ANNEXURE B1

LOWER PLAN SCHEDULE (name changed to AQUARIUM)

Schedule of benefits with effect from 1 January 2016

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 term:

"Polmed rate" shall mean: 2006 NHRPL + 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 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 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.

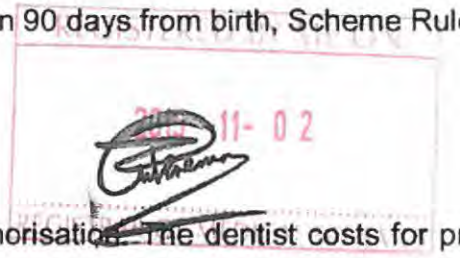
Benefits for private or semi-private rooms are excluded unless they are motivated and approved prior to admission upon the basis of clinical need.

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 or a rand value equivalent per beneficiary per admission, except 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:

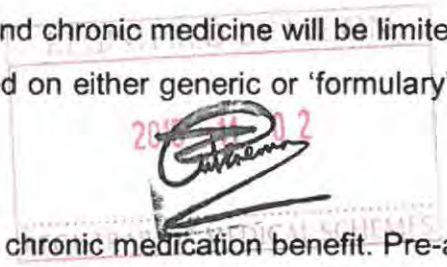
All dental procedures performed in-hospital require pre-authorisation. The dentist costs for procedures that are normally done in doctor's rooms, when performed in-hospital, shall be reimbursed from the out-of-hospital benefit, subject to the availability of funds. The hospital and anaesthetist's costs 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 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 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 which may be based on either generic or 'formulary' reference pricing. The balance of the cost needs to be funded by the member.

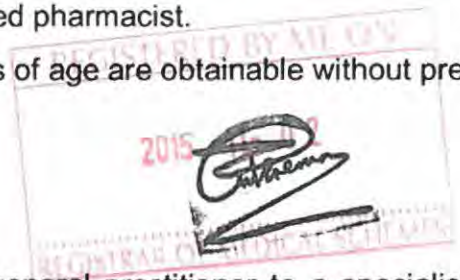


Pre-authorisation is required for items funded from the chronic medication benefit. Pre-authorisation is based on evidence based medicine (EBM) principles and the funding guidelines of the Scheme. Once predefined criteria are met, an authorisation will be granted for the diagnosed condition/s. Beneficiaries will have access to a group ("basket") of medicines appropriate for the management of a particular condition / 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 basket. Updates to the authorisation will be required for newly diagnosed condition for the beneficiary. Medication that may not be included in the "basket(s)" 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 reviewed will not pay from the chronic medicine benefit and will pay from the acute medicine benefits if benefits exist. This only applies to authorisations that are not on-going and have an expiry date.

The scheme shall only consider claims for medicines obtained on prescription of a person legally entitled to prescribe medicine and dispensed by such 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 by a general practitioner to a specialist. The beneficiary or the referring general practitioner (GP) is required to obtain a referral number which can be obtained from the Scheme. The Scheme will impose a co-payment 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 specialists 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, ENT, paediatrician, physician or neurologist.

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 the 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 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 paid directly to the provider by the member.

Access the list of the providers at www.polmed.co.za , on the cellphone via the mobile site or the request via the Client Service Department.

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

Designated GP provider (network GP)

Members are allowed two visits out of a GP network per beneficiary per annum (i.e. to a GP who is not part of the network) 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 provider(s) 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 paid directly to the provider by the member.

Access the list of the providers at www.polmed.co.za , via the mobile telephone site or on request via the Client Service Department.

- Pharmacy(Medicine) DSP

DEFINITION OF TERMS

Co-payment

A co-payment is an amount payable by a member to the service provider at the point of service. This includes all the costs in excess of those agreed 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 derived based on generic reference price or 'formulary' 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. 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. Accessibility of products within the reference price groups is taken into accounts when defining the group.

Specialised dentistry

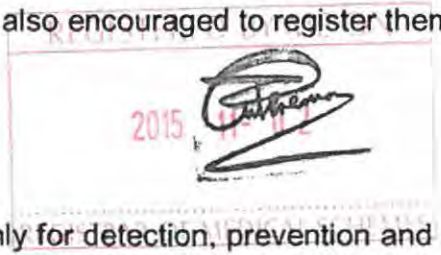
Specialised dentistry refers to services that are not defined as basic dentistry. These include periodontal surgery, crowns and bridges, implant procedures, inlays, indirect veneers, orthodontic treatment, removal of impacted teeth, and maxillo-facial surgery. All specialised dentistry services and procedures must be pre-authorised, falling which the Scheme will impose a co-payment of R 500.

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 that members apply via the Chronic Medicine Management programme to obtain an authorisation to access this chronic medication benefit. The beneficiary will be issued with a disease specific authorisation which will grant access to a range of medicines, referred to as the "disease authorisation basket". The members will also receive a letter by post, or email indicating the decision on the application.

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 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. Members are also encouraged to register themselves 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.

AQUARIUM BENEFIT SCHEDULE		
GENERAL BENEFIT RULES	**Benefit design**	This option provides for benefits to be provided only in appointed designated service provider (DSP) hospitals. It also provides a reasonable level of out-of-hospital (day-to-day) care. This option is intended to provide for the needs of families who have little healthcare needs or whose chronic conditions are under control. This option is not intended for members who require to seek medical assistance on a regular basis, or who are concerned about having extensive access to health benefits.
	Preauthorisation, 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 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 preauthorisation, 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 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	There is no overall annual limit for PMBs / life-threatening emergency.
	Tariff	100% of Polmed rate or agreed tariff or at cost for involuntary access to PMB's.

AQUARIUM		
IN-HOSPITAL BENEFITS	**Annual overall in-hospital limit** In hospital benefits are : Subject to the Scheme's relevant managed healthcare programme(s) which includes the application of treatment protocols, case management and pre-authorisation. R5 000 penalty may be imposed if no pre-authorisation is obtained. Subject to PMBs i.e. no limit in case of life-threatening emergency or PMB condition. Subject to applicable tariff i.e. 100% of Polmed rate or agreed tariff or at cost for involuntary PMB access	Non-PMB admissions will be subject to an overall limit of R 200 000 per family. R8 000 co-payment for admission in a non-DSP hospital. No co-payment if the procedure is performed in a DSP and or a day clinic.
	Dentistry (conservative, restorative)	100% of Polmed rate Dentists' 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) is the DSP*	100% of agreed tariff

AQUARIUM		
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 3 days hospitalisation for beneficiaries admitted by a general practitioner or a specialist physician. Additional hospitalisation to be motivated by the medical practitioner.
	Medication: Non-PMBs specialist drug limit, e.g. biologicals	100% of Polmed rate Pre-authorisation required ; Specialised medicine sublimit of R 69 430 per family
	Oncology (chemotherapy and radiotherapy) Independent Clinical Oncology Network (ICON) is a designated service provider	100% of agreed tariff at DSP Limited to R 231 578 per beneficiary per annum; includes MRI / CT or PET scans related to oncology.

AQUARIUM		
IN-HOSPITAL BENEFITS	**Organ and tissue transplants**	100% of agreed tariff at DSP or at costs 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 preauthorisation
	Physiotherapy	Service will be linked to hospital preauthorisation
	Prosthesis (internal and external)	100% of Polmed rate Subject to pre-authorisation and approved product list. Limited to R 57 240 per beneficiary
	Refractive surgery	No benefit
	GP	100% of agreed tariff at DSP, 100% of Polmed rate for non-DSP or at cost for involuntary PMB access
	Specialists	100% of agreed tariff at DSP, 100% of Polmed rate for non-DSP or at cost for involuntary PMB access.
	Anaesthetists	150% of Polmed rate or at cost for PMBs

AQUARIUM		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Annual overall out-of-hospital (OOH) limit.** Benefits shall not exceed the amount set out in the table. PMB benefits 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. Out of hospital benefits are: Subject to protocols and clinical guidelines, Subject to PMBs, Subject to applicable tariff i.e. 100% of Polmed rate or agreed tariff or at cost for involuntary access to PMB's.	• M0 - R 7 865 • M1 -R 9 529 • M2 -R 11 575 • M3 -R 12 349 • M4+ R 14 151

AQUARIUM		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Dentistry (conservative and restorative)**	100% of Polmed rate Subject to OOH limit and includes dentist's cost for in-hospital non-PMB procedures. Routine consultation, scale and polish are subject to two annual check-ups per beneficiary. Oral hygiene instructions are subject to once in 12 months per beneficiary.
	General practitioners(GPs) POLMED has a GP Network	100% of agreed tariff at DSP or at cost for involuntary access to PMB's. The limit for consultations shall accrue towards OOH limit. Subject to maximum numbers of visits /consultation per family per annum as follows: • M0 - 8 • M1 - 12 • M2 - 15 • M3 – 18 • M4 – 22

AQUARIUM		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Medication (acute)**	100% of Polmed rate Annual limit of R 8 544 per family. Subject to OOH limit and the Medicine reference price
	Medication: over-the-counter (OTC)	100% of Polmed rate Annual limit of R 850 per family Subject to OOH and it is a shared limit with acute medication
	Audiology	100% of Polmed rate Subject to OOH limit. Subject to referral by GP, ENT, Paediatrician, Physician or Neurologist.
	Occupational and speech therapy	PMBs only Benefit first accrue to the OOH limit
	Pathology	M0 -R 2 767 M1 -R 4 092 M2 -R 4 950 M3 -R 6 127 M4+ R 7 590 The defined limit per family will apply for any pathology service done out of hospital.

AQUARIUM		
OVERALL OUT-OF-HOSPITAL BENEFITS	**Physiotherapy**	100% of Polmed rate Annual limit of R 2 141 per family Subject to OOH limit
	Social worker	100% of Polmed rate Annual limit of R 2 020 per family Subject to OOH limit
	Specialists Referral is not necessary for gynaecologists, psychiatrists, oncologists, ophthalmologists, nephrologists (dialysis), dental specialists and supplementary / allied health services (excluding audiology service).	100% of agreed tariff at DSP or at cot for involuntary PMB access The limit for consultations shall accrue towards OOH limit Limited to 4 visits per beneficiary and 8 visits per family per annum. Subject to referral by a GP (two specialist visits per beneficiary without GP referral allowed). R 1000 co-payment if no referral is obtained

AQUARIUM		
STAND-ALONE BENEFITS	**Allied health services and alternative healthcare providers** Includes bio kinetics, chiropractors, dieticians, homeopaths, chiropodists, podiatrists, reflexologists, naturopaths, orthoptists, osteopaths, and therapeutic massage therapist **Benefit is subject to clinical appropriate services**	No Benefit REGISTERED BY ME ON 11- 02 REGISTRAR OF MEDICAL SCHEMES

AQUARIUM		
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 the hearing aids to be reimbursed.	100% of Polmed rate and subject to:

Blood transfusions	No Limit
Hearing aids	R 10 102 per hearing aid or R 20 076 per set per three years
Nebuliser	R1 145 per family once every four years
Glucometer	R 1 145 per family once every four years
CPAP machine	R 8 183 per family once every four years
Wheelchair (not motorized)	R 10 695 per beneficiary once every three years
Wheelchair (motorized)	R30 676 per beneficiary once every three years
Insulin delivery device, Urine catheters	Paid from hospital benefit up to the mean price of three quotations
Medical Assistive device	Annual limit of R 2 406 per family and includes medical devices in/out of hospital.

AQUARIUM		
STAND-ALONE BENEFITS	**Dentistry (specialised)** Pre - authorisation required	No benefit except for PMBs Only cover specialized dental procedures done in /out of hospital that meet PMB criteria.
	Maternity benefits : including home birth Pre - authorisation required and treatment protocols apply.	100% of Agreed tariff for DSP, 100% of Polmed rate for non-DSP or costs for involuntary access to PMB's. The limit for consultations shall not accrue towards OOH limit The benefit shall include three specialist consultation visits per beneficiary per pregnancy. Home birth is limited to R 12 868 per beneficiary per annum. Annual limit of R3 604 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.
	Maxillo-facial Pre - authorisation required	No benefit except for PMBs Surgical removal of impacted teeth is covered subject to non-PMB overall limit.

AQUARIUM		
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 are: Courier Pharmacies: Medipost and Pharmacy Direct Retail Pharmacies : Clicks and MediRite	No benefit except for PMBs Subject to Medicine reference price

AQUARIUM		
STAND-ALONE BENEFITS	**Optical** Includes frames, lenses and eye examinations Eye examination per beneficiary per 2 years (unless prior 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 2-year benefit cycle. Annual contact lens limit is specified. Contact lens re-examination which can be claimed in 6 monthly intervals	The benefit per beneficiary (per 24 month benefit cycle) at a PPN provider would be : One Composite Consultation inclusive of Refraction, Tonometry &Visual Field Screening; collection of BP, glucose and cholesterol readings. **AND EITHER SPECTACLES** A PPN frame to the value of R150 and R430 towards lens enhancements **OR** R580 towards the cost of any alternative frame /or lens enhancements **WITH EITHER** One pair of Clear Aquity Single vision or clear Aquity Bifocal lenses or clear Aquity Multifocal lenses covered up to the value of clear Bifocal lens limit. **OR CONTACT LENSES** Contact Lenses to the value of R580 Contact lens re-examination to a maximum cost of R210 per consult

AQUARIUM		
STAND- ALONE BENEFITS	PPN is the preferred provider network.	*Non PPN provider would be*: One consultation limited to a maximum cost of R325 ; **AND EITHER SPECTACLES** R580 towards a 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 lens limit. **OR CONTACT LENSES** Contact lenses to the value of R580 Contact lens re-examination to a maximum cost of R210 per consult.

AQUARIUM		
STAND-ALONE BENEFITS	**Preventative care (refer to Annexure E)** One wellness measure per year including : Blood Pressure Body mass index test Waist to hip ratio measurement Cholesterol screening (Z 13.8), Glucose screening (Z 13.1), Healthy Diet Counselling (Z 71.3) , Risk assessment tests • Baby immunisation (as per the DoH guidelines) • Bone densitometry scan • Circumcision • Contraceptives (as per DoH guideline) • Dental screening (codes 8101,8151 and 8102) • Flu vaccine • Glaucoma 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 Risk and the benefit shall not accrue to OOH limit

AQUARIUM		
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 R 4 950 per family Includes any basic radiology done in/out of hospital Claims for PMB's first accrue towards the limit
	Radiology (specialised) Pre - authorisation required	100% of agreed tariff or at cost for PMBs Limited to R 34 610 per family Includes any specialised radiology service done in/out of hospital. Claims for PMB's first accrue towards the limit Subject to a limit of two scans per beneficiary per annum, except for PMBs