AMS | ANGLO MEDICAL SCHEME

Digital Benefit Guide **2026**

Anglo Medical Scheme Member Guide

The purpose of this guide is to provide you with a quick reference and look up tool. At the end of this guide, you will find more information sources and contact details. We strongly encourage you to explore these resources to gain a deeper understanding of how your Scheme works and how you can fully utilise your benefits.

Contents

The AMS vision

Anglo Medical Scheme's vision is to address the healthcare needs of our members for all stages of life. We will achieve this through offering market competitive plans with benefits that enable access to relevant healthcare services in a cost-effective manner, as well as member focused service.

Our efforts will be supported by sound financial risk management, administrative efficiency and our members' and employers' active participation.

Your benefits of being a member of the Anglo Medical Scheme

Tailored service just for you

We provide exceptional service through our dedicated teams, especially in complex or urgent medical situations.

Customised benefits, some of them better than market

We offer quality, cost-effective medical cover tailored to the unique needs of our members, often surpassing industry standards.

Low contributions

Our plans feature some of the lowest contributions in their category relative to the benefits value offered.

Cost savings

We save on marketing and broker fees, using these savings for member claims, resulting in lower contributions and administrative costs.

Better quality and efficiency of healthcare

We select our healthcare providers carefully, ensuring high-quality, efficient care through a tailored network.

Patient advocacy programme

Our patient advocacy philosophy is a unique initiative that supports and empowers you through your healthcare journey. Our team acts as your advocate, ensuring effective communication with healthcare providers, optimising benefits, and providing support.

Our long-term interest in the wellbeing of our members

We ensure peace of mind for employees and employers by focusing on sustainable healthcare funding and long-term commitment.

Financial stability

Our financial stability ensures we consistently meet healthcare needs with high-quality benefits and competitive contributions.

Find out more

How you benefit from being a member of the Anglo Medical Scheme.

Which plan is the right one for me?

	Value Care Plan	Standard Care Plan	Managed Care Plan
Plan highlights	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. This plan is ideal **for budget conscious young members and young families.**	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. This plan is ideal **for members** and families **that need more flexibility** in their healthcare spending and have **average healthcare needs.**	Managed Care Plan offers **comprehensive benefits and a Medical Savings Account** for out of hospital services and discretionary spend, a top-up rate for specialist services in hospital, extensive chronic medication, and additional benefits, such as unlimited radiology and pathology, as well as frail care – as one of the few Schemes in the industry - where clinically required. This plan has the most comprehensive benefits, ideal **for members with higher healthcare needs.**
Healthcare providers you can use	Prime Cure providers and facilities only **Find providers here**	Use a hospital on the **hospital network** You can **use any out of hospital healthcare service providers** For certain benefits there are network or Designated Service Providers (DSPs) you can use without experiencing a co-payment **Find providers here**	You can use **any hospital and out of hospital healthcare service providers** For certain benefits there are network or Designated Service Providers (DSPs) you can use without experiencing a co-payment **Find providers here**

Which plan is the right one for me?

	Value Care Plan	Standard Care Plan	Managed Care Plan
Tariff / Rate at which your claims are paid.	Your claims are paid at the Prime Cure agreed Tariff	Your claims are paid at 100% of the Scheme Reimbursement Rate (SRR) In and out of hospital Premier Network Specialists paid at the agreed rate	Your claims are paid as follows: GP network rate (negotiated Discovery Health Rate): no co-payments GPs out of network are paid at 100% of SRR Specialists (excluding pathologists and radiologists): - In hospital: Top-Up rate of up to 230% (100% of SRR plus 130%) - Out of hospital: Up to 125% of SRR - In and out of hospital Premier Network Specialists paid at the agreed rate - Pathologists and radiologists: 100% of SRR
Benefit limits	Out of hospital benefits: Primary healthcare Family Hospital Limit: R208 000 (non PMB) Private Hospital Specialist sublimit: R89 900	Out of hospital benefits: Mostly paid from limited benefits, some from risk Hospital benefits: Unlimited	Out of hospital benefits: Paid from your Medical Savings Account and from limited benefits, some from risk Hospital benefits: Unlimited
Medicine funding on this plan	The Scheme pays for **formulary medicine** dispensed by network provider/ pharmacy only	The Scheme pays for medicine according to **strict protocols.** Use Scheme preferred pharmacies for lower dispensing fees	The Scheme pays for medicine according to **moderate protocols.** Use Scheme preferred pharmacies for lower dispensing fees

Which plan is the right one for me?

For more information	Value Care Plan	Standard Care Plan	Managed Care Plan
	Visit the **Value Care Plan** page	Visit the **Standard Care Plan** page	Visit the **Managed Care Plan** page

When you consider switching plans, you may do so only at the end of the year. We recommend you speak to one of our Client Liaison Officers or your Paypoint Consultant to understand the differences between the plans, and to speak to your financial adviser to guide you. A **plan change request form** has to be handed to your employer or pension fund administrator no later than the second Friday in December. If you are a direct paying member, please submit the form to the Scheme.

2026 Contributions

Value Care Plan

Member	Adult dependant	Child dependant
R1 375	R1 375	R335

Standard Care Plan

Member	Adult dependant	Child dependant
R3 855	R3 855	R1 155

Managed Care Plan

Contributions (excluding savings)			Savings portion			Total contribution (including savings)		
Member	Adult dependant	Child dependant	Member	Adult dependant	Child dependant	Member	Adult dependant	Child dependant
R5 560	R5 560	R1 290	R1 480	R1 480	R340	R7 040	R7 040	R1 630

Compare contributions

Use our **contribution calculator** to compare the monthly contributions of the different plans that Anglo Medical Scheme offers.

Benefit highlights

Prescribed minimum benefits

Prescribed Minimum Benefits (PMBs) are a set of defined benefits to ensure that all members have access to certain minimum health services, regardless of the plan they have selected. The aim is to provide you with continuous care to improve your health and well-being.

PMBs are a feature of the Medical Schemes Act, in terms of which medical schemes have to cover the costs related to the diagnosis, treatment, and care of:

- Any emergency medical condition
- A limited set of 271 medical conditions (defined in the Diagnosis Treatment Pairs)
- 26 chronic conditions (defined in the Chronic Disease List)
- When a condition is a PMB, we pay the costs of its diagnosis, treatment, and care. This means that even if your benefits for a year have run out, we pay for the treatment of PMB conditions.

Read more about PMBs on **www.angloms.co.za**

AMS benefit highlights per plan

Additionally, to PMBs we pay for the benefits you find in our highlights table below. The information provided in the table is meant to give you a quick overview. Please click the 'find out more' icon of the benefit you are interested in, to find the full information and requirements to access the relevant benefit.

For more information on your benefits, visit your plan page on **www.angloms.co.za** and/or the **Scheme Rules.**

In case of emergency

If you need an ambulance or need to go to casualty or hospital for an emergency, please remember to use our network providers, DSPs or providers permitted on your plan. Don't forget to get authorisation either prior to the service, or latest by the next day. Read here to understand **what is considered a medical emergency.**

Legend:

- Authorisation needed
- Join our Management Programme to access benefits
- You need to use a DSP
- Use a Network provider/facility
- You need referral
- This benefit is funded from your MSA
- Find out more
- Subject to PMB guidelines
- Co-payment
- Limits or frequency of benefits are indicated in the table

Abbreviations

pb: per beneficiary
pf: per family
pa: per adult
pc: per child
PMB: Prescribed Minimum Benefits
DSP: Designated Service Provider
MSA: Medical Savings Account (MCP)
FHL: Family Hospital Limit (VCP)
PHL: Private Hospital Limit (VCP)
OHFL: Out of Hospital Family Limit (SCP)
FL: Family Limit (SCP)

Emergencies	Value Care Plan	Standard Care Plan	Managed Care Plan
Casualty visit	FHL unless PMB		
Ambulance	FHL unless PMB		
Emergency hospital admission	FHL unless PMB		

Your hospital benefits

Which hospital you can use depends on your plan. Below are your hospital benefits and how you can access them.

View Legend and Abbreviations:

Hospital benefits Planned admissions	Value Care Plan	Standard Care Plan	Managed Care Plan
Alcohol & drug treatment	21 Days	21 Days	21 Days
Allied health care	R10 130 pf and FHL		
Blood transfusions (non-PMB)	R20 750 pf and FHL		
Cancer related admissions	FHL unless PMB Public facilities or contracted network service provider. If diagnosed with cancer, you can upgrade to the Managed Care Plan within 3 months of diagnosis or treatment start date	R382 875 pb per 12-month period. If diagnosed with cancer, you can upgrade to the Managed Care Plan within 3 months of diagnosis or treatment start date	
Overall hospital benefit	Family Hospital Limit (FHL) R208 000 pf Private hospital Limit (PHL) for specialist services R89 900 pf Public and private Prime Cure facilities Limited benefit	No limit Private facilities Hospital network	No limit Private facilities

Your hospital benefits

View Legend and Abbreviations:

Hospital benefits Planned admissions	Value Care Plan	Standard Care Plan	Managed Care Plan
Cataract surgery		Lense subject to Internal Surgical Prosthesis Limit	Lense subject to Internal Surgical Prosthesis Limit
Consultations in hospital	PMB, FHL, PHL		
Dental hospitalisation	FHL and PHL		
Diabetes related admissions	FHL and PHL		
Endoscopies	FHL and PHL		
General hospital services	FHL and PHL		
HIV/AIDS related admissions			

Your hospital benefits

View Legend and Abbreviations:

Hospital benefits Planned admissions	Value Care Plan	Standard Care Plan	Managed Care Plan
Hospital top-up rate	No benefit	No benefit	
Infertility			
Internal surgical prothesis	R36 400 pf and FHL	R84 570	R179 370
Kidney disease admissions	FHL		
Maternity admissions	FHL		
Maternity confinement	FHL		
Mental health admissions	PMB: 21 days Non-PMB: FHL, 5 days per admission, R10 130 pf		
Organ transplant			

Your hospital benefits

View Legend and Abbreviations:

Hospital benefits Planned admissions	Value Care Plan	Standard Care Plan	Managed Care Plan
Pathology	PMB, R23 620 pf, FHL		
Radiology	FHL		
Specialised radiology	R23 620 pf, combined limit with OH		
Specialised medicine and technology	No benefit		
Specialist services	FHL and PHL		
To take out medication 7 days	FHL and PHL		

Hospital alternatives

For some services and procedures, you don't need to be in hospital. Here is a list of convenient, effective, and cost-effective alternatives to being admitted to hospital.

View Legend and Abbreviations:

Hospital alternatives	Value Care Plan	Standard Care Plan	Managed Care Plan
Day clinics			
Hospice	No benefit		
Hospital at Home	No benefit		
Private nursing	No benefit		
Specialist procedures in rooms			
Step-down facilities	No benefit		

Your out of hospital benefits

AMS offers benefits for all stages of life. Below benefits are out of hospital benefits for your day-to-day healthcare needs.

View Legend and Abbreviations:

Out of hospital benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Alcohol and drug treatment		OHFL and sublimit 2: R6 380 pa, R3 190 pc	
Alternative and allied health care services	R3 460 pf, max R2 305 pb	OHFL and sublimit 1: R4 390 pa, R920 pc	

Your out of hospital benefits

View Legend and Abbreviations:

Out of hospital benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Cancer treatment	FHL unless PMB, state facilities	R382 875 pb per 12-month period	
Cancer medicine	FHL unless PMB, state facilities		
Cancer innovation medicine	No benefit	R382 875 pb per 12-month period	
Consultations GP network	Authorise after 4th consult and subject to clinical triage	No network	Network rate for consults and procedures
Consultations GP non-network	R1 275 pb per event consults: 1 pb, 2 pf	OHFL and sublimit 2: R6 380 pa, R3 190 pc	
Consultations GP additional funding	No benefit	No benefit	Once MSA and ASA depleted, 2 additional GP consults pf
Consultations nurse		OHFL and sublimit 1: R 4 390 pa, R920 pc	
Consultations specialists		OHFL and sublimit 2: R6 380 pa, R3 190 pc	
Consultations virtual		OHFL and sublimit 2: R6 380 pa, R3 190 pc	
Contraceptives	R2 810 pb and FHL	OHFL and sublimit 2: R6 380 pa, R3 190 pc	
Dentistry	1 consult pb for conservative dentistry and emergency treatment. Dentures: 2 sets pf every 3 years.	List of basic dentistry services and additional basic and specialised dentistry: R1 970 pa, R495 pc	FL: R5 345 pa, R2 020 pc, thereafter MSA

Your out of hospital benefits

View Legend and Abbreviations:

Out of hospital benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Diabetes management			
Frail care	No benefit	No benefit	R90 215 pb
Hearing aids	No benefit	Appliance limit R12 100 1 pair every 2 years pb	R25 815 pb per hearing aid every 2 years
HIV/AIDS treatment			
HIV medicine			
Infertility			
Kidney disease	FHL		
Maternity		8 consults, 2 scans, R210 pm for vitamins, 5 antenatal classes	12 consults, 2 scans, R210 pm for vitamins, 5 antenatal classes
Medical appliances	No benefit	R12 100 pf	R20 515 pf
Medicine acute	Formulary medicine at network provider	OHFL and sublimit 2: R6 380 pa, R3 190 pc	
Medicine chronic non-PMB	No benefit	R5 805 pb	R22 405 pb

Your out of hospital benefits

View Legend and Abbreviations:

Out of hospital benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Medicine chronic PMB			
Medicine pharmacist advised	R375 pb max 3 events (R125 per purchase)	R735 pf per 3 months, OHFL and sublimit 2: R6 380 pa, R3 190 pc	
Mental health treatment		PMB: 15 consults non-PMB: 3 GP or psychologist consults up to R3 465 pb. Relapse programme: 2 psychiatric visits and 6 counselling sessions	PMB: 15 consults non-PMB: 3 GP or psychologist consults up to R3 465 pb. Relapse programme: 2 psychiatric visits and 6 counselling sessions
Optometry	1 examination and 1 pair of spectacles every 2 years pb	Eye check: R515 pf, lenses/frames: R3 085 pf	Eye check: R515 pb, lenses/frames: R4 625 pf
Organ transplant			
Oxygen therapy	No benefit		
Pathology	approved tests	FL: R1 725 pa, R620 pc	
Radiology	approved tests	FL: R2 245 pa, R1 355 pc	
Specialised medicine and technology	No benefit		
Specialised radiology	FHL and R23 620 pf		
Specialist services		OHFL and sublimit 2: R6 380 pa, R3 190 pc	

Your out of hospital benefits

View Legend and Abbreviations:

Out of hospital benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Wheelchair	No benefit	Appliance limit R12 100 1 wheelchair every 2 years pb	R32 290 pb, 1 wheelchair every 2 years

Your preventative care benefits

We encourage you to know and manage your health status proactively. Detecting health risks or disease early could prevent a disease or at least improve the success rate of the treatment. Find your preventative care benefits here and make use of them today.

View Legend and Abbreviations:

Preventative care benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Baby and child paediatric assessment		OHFL and sublimit 2: R6 380 pa, R3 190 pc	
Bone density scan	No benefit		
Colon screening	No benefit	1 FOBT every 2 years pb age: 50 – 75	1 FOBT every 2 years pb age: 50 – 75
Dental check	1 check and one treatment pb	1 check every 180 days	
Endoscopies for cancer screening	FHL		
Eyesight test	1 test pb	R515 pb	R515 pb

Your preventative care benefits

View Legend and Abbreviations:

Preventative care benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Glaucoma screening	No benefit	OHFL and sublimit 2: R6 380 pa, R3 190 pc	
Gynaecological check		OHFL and sublimit 2: R6 380 pa, R3 190 pc	
Hearing test		OHFL and sublimit 1: R4 390 pa, R920 pc	
HIV screening/test			
Mammogram		1 test pb	1 test pb
Pap smear		1 test pb	1 test pb
Prostate check		1 PSA test pb	1 PSA test pb
Skin check		OHFL and sublimit 2: R6 380 pa, R3 190 pc	
Vaccines - Childhood	No benefit		
Vaccines – Flu		1 vaccine, 1 consult pb	1 vaccine, 1 consult pb
Vaccine – HPV		3 lifetime vaccine pb	3 lifetime vaccine pb

Your preventative care benefits

View Legend and Abbreviations:

Preventative care benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Vaccine – Pneumococcal	No benefit	2 vaccines, 2 consults pb, age: 55+, per lifetime	2 vaccines, 2 consults pb, age: 55+, per lifetime
Wellness check - Cholesterol - Blood glucose - BMI - Blood pressure	1 test pb	1 test pb	1 test pb

Disclaimer:

Limits, co-payments, Scheme protocols, formularies, lists of codes, DSPs and PMB rules may apply to certain benefits.

The Benefit Guide is a summary of the benefits and reimbursement rate as per the Scheme Rules. The benefit and contribution schedule is for information purposes only and does not supersede the Rules of the Scheme. In the event of any discrepancy between this schedule and the Rules, the Rules shall prevail.

Benefits and contributions are subject to approval from the Registrar for Medical Schemes.

Unlocking benefits through authorisation

The Rules and the Benefit Guide outline whether authorisation is needed for each benefit. Authorisation can be either pre-authorisation (obtained before planned procedures) or retrospective authorisation (given for an event that has already occurred). Without authorisation, healthcare services will be paid from your day-to-day benefits or rejected. Some procedures will be considered for payment from the Scheme 'Risk', not from your limited benefits or MSA.

Provide the following information to request authorisation

- Membership number
- Date of admission
- Name of the patient
- Name of the hospital or facility
- Type of procedure, diagnosis with CPT code and the ICD-10 code (you get this from your doctor)
- Name of your healthcare provider and practice number

Key rules to note:

- Authorisation for hospital admission is valid for 4 months
- If the admission is postponed or not taken up before it becomes invalid, you need a new authorisation number
- An authorisation for benefits is only valid for the current benefit year
- You can't get authorisation for the following benefit year
- Always ask which benefits will be used for your authorised event

If your claim was rejected for 'no authorisation', call us to find out what information we need to consider retrospective authorisation. If you think your claim was paid from the wrong benefit, ask for a re-evaluation.

For Standard Care Plan and Managed Care Plan authorisations and registrations, or any questions, please call us on **0860 222 633.** Value Care Plan members call **0861 665 665** or get authorisation on the Value Care Plan app.

Our Management Programmes

AMS Care and Management Programmes

This programme supports members with hypertension, hyperlipidaemia, and coronary artery disease. Once registered for one of these conditions, a Premier Plus GP* can enrol you through HealthID**, with your consent, to manage and initiate treatment with a multi-disciplinary care team.

Below are examples of the most frequently used management programmes that we offer our members. If you join these programmes, you will unlock additional, condition specific benefits.

By using a Designated Service Provider (DSP), you can access additional benefits.

For more information on our other care programmes please call us on **0860 222 633** (Standard and Managed Care Plan members), or on **0861 665 665** (Value Care Plan members).

Value Care Plan

The Hospital Benefit Management Programme is a programme which involves the approval of all hospital events, and on-going monitoring, hospital treatment of all medical conditions.

The Disease/Condition Management Programmes are programmes which incorporate evidenced clinical protocols for containing costs and/or on-going review and monitoring of patients with a defined medical condition. Specific Disease/Condition Management Programmes, which have been adopted by the Scheme are the Prime Cure HIV/AIDS Management Programme and the Prime Cure Oncology Management Programme.

Standard Care Plan and Managed Care Plan

Cardio Care Programme

This programme supports members with hypertension, hyperlipidaemia, and coronary artery disease. Once registered for one of these conditions, a Premier Plus GP* can enrol you through HealthID**, with your consent, to manage and initiate treatment with a multi-disciplinary care team.

Diabetes Care Programme

The Diabetes Care Programme brings together a team of healthcare providers to ensure you get high-quality, coordinated healthcare and improved outcomes. You have access to various tools and benefits to monitor and manage your condition, as well as dedicated care navigators to assist with all your diabetes-related needs. For any diabetes-related questions, contact one of the care navigators at **0860 444 439** or email Members_DCP@angloms.co.za.

If you are registered for chronic conditions for diabetes, you can access the Diabetes Care Programme through your network healthcare provider.
If you are not yet registered, ask your healthcare provider to help you get started. Make sure your healthcare provider is a network provider.
To check if your healthcare provider is on the network, log into www.angloms.co.za and use the **'Find a provider'** tool or call **0860 444 439**.

You need to authorise your diabetes medication through MediKredit by calling **0860 222 633** to access the MediKredit diabetes basket of care.

Disease Prevention Programme

For members at risk of diabetes or cardiovascular disease. Manage risks with support from your Premier Plus GP*, Health Coach, and network dietitian. Eligible members will be contacted by a Health Coach for enrolment. Benefits provided: Two extra consultations, blood tests for monitoring, 12 months Health Coach support.

HIV Care/Management Programme

The confidential HIV Management Programme helps HIV-positive members manage their condition effectively. Early detection and registration improve quality of life and reduce complications. To register, email **HIV@angloms.co.za** or call **0860 222 633.**

Benefits provided: Three GP consultations, one specialist consultation, approved medicine and multivitamins, radiology and blood tests. DSP for medicine is Dis-Chem Direct.

Additional benefits if your Premier Plus GP* enrols you also on the HIV Care Programme: one social worker consultation and coordinated care with a Premier Plus GP* via HealthID**.

Maternity Management Programme

Notify us of your pregnancy at 12 weeks to access maternity benefits.

Benefits: 12 consultations for Managed Care Plan members, eight for Standard Care Plan members, with midwives, GPs or gynaecologists; two pregnancy scans (additional scans require authorisation); prescribed ante-natal vitamins (up to R210/ month); five antenatal classes; hospital stays: three days for natural births, four days for caesarean deliveries; access up to 20% discount on umbilical cord blood and tissue storage with Next Biosciences; medically necessary circumcisions (with authorisation).

Newborns are funded under the parent's name until the end of the birth month. Register your baby within 30 days to ensure continuous funding.

Spinal Conservative Care Programme

The Spinal Conservative Care Programme is an out-of-hospital management programme designed to reduce the need for spinal surgeries through conservative treatment. Enrolment is limited to once per year and is subject to the clinical entry criteria, a valid referral and treatment by network providers. Eligible members are referred via HealthID by network GPs or network spinal surgeons and assessed by network physiotherapists or chiropractors. Treatment includes up to eight in-person sessions over 24 weeks.

Mental Health Care Programme

Manage major depression with tools and support over 6-12 months. Enrol through the DSP (a Premier Plus GP* or a network psychologist) via HealthID**.

Benefits: three GP consultations, psychotherapy consultations (up to a limit), antidepressant medication (funded from non-PMB Chronic Medicine Benefit).

Relapse Prevention Programme: Further consultations if a mental relapse occurs after completing the programme.

Oncology Management Programme

Our dedicated oncology team supports members through their cancer treatment.

To register, email **oncology@angloms.co.za** or call **0860 222 633** with your diagnosis details.

Benefits on the Managed Care Plan: Unlimited in/out of hospital benefits;

Benefits on the Standard Care Plan: Limited benefits per 12-month cycle, 80% SRR funding after limit is depleted.

Medicine DSP:

Dis-Chem Oncology Courier, Medipost, MedXpress Network Pharmacy, Qestmed, Olsens Pharmacy, Southern Rx. A 20% co-payment will apply from 2026 for the use of a non-DSP.

Innovation medicine:

For Managed Care Plan members 100% of SEP will be funded up to a sublimit, 80% SRR funding for defined innovative cancer medicines for SCP, and for MCP after sublimit has been reached.

Treatments:

Chemotherapy, radiotherapy, hormone therapy, consultations, blood tests, radiology, and more.

Hospital admissions:

Funded according to your plan, most surgery expenses funded from Risk Benefit.

Bone marrow transplants:

Funded up to SRR.

Diagnosis tests:

Unlimited benefit for Managed Care Plan, limited for Standard Care Plan.

Other Management and Care Programmes

Above Management and Care Programmes are the most frequently used programmes. Other management programmes available, subject to clinical protocols are:

- The Alcohol and Drug Dependency Programme
- Organ Transplant Management Programme

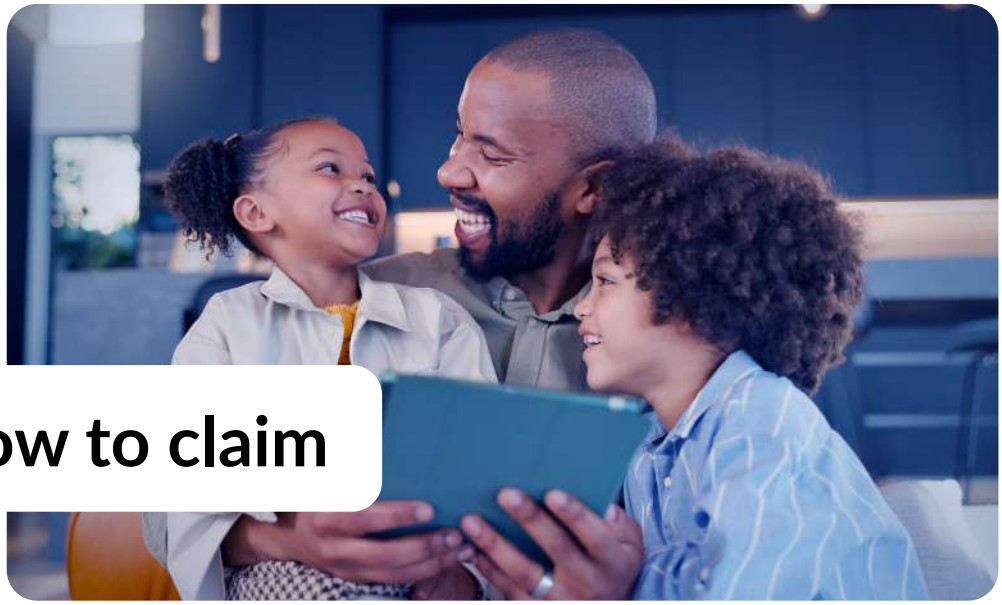
*Premier Plus General Practitioner (GP)

A Premier Plus GP is a network GP who can enrol you in the Scheme's Care Programmes for chronic conditions, providing coordinated care. Members of the Standard and Managed Care Plans can consult with a Premier Plus GP* for additional benefits. Find a Premier Plus GP* using the 'Find a Provider' tool on **www.angloms.co.za** or call **0860 222 633.**

**HealthID

HealthID is an online platform that allows healthcare providers to access your health information securely with your consent. It helps your provider to view your medical history, check test results, track progress, and make referrals for coordinated care.

Additional information about all our Management Programmes is available in the Management Programme guide you will receive upon registration, on the relevant benefit description page on our website, or by contacting the Call Centre at **0860 222 633.**



How to claim

If you pay for healthcare services, send us an accurate invoice and proof of payment for reimbursement per your available benefits. Your healthcare provider can also submit the claim directly. If you don't have available benefits, you can still submit your claim so it will reflect on your medical aid tax certificate.

Payment Responsibility:

Regardless of who submits the claim, you, the member, are responsible for payment to your healthcare provider.

Deadlines:

Claims must be submitted within four months of treatment. After this, you'll have to settle any outstanding amount without Scheme reimbursement.

Information needed on your claim:
Ensure your claim is valid and includes:

- Main member's full name and membership number
- Patient's name (main member or registered dependant)
- Provider's name and practice number
- Treatment date and service details (tariff code, CPT code, and explanation) and diagnosis code (ICD-10)
- Proof of payment if you settled your account
- Value Care Plan members only: complete refund form, available on **www.primecure.co.za/refund-request-form/** or in the Value Care Plan app

If any information is incorrect or missing, we might have to reject the claim.

For more information how to claim go to **www.angloms.co.za** > your plan > how to claim.

How to claim

Here are a few more tips per plan:

Value Care Plan

Members can only use Prime Cure facilities or network healthcare providers. Prime Cure pays these providers for your healthcare services directly. You don't need to pay any accounts unless you didn't follow the Rules or used a non-network provider in an emergency.

Emergency services outside network:

If you receive emergency services outside the network, take a picture and submit the claim in the Value Care Plan app, or scan and email your claim to **ams@kaelo.co.za**

Standard Care Plan and Managed Care Plan

- Upload: Scan and upload claims on the website or app.
- Email: Send to **claims@angloms.co.za**

Once you submitted

Claims are usually processed within five days. Payments are made weekly to you or your provider. Check your claims statement to ensure correct payment. If additional information is needed, respond promptly to avoid payment demands from your provider.

Rejected claims

If a claim is rejected, you have 60 days to provide the required information for re-processing. Check rejection codes for required action. If the Scheme does not pay a portion or the entire claim per Scheme Rules, you will have to pay the provider.

The Medical Savings Account on the Managed Care Plan

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:

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

Charges above the Scheme Reimbursement Rate (SRR), excluding PMBs, can be considered for payment from your MSA. You only have to instruct once-off. You can also request that we pay 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 your available MSA. The Scheme needs to be instructed in every instance.

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

Find more information on how to use your MSA and what else you can and cannot pay from your MSA.

Make the most of your membership and benefits

- Contact us before you have to go to hospital, or before you have a procedure, to confirm benefits, get authorisation and advice. Authorisation is your responsibility, not your healthcare provider's, but we are here to help.
- Register your chronic conditions to get access to additional, dedicated benefits. No forms to complete, your doctor or pharmacist can just call us.
- Use pharmacies, doctors, facilities, hospitals or healthcare providers that have an agreement with the Scheme, to ensure your claims will be paid in full. Ask your doctor to prescribe the most cost-effective medicine possible and make use of generic medication to avoid co-payments. **Look up here** how you can avoid medicine co-payments if you are on the Standard Care Plan or Managed Care Plan. If you are on the Value Care plan, your network provider will automatically assist you with this.
- Make use of your preventative care benefits. Detecting health risks or disease early could prevent a disease or a least improve the success rate of the treatment.
- Send us all your claims, even for items that we will not pay for, so they are captured for your tax return.
- Check the statement if payments have been made correctly and check rejections on your statements. If a mistake has been made on the claim, correct it and resubmit within 60 days. If anything is unclear, contact us so we can assist you.
- Keep contact details up to date - for you and every adult member of the family. If we do not have the right information, you might miss out on information about your benefits and membership. Please ensure we have your personal email address and your cell phone number. Log on to the website at **www.angloms.co.za** to update your details or call us on **0860 222 633.**

Make the most of your membership and benefits

Premier Specialist Network

Members can consult a Specialist on the Premier Specialist Network for in- and out of-hospital events.

Specialists who are part of this network will charge the agreed rates for authorised consultations and procedures, and will not ask for co-payments unless your benefits are exhausted.

Utilising the Premier Specialist Network is voluntary. If you use a non-network Specialist, the Scheme will still fund your consultations and procedures as per your Plan benefits, but you may have to pay out of your own pocket if this specialist charges more than the SRR.

If a procedure is not authorised by the Scheme, or the Specialist uses medicines and/or materials above the SRR, there may also be a co-payment. Claims will be submitted directly to the Scheme and paid as per your Plan benefits or by the Scheme if it is a Prescribed Minimum Benefit (PMB).

Find the nearest Specialist on the Premier Specialist Network by using the 'Find a Provider' search tool on **www.angloms.co.za** after logging in as a member, or by calling the Call Centre on **0860 222 633.**

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. Members may apply based on the following criteria:

- Demonstrated financial hardship in the case of a benefit depletion and the medical condition necessitates continuation of treatment; or
- A genuine medical necessity where the benefit is expressly excluded from the Rules or is not provided for in the Rules.

Ex Gratia is not a guaranteed benefit and means 'as a favour'. Decisions do not set precedent.

Call **0860 222 633** or download the Ex Gratia application form **from our website.**

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

Upon approval, email your claims to:
ex-gratiaclaims@angloms.co.za

Exclusions

We strive to provide access to comprehensive healthcare to our members. However, it is important to understand that some services and treatments are not covered under our plans. These are known as exclusions and limitations.

Exclusions are specific conditions or treatments that are not covered by the Scheme. These might include:

- Cosmetic surgery
- Experimental treatments
- Certain medications

Limitations are caps or restrictions on the amount of funding provided for certain services or treatments. For example, there might be a limit on the number of specific healthcare services (such as number of vaccinations) covered per year or a rand limit for a certain benefit category.

Detailed information about exclusions and limitations can be found in our **Rules**, or on the bottom of your plan overview page on **www.angloms.co.za**

Glossary

We understand that navigating through Scheme and industry-specific terminology can be a challenge. To assist you we have created a **glossary** that explains the most frequently used terms.

More information sources and communication tools

Download the Anglo Medical Scheme app

We offer two different apps for our members. One app for all members, with focus on Standard Care Plan and Managed Care Plan, and a separate app for Value Care Plan members.

Access information about your benefits, plan and membership – anywhere, anytime.

Anglo Medical Scheme app:

Download on the App Store

GET IT ON Google Play

Value Care plan app:

Download on the App Store

GET IT ON Google Play

For even more information

Visit our website **www.angloms.co.za**

Ask AMS now on WhatsApp **011 292 8797**

You can access information and support through our WhatsApp channel.

Need help on the go? Our chatbot is available on WhatsApp 24/7 to help you with all your membership and benefit questions. Just add our number **011 292 8797** or scan the below QR code from your device and ask your question on WhatsApp.

More information sources and communication tools

	Standard Care Plan Managed Care Plan	Value Care Plan
Email us on	member@angloms.co.za	ams@kaelo.co.za
Call us on	0860 222 633	0861 665 665

Meet our Client Liaison Officer at your workplace – ask your HR manager for the next date of visit.

Escalations and complaints

If you are not happy with the service you get or if you have a complaint, **follow the escalation process** as described on our website, where you will also find contact details for our Principal Officer and the Council for Medical Schemes.

Whistleblowing/Fraud Hotline 0860 004 500

The Whistleblowing/Fraud Hotline is an independent entity where members, providers and employers can report any form of unethical practice in an anonymous and secure manner.

AMS | ANGLO MEDICAL SCHEME