ANNEXURE A1

MARINE SCHEDULE

Schedule of benefits with effect from 1 January 2017

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).

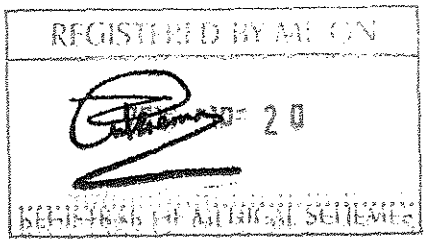
Reference in this Annexure and the following Annexures to the term:

'Polmed rate' shall mean: 2006 National Health Reference Price List (NHRPL) rates + inflationary figure (i.e. the 2006 base tariff increased by the inflationary amounts); and

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

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

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



General rules

In hospital

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

In the case of 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 has to be used to perform a procedure, based on the clinical requirements, as well as the expertise of the doctor doing the procedure.

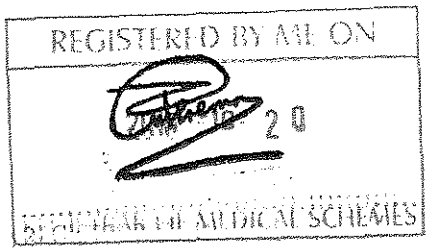
Benefits for private or semi-private rooms are excluded unless they are motivated and approved prior to admission upon the basis of clinical need.

Medicine prescribed during hospitalisation forms part of the hospital benefits.

Medicine prescribed during hospitalisation to 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.



Dental procedures

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

Specialised radiology

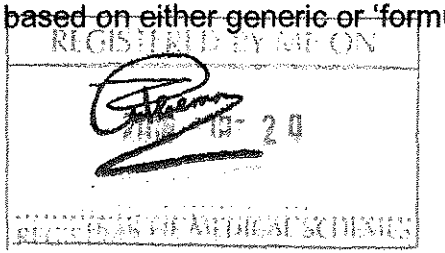
Pre-authorisation is required for all scans, failing which the Scheme may impose a co-payment up to R1 000 per procedure. In the case of emergency the Scheme must be notified within 48 hours or on the first working day of the treatment of the patient.

Medication

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 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.)

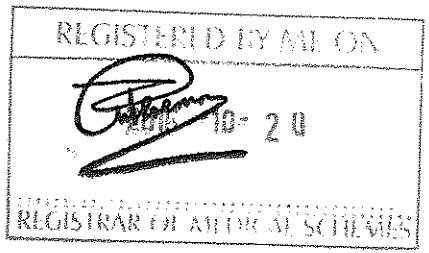
Payment in respect of over-the-counter (OTC), acute and chronic medicine, will be limited to the medicine reference price. This is the maximum allowed cost and may be based on either generic or 'formulary' reference pricing. The balance of the cost needs to be funded by the member.



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, an authorisation will be granted for the diagnosed conditions. Beneficiaries will have access to a group ('basket') of medicines appropriate for the management of their particular conditions/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 medicines are included in the condition-specific medicine formulary. Updates to the authorisation will be required for newly diagnosed conditions for the beneficiary. Medication that is not included in the baskets may be available through an exception management process, for which a medicine-specific authorisation may be granted; this process requires motivation from the treating service provider and will be reviewed based on the exceptional needs of the beneficiary.

The member needs to re-apply for an authorisation at least one month prior to expiry of an existing chronic medicine authorisation, failing which any claims received will not be paid from the chronic medicine benefit, but from the acute medicine benefit, subject to the available benefits. This only applies to authorisations that are not on-going and have an expiry date.

The Scheme shall only consider claims for medicines prescribed by a person legally entitled to prescribe medicine and which is dispensed by such a person or a registered pharmacist.
Flu vaccines and vaccines for children under six years of age are obtainable without prescription.



Specialist referral

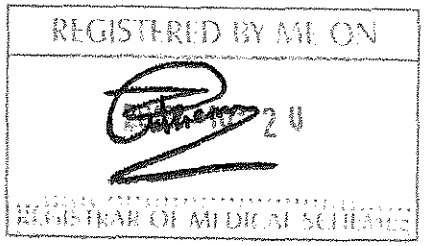
All Polmed beneficiaries need to be referred to specialists by a general practitioner (GP). The Scheme will impose a co-payment of up to R1 000 if the member consults a specialist without the referral. The co-payment will be payable by the member to the specialist and is not refundable by the Scheme.

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

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

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. The cut-off date for Ex gratia applications will be the end of April in the year after the service was rendered.



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 financial year.

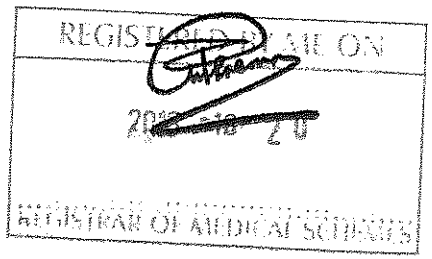
Designated service provider (*out-of-network rule*)

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

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

Examples of designated service providers (where applicable) are:

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



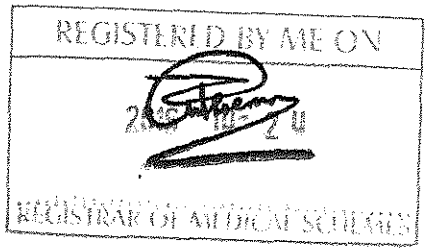
Designated GP provider (network GP)

Members are allowed two visits to a GP who is not part of the network per beneficiary per annum for emergency or out-of-town situations. Co-payments shall apply once the maximum out-of-network consultations are exceeded.

Designated pharmacy network

Polmed has appointed service providers for the provision of chronic medication. The Scheme utilises the courier pharmacies 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 that must be paid directly to the provider by the member.

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



DEFINITION OF TERMS

Designated Service Provider

This is a list of service providers that have been contracted by Polmed to render services to its members at a negotiated tariff and or agreed treatment protocols and or agreed adherence to other managed care interventions.

Formulary

A formulary is a list of cost effective, evidence based medicines that will be reimbursed for the treatment of chronic conditions. This list is constantly reviewed, and funding is subject to clinical guidelines, protocols and Scheme Rules.

Generic Substitution

This means substituting the chemical entity in the same dosage form for one marketed by a different company.

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 in excess of those agreed upon with the service provider or in excess of 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

Medicine reference price

This is the reference pricing system applied by the Scheme; it may be based on either generic or 'formulary' reference pricing. 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.

The fundamental principle of any reference pricing system is that it does not restrict a member's choice of medicine, but instead limits the amount that will be paid for it. Accessibility of products within the reference price groups is taken into account when defining the 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 and maximillofacial surgery. All specialised dentistry services and procedures must be pre-authorised, falling which the Scheme will impose a co-payment of R500.

Registration for chronic medication

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

Enrolment on the Disease Management Programme

Members will be identified and contacted in order to enrol 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 are

registered on the programme receive a treatment plan (care plan) which lists authorised medical services, such as consultations, blood tests and radiological tests related to the management of their conditions.

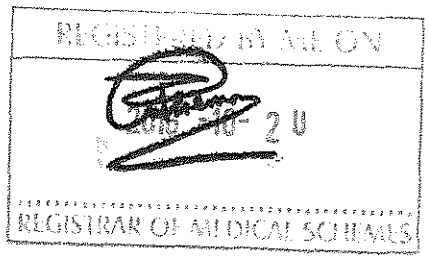
The claims data for chronic medication, consultations and hospital admissions is used to identify the members that are eligible for enrolment on the programme. Members are also encouraged to register themselves on the programme.

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/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.



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

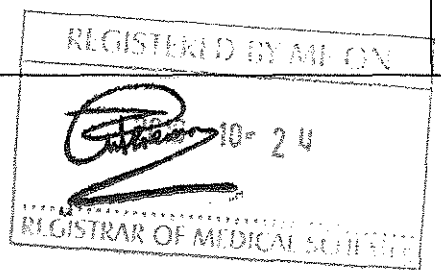
	MARINE	
IN-HOSPITAL BENEFITS	**Annual overall in-hospital limit** In-hospital benefits are: Subject to the Scheme's relevant managed healthcare programmes and includes the application of treatment protocols, case management and pre-authorisation; a R5 000 penalty may be imposed if no pre-authorisation is obtained 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	Unlimited in private hospitals
	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 The hospital and anaesthetist's costs will be reimbursed from the in-hospital benefit
	Emergency medical assistance *Netcare 911 (082 911) is the DSP*	

	MARINE	
IN-HOSPITAL BENEFITS	**Chronic kidney dialysis** National Renal Care (NRC) and Fresenius Medical Care are preferred providers	100% of agreed tariff at DSP
	Mental health	100% of Polmed rate or at cost for PMB's. Annual limit of 21 days per beneficiary Limited to a maximum of three days' hospitalisation for beneficiaries admitted by a GP or a specialist physician Additional hospitalisation to be motivated by the medical practitioner
	Medication: Non-PMB specialist drug limit, e.g. biologicals	100% of Polmed rate Pre-authorisation required Specialised medicine sub-limit of R104 511 per family
	Oncology (chemotherapy and radiotherapy) Independent Clinical Oncology Network (ICON) is the DSP	100% of agreed tariff at DSP Limited to R420 428 per beneficiary per annum; includes MRI/CT or PET scans related to oncology
	Organ and tissue transplants	100% of agreed tariff at DSP or at cost for PMBs Subject to clinical guidelines used in State facilities Unlimited radiology and pathology for organ transplant and immunosuppressant's

	MARINE	
IN-HOSPITAL BENEFITS	**Pathology**	Service will be linked to hospital pre-authorisation
	Physiotherapy	Service will be linked to hospital pre-authorisation
	Prostheses (internal and external)	100% of Polmed rate or at cost for PMBs Subject to pre-authorisation and approved product list Limited to R61 798 per beneficiary
	Refractive surgery	100% of Polmed rate Subject to pre-authorisation Procedure is performed out of hospital and in day clinics
	General practitioners (GPs)	100% of agreed tariff at DSP, 100% of Polmed rate at non-DSP or at cost for involuntary access to PMBs
	Specialists **Anaesthetists**	100% of agreed tariff at DSP, 100% of Polmed rate at non-DSP or at cost for involuntary access to PMBs 150% of Polmed rate or at cost for PMBs

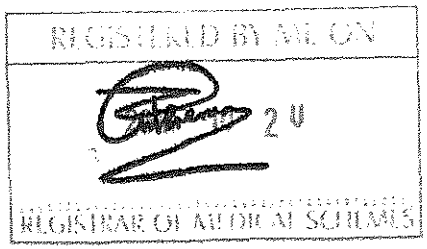
MARINE		
OVERALL OUT-OF- HOSPITAL BENEFITS	**Annual overall out-of-hospital (OOH) limit** Benefits shall not exceed the amount set out in the table PMBs shall first accrue towards the total benefit, but are not subject to a limit In appropriate cases the limit for medical appliances shall not accrue 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 – R19 057 M1 – R23 191 M2 – R27 944 M3 – R32 045 M4+ R34 775
	Dentistry (conservative and restorative)	100% of Polmed rate Subject to the OOH limit and includes dentist's costs for in-hospital, non-PMB procedures 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	
OVERALL OUT-OF- HOSPITAL BENEFITS	**General practitioners (GPs)** Polmed has a GP network	100% of agreed tariff at DSP or at cost for involuntary access to PMBs The limit for consultations shall accrue towards the OOH limit Subject to maximum number of visits/consultations per family per annum, as follows: • M0 – 11 • M1 – 16 • M2 – 20 • M3 – 24 • M4 – 29
	Medication (acute)	100% of Polmed rate Annual limit of R16 551 per family Subject to the OOH limit and the medicine reference price

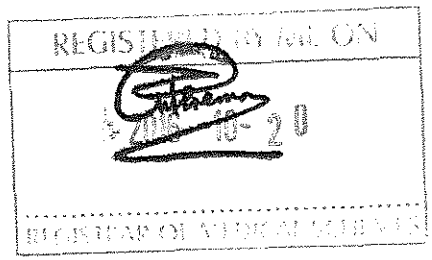


	MARINE	
OVERALL OUT-OF-HOSPITAL BENEFITS	**Medication (over the counter [OTC])**	100% of Polmed rate Annual limit of R1 090 per family Subject to the OOH limit; shared limit with acute medication
	Audiology	100% of Polmed rate Subject to the OOH limit Subject to referral by GP, ear, nose and throat (ENT) specialist, paediatrician, physician or neurologist
	Occupational and speech therapy	100% of Polmed rate Annual limit of R2 528 per family Subject to OOH limit
	Pathology	M0 – R3 180 M1 – R4 585 M2 – R5 483 M3 – R6 753 M4+ R8 281 The defined limit per family will apply for any pathology service done out of hospital

MARINE		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Physiotherapy**	100% of Polmed rate Annual limit of R4 585 per family Subject to the OOH limit
	Social worker	100% of Polmed rate Annual limit of R4 585 per family Subject to the OOH limit
	Specialists Referral is not necessary for gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists (dialysis), dental specialists and supplementary/allied health services (excluding audiology services)	100% of agreed tariff at DSP or at cost for involuntary access to PMBs The limit for consultations shall accrue towards the OOH limit Limited to five visits per beneficiary and 11 visits per family per annum Subject to referral by a GP (two specialist visits per beneficiary without GP referral allowed) R1 000 co-payment if no referral is obtained



	MARINE	
STAND-ALONE BENEFITS	**Allied health services and alternative healthcare providers** Includes chiropractors, biokineticists, dieticians, homeopaths, chiropodists, podiatrists, reflexologists, naturopaths, orthoptists, osteopaths, and therapeutic massage therapists **Benefits will be paid for clinically appropriate services**	100% of Polmed rate Annual limit of R2 528 per family Subject to the OOH limit



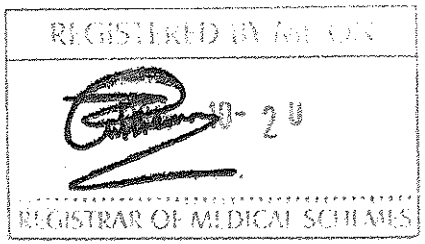
STAND-ALONE BENEFITS

Appliances (medical and surgical)

Pre-authorisation is required for the supply of oxygen

All costs for maintenance are a Scheme exclusion

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

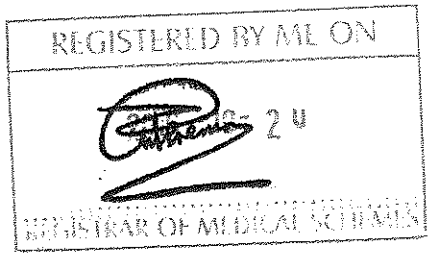


100% of Polmed rate and subject to:

Blood transfusions	Unlimited
Hearing aids	R13 381 per hearing aid or R26 595 per beneficiary per set every three years
Nebuliser	R1 270 per family once every four years
Glucometer	R1 270 per family once every four years
CPAP machine	R8 933 per family once every four years
Wheelchair (non-motorised)	R14 865 per beneficiary once every three years
Wheelchair (motorised)	R49 966 per beneficiary once every three years
Insulin delivery devices and urine catheters	Paid from the hospital benefit up to the mean price out of three quotations
Medical assistive devices	Annual limit of R3 180 per family and includes medical devices in/out of hospital

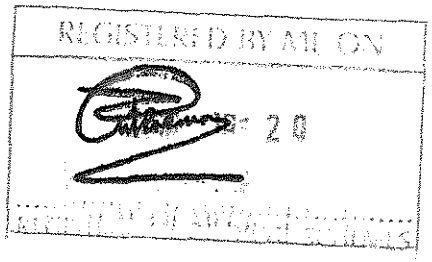
	MARINE	
STAND-ALONE BENEFITS	**Dentistry (specialised)** Pre-authorisation required	100% of Polmed rate or at cost for PMBs An annual limit of R13 439 per family Benefits shall not exceed the set out limit and includes any specialised dental procedures done in/out of hospital Includes metal-based dentures Excludes osseointegrated implants Subject to dental protocols
	Maternity benefits, including home birth Pre-authorisation required and 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 R15 921 per beneficiary per annum Annual limit of R4 472 for ultrasound scans per family; 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
	Maxillofacial Pre-authorisation required	Shared limit with specialised dentistry Excludes osseointegrated implants

	MARINE	
STAND-ALONE BENEFITS	**Chronic medication refers to non-PMB conditions** Subject to prior application and/or registration of the condition Approved PMB-CDL conditions are not subject to a limit Designated service providers: Courier pharmacies: Medipost and Pharmacy Direct Retail pharmacies: Clicks and MediRite	100% of medicine reference price The extended list of chronic conditions (non-PMBs) are subject to the following limits: Member with no registered dependants: Annual limit of R9 230 Member with registered dependants: Annual limit of R16 568 Subject to the medicine reference price and formulary.



MARINE		
STAND-ALONE BENEFITS	**Optical** Includes frames, lenses and eye examinations The eye examination is per beneficiary every two years (unless prior approval for clinical indication has been obtained) Benefits are not pro rata, but calculated from the benefit service date Each claim for lenses or frames must be submitted with the lens prescription 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	The benefit per beneficiary (per 24-month benefit cycle) at a *Preferred Provider Negotiators (PPN) provider would be*: One composite consultation, inclusive of refraction, tonometry and visual field screening; collection of blood pressure, glucose and cholesterol readings **AND EITHER SPECTACLES** A PPN frame or alternative frame plus lens enhancement to the value of R950. **WITH EITHER** One pair of clear Aquity single-vision or clear Aquity bifocal lenses or clear Aquity multifocal lenses **OR CONTACT LENSES** Contact lenses to the value of R1510 Contact lens re-examination to a maximum cost of R220 per consultation

MARINE		
STAND-ALONE BENEFITS	PPN is the preferred provider network	*Non-PPN provider would be*: One consultation limited to a maximum cost of R345 **AND EITHER SPECTACLES** R950 towards a frame and/or lens enhancements **WITH EITHER** One pair of single-vision lenses, limited to R165 per lens, or one pair of clear flat-top bifocal lenses, limited to R360, or one pair of clear flat-top multifocal lenses, limited to R660 per lens **OR CONTACT LENSES** Contact lenses to the value of R1 510 Contact lens re-examination to maximum cost of R220 per consultation



STAND-ALONE BENEFITS	**Preventative care (refer to Annexure E)** One wellness measure per year, including: • Blood pressure test • Body mass index test • Occult blood test • Waist-to-hip ratio measurement • Cholesterol screening (Z13.8) • Glucose screening (Z13.1) • Healthy diet counselling (Z71.3) • Risk assessment tests: - Baby immunisation (as per the Department of Health guidelines) - Bone densitometry scan - Circumcision - Contraceptives (as per Department of Health guidelines) - Dental screening (codes 8101, 8151and 8102) - Flu vaccine - Glaucoma screening - Glucose screening - HIV tests - Mammogram - Pap smear - Pneumococcal vaccine - Prostate screening - Psycho-social services	100% of Polmed rate or agreed tariff where applicable Early detection screening limited to periods specified in Annexure E Funded from the risk pool; the benefit shall not accrue to the OOH limit Beneficiary over the age 50.

	MARINE	
STAND-ALONE BENEFITS	**Radiology (basic)** i.e. black and white X-rays and soft tissue ultrasounds	100% of agreed tariff or at cost for PMBs Limited to R6 180 per family Includes any basic radiology done in/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
	Two (2) MRI	Subject to a limit of two scans per family per annum, except for PMBs
	Three (3) CT Scans	Subject to a limit of three scans per family per annum, except for PMBs