AMS | ANGLO MEDICAL SCHEME



BENEFIT GUIDE **2027**

>>



Our promise

We promise you lifelong, quality products that are market-competitive and cost-effective in order to meet your healthcare needs. In addition, we will strive to offer you exceptional administrative efficiency and sound financial risk management.

Your guarantee

As a member of a medical scheme, you have access to Prescribed Minimum Benefits (PMBs). PMBs are a set of defined benefits put in place to ensure all beneficiaries have access to certain minimum healthcare services, regardless of the benefit option they have selected.

These 271 PMBs cover the most common conditions, ranging from fractured bones to various cancers, menopause management, cardiac treatment, medical emergencies and COVID-19. Some of them are life-threatening conditions for which cost-effective treatment would sustain and improve the member's quality of life.

PMB diagnosis, treatment and care is not limited to hospitals. Treatment can be received wherever it is most appropriate – in a clinic, an outpatient setting or even at home. The access to diagnosis, medical or surgical management and treatment of these conditions is not limited and is paid according to specific protocols per condition.

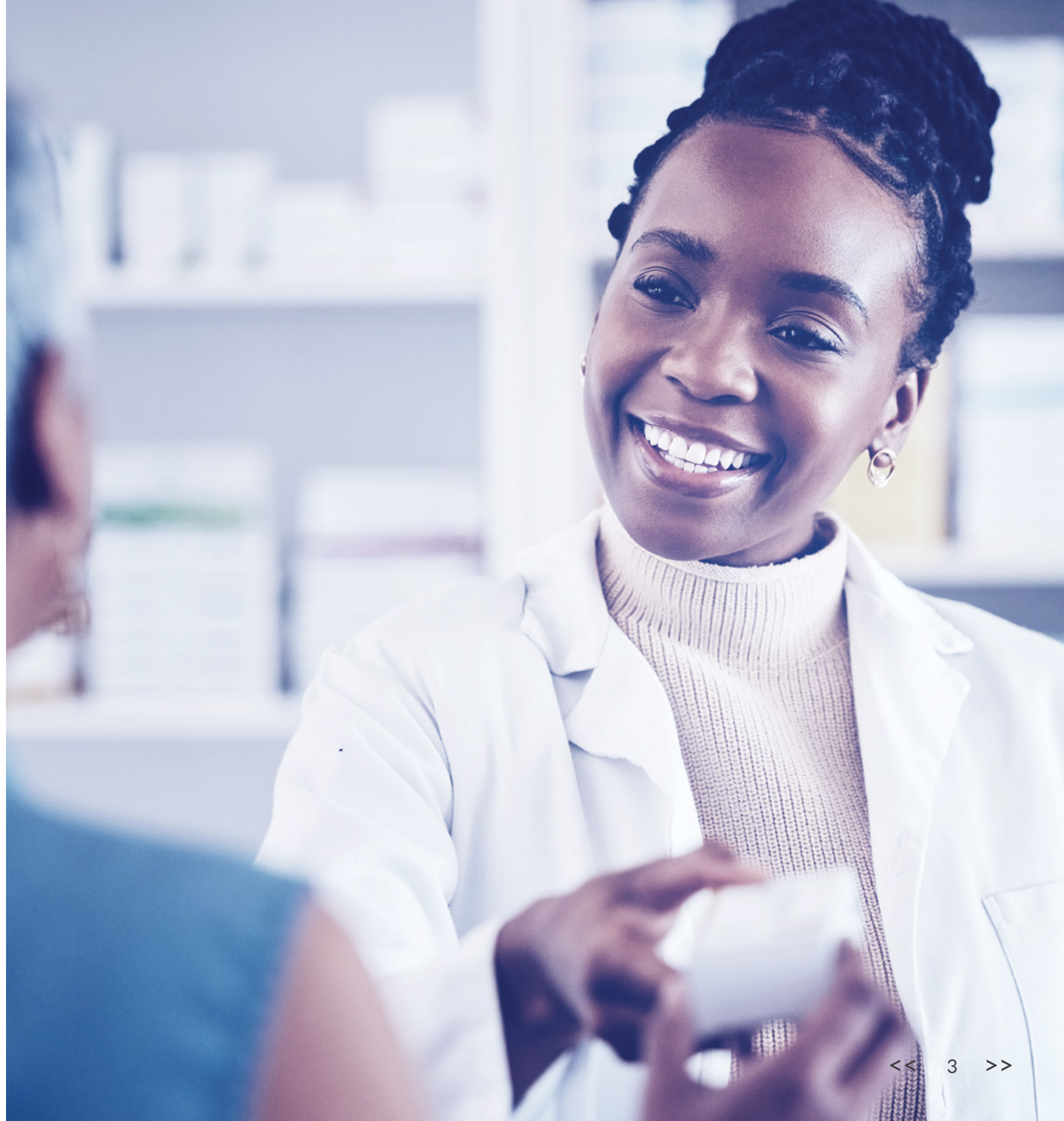
If your doctor has diagnosed you with a chronic PMB condition, the doctor or the pharmacist needs to call us to verify if you meet the Scheme's clinical entry criteria. If you do, your chronic condition will be registered with the Scheme so that your medicine and disease management will be funded from the correct benefit category and not from your day-to-day benefits.

In addition to the 271 PMBs, you are also guaranteed treatment and medication for 26 chronic conditions. Members with these chronic conditions will need to visit their healthcare professional and may have to register the condition with a specialised chronic disease management programme. Some disease management programmes are obtained from a Designated Service Provider (DSP). Once registered, members will be entitled to treatment, including medication according to treatment protocols and reference pricing.

Anglo Medical Scheme is a registered medical scheme and regulated by the Council for Medical Schemes (CMS). The CMS contact details are as follows:
Email: complaints@medicalschemes.co.za I Customer Care Centre. 0861 123 267 I Website: www.medicalschemes.co.za I Physical address: Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157

PMB chronic conditions

- Addison's Disease
- Asthma
- Bipolar Mood Disorder
- Bronchiectasis
- Cardiac Failure
- Cardiomyopathy Disease
- Chronic Renal Disease
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Crohn's Disease
- Diabetes Insipidus
- Diabetes Mellitus Type 1
- Diabetes Mellitus Type 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple Sclerosis
- Parkinson’s Disease
- Rheumatoid Arthritis
- Schizophrenia
- Systemic Lupus Erythematosus
- Ulcerative Colitis



Scheme website benefits

As this Benefit Guide is a summary of the registered Scheme Rules only, in some instances, we will refer you to the Scheme website www.angloms.co.za for more information. The benefit and contribution information for next year will be available online from January. The Scheme website offers you a public and a member-only login area.

The public area contains:

- The full set of registered Scheme Rules
- Information on how your Scheme works
- Detailed information on plans and products
- The Info Centre, containing documents and forms, as well as a glossary of medical scheme terms
- All contact details and more.

In the member login area you can additionally, after registration (depending on your plan):

- View all past interactions with the Scheme
- Upload and track your claims
- Check your chronic condition cover
- See your hospital authorisations and events
- Update your personal details (including your banking details)
- Register your eligible dependants for AMS web access
- Change your communication preferences
- Check your available benefits
- Check your Medical Savings Account (Managed Care Plan only)
- Search for healthcare professionals and accredited network facilities
- Access a library including all forms, information about procedures and medical scheme topics, the MediBrief newsletter archive and more.

We encourage you to register on the Scheme website and to make use of these administrative benefits.

Web chat and WhatsApp:
Use the "Ask AMS" chat on the website,
or WhatsApp us on **011 292 8797**.

Anglo Medical Scheme Apps

We offer two different apps for our members. One app for all members, with focus on Standard Care Plan and Managed Care Plan, and a separate app for Value Care Plan members. Both apps offer you convenient access to information about your membership, plan and benefits - anywhere, anytime.

Anglo Medical Scheme app:

Create and use the same username and password as for the member area on the AMS website www.angloms.co.za.

Features for all members:

- View membership card
- Request membership documents and tax certificates
- Access Application forms
- Update your personal details and banking details

Additional features for Standard Care Plan and Managed Care Plan members:

- Submit and track your claims
- View recent interactions with the Scheme
- View your available benefits
- Find healthcare professionals

Should you require any further assistance please contact us via email on webinfo@discovery.co.za or call us on **0860 100 696** Monday to Friday 7h00 - 18h00.

GET IT ON Google Play | Download on the App Store

Value Care Plan app:

Open the app and **register a new app user account.**

Features of the Value Care Plan App:

- Access your Value Care Plan benefits
- Create your unique digital membership card
- Find and select doctors
- Find benefit application forms
- Request authorisations
- Submit claims and request a refund
- View and change your contact details
- View your claims and authorisation history
- Contact us directly through the app
- Send invitations to your dependants to download the app

If you encounter any issues or have any questions, please do not hesitate to contact our dedicated support team at Prime Cure by calling **0861 665 665**.

GET IT ON Google Play | Download on the App Store

Your Scheme at a glance

	VALUE CARE PLAN	STANDARD CARE PLAN	MANAGED CARE PLAN
Type	Network Prime Cure practitioner and facilities only	Traditional **with certain network limitations**	Comprehensive with Medical Savings Account (MSA)
Tariff	Prime Cure Tariff	Scheme Reimbursement Rate (SRR): 100%	GP rate: 100% of SRR, or GP network rate (negotiated Discovery Health Rate): no co-payments Specialists excluding Pathology and Radiology: – In hospital and in lieu of hospitalisation: Top-Up rate up to 230% (100% SRR + 130%) – Out of hospital: Up to 125% of SRR
Benefits	Primary healthcare services Formulary medicine dispensed by network professional/pharmacy Hospital: Family Hospital Limit: R217 000 (non-PMB)	See table on next page Limited Out of Hospital benefits Hospital Network: Unlimited	See table on next page Medical Savings Account for Out of Hospital benefits Hospital (no network): Unlimited
Contribution rate* * Subject to underwriting	Main member: R1 447 Adult dependant: R1 447 Child dependant: R352	Main member: R4 055 Adult dependant: R4 055 Child dependant: R1 215	Total contributions Main member: R7 405 Adult dependant: R7 405 Child dependant: R1 715
			Excluding MSA Main member: R5 850 Adult dependant: R5 850 Child dependant: R1 355
			Savings Main member: R1 555 Adult dependant: R1 555 Child dependant: R360

When you consider switching plans (for reasons such as a change in income or medical need), you may do so at the end of the year. We recommend you speak to one of our Client Liaison Officers or your Paypoint Consultant to understand the differences between the plans, and to speak to your financial adviser to guide you.

A plan change request form is available on the website and has to be handed to your employer or pension fund administrator or submitted to the Scheme as soon as possible, but not later than 11 December if you want to change your plan for the next year. If you are a direct paying member, please submit the form to the Scheme.

To calculate your individual contribution, use the Contribution Calculator on www.angloms.co.za **> Plans & Products > Plan Comparison.**

High-level comparison

Please refer to more detailed benefit information in the relevant section of your plan and to the Scheme Rules.

CATEGORY	STANDARD CARE PLAN	MANAGED CARE PLAN
Hospital services, incl. Radiology and Pathology	Unlimited	Unlimited
Hospital Network	Defined list of hospitals	None
Internal Surgical Prostheses	R88 120 per beneficiary	R186 900 per beneficiary
Cancer (Oncology) Treatment	R398 955 per beneficiary, thereafter 20% co-payment	Unlimited subject to protocols
Cancer (Oncology) Medicine	Subject to Oncology limit. Use DSP. Innovation drugs incur a 20% co-payment	Use DSP. Innovation drugs subject to Oncology Innovation Medicine limit. Incur a 20% co-payment once limit is depleted
Medical Savings Account (MSA)	No MSA	21% of contributions are allocated to MSA
Specialised Medicine and Technology	20% co-payment	Unlimited
Co-payments	Co-payments for non-DSP ambulance, non-DSP hospitalisation, non-DSP dental healthcare professional, non-DSP alcohol & drug facility, non-network endoscopic and cataract procedures, non-DSP HIV healthcare professional, 20% co-payment for oncology innovation drugs, 20% co-payment for use of non-DSP pharmacy for oncology medicines	Co-payments for non-DSP ambulance, non-PMB hospitalisation, non-DSP alcohol & drug facility, non-network endoscopic and cataract procedures, non-DSP HIV healthcare professional, 20% co-payment for oncology innovation drugs, 20% co-payment for use of non-DSP pharmacy for oncology medicines
Out of Hospital (OH) Services	Overall OH limit: Adult R7 080 Child R3 525	MSA
Acute Medicine, GP and Specialist	OH sublimit 2: Adult R6 650 child R3 325	MSA
Chronic Conditions Covered (non-PMB)	21 conditions	47 conditions
Chronic Medicine (non-PMB)	R6 040 per beneficiary	R23 345 per beneficiary
Medicine Management	Strict protocol management	Moderate protocol management
OH Pathology	Adult R1 795 Child R645	Unlimited
OH Radiology	Adult R2 340 Child R1 415	Unlimited
Basic Dentistry	Basic services at DSP	Adult R5 570 Child R2 105
Additional Basic and Specialised Dentistry	Adult R2 055 Child R515	
Eye Care Examinations	R540 per beneficiary	R540 per beneficiary*
Eye Care Lenses and Frames	R3 215 per family	R4 820 per family*
Frail Care	None	R94 000 per beneficiary

*once limit is depleted payable from available MSA

VALUE CARE PLAN
Healthcare services as per your plan benefits are fully covered, according to protocols, within network.

2027 benefits and contributions are subject to the approval of the Registrar of Medical Schemes



Value Care Plan

Value Care Plan provides primary healthcare through a network of Prime Cure facilities and healthcare professionals only.
In return for receiving quality, basic healthcare at the Scheme's most affordable contribution rate, members of this plan may only obtain healthcare services from a Prime Cure facility or network healthcare professional.

Value Care Plan Limits unless PMB

IH

Family Hospital Limit	R217 000
Sublimit Private Prime Cure hospital	R93 700
Sublimit Blood transfusions	R21 625
Sublimit Pathology	R24 615 per family
Sublimit Internal surgical prostheses	R37 930 per family
Sublimit non-PMB Psychiatric services	R10 555 per family 5 days
Sublimit Allied healthcare services	R10 555 per family

OH

Virtual GP consultations at Dis-Chem pharmacy clinics	Unlimited, if clinically required
+	
Consultations Prime Cure network GPs	Unlimited Authorisation needed after 4th consultation per beneficiary subject to clinical triage
+	
Consultations at a Nurse practitioner at Prime Cure network pharmacy	R730 per family, maximum R365 per visit
+	
Consultations Specialist	R4 640 per family, 5 consultations per family, limited to 3 per beneficiary
+	
Allied healthcare services	R3 605 per family with a maximum amount of R2 405 per beneficiary
+	

Sublimit Specialised Radiology R24 615 per family

+	
Pharmacist Advised Therapy (PAT)	R130 per purchase limited to three purchases up to R390 per beneficiary
+	
Consultations GPs out-of-network	R1 330 per event One consultation per beneficiary or two per family
+	
Contraceptives	R2 930 per beneficiary

Contributions*	Main member	R1 447
	Adult dependant	R1 447
* Subject to underwriting	Child dependant	R352

How it works

To call an ambulance

Call **0861 665 665** and press **option 1**. If it is an emergency, Prime Cure will send an ambulance. If you did not get authorisation, call the next working day to provide details. For non-emergencies, you will be responsible for the cost.

To find a Prime Cure network doctor or facility

Use the Value Care Plan app or visit www.angloms.co.za > Plans & Products > Value Care Plan to find network healthcare professionals.

If needed, you can also call **0861 665 665**.

You will not be responsible for settling any account as Prime Cure handles payments to network healthcare professionals (unless you have not complied with the Rules). For out-of-hospital specialist consultations and services, you may need to pay upfront and then submit the claim to Prime Cure for reimbursement at the agreed rate.

To obtain authorisation

To obtain authorisation for certain procedures, treatments, and hospitalisations, as indicated in the benefit table, members or beneficiaries should use the Value Care Plan app. Alternatively, you can call Prime Cure at **0861 665 665**. Remember, failure to obtain authorisation may result in a co-payment or full cost liability, as specified in the benefit table.

To claim

If you received emergency medical services outside the network and they were authorised the next working day, please submit your claim in the Value Care Plan app or email it to ams@kaelo.co.za. Include a completed refund form, available at www.primecure.co.za/refund-request-form. Note that third-party claims (e.g., the Road Accident Fund) are not the Scheme's responsibility. Emergency treatments will be paid but need to be refunded. To be refunded, provide a detailed account and proof of payment.

Your responsibilities

- Comply with Scheme Rules
- Obtain authorisation for services listed in the benefit table. It is your responsibility, not your healthcare professional's
- Be responsible for co-payments if you use out-of-network services
- Obtain services and referrals from your Prime Cure network healthcare professional only. Use of a healthcare professional outside of the Prime Cure network results in a co-payment, which can be the difference between the actual cost and the network rate, or a specified value, as per the Rules.

Preventative Care Benefits

To support you in managing your health proactively, we encourage you to take preventative measures. Detecting health risks or a disease early could prevent a disease or at least improve the success rate of the treatment. The following table describes the preventative care measures and explains from which benefit category they will be funded. Please find more information to the benefit categories, their limits and how you can access them in the tables on the following pages.

Description	Sex	Age*	Benefit Category	Purpose
Contraceptives	F	All	Contraceptive medicine	Prevention of unintended pregnancies and promotion of reproductive health
Dental check and preventative treatment	F/M	All	Dental benefits	Early detection of dental disease and preservation of dentine
Endoscopies	F/M	All	Endoscopies	Detection and treatment of early signs of gastrointestinal diseases, including cancers
Eyesight check	F/M	All	Eye care benefits	Early detection of eye disease or deterioration
Gynaecological check	F	All	GP consultations or specialist consultations	Early detection and management of reproductive health issues, including cancers and infections
Hearing test	F/M	All	Allied / auxiliary health services out of hospital	Early detection of signs of hearing loss and related conditions
HIV screening/test	F/M	All	HIV screening/test	Early detection of HIV, timely treatment and reduction of the spread of the virus.
Immunisation – Influenza (Flu)	F/M	All	Flu Vaccine	Influenza prevention; particularly important for people who are at risk of serious complications from influenza (chronic conditions, pregnant, HIV patients or ageing members)
Immunisation – COVID-19	F/M	All	COVID-19 Vaccine	Prevention of severe illness and death
Mammogram	F	40+	Radiology: Mammogram	Early detection of breast cancer
Maternity care • Consultations • Ultrasounds • Vitamins	F	All	Maternity	Monitoring of your pregnancy and prevention of complications
Pap smear	F	All	Pathology: Cancer Screening	Early detection of cervical cancer
Prostate check (PSA)	M	All	Pathology: Cancer Screening	Early detection of prostate cancer
Skin test	F/M	All	Specialist consultations out of hospital	Detection of skin cancer
Wellness check • Blood glucose • Cholesterol • Blood pressure • Body Mass Index	F/M	All	Wellness screening at Dis-Chem or Clicks pharmacies	Early detection of chronic illness
Nurse practitioner consultation	F/M	All	Nurse practitioner consultation	Consultation for early detection of disease. Performed at Pime Cure contracted network pharmacy wellness clinic
GP consultations	F/M	All	GP Consultations network and non-network	Consultation for early detection of disease
Virtual consultations	F/M	All	Virtual consultations	Consultation for early detection of disease at Prime Cure Virtual clinics

*recommended age unless you have specific risk factors

Benefits

Prime Cure network professionals only

What you are entitled to (per annum)	Is authorisation required? 0861 665 665*	Limit**	Is a referral required? ***	Co-payments and comments	Is programme registration required?	IH In hospital / 0H Out of hospital
Alcohol and drug treatment: Management programme, including hospitalisation and medication	Y	21 days, PMB only	Y	Network healthcare professionals only	Y	IH 0H
Allied healthcare services: Audiology, dietetics, occupational therapy, podiatry, physiotherapy, psychology, social services and speech therapy	Y	R3 605 per family with a maximum of R2 405 per beneficiary	Y	Co-payment of 30% of Prime Cure negotiated/agreed rates applies if you self-refer to any healthcare professionals	N	0H
Ambulance services	Y	Subject to Family Hospital Limit unless PMB	N	Authorisation is required the next working day after the emergency incident. Authorise inter-hospital transfers before the event. Voluntary use of non-DSP results in a 30% co-payment	N	IH 0H
Cancer treatment: Management programme including chemotherapy and radiotherapy	Y	Subject to Family Hospital Limit unless PMB	Y	In Public Facilities only. If diagnosed with cancer you can upgrade to the Managed Care Plan within three months of initial diagnosis or commencement of treatment. Subject to Scheme protocols	Y	IH 0H
Consultations GP: Network GP in rooms (PMB and non-PMB)	N		N	Authorisation required after 4 consultations per beneficiary and will be subject to clinical triage. If you do not get authorisation, you will be liable for a co-payment of 30% of the cost	N	0H
Consultations GP: Non-network GP (non-PMB)	Y	A maximum of R1 330 per event (including related expenses) per beneficiary, maximum of 1 consultation per beneficiary or 2 per family	N	Subject to a co-payment of 30% per visit and authorisation on the day, or first day after the visit	N	0H
Consultations Nurse Practitioner: at a network pharmacy wellness clinic	N	R365 per visit subject to a Family Limit of R730	N		N	0H
Consultations Virtual: Virtual consultations at Dis-Chem Pharmacy Clinics	N		Y	A registered nurse will do a clinical assessment and refer if necessary	N	0H

* Unless otherwise specified

** PMB rules apply

*** Subject to referral by Prime Cure network healthcare professional

What you are entitled to (per annum)	Is authorisation required? 0861 665 665*	Limit**	Is a referral required? ***	Co-payments and comments	Is programme registration required?	IH In hospital 0H Out of hospital
Consultations out of hospital: Specialists (non-PMB)	Y	Limited to R4 640 per family, 5 consultations per family and a maximum of 3 consultations per beneficiary	Y	A 30% co-payment will apply where authorisation was not obtained. Services paid up to the Prime Cure agreed rate only. Medication prescribed and obtained at a Prime Cure network pharmacy is included in this limit	N	0H
Consultations out of hospital: Specialists in rooms (PMB and emergencies)	Y		Y	Emergencies: A 30% co-payment will apply where authorisation was not obtained the next working day. Services paid up to the Prime Cure agreed rate only	Y	0H
COVID-19	N		N	Funding for COVID-19 Prescribed Minimum Benefits and additional funding from your normal out of hospital and hospital benefits. Subject to Scheme clinical and benefit entry criteria, network healthcare professional utilisation and authorisation for hospital events	N	IH 0H
Dentistry: Conservative treatments including fillings, x-rays, extractions and consultations	N	One consultation per beneficiary	N	Subject to Prime Cure protocols. Specific codes will be paid if clinically appropriate. Authorisation needed for 5 or more extractions or restorations	N	0H
Dentistry: Emergency consultations – pain, sepsis and extractions (non-network professional)	N	One event per beneficiary	N	Specific approved codes will be paid at Prime Cure agreed rate	N	0H
Dentistry: Hospital admissions for children under the age of 7 for the removal of impacted third molars and trauma (PMB)	Y	Subject to Family Hospital Limit	Y		N	IH
Dentistry: Preventative treatment – cleaning, scaling, polishing and fluoride treatment	N	One treatment per beneficiary	N	Authorisation needed for children under 12 years. Paid at the Prime Cure agreed rate	N	0H
Dentistry: Specialised	Y	Two sets of acrylic dentures per family every 3 years	N	Benefit only for members over the age of 21 years and subject to a co-payment, payable to the dentist, of 20% per set. Denture repairs after a period of 6 months	N	0H
Diabetes	Y	Subject to Family Hospital Limit	N	Must authorise and adhere to Scheme protocols	N	0H
Endoscopies	Y	Subject to Family Hospital Limit	Y	Procedure to be performed in Prime Cure hospital contracted for endoscopic procedures	N	IH
Eye care: Eye examination	N	One examination per beneficiary	N		N	0H
Eye care: Lenses and frames	N	One pair of spectacles per beneficiary every 2 years	N	No contact lenses or sunglasses. Spectacles: Prescription valid for one month	N	0H
External appliances	Y	R6 000 per beneficiary	Y	This benefit is separate from the annual hospital limit. Cover includes approved items such as artificial limbs, breast prostheses and ocular prostheses, as well as clinically necessary repairs or replacements. Cosmetic enhancements, upgrades and other non-medically necessary items are not covered	N	IH 0H

* Unless otherwise specified

** PMB rules apply

*** Subject to referral by Prime Cure network healthcare professional

What you are entitled to (per annum)	Is authorisation required? 0861 665 665*	Limit**	Is a referral required? ***	Co-payments and comments	Is programme registration required?	IH In hospital OH Out of hospital
HIV screening/test	N		N	Screening at network pharmacy, HIV test at registered pathologist or medical technologist subject to approved codes for pathology	N	OH
HIV: Confidential management programme including medicine and related expenses	Y		N	Must register and adhere to Scheme protocols. Your status will at all times remain confidential	Y	OH
Hospitalisation: Allied healthcare services: dietetics, occupational and speech therapy, physiotherapy, podiatry and social services	Y	Sublimit: R10 555 subject to the Family Hospital Limit	Y		N	IH
Hospitalisation: Blood transfusions (non-PMB)	Y	Sublimit: R21 625 subject to the Family Hospital Limit	Y		N	IH
Hospitalisation: Hospital services including GP and specialist consultations in hospital, day cases and 7 day supply of to-take-out medicines	Y	Family Hospital Limit: R217 000 Private Hospital Specialist sublimit: R93 700	Y	A R2 405 co-payment applies if no authorisation was obtained. Authorisation must be obtained within 24 hours or first working day after admission. Obtain authorisation if admitted via casualty as well	N	IH
Hospitalisation: Internal surgical prostheses	Y	Sublimit: R37 930 per family, subject to the Family Hospital Limit	Y		N	IH
Kidney disease: Dialysis (haemo, peritoneal)	Y	Family Hospital Limit	Y	In Public Facilities only	Y	IH OH
Maternity: Antenatal consultations, GP and specialists	Y	3 specialist consultations, 2 ultrasound scans (paid up to the cost of 2D) per pregnancy, one foetal anomaly scan, prescribed folic acid supplements	Y	Paid at Prime Cure agreed rate. Authorisation required between week 12 and 20 of the pregnancy to qualify for benefits. Folic acid subject to medicine formulary list. Authorisation required for routine foetal anomaly scan performed between 18 and 24 weeks of the pregnancy	Y	OH
Maternity: Confinement in hospital	Y	Family Hospital Limit	Y		Y	IH
Medicine: Acute, inclusive of dental medication	N		N	Formulary medicine only; obtained at network GP, dentist or pharmacy	N	OH
Medicine: Contraceptives	N	R2 930 per qualifying beneficiary. Subject to Family Hospital Limit	N	Subject to medicine formulary list	N	OH
Medicine: Pharmacist Advised Therapy (PAT)	N	R390 per beneficiary (R130 per purchase) maximum of 3 events per beneficiary	N	Formulary medicine only; obtained at network pharmacy	N	OH

* Unless otherwise specified

** PMB rules apply

*** Subject to referral by Prime Cure network healthcare professional

What you are entitled to (per annum)	Is authorisation required? 0861 665 665*	Limit**	Is a referral required? ***	Co-payments and comments	Is programme registration required?	IH In hospital 0H Out of hospital
Medicine (PMB chronic)	Y	Medicine formulary	N	One month's supply at a time; obtained only at a network GP or pharmacy	Y	0H

PMB chronic conditions

Addison's Disease	Cardiomyopathy	Diabetes Insipidus	Epilepsy	Hypertension	Rheumatoid Arthritis
Asthma	Chronic Renal Disease	Diabetes Mellitus Type 1	Glaucoma	Hypothyroidism	Schizophrenia
Bipolar Mood Disorder	Chronic Obstructive Pulmonary Disease	Diabetes Mellitus Type 2	Haemophilia	Multiple Sclerosis	Systemic Lupus Erythematosus
Bronchiectasis	Coronary Artery Disease	Dysrhythmias	Hyperlipidaemia	Parkinson's Disease	Ulcerative Colitis
Cardiac Failure	Crohn's Disease				

Mental health: psychiatric conditions PMB	Y	21 days in hospital or 15 consultations out of hospital	Y	Prime Cure or public hospital psychiatric facilities	N	IH 0H
Mental health: psychiatric conditions non-PMB	Y	5 days per admission, with a maximum of R10 555 per family, subject to the Family Hospital Limit	Y	Public hospital psychiatric facilities	N	IH
Organ transplant: Harvesting of the organ, post-operative care of the member and the donor, anti-rejection medicine, healthcare professional services in hospital and payment of donor	Y		Y	In Public Hospital facilities only	Y	IH 0H
Pathology: Cancer screening (Pap smear and Prostate Specific Antigen test)	N	1 test per beneficiary	Y		N	0H
Pathology: In hospital	N	Sublimit: R24 615 per family, subject to the Family Hospital Limit	N		N	IH
Pathology: Out of hospital	N		N	Limited to approved tests. Must be requested by network healthcare professional. Programme registration for PMB conditions	Y N	0H
Radiology: Basic (Out of hospital)	N		N	Limited to approved x-rays. Must be requested by network healthcare professional	N	0H

* Unless otherwise specified

** PMB rules apply

*** Subject to referral by Prime Cure network healthcare professional

What you are entitled to (per annum)	Is authorisation required? 0861 665 665*	Limit**	Is a referral required? ***	Co-payments and comments	Is programme registration required?	IH In hospital 0H Out of hospital
Radiology: Basic (In hospital)	N	Family Hospital Limit (unless PMB)	N	Subject to approved codes	N	IH
Radiology: Basic (Out of hospital)	Y	1 mammogram	Y	For female beneficiaries 40 years of age and older	N	0H
Radiology: Specialised radiology, MRI and CT scans	Y	R24 615 per family subject to the Family Hospital Limit	Y		N	IH 0H
Vaccines: COVID-19	N	Vaccine and administration fee	N	Frequency subject to PMB	N	0H
Vaccines: Flu	N		N	Subject to age and protocols	N	0H
Wellness check: Cholesterol, blood glucose, BMI, blood pressure	N	1 per beneficiary per year	N	Wellness check done at Dis-Chem or Clicks pharmacies	N	0H

* Unless otherwise specified

** PMB rules

*** Subject to referral by Prime Cure network healthcare professional

General exclusions

The following are some of the Scheme exclusions (for a full list please refer to the Rules). These you would need to pay:

- Frail care
- PET scans
- Deep brain stimulator devices for Parkinson's disease or epilepsy
- Implant devices for chronic pain management
- Polysomnogram and CPAP titrations
- Facility fees
- Medicine not found on the medicine list
- Injury or illness that occur beyond the borders of the Republic of South Africa
- Dental extractions for non-medical purposes
- All costs related to radial keratotomy and refractive surgery
- Sunglasses and accessories.

The following medicines are specifically excluded unless authorised:

- Erythropoietin (unless the beneficiary is eligible for renal transplantation)
- Interferons
- Biologicals and biotechnological substances
- Immunoglobulins.

General Rule reminders

- This Benefit Guide is a summary of the 2027 AMS benefits, pending approval from the Registrar of Medical Schemes.
- Please refer to **www.angloms.co.za** (My Scheme, Scheme Rules) for the full set of registered Rules.
- The Anglo Medical Scheme Rules are binding on all beneficiaries, officers of the Scheme and on the Scheme itself.
- The member, by joining the Scheme, consents on his or her own behalf and on behalf of any registered dependants, that the Scheme may disclose any medical information to the administrators and contracted third-parties for reporting or managed care purposes.
- A registered dependant can be a member's spouse or partner, a biological or stepchild, legally adopted child, grandchild or immediate family relation (first-degree blood relation) who is dependent on the member for family care and support.
- To avoid underwriting, a member who gets married must register his or her spouse as a dependant within 30 days of the marriage. Newborn child dependants must be registered within 30 days of birth to ensure benefits from the date of birth. If the newborn is registered within 90 days, benefits will only be made available from the date of registration.
- A child dependant, 23 years or younger on 01 January of a benefit year, may remain on your membership at the child dependant contribution rate until year-end. If your dependant is 24 years old on 01 January and you wish to keep him/her on the Scheme as an adult dependant, you may apply for continuation of membership against the Scheme's dependant eligibility criteria. If the criteria are met, adult contribution rates will apply.
- It is the member's or dependant's responsibility to notify the Scheme of any material changes, such as marital status, banking details, home address or any other contact details and death of a member or dependant.

Disclaimer: This Benefit Guide provides a summary of the benefits and rules of the Anglo Medical Scheme. While every effort has been made to ensure accuracy, the registered Scheme Rules shall take precedence in the event of any discrepancy, omission or inconsistency between this Benefit Guide and the Scheme Rules. The Scheme Rules will be the definitive and binding source for all benefit interpretations and decisions.

How it works

Standard Care Plan and Managed Care Plan

To call an ambulance

Call our Designated Service Provider (DSP) **Netcare 911** at **082 911**. If it is an emergency, Netcare 911 will authorise a road or air ambulance. For non-emergencies or home assessments without transport, you will be responsible for the full cost. In a medical emergency without prior authorisation, provide details to Netcare 911 the next working day. Using a non-DSP voluntarily results in a 20% co-payment.

To obtain authorisation

To access benefits for procedures, treatments, hospitalisation, specialised radiology, internal surgical prostheses and external medical appliances over R3 425 for Standard Care Plan and R3 420 for Manager Care Plan, call **0860 222 633** for authorisation as indicated in the benefit table. Elective admissions need authorisation 48 hours before the event; emergency admissions require authorisation the next working day.

Information required when calling for authorisation:

- Membership number
- Date of admission
- Name of the patient
- Name of the hospital
- Type of procedure or operation, diagnosis with CPT code and the ICD-10 code (obtainable from the doctor)
- The name of your doctor or service provider and the practice number.

Quote the authorisation number on admission. It is valid for four months or until year-end, whichever comes first. If details change or the admission is postponed, call **0860 222 633** for a new authorisation number.

Chronic medicine

If diagnosed with a chronic condition (PMB or non-PMB), ask your doctor or pharmacist to register it by calling **0860 222 633**. Once registered, your medicine will be paid from the chronic medicine benefit, not your day-to-day benefits or Medical Savings Account (MSA). You can get a repeat of a month's medication after 24 days.

To reduce your medicine costs

Visit www.angloms.co.za **> Standard or Managed Care Plan > Medicine** to find a Scheme Preferred Pharmacy near you for lower medicine prices and reduced co-payments.

To claim

Ensure your claim is valid, you have received the treatment or services you have been charged for, and that the following details are correct and complete:

- Full name of main member
- Membership number
- Name of patient (main member or dependant)
- Name of practitioner and practice number
- Details of the service rendered (tariff code, CPT code and explanation)
- The diagnosis code (ICD-10)
- The treatment date
- Proof of payment if you have settled your account.

Send your completed claim to:

Email: claims@angloms.co.za

Call: **0860 222 633 for further assistance**

Upload: on the Anglo Medical Scheme App or on www.angloms.co.za **after logging in as a member**

Third-party claims (e.g. Road Accident Fund) are not the Scheme's responsibility. Emergency treatments will be paid but must be refunded. You need to provide a letter of undertaking to refund the Scheme for any amounts paid on your behalf where a third party is responsible.

You or your healthcare professional have four months from the treatment date to submit a claim. After four months, the claim will be considered 'stale', and the Scheme will not be responsible for payment.

Keep all receipts so you can claim back from your personal tax, and keep copies in case the originals get lost.

After submission of your claim, the Scheme will:

- Notify you by SMS or email once your claim has been processed (depending on your communication preference)
- Pay amounts according to the Scheme Rules and at the Scheme Reimbursement Rate (SRR)
- Pay directly into your (or your healthcare professional's) bank account
- Send a statement by showing amounts paid, to whom, rejections, and amounts for you to settle.

Your responsibility

- Check the statement if payments have been made correctly
- Check rejections on your statements. If a mistake has been made on the claim, correct it, and resubmit within 60 days
- Settle any outstanding amounts with your service provider
- Obtain authorisation for services listed in the benefit table. It is your responsibility to get an authorisation, not your healthcare professional's.

International claims

Emergency and acute medical treatment received overseas

The Scheme may, at its sole discretion, reimburse overseas healthcare costs according to the Rules and necessary authorisations.

- You must pay for services upfront; the Scheme cannot pay healthcare professionals outside RSA directly.
- If you are entitled to benefits from another insurer, claim from them first; submit any shortfall to the Scheme for consideration, based on your available benefits and the Scheme Rules.
- Complete the international claim form and submit a detailed account, in English, with proof of payment. The account must provide the same details as required for South African claims.
- Any payment made towards the cost of a claim will be at the Scheme's absolute discretion and will be made in South African rands into your South African bank account. Reimbursement will not be a direct foreign currency conversion. The amount paid will be at the average local equivalent cost and Scheme Reimbursement Rate (SRR), had the service been obtained in South Africa. If the service is not available in South Africa, the amount paid will be for a similar or equivalent service if it exists.
- For non-emergency healthcare services, the normal authorisation procedure must be followed.
- Repatriation and social transfers are not covered. Adequate medical travel insurance is recommended for major medical emergencies.

Chronic medicine advanced supply

For an advanced supply of chronic medicine, please submit:

- A completed advanced supply form (available on www.angloms.co.za)
- A prescription covering the period
- A copy of your ticket or itinerary.

Call **0860 222 633** for assistance.

WELLth Fund

The WELLth Fund complements and is offered in addition to your Preventative Cate Benefits. It is designed to reward you for taking charge of your health while helping you make the most of your day-to-day benefits. Once activated, eligible healthcare services that would normally be paid from your day-to-day benefits will be funded from your WELLth Fund first. This helps preserve your available day-to-day benefits for when you need them.

How to activate your WELLth Fund

To activate the WELLth Fund, the member and/or any registered beneficiary on the membership must complete a health check at one of the Scheme's contracted healthcare professionals during 2027.

An adult dependant may activate the benefit for themselves and for registered child dependants older than 2 years and younger than 18 years. Once the required health checks have been completed, the membership will receive a combined WELLth Fund allocation based on the number and age of eligible beneficiaries on the membership.

The WELLth Fund is a once-off benefit

The WELLth Fund is a once in a membership lifetime benefit. It is available for a limited period and must be activated before it can be used.

Once activated, the WELLth Fund is available for use by all registered beneficiaries on the membership, regardless of their age.

The WELLth Fund limits

Standard Care Plan

R1 500 per adult (>18 years old) | R500 per child (>2 years old) | Maximum of R5 000 per membership

Managed Care Plan

R2 500 per adult (>18 years old) | R1 000 per child (>2 years old) | Maximum of R8 000 per membership

What can the WELLth Fund be used for?

Qualifying healthcare services are covered up to Scheme Reimbursement Rate.

The WELLth Fund may be used for a defined list of general health and allied healthcare services.

General health services	• GP consultations • Out-of-hospital basic and specialised dentistry (SCP will be subject to DRC protocols) • Optical services • Gynaecological check-up • Hearing test • Glaucoma screening • Pathology screening • Lung cancer screening • Skin cancer screening
Allied health services	• Acupunture • Audiology • Chiropody and podiatry services • Chiropractic consultations, including x-rays • Clinical psychology • Dietitian services • Homeopathic consulations and procedures, including non-NAPPI coded medicines compounded and dispensed by a homeopath • Naturopathy • Orthoptics • Physiotherapy • Nurse practitioner consultations and procedures • Social services • Speech and occupational therapy • Orthotists and prosthetists

The WELLth Fund may not be used to fund Prescribed Minimum Benefit claims, chronic and acute medication, medical devices, shortfalls or co-payments incurred as a result of the voluntary use of a non-Designated Service Provider (DSP).

How long is the WELLth Fund available?

Activated WELLth Funds remain available until 31 December 2028 or until the allocated WELLth Fund limit has been exhausted, whichever occurs first.

The sooner you complete your health check, the sooner you can access your WELLth Fund and start preserving your day-to-day benefits.

Beneficiaries whose membership commences after 31 December 2027 are not eligible for the WELLth Fund Benefit.

Medical Savings Account - Managed Care Plan

The annual Medical Savings Account (MSA) allocation is made available to you in January (in advance for the year) and offers the flexibility to pay for:

- Non-PMB GP and specialist consultations and procedures
- Acute medicine, including Pharmacist Advised Therapy (PAT) medicine
- Eye care, spectacles, lenses and contact lenses (after your optometry benefits have been exhausted)
- Dental services including orthodontic treatment (after your dentistry benefit has been exhausted)
- Chiropractic services
- Homeopaths, naturopaths and osteopaths, including medicine
- Chiropody and podiatry
- Non-PMB hospital co-payments
- Co-payments for endoscopies and cataract surgeries in hospital
- Physiotherapy
- Audiology
- Speech and occupational therapy
- Clinical psychology
- Dietitian services
- Orthotists and prosthetists
- Social worker and other allied healthcare services.

Charges above the Scheme Reimbursement Rate (SRR), excluding PMBs, can be paid from your MSA with a once-off instruction. You can request reimbursement for Scheme exclusions (assessed for clinical appropriateness), non-PMB chronic medication co-payments, or costs exceeding annual benefits from your available MSA. Each instance requires your instruction.

Contact the Scheme on **0860 222 633** or download the form from www.angloms.co.za **> Info Centre >Find documents and forms.**

Unspent savings roll over to the next year. Positive savings from previous years help build a healthy balance for extra medical cover when needed.

General Practitioner (GP) network - Managed Care Plan

Members of the Managed Care Plan can consult a GP on the Discovery Health GP network. GPs who are part of this network will charge the agreed rates and will not ask for upfront payment or co-payments unless your benefits are exhausted.

Utilising a network GP is voluntary. If you use a non-network GP, the Scheme will reimburse consultations and procedures at the normal Scheme Reimbursement Rate (SRR), and you may have to pay more out of your own pocket. If a procedure is not authorised by the Scheme, or the GP uses medicines and/or materials above the SRR, there may also be a co-payment.

Claims will be submitted directly to the Scheme and paid from your available MSA or by the Scheme if it is a Prescribed Minimum Benefit (PMB). Find the nearest participating Discovery Health network GP by using the "Find a Healthcare Provider' search tool on www.angloms.co.za after logging in as a member, or by calling the Call Centre on **0860 222 633**.

Premier Plus General Practioner (GP)

A Premier Plus GP is a network GP who has contracted with us as Designated Service Providers (DSP) to enrol you in one of the Scheme's Care Programmes for defined chronic conditions, and provide you with high quality, co-ordinated care. Members of the Standard Care Plan and Managed Care Plan can choose to consult with a Premier Plus GP to enrol in the Care Programmes, which, depending on the programme, can unlock additional benefits for conditions like cardiovascular disease, mental health conditions, and HIV.

To find a Premier Plus GP use the 'Find a Healthcare Provider' search tool on www.angloms.co.za and select Premier Plus under Care Programmes or call us on **0860 222 633**.

Premier Specialist Network

Members of the Standard Care and Managed Care Plan can consult a Specialist on the Premier Specialist Network for in- and out-of-hospital events. Specialists who are part of this network will charge the agreed rates for consultations and procedures, and will not ask for co-payments unless your benefits are exhausted.

Utilising the Premier Specialist Network is voluntary. If you use a non-network Specialist, the Scheme will reimburse as per the Plan benefits, and you may have to pay more out of your own pocket. If a procedure is not authorised by the Scheme, or the Specialist uses medicines and/or materials above the SRR, there may also be a co-payment. Claims will be submitted directly to the Scheme and paid as per your Plan benefits or by the Scheme if it is a Prescribed Minimum Benefit (PMB).

Find the nearest Specialist on the Premier Specialist Network by using the "Find a Healthcare Provider' search tool on www.angloms.co.za after logging in as a member, or by calling the Call Centre on **0860 222 633**.

HealthID

HealthID is an online platform that allows participating healthcare professionals, after you have given consent, to access your health information quickly and securely. With HealthID, your healthcare professional can view your medical history, check test results, track your progress, and make referrals to other healthcare professionals. Your healthcare professional can track your progress on a personalised dashboard on HealthID. This will help to identify which areas require attention so that your healthcare professional can improve the management of your condition and provide co-ordinated and efficient care.

AMS Care and Management Programmes

AMS provides a variety of specialised Care and Management Programmes, designed to offer enhanced support, co-ordinated care, and improved health outcomes for specific conditions. By using a Designated Service Provider (DSP), you can access additional benefits. For more details about our programmes, please visit the benefit information on our website or call us at **0860 222 633**.

Cardio Care Programme

The Cardio Care Programme is designed to offer optimal support to members living with hypertension, hyperlipidaemia and coronary artery disease, to achieve best quality care and outcomes. Once you are registered on the Chronic Illness Benefit for one of these conditions, the Designated Service Provider (DSP) of this programme, a Premier Plus GP, can enrol you through HealthID, with your consent. This programme allows your Premier Plus GP to manage and initiate appropriate treatment with the support of a multi-disciplinary care team.

Diabetes Care Programme

Diabetes Mellitus, or diabetes, is a chronic disease that can lead to severe complications if not managed effectively. If you are registered for diabetes, you have access to the Diabetes Care Programme through your network healthcare professional. By using a healthcare professional on our network you can agree on key goals and track your progress on a personalised dashboard on HealthID. For more information call **0860 444 439** or email Members_DCP@angloms.co.za.

Members of the Standard Care Plan and Managed Care Plan can choose to consult with a healthcare professional on the network. Should you choose a healthcare professional, you will unlock additional benefits for your diabetes care. To find a DSP use the 'Find a Healthcare Provider' search tool on www.angloms.co.za or call us on **0860 444 439**.

Unlock Diabetes-related benefits
Once registered, you have access to diabetes-related benefits, such as doctor visits, diabetic foot care, eye screenings, dietary advice, diabetes education and support, laboratory screening, and access to medicine and accessories. More details on the benefits are available in the Diabetes Care Programme information that you will receive on registration.

MediKredit will handle the registration of your diabetes medication and the MediKredit diabetes basket of care will apply.

If there is a change in your diabetes medication, your healthcare professional or your pharmacist can call us on **0860 222 633** or email ams@medikredit.co.za.

Disease Prevention Programme

Our Disease Prevention Programme is designed for members with a risk of diabetes or cardiovascular disease. Risk factors include high blood pressure, elevated blood sugar, abnormal cholesterol, high triglycerides, high BMI, and increased waist circumference. These factors increase the likelihood of diabetes, cardiovascular disease, strokes, or heart attacks. The programme, along with your Premier Plus GP, a Health Coach, and a network dietitian, helps manage these risks, ensuring co-ordinated healthcare and improved outcomes.

How to join and access additional benefits

If you meet the Scheme's eligibility criteria, a Health Coach will contact you to explain the programme. With your consent, a Premier Plus GP can enrol you through HealthID. Once enrolled, you have access to two additional consultations with the Premier Plus GP and network dietitian, a defined set of blood tests for monitoring progress, and access to a Health Coach for 12 months for clinical support to track and improve your health and quality of life.

HIV Care / Management Programme

The confidential HIV Management Programme helps HIV-positive members and their dependants to stay well and provides access to increased benefits to help manage their condition more effectively. We encourage you and your dependants to register on the programme, as early detection of HIV infection allows preventive or other treatment to start immediately. This lengthens and improves quality of life and decreases the chance of complications, which can occur if the condition is unmanaged. It is therefore essential that members know their status and take early preventative measures.

Registration: If diagnosed with HIV, register on the Scheme's HIV Management Programme by emailing HIV@angloms.co.za or calling **0860 222 633**. A consultant will guide you through the confidential registration process.

Benefits: If registered on the HIV Management Programme, members are funded three GP consultations and one specialist consultation at SRR. Approved medicine, including multivitamins is funded at SRR, as well as certain radiology tests and a list of blood tests. Additionally, a flu vaccination will be funded from the Screening and Prevention Benefit. Members registered on the HIV Management Programme must follow the agreed treatment plan and remain compliant.

Pharmacy Network: Dis-Chem Direct is the Designated Service Provider. Call Dis-Chem Direct on **010 589 2788** if you have any questions relating to the dispensing of your HIV medication.

If a member voluntarily obtains HIV medicines from a non-DSP, the member will be liable to pay any difference between the actual cost incurred and the cost that would have been incurred had the medicine been obtained from the DSP.

How to access additional benefits:
The HIV Care Programme is offered in addition to the HIV Management Programme. To access the additional benefits offered by the HIV Care Programme (as part of one of the Scheme's Care Programmes), you must visit a Premier Plus GP, who is the DSP for this programme. The Premier Plus GP will enrol you, with your consent, through HealthID. Once enrolled, you will have access to one additional social worker consultation, and you and your Premier Plus GP can agree on key goals and track your progress on a personalised dashboard to improve your healthcare outcomes.

Maternity Management Programme

We understand pregnancy can be a whirlwind of life-changing experiences. Your Scheme is here to support you with our Maternity Management Programme, providing the care and resources you need. Notify us of your pregnancy at 12 weeks to access your maternity benefits.

Maternity benefits: We fund maternity consultations and tests with midwives, GPs, or gynaecologists, offering twelve consultations for Managed Care Plan members and eight for Standard Care Plan members. Two pregnancy scans are funded, with additional scans requiring authorisation. We also fund prescribed ante-natal vitamins up to R220 per month, and five antenatal classes. For hospital admissions, Standard Care Plan members pay a R4 125 co-payment if choosing a non-network hospital, while Managed Care Plan members can choose any hospital. We fund a three-day stay for natural births, and a four-day stay for caesarean or epidural deliveries, covering all related hospital accounts.

You can receive up to a 20% discount on umbilical cord blood and tissue storage with Next Biosciences. This is not funded by the Scheme, but as an AMS member you have access to the discount.

We fund medically necessary circumcisions from the Risk Benefit if authorised. More details on your maternity benefits are available in the Maternity Management Programme information that you will receive on registration.

Claims for your newborn: We cover newborns under the parent's name up to the last day of the calendar month of their birth. Should your newborn require medical treatment, a separate authorisation is needed in addition to the mother's authorisation for the delivery. Important: Register your baby on your plan within 30 days from the date of birth, to ensure all necessary treatment for your baby is funded.

Mental Health Care Programme

This programme equips both you, and your healthcare professional, with tools to effectively manage episodes of major depression. It runs over a six-month period but can be extended to 12 months, if clinically appropriate. The Designated Service provider (DSP), either a Premier Plus GP or a Psychologist in the Mental Health Care Programme network can, with your consent, enrol you on the Mental Health Care Programme through HealthID.

Additional benefits: Once enrolled, you will have access to three consultations with your Premier Plus GP, psychotherapy consultations up to a limit, and antidepressant medication. Register your chronic condition with us on **0860 222 633** so we can fund your antidepressant medication from the dedicated non-PMB Chronic Medicine Benefit and not from your day-to-day benefits.

Relapse Prevention Programme: After completing the Mental Health Care Programme, if you experience a mental relapse, you are entitled to further consultations.

More details on mental health benefits are available in the Mental Health Care Programme information that you will receive on registration.

Kidney Care Programme

Living with chronic kidney disease can be challenging. Our Kidney Care Programme, based on international best-practice guidelines, aims to enhance your quality of care and life. Participation is voluntary and free, without affecting your medical scheme benefits, and is offered in addition to our Kidney Disease Management Programme. Members will be automatically enrolled and informed about this programme if clinical entry criteria are fulfilled.

Oncology Management Programme

We understand that a cancer diagnosis can be overwhelming, but our dedicated oncology team is here to support you. The Scheme has an Oncology Management Programme to help members to get the right treatment, to manage their treatment, and to improve the quality of their lives.

Registration: To register on the Oncology Management Programme, your treating healthcare professional must send us a copy of your histology and relevant results that confirm your diagnosis. Please email the information to oncology@angloms.co.za or call us on 0860 222 633 for assistance.

Benefits: Once you have an approved treatment plan, on the Managed Care Plan, in and out of hospital benefits are unlimited.

The Standard Care Plan has a limited oncology benefit per 12 months cycle. Should you reach your limit, the Scheme will still pay 80% of the Scheme Reimbursement Rate (SRR) for your treatment.

Pharmacy network: The Designated Service Providers (DSP) for approved oncology medicines administered in rooms or scripted and dispensed medicines at a retail pharmacy, are Dis-Chem Oncology Courier Pharmacy, Medipost Pharmacy, MedXpress, MedXpress Network Pharamcy, Qestmed, Olsens Pharmacy or Southern Rx. A 20% co-payment will apply for the use of a non-DSP.

Innovation medicine: Funding is available for a defined list of innovative cancer medicines. The Scheme will pay 80% of the Scheme Reimbursement Rate (SRR) for approved treatments on the Standard Care Plan and 80% of the SRR on the Managed Care Plan once the Oncology Innovation Medicine Benefit limit has been exceeded.

Treatments: The programme covers a wide range of treatments and services, including chemotherapy, radiotherapy, hormonal therapy, consultations, blood tests, radiology, and more.

Hospital admissions: Approved hospital admissions for surgery and chemotherapy or radiotherapy are funded according to your plan. Most medical expenses for surgery will be paid from the Risk Benefit and not your Oncology Benefit.

Bone marrow transplants: The Scheme funds bone marrow donor searches and transplants up to the Scheme Reimbursement Rate.

Diagnosis tests: All investigative tests related to pathology and radiology, prior to your diagnosis, will be paid from an unlimited benefit on the Managed Care Plan and a limited pathology and radiology benefit limit on the Standard Care Plan.

More information on the oncology benefits is available in the Oncology Management Programme information that you will receive on registration.

Spinal Conservative Care Programme

The Spinal Conservative Care Programme is an out of hospital programme for the conservative treatment of spinal pain.

The aim of the Spinal Conservative Care Programme is to manage back pain effectively and, where possible, prevent the need for surgery.

This programme will help you manage your condition with the support of a network of healthcare professionals that specialise in the treatment and rehabilitation of back and neck pain.

Members are identified through claims data or referred via HealthID by a network GP or network spinal surgeon. Enrolment is subject to an assessment and clinical entry criteria.

Once you are identified as eligible for the programme, you will need to consult a chiropractor or physiotherapist in the conservative care network for this benefit to be funded from the Risk Benefit.

Other Management and Care Programmes

Above Management and Care Programmes are the most frequently used programmes. Other management programmes you have access to, subject to clinical protocols are:

- The Alcohol and Drug Dependency Programme
- Organ Transplant Management Programme

For any questions about these Management and Care Programmes, please contact us on **0860 222 633** or visit the plan and benefit information on www.angloms.co.za.

Standard Care Plan

Standard Care Plan is a **traditional medical plan** with defined benefits, Out of Hospital Family Limits and **certain network limitations.**

Out of Hospital benefits are limited and grouped by service under individual limits. Unless it is a Prescribed Minimum Benefit (PMB), all benefits are paid at 100% of the Scheme Reimbursement Rate (SRR):

- The SRR is based on the previously negotiated rate between medical schemes and healthcare professionals
- Healthcare professionals are entitled to charge above the SRR
- Members are encouraged to request the actual costs of services before purchasing them and to compare with the SRR
- Obtain a quotation from your healthcare professional and call **0860 222 633** to receive an estimate of the SRR
- Members may negotiate a better rate with their healthcare professional.

Hospital cover is unlimited and paid at **100% of SRR. If you use a non-network hospital, you will have to pay a co-payment.**

Contributions*: Main member R4 055, adult dependant R4 055, child dependant R1 215

* Subject to underwriting

Standard Care Plan Limits unless PMB

EXAMPLE

How to calculate your Family Limit

Adult R1 000 x 2 = R2 000

\+

Child R200 x 1 = R200

Family Limit R2 200

Use the combined available limit for one or more family members

IH

General services in network hospitals Radiology and Pathology	Unlimited Paid at 100% of SRR
\+	
Internal surgical prostheses	R88 120 per beneficiary

OH

Overall Out of Hospital Family Limit	Adult R7 080 Child R3 525
Sublimit 1: Alternative and allied healthcare	Adult R4 575 Child R960
Sublimit 2: Consultations, acute medication and Pharmacist Advised Therapy (PAT)	Adult R6 650 Child R3 325
\+	
Optometry Examination Lenses and frames	R540 per beneficiary R3 215 per family
\+	
Additional basic and specialised Dentistry Family Limit	Adult R2 055 Child R515
\+	
Radiology Family Limit	Adult R2 340 Child R1 415
\+	
Pathology Family Limit	Adult R1 795 Child R645
\+	
Medical and surgical appliances	R12 610 per family
\+	
Chronic medication (non-PMB)	R6 040 per beneficiary

Oncology:	**R398 955 per beneficiary per 12-month period. 20% co-payment after depletion of limit, subject to protocols**
Specialised medicine and technology:	**80% of SRR for medicine and technology costing in excess of R6 435 per unit of treatment per beneficiary**



Preventative Care Benefits

To support you in managing your health proactively, we encourage you to take preventative measures. Detecting health risks or a disease early could prevent a disease or at least improve the success rate of the treatment. The below preventative care benefits are **paid by the Scheme** (not from your normal benefits) at the Scheme Reimbursement Rate. Refer to the benefit table for more detail.

Description	Sex	Age*	Benefit Category	Purpose
Bone density scan	F	65+	Specialised Radiology	Detection of osteopaenia or osteoporosis (fragile bones)
Colonoscopy	F/M	50+	Endoscopy**	Early detection of colorectal or colon cancer
(1 faecal occult blood test every 2 years)	F/M	50+	Pathology	Early detection of colorectal cancer
Childhood vaccines As per Department of Health schedule	F/M	0-12	Vaccines	Early detection and reduction of childhood diseases
HIV screening/test	F/M	All	HIV Care Management Programme	Early detection of HIV
Immunisation COVID-19 Vaccine	F/M	As per DoH# schedule	Vaccines	Prevention of severe illness and death
Flu Vaccine	F/M	All	Vaccines	Influenza prevention; particularly important for people who are at risk of serious complications from influenza (chronic conditions, pregnant, HIV patients or ageing members)
Human Papillomavirus (HPV): Cervarix/Gardasil	F/M	9-26	Vaccines	Prevention of cervical cancer caused by HPV
Pneumococcal Vaccine	F/M	55+	Vaccines	Prevention of serious lung infections; particularly important for people who are at high risk for serious complications (certain chronic conditions, HIV patients or ageing members)
Mammogram	F	40+	Specialised Radiology	Early detection of breast cancer
Maternity Consultation	F		Maternity	Monitoring of your pregnancy and prevention of complications
Ultrasound	F		Maternity	
Newborn screening for metabolic disorders	F/M	2 - 3 days	Pathology	Early detection of metabolic disorders that can interfere with your baby's development
Pap smear	F	All	Pathology: Pap smear	Early detection of cervical cancer
Prostate check 1 blood test per year	M	50+	Pathology	Early detection of prostate cancer
Health check • Cholesterol • Blood glucose (sugar) • BMI • Blood pressure	F/M	All	Health check	Early detection of chronic illness

* recommended age unless you have specific risk factors

**co-payments may apply in hospital

Department of Health

The following preventative care measures are recommended, and will be **paid from your Out of Hospital Family Limit or other relevant benefit limit** at the Scheme Reimbursement Rate or negotiated rate or cost if PMB. Please discuss your individual need with your doctor. Refer to the benefit table for more detail.

Description	Sex	Age*	Paid from	Purpose
Eyesight check	F/M	40+	Eye Care Benefit	Early detection of eye disease or deterioration
Dental check-up at DSP	F/M	All	Basic Dental Benefit	Early detection of dental disease and preservation of dentine
Glaucoma screening	F/M	All	Out of Hospital Services Sublimit 2	Early detection of glaucoma
Gynaecological check-up	F	All	Out of Hospital Services Benefit, Sublimit 2	Early detection of cancer and gynaecological problems
Hearing test	F/M	All	Out of Hospital Services Benefit, Sublimit 1	Early detection of medical conditions and hearing dysfunction
Baby and child Paediatric assessment	F/M	Baby/ Child	Out of Hospital Services Benefit, Sublimit 2	Early detection of developmental problems
Pathology screening • Cholesterol • Glucose • Thyroid	F/M	All	Pathology Out of Hospital Benefit (non-PMB)	Early detection of chronic illness
Prostate check-up (examination)	M	50+	Out of Hospital Services Benefit, Sublimit 2	Early detection of prostate cancer
Senior members Home nursing assessment on Doctor or Scheme request	F/M	65+	Out of Hospital Services Benefit, Sublimit 1	Detection of complications or mobility problems negatively impacting on wellbeing or illness
Podiatry care	F/M	All		
Skin health	F/M	All	Out of Hospital Services Benefit, Sublimit 2	Detection of skin cancer
Stool test (cancer and other screening)	F/M	50+	Pathology Out of Hospital Benefit (non-PMB)	Detection of cancer and other diseases

*recommended age unless you have specific risk factors

Benefits

All benefits paid at 100% of SRR*, or negotiated rate or at cost if PMB

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital / 0H Out of hospital	Comments and co-payments
Alcohol and drug treatment: Admission and medication in DSP facility (subject to PMB)	Y	21 days	N	Discovery Health Network of Drug and Rehabilitation facilities	IH	A 20% co-payment will apply for admission and treatment at a non-DSP facility
Alcohol and drug treatment: Consultations and medication upon discharge	Y	Overall Out of Hospital Family Limit and Sublimit 2: Adult R6 650, Child R3 325	N		0H	
Ambulance services: Life-threatening medical emergency transport	Y 082 911		N	Netcare 911	IH 0H	Notify Netcare 911 at the time of emergency or the next working day. Authorise inter-hospital transfers before the event. Voluntary use of non-DSP results in 20% co-payment
Cancer treatment: Medicine	Y	Oncology Limit: R398 955 per beneficiary, per 12-month period	Y	Dis-Chem Oncology Courier Pharmacy, Medipost Pharmacy, MedXpress, MedXpress Network Pharmacy, Qestmed, Olsens Pharmacy or Southern Rx	IH 0H	A 20% co-payment for non-DSP oncology medicines administered in rooms or dispensed at retail pharmacies. Innovation drugs incur a 20% co-payment. Subject to clinical entry criteria and Scheme protocols. After limit is exhausted, non-PMB treatment is paid at 80% of SEP

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital 0H Out of hospital	Comments and co-payments
Cancer treatment: Oncology management programme	Y	Oncology Limit R398 955 per beneficiary, per 12-month period	Y	Oncology facility or accredited hospital	IH 0H	100% of SRR for in and out of hospital services subject to protocols. After the depletion of the Oncology Limit, a co-payment of 20% applies. Post-oncology treatment is part of your oncology treatment but must be registered separately. If diagnosed with cancer you can upgrade to the Managed Care Plan within three months of initial diagnosis or commencement of treatment. Subject to Scheme protocols. More info on the Oncology Management Programme (see page 35)
COVID-19	N		N	N§	IH 0H	Funding for COVID-19 Prescribed Minimum Benefits and additional funding from your normal out of hospital and hospital benefits. Subject to Scheme clinical and benefit entry criteria and authorisation for hospital events
Dental hospitalisation (including medicine and related products): In the case of trauma or patients under the age of 7 years requiring anaesthetic, the removal of impacted molars, maxillo-facial and oral surgery (PMB conditions)	Y		N	Day clinic or Hospital Network	IH	
Dentistry: Basic dental services provided by the DRC network	N	Per beneficiary: • Every 180 days: 1 consultation, 1 scaling, polishing and fluoride treatment; at a network dentist or oral hygienist • 4 intra-oral radiographs per visit every 180 days up to 7 per year; • 1 local anaesthetic per visit; • 4 extractions per year; • 5 restorations (amalgam or resin) per year; • 1 panoramic radiograph every 36 months, • 1 pair of plastic dentures every 4 years, including 1 annual relining and repair per year	N	Dental Risk Company (DRC)	0H	Subject to services as stated under limits and DRC protocols. For a list of DRC network healthcare professionals, call the Call Centre or visit www.angloms.co.za Authorisation required for more than 4 extractions. Authorisation required for more than 5 resin restorations Use of non-network professional results in a co-payment (the difference between 80% of SRR and the claimed amount)

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

§ If condition results in hospital admission, the Hospital Network applies

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital OH Out of hospital	Comments and co-payments
Dentistry: Basic dentistry provided by non-network professional	N	Limited to basic dental services listed above	N	N	OH	Subject to services as stated under limits and DRC protocols. Use of non-network healthcare professional results in a co-payment (the difference between 80% of SRR and the claimed amount)
Dentistry: Additional basic and specialised dentistry	N	Family Limit: Adult R2 055, Child R515	N	N§	IH OH	Limit applies to both, network and non-network professionals
Dentistry: Root canal treatment	N		N	N	OH	Root canal treatment for non-functional wisdom teeth will not be covered. Scheme managed care protocols will apply
Diabetes Care Programme: Consultation with doctors, dietitians, ophthalmologists, pathology tests, podiatrists, medicine and related products	Y 0860 444 439		Y	Discovery Care Coordination Network	IH OH	Register on the Diabetes Care Programme to consult with a healthcare professional that is part of the Diabetes Care Network. If you choose not to register on the Programme or consult with a healthcare professional outside the network, your chronic condition benefit limits will apply which may lead to out of pocket payments. MediKredit will handle the registration of your diabetes medication and the MediKredit diabetes basket of care will apply. More info on the Diabetes Care Programme (see page 31)
Endoscopy: Gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	Y		N	Network of day clinics or accredited facility	IH OH	No co-payment if performed in a day clinic or an accredited network facility, or in case of emergency treatment. For a list of accredited facilities, call the Call Centre or visit www.angloms.co.za. Co-payment of R4 125 if admitted to hospital specifically for an endoscopy
Eye care: Eye examinations	N	R540 per beneficiary	N	N	OH	
Eye care: Lenses, frames	N	R3 215 per family	N	N	OH	20% discount on frames and eyeglass lenses at optometrists in the Discovery Health Optometry Network
Eye care: Cataract surgery with intra-ocular lens replacement	Y	Intra-ocular lens subject to the Internal Surgical Prostheses Limit	N	Day clinic or accredited facility	IH OH	No co-payment when performed out of hospital. For a list of accredited facilities, please call the Call Centre or visit www.angloms.co.za. Co-payment of R1 290 when performed in hospital

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

§ If condition results in hospital admission, the Hospital Network applies

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital / 0H Out of hospital	Comments and co-payments
HIV: Confidential HIV Care / Management Programme (HIV test/screening, GP, social worker and specialist consultations, medicine, radiology and pathology)	Y		Y	Premier Plus GP	0H	Once registered, you need to follow the treatment plan. Your status will at all times remain confidential. If you chose to use a non-DSP voluntarily, you must pay the cost difference compared to using a DSP. To access more HIV benefits join the HIV Care Programme (see page 32)
HIV/AIDS: Medicines	Y		Y	Dis-Chem Direct	0H	After registration, phone Dis-Chem Direct (011 589 2788) to confirm how you want to receive your medication. If you use a non-DSP voluntarily, you must pay the cost difference compared to using a DSP
Hospice: Instead of hospitalisation (in-patient care facility and out-patient home care)	Y		N		0H	Subject to Scheme protocols
Hospitalisation: Hospital services including allied healthcare services (as determined by the Scheme), day cases, blood transfusions, radiology, pathology, professional services and 7 day supply of to-take-out medication	Y	Unlimited	N	Hospital Network	IH	R4 125 co-payment for voluntary admission to non-network hospitals, except in medical emergencies. Network hospital information available from the Call Centre or website. Subject to Scheme protocols
Hospitalisation: Internal surgical prostheses	Y	R88 120 per beneficiary	N	N	IH	
Hospitalisation: Professional services for a defined list of minor procedures performed by specialists in doctor's rooms instead of hospital	Y		N	N	0H	
Hospitalisation: Step-down instead of hospitalisation	Y		N	N	0H	Subject to Scheme protocols
Hospitalisation: Hospital at home (acute care at home in lieu of hopitalisation	Y		N	Discovery Hospital at Home, Mediclinic at Home and Quro Medical	0H	Subject to clinical entry criteria

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital / 0H Out of hospital	Comments and co-payments
Hospitalisation: Psychiatric admission	Y	21 days or 15 consultations out of hospital	N	N	IH	Subject to Scheme protocols. Admission to a registered psychiatric or psychotherapy facility. To access more mental health benefits join the Mental Healthcare Programme (see page 34)
Infertility: Treatment subject to PMB	Y		N	N §	IH 0H	
Kidney Disease Management Programme: Dialysis (haemo or peritoneal)	Y		Y	Hospital Network	IH 0H	Subject to Scheme protocols. To access more kidney related benefits join the Kidney Care Programme (see page 34)
Maternity Management Programme: Consultations, ultrasound scans and prescribed vitamins	Y	8 consultations, 2 ultrasound scans (paid up to the cost of 2D) per pregnancy, R220 per month for prescribed ante-natal vitamin supplements, 5 antenatal classes	N	N	IH 0H	Authorisation required between weeks 12 and 20 of the pregnancy to qualify for benefits. Vitamins subject to Scheme protocols. More info on the Maternity Management Programme (see page 33)
Maternity: Confinement	Y		N	Hospital Network	IH	Confinement in network hospital or in a low-risk maternity unit provided by a registered midwife if preferred. R4 125 co-payment for voluntary admission to non-network hospitals, except in medical emergencies
Medical appliances: External appliances provided by orthotists and prosthetists	Y	Medical and Surgical Appliance Family Limit: R12 610	N	Discovery Health network of orthotists and prosthetists	0H	Authorisation required for appliances over R3 425 each. You are responsible for the difference in cost when using a non-DSP
Medical appliances: External appliances provided by healthcare professionals other than orthotists and prosthetists	Y	Medical and Surgical Appliance Family Limit	N	N	0H	Authorisation required for appliances over R3 425 each, paid at network rate
Medical appliances: Hearing aids (1 pair every 2 years per beneficiary)	Y	Medical and Surgical Appliance Family Limit	N	N	0H	Clinical motivation by ENT required for beneficiaries younger than 60 years
Medical appliances: Wheelchair (1 wheelchair every 2 years per beneficiary)	Y	Medical and Surgical Appliance Family Limit	N	N	0H	

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

§ If condition results in hospital admission, the Hospital Network applies

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital 0H Out of hospital	Comments and co-payments
Medicine Management Programme: Chronic conditions (PMB)	Y		Y	N Except HIV/AIDS, cancer and diabetes	0H	1 month's supply at a time. 100% of SEP and dispensing fee, subject to the Medicine Reference Price List and Scheme protocols. Generic medicine can prevent co-payments. Find generic alternatives and co-payments on **www.angloms.co.za** > My Plan > SCP > Medicine. Registration by pharmacist or doctor

PMB chronic conditions[§]

Addison's Disease	Cardiomyopathy	Diabetes Insipidus
Asthma	Chronic Renal Disease	Diabetes Mellitus Type 1
Bipolar Mood Disorder	Chronic Obstructive Pulmonary Disease	Diabetes Mellitus Type 2
Bronchiectasis	Coronary Artery Disease	Dysrhythmias
Cardiac Failure	Crohn's Disease	Epilepsy
Hypertension	Rheumatoid Arthritis	
Glaucoma	Hypothyroidism	Schizophrenia
Haemophilia	Multiple Sclerosis	Systemic Lupus Erythematosus
Hyperlipidaemia	Parkinson's Disease	Ulcerative Colitis

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

§ when recognised as chronic according to Scheme protocol

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital 0H Out of hospital	Comments and co-payments
Medicine Management Programme: Chronic conditions (non-PMB)	Y	R6 040 per beneficiary	N	N	0H	1 month's supply at a time. 100% of SEP and dispensing fee, subject to the Medicine Reference Price List and Scheme protocols. Generic medicine can prevent co-payments. Find generic alternatives and co-payments on www.angloms.co.za > My Plan > SCP > Medicine. Registration by pharmacist or doctor
Non-PMB chronic conditions§						
Acne	Ankylosing Spondylitis	Degeneration of the Macula	Ménière's Disease	Osteoarthritis	Peptic Ulcer	
Allergy Management	Atopic Dermatitis (Eczema)	Depression	Migraine	Osteoporosis	Psoriasis Vulgaris	
Alzheimer's Disease	Attention Deficit Disorder	Gastro-oesophageal Reflux Disease (GORD)	Myasthenia Gravis	Other Venous Embolism and Thrombosis	Pulmonary Embolism	
Anaemia	Benign Prostatic Hyperplasia	Gout (chronic)				
Mental Health Care Programme: Consultations and anti-depressant medicine	Y	3 GP consults, 3 psychotherapy sessions at psychologist, up to R3 610 per beneficiary;	Y	Premier Plus GP or network psychologist	0H	Subject to protocols. Medication subject to registration
Mental Health Care Programme: Relapse prevention programme	Y	2 psychiatric visits and 6 counselling sessions	Y	Premier Plus GP or network psychologist	0H	Counselling with psychologist, social worker or registered counsellor
Organ Transplant Management Programme: Harvesting of the organ, post-operative care of the member and the donor and anti-rejection medicine	Y		Y	Hospital Network	IH 0H	Costs for organ donations are excluded for anyone who is not a registered dependant of the Scheme

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

§ when recognised as chronic according to Scheme protocol

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital OH Out of hospital	Comments and co-payments
Out of hospital services (non-PMB): Including consultations, visits, procedures, alternative and allied healthcare services, acute medicine and Pharmacist Advised Therapy (PAT)	N	Overall Out of Hospital Family Limit: Adult R7 080 Child R3 525	N	N	OH	Sublimits to Overall Limit: Sublimit 1: Alternative and allied healthcare services. Sublimit 2: Consultations, acute medicine out of hospital and PAT. The two OH sublimits do not add up, to allow member benefit flexibility within the overall OH Limit
Sublimit 1 **Alternative and allied healthcare services** Acupuncture, audiology, chiropody, chiropractic services (including x-rays), dietetics, homeopathy, naturopathy, occupational therapy, orthoptics, physiotherapy, podiatry, psychology, registered nurse services, social services, speech therapy	N	Family Limit for alternative and allied healthcare: Adult R4 575 Child R960 and Overall Out of Hospital Family Limit	N	N	OH	Family Limit also includes homeopathic, NAPPI coded compounded medicine, dispensed by a registered homeopath
Orthotists and prosthetists consultations	N		N	Discovery Health network of orthotists and prosthetists	OH	
Private nursing instead of hospitalisation	Y		N	N	OH	
Sublimit 2		Family Limit for consultations, acute medicine and PAT Adult R6 650, Child R3 325 and Overall Out of Hospital Family Limit				
GP and specialist in rooms (non-PMB), consultations, visits, procedures and treatments in rooms and acute medicine and injection material relevant to the treatment	N		N	N	OH	
Medicine: NAPPI coded acute medicine and injection material prescribed or dispensed by a registered homeopath, GP, specialist or dispensed by a pharmacy	N		N	N	OH	
PAT medicine: R765 per family per 3 months	N		N	N	OH	
Out of hospital services (PMB): Specialist and GP consultations for chronic PMB conditions	N		N	N	OH	Subject to Scheme protocols and registration of chronic condition (registration on management programme required for cancer, renal, HIV and diabetes)
Out of hospital consultations: For treatment of general conditions and minor procedures by Specialists within the Premier Specialist Network	N	Family Limit for consultations, acute medicine and PAT Adult R6 650, Child R3 325 and Overall Out of Hospital Family Limit	N	N	OH	Network rate for consultations

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital / 0H Out of hospital	Comments and co-payments
Oxygen therapy: At home, cylinder, concentrator (rental only) and consumables	Y		N	N	0H	Subject to Scheme clinical entry criteria
Pathology: Out of hospital chronic disease conditions (PMB)	N		N	N	0H	Subject to Scheme protocols and registration of the chronic condition
Pathology: Cancer screening	N		N	N	0H	Cervical cancer screening: one pap smear test for beneficiaries. Prostate screening: one PSA test. Colon screening: One faecal occult blood test every 2 years for beneficiaries from 50-70 years
Pathology: In hospital	N		N	N	IH	
Pathology: Out of hospital (non-PMB)	N	Family Limit Adult R1 795, Child R645	N	N	0H	The Scheme will not pay for DNA testing and investigations, including genetic testing for familial cancers and paternal testing
Radiology: In hospital	N		N	N	IH	
Radiology: Out of hospital, x-rays (non-PMB)	N	Family Limit Adult R2 340, Child R1 415	N	N	0H	
Specialised radiology: Mammogram	N	1 per year	N	N	0H	
Specialised radiology: Isotope therapy, MRI and CT scans, and bone densitometry	Y		N	N	IH 0H	Referral required. 1 scan for bone densitometry per beneficiary. Additional scans must meet clinical criteria for it to be authorised
Specialised medicine and technology: This benefit applies to a specified list of specialised medicine (excluding oncology medicine) in excess of R6 435 per month and specialised technology in excess of R6 435 per item as a once-off purchase	Y		N	N	IH 0H	Paid at 80% of SRR, subject to Scheme protocols. 20% to be paid as co-payment by member

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital OH Out of hospital	Comments and co-payments
Vaccines: Childhood vaccines for children up to 12 years	N	Department of Health protocol	N	N	OH	
Vaccine: COVID-19	N	Frequency of vaccine(s) and administration according to DoH# guideline	N	N	OH	
Vaccine: Influenza (Flu)	N	1 vaccine and 1 consultation per beneficiary	N	N	OH	Recommended for high-risk patients (chronic conditions, HIV patients, pregnant or ageing members)
Vaccine: Pneumococcal	N	1 vaccine and 1 consultation per beneficiary over the age of 55, 2 per lifetime	N	N	OH	Recommended for high-risk patients (chronic conditions, HIV patients or ageing members)
Vaccine: Human Papillomavirus (HPV)	N	1 lifetime vaccination per beneficiary	N	N	OH	For beneficiaries from age 9-26, unless motivated by your doctor
Health check: Cholesterol, blood glucose, BMI, blood pressure	N	1 per beneficiary per year	N	N	OH	Health check done at contracted providers

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

Department of Health

Ex gratia

Members may apply for benefits in addition to those provided in the Rules. An application will be considered by the Scheme which may assist members by awarding additional funding.

Members may apply based on the following criteria:

- Demonstrated financial hardship in the case of a benefit depletion and the medical condition necessitates continuation of treatment; or
- A genuine medical necessity where the benefit is expressly excluded from the Rules or is not provided for in the Rules.

Ex Gratia is not a guaranteed benefit and means “as a favour”. Decisions do not set precedent.

Call **0860 222 633** or download the ex gratia application form at www.angloms.co.za

Submit the completed application form:
Email: ex-gratia@angloms.co.za

Upon approval, submit your claims:
Email: ex-gratiaclaims@angloms.co.za

General exclusions

The following are some of the Scheme exclusions (for a full list please refer to the Rules). These you would need to pay:

- Services rendered by any person who is not registered to provide healthcare services, as well as medicine that has been prescribed by someone who is not registered to prescribe
- Experimental or unproven services, treatments, devices or pharmacological regimes
- Patent and proprietary medicines and foods, including anabolic steroids, baby food and baby milk, mineral and nutritional supplements, tonics and vitamins except where clinically indicated in the Scheme’s managed care protocols and prescribed vitamins during pregnancy
- Cosmetic operations, treatments and procedures, cosmetic and toiletry preparations, medicated or otherwise
- Obesity treatment, including slimming preparations, appetite suppressants and bariatric surgery
- Examinations for insurance, school camps, visas, employment or similar
- Holidays for recuperative purposes, regardless of medical necessity
- Interest or legal fees relating to overdue medical accounts
- Stale claims, which are claims submitted more than four months after the date of treatment
- Claims for appointments that a member fails to keep
- Costs that exceed any annual maximum benefit and costs that exceed any specified limit to the benefits to which members are entitled in terms of the Rules.
- All costs related to:
    - Anaesthetic and hospital services for dental work (except in the case of trauma (PMB), patients under the age of seven years and the removal of impacted third molars)
    - Bandages, dressings, syringes (other than for diabetics) and instruments unless authorised for payment from risk
    - Lens preparations
    - DNA testing and investigations, including genetic testing for familial cancers and paternal testing
    - Gum guards, gold in dentures and in crowns, inlays and bridges
    - Immunoglobulins except where clinically indicated against the Scheme’s protocols
    - In vitro fertilisation, including GIFT and ZIFT procedures, and infertility treatments which are not PMBs
    - Organ donations to any person other than to a member or registered dependant

General Rule reminders

- This Benefit Guide is a summary of the 2027 AMS benefits, pending approval from the Registrar of Medical Schemes.
- Please refer to www.angloms.co.za (My Scheme, Scheme Rules) for the full set of registered Rules.
- The Anglo Medical Scheme Rules are binding on all beneficiaries, officers of the Scheme and on the Scheme itself.
- The member, by joining the Scheme, consents on his or her own behalf and on behalf of any registered dependants, that the Scheme may disclose any medical information to the administrators and contracted third-parties for reporting or managed care purposes.
- A registered dependant can be a member's spouse or partner, a biological or stepchild, legally adopted child, grandchild or immediate family relation (first-degree blood relation) who is dependent on the member for family care and support.
- To avoid underwriting, a member who gets married must register his or her spouse as a dependant within 30 days of the marriage. Newborn child dependants must be registered within 30 days of birth to ensure benefits from the date of birth. If a newborn is registered within 90 days, benefits will only be made available from the date of registration.
- A child dependant, 23 years or younger on 01 January of a benefit year, may remain on your membership at the child dependant contribution rate until year-end.
  If your dependant is 24 years old on 01 January and you wish to keep him/her on the Scheme as an adult dependant, you may apply for continuation of membership against the Scheme's dependant eligibility criteria. If the criteria are met, adult contribution rates will apply.
- It is the member's or dependant's responsibility to notify the Scheme of any material changes, such as marital status, banking details, home address or any other contact details and death of a member or dependant.

Disclaimer: This Benefit Guide provides a summary of the benefits and rules of the Anglo Medical Scheme. While every effort has been made to ensure accuracy, the registered Scheme Rules shall take precedence in the event of any discrepancy, omission or inconsistency between this Benefit Guide and the Scheme Rules. The Scheme Rules will be the definitive and binding source for all benefit interpretations and decisions.

Managed Care Plan

Managed Care Plan offers the following comprehensive benefits:

- Unlimited **hospital cover** paid at 100% of the Scheme Reimbursement Rate (SRR)
- The **Top-Up** rate pays up to a maximum of 230% of the SRR for specialist services in hospital, excluding pathology, radiology, allied healthcare services and GPs performing specialist services

  (230% = 100% of SRR + additional 130% of SRR)
- A **Medical Savings Account** for out of hospital services and discretionary spend
- Unlimited Radiology and Pathology
- Frail care where clinically required
- Extensive chronic medication
- Voluntary use of a GP network (no co-payments)
- Reimbursement for specialist consultations and procedures out of hospital up to 125% of SRR.

Contributions are split as follows:

- 79% allocated to limited/unlimited benefits
- 21% allocated to savings, for discretionary spend.

Contributions*		
Excluding Savings **Main member: R 5 850** **Adult dependant: R5 850** **Child dependant: R1 355**	**Savings** **Main member: R1 555** **Adult dependant: R1 555** **Child dependant: R360**	**Total contributions** **Main member: R7 405** **Adult dependant: R7 405** **Child dependant: R1 715**

* Subject to underwriting

Managed Care Plan Limits unless PMB

EXAMPLE

How to calculate your Family Limit

Adult R1 000	x 2 = R2 000	Family Limit R2 200
Child R200	x 1 = R200	

Use the combined available limit for one or more family members

IH

General Hospital Services, Radiology and Pathology	Unlimited at 100% of SRR
+	
Internal surgical prostheses	R186 900 per beneficiary
+	
Top-Up rate	Up to a maximum of 230% of SRR for specialists. Excludes pathology, radiology and allied healthcare services in hospital

OH

Medical Savings Account	Discretionary spend for out of hospital services and costs in excess of Limits below
+	
Dentistry Family Limit	Adult R5 570 Child R2 105
+	
Optometry Examination Lenses and frames	R540 per beneficiary R4 820 per family
+	
Radiology	Unlimited
+	
Pathology	Unlimited
+	
Medical and surgical appliances	R21 380 per family
+	
Wheelchair	Every 2 years R33 645 per beneficiary
+	
Hearing Aids	R26 900 per hearing aid per beneficiary every 2 years
+	
Chronic medication (non-PMB)	R23 345 per beneficiary
+	
Frail care	R94 000 per beneficiary

Specialised medicine and technology: Unlimited, subject to Scheme protocols



Preventative Care Benefits

To support you in managing your health proactively, we encourage you to take preventative measures. Detecting health risks or a disease early could prevent a disease or at least improve the success rate of the treatment. The below preventative care benefits are **paid by the Scheme** (not from your normal benefits) at the Scheme Reimbursement Rate. Refer to the benefit table for more detail.

Description	Sex	Age*	Benefit Category	Purpose
Bone density scan	F	65+	Specialised Radiology	Detection of osteopaenia or osteoporosis (fragile bones)
Colonoscopy	F/M	50+	Endoscopy**	Early detection of colorectal or colon cancer
(1 faecal occult blood test every 2 years)	F/M	50+	Pathology	Early detection of colorectal cancer
Childhood vaccines As per Department of Health schedule	F/M	0-12	Vaccines	Early detection and reduction of childhood diseases
HIV screening/test	F/M	All	HIV Care Management Programme	Early detection of HIV
Immunisation COVID-19 Vaccine	F/M	as per DoH# schedule	Vaccines	Prevention of severe illness and death
Flu Vaccine	F/M	All	Vaccines	Influenza prevention; particularly important for people who are at risk of serious complications from influenza (chronic conditions, pregnant, HIV patients or ageing members)
Human Papillomavirus (HPV): Cervarix/Gardasil	F/M	9-26	Vaccines	Prevention of cervical cancer caused by HPV
Pneumococcal Vaccine	F/M	55+	Vaccines	Prevention of serious lung infections; particularly important for people who are at high risk for serious complications (chronic conditions, HIV patients or ageing members)
Mammogram	F	40+	Specialised Radiology	Early detection of breast cancer
Maternity Consultation	F		Maternity	Monitoring of your pregnancy and prevention of complications
Ultrasound	F		Maternity	
Newborn screening for metabolic disorders	F/M	2 - 3 days	Pathology	Early detection of metabolic disorders that can interfere with your baby's development.
Pap smear	F	All	Pathology	Early detection of cervical cancer
Pathology screening • Cholesterol • Glucose • Thyroid • Cancer (Stool test)	F/M	All All All 50+	Pathology	Early detection of chronic illness or cancer
Prostate check (1 blood test per year)	M	50+	Pathology	Early detection of prostate cancer
Stool test (cancer and other screening)	F/M	50+	Pathology	Detection of cancer and other diseases
Health check • Cholesterol • Blood glucose (sugar) • BMI • Blood pressure	F/M	All	Health check	Early detection of chronic illness

The following preventative care measures are recommended, and will be **paid from your relevant benefit limit or Medical Savings Account** at the Scheme Reimbursement Rate or negotiated rate or cost if PMB. Please discuss your individual need with your doctor. Refer to the benefit table for more detail.

Description	Sex	Age*	Paid from	Purpose
Eyesight check	F/M	40+	Eye Care Benefit or Member Savings	Early detection of eye disease or deterioration
Dental check-up	F/M	All	Dental Benefit or Member Savings	Early detection of dental disease and preservation of dentine
Glaucoma screening	F/M	All	Member Savings	Early detection of glaucoma
Gynaecological check-up	F	All	Member Savings	Early detection of cancer and gynaecological problems
Hearing test	F/M	All	Member Savings	Early detection of medical conditions and hearing dysfunction
Baby and child Paediatric assessment	F/M	Baby/ Child	Member Savings	Early detection of developmental problems
Prostate check-up (examination)	M	50+	Member Savings	Early detection of prostate cancer
Senior members Home nursing assessment on Doctor or Scheme request	F/M	65+	Member Savings	Detection of complications or mobility problems negatively impacting on wellbeing or illness
Podiatry care	F/M	All	Member Savings	
Skin health	F/M	All	Member Savings	Detection of skin cancer

* recommended age unless you have specific risk factors

** co-payments may apply in hospital

Department of Health

* recommended age unless you have specific risk factors

Benefits

All benefits paid at 100% of SRR*, Top-Up rate, negotiated rate or at cost if PMB

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital / 0H Out of hospital	Comments and co-payments
Alcohol and drug treatment: Admission and medication in DSP facility (subject to PMB)	Y	21 days	N	Discovery Health Network of Drug and Alcohol rehabilitation facilities	Scheme to pay up to limit	IH	A 20% co-payment will apply for admission and treatment at a non-DSP facility
Alcohol and drug treatment: Consultations and medication upon discharge	Y	Available savings	N		Member savings	0H	
Alternative and allied healthcare: Audiology, acupuncture, chiropody, chiropractic services, (including x-rays), dietitians, homeopathy, naturopathy, occupational therapy, orthoptics, physiotherapy, podiatry, psychology, registered nurse services, social services, speech therapy	N	Available savings	N	N	Member savings	0H	
Ambulance services: Life-threatening medical emergency transport	Y 082 911		N	Netcare 911	Scheme to pay	IH 0H	Notify Netcare 911 at the time of emergency or the next working day. Authorise inter-hospital transfers before the event. Voluntary use of non-DSP results in a 20% co-payment
Allied healthcare services: Orthotists and prosthetists (consultations)	N	Available savings	N	Discovery Health network of orthotists and prothetists	Member savings	IH 0H	

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital 0H Out of hospital	Comments and co-payments
Cancer treatment: Oncology Management Programme	Y		Y	N	Scheme to pay if PMB	IH 0H	100% of SRR and Single Exit Price SEP for medicines, subject to chemo and radiation therapy protocols. Drug therapies for chemotherapy side effects and pain relief require authorisation. Post-oncology treatment is part of your oncology treatment but must be registered separately. More info on the Oncology Management Programme (see page 35)
Cancer treatment: Medicine	Y	Oncology Innovation Medicine limit R814 300	Y	Y	Dis-Chem Oncology Courier Pharmacy, Medipost Pharmacy, MedXpress, MedXpress Network Pharmacy, Qestmed, Olsens Pharmacy or Southern Rx	IH 0H	A 20% co-payment for non-DSP oncology medicines administered in rooms or dispensed at retail pharmacies. Oncology Innovation Medicine limit of R814 500 for specified innovative or high cost medicine and a 20% co-payment applies once this limit is depleted. Subject to clinical entry criteria and Scheme protocols
Consultations out of hospital: Specialist and GP for chronic PMB conditions	N		N	N	Scheme to pay	0H	Subject to Scheme protocols and registration of chronic condition (registration on management programme required for cancer, renal, HIV and diabetes)
Consultations out of hospital: GP for treatment of general conditions and minor procedures	N	Available savings	N	N	Member savings	0H	Paid at SRR. Cost in excess of SRR can be paid from available savings upon special request. Once MSA and ASA (Accummulated Savings Account) are exhausted: 2 additional GP consultations per family paid by the Scheme
Consultations out of hospital: GP for treatment of general conditions and minor procedures (GP within the Discovery Health GP network)	N	Available savings	N	Voluntary GP network	Member savings	0H	Network rate for consultations and a defined list of procedures, paid directly by the Scheme, no co-payment, (see page 30)
Consultations out of hospital: Specialist for treatment of general conditions and minor procedures (excluding radiologists and pathologists)	N	Available savings	N	N	Member savings	0H	Up to 125% of SRR
Consultations out of hospital: Specialist for treatment of general conditions and minor procedures (excluding radiologists and pathologists) (Specialist within the Premier Specialist Network)	N	Available savings	N	N	Member savings	0H	Network rate for consultations

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital / 0H Out of hospital	Comments and co-payments
COVID-19	N		N	N	Scheme to pay	IH 0H	Funding for COVID-19 Prescribed Minimum Benefits and additional funding from your normal out of hospital and hospital benefits. Subject to Scheme clinical and benefit entry criteria and authorisation for hospital events
Dental hospitalisation (including medicine and related products): In the case of trauma or patients under the age of 7 years requiring anaesthetic, the removal of impacted molars, maxillo-facial and oral surgery (PMB conditions)	Y		N	N	Scheme to pay	IH	Top-Up rate up to 230% of SRR for specialist services or in full if PMB
Dentistry: Conservative treatments including fillings, x-rays, extractions and oral hygiene. Specialised treatments including crowns, bridges, inlays, study models, dentures, orthodontics, osseo-integrated implants or similar tooth implants and periodontics	N	Family Limit Adult R5 570 Child R2 105	N	N	Scheme to pay up to limit	IH 0H	Once the dental benefit is depleted, payment will be allocated to available MSA. Up to 125% of SRR for non-PMB specialised dental services, performed by dental specialist. Cost above SRR may be paid from your available MSA upon instruction
Diabetes Care Programme: Consultation with doctors, dietitians, ophthalmologists, pathology tests, podiatrists, medicine and related products	Y 0860 444 439		Y	Discovery Care Coordination Network		IH 0H	Register on the Diabetes Care Programme to consult with a healthcare professional that is part of the Diabetes Care Network. If you choose not to register on the Programme or consult with a healthcare professional outside the network, your chronic condition benefit limits will apply which may lead to out of pocket payments. MediKredit will handle the registration of your diabetes medication and the MediKredit diabetes basket of care will apply. More info on the Diabetes Care Programme (see page 31)
Endoscopy: Gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	Y		N	Network of day clinics or accredited facility	Scheme to pay	IH 0H	No co-payment if performed in a day clinic or an accredited network facility or in case of emergency treatment. For a list of accredited facilities, please call the Call Centre or visit www.angloms.co.za. Co-payment of R4 125 if admitted to hospital specifically for an endoscopy. Top-Up rate up to 230% of SRR for specialist services or in full if PMB
Eye care: Examinations	N	R540 per beneficiary	N	N	Scheme to pay	0H	Once the optometry benefit is depleted, payment will be allocated to available MSA. Cost above SRR may be paid from your available MSA upon instruction

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital 0H Out of hospital	Comments and co-payments
Eye care: Lenses, frames and contact lenses	N	R4 820 per family	N	N	Scheme to pay	0H	Once the optometry benefit is depleted, payment will be allocated to available MSA at SRR. Cost above SRR may be paid from your available MSA upon instruction. 20% discount on frames and eyeglass lenses at optometrists in the Discovery Health Optometry Network
Eye care: Cataract surgery with intra-ocular lens replacement	Y	Intra-ocular lens subject to the Internal Surgical Prostheses Limit	N	Day clinic or accredited facility	Scheme to pay	IH 0H	No co-payment when performed out of hospital. For a list of accredited facilities, please call the Call Centre or visit www.angloms.co.za. Co-payment when performed in hospital. Top-Up rate up to 230% of SRR for specialist services or in full if PMB
Frail care: Medically related frail care services where clinically appropriate	Y	R94 000 per beneficiary	N	N	Scheme to pay from limit	0H	According to Scheme protocols. Only registered facilities or services provided at home supervised by a registered Nursing Practitioner. The benefit will not be advanced for the year, but paid monthly against the SRR
Hearing aids (1 pair every 2 years)	Y	R26 900 per hearing aid per beneficiary every 2 years	N	N	Scheme to pay up to limit	0H	Clinical motivation by ENT required for beneficiaries younger than 60 years
HIV: Confidential HIV Care / Management Programme (HIV test/screening, GP, social worker and specialist consultations, medicine, radiology and pathology)	Y		Y	Premier Plus GP	Scheme to pay	0H	Once registered you need to follow the treatment plan. Your status will at all times remain confidential. If you chose to use a non-DSP voluntarily, you must pay the cost difference compared to using a DSP
HIV/AIDS: Medicines	Y		Y	Dis-Chem Direct	Scheme to pay	0H	After registration, phone Dis-Chem Direct (011 589 2788) to confirm how you want to receive your medication. If you use a non-DSP voluntarily, you must pay the cost difference compared to using a DSP. To access more HIV benefits join the HIV Care Programme (see page 32)
Hospice: Instead of hospitalisation (in-patient care facility and out-patient home care)	Y		N		Scheme to pay	0H	Subject to Scheme protocols

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital / OH Out of hospital	Comments and co-payments
Hospitalisation: Hospital services including allied healthcare services (as determined by the Scheme), day cases, blood transfusions, radiology, pathology, professional services and 7 day supply of to-take-out medication	Y		N	N	Scheme to pay	IH	Co-payment of R530 per day, to a maximum of R1 595 per admission for non-PMB conditions. Top-Up rate up to 230% of SRR for specialist services (excluding pathology and radiology) or in full if PMB. Subject to Scheme protocols
Hospitalisation: Internal surgical prostheses	Y	R186 900 per beneficiary	N	N	Scheme to pay up to limit	IH	
Hospitalisation: Professional services for minor procedures performed by specialists in doctor's rooms instead of hospital	Y		N	N	Scheme to pay	OH	Subject to Scheme protocols and a defined list of procedures
Hospitalisation: Step-down and private nursing instead of hospitalisation	Y		N	N	Scheme to pay	OH	Subject to Scheme protocols
Hospitalisation: Hospital at home (acute care at home in lieu of hopitalisation)	Y		N	Discovery Hospital at Home, Mediclinic at Home and Quro Medical	Scheme to pay	OH	Subject to clinical entry criteria
Hospitalisation: Psychiatric admission	Y	21 days or 15 consultations out of hospital	N	N	Scheme to pay up to limit	IH	Admission to a registered psychiatric or psychotherapy facility. To access more mental health benefits join the Mental Healthcare Programme (see page 34)
Infertility: Treatment subject to PMB	Y		N	N	Scheme to pay	IH OH	
Assisted Reproductive Therapy (ART)	Y	R145 450 per annum	N	SASREG-accredited facilities	Scheme to pay up to limit	IH OH	Subject to activation and qualifying clinical criteria, includes cover for consultations with fertility specialists and approved fertility medicine, specified pathology test, egg retrieval, embryo and sperm storage, embryo transfer and freezing, ultrasound scans and admissions
Kidney Disease Management Programme: Dialysis (haemo or peritoneal)	Y		Y	N	Scheme to pay	IH OH	Subject to Scheme protocols. More kidney related benefits through the Kidney Care Programme (see page 34)

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital 0H Out of hospital	Comments and co-payments
Maternity Management Programme: Consultations, ultrasound scans and prescribed vitamins	Y	12 consultations, 2 ultrasound scans (paid up to the cost of 2D) per pregnancy, prescribed ante-natal vitamin supplements up to R220 per month, 5 antenatal classes	N	N	Scheme to pay up to limit	IH 0H	Authorisation required between weeks 12 and 20 of the pregnancy to qualify for benefits. Vitamins subject to Scheme protocols. More maternity benefits (see page 33)
Maternity: Confinement	Y		N	N	Scheme to pay	IH 0H	Confinement in hospital or in a low-risk maternity unit provided by a registered midwife if preferred
Medical appliances: External appliances provided by orthotists and prosthetists	Y	Medical and Surgical Appliance Family Limit: R21 380 per family	N	Discovery Health network of orthotists and prosthetists	Scheme to pay up to limit	IH 0H	Authorisation required for appliances over R3 420 each. You are responsible for the difference in cost when using a non-DSP
Medical appliances: External appliances provided by healthcare professionals other than orthotists and prosthetists	Y	Medical and Surgical Appliance Family Limit: R21 380 per family	N	N	Scheme to pay up to limit	IH 0H	Authorisation required for appliances over R3 420 each paid at network rate
Medicines: Acute medicine and injection material, homeopathic and PAT medicine	N	Available savings	N	N	Member savings	0H	100% of SEP and dispensing fee

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital 0H Out of hospital	Comments and co-payments
Medicine Management Programme: Chronic conditions (PMB)	Y		Y	N Except HIV/ AIDS, cancer and diabetes	Scheme to pay	0H	1 month's supply at a time, 100% of SEP and dispensing fee, subject to the Medicine Reference Price List and Scheme protocols. Generic medicine can prevent co-payments. Find generic alternatives and co-payments on www.angloms.co.za > My Plan > MCP > Medicine. Registration by pharmacist or doctor

PMB chronic conditions[§]

Addison's Disease	Cardiomyopathy	Diabetes Insipidus	Epilepsy	Hypertension	Rheumatoid Arthritis
Asthma	Chronic Renal Disease	Diabetes Mellitus Type 1	Glaucoma	Hypothyroidism	Schizophrenia
Bipolar Mood Disorder	Chronic Obstructive Pulmonary Disease	Diabetes Mellitus Type 2	Haemophilia	Multiple Sclerosis	Systemic Lupus Erythematosus
Bronchiectasis	Coronary Artery Disease	Dysrhythmias	Hyperlipidaemia	Parkinson's Disease	Ulcerative Colitis
Cardiac Failure	Crohn's Disease				

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

§ when recognised as chronic according to Scheme protocol

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital 0H Out of hospital	Comments and co-payments
Medicine Management Programme: Chronic conditions (non-PMB)	Y	R23 345 per beneficiary	N	N	Scheme to pay up to limit	0H	1 month's supply at a time, 100% of SEP and dispensing fee, subject to the Medicine Reference Price List and Scheme protocols. Generic medicine can prevent co-payments. Find generic alternatives and co-payments on www.angloms.co.za > My Plan > MCP > Medicine. Registration by pharmacist or doctor

Non-PMB chronic conditions[§]

Acne	Auto-immune Disorders	Gastro-oesophageal Reflux Disease (GORD)	Muscular Dystrophy and other inherited myopathies	Paget's Disease	Restless Leg Syndrome
Allergy Management	Benign Prostatic Hyperplasia	Gout (chronic)	Myasthenia Gravis	Pancreatic Disease	Sarcoidosis
Alzheimer's Disease	Cystic Fibrosis	Hidradenitis Suppurativa	Narcolepsy	Peptic Ulcer	Systemic Sclerosis
Anaemia	Cystitis (chronic)	Huntington's Disease	Obsessive Compulsive Disorder	Polymyositis	Tourette's Syndrome
Ankylosing Spondylitis	Degeneration of the Macula	Liver Disease	Osteoarthritis	Polyneuropathy	Trigeminal Neuralgia
Anxiety Disorder	Depression	Ménière's Disease	Osteopaenia	Psoriasis Vulgaris	Urinary Calculi
Atopic Dermatitis (Eczema)	Diverticulitis	Migraine	Osteoporosis	Pulmonary Embolism	Urinary Incontinence
Attention Deficit Disorder	Fibrous Dysplasia	Motor Neuron Disease	Other Venous Embolism and Thrombosis	Pulmonary Interstitial Fibrosis	

Mental Health Care Programme: Consultations and anti-depressant medication	Y	3 GP consults, 3 psychotherapy sessions at psychologist, up to R3 610 per beneficiary;	N	Premier Plus GP or network psychologist	Scheme to pay	0H	Subject to protocols. Medication subject to registration
Mental Health Care Programme: Relapse prevention programme	Y	2 psychiatric visits and 6 counselling sessions		Premier Plus GP or network psychologist	Scheme to pay	0H	Counselling with psychologist, social worker or registered counsellor
Organ Transplant Management Programme: Harvesting of the organ, post-operative care of the member and the donor and anti-rejection medicine	Y		Y	N	Scheme to pay	IH 0H	Costs for organ donations are excluded for anyone who is not a registered dependant of the Scheme

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

§ when recognised as chronic according to Scheme protocol

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital 0H Out of hospital	Comments and co-payments
Oxygen therapy: At home, cylinder, concentrator (rental only) and consumables	Y		N	N	Scheme to pay	0H	Subject to the Scheme clinical entry criteria.
Pathology: Chronic disease conditions (PMB)	N		N	N	Scheme to pay	IH 0H	Subject to Scheme protocols and registration of the chronic condition
Pathology: Out of hospital (non-PMB)	N		N	N	Scheme to pay	0H	The Scheme will not pay for DNA testing and investigations, including genetic testing for familial cancers and paternal testing. Members may claim these from their savings
Pathology: Cancer screening	N		N	N	Scheme to pay	0H	Cervical cancer screening: one pap smear test for beneficiaries. Prostate screening: one PSA test. Colon screening: One faecal occult blood test every 2 years for beneficiaries from 50-70 years
Radiology: General services	N		N	N	Scheme to pay	IH 0H	
Specialised radiology: Mammogram	N	1 per year	N	N	Scheme to pay	0H	
Specialised Radiology: MRI, CT scan and isotope therapy, and bone densitometry	Y		N	N	Scheme to pay	IH 0H	Referral required. 1 scan for bone densitometry per beneficiary. Additional scans must meet clinical criteria for it to be authorised
Specialised medicine and technology: This benefit applies to certain specialised medicine (excluding oncology medicine) in excess of R6 410 per month and specialised technology in excess of R6 410 per item	Y		N	N	Scheme to pay	IH 0H	Subject to Scheme protocols. Specialised medicine and technology in excess of the mentioned amounts will be paid in full, if not covered in another benefit
Vaccines: Childhood vaccines for children up to 12 years	N	Department of Health protocol	N	N	Scheme to pay	0H	
Vaccine: COVID-19	N	Frequency of vaccine(s) and administration according to DoH# guidelines	N	N	Scheme to pay	0H	

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

Department of Health

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital OH Out of hospital	Comments and co-payments
Vaccine: Influenza (Flu)	N	1 vaccine and 1 consultation per beneficiary	N	N	Scheme to pay	OH	Recommended for high-risk patients (chronic conditions, HIV patients, pregnant or ageing members)
Vaccine: Pneumococcal	N	1 vaccine and 1 consultation per beneficiary, 2 per lifetime	N	N	Scheme to pay	OH	Recommended for high-risk patients (chronic conditions, HIV patients or ageing members)
Vaccine: Human Papillomavirus (HPV)	N	1 lifetime vaccination per beneficiary	N	N	Scheme to pay	OH	For beneficiaries from age 9-26, unless motivated by your doctor
Health check: Cholesterol, Blood Glucose, BMI, Blood Pressure	N		N	N	Scheme to pay	OH	Health check done at contracted providers.
Wheelchair (1 wheelchair every 2 years)	Y	R33 645 per beneficiary	N	N	Scheme to pay	OH	

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

Ex gratia

Members may apply for benefits in addition to those provided in the Rules. An application will be considered by the Scheme which may assist members by awarding additional funding.

Members may apply based on the following criteria:

- Demonstrated financial hardship in the case of a benefit depletion and the medical condition necessitates continuation of treatment; or
- A genuine medical necessity where the benefit is expressly excluded from the Rules or is not provided for in the Rules.

Ex Gratia is not a guaranteed benefit and means “as a favour”. Decisions do not set precedent.

Call **0860 222 633** or download the ex gratia application form at www.angloms.co.za.

Submit the completed application form:
Email: ex-gratia@angloms.co.za

Upon approval, submit your claims:
Email: ex-gratiaclaims@angloms.co.za

General exclusions

The following are some of the Scheme exclusions (for a full list please refer to the Rules). These you would need to pay:

- Services rendered by any person who is not registered to provide healthcare services, as well as medicine that have been prescribed by someone who is not registered to prescribe
- Experimental or unproven services, treatments, devices or pharmacological regimes
- Patent and proprietary medicines and foods, including anabolic steroids, baby food and baby milk, mineral and nutritional supplements, tonics and vitamins except where clinically indicated in the Scheme’s managed care protocols and prescribed vitamins during pregnancy
- Cosmetic operations, treatments and procedures, cosmetic and toiletry preparations, medicated or otherwise
- Obesity treatment, including slimming preparations, appetite suppressants and bariatric surgery
- Examinations for insurance, school camps, visas, employment or similar
- Holidays for recuperative purposes, regardless of medical necessity
- Interest or legal fees relating to overdue medical accounts
- Stale claims, which are claims submitted more than four months after the date of treatment
- Claims for appointments that a member fails to keep
- All costs related to:
  - Bandages, dressings, syringes (other than for diabetics) and instruments unless authorised for payment from risk
  - Lens preparations
  - DNA testing and investigations, including genetic testing for familial cancers and paternal testing
  - Gum guards, gold in dentures, gold used in crowns, inlays and bridges
  - Organ donations to any person other than to a member or registered dependant
- Medical Savings Account cannot be used to fund:
  - Items and services non-clinical in nature; and
  - NAPPI and relevant codes in the absence of a valid procedure.

General Rule reminders

- This Benefit Guide is a summary of the 2027 AMS benefits, pending approval from the Registrar of Medical Schemes.
- Please refer to www.angloms.co.za (My Scheme, Scheme Rules) for the full set of registered Rules.
- The Anglo Medical Scheme Rules are binding on all beneficiaries, officers of the Scheme and on the Scheme itself.
- The member, by joining the Scheme, consents on his or her own behalf and on behalf of any registered dependants, that the Scheme may disclose any medical information to the administrators and contracted third-parties for reporting or managed care purposes.
- A registered dependant can be a member's spouse or partner, a biological or stepchild, legally adopted child, grandchild or immediate family relation (first-degree blood relation) who is dependent on the member for family care and support.
- To avoid underwriting, a member who gets married must register his or her spouse as a dependant within 30 days of the marriage. Newborn child dependants must be registered within 30 days of birth to ensure benefits from the date of birth. If a newborn is registered within 90 days, benefits will only be made available from the date of registration.
- A child dependant, 23 years or younger on 01 January of a benefit year, may remain on your membership at the child dependant contribution rate until year-end.
  If your dependant is 24 years old on 01 January and you wish to keep him/her on the Scheme as an adult dependant, you may apply for continuation of membership against the Scheme's dependant eligibility criteria. If the criteria are met, adult contribution rates will apply.
- It is the member's or dependant's responsibility to notify the Scheme of any material changes, such as marital status, banking details, home address or any other contact details and death of a member or dependant.

Disclaimer: This Benefit Guide provides a summary of the benefits and rules of the Anglo Medical Scheme. While every effort has been made to ensure accuracy, the registered Scheme Rules shall take precedence in the event of any discrepancy, omission or inconsistency between this Benefit Guide and the Scheme Rules. The Scheme Rules will be the definitive and binding source for all benefit interpretations and decisions.



Glossary

Authorisation
Members of medical schemes are required to notify and obtain authorisation from their medical schemes before accessing certain benefits.

This is known as authorisation. Your medical scheme will supply you with prior approval in the form of an authorisation number.

Co-payment
A co-payment is a certain percentage of the cost of relevant healthcare services for which the member is responsible. The member pays the co-payment directly to the healthcare professional for services not covered by the medical scheme in full.

Day clinics
A day clinic offers outpatient or same day procedures, usually less complicated than those requiring hospitalisation. It is a facility which allows for a patient to be discharged on the very same day as the procedure is done. For a list of accredited facilities please call the Call Centre on **0860 222 633** or visit www.angloms.co.za.

Designated Service Provider (DSP)
Medical schemes contract or select preferred healthcare professionals (doctors, hospitals, health facilities, pharmacies, etc.), to provide diagnosis, treatment and care of one or more PMB and non-PMB conditions. This relationship often brings the benefit of negotiated, preferential rates for the members.

Emergency
An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment or intervention.

If the treatment or intervention is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or would place the person's life in jeopardy.

Generic medicine
A medicine with the same active ingredient as original brand name medicine, usually at a lower cost.

Health Coach
The Scheme, through Discovery Health Care Services (Pty) Ltd, provides health coaching to eligible members through specific management programmes. A Health Coach offers clinical support to help the member track, monitor, change and improve their health and quality of life. Health Coaching is a human-led, digitally supported member journey aimed at improving a patient's health status through supported behavioural change and self-management, underpinned by benefit navigation, disease education/management, physical activity and other lifestyle changes, such as diet and nutrition.

HealthID
HealthID is an online platform that allows healthcare professionals to access your health information quickly and securely with your consent. It enables them to view your medical history, check test results, track your progress, and make referrals. The personalised dashboard helps your healthcare professional manage your condition more effectively and provide coordinated care.

ICD-10, NAPPI and Tariff codes
ICD stands for International Classification of Diseases. By law, every medical claim must include an ICD-10 code, which identifies specific medical conditions and diagnoses. This ensures accurate claim processing and appropriate reimbursement for healthcare professionals.

NAPPI codes uniquely identify products for electronic information transfer in healthcare.

Tariff codes standardise electronic information exchange for procedure and consultation claims.

Pharmacist Advised Therapy (PAT)
Most common ailments can be treated effectively by medicine available from your pharmacy without a doctor's prescription. If your medical scheme option offers a PAT benefit, it means that some of these costs will be paid from the relevant benefit.

Premier Plus GP
The Premier Plus GP network offers high-quality, coordinated care as DSP for chronic conditions like cardiovascular disease, mental health, and HIV for Standard and Managed Care Plan members. Consulting a Premier Plus GP can unlock additional benefits.

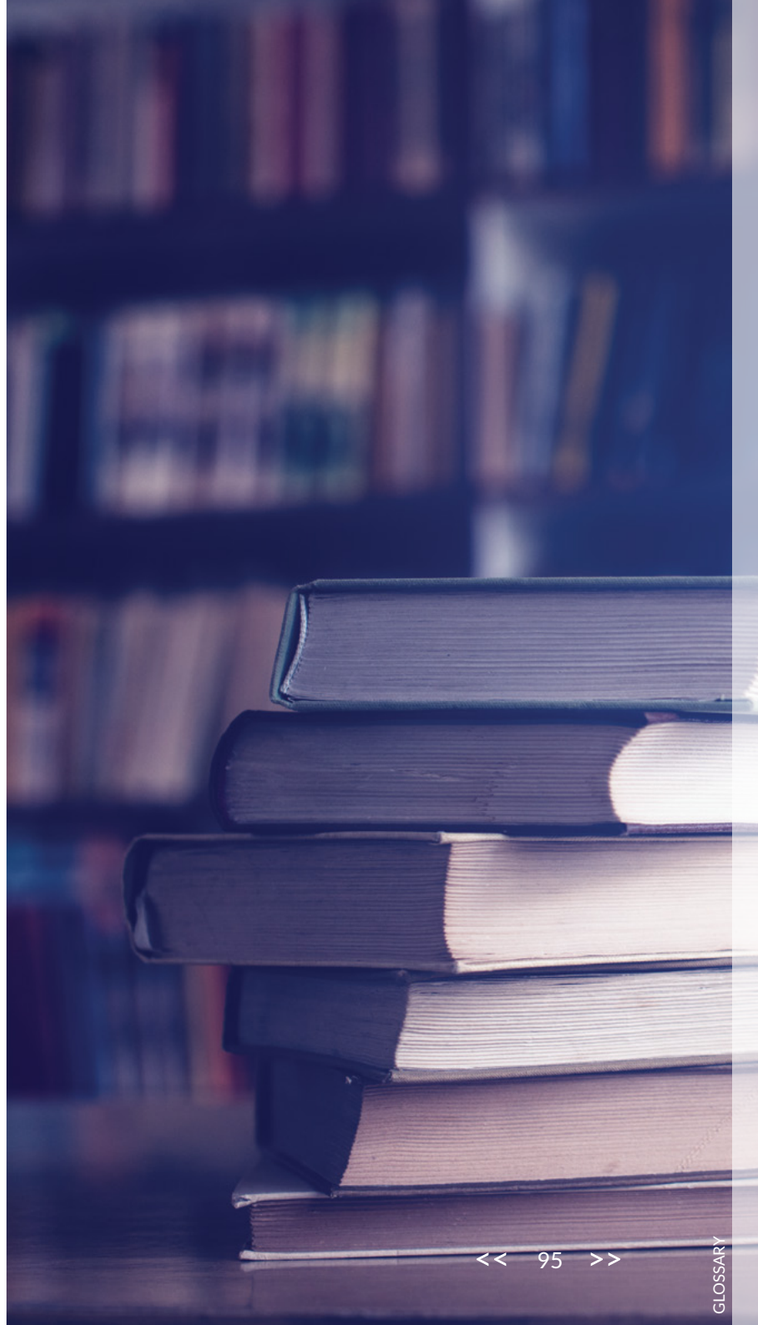
To find a Premier Plus GP, call **0860 222 633** or use the Healthcare Provider Search on the Scheme website.

Protocols
Guidelines set for the procedures in which certain health conditions are to be diagnosed and treated.

Scheme Reimbursement Rate (SRR)
This is a rate set by Anglo Medical Scheme for the payment of services rendered by hospitals and other service providers.

Service date
This can be the date on which you are discharged from hospital or the date you have received a medical service or medical supplies.

For more information, go to the full Scheme Glossary at www.angloms.co.za **> Info Centre > Glossary.**





Contact us

VALUE CARE PLAN

0861 665 665
- Ambulance services
- Chronic authorisation and registration
- Claims
- HIV management programme
- Authorisation and health advice

Claims & queries:
ams@kaelo.co.za

GENERAL

Principal Officer
011 638 5471
144 Oxford Road, Melrose,
Rosebank 2196

Ex gratia applications
ex-gratia@angloms.co.za

Fraud hotline (ethics line)
0800 004 500

Web
www.angloms.co.za: Learn more about your Scheme and benefits and register to access your membership information 24/7

App
Download the **Value Care Plan** App from the App Store or Google Play store

STANDARD & MANAGED CARE PLAN

Ambulance services
Netcare 911: **082 911** (emergency)

Administration
Call Centre: **0860 222 633**
International calls +27 11 529 2888
- Authorisations
- Chronic authorisation and registration
- AMS Care and Management Programmes
- Third party claims & membership queries

General enquiries:
member@angloms.co.za

Claims: claims@angloms.co.za

App
Download the **Anglo Medical Scheme** App from the App Store or Google Play store

Diabetes Care Programme
0860 444 439
Members_DCP@angloms.co.za

HIV/AIDS
Chronic medicine
Dis-Chem Direct: **011 589 2788**

COMPLAINTS

Please direct all queries and complaints to the Call Centre.

If unsatisfied, please follow the escalation process described on www.angloms.co.za **> MyScheme > Governance.**

Should all efforts fail to resolve the issue with the Scheme, queries and complaints can be directed to:

Council for Medical Schemes
Private Bag X34, Hatfield 0028
Share call number: **0861 123 267**
complaints@medicalschemes.co.za
www.medicalschemes.co.za

SPEAK TO US ON WHATSAPP

Chat with us on **011 292 8797**
You can access information and support through our WhatsApp Channel.

Need help on the go?
Our chatbot is available 24/7 to help you with all your membership and benefit questions.

AMS ANGLO MEDICAL SCHEME