



| **Digital Benefit Guide 2025**



# 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.](#)

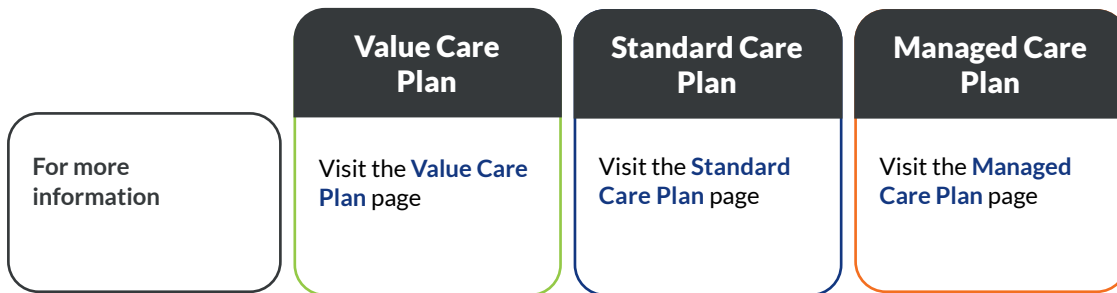
# Which plan is the right one for me?

	Value Care Plan	Standard Care Plan	Managed Care Plan
Plan highlights	<p>Value Care Plan provides <b>primary healthcare</b> through a network of Prime Cure facilities and providers only.</p> <p>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.</p> <p>This plan is ideal for <b>budget conscious young members and young families.</b></p>	<p>Standard Care Plan is a <b>traditional medical plan with defined benefits</b> and out of hospital family limits.</p> <p>Out of hospital benefits are limited and grouped by service.</p> <p>This plan is ideal <b>for members and families that need more flexibility</b> in their healthcare spending and have <b>average healthcare needs.</b></p>	<p>Managed Care Plan offers <b>comprehensive benefits and a Medical Savings Account</b> 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.</p> <p>This plan has the most comprehensive benefits, ideal <b>for members with higher healthcare needs.</b></p>
Healthcare providers you can use	<p>Prime Cure providers and facilities only</p> <p><a href="#">Find providers here</a> ↘</p>	<p>Use a hospital on the <b>hospital network</b></p> <p>You can use any <b>out of hospital healthcare service providers</b></p> <p>For certain benefits there are network or Designated Service Providers (DSPs) you can use without experiencing a co-payment</p> <p><a href="#">Find providers here</a> ↘</p>	<p>You can use any <b>hospital and out of hospital healthcare service providers</b></p> <p>For certain benefits there are network or Designated Service Providers (DSPs) you can use without experiencing a co-payment</p> <p><a href="#">Find providers here</a> ↘</p>

# 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)	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  - Pathologists and radiologists: 100% of SRR
Benefit limits	Out of hospital benefits: Primary healthcare  Family Hospital Limit: R200 000 (non PMB) Private Family Hospital sublimit: R86 415	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 <b>formulary medicine</b> dispensed by network provider/ pharmacy only	The Scheme pays for medicine according to <b>strict protocols</b> . Use Scheme preferred pharmacies for lower dispensing fees	The Scheme pays for medicine according to <b>moderate protocols</b> . Use Scheme preferred pharmacies for lower dispensing fees

# Which plan is the right one for me?



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.



# 2025 Contributions

## Value Care Plan

Member	Adult dependant	Child dependant
R1 310	R1 310	R320

## Standard Care Plan

Member	Adult dependant	Child dependant
R3 670	R3 670	R1 100

## 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 295	R5 295	R1 225	R1 410	R1 410	R325	R6 705	R6 705	R1 550

### 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](http://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](http://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
  -  This benefit is funded from your MSA
  -  Join our Management Programme to access benefits
  -  Find out more
  -  You need to use a DSP
  -  Subject to PMB guidelines
  -  Use a Network provider/facility
  -  Co-payment
  -  You need referral
- 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.

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	 R9 740 pf and FHL		
Blood transfusions (non-PMB)	 R19 950 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	 R367 440 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) R200 000 pf Private hospital Limit (PHL) for specialist services R86 415 pf Public and private Prime Cure facilities  Limited benefit	No limit Private facilities Hospital network 	No limit Private facilities 





















# Your hospital benefits

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

# Your hospital benefits















Hospital benefits Planned admissions	Value Care Plan	Standard Care Plan	Managed Care Plan
Hospital top-up rate	No benefit	No benefit	
Infertility			
Internal surgical prosthesis	 R35 000 pf and FHL	 R81 160 pb	 R172 140 pb
Kidney disease admissions	  FHL		
Maternity admissions	  FHL		
Maternity confinement	  FHL		
Mental health admissions	 PMB: 21 days Non-PMB: FHL, 5 days per admission, R9 740 pf		
Organ transplant			

# Your hospital benefits

Hospital benefits Planned admissions	Value Care Plan	Standard Care Plan	Managed Care Plan
Pathology	 PMB, R22 710 pf, FHL		
Radiology	 FHL		
Specialised radiology	   R22 710 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.

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.

Out of hospital benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Alcohol and drug treatment		 OHFL and sublimit 2: R6 120 pa, R3 060 pc	
Alternative and allied health care services	 R3 325 pf, max R2 215 pb	 OHFL and sublimit 1: R4 210 pa, R880 pc	



















































# Your out of hospital benefits

Out of hospital benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Cancer treatment	 <p>FHL unless PMB, state facilities</p>	 <p>R367 440 pb per 12-month period</p>	
Cancer medicine	 <p>FHL unless PMB, state facilities</p>		
Cancer innovation medicine	No benefit	 <p>R367 440 pb per 12-month period</p>	
Consultations GP network	 <p>Authorise after 6th consult</p>	No network	 <p>Network rate for consults and procedures</p>
Consultations GP non-network	 <p>R1 275 pb per event consults: 1 pb, 2 pf</p>	OHFL and sublimit 2: R6 120 pa, R3 060 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: R4 210 pa, R880 pc	
Consultations specialists		OHFL and sublimit 2: R6 120 pa, R3 060 pc	
Consultations virtual		OHFL and sublimit 2: R6 120 pa, R3 060 pc	
Contraceptives	 <p>R2 700 pb and FHL</p>	OHFL and sublimit 2: R6 120 pa, R3 060 pc	
Dentistry	 <p>1 consult pb for conservative dentistry and emergency treatment. Dentures: 2 sets pf every 3 years.</p>	 <p>List of basic dentistry services and additional basic and specialised dentistry: R1 890 pa, R475 pc</p>	 <p>FL: R5 130 pa, R1 940 pc, thereafter MSA</p>



# Your out of hospital benefits

Out of hospital benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Diabetes management			
Frail care	No benefit	No benefit	 R86 580 pb
Hearing aids	No benefit	 Appliance limit R11 610 1 pair every 2 years pb	 R24 775 pb per hearing aid every 2 years
HIV/AIDS treatment			
HIV medicine			
Infertility			
Kidney disease	 FHL		
Maternity		 8 consults, 2 scans, R200 pm for vitamins, 5 antenatal classes	 12 consults, 2 scans, R200 pm for vitamins, 5 antenatal classes
Medical appliances	No benefit	 R11 610 pf	 R19 690 pf
Medicine acute	 Formulary medicine at network provider	 OHFL and sublimit 2: R6 120 pa, R3 060 pc	
Medicine chronic non-PMB	No benefit	R5 620 pb	 R21 690 pb

# Your out of hospital benefits

















Out of hospital benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Medicine chronic PMB	 	 	 
Medicine pharmacist advised	 R360 pb max 3 events (R120 per purchase)	R710 pf per 3 months, OHFL and sublimit 2: R6 120 pa, R3 060 pc	
Mental health treatment	  	  PMB: 15 consults non-PMB: 3 GP or psychologist consults up to R3 325 pb. Relapse programme: 2 psychiatric visits and 6 counselling sessions	  PMB: 15 consults non-PMB: 3 GP or psychologist consults up to R3 325 pb. Relapse programme: 2 psychiatric visits and 6 counselling sessions
Optometry	  1 examination and 1 pair of spectacles every 2 years pb	Eye check: R495 pf, lenses/frames: R2960 pf	 Eye check: R495pb, lenses/frames: R4 440 pf
Organ transplant	  	  	 
Oxygen therapy	No benefit		
Pathology	   approved tests	FL: R1 655 pa, R595 pc	
Radiology	   approved tests	FL: R2 155 pa, R1 300 pc	
Specialised medicine and technology	No benefit	 	
Specialised radiology	   FHL and R22 710 pf	 	 
Specialist services	  	OHFL and sublimit 2: R6 120 pa, R3 060 pc	

# Your out of hospital benefits











Out of hospital benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Wheelchair	No benefit	 Appliance limit R11 610 1 wheelchair every 2 years pb	 R30 990 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.

Preventative care benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Baby and child paediatric assessment		OHFL and sublimit 2: R6 120 pa, R3 060 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	R495 pb	R495 pb

# Your preventative care benefits

Preventative care benefits	Value Care Plan	Standard Care Plan	Managed Care Plan
Glaucoma screening	No benefit	OHFL and sublimit 2: R6 120 pa, R3 060 pc	
Gynaecological check		OHFL and sublimit 2: R6 120 pa, R3 060 pc	
Hearing test		OHFL and sublimit 1: R4 210 pa, R880 pc	
HIV screening/test			
Mammogram		1 test pb	1 test pb
Pap smear		1 test pb, age 21 - 65	1 test pb, age 21 - 65
Prostate check		1 PSA test pb	1 PSA test pb
Skin check		OHFL and sublimit 2: R6 120 pa, R3 060 pc	
Vaccines - Childhood	No benefit		
Vaccines - Flu		1 vaccine, 1 consult pb	1 vaccine, 1 consult pb
Vaccine - HPV		1 lifetime vaccine pb	1 lifetime vaccine pb

# Your preventative care benefits

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

AMS provides specialised Care and Management Programmes, designed to offer enhanced support, co-ordinated care, and improved health outcomes for specific conditions.

Our programmes give you and your healthcare provider access to tools and benefits to monitor and manage your condition and ensure you get high quality coordinated healthcare and the best outcomes.

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 Management Programme

Manage diabetes effectively with our comprehensive programme from the Centre for Diabetes and Endocrinology (CDE). Register for type 1 or type 2 diabetes by calling **011 053 4400** or emailing [members@cdediabetes.co.za](mailto:members@cdediabetes.co.za).

Benefits provided: Doctor visits, diabetic foot care, eye screenings, dietary advice, diabetes education and support, laboratory screening, access to medicine and accessories.

## 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](mailto: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\* enrolls 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 R200/month); five antenatal classes; hospital stays: three days for natural births, four days for caesarean deliveries;

access up to 25% 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.

## 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](mailto: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 (No co-payment in 2025 for non-DSP use).



### 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](http://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.

**More information** on all our Management Programmes, is available in the Management Programme information that you will receive on registration, on the relevant benefit description on the website, or from the Call Centre on **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/](http://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](http://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](mailto: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](mailto: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 at 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](http://www.angloms.co.za) to update your details or call us 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](mailto:ex-gratia@angloms.co.za) or  
Post: The Ex Gratia Department,  
P.O. Box 746, Rivonia 2128

**Upon approval, email your claims to:**  
[ex-gratiacclaims@angloms.co.za](mailto:ex-gratiacclaims@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](http://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:

Value Care plan app:

For even more information

Visit our website [www.angloms.co.za](http://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	<a href="mailto:member@angloms.co.za">member@angloms.co.za</a>	<a href="mailto:anglo@kaelo.co.za">anglo@kaelo.co.za</a>
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.

