

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

BENEFITS – Effective 1 January 2027

1 Definitions

The following words or expressions have the following meanings:

- 1.1 “annual family limit” – the total benefit amount that is available to a member family, in respect of a particular benefit, in any one financial year;
- 1.2 “beneficiary” – a member, adult dependant or child dependant;
- 1.3 “chronic condition” – is a medical condition that is either a prescribed minimum benefit (PMB) condition as listed in Annexure A to the regulations; or an additional non-prescribed minimum benefit (non-PMB) condition recognised by the Board of Trustees from time to time;
 - 1.3.1 a prescribed minimum benefit (PMB) condition contemplated in the diagnosis and treatment pairs (DTPs) listed in Annexure A to the regulations includes the diagnosis, medical management and medicine to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specified chronic condition. This includes the PMB chronic disease list for the following chronic conditions:

Addison’s disease; Asthma; Bipolar Mood Disorder; Bronchiectasis; Cardiac failure; Cardiomyopathy; Chronic Renal disease; Chronic obstructive pulmonary disease.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

Coronary artery disease; Crohn's disease; Diabetes insipidus; Diabetes mellitus Type 1 and 2; Dysrhythmias; Epilepsy; Glaucoma; Haemophilia; Hyperlipidaemia; Hypertension; Hypothyroidism; Multiple sclerosis; Parkinson's disease; Rheumatoid arthritis; Schizophrenia; Systemic lupus erythematosus; Ulcerative colitis; or

- 1.3.2 a non-PMB chronic condition recognised by the Board of Trustees, that provides for the payment of chronic medicine according to a Medicine Reference Price List (MRPL) for the following conditions:

Acne; Allergy management; Alzheimer's Disease; Anaemia (chronic non-PMB); Ankylosing Spondylitis (non- PMB); Atopic Dermatitis (Eczema); Attention Deficit Disorder; Benign Prostatic Hyperplasia; Degeneration of the Macula (non-PMB); Depression (non-PMB); Gastro- oesophagael Reflux Disease; Gout (chronic); Ménière Disease; Migraine; Myasthenia gravis; Osteoarthritis; Osteoporosis (non-PMB); Other Venous Embolism and Thrombosis; Peptic Ulcer (non-PMB); Psoriasis Vulgaris; and Pulmonary Embolism.

- 1.4 "Medication Reference Price List" (MRPL) – a list of fees/prices in respect of medicines, determined by the Scheme from time to time;
- 1.5 "designated service provider" (DSP) – a health care provider contracted by the Scheme as the preferred provider for the diagnosis, treatment

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

and care of one or more PMB conditions;

- 1.6 “network provider” – a health care provider selected by the Scheme as a preferred provider for the diagnosis, treatment and care of defined PMB and/or non-PMB conditions;
- 1.7 “National Health Reference Price List” (NHRPL) – a list of fees in respect of relevant health services, published by the Minister of Health or any other appointee designated by the Minister from time to time;
- 1.8 “Scheme Reimbursement Rate” (SRR) – is equivalent to one of the following:
 - 1.8.1 100% of the reimbursement rate charged in respect of the payment of relevant health services as prescribed in the Discovery Health Guide to Fees or the Discovery Health Network rate; or
 - 1.8.2 100% of the reimbursement rate as determined in terms of an agreement between the Scheme and a service provider or group of providers in respect of the payment of relevant health services; or
 - 1.8.3 the dispensing fee for dispensed medicines as regulated by the Medicines and Related Substances Act (Act 101 of 1965), or the fee agreed by the Board of Trustees; or
 - 1.8.4 100% of the NHRPL last published in 2006, plus an inflationary factor equal to:

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

$$2026 = 2006 + 324.9\%$$

- 1.9 “single exit price” (SEP) – the price of a specific drug as regulated by Act 101 of 1965, as amended, and determined annually by the Department of Health on recommendation of the Pricing Committee.

2 Pro-ration of benefits

A member or registered dependant who is admitted to the Scheme during the course of a financial year shall have his/her benefits pro-rated. The benefits to which he/she is entitled will therefore be adjusted in proportion to the period of his/her membership, which will be calculated from the admission date to the end of that financial year.

3 Management Programmes

The following management programmes have been adopted by the Scheme:

- 3.1 The Chronic Medicine Programme – a programme which authorises the use of scientifically evidenced, clinically appropriate, cost effective medicine for a chronic condition following the confirmation of the diagnosis and severity of the condition;
- 3.2 The Hospital Benefit Management Programme – a programme which involves the approval of all hospital events and ongoing monitoring, by or on behalf of the Scheme, of the hospital treatment of all medical conditions;
- 3.3 The Spinal Conservative Care Programme – an out-of-hospital management programme to reduce the need for spinal surgeries through conservative treatment. A beneficiary is entitled to 100% of the SRR, limited to one enrolment per year. Enrolment is subject to a valid referral and meeting the clinical entry criteria for treatment

**ANGLO MEDICAL SCHEME STANDARD
CARE PLAN ANNEXURE B1**

by network providers;

- 3.4 The Disease/Condition Management Programme – a programme which follows scientifically evidenced clinical protocols and includes the review and monitoring of patients with defined medical conditions to ensure clinically appropriate, cost-effective treatment. Where required, benefits may be extended beyond the PMB limitations to achieve the desired clinical outcome. Specific Disease/Condition Management Programmes include:

- 3.4.1 The HIV Care Management Programme;
- 3.4.2 The Renal Disease Management Programme;
- 3.4.3 The Maternity Management Programme;
- 3.4.4 The Oncology Management Programme;
- 3.4.5 The Diabetes Care Programme;
- 3.4.6 The Alcohol and Drug Dependency Programme;
- 3.4.7 Organ Transplant Management Programme;
- 3.4.8 Mental Healthcare Programme;
- 3.4.9 Disease Prevention Programme;
- 3.4.10 Cardio Care Programme; and
- 3.4.11 Kidney Care Programme.

- 3.5 Where the Scheme has adopted a disease or condition management programme for a particular condition, the benefit in respect of such a

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

programme is subject to pre-authorisation.

If the Scheme has contracted a DSP to manage the programme, a beneficiary voluntarily obtaining services from a provider other than a DSP, will be liable to pay any difference between the actual cost incurred and the cost that would have been incurred had the service been obtained from a DSP, unless otherwise specified in the Rule relating to the condition.

4 Pre-authorisation

Pre-authorisation is the procedure a beneficiary needs to follow to obtain prior approval based on clinical criteria to secure access to benefits and to facilitate the correct payment processes. It is not a guarantee of the availability of benefits nor the payment thereof.

Where a benefit is subject to pre-authorisation, a beneficiary shall obtain authorisation 48 hours prior to obtaining the relevant health service to which the benefit relates, unless a medical emergency, in which case authorisation shall be obtained on the next working day post receiving the service or admission to a hospital. Retrospective authorisations will be considered.

Authorisation of a relevant health service granted by the Scheme is valid for a maximum of 4 months and may not be carried over to the following benefit year.

5 Benefits

The benefits to which a member is entitled in respect of himself/herself, and each of his/her registered dependants, are set out below.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

5.1 PRESCRIBED MINIMUM BENEFITS (PMBs)

A beneficiary is entitled to 100% of the cost of the diagnosis, treatment and care of the PMB conditions contemplated by the Act, provided that any services in relation to PMB conditions are obtained from a registered health care provider or public hospital or, where specified, a DSP or network provider.

5.1.1 Designated Service Providers (DSPs) have been contracted by the Scheme for the provision of services to beneficiaries relating to the following benefits:

- 5.1.1.1 Alcohol and Drug Dependency; the DSP is the Discovery Health Network of Drug and Alcohol rehabilitation facilities. A 20% co-payment will apply for the use of a non-DSP facility.
- 5.1.1.2 Ambulance services; the DSP is Netcare 911.
- 5.1.1.3 Diabetes Management; the DSP is the contracted network general practitioner with effect from 1 May 2025.
- 5.1.1.4 HIV/AIDS medicine; the DSP is Dis-Chem Direct.
- 5.1.1.5 Services and medical and surgical appliances supplied by Orthotists and Prosthetists; the DSP is the Discovery Health Network of Orthotists and Prosthetists.
- 5.1.1.6 Basic dental benefits and dentures; the DSP is Dental Risk Company (DRC).

Annexure B 1 - 2027

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

5.1.1.7 Hospital accommodation, emergency and theatre services including the supporting equipment, personnel and related medicine costs; the DSP is the Scheme Hospital DSP, subject to the nearest hospital being situated within a 35-kilometer radius of the beneficiary's permanent or temporary residence or place of work.

If there is no Scheme DSP hospital within the 35-kilometer radius, admission to the nearest non-DSP hospital will be deemed an involuntary admission and no co-payment will apply.

No co-payment will be due in respect of a hospital admission to a non-DSP hospital in the event of a medical emergency;

5.1.1.8 Oncology medicines; the DSP is Dis-Chem Oncology Courier Pharmacy, Medipost Pharmacy, MedXpress or MedXpress Network Pharmacy, Qestmed, Olsens Pharmacy and Southern Rx. A 20% co-payment will apply for the use of a non-DSP for oncology medicines administered in rooms or scripted and dispensed medicines at a retail pharmacy;

5.1.1.9 The contracted network general practitioner is the DSP for the:

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

5.1.1.9.1 Cardio Care Programme;

5.1.1.9.2 Diabetes Care Programme;

5.1.1.9.3 Disease Prevention Programme;

5.1.1.9.4 Mental Healthcare Programme and

5.1.1.9.5 HIV Care Management
Programme; and

5.1.1.10 Hospital at Home; the DSP is Discovery Hospital
at Home, Mediclinic at Home and Quro Medical.

5.1.2 A co-payment will be imposed if a beneficiary voluntarily obtains such services from a non-DSP. This co-payment will be the difference between the actual cost incurred and the cost that would have been incurred had the service been obtained from a DSP or is the specified value detailed in the Rule relating to the relevant benefit. No co-payment will be imposed on a member if the service was involuntarily obtained from a non-DSP.

5.1.3 In the case of diabetic members not registered with the Diabetes Care Programme, the member will be liable to pay any difference between the actual cost incurred and the cost that would have been incurred had the service been obtained from a DSP.

5.1.4 In the case of members registered on the HIV Care Management Programme who voluntarily obtain their HIV

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

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.

5.2 ALCOHOL AND DRUG DEPENDENCY

Subject to PMB regulations and pre-authorisation a beneficiary is entitled to 100% of the SRR, or actual cost, if lower, of treatment for alcohol and drug dependency subject to the following:

5.2.1 Hospitalisation

Subject to admission to the Scheme's Hospital DSP or the Alcohol and Drug Dependency DSP, a beneficiary is entitled to 100% of the SRR for the treatment of alcohol and / or drug detoxification for three days.

Thereafter, subject to admission to the Scheme's Alcohol and Drug Dependency DSP, a beneficiary is entitled to 100% of the SRR for the treatment of the dependency for a maximum of twenty-one days.

5.2.2 Professional Services In hospital

A beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of professional services rendered in hospital in connection with the treatment of alcohol and / or drug dependency, subject to PMB regulations.

5.2.3 Professional Services Out of hospital

Subject to the annual Out of Hospital services and Medicines Family limit detailed in Table B1.4 and sub limits, a beneficiary is entitled to 100% of the SRR, or

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

the actual cost, if lower, of professional services rendered out of hospital, in connection with the treatment of alcohol and / or drug dependency.

5.3 OUT OF HOSPITAL ALTERNATIVE AND ALLIED HEALTH CARE

Subject to the exclusions in Annexure C, PMB regulations, and the overall annual family limit for Out of Hospital Services and Medicines detailed in Table B1.4, and the sub-limit for Out of Hospital Alternative and Allied Health Care services detailed in Table B1.1 below, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of the following:

- 5.3.1 acupuncture;
- 5.3.2 audiology;
- 5.3.3 chiropody and podiatry services;
- 5.3.4 chiropractic consultations, including x-rays;
- 5.3.5 clinical psychology;
- 5.3.6 dietician services;
- 5.3.7 homeopathic consultations and procedures, including non-NAPPI coded medicines compounded and dispensed by the practitioner;
- 5.3.8 naturopathy;

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

- 5.3.9 orthoptics;
- 5.3.10 physiotherapy;
- 5.3.11 nurse practitioner consultations and procedures;
- 5.3.12 social services;
- 5.3.13 speech and occupational therapy; and
- 5.3.14 orthotists and prosthetists.

OUT OF HOSPITAL ALTERNATIVE AND ALLIED HEALTH CARE

OUT OF HOSPITAL SUB-LIMIT 1

TABLE B1.1

Member/Adult dependant	R4 575
Child dependant	R960

5.4 AMBULANCE SERVICES

Subject to the PMB regulations, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of emergency transport and other ambulance services when obtained from the Scheme's DSP, Netcare 911. Where a beneficiary elects not to use the DSP, the member will be required to pay **20%** of the cost of the service.

The use of any ambulance service (whether in respect of a PMB condition or non-PMB condition) is subject to authorisation within 48 hours post receiving the service or admission to a hospital, or on the next working day whichever is the sooner.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

A member will be required to pay the full cost of a non- medically justifiable use of an ambulance service.

5.5 BLOOD TRANSFUSIONS

A beneficiary is entitled to 100% of the cost of blood transfusions, including the cost of material, blood and blood products, apparatus and operator's fees.

5.6 CONSULTATIONS, VISITS AND ACUTE MEDICINE AND PHARMACIST ADVISED THERAPY (PAT)

5.6.1 Out of Hospital Consultations

Subject to the exclusions in Annexure C, PMB regulations, and the annual family limit detailed in Table B1.4 for Out of Hospital Services and Medicines and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2 below, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of consultations and procedures by general practitioners, nurse practitioners and medical specialists, out of hospital.

5.6.1.1 Consultations for Immunisation

A beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of:

- 5.6.1.1.1 one consultation per annum by a general practitioner or nurse practitioner to be inoculated against influenza and,

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

5.6.1.1.2 according to age, two consultations per lifetime to be inoculated against the pneumococcal virus.

5.6.1.2 Consultations for Specialists

Subject to the annual sub-limit detailed in Table B1.2 for Out of Hospital Consultations, Visits and Acute Medicines and PAT.

Out of hospital consultations and procedures performed by specialists who are contracted to the Discovery Health Premier Specialist Network, will not be subject to the normal SRR, but will be reimbursed at the Discovery Health Premier Specialist Network Rate.

Out of hospital consultations and procedures performed by specialists outside of the Discovery Health Premier Specialist Network, will be reimbursed at 100% of SRR.

5.6.2 Acute Medicine

5.6.2.1 Subject to the MRPL, exclusions in Annexure C, PMB regulations and the annual family limit for Out of Hospital Services and Medicines detailed in Table B1.4 and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2 below, a beneficiary is entitled to 100% of the SEP including the SRR for the dispensing fee for prescribed acute medicine obtained from

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

a pharmacy or a registered dispensing practitioner.

- 5.6.2.2 Subject to the exclusions in Annexure C, PMB regulations and the annual family limit for Out of Hospital Services and Medicines detailed in Table B1.4 and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2 below, a beneficiary is entitled to 100% of the SEP for injection material provided or prescribed by a general practitioner or a medical specialist.

The annual family limit in respect of Out of Hospital Consultations, Visits and Acute Medicines and PAT will vary according to the size of a particular member family. The annual family limit will be the sum of the amounts allocated to each beneficiary, reflected in Table B1.2 below.

Any one beneficiary in a member family may use a portion, or the full amount, of the annual sub-limit.

5.6.3 Glaucoma Screening

Subject to the exclusions in Annexure C, PMB regulations, and the annual family limit detailed in Table B1.4 for Out of Hospital Services and Medicines and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2 below, a beneficiary is entitled

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

to 100% of the SRR, or the actual cost, if lower.

**OUT OF HOSPITAL CONSULTATIONS, VISITS AND ACUTE
MEDICINES AND PHARMACIST ADVISED THERAPY (PAT) SUB-
LIMITS**

OUT OF HOSPITAL SUB-LIMIT 2

TABLE B1.2

Member/Adult dependant	R6 650
Child dependant	R3 325

5.7 DENTAL

5.7.1 Basic dental services

Subject to Scheme protocols, and the Scheme DSP, Dental Risk Company (DRC), a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of the following out of hospital basic dental services:

- 5.7.1.1 Two consultations per beneficiary per year which are 180 days apart, including one local anaesthetic per visit;
- 5.7.1.2 One scaling, polishing and fluoride treatment every 180 days at a network dentist or oral hygienist;
- 5.7.1.3 Four intra-oral radiographs per visit every 180 days up to a limit of 7 radiographs per annum and one panoramic radiograph every three years;

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

- 5.7.1.4 Extractions, pre-authorisation is required for more than four extractions per beneficiary per year;
- 5.7.1.5 Amalgam and resin restorations, authorisation is required after the fifth restoration per beneficiary per year; and
- 5.7.1.6 One pair of plastic dentures per beneficiary every four years, including one annual relining and repair per year.

Where a beneficiary elects not to use the DSP, the member shall be liable to pay the provider the difference between **80%** of the SRR and the claimed amount.

5.7.2 Root Canal Treatment

Subject to Scheme protocols, a beneficiary twelve years and older, is entitled to 100% of the SRR, or the actual cost if lower, of out- of hospital root canal treatment, excluding treatment on a third molar or primary tooth.

5.7.3 Additional Basic and Specialised Dentistry

Subject to the annual combined family limit for additional basic and specialised dentistry, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of in- or out- of hospital basic dental and specialised services including orthodontic treatment, crowns or bridges, periodontic treatment, maxillo-facial treatment, osseo-integrated implants and any other dental services, including the cost of appliances and prosthesis not covered under Rule 5.7.1.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

The annual family limit in respect of additional basic and specialised dentistry will vary according to the size of a particular member family. The annual family limit will be the sum of the amounts allocated to each beneficiary, reflected in Table B1.3 below.

Any one beneficiary in a member family may use a portion, or the full amount, of the annual family limit.

ADDITIONAL BASIC AND SPECIALISED DENTISTRY LIMITS

TABLE B1.3

Member/Adult dependant	R2 055
Child dependant	R515

5.7.4 Dental hospitalisation

Subject to pre-authorisation and the Scheme Hospital DSP or an accredited dental practitioner's room, unattached theatre unit or registered day clinic, a beneficiary is entitled to 100% of the Scheme Reimbursement Rate (SRR), or the actual cost, if lower, of hospitalisation:

5.7.4.1 in the case of trauma,

5.7.4.2 patients under the age of seven years requiring dental treatment under anaesthetic and

5.7.4.3 the removal of impacted third molars, by either a dentist or a maxillo-facial surgeon.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

5.8 ENDOSCOPIC PROCEDURES (gastrosopies, colonoscopies, sigmoidoscopies and proctoscopies)

5.8.1 Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR or the actual cost, if lower, of hospitalisation for an endoscopic procedure if performed in an accredited doctor's room, unattached theatre unit or registered day clinic on the Scheme's defined list of network facilities contracted to perform endoscopic procedures. This Rule will not apply in respect of a medical emergency endoscopic procedure and treatment. An emergency endoscopic procedure will not be subject to the Scheme Hospital DSP for hospital services detailed in Rule 5.9.1.

5.8.2 Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR of hospitalisation, or the actual cost if lower, and a co-payment of **R4 125** is payable by the member if a beneficiary is voluntarily admitted to a non-network registered hospital specifically for the purpose of an endoscopic procedure. No co-payment will be due in respect of a medical emergency procedure.

5.9 HOSPITALISATION

5.9.1 General

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR, inclusive of fixed fee procedures, for all hospital services received in hospitals on the Scheme Hospital DSP or in nursing homes, day clinics, unattached theatre units and government and provincial hospitals.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

A co-payment of **R4 125** is payable by the member if a beneficiary is voluntarily admitted to a non-DSP hospital. No co-payment will be due in respect of a medical emergency.

5.9.2 Pre-Authorisation

Any hospital admission is subject to pre-authorisation 48 hours prior to obtaining the relevant health service, unless a medical emergency, in which case authorisation shall be obtained on the next working day. Retrospective authorisations will be considered.

5.9.3 Ward Fees

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR of ward fees in a hospital detailed in Rule 5.9.1.

5.9.3.1 general ward fees; and

5.9.3.2 high care and intensive care unit fees, where occupation of such unit is certified by a medical practitioner as being clinically appropriate and necessary for the recovery of the patient.

5.9.4 Ward and Theatre Drugs, Appliances and Surgical Prostheses

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR for ward and theatre drugs, surgicals, prostheses and appliances that are prescribed and used while the beneficiary is resident in a hospital detailed in Rule 5.1.1.7.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

- 5.9.4.1 In the case of prescribed drugs, the SEP for such drugs;
- 5.9.4.2 In the case of 'To Take Out' drugs (TTOs), a limit of seven day's supply on discharge;
- 5.9.4.3 In the case of appliances, paid up to the limit in Rule 5.14; and
- 5.9.4.4 In the case of internal surgical prostheses, subject to Rule 5.25.

5.9.5 Theatre Fees and Materials

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR for theatre fees, labour ward charges and dressings and materials used in theatre in a hospital detailed in Rule 5.9.1.

5.9.6 Consultations In Hospital

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of consultations and procedures performed in a hospital by general practitioners, nurse practitioners and medical specialists and related allied health services (excluding, audiologists, orthoptists, chiropodists, podiatrists, and chiropractors).

- 5.9.6 A Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of specified procedures usually performed in a hospital by a specialist when performed in a

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

consulting room in lieu of a hospital admission.

- 5.9.6 B In hospital consultations and procedures performed by specialists who are contracted to the Discovery Health Premier Specialist Network, will not be subject to the normal SRR, but will be reimbursed at the Discovery Health Premier Specialist Network Rate.

5.9.7 Home Nursing

Subject to pre-authorisation by the Scheme, a beneficiary is entitled to 100% of the SRR, or the actual cost if lower, of nursing at home in lieu of hospitalisation according to Scheme protocols.

5.9.8 Terminal Care

Subject to PMB regulations and pre-authorisation by the Scheme, a beneficiary is entitled to 100% of the cost of palliative treatment and terminal care in the case of imminent death in a registered terminal care facility or care provided in a home setting as an out-patient by a qualified palliative care provider.

5.9.9 Step Down Nursing Facilities

Subject to pre-authorisation by the Scheme, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of services in a step down nursing facility according to Scheme protocols.

5.9.10 Hospital at Home

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

Subject to PMB regulations, clinical entry criteria and pre-authorisation by the Scheme, a beneficiary is entitled to 100% of the SRR, or actual cost, if lower, of acute care in lieu of hospitalisation.

5.10 HIV / AIDS

Subject to PMB limitations, a beneficiary is entitled to 100% of the cost of the diagnosis, treatment and care of HIV/AIDS.

- 5.10.1 Subject to registration on the HIV Care Management Programme, a beneficiary is entitled to 100% of the cost of services relating to the treatment or management of HIV/AIDS at a DSP and, where required to achieve the desired clinical outcome, to benefits extended beyond the PMB limitations;
- 5.10.2 the SEP and the dispensing fee for medicine for the treatment of HIV/AIDS, provided that the medicine is obtained directly from the DSP, Dis-Chem Direct;
- 5.10.3 HIV test at 100% of SRR or the actual cost, if lower, for pathology services rendered by a registered pathologist or medical technologist; and
- 5.10.4 HIV screening test at a pharmacy clinic at 100% of SRR.

Where a beneficiary elects not to use the DSP, the benefit allowed will be subject to co-payments, Rules 3.4 and 5.1 above.

5.11 INFERTILITY

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

Subject to PMB regulations and the exclusions as reflected in Annexure C, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of the investigation and treatment of infertility out of hospital, subject to:

- 5.11.1 the annual family limits for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2 and the Out of Hospital Services and Medicines detailed in Table B1.4.

5.12 MATERNITY

Subject to PMB limitations, a beneficiary is entitled to 100% of all costs related to the delivery of a child and the cost of all ante-natal care if hospitalisation is medically required prior to the date of delivery.

5.12.1 Confinement in a Hospital (subject to Rule 5.1)

A beneficiary is entitled to 100% of the cost for services provided for normal delivery or for a Caesarean section if medically appropriate in a hospital on the Scheme Hospital DSP or a private nursing home or a low- risk Obstetric Unit.

A co-payment of **R4 125** is payable by the member if a beneficiary is voluntarily admitted to a non-DSP hospital. No co-payment will be due in respect of a medical emergency.

5.12.2 Ante-natal Consultations and Post-natal Care

Subject to pre-authorisation, a beneficiary is entitled to

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

100% of the SRR, or the actual cost, if lower, of the following additional non-PMB benefits:

5.12.2.1 eight consultations (inclusive of ante- or post-natal care) with a general practitioner, nurse practitioner or obstetrician in or out of hospital,

5.12.2.2 two, two-dimensional ultrasound pregnancy scans per pregnancy

5.12.2.3 prescribed ante-natal vitamin supplementation limited to **R220** per month, subject to Scheme protocol, and

5.12.2.4 five antenatal classes.

Should a beneficiary not obtain pre-authorisation, the cost of all non-PMB out of hospital ante-natal and post-natal care, including ultrasound scans, shall be reimbursed according to Out of Hospital Services and Medicines detailed in Table B1.4 and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2, and the annual family limit for out of hospital radiology services, detailed in Table B1.6.

5.13 **MAXILLO-FACIAL AND ORAL SURGERY**

5.13.1 Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the cost of maxillo-facial and oral surgery limited to the diagnosis, treatment and care of PMB conditions when obtained from a maxillo-facial or oral surgeon.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

5.14 MEDICAL AND SURGICAL APPLIANCES

- 5.14.1 A beneficiary is entitled to 100% of the SRR of medical and surgical appliances with an annual family limit of **R12 610**, subject to pre-authorisation for any appliances in excess of **R3 425** per appliance. Medical and surgical appliances obtained from Orthotists and Prosthetists will be paid up to the Discovery Health Network rate.
- 5.14.2 Subject to pre-authorisation and the annual family limit for medical and surgical appliances, a beneficiary is entitled to 100% of the cost of one wheelchair, per beneficiary, every two years.
- 5.14.3 Subject to pre-authorisation and a prescription by an Ear, Nose and Throat specialist for beneficiaries younger than 60 years and the annual family limit for medical and surgical appliances, a beneficiary is entitled to 100% of the cost of one pair of hearing aids, per beneficiary, every two years.
- 5.14.4 Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the SRR of oxygen therapy to save or maintain life, including the cost of hiring of the apparatus for administration of oxygen. This benefit is not subject to the annual family limit for medical and surgical appliances.
- 5.14.5 A beneficiary who voluntarily obtains such services from a

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

non-DSP will be liable for a co-payment equal to the difference between the actual cost incurred and the cost that would have been incurred had the services been obtained from the DSP.

5.15 MEDICINES

A beneficiary is entitled to 100% of the MRPL of prescribed medicines, subject to a maximum of one month's supply or repeat thereof.

Where a beneficiary accepts a medicine that is not specified on the MRPL or a higher priced medicine than the MRPL equivalent, the member will be liable for the full cost or the difference between the actual cost of a medicine dispensed and the agreed MRPL price.

5.15.1 Acute Medicines

A beneficiary is entitled to 100% of prescribed acute medicines subject to the exclusions in Annexure C, PMB regulations and the annual family limit for Out of Hospital Services and Medicines detailed in Table B1.4 and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2.

The annual family limit in respect of acute medicines will vary according to the size of a particular member family. The annual family limit will be the sum of the amounts allocated to each beneficiary reflected in Table B1.2. Any one beneficiary in a member family may use a portion, or the full amount, of the annual sub-limit.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

5.15.2 Chronic Medicine

5.15.2.1 PMB Conditions

Subject to registration on the Chronic Medicine Programme and PMB regulations, a beneficiary is entitled to a chronic prescribed medicine for a PMB condition at 100% of the price specified on the MRPL, and the dispensing fee at the SRR.

5.15.2.2 Non-PMB Conditions

Subject to registration of the non-PMB chronic condition, a beneficiary is entitled to 100% of the price specified on the MRPL and the dispensing fee at the SRR for non-PMB chronic conditions as listed in Rule 1.3.2 above, subject to an annual limit of **R6 040** per beneficiary and provided that:

5.15.2.2.1 the medicine has been approved on the Chronic Medicine Programme; and

5.15.2.2.2 The medicine is included on the MRPL.

5.15.3 Vaccines

A beneficiary is entitled to 100% of the SEP and the dispensing fee of:

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

- 5.15.3.1 one influenza vaccine per annum,
- 5.15.3.2 according to age, two pneumococcal virus vaccines per lifetime;
- 5.15.3.3 according to age, one human papilloma virus vaccine per lifetime;
- 5.15.3.4 subject to PMB regulations, a Covid-19 vaccine zero-rated and the vaccine administration fee; and
- 5.15.3.5 subject to the Department of Health protocol, childhood vaccines for children up to age of 12 years.

5.15.4 Homeopathic Medicines

Subject to the annual family limit for Out of Hospital Services and Medicines detailed in Table B1.4 and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2, a beneficiary is entitled to 100% of SRR of NAPPI coded homeopathic medicines.

5.15.5 Pharmacist Advised Therapy (PAT)

Subject to PMB regulations and the annual family limit for Out of Hospital Services and Medicines detailed in Table B1.4 and the sub-limit for Out of Hospital Consultations, Visits and Acute Medicines and PAT, detailed in Table B1.2, a beneficiary may obtain medicines on the advice of

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

a pharmacist and is entitled to 100% of the cost of certain medicines limited to **R765** per pharmacist advised prescription per family per three months.

5.16 MENTAL HEALTHCARE PROGRAMME**5.16.1 Professional Services In Hospital**

Subject to PMB regulations and admission in a registered psychiatric treatment facility or at a facility of healthcare providers registered to provide psychotherapy, a beneficiary is entitled to the treatment for a maximum of twenty-one days in-hospital or up to 15 out of hospital consultations.

5.16.2 Professional Services Out of Hospital

Subject to PMB limitations, Scheme protocols, pre-authorisation and services provided by a contracted network healthcare provider, a beneficiary is entitled to 100% of the cost of three general practitioner consultations, three psychotherapy sessions with a psychologist, up to a limit of **R3 610** per beneficiary per year and anti-depressant medication subject to registration.

5.16.3 Relapse Prevention Programme

Following treatment on the Mental Healthcare Programme, in the event of a mental relapse, a beneficiary is entitled to 100% of the cost of two psychiatric visits and six additional counselling sessions with a psychologist, social worker or a registered counsellor.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

5.17 ONCOLOGY

5.17.1 Subject to the PMB regulations, the Scheme protocols as endorsed by the South African Oncology Consortium, registration on the Oncology Management Programme or registration for benefits when in remission, and a limit of **R398 955** per beneficiary per 12-month treatment cycle, a beneficiary is entitled to:

5.17.1.1 100% of the SRR, or the actual cost, of consultations and procedures performed by general practitioners and medical specialists and diagnostic tests and materials;

5.17.1.2 100% of the SRR, or the actual cost, of radiotherapy and chemotherapy treatment;

5.17.1.3 the SEP of cytostatics, adjuvant and palliative medicines used in chemotherapy treatment subject to the MRPL; and

5.17.1.4 the facility fees.

5.17.2 Once the benefit limit has been exhausted, subject to PMB regulations, Scheme protocols and the continued registration on the Oncology Management Programme, or registration for benefits when in remission, a beneficiary is entitled to:

5.17.2.1 **80%** of the SRR, or the actual cost, of consultations and procedures by general practitioners and

medical specialists;

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

5.17.2.2 **80%** of the SRR, or the actual cost, if lower, of radiotherapy and chemotherapy treatment;

5.17.2.3 **80%** of the SEP of cytostatics adjuvant and palliative medicines used in chemotherapy treatment subject to the MRPL;

5.17.2.4 **80%** of the facility fees.

5.17.3 Subject to the PMB regulations, clinical entry criteria, the Scheme protocols, registration on the Oncology Management Programme or registration for benefits when in remission, a beneficiary is entitled to **80%** of the SEP of specified innovative or high cost medicines which will accrue to the oncology limit and, once the limit has been exhausted, will continue to be reimbursed at **80%** of the SEP.

5.18 OPHTHALMOLOGY (cataract surgery with intraocular lens replacement)

5.18.1 Subject to the PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the cost of cataract surgery with an intraocular lens replacement procedure if performed in an accredited ophthalmologist's room or registered day clinic on the Scheme's defined list of network facilities; and

5.18.2 if a beneficiary voluntarily uses a non-network facility, a co-payment of **R1 290** is payable by the member.

5.18.3 Subject to preauthorisation, clinical protocols and the internal

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

prostheses limit, a beneficiary is entitled to an intraocular lens replacement procedure if performed in an accredited ophthalmologist's room or registered day clinic on the Scheme's defined list of network facilities.

5.19 OPTICAL SERVICES

- 5.19.1 Subject to the annual family limit of **R3 215**, a beneficiary is entitled to 100% of the cost of spectacles (including lenses and frames), contact lenses, where they have been prescribed for normal eye complaints, and non-PMB intraocular lenses; and
- 5.19.2 a beneficiary is limited to **R540** per optic examination or test supplied by a registered optometrist, ophthalmologist or supplementary optical practitioner annually.

This benefit excludes the costs of sunglasses.

5.20 OUT OF HOSPITAL SERVICES AND MEDICINES (INCLUDING CONSULTATIONS, VISITS AND PROCEDURES, ALTERNATIVE AND ALLIED HEALTHCARE, ACUTE MEDICINE AND PHARMACIST ADVISED THERAPY (PAT))

Subject to the exclusions in Annexure C, PMB regulations, and the annual family limit for Out of Hospital Services and Medicines, detailed in Table B1.4 below, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of consultations and procedures provided by general practitioners, specialist and alternative and allied health care practitioners and out of hospital acute medicine prescribed by registered practitioners in accordance with the discipline's scope of practice including PAT.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

The annual family limit in respect of out of hospital services will vary according to the size of a particular member family. The annual family limit will be the sum of the amounts allocated to each beneficiary, reflected in Table B1.4 below. Any one beneficiary in a member family may use a portion, or the full amount, of the annual family limit.

OVERALL OUT OF HOSPITAL SERVICES AND MEDICINES LIMITS

TABLE B1.4

Member/Adult dependant	R7 080
Child dependant	R3 525

5.21 PATHOLOGY

5.21.1 Pathology Services Out of Hospital

Subject to PMB regulations and the annual family limit for pathology, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of pathology services, rendered by a registered pathologist or medical technologist, out of hospital.

The annual family limit in respect of pathology will vary according to the size of a particular member family. The annual family limit will be the sum of the amounts allocated to each beneficiary, reflected in Table B1.5 below. Any one beneficiary in a member family may use a portion, or the full amount, of the annual family limit.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

OUT OF HOSPITAL PATHOLOGY SERVICES LIMITS TABLE

B1.5

Member/Adult dependant	R1 795
Child dependant	R645

5.21.2 Pathology Services In Hospital

A beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of services rendered by a registered pathologist or medical technologist, in hospital.

5.21.2.1 Newborn Screening for Metabolic Disorders

A newborn beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, if rendered by a registered pathologist and medical technologist, in hospital. Heel prick blood specimen must be done within two to three days.

5.21.3 Cancer Screening Tests

A beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, if rendered by a registered pathologist and medical technologist, in or out of hospital, of:

5.21.3.1 one PAP smear or one Prostate Specific Antigen (PSA) screening test, per annum, and

5.21.3.2 according to age, one faecal occult blood

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

test every two years.

5.22 RADIOLOGY

5.22.1 Radiological Services Out of Hospital

Subject to PMB regulations and the annual family limit for radiology, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of radiological services and materials, out of hospital.

The annual family limit in respect of radiology will vary according to the size of a particular member family. The annual family limit will be the sum of the amounts allocated to each beneficiary, reflected in the table B1.6 below. Any one beneficiary in a member family may use a portion, or the full amount, of the annual family limit.

OUT OF HOSPITAL RADIOLOGY SERVICES LIMITS

TABLE B1.6

Member/Adult dependant	R2 340
Child dependant	R1 415

5.22.2 Radiological Services In Hospital

A beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of radiological services and materials, in hospital.

5.22.3 MRIs, CT Scans and Isotope Therapy

Subject to pre-authorisation by the Scheme, a beneficiary

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

is entitled to 100% of the SRR, or the actual cost, if lower, of Magnetic Resonance Imaging Scans (MRI Scans), Computerised Axial Tomography Scans (CT Scans) and isotope therapy, both in and out of hospital.

5.22.4 Densitometry

Subject to pre-authorisation, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of one bone densitometry scan per annum.

5.22.5 Mammogram

A beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of one mammogram annually.

5.23 RENAL DIALYSIS

Subject to PMB regulations, hospital pre-authorisation and registration on the Renal Disease Management Programme, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of renal dialysis.

**5.24 SPECIALISED MEDICINE AND TECHNOLOGY (SMT)
OUT OF HOSPITAL BENEFIT**

Subject to PMB regulations, Scheme protocols and pre-authorisation, a beneficiary is entitled to **80%** of the SRR of certain specified specialised medicines and technology or devices costing in excess of **R6 435** per unit or per treatment per beneficiary per month that are not covered by other Scheme benefits.

5.25 SURGICAL PROSTHESES (INTERNAL)

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the SRR for internal prostheses limited to **R88 120** per beneficiary per annum.

5.26 TRANSPLANTS

Subject to PMB regulations, pre-authorisation and registration on the Organ Transplant Management Programme, a beneficiary is entitled to 100% of the cost, of services relating to organ transplants.

Hospitalisation includes harvesting of the organ, post-operative care of member and donor, anti-rejection medicines, professional services in hospital and payment of any other costs relating to the donor, if authorised in accordance with the Organ Transplant Management Programme.

5.27 WELLNESS

A beneficiary is entitled to 100% of the SRR, of one screening benefit group of tests consisting of a blood glucose test, a blood pressure test, a cholesterol test and a Body Mass Index (BMI) if performed at a Discovery Network Partner as detailed on the Discovery website.

6 THIRD PARTY LIABILITY

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of relevant health care services obtained by a member when involved in an incident which is covered by any statutory compensation provision or, in respect of which, the member has a civil claim against a third party, subject to:

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

- 6.1 the member agreeing, by way of a signed undertaking, to reimburse the Scheme the amount of such benefits paid by the Scheme from any payment received in respect of medical treatment costs made by the statutory body or third party.

7 INTERNATIONAL CLAIMS – TRAVEL OR RESIDENCE OUTSIDE THE BORDERS OF SOUTH AFRICA

- 7.1 A member who incurs a cost of a relevant health service outside the borders of South Africa shall:

7.1.1 be liable for the payment for such service, in full, in the country where the service was provided; and

7.1.2 claim the costs of the service from any existing third party health insurance or travel insurance to which the member may be entitled, other than the Scheme.

- 7.2 A Member with no, or insufficient third party health insurance or travel insurance, may submit a claim to the Scheme for the cost of the service or any un-covered portion, as the case may be, in accordance with the Scheme Rules, including having obtained authorisation for the service rendered where required, within four months from the date of service, on completion of the International Claim form, which shall be submitted to the Scheme together with:

7.2.1 a detailed account or statement for the full service;

7.2.2 a detailed account or statement for the shortfall or uncovered service; and

7.2.3 proof of payment of the service,

to be submitted in English or accompanied by a sworn English

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

translation.

- 7.3 Any payment towards the cost of a claim submitted in accordance with Rule 7.2, shall be made in a Rand amount into a South African bank account held in the member's name, determined by the Scheme in its absolute discretion, in accordance with the benefit entitlement of the member in terms of the Rules and based on the average SRR for the same or similar service in South Africa.
- 7.4 Where detail of the service is not provided, the Scheme cannot process the claim and no payment shall be considered.

8 WELLth FUND BENEFIT

- 8.1.1. The WELLth Fund provides additional benefits to beneficiaries, subject to Prescribed Minimum Benefits.
- 8.1.2. The benefit is available once per membership and must be activated before it can be used.
- 8.1.3. An adult dependant may activate the WELLth Fund Benefit for themselves and for any registered child dependant aged 2 years and older but younger than 18 years by completing a health check with a contracted provider.
- 8.1.4. Adult dependants and child dependants aged 18 years or older must each complete an individual health check with a contracted provider to activate their WELLth Fund Benefit.
- 8.1.5. Once activated, the WELLth Fund Benefit is available until 31 December 2028.

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

8.1.6. Out-of-hospital claims funded from the WELLth Fund will not impact a beneficiary's day-to-day benefits.

8.1.7. Claims for services provided prior to the activation of the WELLth Fund Benefit are not eligible for funding from the WELLth Fund.

8.2. WELLth Fund Benefit details

8.2.1. The WELLth Fund will be available to all registered beneficiaries from 1 January 2027 for a 2-year period until 31 December 2028.

8.2.2. Beneficiaries who activate the WELLth Fund during 2027 may use the available funds until 31 December 2028.

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

8.2.4. Any unused WELLth Fund balance will expire on 31 December 2028 and may not be transferred, refunded or carried forward.

8.2.5. The WELLth Fund may be used for the defined list of out-of-hospital general health and allied health services:

WELLth FUND BENEFITS

TABLE B1.7

General health services	<ul style="list-style-type: none"> • GP consultations • Out-of-hospital basic and specialised dentistry subject to DRC protocols • Optical services • Gynaecological check-up • Hearing test
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**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

General health services	<ul style="list-style-type: none"> • Glaucoma screening • Pathology screening • Lung cancer screening • Skin cancer screening
Allied health services	<ul style="list-style-type: none"> • As set out in Rule 5.3.

8.2.6 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.

8.3 Activating the WELLth Fund Benefit

8.3.1 The WELLth Fund allocation is determined according to the beneficiary category reflected in Table B1.8.

8.3.2 Although allocations are shown per beneficiary category, the WELLth Fund is subject to an overall family limit for the membership.

8.3.3 Once the WELLth Fund has been activated, the available funds may be used by any registered beneficiary on the membership, irrespective of age.

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

**ANGLO MEDICAL SCHEME
STANDARD CARE PLAN
ANNEXURE B1**

WELLth FUND LIMITS

TABLE B1.8

Member	R1 500
Adult dependant	R1 500
Child dependant	R 500
Family limit	R5 000

8.4 Clinical Criteria

Benefits are subject to Scheme Rules, clinical protocols, treatment guidelines and utilisation of preferred providers.

8.5 Scheme Reimbursement Rate (SRR)

The benefits listed in Table B1.7 will be funded at 100% of the Scheme Reimbursement Rate, subject to the available activated WELLth Fund balance and the overall benefit limit.