BENEFIT GUIDE 2022

AMS ANGLO MEDICAL SCHEME

Our promise

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

Your guarantee

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

These 270 PMBs cover the most common conditions, ranging from fractured bones to various cancers, menopause management, cardiac treatment, medical emergencies and Covid-19. Some of them are life-threatening conditions for which cost-effective treatment would sustain and improve the member's quality of life.

PMB diagnosis, treatment and care is not limited to hospitals. Treatment can be received wherever it is most appropriate – in a clinic, an outpatient setting or even at home.

The access to diagnosis, medical or surgical management and treatment of these conditions is not limited and is paid according to specific protocols per condition.

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

In addition to the 270 PMBs, you are also guaranteed treatment and medication for 26 chronic conditions. Members with these chronic conditions will need to visit their healthcare practitioner and may have to register the condition with a specialised chronic disease management programme. Some disease management programmes are obtained from a Designated Service Provider (DSP). Once registered, members will be entitled to treatment, including medication according to treatment protocols and reference pricing.

PMB 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
Diabetes Mellitus Type 2
Dysrhythmias
Epilepsy
Glaucoma
Haemophilia
Hyperlipidaemia
Hypertension
Hypothyroidism
Multiple Sclerosis
Parkinson's Disease
Rheumatoid Arthritis
Schizophrenia
Systemic Lupus Erythematosus
Ulcerative Colitis

Scheme website benefits

As this Benefit Guide is a summary of the registered Scheme Rules only, in some instances, we will refer you to the Scheme website **www.angloms.co.za** for more information. The Scheme website offers you a public and a member-only login area.

The public area contains:

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

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

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

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

The Anglo Medical Scheme App

Download the Anglo Medical Scheme App on your Android or iPhone for a convenient way to access information about your membership, plan and benefits anywhere, anytime.

To use the App, you must be registered on the AMS website. You will use the same username and password for this App as for the AMS website. If you are not yet registered on the AMS website, register on **www.angloms.co.za** - you will find the link to register on the top right of the homepage.

The App will work on an iPhone or an iPod touch with iOS version 8.0 or later. Although the functionality will work on your iPad, it may not display properly. Your Android device needs to be version 2.3 or later. Android devices include popular makes such as HTC, Samsung, LG, Sony and Huawei to name a few. The App has been optimised for both smartphones and tablets.

We are launching the App with the most frequently used functionality to start, but development will be ongoing with more content and functionality added as we go. Information and functionality might differ depending on your plan. Value Care Plan members will be able to access general membership information and functionality only as this plan offers benefits via the Prime Cure network of providers.

We have compiled a user guide for you which you will find in the Info Centre on the website.

Should you require any further assistance, please contact our administrator's app & web team on **webinfo@discovery.co.za** or call them on **0860 100 696**, Monday to Friday 7h00 – 18h00.

Your Scheme at a glance

	VALUE CARE PLAN	STANDARD CARE PLAN	MANAGED CARE PLAN
Type	Network Prime Cure providers and facilities only	Traditional **with certain network limitations**	Comprehensive with Medical Savings Account (MSA)
Tariff	Prime Cure Tariff	Scheme Reimbursement Rate (SRR):100%	GP rate: 100% of SRR, or GP network rate (negotiated Discovery Health Rate): no co-payments Specialists excluding Pathology and Radiology: – In hospital and in lieu of hospitalisation: Top-Up rate up to 230% (100% SRR + 130%) – Out of hospital: Up to 125% of SRR
Benefits	Primary healthcare services Formulary medicine dispensed by network provider/pharmacy Hospital: Family Hospital Limit: R173 000 (non-PMB)	See table on next page Limited Out of Hospital benefits Hospital Network: Unlimited	See table on next page Medical Savings Account for Out of Hospital benefits Hospital: Unlimited
Contribution rate* * Subject to underwriting	Main member: R1 075 Adult dependant: R1 075 Child dependant: R265	Main member: R2 980 Adult dependant: R2 980 Child dependant: R895	Total contributions Main member: R5 450 Adult dependant: R5 450 Child dependant: R1 260
			Excluding MSA Main member: R4 305 Adult dependant: R4 305 Child dependant: R995
			Savings Main member: R1 145 Adult dependant: R1 145 Child dependant: R265

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

A plan change request form is included in the back of your Benefit Guide or on the website and has to be handed to your employer or pension fund administrator as soon as possible, but not later than 10 December if you want to change your plan for the next year. If you are a direct paying member, please submit the form to the Scheme.

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

High-level comparison

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

CATEGORY	STANDARD CARE PLAN	MANAGED CARE PLAN
Hospital services, incl. Radiology and Pathology	Unlimited	Unlimited
Hospital Network	Defined list of hospitals	None
Internal Surgical Prostheses	R68 470 per beneficiary subject to pre-authorisation	R145 235 per beneficiary subject to pre-authorisation
Cancer (Oncology) Treatment	R310 000 per beneficiary	Unlimited subject to protocols
Medical Savings Account (MSA)	No MSA	21% of your contributions are allocated to your MSA
Specialised Medicine and Technology	20% co-payment	Unlimited
Co-payments	Co-payments for non-DSP ambulance, **non-DSP hospitalisation,** non-DSP dental services, non-network endoscopic and cataract procedures, CDE de-registered members	Co-payments for non-DSP ambulance, non-PMB hospitalisation, non-network endoscopic and cataract procedures, CDE de-registered members
Out of Hospital (OH) Services	Overall OH limit: Adult R5 500, Child R2 745	MSA
Acute Medicine, GP and Specialist	OH sublimit 2: Adult R5 165, Child R2 580	MSA
Chronic Conditions Covered (non-PMB)	20 conditions	47 conditions
Chronic Medicine (non-PMB)	R4 740 per beneficiary	R18 300 per beneficiary
Medicine Management	Strict protocol management	Moderate protocol management
OH Pathology	Adult R1 395, Child R500	Unlimited
OH Radiology	Adult R1 820, Child R1 100	Unlimited
Basic Dentistry	Basic services at DSP	Adult R3 970; Child R1 500
Additional Basic and Specialised Dentistry	Adult R1 435, Child R360	
Eye Care Examinations	R415 per beneficiary	MSA
Eye Care Lenses and Frames	R2 280 per family	MSA
Frail Care	None	R73 040 per beneficiary

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

2022 benefits and contributions are subject to the approval of the Council for Medical Schemes

Value Care Plan

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

Value Care Plan Limits unless PMB

IH

Family Hospital Limit	R173 000
Sublimit Private Prime Cure hospital	R75 000
Sublimit Blood transfusions	R17 110
Sublimit Pathology	R19 700 per family
Sublimit Internal surgical prostheses	R30 000 per family
Sublimit Psychiatric services	R8 320 per family 5 days
Sublimit Allied healthcare services	R8 320 per family

OH

Consultations Nurse practitioner at Prime Cure network pharmacy	R580 per family, maximum R290 per visit
+	
Consultations Prime Cure network GPs	Unlimited Authorisation needed after 6th consultation per beneficiary
+	
Consultations Specialist	R3 815 per family, 5 consultations per family, limited to 3 per beneficiary
+	
Allied healthcare services	R2 905 per family with a maximum amount of R1 935 per beneficiary
+	
Pharmacist Advised Therapy (PAT)	R105 per purchase limited to three purchases up to R315 per beneficiary
+	
Consultations GPs out-of-network	R1 100 per consultation One consultation per beneficiary or two per family

Sublimit Specialised Radiology R19 700 per family

Contributions*		
* Subject to underwriting	Main member	R1 075
	Adult dependant	R1 075
	Child dependant	R265

How it works

To call an ambulance

Phone **0861 665 665** and press **option 1.** If deemed an emergency, Prime Cure will authorise and send an ambulance.

In a medical emergency, where authorisation was not obtained, you need to provide details to Prime Cure by calling **0861 665 665** the next working day following the incident. If deemed a non-emergency, you will be liable for the full cost.

To find a Prime Cure network doctor or facility

Call **0861 665 665** or visit **www.angloms.co.za > Plans & Products > Value Care Plan.** You will not be responsible to settle any account as Prime Cure is responsible for the payment of claims to network healthcare providers (unless you have not complied with the Rules). You may have to pay specialists for out of hospital consultations and services upfront; you then submit the claim to Prime Cure. Prime Cure will reimburse costs for specialists at the Prime Cure agreed rate.

To obtain authorisation

Authorisation is required for certain procedures, treatment and hospitalisation before the event, as indicated in the benefit table, to ensure benefits are available and correctly paid. Authorisation to be obtained by the member or beneficiary by calling Prime Cure on **0861 665 665.** If you do not obtain authorisation you will, in some instances, be liable for a co-payment as stated in the benefit table, or you will be liable for the full cost of the service, unless otherwise stipulated.

To claim

If you received emergency medical services outside the network which were authorised the next working day, please submit your claim to:

Email: **refunds@primecure.co.za**
Send your claim with completed refund form, available on **www.primecure.co.za/refund-request-form/**

Post: **Prime Cure Health, Private Bag 2108, Houghton, 2041**

Third-party claims (for example, the Road Accident Fund) are not the responsibility of the Scheme. Emergency treatments will be paid, but will need to be refunded.

In order to be refunded, please ensure you provide the following information:

- A detailed account; and
- Proof of payment

Your responsibilities

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

Benefits

Prime Cure network providers only

What you are entitled to (per annum)	Is authorisation required? 0861 665 665*	Limit**	Is a referral required? ***	Co-payments and comments	Is programme registration required?	IH In hospital OH Out of hospital
Alcohol and drug treatment programme, including hospitalisation and medication	Y	21 days	Y	Network providers only	Y	IH OH
Allied healthcare services: Audiology, dietetics, occupational therapy, podiatry, physiotherapy, psychology, social services and speech therapy	Y	R2 905 per family with a maximum of R1 935 per beneficiary	Y	Co-payment of 50% of Prime Cure negotiated/ agreed rates applies if you self-refer to any practitioner	N	OH
Ambulance services	Y	Subject to Family Hospital Limit unless PMB	N	Authorisation is required the next working day after the emergency incident. Authorise inter-hospital transfers before the event. Voluntary use of non-DSP results in a 30% co-payment	N	IH OH
Cancer treatment: Management Programme including chemotherapy and radiotherapy	Y	Subject to Family Hospital Limit unless PMB	Y	In Public Facilities only	Y	IH OH
Consultations at a network pharmacy wellness clinic: Nurse practitioner	N	R290 per visit subject to a Family Limit of R580	N		N	OH
Consultations out of hospital: Network GP in rooms (PMB and non-PMB)	N		N	Authorisation required after 6 consultations per beneficiary. If you do not get authorisation, you will be liable for a co-payment of 30% of the cost	N	OH
Consultations out of hospital: Non-network GP (non-PMB)	Y	A maximum of R1 100 per consultation (including related expenses) per beneficiary, maximum of 1 consultation per beneficiary or 2 per family	N	Member liable for 20% of the cost per visit, subject to authorisation obtained the next working day after the consultation. Facility fees not covered	N	OH

* Unless otherwise specified

** PMB rules apply

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

What you are entitled to (per annum)	Is authorisation required? 0861 665 665*	Limit**	Is a referral required? ***	Co-payments and comments	Is programme registration required?	IH In hospital OH Out of hospital
Consultations out of hospital: Specialists (non-PMB)	Y	Limited to R3 815 per family, 5 consultations per family and a maximum of 3 consultations per beneficiary	Y	A 30% co-payment will apply where authorisation was not obtained. Services paid up to the Prime Cure agreed rate only. Medication prescribed and obtained at a Prime Cure network pharmacy is included in this limit	N	OH
Consultations out of hospital: Specialists in rooms (PMB and emergencies)	Y		Y	Emergencies: A 30% co-payment will apply where authorisation was not obtained the next working day. Services paid up to the Prime Cure agreed rate only	Y	OH
Covid-19	N		N	Due to the changing nature of this benefit, please visit the Scheme website or call the Call Centre for more information	N	IH OH
Dentistry: Conservative treatments including fillings, x-rays, extractions and consultations	N	One consultation per beneficiary	N	Specific codes will be paid if clinically appropriate. Authorisation needed for 5 or more extractions	N	OH
Dentistry: Emergency consultations – pain, sepsis and extractions (non-network provider)	N	One event per beneficiary	N	Paid at Prime Cure agreed rate	N	OH
Dentistry: Hospital admissions for children under the age of 7 for the removal of impacted third molars and trauma (PMB)	Y	Subject to Family Hospital Limit	Y		N	IH
Dentistry: Preventative treatment – cleaning, scaling, polishing and fluoride treatment	N	One treatment per beneficiary	N	Authorisation needed for children over 12 years. Paid at the Prime Cure agreed rate	N	OH
Dentistry: Specialised	Y	One set of acrylic dentures per family every 2 years	N	Benefit only for members over the age of 21 years and subject to a co-payment, payable to the dentist, of 20% per set	N	OH
Diabetes	Y		N	Must authorise and adhere to Scheme protocols	N	OH
Eye care: Eye examination	N	One examination per beneficiary	N		N	OH
Eye care: Lenses and frames	N	One pair of spectacles per beneficiary every 2 years	N	No contact lenses or sunglasses. Spectacles: Prescription valid for one month	N	OH
HIV/AIDS: Confidential management programme including medicine and related expenses	Y		N	Must register and adhere to Scheme protocols. Your status will at all times remain confidential	Y	OH

* Unless otherwise specified

** PMB rules apply

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

What you are entitled to (per annum)	Is authorisation required? 0861 665 665*	Limit**	Is a referral required? ***	Co-payments and comments	Is programme registration required?	IH In hospital OH Out of hospital
Hospitalisation: Allied healthcare services: dietetics, occupational and speech therapy, physiotherapy, podiatry and social services	Y	Sublimit: R8 320, subject to the Family Hospital Limit	Y		N	IH
Hospitalisation: Blood transfusions (non-PMB)	Y	Sublimit: R17 110 subject to the Family Hospital Limit	Y		N	IH
Hospitalisation: Hospital services including GP and specialist consultations in hospital, day cases and 7 day supply of to-take-out medicines	Y	Family Hospital Limit: R173 000 Private Hospital sublimit: R75 000	Y	A R2 000 co-payment applies if no authorisation was obtained. Authorisation must be obtained within 24 hours or first working day after admission. Obtain authorisation if admitted via casualty as well	N	IH
Hospitalisation: Internal surgical prostheses	Y	Sublimit: R30 000 per family, subject to the Family Hospital Limit	Y		N	IH
Hospitalisation: Psychiatric services (non-PMB)	Y	5 days per admission, with a maximum of R8 320 per family, subject to the Family Hospital Limit	Y	In Public Psychiatric Facility	N	IH
Hospitalisation: Psychiatric services (PMB)	Y	21 days	Y	In Public Psychiatric Facility	N	IH
Kidney disease: Dialysis (haemo, peritoneal)	Y	Family Hospital Limit (unless PMB)	Y	In Public Facilities only	Y	IH OH
Maternity: Antenatal consultations, GP and specialists	Y	2 specialist consultations, 2 ultrasound scans (2D) per pregnancy	Y	Paid at Prime Cure agreed rate. Register your pregnancy between week 12 and 20 of the pregnancy to qualify for benefits	Y	OH
Maternity: Confinement in hospital	Y	Family Hospital Limit	Y		Y	IH
Medicine: Acute, inclusive of dental medication	N		N	Formulary medicine only; obtained at network GP, dentist or pharmacy	N	OH
Medicine: Pharmacist Advised Therapy (PAT)	N	R315 per beneficiary (R105 per purchase)	N	Formulary medicine only; obtained at network pharmacy	N	OH

* Unless otherwise specified

** PMB rules apply

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

What you are entitled to (per annum)	Is authorisation required? 0861 665 665*	Limit**	Is a referral required? ***	Co-payments and comments	Is programme registration required?	IH In hospital OH Out of hospital
Medicine (PMB chronic)	Y	Medicine formulary	N	One month's supply at a time; obtained only at a network GP or pharmacy	Y	OH
PMB chronic conditions						
Addison's Disease	Chronic Obstructive Pulmonary Disease		Epilepsy		Parkinson's Disease	
Asthma	Coronary Artery Disease		Glaucoma		Rheumatoid Arthritis	
Bipolar Mood Disorder	Crohn's Disease		Haemophilia		Schizophrenia	
Bronchiectasis	Diabetes Insipidus		Hyperlipidaemia		Systemic Lupus Erythematosus	
Cardiac Failure	Diabetes Mellitus Type 1		Hypertension		Ulcerative Colitis	
Cardiomyopathy	Diabetes Mellitus Type 2		Hypothyroidism			
Chronic Renal Disease	Dysrhythmias		Multiple Sclerosis			
Organ transplant: Harvesting of the organ, post-operative care of the member and the donor, anti-rejection medicine, professional services in hospital and payment of donor	Y		Y	In Public Hospital facilities only	Y	IH OH
Pathology: In hospital	N	Sublimit: R19 700 per family, subject to the Family Hospital Limit	N		N	IH
Pathology: Out of hospital	N		N	Limited to approved tests. Must be requested by network provider. Programme registration for PMB conditions	Y N	OH
Radiology: Basic (Out of hospital)	N		N	Limited to approved x-rays. Must be requested by network provider	N	OH
Radiology: Basic (In hospital)	N	Family Hospital Limit (unless PMB)	N	Subject to approved codes	N	IH
Radiology: Specialised radiology, MRI, CT scans and mammograms	Y	R19 700 per family subject to the Family Hospital Limit	Y		N	IH OH
Vaccines: Covid-19 and flu	N		N	Subject to age and protocols. Flu - cost of vaccine only.	N	OH
Vitality check: Cholesterol, blood glucose, BMI, blood pressure	N	1 per beneficiary per year	N	Vitality check done at Vitality Wellness network partners	N	OH

* Unless otherwise specified

** PMB rules apply

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

General exclusions

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

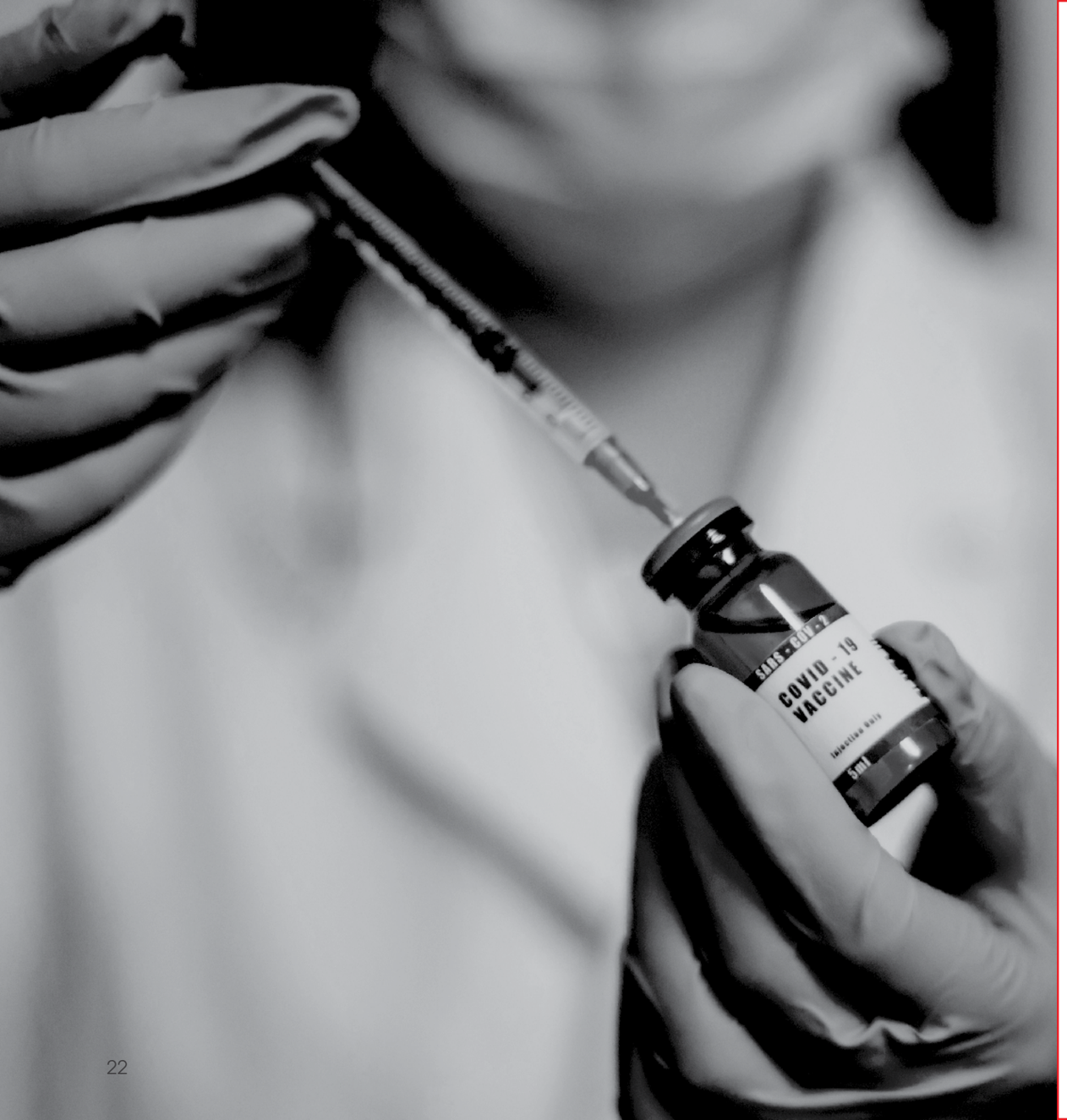
- Frail care
- PET scans
- Deep brain stimulator devices for Parkinson's disease or epilepsy
- Implant devices for chronic pain management
- Polysomnogram and CPAP titrations
- Facility fees
- Medicine not found on the medicine list
- Injury or illness that occur beyond the borders of the Republic of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

The following medicines are specifically excluded unless authorised:

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

General Rule reminders

- This Benefit Guide is a summary of the 2022 AMS benefits, pending approval from the Council for Medical Schemes
- Please refer to **www.angloms.co.za** (My Scheme, Scheme Rules) for the full set of registered Rules
- The Anglo Medical Scheme Rules are binding on all beneficiaries, officers of the Scheme and on the Scheme itself
- The member, by joining the Scheme, consents on his or her own behalf and on behalf of any registered dependants, that the Scheme may disclose any medical information to the administrators and contracted third-parties for reporting or managed care purposes
- A registered dependant can be a member's spouse or partner, a biological or stepchild, legally adopted child, grandchild or immediate family relation (first-degree blood relation) who is dependent on the member for family care and support
- To avoid underwriting, a member who gets married must register his or her spouse as a dependant within 30 days of the marriage. Newborn child dependants must be registered within 30 days of birth to ensure benefits from the date of birth
- If your dependant reaches the age of 23 and you wish to keep him or her on the Scheme as an adult dependant, you may apply for continuation of membership
- It is the member's or dependant's responsibility to notify the Scheme of any material changes, such as marital status, banking details, home address or any other contact details and death of a member or dependant



Standard Care Plan

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

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

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

Hospital cover is unlimited and paid at **100% of SRR in network facilities.**

Contributions*: Main member R2 980, adult dependant R2 980, child dependant R895

* Subject to underwriting

Standard Care Plan Limits unless PMB

EXAMPLE

How to calculate your Family Limit

Adult R1 000 x 2 = R2 000

\+

Child R200 x 1 = R200

Family Limit R2 200

Use the combined available limit for one or more family members

OH

Overall Out of Hospital Family Limit	Adult R5 500 Child R2 745
Sublimit 1: Alternative and allied healthcare	Adult R3 550 Child R745
Sublimit 2: Consultations, acute medication and Pharmacist Advised Therapy (PAT)	Adult R5 165 Child R2 580
+	
Additional basic and specialised Dentistry Family Limit	Adult R1 435 Child R360
+	
Radiology Family Limit	Adult R1 820 Child R1 100
+	
Pathology Family Limit	Adult R1 395 Child R500
+	
Medical and surgical appliances	R9 795 per family
+	
Chronic medication (non-PMB)	R4 740 per beneficiary

IH

General services in network hospitals Radiology and Pathology	Unlimited Paid at 100% of SRR
+	
Internal surgical prostheses	R68 470 per beneficiary

Oncology:	R310 000 per beneficiary per 12-month period. 20% co-payment after depletion of limit, subject to protocols
Specialised medicine and technology:	80% of SRR

How it works

To call an ambulance

Phone our Designated Service Provider (DSP) **Netcare 911** on **082 911**. If deemed an emergency, Netcare 911 will authorise a road or air ambulance. If deemed a non-emergency, or services regarded as "home assessments" without transport to a casualty or hospital, you will be liable for the full cost. In a medical emergency where authorisation was not obtained, you need to provide details to Netcare 911 the next working day after the incident.

Voluntary use of a non-DSP results in a 20% co-payment.

To obtain authorisation

Procedures, treatments, hospitalisation, external medical or surgical appliances, specialised radiology

To access benefits and to ensure they are available and correctly paid, call **0860 222 633** to get authorisation for procedures, treatments, hospitalisation, specialised radiology, internal surgical prostheses and external medical appliances exceeding R3 000, before the event as indicated in the benefit table. Elective admissions need to be authorised 48 hours before the event. Emergency admissions require authorisation the next working day after the event.

Information required when calling for authorisation:

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

The authorisation number must be quoted on admission. It will be valid for a period of four months or until the end of the year, whichever comes first. Please phone **0860 222 633** if any of the details change such as the date of operation, procedure, etc. If the admission is postponed or not taken up before it becomes invalid, a new authorisation number will need to be obtained.

Chronic medicine

If you are diagnosed with a chronic condition (PMB or non-PMB), ask your doctor or pharmacist to register the chronic condition by calling **0860 222 633.**

We will then pay for your medicine from the relevant chronic medicine benefit and not from your day-to-day benefits. You can get a repeat of a month's medication after 24 days (not before).

Diabetes, HIV/AIDS and oxygen therapy management

Register on the programme to ensure maximum benefits:

- Diabetes – call the Centre for Diabetes and Endocrinology (CDE) on **011 053 4400**
- HIV/AIDS management – call **0860 222 633**
- Oxygen therapy management – call **0860 222 633** to receive services from VitalAire

To reduce your medicine costs

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

To claim

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

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

Send your completed claim to:

Email: **claims@angloms.co.za**
Post: **Anglo Medical Scheme, PO Box 746, Rivonia, 2128**
Call: **0860 222 633 for further assistance**
Upload: **www.angloms.co.za after logging in as a member or upload on the Anglo Medical Scheme App**

We can only process your claims if all details are legible. Fax submissions are therefore not recommended. If you still prefer to fax the claims, please send them to **011 539 1008**.

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

You or your service provider have up to four months from the treatment date to submit a claim for payment. After four months, it will be considered 'stale' and the Scheme will no longer be responsible for payment.

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

After submission of your claim, the Scheme will:

- Notify you by SMS or email once your claim has been processed (if you have subscribed to this service)
- Pay all amounts according to the Scheme Rules and at the Scheme Reimbursement Rate (SRR)
- Pay this amount directly into your bank account (or the provider's account)
- Send you a statement by email or post showing amounts paid, to whom, rejections and amounts for you to settle

Your responsibility

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

International claims

Emergency and acute medical treatment received when travelling or residing overseas

The Scheme will consider, in accordance with the Rules and necessary authorisations, making a payment towards your overseas healthcare cost.

- The Scheme will not pay a doctor or service provider outside RSA borders directly. You must pay for the services at the time of the treatment and the Scheme may refund you
- If you are entitled to benefits from another insurer you must claim from that insurer first. Any shortfall or uncovered cost may be submitted to the Scheme, which will be considered based on your benefit entitlements and the Scheme Rules
- Complete the international claim form and submit a fully specified account, in English, with your proof of payment to the Scheme
- The account must give details of the service rendered and the relevant healthcare provider
- Any payment made towards the cost of a claim will be made in South African Rands into your South African bank account. The amount paid will be at the SRR had the service been obtained in South Africa in the Scheme's absolute discretion. If the service is not available in South Africa, the amount paid will be for a similar or equivalent service if it exists. Remember that, except in the case of a medical emergency, the normal authorisation procedure needs to be followed before undergoing any routine or specialised treatment overseas

Repatriation and social transfers will not be covered. We suggest you take out adequate medical travel insurance to cover any major medical emergency.

Chronic medicine advanced supply

For an advanced supply of chronic medicine, please submit:

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

The Scheme will only approve advanced supplies within the current benefit year. Call **0860 222 633** for further assistance.

Preventative Care Benefits

To support you in managing your health proactively, we encourage you to take preventative measures. Detecting health risks or a disease early could prevent a disease or at least improve the success rate of the treatment.

The below preventative care benefits are **paid by the Scheme** (not from your normal benefits) at the Scheme Reimbursement Rate. Refer to the benefit table for more detail.

Description	Sex	Age*	Benefit Category	Purpose
Bone density scan	F	65+	Specialised Radiology	Detection of osteopaenia or osteoporosis (fragile bones)
Colonoscopy	F/M	50+	Endoscopy**	Early detection of colorectal or colon cancer
Immunisation Covid-19 Vaccine	F/M	As per DoH# schedule	Vaccines	Prevention of severe illness and death
Flu Vaccine	F/M	All	Vaccines	Influenza prevention; particularly important for people who are at risk of serious complications from influenza (chronic conditions, pregnant, HIV patients or ageing members)
Human Papillomavirus (HPV): Cervarix/Gardasil	F/M	9-26	Vaccines	Prevention of cervical cancer caused by HPV
Pneumococcal Vaccine	F/M	55+	Vaccines	Prevention of serious lung infections; particularly important for people who are at high risk for serious complications (certain chronic conditions, HIV patients or ageing members)
Mammogram	F	40+	Specialised Radiology	Early detection of breast cancer
Maternity Consultation	F		Maternity	Monitoring of your pregnancy and prevention of complications
Ultrasound	F		Maternity	
Pap smear	F	21-65	Pathology: Pap smear	Early detection of cervical cancer
Prostate check (blood test)	M	50+	Pathology	Early detection of prostate cancer
Vitality check • Cholesterol • Blood glucose (sugar) • BMI • Blood pressure	F/M	All	Vitality check	Early detection of chronic illness

* recommended age unless you have specific risk factors

**co-payments may apply in hospital

Department of Health

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

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

*recommended age unless you have specific risk factors

Benefits

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

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital / OH Out of hospital	Comments and co-payments
Alcohol and drug treatment: Admission and medication in SANCA facility (subject to PMB)	Y	21 days	N	SANCA and SANCA approved facilities	IH	If you do not register with SANCA, you may continue using your existing provider, but you will be responsible for the difference between the amount charged and the amount the Scheme would have paid to SANCA
Alcohol and drug treatment: Consultations and medication upon discharge	Y	Overall Out of Hospital Family Limit and Sublimits: Adult R5 500, Child R2 745	N	SANCA and SANCA approved facilities	OH	
Ambulance services: Life-threatening medical emergency transport	Y 082 911		N	Netcare 911	IH OH	Notify Netcare 911 at the time of emergency or the next working day. Authorise inter-hospital transfers before the event. Voluntary use of non-DSP results in 20% co-payment
Cancer treatment: Oncology management programme	Y	Oncology Limit R310 000 per beneficiary, per 12-month period	Y	Oncology facility or accredited hospital	IH OH	100% of SRR for in and out of hospital services subject to protocols. After the depletion of the Oncology Limit, a co-payment of 20% applies. Innovation drugs will incur a co-payment of 20% from commencement of treatment. Post-oncology treatment will be recognised as part of your oncology treatment which needs to be registered separately
Covid-19	N		N	N	IH OH	Due to the changing nature of this benefit, please visit the Scheme website or call the Call Centre for more information.

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital OH Out of hospital	Comments and co-payments
Dental hospitalisation (including medicine and related products): In the case of trauma or patients under the age of 7 years requiring anaesthetic, the removal of impacted molars, maxillo-facial and oral surgery (PMB conditions)	Y		N	Day clinic or Hospital Network	IH	
Dentistry: Basic dental services provided by the DRC network	N	Basic Dental Services Limit per beneficiary: Every 180 days: 1 consultation, 1 scaling, polishing, and fluoride treatment, 2 intra-oral radiographs per visit, 1 local anaesthetic per visit, 4 extractions, 5 restorations (amalgam or resin), one pair of plastic dentures every 4 years incl. 1 relining and repair per year	N	Dental Risk Company (DRC)	OH	Subject to DRC protocols For a list of DRC network providers, call the Call Centre or visit www.angloms.co.za Authorisation required for more than 4 extractions. Authorisation required for more than 5 resin restorations
Dentistry: Basic dentistry provided by non-network provider	N	Limited to basic dental services listed above	N	N	OH	Subject to DRC protocols. Use of non-network provider results in a co-payment (the difference between 80% of SRR and the claimed amount)
Dentistry: Additional basic and specialised dentistry	N	Family Limit: Adult R1 435, Child R360	N	N	IH OH	Limit applies to both, network and non-network providers
Diabetes management programme: Consultation with doctors, dietitians, ophthalmologists, pathology tests, podiatrists, medicine and related products	Y 011 053 4400		Y	CDE§	IH OH	Register on the Diabetes Programme with the Centre for Diabetes and Endocrinology (CDE) to receive medicine, testing equipment and related treatments according to the programme. If you choose not to register with CDE, you may continue using your existing doctor, but you will be responsible for the difference between the SRR and the claimed amount on all diabetic-related services including diabetic-related hospitalisation

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

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

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital OH Out of hospital	Comments and co-payments
Endoscopy: Gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	Y		N	Day clinic or accredited facility	IH OH	No co-payment if performed in a day clinic or an accredited network facility, or in case of emergency treatment. For a list of accredited facilities, call the Call Centre or visit www.angloms.co.za. Co-payment of R3 200 if admitted to hospital specifically for an endoscopy
Eye care: Eye examinations	N	R415 per beneficiary	N	N	OH	
Eye care: Lenses, frames	N	R2 280 per family	N	N	OH	20% discount on frames and eyeglass lenses at optometrists in the Discovery Health Optometry Network
Eye care: Cataract surgery with intra-ocular lens replacement	Y	Intra-ocular lens subject to the Internal Surgical Prostheses Limit	N	Day clinic or accredited facility	IH OH	No co-payment when performed out of hospital. For a list of accredited facilities, please call the Call Centre or visit www.angloms.co.za. Co-payment of R1 000 when performed in hospital
HIV/AIDS: Confidential management programme	Y		Y	N §	OH	Once registered on the HIV/AIDS management programme, members must adhere to Scheme protocols. Your status will at all times remain confidential
HIV/AIDS: Medicines	Y		Y	Dis-Chem Direct	OH	After registration, phone Dis-Chem Direct (011 589 2788) to confirm how you want to receive your medication
Hospice: Instead of hospitalisation (in-patient care facility and out-patient home care)	Y		N		IH OH	Subject to Scheme protocols

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

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

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital OH Out of hospital	Comments and co-payments
Hospitalisation: Hospital services including allied healthcare services (as determined by the Scheme), day cases, blood transfusions, radiology, pathology, professional services and 7 day supply of to-take-out medication	Y	Unlimited	N	Hospital Network	IH	Hospital services covered in network hospitals. Co-payment of R3 200 for voluntary admission to a non-network hospital. No co-payment if medical emergency. List of hospitals available from the Call Centre or Scheme website. Authorisation procedure, see page 25. Subject to Scheme protocols
Hospitalisation: Internal surgical prostheses	Y	R68 470 per beneficiary	N	N	IH	
Hospitalisation: Step-down instead of hospitalisation	Y		N	N	OH	Subject to Scheme protocols
Hospitalisation: Professional services for a defined list of minor procedures performed by specialists in doctor's rooms instead of hospital	Y		N	N	OH	
Hospitalisation: Psychiatric admission	Y	21 days	N	Accredited facility or Hospital Network	IH	Co-payment of R3 200 per admission for voluntary admission to a non-network hospital. Authorisation procedure, see page 25. Subject to Scheme protocols
Infertility: Treatment subject to PMB	Y		N	N §	IH OH	
Kidney (renal) disease management programme: Dialysis (haemo or peritoneal)	Y		Y	N	IH OH	Subject to Scheme protocols
Maternity management programme: Consultations and ultrasound scans	Y	8 consultations, 2 ultrasound scans (2D) per pregnancy	N	N	IH OH	Register between weeks 12 and 20 of the pregnancy to qualify for benefits

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

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

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital OH Out of hospital	Comments and co-payments
Maternity: Confinement	Y		N	Hospital Network	IH	Confinement in network hospital or in a low-risk maternity unit provided by a registered midwife if preferred. Co-payment of R3 200 for voluntary admission to a non-network hospital. No co-payment if medical emergency
Medical appliances: External appliances provided by orthotists and prosthetists	Y	Medical and Surgical Appliance Family Limit: R9 795	N	Discovery Health network of orthotists and prosthetists	OH	Authorisation required for appliances over R3 000 each. You are responsible for the difference in cost when using a non-DSP
Medical appliances: External appliances provided by providers other than orthotists and prosthetists	Y	Medical and Surgical Appliance Family Limit	N	N	IH OH	Authorisation required for appliances over R3 000 each, paid at network rate
Medical appliances: Hearing aids (1 pair every 2 years per beneficiary)	Y	Medical and Surgical Appliance Family Limit	N	N	OH	Clinical motivation by ENT required for beneficiaries younger than 60 years
Medical appliances: Wheelchair (1 wheelchair every 2 years per beneficiary)	Y	Medical and Surgical Appliance Family Limit	N	N	OH	

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

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

PMB chronic conditions[§]

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

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

§ when recognised as chronic according to Scheme protocol

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital OH Out of hospital	Comments and co-payments
Medicine management programme: Chronic conditions (non-PMB)	Y	R4 740 per beneficiary	N	N	OH	One month's supply at a time. 100% of SEP and dispensing fee, subject to the Medicine Reference Price List. Generic medicine, where appropriate, will prevent co-payments. Check generic alternatives and co-payments on www.angloms.co.za > My Plan > SCP > Medicine. Subject to Scheme protocols. Registration by pharmacist or doctor

Non-PMB chronic conditions§

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

Organ transplant: Harvesting of the organ, post-operative care of the member and the donor and anti-rejection medicine	Y		Y	N	IH OH	In accordance with the organ transplant management programme. All costs for organ donations for any person other than a member or registered dependant of the Scheme are excluded

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

§ when recognised as chronic according to Scheme protocol

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital OH Out of hospital	Comments and co-payments
Out of hospital services (non-PMB): Including consultations, visits, procedures, alternative and allied healthcare services, acute medicine and Pharmacist Advised Therapy (PAT)	N	Overall Out of Hospital Family Limit: Adult R5 500 Child R2 745	N	N	OH	Sublimits to Overall Limit: Sublimit 1: Alternative and allied healthcare services. Sublimit 2: Consultations, acute medicine out of hospital and PAT. The two OH sublimits do not add up, to allow member benefit flexibility within the overall OH Limit
Sublimit 1 **Alternative and allied healthcare services** Acupuncture, audiology, chiropody, chiropractic services (including x-rays), dietetics, homeopathy, naturopathy, occupational therapy, orthoptics, physiotherapy, podiatry, psychology, registered nurse services, social services, speech therapy	N	Family Limit for alternative and allied healthcare: Adult R3 550, Child R745 and Overall Out of Hospital Family Limit	N	N	OH	Family Limit also includes homeopathic, NAPPI coded compounded medicine, dispensed by a registered homeopath
Orthotists and prosthetists consultations	N		N	Discovery Health network of orthotists and prosthetists	OH	
Private nursing instead of hospitalisation	Y		N	N	OH	
Sublimit 2		Family Limit for consultations, acute medicine and PAT Adult R5 165, Child R2 580 and Overall Out of Hospital Family Limit				
GP and specialist in rooms (non-PMB), consultations, visits, procedures and treatments in rooms and acute medicine and injection material relevant to the treatmentl	N		N	N	OH	
Medicine: NAPPI coded acute medicine and injection material prescribed or dispensed by a registered homeopath, GP, specialist or dispensed by a pharmacy	N		N	N	OH	
PAT medicine: R115 per purchase, 5 purchases per family every 3 months	N		N	N	OH	
Out of hospital services (PMB): Specialist and GP consultations for chronic PMB conditions	N		N	N	OH	Subject to Scheme protocols and registration of chronic condition (registration on management programme required for cancer, renal, HIV and diabetes)

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital OH Out of hospital	Comments and co-payments
Oxygen therapy management programme: At home, cylinder, concentrator (rental only) and consumables	Y		N	VitalAire	OH	Subject to the Scheme clinical entry criteria. You are responsible for the difference in cost when using a non-DSP
Pathology: Out of hospital chronic disease conditions (PMB)	N		N	N	OH	Subject to Scheme protocols and registration of the chronic condition
Pathology: Pap smear/prostate check	N		N	N	IH OH	Cervical cancer screening: beneficiaries from 21-65 years, one pap smear test. Prostate screening: one PSA test
Pathology: In hospital	N		N	N	IH	
Pathology: Out of hospital (non-PMB)	N	Family Limit Adult R1 395, Child R500	N	N	OH	The Scheme will not pay for DNA testing and investigations, including genetic testing for familial cancers and paternal testing
Radiology: In hospital	N		N	N	IH	
Radiology: Out of hospital, x-rays (non-PMB)	N	Family Limit Adult R1 820, Child R1 100	N	N	OH	
Radiology: Specialised radiology, isotope therapy, MRI and CT scans, bone densitometry and mammogram	Y		N	N	IH OH	Referral required. 1 scan for bone densitometry per beneficiary

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	IH In hospital OH Out of hospital	Comments and co-payments
Specialised medicine and technology: This benefit applies to a specified list of specialised medicine (excluding oncology medicine) in excess of R5 000 per month and specialised technology in excess of R5 000 per item as a once-off purchase	Y		N	N	IH OH	Paid at 80% of SRR, subject to Scheme protocols. 20% to be paid as co-payment by member
Vaccine: Covid-19	N	Frequency of vaccine(s) and administration according to DoH# guideline.	N	N	OH	
Vaccine: Influenza (Flu)	N	1 vaccine and 1 consultation per beneficiary	N	N	OH	Recommended for high-risk patients (chronic conditions, HIV patients, pregnant or ageing members)
Vaccine: Pneumococcal	N	1 vaccine and 1 consultation per beneficiary over the age of 55 per lifetime	N	N	OH	Recommended for high-risk patients (chronic conditions, HIV patients or ageing members)
Vaccine: Human Papillomavirus (HPV)	N	1 lifetime vaccination per beneficiary	N	N	OH	For beneficiaries from age 9-26, unless motivated by your doctor
Vitality check: Cholesterol, blood glucose, BMI, blood pressure	N	1 per beneficiary per year	N	N	OH	Vitality check done at Vitality Wellness network partners

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

#Department of Health

Ex gratia

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

These cases will be considered on the basis of financial hardship and/or in cases of exceptional clinical circumstances. Decisions do not set precedent or determine future policy as each case is dealt with on its own merits.

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

Submit the completed application form:
Email: **ex-gratia@angloms.co.za** or
Fax: **011 539 1021** or
Post: **The Ex Gratia Department, P.O. Box 746, Rivonia 2128**

Upon approval, submit your claims:
Email: **ex-gratiaclaims@angloms.co.za** or
Fax: **011 539 1021** or
Post: **Anglo Medical Scheme, P.O. Box 746, Rivonia 2128**

General exclusions

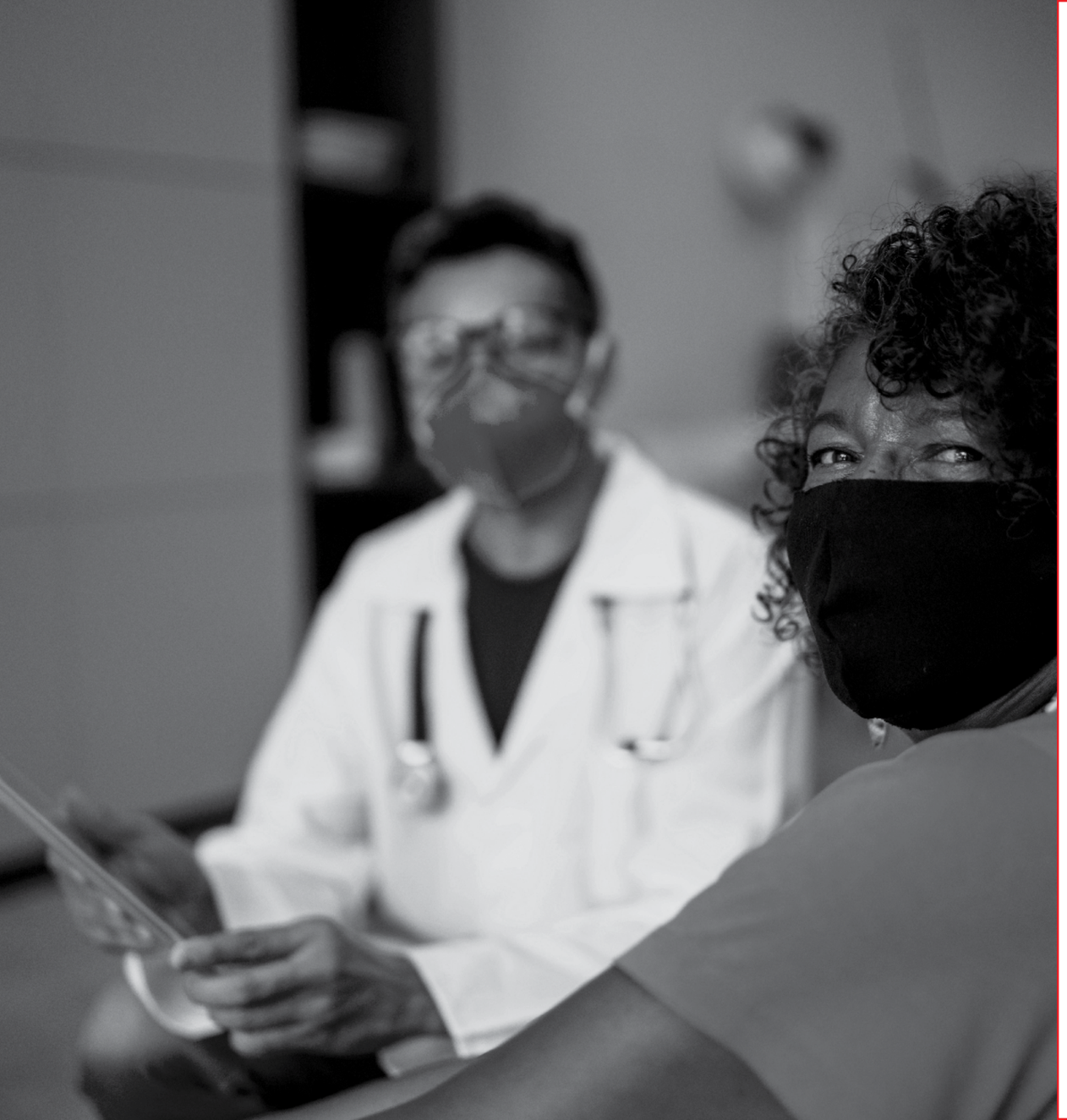
The following are some of the Scheme exclusions (for a full list please refer to the Rules). These you would need to pay:

- Services rendered by any person who is not registered to provide healthcare services, as well as medicine that have been prescribed by someone who is not registered to prescribe
- Experimental or unproven services, treatments, devices or pharmacological regimes
- Patent and proprietary medicines and foods, including anabolic steroids, baby food and baby milk, mineral and nutritional supplements, tonics and vitamins except where clinically indicated in the Scheme's managed care protocols
- Cosmetic operations, treatments and procedures, cosmetic and toiletry preparations, medicated or otherwise
- Obesity treatment, including slimming preparations and appetite suppressants
- Examinations for insurance, school camps, visas, employment or similar
- Holidays for recuperative purposes, regardless of medical necessity
- Interest or legal fees relating to overdue medical accounts
- Stale claims, which are claims submitted more than four months after the date of treatment
- Claims for appointments that a member fails to keep
- Costs that exceed any annual maximum benefit and costs that exceed any specified limit to the benefits to which members are entitled in terms of the Rules

- All costs related to:
  - Anaesthetic and hospital services for dental work (except in the case of trauma (PMB), patients under the age of seven years and the removal of impacted third molars)
  - Bandages, dressings, syringes (other than for diabetics) and instruments
  - Lens preparations
  - DNA testing and investigations, including genetic testing for familial cancers and paternal testing
  - Gum guards, gold in dentures and in crowns, inlays and bridges
  - Immunoglobulins except where clinically indicated against the Scheme's protocols
  - In vitro fertilisation, including GIFT and ZIFT procedures, and infertility treatments which are not PMBs
  - Organ donations to any person other than to a member or registered dependant
  - Wilful self-inflicted injuries

General Rule reminders

- This Benefit Guide is a summary of the 2022 AMS benefits, pending approval from the Council for Medical Schemes
- Please refer to **www.angloms.co.za** (My Scheme, Scheme Rules) for the full set of registered Rules
- The Anglo Medical Scheme Rules are binding on all beneficiaries, officers of the Scheme and on the Scheme itself
- The member, by joining the Scheme, consents on his or her own behalf and on behalf of any registered dependants, that the Scheme may disclose any medical information to the administrators and contracted third-parties for reporting or managed care purposes
- A registered dependant can be a member's spouse or partner, a biological or stepchild, legally adopted child, grandchild or immediate family relation (first-degree blood relation) who is dependent on the member for family care and support
- To avoid underwriting, a member who gets married must register his or her spouse as a dependant within 30 days of the marriage. Newborn child dependants must be registered within 30 days of birth to ensure benefits from the date of birth
- If your dependant reaches the age of 23 and you wish to keep him or her on the Scheme as an adult dependant, you may apply for continuation of membership
- It is the member's or dependant's responsibility to notify the Scheme of any material changes, such as marital status, banking details, home address or any other contact details and death of a member or dependant



Managed Care Plan

Managed Care Plan offers the following comprehensive benefits:

- Unlimited **hospital cover** paid at 100% of the Scheme Reimbursement Rate (SRR)
- The **Top-Up** rate pays up to a maximum of 230% of the SRR for specialist services in hospital, excluding pathology, radiology, allied healthcare services and GPs performing specialist services (230% = 100% of SRR + additional 130% of SRR)
- A **Medical Savings Account** for out of hospital services and discretionary spend
- Unlimited Radiology and Pathology
- Frail care where clinically required
- Extensive chronic medication
- Voluntary use of a GP network (no co-payments)
- Reimbursement for specialist consultations and procedures out of hospital up to 125% of SRR

Contributions are split as follows:

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

Contributions*		
Excluding Savings **Main member: R4 305** **Adult dependant: R4 305** **Child dependant: R995**	**Savings** **Main member: R1 145** **Adult dependant: R1 145** **Child dependant: R265**	**Total contributions** **Main member: R5 450** **Adult dependant: R5 450** **Child dependant: R1 260**

* Subject to underwriting

Managed Care Plan Limits unless PMB

EXAMPLE

How to calculate your Family Limit

Adult R1 000 x 2 = R2 000

\+

Child R200 x 1 = R200

Family Limit R2 200

Use the combined available limit for one or more family members

IH

General Hospital Services, Radiology and Pathology	Unlimited at 100% of SRR
+	
Internal surgical prostheses	R145 235 per beneficiary
+	
Top-Up rate	Up to a maximum of 230% of SRR. Excludes pathology, radiology and allied healthcare services in hospital

OH

Medical Savings Account	Discretionary spend for out of hospital services and costs in excess of Limits below
+	
Dentistry Family Limit	Adult R3 970 Child R1 500
+	
Radiology	Unlimited
+	
Pathology	Unlimited
+	
Medical and surgical appliances	R16 610 per family
+	
Wheelchair	Every 2 years R26 140 per beneficiary
+	
Hearing Aids	Every 2 years R41 800 per pair per beneficiary
+	
Chronic medication (non-PMB)	R18 300 per beneficiary
+	
Frail care	R73 040 per beneficiary

Specialised medicine and technology: Unlimited

Medical Savings Account

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

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

Charges above SRR (excluding PMBs), can be considered for payment from your MSA. This is a once-off instruction. Members may request reimbursement for Scheme exclusions (which will be assessed based on clinical appropriateness) or non-PMB chronic medication co-payments, or costs in excess of annual benefits from their available MSA. The Scheme needs to be instructed in every instance.

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

Any unspent savings belong to you and roll over to the next year. Positive savings carried forward from previous years allow you to build up a healthy savings balance for a time when you need extra medical cover.

How it works

To call an ambulance

Phone our Designated Service Provider (DSP) **Netcare 911** on **082 911**. If deemed an emergency, Netcare 911 will authorise a road or air ambulance. If deemed a non-emergency, or services regarded as "home assessments" without transport to a casualty or hospital, you will be liable for the full cost. In a medical emergency where authorisation was not obtained, you need to provide details to Netcare 911 the next working day after the incident.

Voluntary use of a non-DSP results in a 20% co-payment.

To obtain authorisation

Procedures, treatments, hospitalisation, external medical or surgical appliances, specialised radiology

To access benefits and to ensure they are available and correctly paid, call **0860 222 633** to get authorisation for procedures, treatments, hospitalisation, specialised radiology, internal surgical prostheses and external medical appliances exceeding R3 000, before the event as indicated in the benefit table. Elective admissions need to be authorised 48 hours before the event. Emergency admissions require authorisation the next working day after the event.

Information required when calling for authorisation:

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

The authorisation number must be quoted on admission. It will be valid for a period of four months or until the end of the year, whichever comes first. Please phone **0860 222 633** if any of the details change such as the date of operation, code, etc. If the admission is postponed or not taken up before it becomes invalid, a new authorisation number will need to be obtained.

Chronic medicine

If you are diagnosed with a chronic condition (PMB or non-PMB), ask your doctor or pharmacist to register the chronic condition by calling **0860 222 633.**

We will then pay for your medicine from the relevant chronic medicine benefit and not from your day-to-day benefits.

Diabetes, HIV/AIDS and oxygen therapy management

Register on the programme to ensure maximum benefits:

- Diabetes – call the Centre for Diabetes and Endocrinology (CDE) on **011 053 4400**
- HIV/AIDS management – call **0860 222 633**
- Oxygen therapy management – call **0860 222 633** to receive services from VitalAire

To reduce your medicine costs

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

To claim

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

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

Send your completed claim to:

Email: **claims@angloms.co.za**
Post: **Anglo Medical Scheme, PO Box 746, Rivonia, 2128**
Call: **0860 222 633 for further assistance**
Upload: **www.angloms.co.za after logging in as a member or upload on the Anglo Medical Scheme App**

We can only process your claims if all details are legible. Fax submissions are therefore not recommended. If you still prefer to fax the claims, please send them to **011 539 1008**.

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

You or your service provider have up to four months from the treatment date to submit a claim for payment. After four months, it will be considered 'stale' and the Scheme will no longer be responsible for payment.

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

After submission of your claim, the Scheme will:

- Notify you by SMS or email once your claim has been processed (if you have subscribed to this service)
- Pay all amounts according to the Scheme Rules and at the Scheme Reimbursement Rate (SRR)
- Pay this amount directly into your bank account (or the provider's account)
- Send you a statement by email or post showing amounts paid, to whom, rejections and amounts for you to settle

Your responsibility

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

International claims

Emergency and acute medical treatment received when travelling or residing overseas

The Scheme will consider, in accordance with the Rules and necessary authorisations, making a payment towards your overseas healthcare cost.

- The Scheme will not pay a doctor or service provider outside RSA borders directly. You must pay for the services at the time of the treatment and the Scheme may refund you
- If you are entitled to benefits from another insurer you must claim from that insurer first. Any shortfall or uncovered cost may be submitted to the Scheme, which will be considered based on your benefit entitlements and the Scheme Rules
- Complete the international claim form and submit a fully specified account, in English, with your proof of payment to the Scheme
- The account must give details of the service rendered and the relevant healthcare provider
- Any payment made towards the cost of a claim will be made in South African Rands into your South African bank account. The amount paid will be at the SRR had the service been obtained in South Africa in the Scheme's absolute discretion. If the service is not available in South Africa the amount paid will be for a similar or equivalent service if it exists. Remember that, except in the case of a medical emergency, the normal authorisation procedure needs to be followed before undergoing any routine or specialised treatment overseas

Repatriation and social transfers will not be covered. We suggest you take out adequate medical travel insurance to cover any major medical emergency.

Chronic medicine advanced supply

For an advanced supply of chronic medicine, please submit:

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

The Scheme will only approve advanced supplies within the current benefit year.
Call **0860 222 633** for further assistance.

GP network

You can choose to consult with a GP on the Discovery Health GP network. Claims for consultations will be submitted directly to the Scheme and be paid from available funds in your MSA or by the Scheme if PMB. The amount the GP will claim for a consultation is a fixed rate, as agreed between Discovery Health and the network GP. This rate will be available from the Call Centre on **0860 222 633.** Before changing to a network GP, compare your current doctor's rate to the network rate. In some instances the network rate might be higher.

Your network GP may also perform certain procedures (as per the network agreement) which will be submitted directly to the Scheme and be paid from available funds in your MSA or by the Scheme. To confirm funding, please call the Call Centre with the specific code for the procedure that your network GP needs to perform. Your network GP will not ask you for payment upfront, nor charge you a co-payment for consultations and most procedures unless your benefits have been exhausted. If the network GP performs a procedure not agreed with the administrator, or uses medicines or materials that are charged above the Scheme Reimbursement Rate (SRR), there may be a co-payment. Choosing to consult a GP on this network is voluntary.

You can find the nearest participating GP using the 'provider search tool' on **www.angloms.co.za,** after logging in as a member, or by calling the Call Centre.

If you choose to use a GP that is not on the network, the Scheme will reimburse your consultations and procedures at the normal SRR.

Preventative Care Benefits

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

Description	Sex	Age*	Benefit Category	Purpose
Bone density scan	F	65+	Specialised Radiology	Detection of osteopaenia or osteoporosis (fragile bones)
Colonoscopy	F/M	50+	Endoscopy**	Early detection of colorectal or colon cancer
HIV test	F/M	All	Pathology	Early detection of HIV/AIDS
Immunisation Covid-19 Vaccine	F/M	as per DoH# schedule	Vaccines	Prevention of severe illness and death
Flu Vaccine	F/M	All	Vaccines	Influenza prevention; particularly important for people who are at risk of serious complications from influenza (chronic conditions, pregnant, HIV patients or ageing members)
Human Papillomavirus (HPV): Cervarix/Gardasil	F/M	9-26	Vaccines	Prevention of cervical cancer caused by HPV
Pneumococcal Vaccine	F/M	55+	Vaccines	Prevention of serious lung infections; particularly important for people who are at high risk for serious complications (chronic conditions, HIV patients or ageing members)
Mammogram	F	40+	Specialised Radiology	Early detection of breast cancer
Maternity Consultation	F		Maternity	Monitoring of your pregnancy and prevention of complications
Ultrasound	F		Maternity	
Pap smear	F	21-65	Pathology	Early detection of cervical cancer
Pathology screening • Cholesterol • Glucose • Thyroid • Cancer (Stool test)	F/M	 All All All 50+	Pathology	Early detection of chronic illness or cancer
Prostate check (blood test)	M	50+	Pathology	Early detection of prostate cancer
Stool test (cancer and other screening)	F/M	50+	Pathology	Detection of cancer and other diseases
Vitality check • Cholesterol • Blood glucose (sugar) • BMI • Blood pressure	F/M	All	Vitality check	Early detection of chronic illness

* recommended age unless you have specific risk factors

** co-payments may apply in hospital

Department of Health

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

Refer to the benefit table for more detail.

Description	Sex	Age*	Paid from	Purpose
Eyesight check Including Glaucoma screening	F/M	40+	Member Savings	Early detection of eye disease or deterioration
Dental check-up	F/M	All	Dental Benefit or Member Savings	Early detection of dental disease and preservation of dentine
Gynaecological check-up	F	All	Member Savings	Early detection of cancer and gynaecological problems
Hearing test	F/M	All	Member Savings	Early detection of medical conditions and hearing dysfunction
Immunisation children As recommended by the Department of Health, GP or paediatrician	F/M	As per schedule	Member Savings	Prevention and reduction of complications of childhood diseases
Baby and child Paediatric assessment	F/M	Baby/ Child	Member Savings	Early detection of developmental problems
Prostate check-up (examination)	M	50+	Member Savings	Early detection of prostate cancer
Senior members Home nursing assessment on Doctor or Scheme request	F/M	65+	Member Savings	Detection of complications or mobility problems negatively impacting on wellbeing or illness
Podiatry care	F/M	All	Member Savings	
Skin health	F/M	All	Member Savings	Detection of skin cancer

* recommended age unless you have specific risk factors

Benefits

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

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital / OH Out of hospital	Comments and co-payments
Alcohol and drug treatment: Admission and medication in SANCA facility (subject to PMB)	Y	21 days	N	SANCA and SANCA approved facilities	Scheme to pay up to limit	IH	If you do not register with SANCA, you may continue using your existing provider, but you will be responsible for the difference between the amount charged and the amount the Scheme would have paid to SANCA
Alcohol and drug treatment: Consultations and medication upon discharge	Y	Available savings	N	SANCA and SANCA approved facilities	Member savings	OH	
Alternative and allied healthcare: Audiology, acupuncture, chiropody, chiropractic services, (including x-rays), dietitians, homeopathy, naturopathy, occupational therapy, orthoptics, physiotherapy, podiatry, psychology, registered nurse services, social services, speech therapy	N	Available savings	N	N	Member savings	OH	
Ambulance services: Life-threatening medical emergency transport	Y 082 911		N	Netcare 911	Scheme to pay	IH OH	Notify Netcare 911 at the time of emergency or the next working day. Authorise inter-hospital transfers before the event. Voluntary use of non-DSP results in a 20% co-payment
Allied healthcare services: Orthotists and prosthetists (consultations)	N	Available savings	N	Discovery Health network of orthotists and prothetists	Member savings	IH OH	

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital OH Out of hospital	Comments and co-payments
Cancer treatment: Oncology Management Programme	Y		Y	N	Scheme to pay if PMB	IH OH	100% of SRR and Single Exit Price (SEP) for medicines. Subject to treatment protocols for chemo and radiation therapy. Drug therapies used for chemotherapy side effects and pain relief must be authorised. Post-oncology treatment will be recognised as part of your oncology treatment which need to be registered separately
Consultations out of hospital: Specialist and GP for chronic PMB conditions	N		N	N	Scheme to pay	OH	Subject to Scheme protocols and registration of chronic condition (registration on management programme required for cancer, renal, HIV and diabetes)
Consultations out of hospital: GP for treatment of general conditions and minor procedures	N	Available savings	N	N	Member savings	OH	Paid at SRR. Cost in excess of SRR can be paid from available savings upon special request
Consultations out of hospital: GP for treatment of general conditions and minor procedures (GP within the Discovery Health GP network)	N	Available savings	N	Voluntary GP network	Member savings	OH	Network rate for consultations and a defined list of procedures, paid directly by the Scheme, no co-payment, see page 60
Consultations out of hospital: Specialist for treatment of general conditions and minor procedures (excluding radiologists and pathologists)	N	Available savings	N	N	Member savings	OH	Up to 125% of SRR
Covid-19	N		N	N	Scheme to pay	IH OH	Due to the changing nature of this benefit, please visit the Scheme website or call the Call Centre for more information
Dental hospitalisation (including medicine and related products): In the case of trauma or patients under the age of 7 years requiring anaesthetic, the removal of impacted molars, maxillo-facial and oral surgery (PMB conditions)	Y		N	N	Scheme to pay	IH	Top-Up rate up to 230% of SRR for specialist services or in full if PMB
Dentistry: Conservative treatments including fillings, x-rays, extractions and oral hygiene. Specialised treatments including crowns, bridges, inlays, study models, dentures, orthodontics, osseo-integrated implants or similar tooth implants and periodontics	N	Family Limit Adult R3 970 Child R1 500	N	N	Scheme to pay up to limit	IH OH	Cost above SRR may be paid from your available MSA upon instruction. Once dental benefit is depleted, payment will be allocated to available MSA. Up to 125% of SRR for non-PMB specialised dental services, performed by dental specialist

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital OH Out of hospital	Comments and co-payments
Diabetes management programme: Consultation with doctors, dietitians, ophthalmologists, pathology tests, podiatrists, medicine and related products	Y 011 053 4400		Y	CDE	CDE to pay	IH OH	Register on the Diabetes Programme with the Centre for Diabetes and Endocrinology (CDE) to receive medicines, testing equipment and related treatments according to the programme. If you choose not to register with CDE, you may continue using your existing doctor, but you will be liable for the difference between SRR and the claimed amount on all the diabetic-related services including diabetic-related hospitalisation
Endoscopy: Gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	Y		N	Day clinic or accredited facility	Scheme to pay	IH OH	No co-payment if performed in a day clinic or an accredited network facility or in case of emergency treatment. For a list of accredited facilities, please call the Call Centre or visit www.angloms.co.za. Co-payment of R3 200 if admitted to hospital specifically for an endoscopy. Top-Up rate up to 230% of SRR for specialist services or in full if PMB
Eye care: Eye examinations, lenses, frames and contact lenses	N	Available savings	N	N	Member savings	OH	100% of cost. 20% discount on frames and eyeglass lenses at optometrists in the Discovery Health Optometry Network
Eye care: Cataract surgery with intra-ocular lens replacement	Y	Intra-ocular lens subject to the Internal Surgical Prostheses Limit	N	Day clinic or accredited facility	Scheme to pay	IH OH	No co-payment when performed out of hospital. For a list of accredited facilities, please call the Call Centre or visit www.angloms.co.za. Co-payment of R1 000 when performed in hospital. Top-Up rate up to 230% of SRR for specialist services or in full if PMB
Frail care: Medically related frail care services where clinically appropriate	Y	R73 040 per beneficiary	N	N	Scheme to pay from limit	OH	According to Scheme protocols. Only registered facilities or services provided at home supervised by a registered Nursing Practitioner. The benefit will not be advanced for the year, but paid monthly against the SRR
Hearing aids (1 pair every 2 years)	Y	R20 900 per hearing aid per beneficiary every 2 years	N	N	Scheme to pay up to limit	OH	Clinical motivation by ENT required for beneficiaries younger than 60 years

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital OH Out of hospital	Comments and co-payments
HIV/AIDS: Confidential management programme	Y		Y	N	Scheme to pay	OH	Once registered on the HIV/AIDS management programme, members must adhere to Scheme protocols. Your status will at all times remain confidential
HIV/AIDS: Medicines	Y		Y	Dis-Chem Direct	Scheme to pay	OH	After registration, phone Dis-Chem Direct (011 589 2788) to confirm how you want to receive your medication
Hospice: Instead of hospitalisation (in-patient care facility and out-patient home care)	Y		N		Scheme to pay	IH OH	Subject to Scheme protocols
Hospitalisation: Hospital services including allied healthcare services (as determined by the Scheme), day cases, blood transfusions, radiology, pathology, professional services and 7 day supply of to-take-out medication	Y		N	N	Scheme to pay	IH	Co-payment of R410 per day, to a maximum of R1 230 per admission for non-PMB conditions. Top-Up rate up to 230% of SRR for specialist services (excluding pathology and radiology) or in full if PMB. Authorisation procedure, see page 60. Subject to Scheme protocols
Hospitalisation: Internal surgical prostheses	Y	R145 235 per beneficiary	N	N	Scheme to pay up to limit	IH	
Hospitalisation: Professional services for minor procedures performed by specialists in doctor's rooms instead of hospital	Y		N	N	Scheme to pay	OH	Subject to Scheme protocols and a defined list of procedures
Hospitalisation: Step-down and private nursing instead of hospitalisation	Y		N	N	Scheme to pay	OH	Subject to Scheme protocols
Hospitalisation: Psychiatric admission	Y	21 days	N	N	Scheme to pay up to limit	IH	
Infertility: Treatment subject to PMB	Y		N	N	Scheme to pay	IH OH	
Kidney (renal) disease management programme: Dialysis (haemo or peritoneal)	Y		Y	N	Scheme to pay	IH OH	Subject to Scheme protocols

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital OH Out of hospital	Comments and co-payments
Maternity management programme: Consultations and ultrasound scans	Y	12 consultations, 2 ultrasound scans (2D) per pregnancy	N	N	Scheme to pay up to limit	IH OH	Register between weeks 12 and 20 of the pregnancy to qualify for benefits
Maternity: Confinement	Y		N	N	Scheme to pay	IH OH	Confinement in hospital or in a low-risk maternity unit provided by a registered midwife if preferred
Medical appliances: External appliances provided by orthotists and prosthetists	Y	Medical and Surgical Appliance Family Limit: R16 610 per family	N	Discovery Health network of orthotists and prosthetists	Scheme to pay up to limit	IH OH	Authorisation required for appliances over R3 000 each. You are responsible for the difference in cost when using a non-DSP
Medical appliances: External appliances provided by providers other than orthotists and prosthetists	Y	Medical and Surgical Appliance Family Limit: R16 610 per family	N	N	Scheme to pay up to limit	IH OH	Authorisation required for appliances over R3 000 each paid at network rate
Medicines: Acute medicine and injection material, homeopathic and PAT medicine	N	Available savings	N	N	Member savings	OH	100% of SEP and dispensing fee

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

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

PMB chronic conditions[§]

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

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

§ when recognised as chronic according to Scheme protocol

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital / OH Out of hospital	Comments and co-payments
Medicine management programme: Chronic conditions (non-PMB)	Y	R18 300 per beneficiary	N	N	Scheme to pay up to limit	OH	One month's supply at a time, 100% of SEP and dispensing fee, subject to the Medicine Reference Price List. Generic medicine, where appropriate, will prevent co-payments. Check generic alternatives and co-payments on www.angloms.co.za > My Plan > MCP > Medicine. Subject to Scheme protocols. Registration by pharmacist or doctor
Non-PMB chronic conditions[§]							
Acne	Degeneration of the Macula						
Allergy Management	Depression						
Alzheimer's Disease	Diverticulitis						
Anaemia	Fibrous Dysplasia						
Ankylosing Spondylitis	Gastro-oesophageal Reflux Disease (GORD)						
Anxiety Disorder	Gout (chronic)						
Atopic Dermatitis (Eczema)	Hidradenitis Suppurativa						
Attention Deficit Disorder	Huntington's Disease						
Auto-immune Disorders	Liver Disease						
Benign Prostatic Hyperplasia	Ménière's Disease						
Cystic Fibrosis	Migraine						
Cystitis (chronic)	Motor Neuron Disease						
Muscular Dystrophy and other inherited myopathies	Psoriasis						
Myasthenia Gravis	Pulmonary Embolism						
Narcolepsy	Pulmonary Interstitial Fibrosis						
Obsessive Compulsive Disorder	Restless Leg Syndrome						
Osteoarthritis	Sarcoidosis						
Osteopaenia	Systemic Sclerosis						
Osteoporosis	Tourette's Syndrome						
Other Venous Embolism and Thrombosis	Trigeminal Neuralgia						
Paget's Disease	Urinary Calculi						
Pancreatic Disease	Urinary Incontinence						
Peptic Ulcer							
Polymyositis							
Polyneuropathy							
Organ transplant management programme: Harvesting of the organ, post-operative care of the member and the donor and anti-rejection medicine	Y		Y	N	Scheme to pay	IH OH	In accordance with the organ transplant management programme. All costs for organ donations for any person other than a member or registered dependant of the Scheme are excluded

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

§ when recognised as chronic according to Scheme protocol

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital OH Out of hospital	Comments and co-payments
Oxygen therapy management programme: At home, cylinder, concentrator (rental only) and consumables	Y		N	VitalAire	Scheme to pay	OH	Subject to the Scheme clinical entry criteria. You are responsible for the difference in cost when using a non-DSP
Pathology: Chronic disease conditions (PMB)	N		N	N	Scheme to pay	IH OH	Subject to Scheme protocols and registration of the chronic condition
Pathology: Out of hospital (non-PMB)	N		N	N	Scheme to pay	OH	The Scheme will not pay for DNA testing and investigations, including genetic testing for familial cancers and paternal testing. Members may claim these from their savings
Pathology: Pap smear/prostate check	N		N	N	Scheme to pay	IH OH	Cervical cancer screening: beneficiaries from 21-65 years, one pap smear test. Prostate screening: one PSA test
Radiology: General services	N		N	N	Scheme to pay	IH OH	
Specialised Radiology: MRI, CT scan and isotope therapy, bone densitometry and mammogram	Y		N	N	Scheme to pay	IH OH	Referral required. 1 scan for bone densitometry per beneficiary
Specialised medicine and technology: This benefit applies to specialised medicine (excluding oncology medicine) in excess of R5 000 per month and specialised technology in excess of R5 000 per item	Y		N	N	Scheme to pay	IH OH	
Vaccine: Covid-19	N	Frequency of vaccine(s) and administration according to DoH# guidelines	N	N	Scheme to pay	OH	
Vaccine: Influenza (Flu)	N		N	N	Scheme to pay	OH	1 vaccine and 1 consultation per beneficiary. Recommended for high-risk patients (chronic conditions, HIV patients, pregnant or ageing members)
Vaccine: Pneumococcal	N	1 lifetime vaccination per beneficiary	N	N	Scheme to pay	OH	1 vaccine and 1 consultation per beneficiary over the age of 55 per lifetime. Recommended for high-risk patients (chronic conditions, HIV patients or ageing members)

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

Department of Health

What you are entitled to (per annum)	Is authorisation required? 0860 222 633**	Limit***	Is programme registration required?	Designated service provider (DSP)	Savings or scheme account	IH In hospital OH Out of hospital	Comments and co-payments
Vaccine: Human Papillomavirus (HPV)	N	1 lifetime vaccination per beneficiary	N	N	Scheme to pay	OH	For beneficiaries from age 9-26, unless motivated by your doctor
Vitality check: Cholesterol, Blood Glucose, BMI, Blood Pressure	N		N	N	Scheme to pay	OH	1 per beneficiary per year. Vitality check done at Vitality Wellness network partners
Wheelchair (1 wheelchair every 2 years)	Y	R26 140 per beneficiary	N	N	Scheme to pay	OH	

* Scheme Reimbursement Rate and Tariffs available from the Call Centre

** unless otherwise specified

*** PMB rules apply

Ex gratia

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

These cases will be considered on the basis of financial hardship and/or in cases of exceptional clinical circumstances. Decisions do not set precedent or determine future policy as each case is dealt with on its own merits.

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

Submit the completed application form:
Email: **ex-gratia@angloms.co.za** or
Fax: **011 539 1021** or
Post: **The Ex Gratia Department, P.O. Box 746, Rivonia 2128**

Upon approval, submit your claims:
Email: **ex-gratiaclaims@angloms.co.za** or
Fax: **011 539 1021** or
Post: **Anglo Medical Scheme, P.O. Box 746, Rivonia 2128**

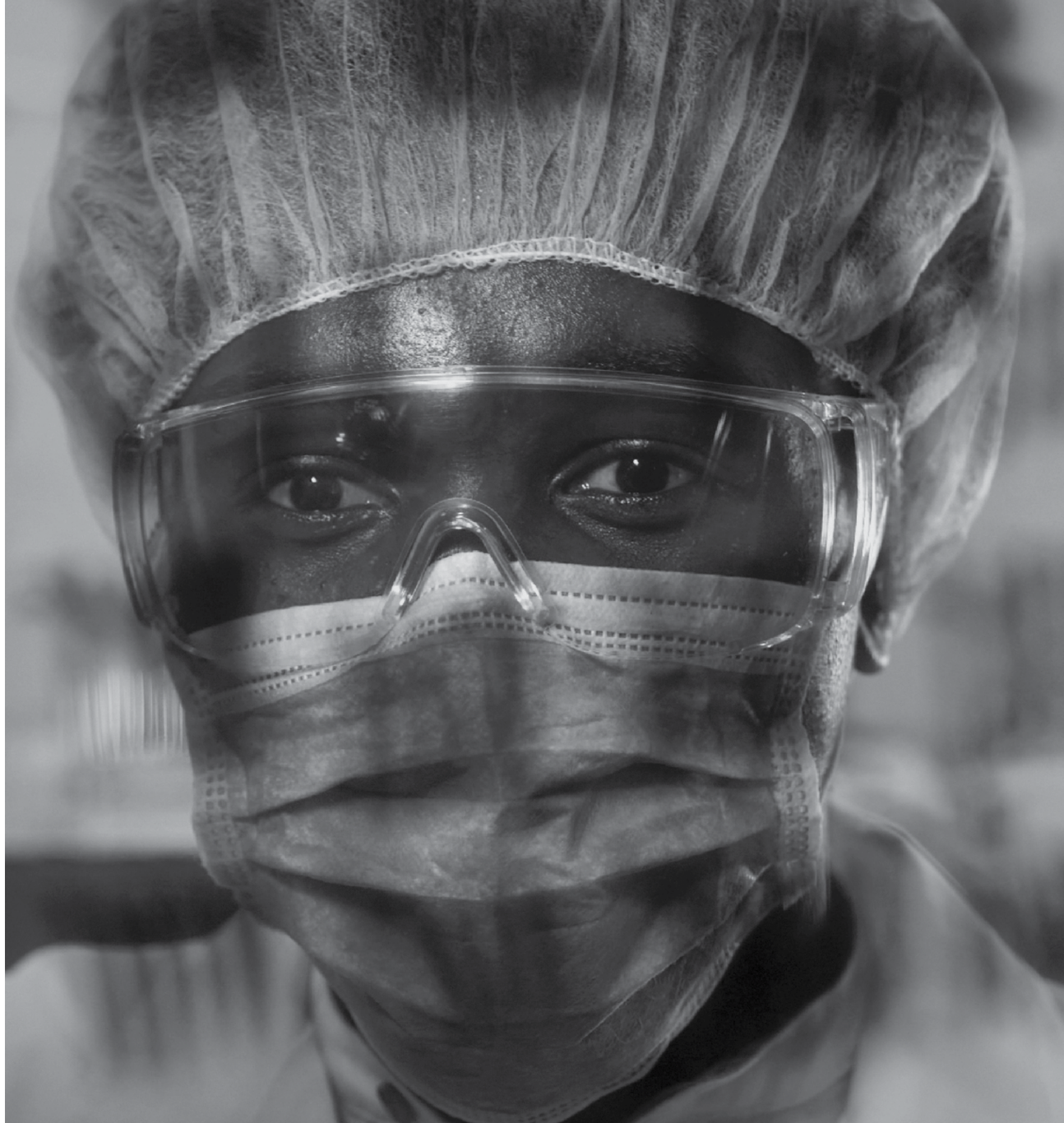
General exclusions

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

- Services rendered by any person who is not registered to provide healthcare services, as well as medicine that have been prescribed by someone who is not registered to prescribe
- Experimental or unproven services, treatments, devices or pharmacological regimes
- Patent and proprietary medicines and foods, including anabolic steroids, baby food and baby milk, mineral and nutritional supplements, tonics and vitamins except where clinically indicated in the Scheme's managed care protocols
- Examinations for insurance, school camps, visas, employment or similar
- Holidays for recuperative purposes, regardless of medical necessity
- Interest or legal fees relating to overdue medical accounts
- Stale claims, which are claims submitted more than four months after the date of treatment
- Claims for appointments that a member fails to keep
- All costs related to:
  - Bandages, dressings, syringes (other than for diabetics) and instruments
  - Lens preparations
  - DNA testing and investigations, including genetic testing for familial cancers and paternal testing
  - Gum guards, gold in dentures, gold used in crowns, inlays and bridges
  - Organ donations to any person other than to a member or registered dependant
  - Wilful self-inflicted injuries

General Rule reminders

- This Benefit Guide is a summary of the 2022 AMS benefits, pending approval from the Council for Medical Schemes
- Please refer to **www.angloms.co.za** (My Scheme, Scheme Rules) for the full set of registered Rules
- The Anglo Medical Scheme Rules are binding on all beneficiaries, officers of the Scheme and on the Scheme itself
- The member, by joining the Scheme, consents on his or her own behalf and on behalf of any registered dependants, that the Scheme may disclose any medical information to the administrators and contracted third-parties for reporting or managed care purposes
- A registered dependant can be a member's spouse or partner, a biological or stepchild, legally adopted child, grandchild or immediate family relation (first-degree blood relation) who is dependent on the member for family care and support
- To avoid underwriting, a member who gets married must register his or her spouse as a dependant within 30 days of the marriage. Newborn child dependants must be registered within 30 days of birth to ensure benefits from the date of birth
- If your dependant reaches the age of 23 and you wish to keep him or her on the Scheme as an adult dependant, you may apply for continuation of membership
- It is the member's or dependant's responsibility to notify the Scheme of any material changes, such as marital status, banking details, home address or any other contact details and death of a member or dependant



Glossary

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

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

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

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

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

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

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

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

ICD-10, NAPPI and Tariff codes
ICD stands for International Classification of Diseases and related problems. By law, every claim that is submitted to a medical scheme, must include an ICD-10 code. Every medical condition and diagnosis has a specific code. These codes are used primarily to enable medical schemes to accurately identify the conditions for which you sought healthcare services. This coding system then ensures that your claims for specific illnesses are paid out of the correct benefit and that healthcare providers are appropriately reimbursed for the services they rendered.

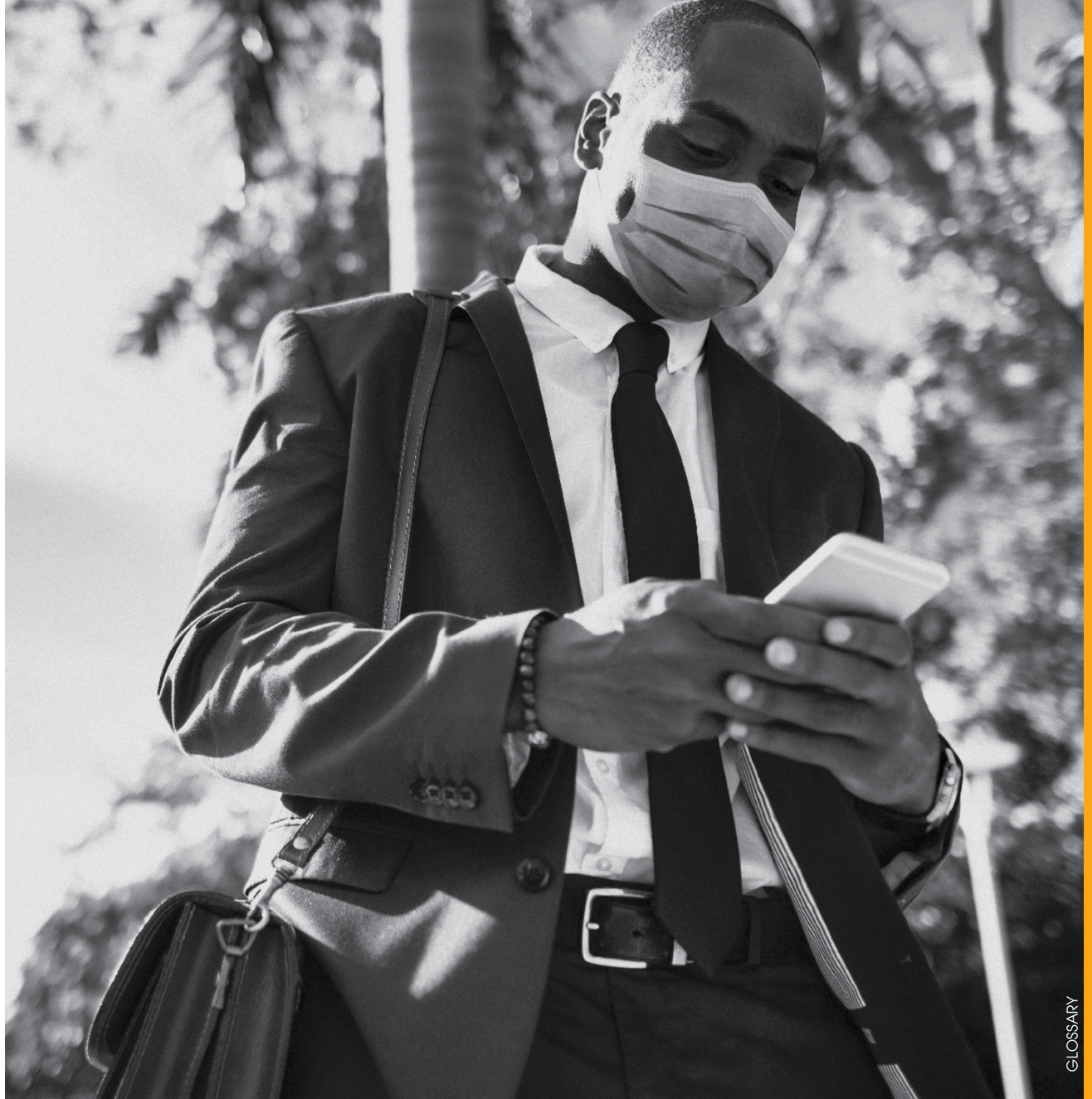
NAPPI codes are unique identifiers for a given ethical, surgical or consumable product which enables electronic transfer of information through the healthcare delivery chain. Tariff codes are used as a standard for electronic information exchange for procedure and consultation claims.

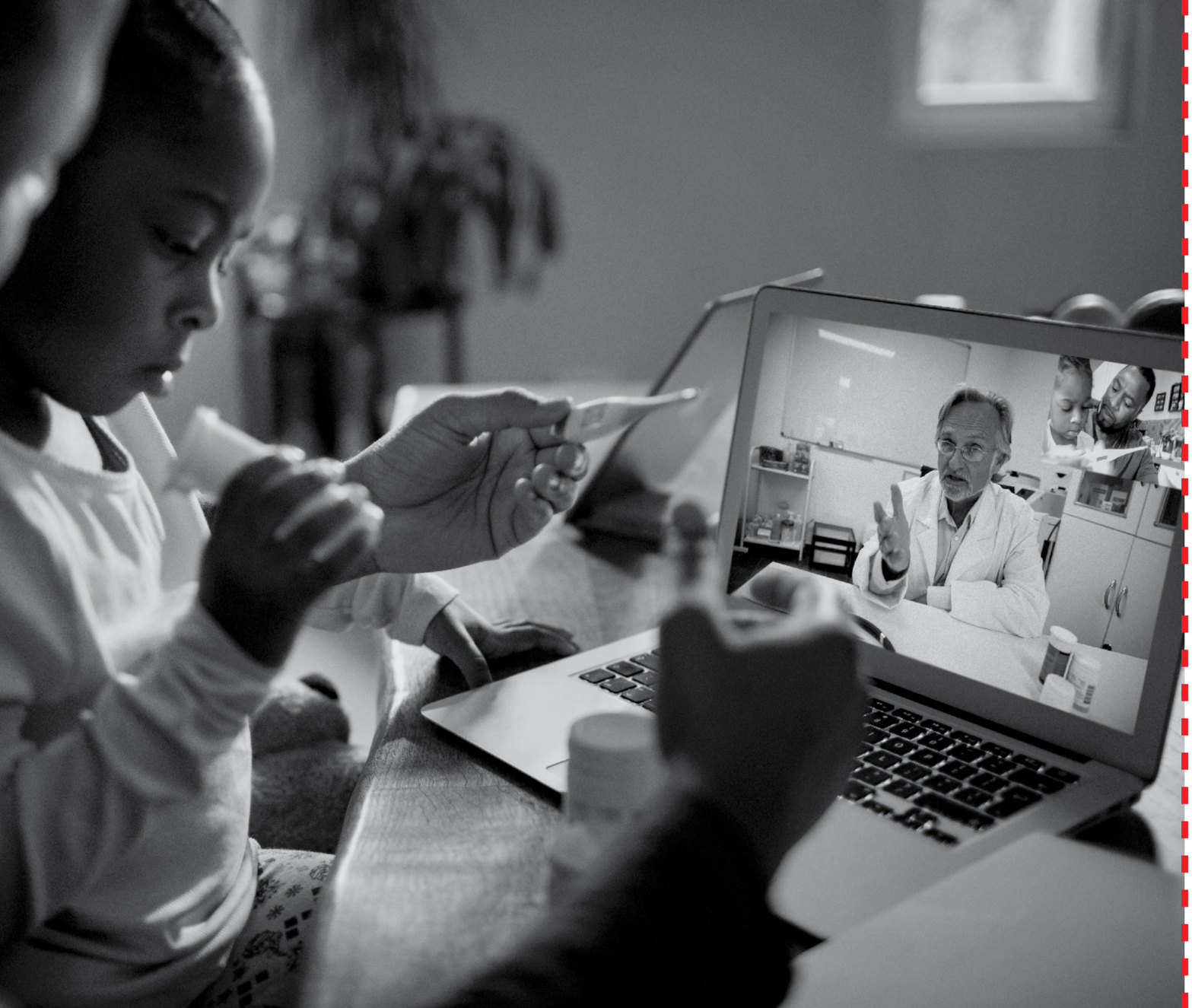
Pharmacist Advised Therapy (PAT)
Most common ailments can be treated effectively by medicine available from your pharmacy without a doctor's prescription. If your medical scheme option offers a PAT benefit, it means that some of these costs will be paid from the relevant benefit.

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

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

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





PLAN CHANGE REQUEST 2022

ANGLO MEDICAL SCHEME

Purpose of this form

- This form is used if a member wishes to change the plan type they are currently on
- The plan change will be effective from 1 January for the entire year
- The plan change will apply to the main member and dependants

How to complete the form

- Complete with black ink and print clearly. You can also access a digital copy of this form on www.angloms.co.za > Info Centre > Find documents and forms
- To avoid administration delays, please make sure this form is completed in full
- Please return the completed form as soon as possible, but no later than the 10th of December 2021.
  - Employees must submit the form to their employer
  - Pensioners submit to their Pension Fund Administrator
  - Self-paying members submit directly to the Scheme (mail to member@angloms.co.za, fax (011) 539 1015 or post PO Box 746, Rivonia, 2128)
- Tick each box as appropriate

Member details

Member name

Telephone (H)

Cellphone

Email

Membership number

Payroll number

I want to change my Plan to ☐ Managed Care Plan ☐ Standard Care Plan ☐ Value Care Plan

Ensure you understand the financial and, if relevant, subsidy implications of your requested change or discuss it with your HR Officer or Pension Fund Administrator (if applicable).

Change from:		**To:**	
☐ Managed Care Plan	R	☐ Managed Care Plan	R
☐ Standard Care Plan	R	☐ Standard Care Plan	R
☐ Value Care Plan	R	☐ Value Care Plan	R

Signature

Date D D M M Y Y Y Y

Contact us

GENERAL

Principal Officer
011 638 5471
144 Oxford Road, Melrose,
Rosebank 2191

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

Fraud hotline (ethics line)
0800 004 500

Web
Visit **www.angloms.co.za** to learn more about your Scheme and benefits and to register as a member to access your membership information 24/7

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

VALUE CARE PLAN

0861 665 665
Queries: support@primecure.co.za
- Ambulance services
- Chronic authorisation and registration
- Claims
- HIV/AIDS management programme
- Authorisation and health advice

Claims: refunds@primecure.co.za

Please call me line
067 415 3974

STANDARD & MANAGED CARE PLAN

Ambulance services
Netcare 911
082 911 (emergency)

Administration
Call Centre **0860 222 633**
Overseas calls +27 11 529 2888
- Authorisations
- Chronic authorisation and registration
- HIV/AIDS management
- Oxygen therapy management
- Third party claims department

General enquiries:
member@angloms.co.za

Claims – claims@angloms.co.za
Fax 011 539 1008
P.O. Box 746, Rivonia 2128

Diabetes management
Centre for Diabetes and Endocrinology (CDE) **011 053 4400**
PO Box 2900, Saxonworld 2132
members@cdecentre.co.za

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

COMPLAINTS

Please direct all queries and complaints to the Call Centre.

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

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

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

AMS ANGLO MEDICAL SCHEME