AMS ANGLO MEDICAL SCHEME

MEDIBRIEF

JANUARY 2022

The three different plans on AMS

As we have welcomed new members to the Scheme and as existing members changed their plans at the end of December, we find it important to highlight the benefits of the three different AMS plans.

All three plans fund the treatment of Prescribed Minimum Benefits (PMBs), a set of 270 largely hospital-based conditions and 26 chronic conditions that are considered the minimum health services every member of a medical scheme should have access to.

The three plans are designed to meet the different healthcare needs of our membership. It is not just about comparing the relative value of the contributions and benefits offered, but rather considering your individual and family's needs. A high-level summary of what to look for and what to consider is given below; the detailed benefits can be found in the AMS Benefit Guide or on www.angloms.co.za.

Value Care Plan

The Value Care Plan offers young, healthy members, not needing extensive medical care, the most affordable solution. It provides the comfort of knowing that there is good cover in the event of a catastrophic event requiring urgent treatment. It also provides for normal day-to-day needs through a network of healthcare facilities and providers. To keep contribution rates as affordable as possible, excellent rates have been negotiated by Prime Cure, meaning you would need to obtain all services from these network providers and comply with their protocols. While members of this plan are members of the Anglo Medical Scheme, they mostly deal with Prime Cure and its network of providers directly. Prime Cure healthcare providers are paid directly, and, in most cases, you would not need to pay for healthcare services received.

Your primary healthcare provider knows you best and would take overall responsibility for the coordination of all your healthcare needs. On the Value Care Plan, you start your healthcare with either a nurse practitioner at a network pharmacy or with your network GP. Should you need any further treatment or procedures that the GP can't provide, they refer you to the appropriate specialised healthcare provider or facility, which you will be able to access after a simple authorisation process. Medicines are generally provided by the network GP or a network pharmacy. The Value Care Plan has a hospital limit of R173 000 per family per year and a sublimit of R75 000 for private hospitals.

Standard Care Plan

This plan is the closest to a traditional medical scheme plan that provides comprehensive benefits, several of which are limited or in some instances, subject to a network. Contribution-wise, the Standard Care Plan lies between the Value Care Plan and the Managed Care Plan – a competitive offering compared to the industry. Certain networks are in place to stretch member benefits through reduced network rates. Members can still choose a provider or facility out of the network if they are willing to contribute to the cost difference by way of a co-payment. The most important network on the Standard Care Plan is the hospital network, with currently 197 hospitals countrywide. The use of day clinics is promoted on the basis of being the most appropriate and, from a health point of view, the safest environment for short procedures such as endoscopies and cataract surgery. They are also the most cost effective as the overheads to run the facilities are much lower. AMS has agreed special rates at certain facilities and applies co-payments to those members choosing to use alternative facilities. The Dental Risk Company, contracting with a vast footprint of dentists, provides members with guaranteed primary health dental benefits.

All benefits are available for one calendar year only. Unused limits will not be carried forward to the next year. Oncology (cancer treatment) on the Standard Care Plan is funded up to R310 000 per beneficiary per year, which is generally more than adequate. Continued treatment thereafter might be subject to a co-payment.

All benefits are paid at 100% of the Scheme Reimbursement Rate (SRR), a rate based on the previously negotiated rate between medical schemes and providers. Providers are entitled to charge above the SRR, which is why we encourage members to request the actual costs of services before purchasing them and to compare with the SRR. You can always get a quote from your provider and call 0860 222 633 to receive an estimate of the SRR and, if necessary, negotiate a better rate with your provider.

Managed Care Plan

The Managed Care Plan is designed for members looking to have very few out-of-pocket expenses or members with increased medical needs. It offers richer benefits such as unlimited radiology, pathology and oncology.

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In some instances, specialist services in and out of hospital are paid at a higher SRR than on the Standard Care Plan. Additional non-PMB chronic conditions are funded on this plan, with moderate protocol management for medicine, a frail care benefit and a Medical Savings Account, which is used to pay for most out-of-hospital services. As the member and their dependants' savings portions are considered a single account for the family to use, a member can choose to spend a bigger amount on the services that might be needed in the short to medium term such as physiotherapy and optometry. Any positive, non-utilised savings will be carried over from one year to the next. This plan has a voluntary GP network, which offers competitive consultation rates that extend the medical savings account or reduce the out-of-pocket expenses.

For more details and benefit information about all three plans, please refer to the Scheme website or your Benefit Guide.

Thank you for participating in our survey

As we informed you in our year-end presentations, the Scheme was concerned about the low vaccination uptake according to the vaccination claims we received. As we suspected that certain vaccination sites had not yet submitted the claims, we asked members without vaccination claims whether they had been vaccinated and, if so, where. The feedback from our members is luckily more encouraging that the stats we had up to that point. We received many questions about booster vaccines from the participants. The Scheme and its administrator will continue to provide you with information as soon as it becomes available.

Farewell to the founder of the Centre for Diabetes & Endocrinology

It is with great sadness that the Scheme learnt of the passing of Prof. Larry Distiller, founder of the Centre for Diabetes & Endocrinology (CDE), who provided our membership with specialised diabetes management with unwavering dedication and compassion for many years. Prof. Distiller was at the forefront of developing a programme to assist members diagnosed with diabetes to manage their condition and health holistically. His passing is not only a loss for the CDE, the Scheme and our members, but also for the medical fraternity at large. We will most certainly miss his guidance, passion and care for his patients.

Chronic medicine co-payments – increases for 2022

Please remember that co-payments for your chronic medicine might be increased in 2022. Members with chronic conditions will receive a letter if their registered chronic medicine is affected. If it is, you can always discuss with your prescribing healthcare provider whether there are alternatives for you. To find alternatives, use our medicine search tool on our website. Select your plan from the 'Plans & Products' page, then select 'Medicine' on the Medicine page and follow the link: Medicine search tool or contact the Chronic Medicine Management Team on 0860 222 633.

When will your Covid test be paid by the Scheme?

It is necessary to talk to your doctor for proper screening to be done before you go for the test. Your doctor will advise whether you need the PCR Covid test done. It is also important to let the laboratory know that you suspect a Covid diagnosis or had exposure to someone that tested positive before going for the test. Once you present the pathology request form completed by the doctor, the claim will be paid by the Scheme. If you do not have a referral, the claim will be rejected and for your own cost.

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