

ANGLOVAAL GROUP MEDICAL SCHEME

BENEFIT BROCHURE



2026

Your Scheme

Anglovaal Group Medical Scheme is a registered medical scheme under the Medical Schemes Act 1998

The Scheme is a restricted-access medical scheme that reserves membership for employees of participating employers. A board of trustees, which represents the employers and members, governs the Scheme.

The trustees are appointed to ensure the financial soundness of the Scheme and to protect members' interests. The Scheme currently holds reserves that are well above the required minimum solvency levels, attesting to its prudent management.

CONTRIBUTIONS FOR EACH MONTH

Income band		Medical scheme	Medical Savings Account	Total
Below R4 600	Main member	R2 635	R657	R3 292
	Adult	R2 635	R657	R3 292
	Child	R814	R204	R1 018
R4 601 – R9 100	Main member	R3 082	R770	R3 852
	Adult	R3 082	R770	R3 852
	Child	R935	R232	R1 167
R9 101 – R13 600	Main member	R3 351	R837	R4 188
	Adult	R3 351	R837	R4 188
	Child	R1 026	R256	R1 282
R13 601 – R18 100	Main member	R3 552	R889	R4 441
	Adult	R3 552	R889	R4 441
	Child	R1 084	R270	R1 354
Above R18 101	Main member	R3 639	R909	R4 548
	Adult	R3 639	R909	R4 548
	Child	R1 101	R272	R1 373



WHAT THE TERMS WE USE MEAN

PMBs: Prescribed Minimum Benefits are a set of conditions for which all medical schemes must provide a basic level of cover.

This basic level of cover includes the costs for the diagnosis, treatment and ongoing care of these conditions.

Designated service provider: A healthcare provider (for example doctor, specialist, pharmacist or hospital) with whom we have an agreement to provide treatment or services at a contracted rate.

Cost: Fees charged by a provider that sometimes could be more than the Scheme Rate. The Scheme pays at 100% of the Scheme Rate for in-hospital events.

MSA: Medical Savings Account, according to Anglovaal Group Medical Scheme rules.

Scheme Rate: The rate at which the Scheme reimburses providers for providing health services. All benefits are covered at 100% of the Scheme Rate unless otherwise indicated.

TREATMENT AND CARE FOR CDL CONDITIONS

If your CDL condition is approved as a PMB condition, the Chronic Illness Benefit covers certain procedures, tests and consultations for the diagnosis and ongoing management of your condition in line with Prescribed Minimum Benefit requirements. The Scheme covers these tests and procedures up to the Scheme Rate and this does not affect your day-to-day benefits. To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare providers to be submitted with the relevant ICD-10 (diagnosis) code(s). Please ask your doctor to include your ICD-10 code(s) on the claims they submit and on the form that they complete when they refer you to pathologists and radiologists for tests. This will enable pathologists and radiologists to include the relevant ICD-10 code(s) on the claims they submit to ensure that we pay your claims from the correct benefit.

YOU NEED TO LET US KNOW WHEN YOUR TREATMENT PLAN CHANGES

You do not have to complete a new Chronic Illness Benefit application form when your treating doctor changes your medicine during the management of your approved chronic condition. However, you do need to let us know when your doctor makes these changes to your treatment so that we can update your chronic authorisation. You can email the prescription for changes to your treatment plan for an approved chronic condition to **CIB_APP_FORMS@avgms.co.za**. Alternatively, your doctor can submit changes to your treatment plan through HealthID, provided that you have given consent to do so. If you do not let us know about changes to your treatment plan, we may not pay your claims from the correct benefit. If you are diagnosed with a new chronic condition, a new Chronic Illness Benefit application form needs to be completed.

ADVANCED ILLNESS (AIB) AND MEMBER SUPPORT BENEFIT PROGRAMME

This programme is offered to oncology patients in the advanced stage of their illness, subject to the patients meeting clinical entry criteria.

This benefit is unlimited and gives patients access to palliative care by a multidisciplinary team. The basket of care can cover medicine, oxygen, psychosocial support, nursing care, hospice, pain management, radiology, pathology and physiotherapy. The care is based on the treatment plan submitted by the doctor and approved by the Scheme.

The costs of the programme do not have an impact on the member's day-to-day benefits.

The Advanced Illness Member Support Programme offers support before it's necessary to register on the Advanced Illness Benefit (AIB). It gives patients access to healthcare providers who specialise in palliative (supportive) care. The programme allows members to establish relationships and create links to support and maintain their wellbeing until the time comes when they might need to use the AIB.

HIV ANTIRETROVIRAL INFORMATION

Dis-Chem is the preferred provider for dispensing antiretroviral medicine. If you do not use the preferred provider, the Scheme will pay your monthly antiretroviral medicine up to the Scheme Rate.

MENTAL HEALTH SUPPORT AND RELAPSE PREVENTION PROGRAMME

The Mental Health Care Programme is a GP-led disease management programme that offers support in treating an episode of major depression or chronic major depression.

Members need to meet the clinical entry criteria and register on the Mental Health Care Programme to use its benefits. Members who register on the Mental Health Care Programme have access to a network of psychologists, occupational therapists, social workers and registered counsellors.

SPINAL CARE PROGRAMME AND CENTRE OF EXCELLENCE

Our Spinal Care Programme aims to promote managing back pain with conservative primary care where appropriate. Qualifying members have access to a network of physiotherapists and chiropractors supported by a network of spinal surgeons and network general practitioners who have been trained to manage back pain, and members have the support of mentors that specialise in back pain management.

In addition, the programme is structured in such a way that when surgery is the only option, this is performed at the best possible place of service (a Centre of Excellence), by the best possible surgeons to ensure the best possible outcome.





READMISSION PREVENTION BENEFIT

This benefit is for members who have been identified as having a high risk for being admitted to hospital again after a hospital stay. It is offered to members who are admitted to hospital for a defined list of conditions and includes a home-care component, a doctor follow-up consultation and a medicine reconciliation done by the treating doctor while the member is being discharged from hospital.



MEMBER CARE PROGRAMME

The Scheme offers a customised, voluntary outpatient programme for members who have complex medical needs and who meet the clinical entry criteria. Members receive high quality, patient-centric care and chronic condition management to improve the quality, continuity and efficiency of their care.



CONTINUOUS GLUCOSE MONITORING

We offer benefits for a home-use blood glucose monitor to members with diabetes who meet our clinical entry criteria. This device makes it easier to continuously monitor blood glucose levels than constantly pricking your finger.

A self-monitoring blood glucose device allows members to conveniently monitor their glucose levels, accurately measure glucose concentrations, and collect a wealth of valuable data that they and their doctors can use to better manage diabetes.



HEALTH @ HOME

Health @ Home includes a number of programmes that give members access to a range of quality hospital-level healthcare services in the comfort of their home for a defined list of medical conditions. Members have to meet the clinical entry criteria and care at home has to be clinically appropriate.



GP VIRTUAL HOUSE CALL

This service is available to all members registered on the Chronic Illness Benefit. A GP will reach out through a virtual consultation if a member is identified as being at high risk of being admitted to hospital and an intervention can reasonably be expected to prevent the admission.

PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL) CONDITIONS

Addison's disease	Epilepsy
Asthma	Glaucoma
Bipolar mood disorder	Haemophilia
Bronchiectasis	HIV and AIDS
Cardiac failure	Hyperlipidaemia
Cardiomyopathy	Hypertension
Chronic obstructive pulmonary disease (COPD)	Hypothyroidism
Chronic renal disease	Multiple sclerosis (MS)
Coronary artery disease	Parkinson's disease
Crohn's disease	Rheumatoid arthritis
Diabetes insipidus	Schizophrenia
Diabetes mellitus type 1	Systemic lupus erythematosus
Diabetes mellitus type 2	Ulcerative colitis
Dysrhythmias	

ADDITIONAL DISEASE LIST (ADL) CONDITIONS COVERED (ABOVE PMB ENTITLEMENT)

Allergic rhinitis	Motor neuron disease
Alzheimer's disease	Myasthenia gravis
Ankylosing spondylitis	Osteoarthritis
Cystic fibrosis	Osteoporosis
Gout	Paget's disease of the bone
Major depression	Psoriasis

Your benefits for 2026



HOSPITAL BENEFITS

The Hospital Benefit covers you when you are admitted to hospital and the Scheme has confirmed your admission and treatment.



COVER FOR DAY-TO-DAY MEDICAL EXPENSES

We pay certain day-to-day expenses from your Insured Procedures Benefit or from the available funds in your Medical Savings Account.



COVER FOR PRESCRIBED MINIMUM BENEFITS

In terms of the Medical Schemes Act and its regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of any emergency medical condition, a defined set of 271 diagnoses as well as 27 chronic conditions, including HIV and AIDS. These conditions and their treatments are known as the Prescribed Minimum Benefits (PMBs).

HOSPITAL BENEFIT	THE LIMIT ON THIS BENEFIT
Please authorise all admissions beforehand Note: the Scheme's in-hospital clinical protocols apply	
Admission for non-Prescribed Minimum Benefits (non-PMBs)	<ul style="list-style-type: none"> ■ Unlimited ■ General ward at a private or state facility or day clinic ■ Scheme Rate
Emergency evacuation (road or air) Subject to authorisation (Note: this excludes planned transfers)	R91 995 per family

INSURED PROCEDURES BENEFIT (IPB)	THE LIMIT ON THIS BENEFIT
No hospital admission required. Please authorise all procedures beforehand. The Scheme's clinical protocols apply. After reaching the IPB limit, the balance of the account can be paid from the Medical Savings Account.	
Oncology (including chemotherapy and radiotherapy)	R486 164 per family each year
Stoma therapy and hospice	R14 886 per family each year
Audiology, including hearing aids	R29 773 per family each year
Ambulance services	R11 288 per family each year
External appliances, including artificial limbs and medical equipment such as glucometers	R11 288 per family each year
MRI and CT scans and radio-isotope scans	R26 174 per family each year
Outpatient surgical and endoscopic procedures (vasectomy, gastroscopy, colonoscopy, cystoscopy, etc)	R22 503 per family each year
Home nursing or step-down after hospitalisation	No limit - Managed through the care coordination programme

INSURED PROCEDURES BENEFIT (IPB)	THE LIMIT ON THIS BENEFIT
Advanced Illness Benefit for oncology patients	Unlimited per patient, subject to clinical criteria
Basic dentistry	R846 per beneficiary each year
Screening test (blood glucose test, blood pressure test, cholesterol test and body mass index (BMI) at a Scheme Wellness Pharmacy)	One per year at Scheme Rate for group of tests
Additional screening test (mammogram, Pap smear, PSA (a prostate screening test) and HIV blood tests – subject to PMB guidelines)	One test for each beneficiary per family
Seasonal flu vaccine	One vaccine for each beneficiary who meets the clinical criteria

NON-HOSPITAL BENEFIT	THE LIMIT ON THIS BENEFIT
All day-to-day expenses, such as:	
<ul style="list-style-type: none"> ▪ Acute medicine ▪ Chiropractors ▪ Clinical psychology ▪ Dentistry ▪ GP visits ▪ Homeopathy ▪ Mental health ▪ Occupational therapy 	<ul style="list-style-type: none"> ▪ Optical ▪ Over-the-counter medicine ▪ Pathology ▪ Private nursing ▪ Physiotherapy ▪ Radiology ▪ Specialist visits ▪ Speech therapy
All benefits are limited to funds in the Medical Savings Account	

This brochure is a summary of the benefits and features of Anglovaal Group Medical Scheme, pending formal approval from the Council for Medical Schemes. This brochure gives you a brief outline of the benefits that Anglovaal Group Medical Scheme offers. This does not replace the Scheme rules.

The registered Scheme rules are legally binding and always take precedence.



Your Enhanced Maternity benefit for 2026

Maternity Programme

For expectant mothers and children under the age of 2 years, a defined basket of both pre- and postnatal care becomes available upon registration on the Maternity Programme. The Scheme will cover these up to the Scheme Rate, and the benefit will not affect your day-to-day benefits.

ENHANCED BENEFIT	BENEFIT ENTITLEMENT
Antenatal classes and consultations	5
Gynaecologist or GP visits during pregnancy	8
2D ultrasound scans	2
Blood tests	Simple basket

ENHANCED BENEFIT	BENEFIT ENTITLEMENT
Prenatal screening test	1
Private ward cover	2 nights (natural delivery) / 3 nights (caesarean section)
Postpartum Gynaecologist visit	1
ENT/Paediatrician visit	2
Lactation consultation	1
Postnatal Dietician consultation	1
Essential devices	R7 055 with 25% co-payment

Your Chronic Illness Benefit for 2026

The Chronic Illness Benefit covers approved medicines for the 27 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) chronic conditions, including HIV and AIDS. We pay your approved chronic medicine in full if it is on the Anglovaal Group Medical Scheme medicine list (formulary). If your approved medicine is not on our list, we pay your chronic medicine up to a set monthly Chronic Drug Amount (CDA) for each medicine category.

The Scheme covers an additional 12 chronic conditions. For these Additional Disease List (ADL) conditions, there is no medicine list (formulary). Approved medicine will be paid up to a set monthly Chronic Drug Amount (CDA) for each medicine category.

You must apply for chronic cover by completing a Chronic Illness Benefit application form with the help of your doctor and submitting it for review. You can get this form from the Scheme's website or by calling 0860 100 693. For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria that you need to meet.

If you use a combination of medicines in the same category, where one medicine is on the medicine list and the other is not, we pay for the medicines up to the one monthly Chronic Drug Amount (CDA) for that medicine category.



COUNCIL FOR MEDICAL SCHEMES COMPLAINTS LINE

Customer care tel: 0861 123 267

Complaints email: complaints@medicalschemes.com

ADMINISTERED BY DISCOVERY HEALTH

Call centre 0860 100 693 | www.avgms.co.za

Reporting fraud to your Scheme toll-free tel: 0800 004 500

Email: discovery@tip-offs.com



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