ANGLO MEDICAL SCHEME
MANAGED CARE PLAN
ANNEXURE B2

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 a non-prescribed 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 that 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 prescribed minimum benefit 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; 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-prescribed minimum benefit ("non-PMB") chronic condition recognised by the Board of Trustees, that provides for the payment of chronic medicine according to a Medication Reference Price List (MRPL) for the following conditions:

Acne; Allergy management; Alzheimer's disease; Anaemia (chronic non-PMB); Ankylosing Spondylitis (chronic non-PMB); Anxiety Disorder (chronic); Atopic Dermatitis (Eczema); Attention Deficit Disorder; Auto-immune Disorders (non-PMB); Benign Prostatic Hyperplasia; Cystic Fibrosis (non-PMB); Cystitis (chronic); Degeneration of the Macula (chronic non-PMB); Depression (non-PMB); Diverticular Disease of the Intestine (non-PMB); Fibrous Dysplasia; Gastro-oesophagael Reflux Disease; Gout (chronic); Hidradenitis Suppurativa; Huntington's Disease; Liver Disease (chronic non-PMB); Ménière Disease; Migraine; Motor Neurone Disease (chronic non-PMB); Muscular Dystrophy & other Myopathies (non-PMB); Myasthenia Gravis; Narcolepsy; Obsessive Compulsive Disorder; Osteoarthritis; Osteopaenia; Osteoporosis (non-PMB); Other Venous Embolism and Thrombosis; Paget's

Disease; Pancreatic Disease (non-PMB); Peptic Ulcer (non-PMB); Polymyositis; Polyneuropathy (non-PMB); Psoriasis; Pulmonary Embolism; Pulmonary Interstitial Fibrosis (non-PMB); Restless Leg Syndrome; Sarcoidosis (non-PMB); Systemic Sclerosis; Tourette's Syndrome; Trigeminal Neuralgia; Urinary Calculi (chronic non-PMB); Urinary Incontinence (non-PMB);

1.4 "Medication Reference Price List" (MRPL) – a list of fees/prices in respect of medicine for chronic conditions, 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 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 as 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 Negotiated 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 medicines dispensed as regulated by the Medicines and Related Substances Act, (Act 101 of 1965) or the fee determined by the Board of Trustees from time to time; or

1.8.4 100% NHRPL last published in 2006, plus an inflationary factor equal to:

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 by the Minister of Health on recommendation of the Pricing Committee as provided for in the Medicines and Related Substances Act.

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 Medication Management 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 on-going 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 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 management programme for a particular condition, the benefit in respect of such a 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 an admission or service for which pre-authorisation is required. 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 Top-Up rate

Subject to the requirements of the Hospital Benefit Management Programme and the provisions of Annexure C, if a beneficiary is hospitalised or treated in an accredited doctor's facility, all specialist professional services relating to in-hospital benefits (excluding Pathology and Radiology and Allied health services) will not be subject to the 100% of SRR but will be paid up to a maximum of **230%** of the SRR ("Top-Up Rate") or actual cost, if lower.

6 Benefits

The benefits to which a beneficiary is entitled, are set out below.

Where a benefit is "subject to available savings in the member's Personal

Medical Savings Account (PMSA)", the benefit shall be paid at

- 300% of the SRR, or
- the actual cost, if lower or
- the actual amount charged if above 300% of the SRR on instruction from the member, and

subject to a limit equal to the available savings in that member's PMSA. The benefit shall be paid,

- firstly, out of any PMSA and
- then out of his/her accumulated savings.

PMSA cannot be used to fund:

- items and services that are non-clinical in nature and
- do not have a relevant procedure or NAPPI code.

6.1 **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 a network provider.

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

6.1.1.1 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;

6.1.1.2 Ambulance services; the DSP is Netcare 911;

6.1.1.3 Diabetes Management; the DSP is the contracted network general practitioner with effect from 1 May 2025;

6.1.1.4 HIV/AIDS medicine; the DSP is Dis-Chem Direct;

6.1.1.5 Services and medical and surgical appliances supplied by Orthotists and Prosthetists; the DSP is the Discovery Health Network of Orthotists and Prosthetists;

6.1.1.6 Endoscopic procedures and cataract surgery; the DSP is the Discovery Health Network of Day-Clinics;

6.1.1.7 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;

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

6.1.1.8.1 Cardio Care Programme;

6.1.1.8.2 Diabetes Care Programme;

6.1.1.8.3 Disease Prevention Programme;

6.1.1.8.4 Mental Healthcare Programme; and

6.1.1.8.5 HIV Care Management Programme;

and

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

6.1.2 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 the 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.

6.1.3 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.

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

6.2 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:

6.2.1 **Hospitalisation**

Subject to admission to a hospital or the Scheme's 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.

6.2.2 **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 or drug dependency, subject to PMB legislation.

6.2.3 **Professional Services Out of Hospital**

Subject to available savings in the member's PMSA, a beneficiary is entitled to 100% of the actual amount charged by the provider, for professional services rendered out of hospital in connection with the treatment of alcohol or drug dependency, except in the case of a PMB.

6.3 **ALTERNATIVE HEALTH CARE PRACTITIONERS**

Subject to available savings in the member's PMSA, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of the following:

6.3.1 homeopathic consultations, procedures and medicines, including non-NAPPI coded medicines compounded and

dispensed by the practitioner;

6.3.2 naturopathy; and

6.3.3 acupuncture.

6.4 AMBULANCE SERVICES

Subject to the PMB legislation, 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-hour post receiving the service or admission to a hospital, or on the next working day whichever is the sooner.

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

6.5 ALLIED HEALTH CARE SERVICES

Subject to available savings in the member's PMSA, a beneficiary is entitled to 100% of the actual amount charged by the provider for the following out of hospital allied health care services:

6.5.1 audiology;

6.5.2 physiotherapy;

6.5.3 clinical psychology;

6.5.4 orthoptics;

6.5.5 speech and occupational therapy;

6.5.6 chiropody and podiatry services;

6.5.7 dietician services;

6.5.8 social services;

6.5.9 nurse practitioner consultations and procedures;

6.5.10 orthotists and prosthetists; and

6.5.11 chiropractic consultations, including x-rays.

6.6 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.

6.7 CONSULTATIONS AND VISITS

6.7.1 Consultations and Visits Out of Hospital

6.7.1.1 **General practitioners, nurse practitioners, anaesthetists, radiologists and pathologists** Subject to the exclusions in Annexure C, the PMB legislation and the available savings in the member's PMSA, a beneficiary is entitled to 100% of the SRR, or if instructed by the member, 100% of the actual amount charged by the provider for out of hospital consultations, procedures and visits.

Once the PMSA and accumulated credit is exhausted, two General Practitioner consultations per family per annum at 100% of the SRR or the actual cost, if lower.

6.7.1.2 **Medical specialists (excluding radiologists and pathologists)**

Specialists outside of the Discovery Health Premier Specialist Network:

Subject to the exclusions in Annexure C, the PMB legislation and the available savings in the member's PMSA, all out of hospital consultations and visits performed by medical specialists, including maxillo-facial surgeons, excluding equipment fees and materials, will be reimbursed up to a maximum of **125%** of the SRR.

Discovery Health Premier Specialist Network:

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.

6.7.1.2.1 Procedures performed during consultations and visits contemplated in 6.7.1.2 for specialists outside of the Discovery Health Premier Specialist Network, subject to a defined list, will be paid out of the risk benefit at **125**% of the SRR, or actual cost, whichever is the lower.

6.7.1.3 **Discovery Health GP Network**

Out of hospital consultations and procedures, as defined in the GP Network Agreement, performed by general medical practitioners who are contracted to the Discovery Health GP Network, will not be subject to the normal SRR, but will be reimbursed at the Discovery Health GP Network Rate.

6.7.1.4 **Consultations for immunisation**

A beneficiary is entitled to 100% of the SRR, the Discovery Health GP Network Rate or the actual cost, if lower, of:

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

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

6.7.1.5 **Glaucoma screening**

Subject to the exclusions in Annexure C, the PMB legislation and the available savings in the member's PMSA, a beneficiary is entitled to 100% of the SRR, or if instructed by the member, 100% of the actual amount charged by the provider.

6.7.2 **Consultations in Hospital: excluding Specialists**

A beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of consultations, visits and procedures in hospital, by general practitioners, nurse practitioners, radiologists, pathologists and allied healthcare practitioners (excluding, audiologists, orthoptists, chiropodists, podiatrists, and chiropractors).

6.7.3 **Consultations in Hospital: Discovery Health Premier Specialist Network**

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.

6.7.4 **Consultations and procedures in lieu of hospitalisation**

Subject to PMB regulations and pre-authorisation, a beneficiary is entitled to 100% of the SRR, or up to the Top-Up rate, or the actual cost, if lower, of specified procedures usually performed in a hospital by a specialist when performed in a consulting room in lieu of a hospital admission.

6.8 DENTAL

Dental out of hospital

6.8.1 Subject to Annexure C and the annual family limit for conservative and specialised dentistry, reflected in Table B2.1 below, a beneficiary is entitled to:

6.8.1.1 100% of the SRR, or the actual cost, if lower of conservative dental services out of hospital, such as consultations, fillings, extractions, x-rays, ~~and~~ prophylaxis or services rendered by oral hygienists; and

6.8.1.2 **125%** of the SRR, or the actual cost, if lower, of specialised dental services out of hospital when performed by dental specialists; and

6.8.1.3 100% of the SRR of dental models; metal and porcelain inlays and foils; crown and bridgework; dentures; orthodontia; osseo-integrated implants or other similar tooth implants; appliances and prostheses whether obtained in or out of hospital.

The annual family limit in respect of conservative 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 B2.1 below. Any one beneficiary may use a portion, or the full amount, of the annual family limit.

TABLE B2.1
CONSERVATIVE AND SPECIALISED DENTISTRY LIMITS

Member/Adult dependant	**R5 570**
Child dependant	**R2 105**

6.8.2 **Further Conservative and Specialised Dentistry in or out of hospital**

Subject to Annexure C and the available savings in the

member's PMSA, a beneficiary is entitled to 100% of the SRR, or the actual cost if lower, for further conservative dental services and **125%** of the SRR, or the actual cost if lower, for further specialised dental services, whether obtained in or out of hospital, including the cost of dental models; metal and porcelain inlays and foils; crown and bridgework; dentures; orthodontia; osseo-integrated implants or other similar tooth implants; appliances and prostheses.

6.8.3 **Dental services in hospital**

Subject to pre-authorisation, a beneficiary is entitled to 100% of the Scheme Reimbursement Rate (SRR), or the actual cost, if lower, of hospitalisation in the case of trauma, patients under the age of seven years requiring dental treatment under anaesthetic and the removal of impacted third molars, by a dentist or, if provided by maxillo-facial surgeon, a beneficiary is entitled to up to **230%** of the SRR.

6.9 **ENDOSCOPIC PROCEDURES (gastroscopies, colonoscopies, sigmoidoscopies and proctoscopies)**

6.9.1 A beneficiary is entitled to 100% of the SRR or the actual cost, if lower, of hospitalisation and up to **230%** of SRR, or the actual cost, if lower, of specialist services 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. This

Rule will not apply in respect of a medical emergency endoscopic procedure and treatment.

6.9.2 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 admitted to a non-network facility for an endoscopic procedure. No co-payment will be due in respect of a medical emergency procedure.

6.10 HOSPITALISATION

6.10.1 General

A beneficiary is entitled to 100% of the SRR, inclusive of fixed fee procedures, as negotiated between the Scheme and the hospital concerned, for all services received in nursing homes, day clinics, unattached theatre units, private hospitals, and government and provincial hospitals.

6.10.2 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.

6.10.3 Co-payments

A co-payment of a minimum of **R530** per day and a maximum of **R1 595** per hospital stay, is payable by members in respect of all hospital admissions including day cases, except where otherwise specified, in which

case this co-payment will be waived. No co-payment will be due in respect of a PMB condition.

6.10.4 **Ward Fees**

A beneficiary is entitled to 100% of the SRR, as negotiated between the Scheme and the hospital concerned, for:

6.10.4.1 general ward fees; and

6.10.4.2 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.

6.10.5 **Ward and Theatre Drugs, Appliances and Surgical Prostheses**

A beneficiary is entitled to 100% of the SRR, as negotiated between the Scheme and the hospital concerned, for ward and theatre drugs, surgicals and appliances that are prescribed and used while the beneficiary is resident in any nursing home, hospital or sanatorium, subject to:

6.10.5.1 in the case of prescribed drugs, the SEP for such drugs;

6.10.5.2 in the case of 'To Take Out' drugs (TTOs), a limit of seven day's supply on discharge;

6.10.5.3 in the case of appliances, subject to Rule 6.15; and

6.10.5.4 in the case of internal surgical prostheses, subject to Rule 6.24.

6.10.6 **Theatre Fees and Materials**

Subject to PMB legislation, a beneficiary is entitled to 100% of the SRR, as negotiated between the Scheme and the hospital concerned, for theatre fees, labour ward charges and dressings and materials used in theatre.

6.10.7 **Frail Care**

A beneficiary is entitled to 100% of the SRR of medically related frail care services according to Scheme protocol obtained at a registered frail care centre or by a registered nurse at home, subject to pre-authorisation by the Scheme and a limit of **R94 000** per beneficiary per annum.

6.10.8 **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.

6.10.9 **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.

6.10.10 **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.

6.10.11 **Hospital at Home**

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.

6.11 **HIV / AIDS**

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

6.11.1 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 the DSP and, where required to achieve the desired clinical outcome, to benefits extended beyond the PMB limitations;

6.11.2 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;

6.11.3 the HIV test at 100% of SRR or the actual cost, if lower, for pathology services rendered by a registered pathologist or medical technologist; and

6.11.4 HIV screening at pharmacy clinic at 100% of SRR.

Where a beneficiary elects not to use the DSP, the benefit allowed will be subject to a co-payment, Rule 6.1 above.

6.12 INFERTILITY

Subject to PMB legislation and the exclusions as reflected in Annexure C, a beneficiary is entitled to:

6.12.1 **125**% of the SRR, or the actual cost, if lower, of the investigation if performed by a medical specialist or 100% of the SRR if performed by a general practitioner; and

6.12.2 subject to available savings in the member's PMSA, non-PMB prescribed medicines for the treatment of infertility.

6.12.3 Assisted Reproductive Therapy (ART)

A beneficiary is entitled to 75% of the SRR up to an annual benefit limit of **R145 450**, subject to clinical guidelines, treatment protocols and the use of a SASREG-accredited facility.

Once this benefit is activated, a beneficiary has access to a basket of care which includes cover for:

- Consultations with fertility specialists and medicine;
- A defined list of pathology tests;
- Oocyte (egg) retrieval;

- Embryo and sperm storage relating to the approved assisted therapy;
- Embryo transfer and freezing;
- Approved fertility medicine;
- Ultrasound scans and admissions.

Any infertility treatment or procedures not listed under this benefit will not be funded by the Scheme, unless related to Prescribed Minimum Benefits.

Subject to the Scheme's clinical entry criteria, beneficiaries registered on the Oncology Programme are eligible for egg or sperm cryopreservation (freezing) and storage for up to five years. No benefit is payable for egg or sperm cryopreservation or storage where a beneficiary is not registered on the Oncology Programme or does not meet the applicable clinical entry criteria, and all associated costs shall be for the beneficiary's own account.

Subject to the qualifying criteria, cover includes:

- Beneficiaries aged 25 to 39 years: up to two IVF cycles per year or two egg donation cycles per year or one IVF cycle and one egg donation cycle per year.
- Beneficiaries aged 40 to 42 years: one IVF cycle per year or one egg donation cycle per year.

- Beneficiaries aged 43 to 50 years: access to one egg donation IVF cycle per year.
- The donor matching fee is funded for all three of the above age groups.
- The cost of using egg donor agencies is not funded.

6.13 MATERNITY

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

6.13.1 Confinement in a Hospital (subject to Rule 6.1)

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

6.13.2 Ante-natal Consultations and Post-natal Care

Subject to pre-authorisation, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of the following additional non-PMB benefits:

6.13.2.1 twelve consultations (inclusive of ante- or post-natal care) and visits with general practitioners or nurse practitioners, or up to **125**% of the SRR if consulting an obstetrician, in or out of hospital;

6.13.2.2 two, two-dimensional ultra- sound pregnancy scans

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

6.13.2.4 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 all ultrasound scans, shall be reimbursed according to Rule 6.7, Consultations and Visits.

6.14 MAXILLO-FACIAL AND ORAL SURGERY

6.14.1 Subject to PMB legislation and pre-authorisation, a beneficiary is entitled to maxillo-facial and oral surgery

limited to the diagnosis, treatment and care of PMB conditions in hospital.

6.14.2 Non-PMB maxillo-facial or oral surgical services will be subject to the annual family limit for conservative and specialised dentistry, thereafter, subject to the available savings in the member's PMSA and dental specialist services shall be paid up to **125**% of the SRR.

6.15 MEDICAL AND SURGICAL APPLIANCES

6.15.1 Excluding the appliances referred to in paragraphs 6.15.2 and 6.15.3, a beneficiary is entitled to 100% of the SRR of medical and surgical appliances, subject to pre-authorisation for any appliances in excess of **R3 420** per appliance and an annual family limit of **R21 380.**

Medical and surgical appliances obtained from Orthotists and Prosthetists will be paid up to the Discovery Health Network rate.

6.15.2 Subject to pre-authorisation, a beneficiary is entitled to 100% of the cost of one wheelchair per beneficiary every two years to a limit of **R33 645** per beneficiary.

6.15.3 A beneficiary is entitled to 100% of the cost of hearing aids, subject to a prescription from an Ear, Nose and Throat specialist for beneficiaries younger than 60 years, as well as pre-authorisation by the Scheme and a limit of **R26 900** per hearing aid per beneficiary every two years.

6.15.4 Subject to PMB legislation and pre-authorisation, a beneficiary is entitled to 100% for 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.

A beneficiary who voluntarily obtains services from a non-DSP will be subject to a co-payment, Rule 6.1.

6.16 MEDICINES

A beneficiary is entitled to one month's supply in respect of medicines obtained on a prescription 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.

6.16.1 Acute Medicine

Subject to exclusions in Annexure C, available savings in the member's PMSA, a beneficiary is entitled to 100% of the SRR or actual amount charged for:

6.16.1.1 Prescribed acute medicine obtained from a pharmacy or registered dispensing practitioner, and

6.16.1.2 100% of the SRR for materials required for injections.

6.16.2 Homeopathic Medicines

Subject to available savings in the member's PMSA, a beneficiary is entitled to 100% of the SRR of homeopathic

medicines.

6.16.3 **Pharmacist Advised Therapy (PAT)**

Subject to available savings in the member's PMSA, a beneficiary is entitled to 100% of the cost of certain medicines on the advice of a pharmacist.

6.16.4 **Chronic Medicine**

6.16.4.1 **PMB Conditions**

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

6.16.4.2 **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 **R23 345** per beneficiary and provided that;

6.16.4.2.1 the medicine has been approved on the Chronic Medicine Management Programme; and

6.16.4.2.2 the medicine is included on the MRPL.

6.16.4.3 **Vaccines**

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

6.16.4.3.1 one influenza vaccine per annum,

6.16.4.3.2 two pneumococcal virus vaccines per lifetime according to age;

6.16.4.3.3 according to age, one human papilloma virus vaccine per lifetime;

6.16.4.3.4 subject to PMB regulations, Covid-19 vaccines zero-rated and the vaccine administration fees; and

6.16.4.3.5 subject to the Department of Health protocol, childhood vaccines for children up to the age of 12 years.

6.17 MENTAL HEALTHCARE PROGRAMME

6.17.1 Professional Services In Hospital

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

6.17.2 Professional Services Out of Hospital

Subject to PMB limitations, Scheme protocols, pre-authorisation and services provided by a contracted healthcare provider, a beneficiary is entitled to 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.

6.17.3 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.

6.18 ONCOLOGY (Subject to PMB regulations)

Subject to the PMB regulations and registration on the Oncology Management Programme, a beneficiary is entitled to:

6.18.1 **125**% of the SRR, or the actual cost, if lower, of consultations, visits and procedures by medical specialists and 100% of the SRR, or actual cost, if lower, of consultations, visits and procedures by general practitioners;

6.18.2 100% of the SRR, or the actual cost, if lower, of radiotherapy and chemotherapy treatment; and

6.18.3 the SEP of cytostatics used in chemotherapy treatment subject to the MRPL

6.18.4 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 **100%** of the SEP of the specified innovative or high-cost medicines up to an Oncology Innovation Medicine limit of **R814 300**, thereafter it will continue to be reimbursed at **80%** of the SEP.

6.19 OPHTHALMOLOGY (cataract surgery with intraocular lens replacement)

6.19.1 Subject to the PMB legislation and pre-authorisation, a beneficiary is entitled to **230**% of the SRR, or the actual cost, if lower, of cataract surgery and 100% of the SRR, or the actual cost, if lower of an intraocular lens replacement and the hospitalisation, if performed in an

accredited ophthalmologist's room or registered day clinic on the Scheme's defined list of network facilities; and

6.19.2 if a beneficiary voluntarily uses a non-network facility, a co-payment of **R1 285** is payable by the member.

6.19.3 Subject to preauthorisation, clinical protocols and the internal 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.

6.20 OPTICAL SERVICES

6.20.1 Subject to the annual family limit of **R4 820**, 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;

6.20.2 a beneficiary is limited to **R540** per optic examination or test supplied by a registered optometrist, ophthalmologist or supplementary optical practitioner annually; and

6.20.3 subject to available savings in the member's PMSA, a beneficiary is entitled to 100% of the costs in excess of the optical benefit.

This benefit excludes the costs of sunglasses.

6.21 PATHOLOGY

6.21.1 Pathology Services Out of Hospital

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

6.21.2 Pathology Services In Hospital

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, in hospital.

6.21.2.1 **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.

6.21.3 **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:

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

6.21.3.2 according to age, one faecal occult blood test every two years.

6.22 RADIOLOGY

6.22.1 **Radiological Services Out of Hospital**

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

6.22.2 **Radiological Services In Hospital**

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

6.22.3 **MRIs, CT Scans and Isotope Therapy**

Subject to pre-authorisation by the Scheme, a beneficiary 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.

6.22.4 **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.

6.22.5 **Mammograms**

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

6.23 **RENAL DIALYSIS (subject to PMB legislation)**

Subject to PMB legislation, 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.

6.24 SPECIALISED MEDICINE AND TECHNOLOGY (SMT) OUT OF HOSPITAL BENEFIT

Subject to PMB legislation, Scheme protocols and pre-authorisation, a beneficiary is entitled to 100% of the SRR of certain specified specialised medicines and technology or devices costing in excess of **R6 410** per unit or per treatment per beneficiary per month that are not covered by other Scheme benefits.

6.25 INTERNAL SURGICAL PROSTHESES

Subject to PMB legislation and pre-authorisation, a beneficiary is entitled to 100% of the SRR, for internal prostheses, with a limit of **R186 900** per beneficiary per annum.

6.26 TRANSPLANTS

Subject to PMB legislation, 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.

6.27 **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.

7 THIRD PARTY LIABILITY

Subject to PMB legislation, 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:

7.1 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.

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

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

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

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

8.2 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:

8.2.1 a detailed account or statement for the full service;

8.2.2 a detailed account or statement for the shortfall or uncovered services; and

8.2.3 proof of payment of the service,

to be submitted in English or accompanied by a sworn English translation.

8.3 Any payment towards the cost of a claim submitted in accordance with Rule 6 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.

8.4 Where detail of the service is not provided, the Scheme cannot process the claim and no payment shall be considered.

9 WELLth FUND BENEFIT

9.1.1 The WELLth Fund provides additional benefits to beneficiaries, subject to Prescribed Minimum Benefits.

9.1.2 The benefit is available once per membership and must be activated before it can be used.

9.1.3 An adult dependant may activate the WELLth Fund Benefit for themselves and for any registered child dependant aged more than 2 years and younger than 18 years by completing a health check at a contracted provider.

9.1.4 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.

9.1.5 Once activated, the WELLth Fund Benefit are available until 31 December 2028.

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

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

9.2 WELLth Fund Benefit details

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

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

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

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

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

WELLth FUND BENEFITS

TABLE B2.2

General health services	• GP consultations • Out-of-hospital conservative and specialised dentistry • Optical services • Gynaecological check-up • Hearing test • Glaucoma screening • Pathology screening • Lung cancer screening • Skin cancer screening
Allied health services	• As set out in Rule 6.5.

9.2.6 The funds in 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.

9.3 Activating the WELLth Fund Benefit

9.3.1 The WELLth Fund allocation is determined according to the beneficiary category reflected in Table B2.3.

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

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

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

WELLth FUND LIMITS

TABLE B2.3

Member	**R2 500**
Adult dependant	**R2 500**
Child dependant	**R1 000**
Family limit	**R8 000**

9.4 Clinical Criteria

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

9.5 Scheme Reimbursement Rate (SRR)

The benefits listed in Table B2.2 will be funded at 100% of the Scheme Reimbursement Rate, subject to the available activated WELLth Fund balance and the overall benefit limit.