the providers at www.polmed.co.za, on your cellphone via the mobi site or on request via the Client Service Department.



DEFINITION OF TERMS

Co-payment

A co-payment is an amount or portion of the cost of a product/service, which is due by the member to the provider at the point of service, e.g. consultation or admission to hospital. The co-payment is not required in the event of a life-threatening injury or PMB condition.

POLMED medicine reference price

This is the reference pricing system applied by the Scheme's managed healthcare provider: Metropolitan Health Risk Management. It may be derived based on the generic reference price (MetRef) or therapeutic reference price. This pricing system refers to the maximum price that POLMED will pay for a particular medication. Should a reference price be set for a generic or therapeutic class of medication, patients are entitled to make use of any medication within this pricing limit, but will be required to make a co-payment on medication priced above the reference pricing limit.

Generic reference price (MetRef)

Generic reference price is the maximum price that may be reimbursed for a group of generic equivalent medicine products. This is derived using a statistical formula, taking into consideration accessibility of products within the generic group.

Specialised dentistry

Specialised dentistry refers to services that are not defined as basic dentistry. These include periodontal surgery, crowns and bridges, implant procedures, inlays, indirect veneers, orthodontic treatment, removal of impacted teeth and maxillo-facial surgery.

Registration for chronic medication

POLMED provides for a specific list of conditions that are funded from the chronic medicine benefit (i.e. through a benefit that is separate from the acute medication benefit). POLMED requires that members apply/register via the managed healthcare programme to access this chronic medication benefit. Some behind-the-scenes management of the cost and quality are applied by the managed healthcare organisation.

The members receive a letter by post or fax indicating the decision of the application.

Enrolment on the Disease Management Programme

Members will automatically be registered on the Disease Management Programme.The Disease 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

LOWER PLAN

are registered on the programme receive a treatment plan (care plan) which contains 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.

Basic dentistry

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

- consultations
- fluoride treatment and fissure sealants
- non-surgical removal of teeth
- cleaning of teeth, including non-surgical management of gum disease
- root canal treatment.

Disclaimer: In the event of a dispute the registered rules of POLMED will apply.

LOWER PLAN BENEFIT SCHEDULE

GENERAL BENEFIT RULES	**Benefit design**	This option provides for benefits to be provided only in appointed designated 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 that have little healthcare needs or whose chronic conditions are under control This option is not intended for members who require medical assistance on a regular basis, or who are concerned about having extensive access to health benefits
	Pre-authorisation, referrals, protocols and management by programmes	Where the benefit is subject to pre-authorisation, referral by a designated service provider (DSP) or general practitioner (GP), established protocols or enrolment on a managed care programme, members' attention is drawn to the fact that there may be a much reduced benefit if the pre-authorisation, referral by a DSP or GP, established protocols or enrolment upon a managed care programme, is not complied with (a co-payment may be applied) The pre-authorisation, referral by a DSP or GP, established protocols or enrolment on a managed care programme is stipulated in order 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)	100% of agreed tariff at DSP or at cost

IN-HOSPITAL BENEFITS	**Annual overall in-hospital limit** Hospital procedures (subject to exclusion list for high-cost "non-effective" procedures) Subject to Hospital Management Programme and managed healthcare protocols Pre-authorisation required No limit in case of life-threatening emergency or PMB condition See Annexure D for the list of procedures that are funded from the hospital benefit if performed in the doctor's rooms or day clinics	100% of POLMED rate OR Agreed tariff Non-PMB admissions will be subject to an overall limit of R200 000 per family No co-payment if the procedure is performed in a DSP and/or day clinic R8 000 co-payment in non-DSP hospitals
	Dentistry Subject to PMBs Pre-authorisation required Subject to dental protocols	100% of agreed tariff at DSP/cost Dentist's costs for all non-PMB procedures will be reimbursed from the out-of-hospital (OOH) benefit The hospital and anaesthetist's costs will be reimbursed from the overall non-PMB limit
	Emergency medical assistance (Netcare 911: 082 911)	100% of agreed tariff through DSP/cost
	HIV/AIDS Subject to PMBs Enrolment on the POLMED HIV Programme is encouraged Case managed according to treatment protocols	100% of agreed tariff at DSP/cost

IN-HOSPITAL BENEFITS	**Chronic kidney dialysis** Subject to PMBs and managed healthcare protocols Pre-authorisation required Enrolment on Disease Management Programme is encouraged National Renal Care (NRC) and Fresenius Medical Care are preferred providers	100% of agreed tariff at DSP/cost
	Mental health Subject to PMBs and managed healthcare protocols Pre-authorisation required Enrolment on relevant managed healthcare programme is encouraged for the following conditions: • depression • bipolar • substance and/or alcohol abuse • post-traumatic stress disorder (PTSD)	100% of agreed tariff at DSP/cost Annual limit of 21 days per beneficiary
	Medication: Non-PMB specialist drug limit, e.g. biologics Pre-authorisation required	100% of MetRef price Specialised medicine sub-limit of R65 500 per family
	Oncology (chemotherapy and radiotherapy) Subject to PMBs and managed healthcare protocols Pre-authorisation required Enrolment on the relevant managed healthcare programme is encouraged Independent Clinical Oncology Network (ICON) is a designated service provider	100% of agreed tariff at DSP/cost Limited to R218 470 per beneficiary MRI/CT scans will be funded from oncology benefit

LOWER PLAN

IN-HOSPITAL BENEFITS		
	Organ and tissue transplants Subject to PMBs and managed healthcare protocols Pre-authorisation required Subject to clinical guidelines used in State facilities	100% of agreed tariff at DSP/cost Unlimited radiology and pathology for organ transplants and immunosuppressants
	Pathology Subject to protocols and clinical guidelines Service will be linked to hospital pre-authorisation	100% of POLMED rate/agreed tariff/ cost
	Physiotherapy Subject to protocols and clinical guidelines Service will be linked to hospital pre-authorisation	100% of POLMED rate/agreed tariff/ cost
	Prostheses (internal and external) Subject to pre-authorisation and approved product list	100% of POLMED rate/agreed tariff/ cost Limited to R57 240 per beneficiary
	Refractive surgery	No benefit
	Specialists Anaesthetists	100% of POLMED rate or agreed tariff 150% of POLMED rate

OVERALL OUT-OF-HOSPITAL BENEFITS		
	Annual overall OOH limit Benefits shall not exceed the amount set out in the table PMBs shall accrue towards the total benefit PMBs are not subject to limit In appropriate cases the limit for medical appliances shall not accrue towards this limit	M0 – R7 420 M1 – R8 990 M2 – R10 920 M3 – R11 650 M4+ – R13 350
	Dentistry (conservative and restorative) Subject to OOH limit	100% of POLMED rate Includes dentist's costs for in-hospital non-PMB procedures
	General practitioners The limit for consultations shall accrue towards OOH limit POLMED GP network	Subject to maximum number of visits/consultations per family per annum, as follows: M0 – 8 M1 – 12 M2 – 15 M3 – 18 M4+ – 22
	Medication (acute) Subject to OOH limit	100% of MetRef price R8 060 per family Subject to MetRef formulary
	Medication (over the counter [OTC]) Subject to OOH limit	100% of MetRef price Maximum of R800 per family per annum Subject to restricted formulary Shared limit with acute medication
	Audiology Subject to OOH limit	100% of POLMED rate Subject to referral by GP, ear, nose and throat (ENT) specialist, paediatrician, physician or neurologist

LOWER PLAN

OVERALL OUT-OF-HOSPITAL BENEFITS	**Occupational and speech therapy** Subject to OOH limit	PMBs only
	Pathology Subject to protocols and clinical guidelines	100% of POLMED rate/agreed tariff/ cost M0 – R2 610 M1 – R3 860 M2 – R4 670 M3 – R5 780 M4+ – R7 160 The defined limit per family will apply for any pathology service done out of hospital
	Physiotherapy Subject to OOH limit, protocols and clinical guidelines	100% of POLMED rate/agreed tariff/ cost Annual limit of R2 020 per family
	Social worker Subject to OOH limit	100% POLMED rate Annual limit of R2 020 per family
	Specialists The limit for consultations shall accrue towards OOH limit POLMED will allow two specialist visits per beneficiary per year without GP referral Referral is not necessary for gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists (dialysis), dental specialists and supplementary/allied health services (excluding audiology services)	100% of POLMED rate or agreed tariff Limited to 4 visits per beneficiary and 8 visits per family per annum Subject to referral by a GP

STAND-ALONE BENEFITS	**Allied health services** Includes biokineticists, chiropractors, dieticians, homeopaths, chiropodists, podiatrists, reflexologists, naturopaths, orthoptists, osteopaths and therapeutic massage therapists **Benefit based upon evidence-based medicine (EBM)**	No benefit	
	Appliances (medical and surgical) Oxygen is subject to pre-authorisation Costs for maintenance are a Scheme exclusion Hearing aid reimbursements are subject to referral by the GP or ENT specialist, paediatrician, physician or neurologist for audiology services	100% of POLMED rate and subject to:	
		Blood transfusions	No limit
		Hearing aids	R9 530 per hearing aid or R18 940 per set per three years per beneficiary
		Nebuliser	R1 080 per family once every four years
		Glucometer	R1 080 per family once every four years
		CPAP machine	R7 720 per family once every four years
		Wheelchair (non-motorised)	R10 090 per beneficiary once every three years
		Wheelchair (motorised)	R28 940 per beneficiary once every three years
		Insulin delivery devices and urine catheters	Paid from hospital benefit up to the mean price of three quotation

LOWER PLAN

STAND-ALONE BENEFITS	**Dentistry (specialised)** PMBs and Scheme rules apply Pre-authorisation required Subject to dental protocols	No benefit except for PMBs Only covers any specialised dental procedures meeting PMB criteria that are done in/out of hospital
	Maternity benefits: Including home birth The limit for consultations shall not accrue towards OOH limit Pre-authorisation required Enrolment on the Maternity Management Programme is encouraged Case managed according to treatment protocols	100% of POLMED rate/agreed tariff/ cost The benefit shall include three specialist consultations per beneficiary per pregnancy Annual limit of R3 400 for ultrasound scans per family Home birth is limited to R12 140 per beneficiary per annum Limited to 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
	Maxillo-facial PMBs and Scheme rules apply Pre-authorisation required	No benefit except for PMBs Surgical removal of impacted teeth is covered subject to non-PMB overall limit Refer to Annexure E for details
	Medical assistive devices i.e. crutches, walking frames, medical inner soles and commodes	100% of POLMED rate/agreed tariff/ cost Annual limit of R2 270 per family Includes medical devices in/out of hospital

LOWER PLAN

STAND-ALONE BENEFITS	**Medication (chronic)** Subject to the completion of the chronic medication application and approval Courier pharmacies: Medipost and Pharmacy Direct Retail pharmacies: Clicks and MediRite	100% of MetRef price Subject to the MetRef formulary Approved PMB CDL conditions are not subject to limit
	Optical Includes frames, lenses and eye examinations One eye examination per beneficiary per two years (unless previously approved for clinical indication) Benefits are not subject to pro rata but calculated from the benefit service date Each claim for lenses/frames must be submitted with 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 Annual contact lens limit is specified Contact lens re-examination can be claimed for in six-monthly intervals PPN is the preferred provider network	The benefit per beneficiary (per 24-month benefit cycle) at a Preferred Provider Network (PPN) provider would be: One composite consultation inclusive of a refraction, tonometry, visual field screening and the collection of blood pressure, glucose and cholesterol readings AND EITHER SPECTACLES A PPN frame to the value of R150 and R380 towards lens enhancements OR R530 towards the cost of any alternative frame and/or lens enhancements WITH EITHER one pair of clear aquity single vision or clear aquity bifocal lenses or clear aquity multifocal lenses up to the value of clear bifocal lenses

STAND-ALONE BENEFITS	**Optical** (continued)	OR CONTACT LENSES Contact lenses to the value of R530 Contact lens re-examination to a maximum cost of R210 per consultation Benefits at a non-PPN provider would be: One consultation, limited to a maximum cost of R310 AND EITHER SPECTACLES R530 towards frame and/or lens enhancements WITH EITHER One pair of clear aquity single vision lenses limited to R150 per lens or one pair of clear aquity bifocal lenses limited to R325 or multifocal clear aquity lenses covered up to the value of clear bifocal lenses OR CONTACT LENSES Contact lenses to the value of R530 Contact lens re-examination to a maximum cost of R210 per consultation

LOWER PLAN

STAND-ALONE BENEFITS	**Preventative care (refer to Annexure F)** Funded from risk; benefit shall not accrue to OOH limit Risk assessment tests: • Annual medical examination (code 0190-0192) • Baby immunisation • Bone densitometry scan • Cholesterol test • Circumcision • Contraceptives (as per Department of Health [DoH] guideline) • Dental • Flu vaccine • Glaucoma screening • Glucose screening • HIV tests • Mammogram • Pap smear • Pneumococcal vaccine • Prostate screening • Psycho-social services	Early detection screening limited to periods specified in the schedule
	Radiology (basic) i.e. black and white X-rays and soft tissue ultrasounds Claims for PMBs accrue towards the limit	100% of POLMED rate/agreed tariff/ cost Limited to R4 670 per family Includes any basic radiology done in/out of hospital
	Radiology (specialised) Pre-authorisation required Claims for PMBs accrue towards the limit	100% of POLMED rate/agreed tariff/ cost Limited to R32 650 per family Includes any specialised radiology done in/out of hospital Subject to a limit of two scans per beneficiary per annum, except for PMBs

ANNEXURE B2

CO-PAYMENTS

OUT OF NETWORK	CO-PAYMENT
GP	Allows for two out-of-network visits
Hospital	R8 000
Pharmacy	20% of costs

ANNEXURE B4

LOWER PLAN CHRONIC LIST

List of chronic conditions: Subject to PMBs

Cardiovascular conditions

Coronary artery disease
Hypertension
Cardiomyopathy
Heart failure
Cardiac dysrhythmias

Pulmonary diseases

Asthma
COPD
Bronchiectasis

Gastro-intestinal conditions

Ulcerative colitis
Crohn's disease

Gynaecological condition

Menopausal treatment

Endocrine conditions

Diabetes mellitus type I
Diabetes mellitus type II
Diabetes insipidus
Hypothyroidism
Addison's disease

Metabolic condition

Hyperlipidaemia

Musculo-skeletal condition

Rheumatoid arthritis

Neurological conditions

Epilepsy
Parkinson's disease
Multiple sclerosis

Psychiatric conditions

Affective disorders (depression and bipolar mood disorder)
Schizophrenic disorders

Urological condition

Chronic renal failure

Ophthalmic condition

Glaucoma

Special category condition

HIV/AIDS

Auto-immune disorder

Systemic lupus erythematosis (SLE)

Haematological condition

Haemophilia

Treatable cancers

As per PMB guideline

LOWER PLAN