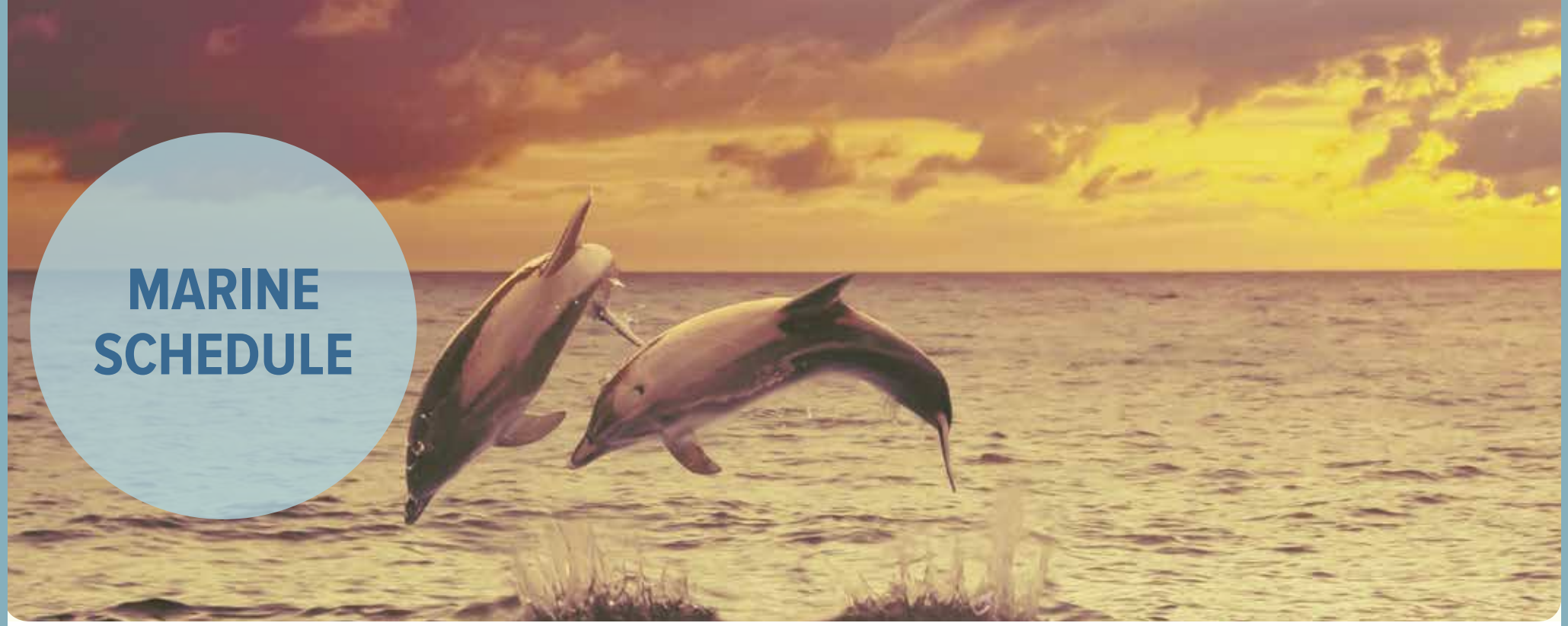


MARINE SCHEDULE

ANNEXURE A1

SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2019

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 herein, with due regard to the provisions in the Act and Regulations in respect of prescribed minimum benefits (PMBs).

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

- **'POLMED rate'** shall mean: 2006 National Health Reference Price List (NHRPL) adjusted on an annual basis with Consumer Price Index (CPI).
- **'Agreed tariff'** shall mean: The rate negotiated by and on behalf of the Scheme with one or more providers/groups.

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

The Scheme does not grant benefits for services rendered outside the borders of the RSA. 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.

MARINE

GENERAL RULES

APPLICATION OF CLINICAL PROTOCOLS AND FUNDING GUIDELINES

POLMED applies clinical protocols, including 'best practice guidelines' as well as evidence-based medicine (EBM) principles in its funding decisions.

DENTAL PROCEDURES

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

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 out-of-network provider, all costs higher than the Scheme 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 cellphones via the mobile site, via POLMED Chat or request it via the Client Service Call Centre.

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.

EMERGENCY MEDICAL SERVICES (EMS): NETCARE 911

72-hour post-authorisation rule
Subject to authorisation within 72 hours of the event, all service providers will need to get an authorisation number from POLMED's DSP.

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

EX GRATIA BENEFIT

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

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

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

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

Pre-authorisation is required for items funded from the chronic medication benefit. Pre-authorisation is based on evidence-based 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 (formulary) of medication appropriate for the management of their conditions or diseases for which they are registered. There is no need for a beneficiary to apply for a new authorisation if the treatment prescribed by the doctor changes and the medication is included in the condition-specific medication formulary. Updates to the authorisation will be required for newly diagnosed conditions for the beneficiary.

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

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

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

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

Flu vaccines and vaccines for children under six years of age are obtainable without prescription and paid from the preventative care benefits.

POLMED GP NETWORK (DESIGNATED GP PROVIDER)

Members are allowed two visits to a General Practitioner (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. PMB rule applies for qualifying emergency consultations.

POLMED HOSPITAL NETWORK (DESIGNATED HOSPITAL NETWORK)

The POLMED Hospital DSP includes hospitals with a national footprint. Members can access the list of hospitals

MARINE

in the network at www.polmed.co.za, on their cellphones via the mobile site, via POLMED Chat or request it via the Client Service Call Centre.

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

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

Pre-authorisation will be managed under the auspices of managed healthcare. The appropriate facility must be used to perform a procedure, based on the clinical requirements, as well as the expertise of the doctor doing the procedure. Benefits for private or semi-private rooms are excluded unless they are motivated and approved prior to admission upon the basis of clinical need.

Medication prescribed during hospitalisation forms part of the hospital benefits. Medication 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 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.

POLMED PHARMACY NETWORK

POLMED has established an open pharmacy network for the provision of acute, chronic and over-the-counter (OTC) medication. Medication included in POLMED's formulary will be funded in full, subject to the availability of funds. **Members who voluntarily opt to use non-formulary products will be liable for a 20% co-payment.** POLMED has agreed dispensing fees with the network pharmacies. **A 20% co-payment will be levied in the event of voluntary utilisation of an out-of-network pharmacy.** Members can access the list of providers at www.polmed.co.za, on their cellphones via the mobile site, via POLMED Chat or request it via the Client Service Call Centre.

PRO RATA BENEFITS

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

SPECIALISED RADIOLOGY (MRI AND CT SCANS)

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

SPECIALIST REFERRAL

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

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

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

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

MARINE

DEFINITION OF TERMS

BASIC DENTISTRY

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

Other procedures that fall under this category are:

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

CO-PAYMENT

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

FORMULARY

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

MEDICINE GENERIC REFERENCE PRICE

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

REGISTRATION FOR CHRONIC MEDICATION

POLMED provides for a specific list of chronic conditions that are funded from the chronic medication benefit (i.e. through a benefit that is separate from the acute medication benefit).

POLMED requires members to apply for authorisation via the Chronic Medicine Management Programme to access this chronic medication benefit. Members will receive communication via email, SMS or post indicating whether their application was successful or not. If successful, the beneficiary will be issued with a disease-specific authorisation, which will allow them access to medication included in the POLMED formulary.

POLMED will reimburse medication intended for an approved chronic condition for up to four months from the acute medication benefit. Members will be required to register such medication as chronic during the four-month period.

REGISTRATION TO DISEASE RISK MANAGEMENT PROGRAMME

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

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

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 maxillofacial surgery. **All specialised dentistry services and procedures must be pre-authorised, failing which the Scheme will impose a co-payment of R500.**

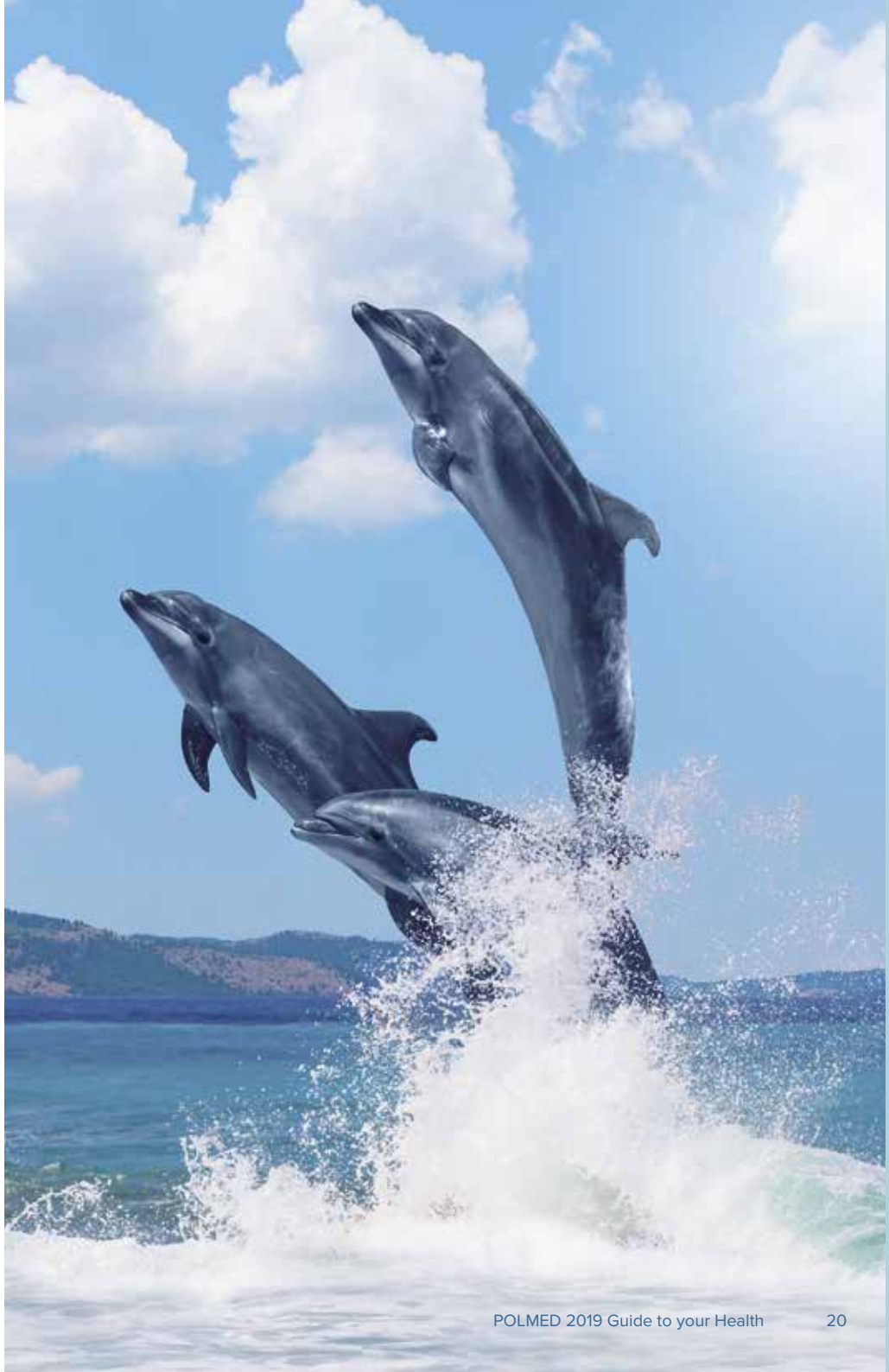
DISCLAIMER

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

MARINE

BENEFIT SCHEDULE

	DESCRIPTION	BENEFIT
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
	Limits are per annum	Unless there is a specific indication to the contrary, all benefit amounts and limits are annual
	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 registration to 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 registration to a management 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 registration to a managed care programme is stipulated to best care for the member and his/her family and to protect the funds of the Scheme
	Statutory prescribed minimum benefits (PMBs)	There is no overall annual limit for PMBs or life-threatening emergencies
	Tariff	100% of POLMED rate **or** Agreed tariff **or** At cost for involuntary access to PMBs



	DESCRIPTION	BENEFIT
IN-HOSPITAL BENEFITS	**Anaesthetists**	150% of POLMED rate
	Annual overall in-hospital limit Subject to the Scheme's relevant managed healthcare programmes and includes the application of treatment protocols, case management and pre-authorisation A R5 000 penalty may be imposed if no pre-authorisation is obtained R8 000 co-payment for admission to a non-DSP hospital	Unlimited at DSPs 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
	Chronic kidney dialysis **Preferred providers:** National Renal Care (NRC) Fresenius Medical Care	100% of agreed tariff at DSP
	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 services (ambulance services)	Subject to POLMED Scheme rules

	DESCRIPTION	BENEFIT
IN-HOSPITAL BENEFITS	**General practitioners (GPs)**	100% of agreed tariff at DSP 100% of POLMED rate at non-DSP **or** At cost for involuntary access to PMBs
	Medication (non-PMB specialist drug limit, e.g. biologicals)	100% of POLMED rate Pre-authorisation required Specialised medication sub-limit of R177 402 per family
	Mental health	100% of POLMED rate **or** At cost for PMBs 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
	Oncology (chemotherapy and radiotherapy) Independent Clinical Oncology Network (ICON) is the DSP	100% of agreed tariff at DSP Limited to R464 834 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 immunosuppressants
	Pathology	Service will be linked to hospital pre-authorisation

MARINE

	DESCRIPTION	BENEFIT
IN-HOSPITAL BENEFITS	**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 R65 320 per beneficiary
	Refractive surgery	100% of POLMED rate Subject to pre-authorisation Procedure is performed out of hospital and in day clinics
	Specialists	100% of agreed tariff at DSP 100% of POLMED rate at non-DSP **or** At cost for involuntary access to PMBs

	DESCRIPTION	BENEFIT
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 – R20 143 M1 – R24 513 M2 – R29 537 M3 – R33 872 M4+ – R36 757
	Audiology Subject to referral by either of the following doctors/specialists: • Ear, nose and throat (ENT) specialist • General practitioner (GP) • Neurologist • Paediatrician • Physician	100% of POLMED rate Subject to the OOH limit
	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

	DESCRIPTION	BENEFIT
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 or consultations per family M0 – 11 M1 – 16 M2 – 20 M3 – 24 M4+ – 29
	Medication (acute)	100% of POLMED rate at DSP M0 – R4 598 M1 – R7 816 M2 – R11 035 M3 – R14 253 M4+ – R17 494 Subject to the OOH limit Subject to the POLMED formulary
	Medication (over the counter [OTC])	100% of POLMED rate at DSP Annual limit of R1 152 per family Subject to the OOH limit Shared limit with acute medication Subject to the POLMED formulary
	Occupational and speech therapy	100% of POLMED rate Annual limit of R2 795 per family Subject to the OOH limit

	DESCRIPTION	BENEFIT
OVERALL OUT-OF-HOSPITAL BENEFITS	**Pathology**	M0 – R3 361 M1 – R4 846 M2 – R5 796 M3 – R7 138 M4+ – R8 753 The defined limit per family will apply for any pathology service done out of hospital
	Physiotherapy	100% of POLMED rate Annual limit of R4 846 per family Subject to the OOH limit
	Social worker	100% of POLMED rate Annual limit of R4 957 per family Subject to the OOH limit
	Specialists Referral is not necessary for the following specialists: • Dental specialists • Gynaecologists • Nephrologists (dialysis) • Oncologists • Ophthalmologists • Psychiatrists • Supplementary or allied health 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 5/five visits per beneficiary **or** 11/eleven visits per family per annum Subject to referral by a GP (2/two specialist visits per beneficiary without GP referral allowed) R1 000 co-payment if no referral is obtained

STAND-ALONE BENEFITS

DESCRIPTION	BENEFIT	
Allied health services and alternative healthcare providers • Biokineticists • Chiropodists • Chiropractors • Dieticians • Homeopaths • Naturopaths • Orthoptists • Osteopaths • Podiatrists • Reflexologists • Therapeutic massage therapists **Benefits will be paid for clinically appropriate services**	100% of POLMED rate Annual limit of R2 733 per family	
Appliances (medical and surgical) Members must be referred for audiology services for hearing aids to be reimbursed Pre-authorisation is required for the listed medical appliances All costs for maintenance are a Scheme exclusion Funding will be based on applicable clinical and funding protocols Quotations will be required	100% of POLMED rate	
	Adult nappies	R946/month (2/two nappies per day) R1 419/month (3/three nappies per day)
	Blood transfusion	Unlimited
	Cochlear implant	
	Consumables associated implanted devices: • Cardiac resynchronisation therapy pacemaker battery replacement • Implantable cardiac defibrillator battery replacement	 Every 5/five years Every 5/five years
	CPAP machine	R9 442 per family Once every 4/four years

STAND-ALONE BENEFITS

DESCRIPTION	BENEFIT	
Appliances (medical and surgical) (continued)	Glucometer	R1 342 per family Once every 4/four years
	Hearing aids	R14 144 per hearing aid **or** R28 111 per beneficiary per set Once every 3/three years
	Implantable cardiac defibrillator	
	Insulin delivery devices Urine catheters and consumables	
	Medical assistive devices	Annual limit of R3 361 per family Includes medical devices in/out of hospital
	Nebuliser	R1 342 per family Once every 4/four years
	Transcatheter aortic valve insertion (TAVI)	
	Wheelchair (motorised) **OR** Wheelchair (non-motorised)	R52 814 per beneficiary Once every 3/three years R15 712 per beneficiary Once every 3/three years

	DESCRIPTION	BENEFIT
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 The extended list of chronic conditions (non-PMBs) are subject to a limit	100% of medication formulary reference price Subject to access at DSP Member with no dependants: Annual limit of R9 756 Member with registered dependants: Annual limit of R17 512
	Dentistry (specialised) Pre-authorisation required	100% of POLMED rate **or** At cost for PMBs An annual limit of R14 205 per family Benefits shall not exceed the set out limit 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 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 R16 828 per beneficiary per annum Annual limit of R4 727 for ultrasound scans per beneficiary; limited to 2/two 2D scans per pregnancy Benefits relating to more than 2/two antenatal ultrasound scans and amniocenteses after 32 weeks of pregnancy are subject to pre-authorisation

	DESCRIPTION	BENEFIT
STAND-ALONE BENEFITS	**Maxillofacial** Pre-authorisation required	Shared limit with specialised dentistry Excludes osseointegrated implants
	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 Contact lens re-examination can be claimed for in six-monthly intervals	***PROVIDER NETWORK*** 100% of cost for a composite consultation, inclusive of the refraction, a glaucoma screening and visual field screening, Authenticate IT and biometric readings **WITH EITHER SPECTACLES** R1 300 towards a frame and/or lens enhancements **LENSES** Either one pair of clear single-vision lenses **or** one pair of clear flat-top bifocal lenses **or** one pair of clear base multifocal lenses **OR CONTACT LENSES** Contact lenses to the value of R1 596 annually Contact lens re-examination to a maximum cost of R233 per consultation ***NON-PROVIDER NETWORK*** One consultation limited to a maximum cost of R300 **WITH EITHER SPECTACLES** R910 towards a frame and/or lens enhancements Single-vision lenses limited to R175 per lens **or** Bifocal lenses limited to R410 per lens **or** Multifocal lenses limited to R710 per lens **OR CONTACT LENSES** Contact lenses to the value of R1 000 annually Contact lens re-examination to a maximum cost of R233 per consultation

MARINE

	DESCRIPTION	BENEFIT
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 532 per family Includes any basic radiology done in or out of hospital Claims for PMBs first accrue towards the limit
	Radiology (specialised) Pre-authorisation required	100% of agreed tariff **or** At cost for PMBs Includes any specialised radiology service done in or out of hospital Claims for PMBs first accrue towards the limit
	2/two MRI scans	Subject to a limit of 2/two scans per family per annum, except for PMBs
	3/three CT scans	Subject to a limit of 3/three scans per family per annum, except for PMBs

ANNEXURE A2

CO-PAYMENTS

OUT OF NETWORK	CO-PAYMENT
General practitioner (GP)	Allows for 2/two out-of-network consultations per beneficiary Co-payments shall apply once maximum out-of-network consultations are exceeded
Hospital	R8 000
Pharmacy	20% of costs for using a non-designated service provider (non-DSP) pharmacy 20% co-payment for voluntarily using a non-formulary product

MARINE

ANNEXURE A4

MARINE: CHRONIC CONDITIONS

Prescribed minimum benefits (PMBs), including chronic Diagnosis and Treatment Pairs (DTPs)

Chronic medication is payable from chronic medication benefits. Once the benefit limit has been reached, it will be funded from the unlimited PMB pool.

Auto-immune disorder

Systemic lupus erythematosus (SLE)

Cardiovascular conditions

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

Endocrine conditions

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

Gastrointestinal conditions

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

Gynaecological conditions

Endometriosis
Menopausal treatment

Haematological conditions

Anaemia
Haemophilia
Idiopathic thrombocytopenic purpura
Megaloblastic anaemia

Metabolic condition

Hyperlipidaemia

Musculoskeletal condition

Rheumatic arthritis

Neurological conditions

Cerebrovascular incident
Epilepsy
Multiple sclerosis
Parkinson's disease
Permanent spinal cord injuries

Ophthalmic condition

Glaucoma

Psychiatric conditions

Affective disorders (depression and bipolar mood disorder)
Post-traumatic stress disorder (PTSD)
Schizophrenic disorders

Pulmonary diseases

Asthma
Bronchiectasis
Chronic obstructive pulmonary disease (COPD)
Cystic fibrosis

Special category conditions

HIV/AIDS
Organ transplantation
Tuberculosis

Treatable cancers

As per PMB guidelines

Urological conditions

Benign prostatic hypertrophy
Chronic renal failure
Nephrotic syndrome and glomerulonephritis
Renal calculi

Extended chronic disease list: Non-PMB

Chronic medication for the conditions listed below is payable from the chronic medication benefit. Benefits subject to the availability of funds.

Dermatological conditions

Acne (clinical photos required)
Eczema
Onychomycosis (mycology report required)
Psoriasis

Ear, nose and throat condition

Allergic rhinitis

Gastrointestinal condition

Gastro-oesophageal reflux disease (GORD) (special motivation required)

Metabolic condition

Gout prophylaxis

Musculoskeletal conditions

Ankylosing spondylitis
Osteoarthritis
Osteoporosis
Paget's disease
Psoriatic arthritis

Neurological conditions

Alzheimer's disease
Meniere's disease
Migraine prophylaxis
Narcolepsy
Tourette's syndrome
Trigeminal neuralgia

Ophthalmic condition

Dry eye or keratoconjunctivitis sicca

Psychiatric condition

Attention deficit hyperactivity disorder (ADHD)

Urological condition

Overactive bladder syndrome

MARINE