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).

**ANNEXURE A1**

**PREVIOUSLY KNOWN AS THE HIGHER PLAN**

**MARINE SCHEDULE**

**SCHEDULE OF BENEFITS WITH EFFECT FROM 1 JANUARY 2016**

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 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 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 basket. 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, 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 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 beneficiary or the referring GP is required to obtain a referral number, which can be obtained from the Scheme. 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 specialties/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.
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
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.

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

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.

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

Pharmacy (medicine) designated service provider.

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.

DEFINITION OF TERMS

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.

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.

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

---

**MARINE BENEFIT SCHEDULE**

### GENERAL BENEFIT RULES

<table>
<thead>
<tr>
<th>Benefit design</th>
<th>This option provides for unlimited hospitalisation paid at the prescribed tariff, as well as for out-of-hospital (day-to-day) benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-authorisation, referrals, protocols and management by programmes</td>
<td>This option is intended to provide for the needs of families who have significant healthcare needs</td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
</tbody>
</table>

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.
<table>
<thead>
<tr>
<th>GENERAL BENEFIT RULES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits are per annum</td>
<td>Unless there is a specific indication to the contrary all benefit amounts and limits are annual</td>
</tr>
<tr>
<td>Statutory prescribed minimum benefits (PMBs)</td>
<td>There is no overall annual limit for PMBs/life-threatening emergencies</td>
</tr>
<tr>
<td>Tariff</td>
<td>100% of Polmed rate or agreed tariff or at cost for involuntary access to PMBs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IN-HOSPITAL BENEFITS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual overall in-hospital limit</td>
<td>Unlimited in private hospitals</td>
</tr>
<tr>
<td>In-hospital benefits are:</td>
<td></td>
</tr>
<tr>
<td>Subject to the Scheme’s relevant managed healthcare programmes and include the application of treatment protocols, case management and pre-authorisation; a R5 000 penalty may be imposed if no pre-authorisation is obtained</td>
<td></td>
</tr>
<tr>
<td>Subject to PMBs, i.e. no limit in case of life-threatening emergencies or for PMB conditions</td>
<td></td>
</tr>
<tr>
<td>Subject to applicable tariff, i.e. 100% of Polmed rate or agreed tariff or at cost for involuntary access to PMBs</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IN-HOSPITAL BENEFITS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentistry (conservative and restorative)</td>
<td>100% of Polmed rate</td>
</tr>
<tr>
<td>Dentist’s costs for basic dental procedures will be reimbursed from the out-of-hospital (OOH) benefit</td>
<td></td>
</tr>
<tr>
<td>The hospital and anaesthetist’s costs will be reimbursed from the in-hospital benefit</td>
<td></td>
</tr>
<tr>
<td>Emergency medical assistance</td>
<td>100% of agreed tariff</td>
</tr>
<tr>
<td>Netcare 911 (082 911) is the DSP</td>
<td></td>
</tr>
<tr>
<td>Chronic kidney dialysis</td>
<td>100% of agreed tariff at DSP</td>
</tr>
<tr>
<td>National Renal Care (NRC) and Fresenius Medical Care are preferred providers</td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>100% of Polmed rate or at cost for PMBs</td>
</tr>
<tr>
<td>Annual limit of 21 days per beneficiary</td>
<td></td>
</tr>
<tr>
<td>Limited to a maximum of three days’ hospitalisation for beneficiaries admitted by a GP or a specialist physician</td>
<td></td>
</tr>
<tr>
<td>Additional hospitalisation to be motivated by the medical practitioner</td>
<td></td>
</tr>
<tr>
<td>Medication: Non-PMB specialist drug limit, e.g. biologicals</td>
<td>100% of Polmed rate</td>
</tr>
<tr>
<td>Pre-authorisation required</td>
<td></td>
</tr>
<tr>
<td>Specialised medicine sub-limit of R98 595 per family</td>
<td></td>
</tr>
<tr>
<td>Oncology (chemotherapy and radiotherapy)</td>
<td>100% of agreed tariff at DSP</td>
</tr>
<tr>
<td>Independent Clinical Oncology Network (ICON) is the DSP</td>
<td></td>
</tr>
<tr>
<td>Limited to R396 630 per beneficiary per annum; includes MRI/CT or PET scans related to oncology</td>
<td></td>
</tr>
<tr>
<td>IN-HOSPITAL BENEFITS</td>
<td>OVERALL OUT-OF-HOSPITAL BENEFITS</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Organ and tissue transplants</strong></td>
<td><strong>Annual overall out-of-hospital (OOH) limit</strong></td>
</tr>
<tr>
<td>100% of agreed tariff at DSP or at cost for PMBs</td>
<td>Benefits shall not exceed the amount set out in the table</td>
</tr>
<tr>
<td>Subject to clinical guidelines used in State facilities</td>
<td>PMBs shall first accrue towards the total benefit, but are not subject to a limit</td>
</tr>
<tr>
<td>Unlimited radiology and pathology for organ transplant and immunosuppressants</td>
<td>In appropriate cases the limit for medical appliances shall not accrue towards this limit</td>
</tr>
<tr>
<td><strong>Pathology</strong></td>
<td>Out-of-hospital benefits are subject to:</td>
</tr>
<tr>
<td>Service will be linked to hospital pre-authorisation</td>
<td>• protocols and clinical guidelines</td>
</tr>
<tr>
<td><strong>Physiotherapy</strong></td>
<td>• PMBs</td>
</tr>
<tr>
<td>Service will be linked to hospital pre-authorisation</td>
<td>• the applicable tariff i.e. 100% of Polmed rate or agreed tariff or at cost for involuntary access to PMBs</td>
</tr>
<tr>
<td><strong>Prostheses (internal and external)</strong></td>
<td><strong>Dentistry (conservative and restorative)</strong></td>
</tr>
<tr>
<td>100% of Polmed rate or at cost for PMBs</td>
<td>100% of Polmed rate</td>
</tr>
<tr>
<td>Subject to pre-authorisation and approved product list</td>
<td>Subject to the OOH limit and includes dentist’s costs for in-hospital, non-PMB procedures</td>
</tr>
<tr>
<td>Limited to R58 300 per beneficiary</td>
<td>Routine consultation, scale and polish are limited to two annual check-ups per beneficiary</td>
</tr>
<tr>
<td><strong>Refractive surgery</strong></td>
<td>Oral hygiene instructions are limited to once in 12 months per beneficiary</td>
</tr>
<tr>
<td>100% of Polmed rate</td>
<td></td>
</tr>
<tr>
<td>Subject to pre-authorisation</td>
<td></td>
</tr>
<tr>
<td>Procedure is performed out of hospital and in day clinics</td>
<td></td>
</tr>
<tr>
<td><strong>General practitioners (GPs)</strong></td>
<td></td>
</tr>
<tr>
<td>100% of agreed tariff at DSP, 100% of Polmed rate at non-DSP or at cost for involuntary access to PMBs</td>
<td></td>
</tr>
<tr>
<td><strong>Specialists</strong></td>
<td></td>
</tr>
<tr>
<td>100% of agreed tariff at 100% of Polmed rate at non-DSP or at cost for involuntary access to PMBs</td>
<td></td>
</tr>
<tr>
<td>Anaesthetists</td>
<td></td>
</tr>
<tr>
<td>150% of Polmed rate or at cost for PMBs</td>
<td></td>
</tr>
</tbody>
</table>
| General practitioners (GPs) | Polmed has a GP network  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of agreed tariff at DSP or at cost for involuntary access to PMBs</td>
</tr>
<tr>
<td></td>
<td>The limit for consultations shall accrue towards the OOH limit</td>
</tr>
<tr>
<td></td>
<td>Subject to maximum number of visits/consultations per family per annum, as follows:</td>
</tr>
</tbody>
</table>
|                             | M0 – 11  
|                             | M1 – 16  
|                             | M2 – 20  
|                             | M3 – 24  
|                             | M4 + – 29  |
| Medication (acute) | 100% of Polmed rate  
|                   | Annual limit of R1 028 per family |
|                   | Subject to the OOH limit; shared limit with acute medication |
| Medication (over the counter [OTC]) | 100% of Polmed rate  
|                             | Annual limit of R1 028 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 385 per family |
|                                   | Subject to OOH limit |
| Pathology | M0 – R3 000  
|           | M1 – R4 325  
|           | M2 – R5 173  
|           | M3 – R6 371  
|           | M4 + – R7 812  
|           | The defined limit per family will apply for any pathology service done out of hospital |
| Physiotherapy | 100% of Polmed rate  
|               | Annual limit of R4 325 per family |
|               | Subject to the OOH limit |
| Social worker | 100% of Polmed rate  
|               | Annual limit of R4 325 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 |
### 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

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefit Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of Polmed rate</td>
<td>Annual limit of R2 385 per family</td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefit Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of Polmed rate and subject to:</td>
<td></td>
</tr>
<tr>
<td>Blood transfusions</td>
<td>No limit</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>R12 624 per hearing aid or R25 090 per beneficiary per set every three years</td>
</tr>
<tr>
<td>Nebuliser</td>
<td>R1 198 per family once every four years</td>
</tr>
<tr>
<td>Glucometer</td>
<td>R1 198 per family once every four years</td>
</tr>
<tr>
<td>CPAP machine</td>
<td>R8 427 per family once every four years</td>
</tr>
<tr>
<td>Wheelchair (non-motorised)</td>
<td>R14 024 per beneficiary once every three years</td>
</tr>
<tr>
<td>Wheelchair (motorised)</td>
<td>R47 138 per beneficiary once every three years</td>
</tr>
<tr>
<td>Insulin delivery devices and urine catheters</td>
<td>Paid from the hospital benefit up to the mean price out of three quotations</td>
</tr>
</tbody>
</table>

### Dentistry (specialised)
Pre-authorisation required

100% of Polmed rate or at cost for PMBs

An annual limit of R12 678 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 020 per beneficiary per annum

Annual limit of R4 219 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
### Chronic medication refers to non-PMB conditions
Subject to prior application and/or registration of the condition

**Approved PMB-CDL conditions do not first accrue to this limit and are not subject to a limit**

Designated service providers:
- Courier pharmacies: Medipost and Pharmacy Direct
- Retail pharmacies: Clicks and MediRite

Subject to the following limits:
- Member with no registered dependants: Annual limit of R8 708
- Member with registered dependants: Annual limit of R15 630

Subject to the medicine reference price

### Optical
Includes frames, lenses and eye examinations
- The extended list of chronic conditions (non-PMBs) are subject to the following limits:
  - Member with no registered dependants: Annual limit of R8 708
  - Member with registered dependants: Annual limit of R15 630
- Subject to the medicine reference price

#### The benefit per beneficiary (per 24-month benefit cycle) at a 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 to the value of R150 and R800 towards lens enhancements OR R950 towards the cost of any alternative frame and/or lens enhancements

### Optical (continued)

#### WITH EITHER
- One pair of clear Aquity single-vision or clear Aquity bifocal lenses or clear Aquity multifocal lenses

Non-PPN provider would be:
- One consultation limited to a maximum cost of R325

### Optical (continued)

#### OR CONTACT LENSES
- Contact lenses to the value of R1 510
- Contact lens re-examination to a maximum cost of R210 per consultation

### Preventative care (refer to Annexure E)
- One wellness measure per year, including:
  - Blood pressure test
  - Body mass index test
  - Waist-to-hip ratio measurement
  - Cholesterol screening (Z13.8)
  - Glucose screening (Z13.1)
  - Healthy diet counselling (Z71.3)

Funded from the risk pool; the benefit shall not accrue to the OOH limit
### STAND-ALONE BENEFITS

**Preventative care (refer to Annexure E)**
(continued)
- 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, 8151 and 8102)
  - Flu vaccine
  - Glaucoma screening
  - Glucose screening
  - HIV tests
  - Mammogram
  - Pap smear
  - Pneumococcal vaccine
  - Prostate screening
  - Psycho-social services

**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
Limited to R37 310 per family
Includes any specialised radiology service done in/out of hospital
Claims for PMBs first accrue towards the limit
Subject to a limit of two scans per beneficiary per annum, except for PMBs

---

### CO-PAYMENTS

<table>
<thead>
<tr>
<th>OUT OF NETWORK</th>
<th>CO-PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner (GP)</td>
<td>Allows for two out-of-network consultations</td>
</tr>
<tr>
<td></td>
<td>Co-payments shall apply once maximum out-of-network consultations are exceeded</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>20% of costs</td>
</tr>
</tbody>
</table>
MARINE: CHRONIC CONDITIONS

Prescribed minimum benefits (PMBs), including chronic diagnostic 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 erythematos (SLE)

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

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

Gastro-intestinal conditions
Crohn’s disease
Ulcerative colitis
Peptic ulcer disease (requires special motivation)

Gynaecological conditions
Endometriosis
Menopausal treatment

Haematological conditions
Haemophilia
Anaemia
Idiopathic thrombocytopenic purpura
Megaloblastic anaemia

Metabolic condition
Hyperlipidaemia

Musculoskeletal condition
Rheumatic arthritis

Neurological conditions
Epilepsy
Multiple sclerosis
Parkinson’s disease
Cerebrovascular incident
Permanent spinal cord injuries

Ophthalmic condition
Glaucoma

Pulmonary diseases
Asthma
COPD
Bronchiectasis
Cystic fibrosis

Psychiatric conditions
Affective disorders (depression and bipolar mood disorder)
Schizophrenic disorders

Special category conditions
HIV/AIDS
Tuberculosis
Organ transplantation

Treatable cancers
As per PMB guidelines

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

Extended chronic disease list: non-PMB
Chronic medication is payable from the chronic medication benefit pool, subject to the availability of funds.

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

Ear, nose and throat condition
Allergic rhinitis

Gastro-intestinal 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
Trigeminal neuralgia
Meniere’s disease
Migraine prophylaxis
Narcolepsy
Tourette’s syndrome

Ophthalmic condition
Dry eye/keratoconjunctivitis sicca

Psychiatric condition
Attention deficit hyperactivity disorder (ADHD)

Urological condition
Overactive bladder syndrome