BENEFIT GUIDE 2019

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 and medical emergencies. 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.

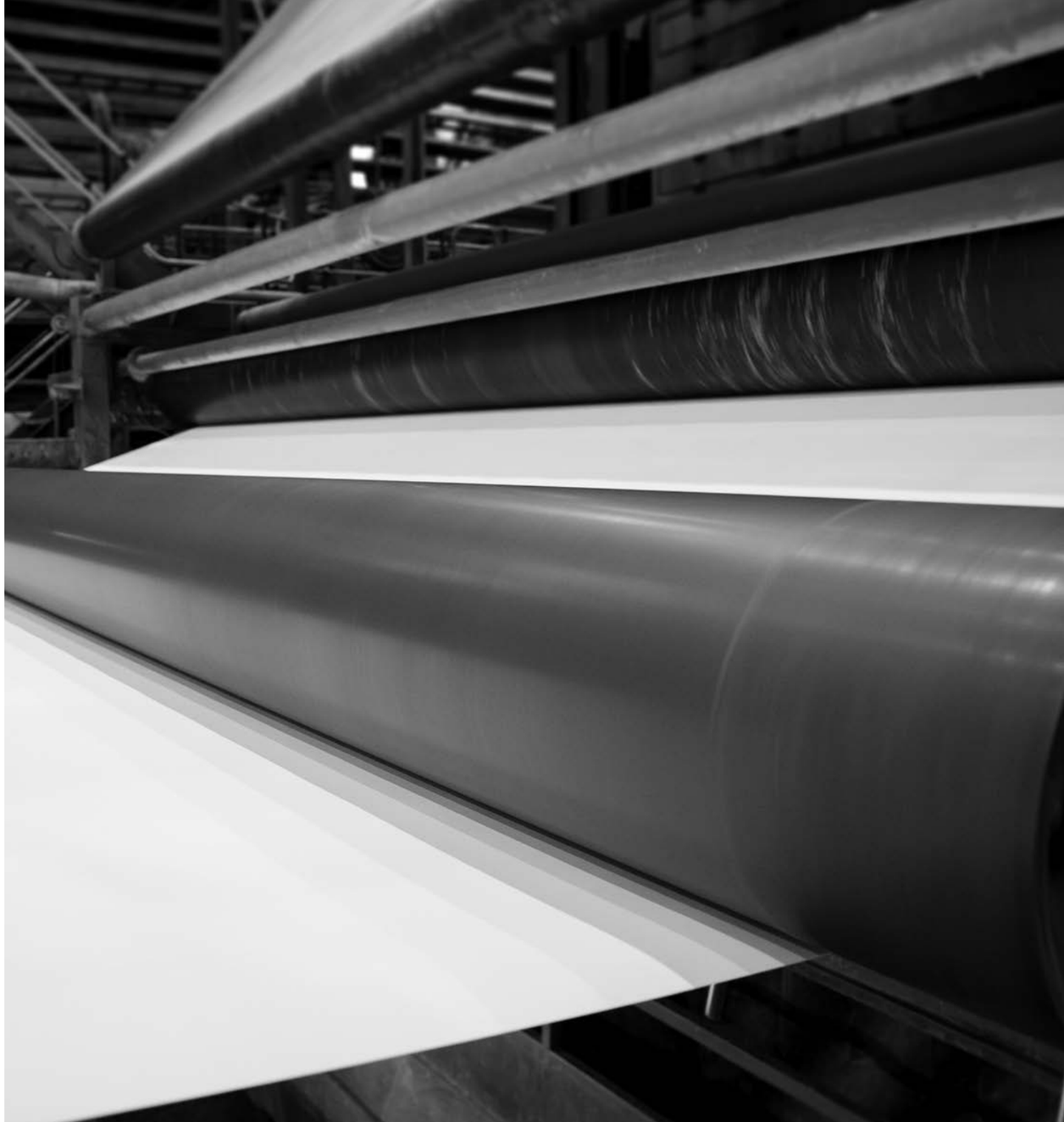
The access to diagnosis, medical or surgical management and treatment of these conditions is not limited, and is paid according to specific protocols per condition.

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 log-in 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 log-in 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)
- 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.

Extend your Scheme benefits

As a member of Anglo Medical Scheme you are able to access certain products offered by our administrator, Discovery Health.

Vitality

Vitality is the wellness programme that facilitates, encourages and rewards members for getting healthier. Not only is a healthy lifestyle more enjoyable, it has been clinically proven that Vitality members live longer and have lower healthcare costs while enjoying the richest rewards. To join Vitality call **0860 99 88 77** or visit **www.vitality.co.za**.

Optometry Network

You can get 20% discount on your frames and eyeglass lenses when you visit an optometrist in the Discovery Health Optometry Network. The discount is immediate at point of sale and independent of your Anglo Medical Scheme benefits. The portion the Scheme pays is subject to Scheme Rules.

These products are not part of Anglo Medical Scheme. Participation or non-participation does not impact or influence Scheme benefits. Discovery Vitality and Vitality HealthyLiving are offered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07, the Optometry Network is offered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, authorised financial services provider. Terms and conditions apply.

More information on **www.angloms.co.za** or call **0860 222 633.**

Your Scheme at a glance

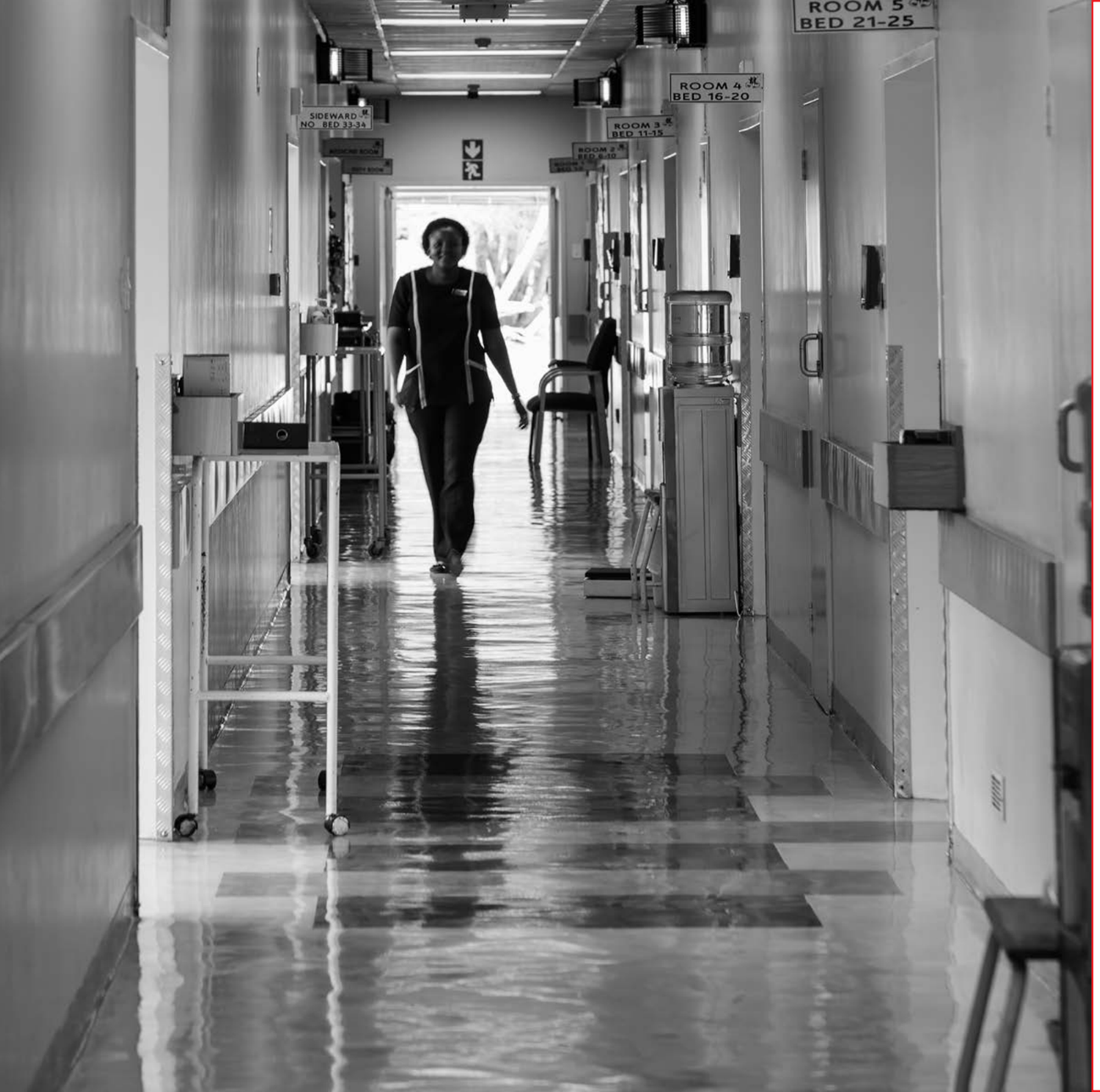
	VALUE CARE PLAN	STANDARD CARE PLAN	MANAGED CARE PLAN
Type	Network	Traditional	Comprehensive with savings account
Provider	Prime Cure providers and facilities only	Your choice of healthcare service provider	Your choice of healthcare service provider
Tariff	Prime Cure Tariff	Scheme Reimbursement Rate (SRR)	GP rate: 100% of SRR, or GP network rate (negotiated Discovery Health Rate): no co-payments Specialists excluding Pathology and Radiology: – In hospital: Top-Up rate up to 230% (100% SRR + 130%) – Out of hospital: Up to 125% of SRR
Benefits	Primary healthcare Hospital: Family Hospital Limit: R157 500 (non-PMB)	Out of hospital benefits: Limited Hospital: Unlimited	Medical Savings Account for Out of hospital benefits Hospital: Unlimited
Medicines	Formulary medicine dispensed by network provider/pharmacy	Strict protocol management	Moderate protocol management
Contribution rate* * Subject to underwriting	Main member: R895 Adult dependant: R895 Child dependant: R220	Main member: R2 470 Adult dependant: R2 470 Child dependant: R745	Total contributions Main member: R4 515 Adult dependant: R4 515 Child dependant: R1 045 Excluding savings Main member: R3 390 Adult dependant: R3 390 Child dependant: R785 Savings Main member: R1 125 Adult dependant: R1 125 Child dependant: R260

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 and has to be handed to your employer or past employer before 31 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.

2019 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	OH
Family Hospital Limit R157 500 including:	Consultations: Nurse practitioner at Prime Cure network pharmacy R520 per family, maximum R260 per visit
	+
Sublimit: Private Prime Cure hospital R68 250	Consultations: Prime Cure network GPs unlimited Authorisation needed after 6th consultation per beneficiary
	+
Sublimit: Blood transfusions R15 550	Consultations: Specialist R3 465 per family, 5 consultations per family, limited to 3 per beneficiary
	+
Sublimit: Pathology R17 850 per family	Allied healthcare services: R2 650 per family with a maximum amount of R1 765 per beneficiary
	+
Sublimit: Specialised Radiology R17 850 per family	
	+
Sublimit: Internal surgical prostheses R27 300 per family	Pharmacist Advised Therapy (PAT): R95 per purchase limited to three purchases up to R285 per beneficiary
	+
Sublimit: Psychiatric services R7 560 per family, 5 days	Consultations out of network: R1 000 per consultation. One consultation per beneficiary or two per family
Sublimit: Allied healthcare services R7 560 per family	

Contributions*: Main member R895, adult dependant R895, child dependant R220

* Subject to underwriting

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 will need to provide details to Prime Cure by calling **0861 665 665** within 48 hours of the incident.

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.

To claim

If you received emergency medical services outside the Network which were authorised within 72 hours, please submit your claim to:

Email: **anglo@primecure.co.za**

Post: **Prime Cure Health, Private Bag X13, Rivonia, 2128**

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 and banking details if they differ from the banking details supplied to Anglo Medical Scheme

Your responsibilities

- Comply with Scheme Rules
- Obtain authorisation for services listed in the Benefit table
- 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	Designated Service Providers only	Y	IH OH
Allied healthcare services: Audiology, dietetics, occupational therapy, podiatry, physiotherapy, psychology, social services and speech therapy	Y	R2 650 per family with a maximum of R1 765 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 within 48 hours after the incident or the next working day post emergency. Authorise inter-hospital transfers before the event. Voluntary use of non-DSP results in 30% co-payment	N	IH OH
Cancer treatment and Oncology 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	R260 per visit subject to a Family Limit of R520	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 000 per consultation (including related expenses) per beneficiary, maximum of 1 consultation per beneficiary or 2 per family	N	20% co-payment per visit, subject to authorisation within 72 hours 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 465 per family, 5 consultations per family and a maximum of 3 consultations per beneficiary	Y	A 30% co-payment will apply where use of a non-designated specialist is voluntary. 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: Authorisation must be obtained within 72 hrs after the event. Services paid up to the Prime Cure agreed rate only	Y	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 co-payment 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
Hospitalisation: Allied healthcare services: dietetics, occupational and speech therapy, physiotherapy, podiatry and social services	Y	Sublimit: R7 560, subject to the Family Hospital Limit	Y		N	IH

* 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: Blood transfusions (non-PMB)	Y	Sublimit: R15 550 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: R157 500 Private hospital sublimit: R68 250	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: R27 300 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 R7 560 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	R285 per family (R95 per purchase up to a maximum of 3 purchases per beneficiary)	N	Formulary medicine only; obtained at network pharmacy	N	OH

* Unless otherwise specified

** PMB rules apply

*** Subject to referral by Prime Cure network healthcare 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 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: R17 850 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

* 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
Radiology: Specialised radiology, MRI, CT scans and mammograms	Y	R17 850 per family subject to the Family Hospital Limit	Y		N	IH OH
Vaccines: Flu	N		N	Cost of vaccine. One per beneficiary	N	OH
Vitality check: Cholesterol, blood glucose, BMI, blood pressure	N	1 per beneficiary per year	N	Vitality check done at Vitality 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:

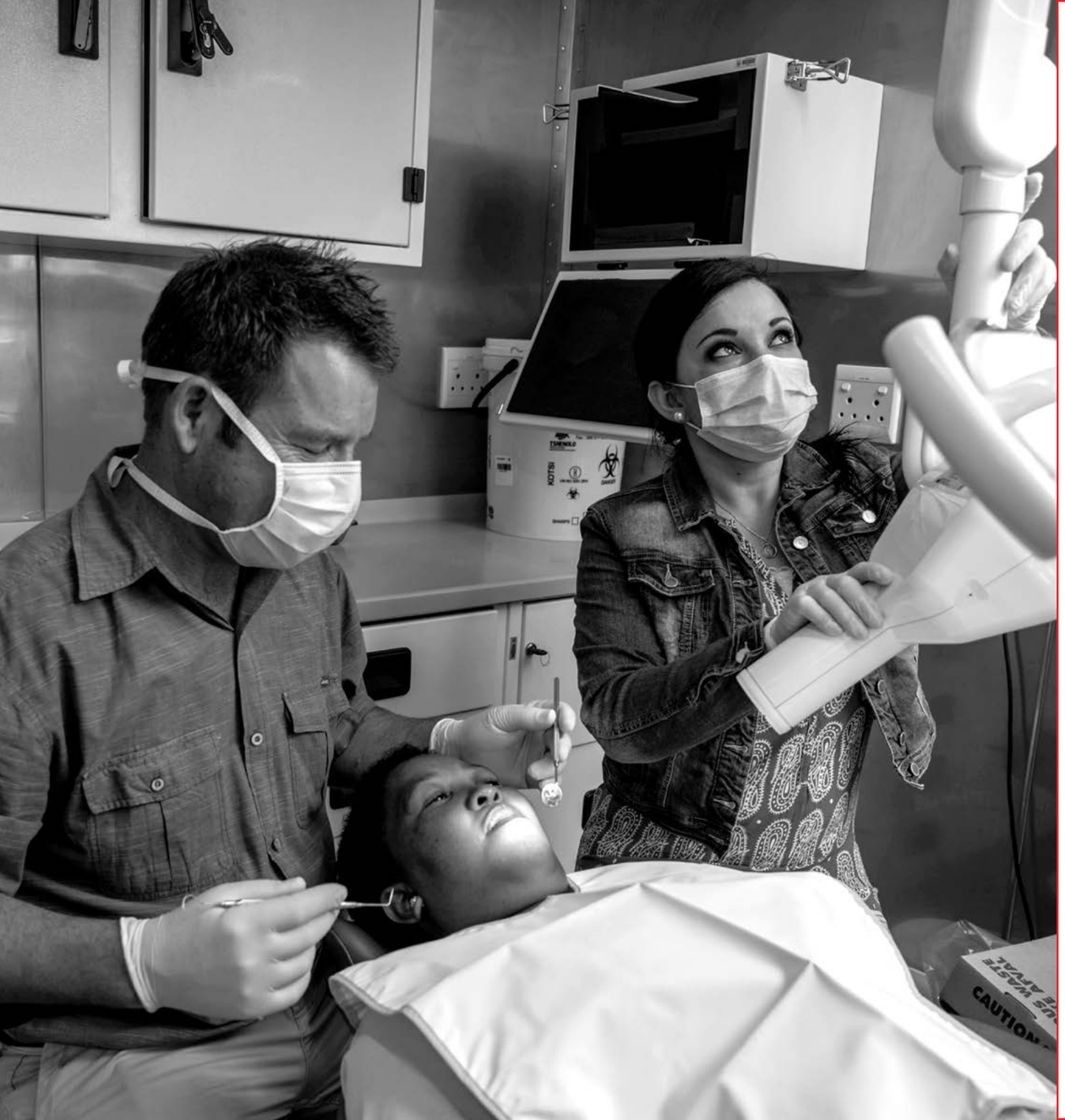
- Frail care
- PET scans
- Deep brain stimulator devices for Parkinson's disease or epilepsy
- Implant devices for chronic pain management
- Polysomnogram and CPAP titrations
- Facility fees
- No cover for medicine not found on the medicine list
- Injury or illness that occur beyond the borders of the 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 bio technological substances
- Immunoglobulins

General Rule reminders

- This Benefit Guide is a summary of the 2019 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 administrator 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 and Out Of Hospital Family Limits.

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

Contributions*: Main member R2 470, adult dependant R2 470, child dependant R745

* Subject to underwriting

Standard Care Plan Limits unless PMB

IH

General hospital services
Radiology and Pathology
unlimited, paid at 100% of SRR

+

Internal surgical prostheses
R63 130 per beneficiary

OH

Overall Out Of Hospital
Family Limit

Adult: R5 070
Child: R2 530

Sublimit 1
Alternative and allied healthcare

Adult: R3 275
Child: R685

Sublimit 2
Consultations, acute medication and Pharmacist Advised Therapy (PAT)

Adult: R4 760
Child: R2 380

+

Additional basic and specialised
Dentistry Family Limit
Adult: R1 325 / Child: R330

+

Radiology Family Limit
Adult: R1 680 / Child: R1 015

+

Pathology Family Limit
Adult: R1 285 / Child: R460

+

Medical and surgical appliances
R9 030 per family

+

Chronic medication (non-PMB)
R4 370 per beneficiary

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

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.

In a medical emergency where authorisation was not obtained, you need to provide details to Netcare 911 within 48 hours, or the next working day after the incident.

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

To obtain authorisation

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

To ensure benefits 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 R1 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

This 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**

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 after 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

Overseas travel

Emergency and acute medical treatment received when travelling 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 will refund you
- If you are entitled to benefits from another insurer you must claim from that insurer first. Any shortfall or uncovered cost will be considered
- 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
- The Scheme will pay the rand value according to the average SRR, had the service been provided in South Africa. 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 Human Papillomavirus (HPV): Cervarix / Gardasil	F	9-26	Vaccines	Prevention of cervical cancer caused by HPV
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)
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: 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

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

Description	Sex	Age*	Paid from	Purpose
Eyesight check Including Glaucoma screening	F/M	40+	Eye Care Benefit	Early detection of eye disease or deterioration
Dental check-up	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, 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: Programme, including hospitalisation and medication in hospital / SANCA facility	Y	21 days	Y	SANCA and SANCA approved facilities	IH	If you do not register on the SANCA programme, 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: Programme including consultations and medication out of hospital	Y	Overall Out Of Hospital Family Limit and Sublimits: Adult R5 070, Child R2 530	Y	SANCA and SANCA approved facilities	OH	If you do not register on the SANCA programme, 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
Ambulance services: Life-threatening medical emergency transport	Y 082 911		N	Netcare 911	IH OH	Notify Netcare 911 at the time of emergency or within 48 hours 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		Y	N	IH OH	100% of SRR and Single Exit Price (SEP) for medicine. Subject to treatment protocols. Drug therapies for chemotherapy side effects and pain relief must be authorised. Post-oncology treatment will be recognised as part of your oncology treatment, which needs to be registered separately
Dental hospitalisation: 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), medicine and related products	Y		N	N	IH	

* 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	
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	Note
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)	Note
Dentistry: Additional basic and specialised dentistry	N	Family Limit: Adult R1 325, Child: R330	N	N	IH OH	Limit applies to both, network and non-network providers	Note
Diabetes: Consultation with doctors, dietitians, ophthalmologists, patholgy 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 a co-payment of 20% on all diabetic-related services including diabetic related hospitalisation	
Endoscopy: Gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	Y		N	N	IH OH	No co-payment if performed in a day clinic, or in case of emergency. For a list of accredited facilities, call the Call Centre or visit www.angloms.co.za. Co-payment of R3 350 if admitted to hospital specifically for an endoscopy	Note
Eye care: Eye examinations	N	R380 per beneficiary	N	N	OH	Eye examination to be done at Optometrist	

* 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
Eye care: Lenses, frames	N	R2 100 per family	N	N	OH	See page 5 for information on discounts through the optometry network
Eye care: Cataract surgery with intra-ocular lens replacement	Y	Intra-ocular lens subject to the Internal Surgical Prostheses Limit	N	N	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 your medicine will be delivered by Dis-Chem Direct (011 589 2788) to your place of choice
Hospice: Instead of hospitalisation (in-patient care facility and out-patient home care)	Y		N	Hospice	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	Unlimited	N	N	IH	Co-payment of R180 per day, to a maximum of R540 per admission for non-PMB conditions. Authorisation procedure, see page 27. Subject to Scheme protocols. Orthotists and prosthetists: DSP to be used
Hospitalisation: Internal surgical prostheses	Y	R63 130 per beneficiary	N	N	IH	
Hospitalisation: Step-down instead of hospitalisation	Y		N	N	OH	Subject to Scheme protocols
Hospitalisation: Professional services for procedures performed in doctor's rooms instead of hospital	Y		N	N	OH	
Hospitalisation: Psychiatric admission	Y	21 days	N	N	IH	
Kidney disease: Dialysis (haemo or peritoneal)	Y		Y	N	IH OH	Subject to Scheme protocols

Note

* 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
Maternity: Consultations and ultrasound scans	Y	8 consultations, 2 ultrasound scans (2D) per pregnancy	Y	N	OH	Register between weeks 12 and 20 of the pregnancy to qualify for benefits
Maternity: Confinement	Y		Y	N	IH	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: R9 030	N	Discovery Health network of orthotists and prosthetists	IH OH	Authorisation required for appliances over R1 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 R1 000 each
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	
Medicine: Acute medicine and injection material incl. NAPPI coded medicine, prescribed or dispensed by a registered homeopath	N	Overall Out Of Hospital Family Limit and Sublimit 2: Adult R5 070, Child R2 530	N	N	OH	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

* 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: 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: Additional chronic conditions (non-PMB)	Y	R4 370 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	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
Cystic Fibrosis	Meniere's Disease
Cystitis (chronic)	Migraine
Motor Neuron Disease	Polyneuropathy
Muscular Dystrophy and other inherited myopathies	Psoriasis
Narcolepsy	Pulmonary Interstitial Fibrosis
Obsessive Compulsive Disorder	Restless Leg Syndrome
Osteoarthritis	Sarcoidosis
Osteopaenia	Systemic Sclerosis
Osteoporosis	Tourette's Syndrome
Paget's Disease	Trigeminal Neuralgia
Pancreatic Disease	Urinary Calculi
Peptic Ulcer	Urinary Incontinence
Polymyositis	

* 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
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
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 070 Child: R2 530	N	N	OH	Sublimits to Overall Limit: Sublimit 1: Alternative and allied healthcare services. Sublimit 2: Consultations, acute medicine out of hospital and PAT
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 275, Child: R685 and Overall Out Of Hospital Family Limit	N	N	OH	Family Limit also includes homeopathic, non-NAPPI coded compounded medicine, dispensed by a registered homeopath
Orthotists and prosthetists	N		N	Discovery Health network of orthotists and prosthetists	OH	You are responsible for the difference in cost when using a non-DSP
Private nursing instead of hospitalisation	Y		N	N	OH	
Sublimit 2		Family Limit for consultations, acute medicine and PAT Adult: R4 760, Child: R2 380 and Overall Out Of Hospital Family Limit				
GP and specialist in rooms (non-PMB), consultations, visits, procedures and treatments in rooms, acute medicine and injection material out of hospital	N		N	N	OH	
PAT medicine: R105 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)
Oxygen therapy: 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

* 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
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: Pap smear, one test per beneficiary from age 21-65, unless motivated by your doctor. Prostate screening: One PSA test
Pathology: In hospital	N		N	N	IH	
Pathology: Out of hospital (non-PMB)	N	Family Limit Adult: R1 285, Child: R460	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 680, Child: R1 015	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
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 female 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 partners

* 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 awards are granted in cases of exceptional clinical circumstances or extreme financial hardship. 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

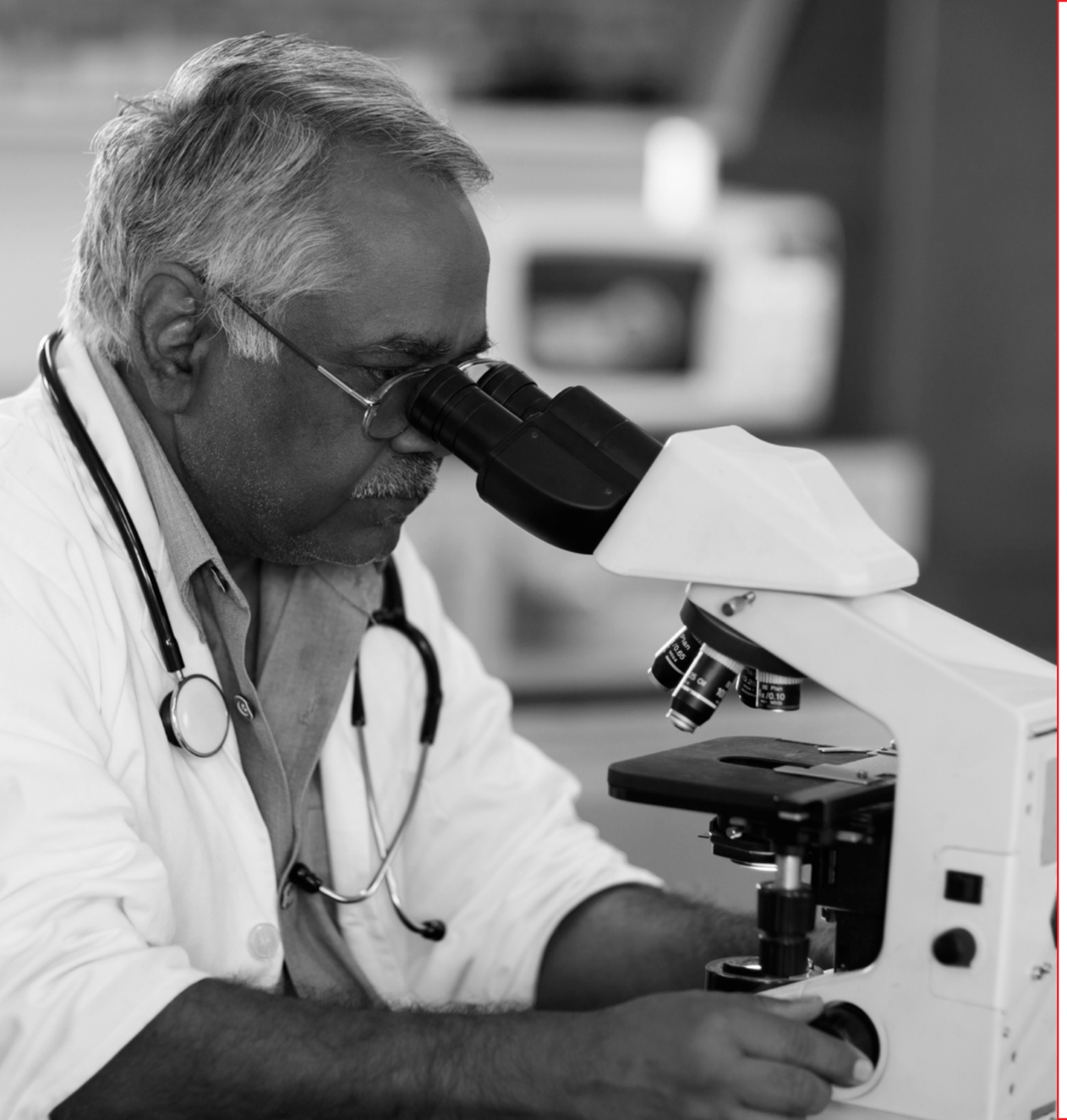
The following are some of the Scheme exclusions (for a full list please refer to the Rules). These you would need to pay:

- 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 2019 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 administrator 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 (previously GAP**) 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:

- 75% goes to the Hospital Benefit or major medical benefit
- 25% goes to savings, for discretionary spend

Contributions*		
Excluding Savings **Main member: R3 390** **Adult dependant: R3 390** **Child dependant: R785**	**Savings** **Main member: R1 125** **Adult dependant: R1 125** **Child dependant: R260**	**Total contributions** **Main member: R4 515** **Adult dependant: R4 515** **Child dependant: R1 045**

* Subject to underwriting
** Change of name to distinguish between AMS GAP rate and gap cover insurance products

Managed Care Plan Benefits unless PMB

IH

General hospital services
Radiology and Pathology
unlimited at 100% of SRR

+

Internal surgical prostheses
R133 900 per beneficiary

+

Top-Up rate
Up to a maximum of 230% of SRR
Excludes pathology, radiology and allied healthcare services in hospital

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

Medical Savings Account
Discretionary spend for out of hospital services and costs in excess of Limits below

+

Dentistry Family Limit
Adult: R3 660 / Child: R1 370

+

Radiology – Unlimited

+

Pathology – Unlimited

+

Medical and Surgical Appliances Limit
R15 315 per family

+

Wheelchair – Every 2 years
R24 100 per beneficiary

+

Hearing Aids – Every 2 years
R38 550 per pair per beneficiary

+

Chronic Medication (non-PMB)
R16 875 per beneficiary

+

Frail care – R67 340 per beneficiary

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 >Application forms.**

Any unspent savings belong to the member 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.

In a medical emergency where authorisation was not obtained, you need to provide details to Netcare 911 within 48 hours, or the next working day after the incident.

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

To obtain authorisation

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

To ensure benefits 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 R1 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

This 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. You will have no co-payment if the condition is a PMB.

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**

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 after 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.

Overseas travel

Emergency and acute medical treatment received when travelling 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 will refund you
- If you are entitled to benefits from another insurer you must claim from that insurer first. Any shortfall or uncovered cost will be considered
- 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
- The Scheme will pay the rand value according to the average SRR, had the service been provided in South Africa. 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 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 availble 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. 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 Human Papillomavirus (HPV): Cervarix / Gardasil	F	9-26	Vaccines	Prevention of cervical cancer caused by HPV
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)
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

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: Programme, including hospitalisation and medication in hospital / SANCA facility	Y	21 days	Y	SANCA and SANCA approved facilities	Scheme to pay up to limit	IH	If you do not register on the SANCA programme, 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: Programme including consultations and medication out of hospital	Y	Available savings	Y	SANCA and SANCA approved facilities	Member savings	OH	If you do not register on the SANCA programme, 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
Alternative healthcare: Acupuncture, chiropody, chiropractic services (including x-rays), homeopathy, naturopathy	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 within 48 hours 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: Audiology, dietitians, occupational therapy, orthoptics, physiotherapy, podiatry, psychology, registered nurse services, social services, speech therapy	N	Available savings	N	N	Member savings	OH	Out of hospital services only (physiotherapy, psychology and related services provided in support of in hospital procedures are paid by the Scheme and not from member savings. Scheme protocols apply. Private nursing subject to authorisation)

* 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
Allied healthcare services: Orthotists and prothetists	N	Available savings	N	Discovery Health network of orthotists and prothetists	Member savings	IH OH	You are responsible for the difference in cost when using a non-DSP
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. 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	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 (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 63
Consultations out of hospital: Specialist for treatment of general conditions (excluding radiologists and pathologists)	N	Available savings	N	N	Member savings	OH	Up to 125% of SRR
Dental hospitalisation: In the case of trauma, patients under the age of 7 years requiring anaesthetic and the removal of impacted molars and maxillo-facial oral surgery (PMB conditions), medicine and related products	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 660 Child: R1 370	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: Consultations 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 a co-payment of 20% on all the diabetic-related services including diabetic related hospitalisation	
Endoscopy: Gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy	Y		N	N	Scheme to pay	IH OH	No co-payment if performed in a day clinic or in case of emergency. For a list of accredited facilities, please call the Call Centre or visit www.angloms.co.za. Co-payment of R3 350 if admitted to hospital specifically for an endoscopy. Top-Up rate up to 230% of SRR for specialist services or in full if PMB	Note
Eye care: Eye examinations, lenses, frames, contact lenses and non-PMB intra-ocular lenses	N	Available savings	N	N	Member savings	OH	100% of cost. See page 5 for information on discounts through the optometry network	
Eye care: Cataract surgery with intra-ocular lens replacement	Y	Intra-ocular lens subject to the Internal Surgical Prostheses Limit	N	N	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	Note
Frail care: Medically related frail care services where clinically appropriate	Y	R67 340 per beneficiary	N	N	Scheme to pay up to limit	OH	According to Scheme protocols. Only registered facilities or services provided at home supervised by a registered Nursing Practitioner	
Hearing aids (1 pair every 2 years)	Y	R19 275 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	
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	

* 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: Medicines	Y		Y	Dis-Chem Direct	Scheme to pay	OH	After registration your medicine will be delivered by Dis-Chem Direct (011 589 2788) to your place of choice
Hospice: Instead of hospitalisation (in-patient care facility and out-patient home care)	Y		N	Hospice	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 R390 per day, to a maximum of R1 170 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 58. Subject to Scheme protocols. Orthotists and prosthetists: DSP to be used
Hospitalisation: Internal surgical prostheses	Y	R133 900 per beneficiary	N	N	Scheme to pay up to limit	IH	
Hospitalisation: Step-down and private nursing instead of hospitalisation	Y		N	N	Scheme to pay	IH OH	Subject to Scheme protocols
Hospitalisation: Psychiatric admission	Y	21 days	N	N	Scheme to pay up to limit	IH	
Kidney disease: Dialysis (haemo or peritoneal)	Y		Y	N	Scheme to pay	IH OH	Subject to Scheme protocols
Maternity: Consultations and 2D ultrasound scans	Y	12 consultations, 2 ultrasound scans (2D) per pregnancy	Y	N	Scheme to pay up to limit	IH	Register between weeks 12 and 20 of the pregnancy to qualify for benefits
Maternity: Confinement	Y		Y	N	Scheme to pay	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 prothetists	Y	Medical and Surgical Appliance Family Limit: R15 315 per family	N	Discovery Health network of orthotists and prosthetists	Scheme to pay up to limit	IH OH	Authorisation required for appliances over R1 000 each. You are responsible for the difference in cost when using a non-DSP

* 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
Medical appliances: External appliances provided by providers other than orthotists and prosthetists	Y	Medical and Surgical Appliance Family Limit: R15 315 per family	N	N	Scheme to pay up to limit	IH OH	Authorisation required for appliances over R1 000 each
Medicines: Acute medicine and injection material, homeopathic and PAT medicine	N	Available savings	N	N	Member savings	OH	100% of SEP and dispensing fee
Medicines: 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

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: Additional chronic conditions (non-PMB)	Y	R16 875 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							
Allergy Management							
Alzheimer's Disease							
Anaemia							
Ankylosing Spondylitis							
Anxiety Disorder							
Atopic Dermatitis (Eczema)							
Attention Deficit Disorder							
Auto-immune Disorders							
Cystic Fibrosis							
Cystitis (chronic)							
Degeneration of the Macula							
Depression							
Diverticulitis							
Fibrous Dysplasia							
Gastro-oesophageal Reflux Disease (GORD)							
Gout (chronic)							
Hidradenitis Suppurativa							
Huntington's Disease							
Liver Disease							
Meniere's Disease							
Migraine							
Motor Neuron Disease							
Muscular Dystrophy and other inherited myopathies							
Narcolepsy							
Obsessive Compulsive Disorder							
Osteoarthritis							
Osteopaenia							
Osteoporosis							
Paget's Disease							
Pancreatic Disease							
Peptic Ulcer							
Polymyositis							
Polyneuropathy							
Psoriasis							
Pulmonary Interstitial Fibrosis							
Restless Leg Syndrome							
Sarcoidosis							
Systemic Sclerosis							
Tourette's Syndrome							
Trigeminal Neuralgia							
Urinary Calculi							
Urinary Incontinence							
Organ transplant: 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: 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: Pap smear, one test per beneficiary from age 21-65, unless motivated by your doctor
Procedures in rooms: GPs and specialists, minor procedures in rooms	N		N	N	Scheme to pay	OH	Subject to Scheme protocols and a defined list of procedures, specialists up to 125% of SRR and GPs 100% of SRR
Procedures in rooms: Specialist procedures performed in rooms instead of in hospital	Y		N	N	Scheme to pay	OH	Subject to Scheme protocols and a defined list of specialist procedures, Top-Up rate up to 230% of SRR
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
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		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)
Vaccine: Human Papillomavirus (HPV)	N	1 lifetime vaccination per beneficiary	N	N	Scheme to pay	OH	For female 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 partners
Wheelchair (1 wheelchair every 2 years)	Y	R24 100 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 awards are granted in cases of exceptional clinical circumstances or extreme financial hardship. 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, gold used 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 2019 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 administrator 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 going in to hospital if they are to receive non life-threatening or hospital treatment. 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.

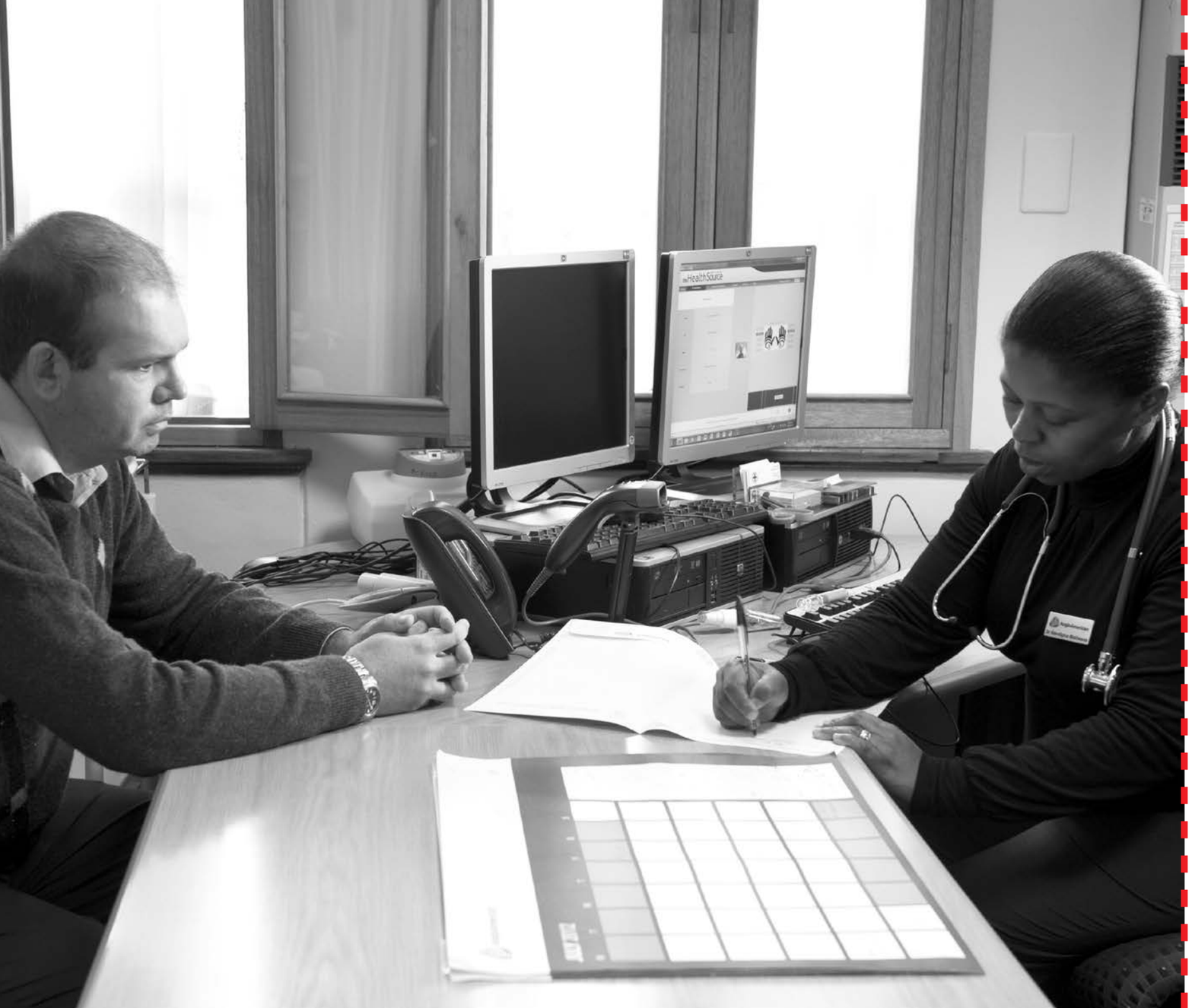
NAPPI codes are unique identifiers for a given ethical, surgical or consumable product which enables electronic transfer of information through the healthcare delivery chain. Tariff codes are used as a standard for electronic information exchange for procedure and consultation claims.

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

- Only the employer or pension fund can instruct the Scheme on option changes.
- The option change will be effective 1 January.
- The option change will apply to the main member and dependants.
- Please return the completed form to your employer or pension fund before 31 December to make sure your request is captured.
- If you are a direct paying member, please submit this form to the Scheme.

1. MEMBER DETAILS

Member name

Telephone (H) (W)

Cellphone Fax

Email

Member number Payroll number

I want to change my Plan with effect Y Y Y Y 0 1 0 1

Signature of member Date Y Y Y Y M M D D

Ensure you understand the financial and, if relevant, subsidy implications of your requested change or discuss it with your HR Department or Pension Office.

Change from:

- ☐ Managed Care Plan R
- ☐ Standard Care Plan R
- ☐ Value Care Plan R

To:

- ☐ Managed Care Plan R
- ☐ Standard Care Plan R
- ☐ Value Care Plan R

2. EMPLOYER OR PENSION FUND APPROVAL (IF APPLICABLE)

Name

Phone Approved Yes ☐ No ☐

Signature

Contact us

GENERAL

Principal Officer
011 638 5471
PO Box 62524, Marshalltown 2107

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

VALUE CARE PLAN

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

Please call me line
079 502 6748

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.com
www.medicalschemes.com

AMS | ANGLO MEDICAL SCHEME