AMS | ANGLO MEDICAL SCHEME

Anglo Medical Scheme, reg.no. 1012 | Administered by Discovery Health (Pty) Ltd, reg. no. 1997/013480/07, an authorised financial services provider

Guide to Prescribed Minimum Benefits | 2025

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This document tells you how Anglo Medical Scheme covers the list of conditions called Prescribed Minimum Benefits (PMBs).

About some of the terms we use in this document

There are a number of terms we refer to in this document that you may not be familiar with. We give you the meaning of these terms.

Terminology	Description
Prescribed Minimum Benefits (PMBs)	A set of minimum benefits that, prescribed by law, must be provided to all medical scheme members. The cover includes the diagnosis, treatment and cost of ongoing care for a defined list of conditions.
Waiting period	A waiting period can be general or condition-specific and means that you have to wait for a set time before you can claim for healthcare services.
Diagnostic treatment pairs Prescribed Minimum Benefits (DTPMB)	Links a specific diagnosis to a treatment and broadly indicates how each of the PMB conditions should be treated.
What are Designated Service Providers (DSPs)?	A DSP is a healthcare provider (a hospital or day clinic or a health care provider such as, the Centre for Diabetes (CDE) for diabetes care) whom we have a payment arrangement with. According to this arrangement, they will provide treatment or services at a contracted rate. This will ensure that you do not have any co-payments when you use their services. You can find a healthcare provider on **www.angloms.co.za** or call us on **0860 222 633** to find a healthcare provider we have a DSP arrangement with.

No matter what medical scheme or plan you decide on, there are some common benefits that apply to all members on all plans.

Understanding the Prescribed Minimum Benefits

What are Prescribed Minimum Benefits (PMBs)?

According to the Medical Schemes Act 131 of 1998 and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- Any life-threatening emergency medical condition
- A defined list of 271 diagnoses
- 27 chronic conditions (Chronic Disease List conditions), including HIV.

Please refer to the Council for Medical Schemes website **www.medicalschemes.co.za** for a full list of the 271 diagnostic treatment pairs.

All medical schemes in South Africa have to include the PMBs in the plans they offer to their members.

How does Anglo Medical Scheme pay claims for PMB and non-PMB claims?

The Scheme will pay for PMBs in full, from the Risk Benefit and in some instances you may have to utilise the services of a DSP. Treatment received from a non-DSP may result in a co-payment if the healthcare provider charges more than what we pay.

The Scheme will pay for benefits not included in the PMBs from your day-to-day benefits, according to the Rules and benefits of your chosen plan.

Requirements to qualify for PMB funding

There are certain requirements before you can benefit from the PMBs. The requirements are:

1. The condition must qualify for cover and be on the list of defined PMB conditions.
2. The treatment needed must match the treatments in the defined benefits on the PMB list.
3. Scheme's DSPs to be used unless there is no DSP applicable on your plan.

If the treatment does not meet the above criteria, funding will be subject to Scheme Rules and benefits.

The treatment needed must match the treatments included in the defined benefits

There are standard treatments, procedures, investigations and consultations for each PMB condition on the 271 diagnostic treatment (DT) PMB list. These defined benefits are supported by thoroughly researched, evidence based clinical protocols, medicine lists (formularies) and treatment guidelines.

Please refer to the Council for Medical Schemes website **www.medicalschemes.co.za** for a full list of the 271 diagnostic treatment pairs.

An example of a Prescribed Minimum Benefit (PMB) provision

Below is an example of a PMB condition and the treatment that qualifies for PMB cover:

Provision	Provision description	Treatment	ICD-10 Code
236K	Iron deficiency; vitamin and other nutritional deficiencies – life-threatening	Medical management	D50.8 - Other iron deficiency anaemias

The PMB Provision is 236K. This is one of the listed 271 Provisions (listed 271 conditions) as published in the Medical Schemes Act and Regulations.

In this example the Provision description lists “Iron deficiency; vitamin and other nutritional deficiencies - life threatening”. The provision states that the condition should be life threatening. For this provision, if the diagnosis is not a life-threatening episode, the condition does not qualify for PMB funding.

The Treatment covered as a PMB for this provision includes medical management for example medicine, doctor consultations investigations etc.

In addition to the above information, the Council for Medical Schemes also provides ICD-10 codes (e.g., D50.8) that fall within the 236K Provision, as per the last column in the above table. The ICD-10 codes (diagnosis codes) are an industry guide as to which conditions may qualify for PMB cover, subject to them still meeting the Provision Description and treatment criteria.

For this example, in order to qualify for the OHPMB funding, you or your healthcare professional may apply for medical management of life-threatening iron deficiency, vitamin and other nutritional deficiencies. This criterion stated in the Provision description needs to be met to qualify for OHPMB funding related to the treatment as outlined.

Any application for treatment that is not listed in the “treatment” provision for a condition, cannot be considered as a PMB as it does not form part of the prescribed treatment that forms part of PMB level of care. Speak to your healthcare professional to ensure that all criteria for treatment are met before applying for PMB cover.

When will Anglo Medical Scheme only fund Prescribed Minimum Benefits

This happens when you have a waiting period or when you have treatments linked to conditions that are excluded by your plan. This can be a general three-month waiting period or a 12-month condition-specific waiting period. You might however have funding, if you meet the requirements stipulated by the PMB regulations.

There may be times when you do not have funding under Prescribed Minimum Benefits

There are some circumstances where you do not have funding for the PMBs. This can happen when you join a medical scheme for the first time, with no medical scheme membership prior to that.

It can also happen if you join a medical scheme more than 90 days after leaving your previous medical scheme. In both instances, the Scheme would impose a waiting period during which you and your dependants will not have access to the PMBs, no matter what conditions you might have been diagnosed with.

You and your dependants must register to get cover for PMBs and Chronic Disease List conditions

How to register your chronic or PMB conditions to get funding from the Risk Benefit

There are different types of claims for PMBs. There are claims for hospital admissions, chronic conditions and other conditions treated out-of-hospital.

If you want to apply or register for out-of-hospital PMBs, your doctor or pharmacist can call **0860 222 633** to register the condition. In some instances, blood tests or reports might be requested before your condition can be registered.

If your application meets the requirements for funding from the PMBs, we will automatically pay the associated approved treatment, medicine, consultations, blood tests and other investigative tests, for the diagnosis and treatment of your condition from the Risk Benefit (not from your day-to-day benefits). You will receive a letter confirming your funding.

If you want to apply for in-hospital PMBs funding, you must call us on **0860 222 633** to request an authorisation.

Why it is important for you and your dependants to register your PMB or chronic conditions

The Scheme pays for specific healthcare services related to each of your approved conditions. These services include treatment, medicine, consultations, blood tests and other investigative tests. We pay for the services without affecting your day-to-day benefits as this is paid from the Risk Benefit (by the Scheme).

We will fund for treatment that falls outside the defined benefits, or if declined, from your available day-to-day benefits according to your chosen plan. If your plan does not fund these expenses, you will have to pay the claims.

There are times when you need to apply for funding under the PMBs. Once your healthcare provider confirms the diagnosis as a PMB condition, you can apply to us for payment of the claims from the Risk Benefit without using your day-to-day benefits.

When you do not register your condition as a PMB or chronic condition

We will fund the consultations, blood tests, other investigative tests, medicine and treatment for the PMB or chronic condition from your day-to-day benefits.

Additional documents needed to support the application

You may need to send the Scheme the results of the medical tests and investigations that confirm the diagnosis of the condition for which you are applying for funding. This will help us to identify that your condition qualifies for the treatment.

We will let you know if we approve your application for PMB funding and what you must do next.

What happens if you need treatment that falls outside of the defined PMBs?

For treatment that falls outside the defined PMBs, you need to send additional clinical information with a detailed explanation of why the treatment is needed. The Scheme will review it and may approve the treatment.

If you request a review for additional PMB funding:

1. Download and print the "Request for additional Prescribed Minimum Benefit Funding form" available on **www.angloms.co.za**
2. Members can also call **0860 222 633** to request the form.
3. Complete the form with the assistance of your healthcare provider:
4. Send the completed and signed form, along with any additional medical information by email to **dtpmbapplications@angloms.co.za**.
5. If we approve the requested medicine/treatment on review, claims will automatically pay from the Risk Benefit. If the review is unsuccessful, you can lodge a formal appeal by following Anglo Medical Scheme's internal appeals and disputes process as outlined on the website.

When you need to get more than one month's supply of medicine

You can get more than one month's supply of approved chronic medicine within the current benefit year if you are travelling outside the borders of South Africa. You need to fill in an "Advanced Supply of Medicine form" that you can find on **www.angloms.co.za** and send it to us as per details provided on the form. The Scheme will review your request and inform you whether this was approved.

Who must register to receive chronic medicine for their PMB or chronic conditions

The main member and all dependants with PMB or chronic conditions must register. Each individual must register their specific conditions.

You only have to register once for a chronic condition (unless otherwise indicated). If your medicine or other treatment changes, your doctor can let us know about the changes.

You have to register for a new condition before we will fund the treatment and consultations from the Risk Benefit and not from your day-to-day benefits.

What happens if there is a change in your approved medicine

For chronic conditions, the treating doctor or dispensing pharmacist can make changes to medicine telephonically by calling

0860 222 633.

Get the most out of your benefits

Elective admissions for PMB conditions and procedures are covered in full if you choose to use a DSP.

The below conditions need to be met for full cover for these providers:

- You are being admitted for a procedure for a PMB condition
- Your chosen hospital or day facility is on the PMB network specific to your plan
- Your primary treating doctor is on the PMB network for your plan.

What to do if there is no available DSP at the time of your request

There are instances where it is not necessary to use DSPs and you will have full funding. An example of this is in a life-threatening emergency.

Cover for COVID-19

The WHO Global Outbreak Benefit provides cover for global disease outbreaks recognised by the World Health Organisation

(WHO) such as COVID-19. This benefit offers cover for out-of-hospital management and appropriate supportive treatment related to the management of acute COVID-19 and long COVID. Please visit our website **www.angloms.co.za** for more information.

Get preauthorisation for hospitalisation and other procedures

What is preauthorisation

Preauthorisation is the approval of certain procedures and any planned admissions to a hospital or day clinic before the procedure or admission takes place. It includes associated treatment or procedures performed during hospitalisation.

You also need specific authorisation for MRI and CT scans, radio-isotope studies and for certain endoscopic procedures whether during hospitalisation or not.

Whenever your doctor plans a hospital admission, you must let us know 48 hours before you go to hospital.

Benefits that require preauthorisation

You need to get preauthorisation from us for:

- Hospital admissions
- Day-clinic admissions
- Special procedures (like scopes, MRI and CT scans etc.).

Who you must contact for preauthorisation

Call us on **0860 222 633** (**+27 11 529 2888** for members situated abroad) to get preauthorisation. We will give you an authorisation number if approved. Provide the authorisation number to the relevant healthcare provider and ask them to include it when they submit their claim.

Make sure you understand what is included in the authorisation and how we will pay the claims and if any co-payments apply.

We will ask for the following information when you request preauthorisation

- Your membership number
- Details of the patient (name and surname, ID number etc.)
- Reason for the procedure or hospitalisation
- Diagnostic codes (ICD-10 codes), tariff codes and procedure codes (you must get these from your treating healthcare provider)
- The practice number and name of the hospital and treating providers.

An authorisation does not guarantee payment of all claims

Your hospital funding is made up of:

- Funding of the account from the hospital (the ward and theatre fees) at the rate agreed with the hospital
- Funding of the accounts from your treating healthcare provider (such as the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology) are separate from the hospital account and are called related accounts.

Remember: Limits, clinical guidelines and policies apply to some healthcare services and procedures in hospital.

There are some expenses you may incur while you are in hospital that we don't fund. Certain procedures, medicine or new technologies need separate approval. Please discuss this with your doctor or the hospital.

What happens once you are admitted to hospital

Your funding is subject to Scheme Rules, funding guidelines and clinical rules.

Contact us to confirm your cover

You can call us on **0860 222 633 (+27 11 529 2888 for members situated abroad)** or visit **www.angloms.co.za** for more information.

Complaints process

You may lodge a complaint or query with Anglo Medical Scheme directly on **0860 222 633** or address a complaint in writing directly to the Principal Officer. Should your complaint remain unresolved, you may lodge an appeal by following Anglo Medical Scheme's internal appeals and disputes process.

Members who wish to approach the Council for Medical Schemes for assistance, may do so in writing to:
Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157 or email **complaints@medicalschemes.co.za**.

Customer Care Centre: **0861 123 267** / website **www.medicalschemes.co.za.**