ANGLO MEDICAL SCHEME
ANNEXURE C

LIMITATION OF BENEFITS AND GENERAL EXCLUSIONS APPLICABLE TO STANDARD CARE, MANAGED CARE AND VALUE CARE PLANS

EFFECTIVE 1 JANUARY 2020

The Scheme will pay in full, without co-payment, the cost of the diagnosis, treatment and care of PMB's. Where a medicine is limited to a protocol or a formulary and has been ineffective in the treatment of the condition, or would cause harm to a beneficiary, the Scheme will fund the cost of the appropriate substitution treatment.

1 Limitation of Benefits

1.1 The maximum benefits to which a member and his/her registered dependants shall be entitled, in any financial year, shall be limited as set out in Annexures B1, B2 and B3.

1.2 In addition, the following general limitations of benefits shall apply to all benefit options:

1.2.1 Where a beneficiary has a health condition of a protracted nature, the Board shall have the right to insist upon the beneficiary consulting a specialist whom the Board may nominate in consultation with the attending practitioner. In such cases, if the specialist's advice is not acted upon, benefits will be limited to the minimum prescribed benefits for that condition.

1.2.2 Unless a different quantity is prescribed as a minimum benefit in the Act, or unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited

to one month's supply (or to the nearest unbroken pack) for every such prescription or repeat thereof.

1.2.3 A member or registered dependant who is admitted during the course of a financial year shall be entitled to the benefits set out in Annexures B1, B2 and B3. The maximum benefits to which he/she shall be entitled will be adjusted in proportion to the period of membership, which will be calculated from the date of admission to the end of that financial year.

2 Excluded benefits as amended 2020-01-01

2.1 Unless otherwise decided by the Board, subject to the PMBs and with the exception of medicines approved and authorised in terms of a Scheme protocol or disease management programme, the following costs incurred by a beneficiary will not be paid by the Scheme. Subject to the availability of a positive carry over savings balance in a member's PMSA and Scheme approval, a beneficiary is entitled to recover the costs of the following excluded benefits from his / her positive savings -

2.1.1 bariatric surgery and related costs incurred for the treatment of obesity;

2.1.2 operations, medicines, treatments and procedures for cosmetic purposes, including, but not limited to, breast augmentations, breast reductions, blepharoplasties, abdominoplasties, rhinoplasties, and bat-ear corrections; or for any other reasons not directly caused by or related to an illness, accident or disease;

2.1.3 general anaesthetics and hospitalisation for dental work, except in the case of trauma, patients under the age of seven years and impacted third molars;

2.1.4 *in vitro* fertilisation, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, embryo transport, surrogate parenting, donor semen and related costs including collection and preparation, and amniocenteses which are not medically necessary;

2.1.5 medicines used specifically to treat infertility, except in the case of PMBs;

2.1.6 single and multivitamin preparations, vitamin combinations, geriatric vitamins and mineral supplements except where clinically indicated in managed care protocols;

2.1.7 sex transformation operations and for reversal of voluntary sterilisation; and

2.1.8 all costs that are more than the annual maximum benefit to which a member or registered dependant is entitled in terms of the Rules.

2.2 The following cost incurred by a member or a registered dependant shall not be paid by the Scheme and may not be funded from a member's PMSA, positive or otherwise -

2.2.1 charges for appointments which a member or registered dependant fails to keep;

2.2.2 interest and/or legal fees relating to overdue medical accounts;

2.2.3 holidays for recuperative purposes, tests for medical insurance and executive medical examinations/fitness;

2.2.4 provider and member travelling expenses, including social transfers and repatriation, incurred in the diagnosis or treatment of a health condition, excluding emergency ambulance transportation;

2.2.5 all costs for services rendered -

2.2.5.1 by persons not registered in terms of any law;

2.2.5.2 by any institution, except a public hospital, which is not registered as a private hospital, unattached theatre or day clinic;

2.2.5.3 by any institution not licensed in terms of the Mental Health Act of 1973;

2.2.5.4 resulting in any claim covered by any existing third-party health or travel insurance, other than the Scheme;

2.2.5.5 resulting in an international claim that does not provide the detail set out in Regulation 5 of the Regulations, contained in “Annexure D” to the Scheme Rules, with the exception of providing the South African regulatory coding requirements; and

2.2.5.6 an international claim submitted in a foreign language.

2.2.6 all costs for health care services -

2.2.6.1 which, in the opinion of the Scheme’s Medical Advisor are not evidence based or are inappropriate or unnecessary in the diagnosis or treatment of a health condition;

2.2.6.2 for experimental, investigative or unproved services, treatments, devices, appliances and pharmacological regimes;

2.2.6.3 related to paternal DNA testing and investigations, including genetic testing for familial cancers;

2.2.6.4 for organ donations to any person other than to a member or registered dependant of a member;

2.2.6.5 for the use of gold in dentures or the cost of gold as an alternative to non-precious metal in crowns,

inlays and bridges;

2.2.6.6 for optical devices which are not regarded by the South African Optometric Association as clinically essential or clinically desirable;

2.2.6.7 related to contact lens preparations;

2.2.6.8 related to the purchase of unregistered and off-label medications, unless authorised in respect of the Medicines and Related Substance Control Act 101 of 1965 and pre-authorised according to Scheme protocol, and proprietary preparations;

2.2.6.9 related to the purchase of prescription medicines not prescribed by a medical practitioner or other person who is legally entitled to prescribe medicine, except for medicines purchased in accordance with the pharmacist advised therapy (PAT) benefit, reflected in Annexures B1 and B2;

2.2.6.10 related to anabolic steroids, aphrodisiacs, tonics and homemade medicines;

2.2.6.11 related to the treatment of slimming products used to treat or prevent obesity, subject to medicine prescribed for bariatric surgery under Rule 2.2.1;

2.2.6.12 related to bandages and dressings;

2.2.6.13 related to the general food/nutritional supplements, including all baby food and milk supplements, except where clinically indicated in managed care protocols;

2.2.6.14 related to soaps, shampoos, cosmetic preparations medicated or otherwise; emollients, moisturisers, sunscreens and other similar topical applications;

2.2.6.15 related to preparations not easily classified or without NAPPI codes; and

2.2.6.16 for frail care for Standard Care Plan members.

3. Specific limitations of benefits and general exclusions applicable to the Value Care Plan inclusive of the aforementioned points

3.1 all services not obtained through a Prime Cure designated service provider, or referrals not pre-authorised, or not provided in terms of the Prime Cure protocol subject to PMB;

3.2 frail care treatment;

3.3 the following medicines are specifically excluded from cover in respect of CDL conditions -

3.3.1 Erythropoietin (unless the beneficiary is eligible for renal transplantation);

3.3.2 Infliximab and related biologics for inflammatory bowel disease and rheumatoid arthritis;

3.3.3 interferon's; and

3.3.4 unregistered and off-label medications unless preauthorised.
Rule 3.3.4 inserted 2018-01-01

3.4 PET scan procedures not used in accordance with the Scheme, PMB and the State protocol;
Rule 3.4 amended 2015-03-25

3.5 medicines classified as biologicals;

3.6 deep brain stimulator devices for Parkinson's disease or epilepsy;

3.7 implant devices for pain management;

3.8 polysomnogram and CPAP titrations;

3.9 should a beneficiary choose not to make use of a DSP, a co-payment equal to the difference between the Prime Cure agreed tariff and the tariff of the Non-DSP, will apply;

3.10 facility fees;

3.11 off formulary medication as prescribed by a specialist;

3.12 injury or illness that occur beyond the borders of the republic of South-Africa;

3.13 dental extractions for non-medical purposes;

3.14 all costs related to radial keratotomy and eximer laser keratectomy;

3.15 immunoglobulin's for chronic use;

3.16 Rule 3.16 deleted 2017-01-01

3.17 iron chelating agents;

3.18 private nursing care;

3.19 contact lenses and preparations;

3.20 consultations relating to impotence, infertility (except PMB), libido problems or sexual dysfunction;

3.21 medical, surgical or other appliances unless PMB;

3.22 extreme and professional sport injuries unless a PMB; and

3.23 reconstructive surgery, port wine stains, keloid scars (not impairing function) and hair removal.

Rules 3.19 to 3.23 inserted 2018-01-01