AMS ANGLO MEDICAL SCHEME

MEDIBRIEF

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Understanding dental benefits on the Standard Care Plan

During our year-end presentations members asked us to provide them with information about the dental benefits on the Standard Care Plan and how the network arrangement with the Dental Risk Company (DRC) works. 78% of member visits for basic or day-to-day dentistry are currently taking place at a contracted DRC network provider.

Accessing available benefits

Standard Care Plan members have access to a basic dental services benefit, provided by the DRC, as well as an additional basic and specialised dentistry family limit of R1 390 per adult and R345 per child.

The purpose of the network arrangement with the DRC is to cover a member's dental maintenance and preventative care from risk and still provide a limited benefit for advanced dentistry procedures. This is achieved through the DRC list of contracted network providers. There are normally two or three providers to choose from in a given area.

AMS encourages members to take advantage of the benefit which, if used correctly, should provide the entire family with basic dental care for the year with minimal or no co-payments. To access the benefit, a member must preferably visit a contracted DRC network provider for claims to be paid at 100% of the Scheme Reimbursement Rate. Members, however, still have a choice of visiting any provider, but AMS will then only pay the claims at 80% of the Scheme Reimbursement Rate.

The best prevention: make regular use of basic dentistry

As basic dentistry is the most important form of dental maintenance and preventative care, the following benefit package, if used properly, will ensure that your teeth remain healthy for the full 365 days of a benefit year:

- Consultations – full mouth examinations managed to ensure 2 visits a year (180 days apart from each other), and specific condition visits. It is only necessary to have a full mouth examination every 180 days as the network provider will formulate a treatment plan to address all your issues found during this examination.
- General hygiene and preventative care – scaling, polishing, and fluoride treatment every 180 days, infection control and sterilisation covered once per visit.
- Diagnostic cover and anaesthetic – intra-oral radiographs at 2 films per visit and local anaesthetic at 1 per visit are covered.
- Extractions – 1 local anaesthetic per visit is covered and providers must pre-authorise more than 4 extractions.
- Restorations – all amalgam and resin restorations are covered, but the provider must obtain authorisation from the 5th restoration for the year.
- Dentures – plastic dentures every 4 years with cover for repairs and relining annually.

Additional basic and specialised dentistry benefit

Should you need additional dental work before the 180 days are up, the claims will be paid from your additional basic and specialised dentistry benefit. In this case, your next preventative consultation would need to be 180 days after the last consult.

The following advanced dentistry procedures will be covered from your family dental limit:

- Root canal treatment
- Orthodontic treatment
- Crowns or bridges
- Periodontic treatment
- Maxilla facial treatment
- Implants
- Any other service not covered in the basic dental maintenance and preventative care package.

Why is a network beneficial?

Network providers have signed a Memorandum of Understanding (MOU) with the DRC and agreed to the following:

- To submit claims to the Scheme for processing and not charge the member upfront for covered procedures.
- To claim according to the Scheme Reimbursement Rate for covered codes.
- To be aware of the Plan's benefit and advise members of what is not covered prior to performing the procedure.
- To facilitate pre-authorisation processes and submit these to the DRC. Upon receipt of a response they need to advise the member of what is covered and what is not covered in accordance with the authorisation document they receive back from the DRC.
- To adhere, wherever possible, to the DRC protocols as provided to them via the DRC provider operational manual, which is distributed annually to ensure that providers are kept abreast of changes to benefits and processes.

Your contracted network provider has received a manual from the DRC explaining all authorisation and protocol requirements. The DRC aims to ensure that all claims are paid efficiently and correctly. Should you have any questions or queries, please call the AMS Call Centre on 0860 222 633.

Specialised Medicine and Technology Benefit (SMTB)

Introduction of the new benefit on the Standard Care Plan and Managed Care Plan

The Scheme introduced a Specialised Medicine and Technology Benefit (SMTB) this year. In this article, we explore what this benefit is about and what you need to do to determine if and how the Scheme will fund specialised medicine and technology, as this might have a financial impact on you.

There are two categories that fall within the SMTB

Category 1 – medicine
The Scheme regards any medicine or technology with a cost equal to or above R5 000 per month, or as a once-off purchase, as specialised treatment. One of these expensive medicines might be a biologic (a product that is produced from living organisms or contains components of living organisms. Biologic drugs include a wide variety of products derived from human, animal or microorganisms using biotechnology). The Scheme will consider these medicines for all registered chronic conditions, for instance, rheumatoid arthritis, multiple sclerosis, and ankylosing spondylitis. Examples of the medication used to treat these conditions are: Revellex, Humira, and interferon beta. The condition treated must be contained within the list of conditions covered by the Scheme. Refer to your Benefit Guide for this list. Some oncology medication will also fall within this expensive medicine category; however, the Scheme considers oncology treatment separately and not within this benefit.

Category 2 – technology (including medical devices)
Medical technology includes a wide range of healthcare products and is used to treat diseases and medical conditions. Medical technology may broadly include medical devices, information technology, biotech, and healthcare services.

The World Health Organization classifies medical device as "any instrument, apparatus, implement, machine, appliance, implant, reagent for in vitro use, software, material or other similar or related article, intended by the manufacturer to be used, alone or in combination, for human beings, for one or more of the specific medical purpose(s) of:

- diagnosis, prevention, monitoring, treatment or alleviation of disease,
- diagnosis, monitoring, treatment, alleviation of or compensation for an injury,
- investigation, replacement, modification, or support of the anatomy or of a physiological process,
- supporting or sustaining life,
- control of conception,
- disinfection of medical devices,
- providing information by means of in vitro examination of specimens derived from the human body".

Examples of these devices and technologies are:

- Pacemakers for members diagnosed with atrial fibrillation (an irregular and often rapid heart rate)
- Internal nerve stimulators for conditions like Parkinson's disease
- Spinal surgery prostheses
- Aortic valves for transcatheter aortic valve implantation (TAVI), a procedure that allows an aortic valve to be implanted using a long, narrow tube called a catheter
- Infusion pumps for insulin-dependent diabetics.

Further dedicated benefit limits for devices

Even though certain components may be regarded as devices, the Scheme will pay for some of these devices from other dedicated benefit limits. Examples of these are wheelchairs and hearing aids, which will be paid from the Hearing Aid and Wheelchair Benefit on the Managed Care Plan and from the Medical and Surgical Appliance Benefit on the Standard Care Plan. Devices that are implanted internally will first be funded from the Internal Surgical Prostheses Limit and then from the SMTB.

Possible financial impact on you as the member: How SMTB is funded by the Scheme

You are required to contact the Call Centre on 0860 222 633 to obtain authorisation. If authorisation is granted, funding will be as follows:

Managed Care Plan:
The Scheme will pay for Scheme-approved SMTB products in full without any co-payment.

Standard Care Plan:
The Scheme will pay for approved SMTB products (medicines and technology) at 80% of the Scheme Reimbursement Rate. You will have a 20% co-payment from 1 January 2020 (even if your condition has been registered for some time). This could possibly have a financial impact for you. If it does, consider other options that might not incur a co-payment by consulting your healthcare provider.

Visit www.angloms.co.za to learn more about your Scheme and benefits.
Find all previous MediBrief editions in the Info Centre > Knowledge Library.

Member Queries:

Value Care Plan: 0861 665 665, anglo@primecure.co.za
Standard and Managed Care Plan: 0860 222 633, member@angloms.co.za
Claims: claims@angloms.co.za