AMS ANGLO MEDICAL SCHEME

MEDIBRIEF

JANUARY 2019

In this first MediBrief of 2019 we answer some of our members' most frequently asked questions from our year-end presentations in November of last year.

Frequently asked questions

Why do we have sublimits for Out of Hospital benefits on the Standard Care Plan and how do they work?
For 2019 your overall 'Out of Hospital Family Limit' is R5 070 per adult and R2 530 per child. If you and one other adult are the only two beneficiaries on the Scheme, your Family Limit will be R10 140. If you are two adults plus one child, it will be R12 670. For more adult or child beneficiaries, you would just add the relevant amounts accordingly. This 'Overall Out of Hospital Limit' provides cover for non-PMB day-to-day conditions and has two sublimits, which are also Family Limits and add up in the same way as the 'Overall Out of Hospital Limit'. The 2019 'Sublimit 1' is R3 275 per adult and R685 per child and is for alternative and allied healthcare services, which include, for example, audiology, chiropractic services, dietetics, homeopathy, occupational therapy, physiotherapy, psychology, speech therapy and other services. The 2019 'Sublimit 2' is R4 760 per adult and R2 380 per child and covers GP and specialist consultations, procedures and treatments in rooms, as well as acute medication and injection material, and Pharmacist Advised Therapy.

These two sublimits do not add up to the overall limit. However, they are both still subject to available funds in the overall limit. This might, at first glance, look confusing or like a shortcoming, but it has advantages. Firstly, it acts as a security net. It allows you to use, for example, all of your 'Family Sublimit 1' on physiotherapy for one family member if needed, but still leaves the family with some benefits for acute medicine and GP or specialist consultations. The amount left over in 'Sublimit 2' will now be the difference between the 'Overall Out of Hospital Family Limit' and 'Sublimit 1'. In this case, assuming there are two adults on the Scheme, the 'Overall Out of Hospital Family Limit' will be R10 140 and the total physiotherapy claims paid by the Scheme will be R6 550 (R3 275 + R3 275) leaving a difference of R3 590 for consultations.

Secondly, it gives you the flexibility of funding the treatment you need the most in the current year. You might require more alternative or allied healthcare services this year, but next year you might need more GP and specialist consultations. If these were not two different sublimits, you would only have a fixed limit per year for each group of services and as a consequence, you would probably have access to fewer benefits.

How long can my child stay on the Scheme?

Your child dependant can stay on your membership up to the age of 24. If your child was 23 or younger on 1 January, he/she is still eligible to stay on your membership at the child dependant contribution rate for the current year. If your child had already turned 24 on 1 January, you will receive a letter from the Scheme, informing you that in terms of the Scheme Rules, your dependant's membership will be terminated in the following year.

Should you wish to enrol your child onto another scheme, it is advisable to ensure that there is no break between scheme memberships. Most schemes apply waiting periods, charge increased contributions and/or apply exclusions if their new member has a break of more than three months between schemes.

My child is still financially dependent on me – are there no exceptions to keep him/her on my membership?
You may apply for him/her to stay on your membership if you can supply the necessary documents that the Scheme will need to determine eligibility. This could be granted if:

- Your child is a student or earning less than the tax threshold of a person younger than 65. If eligibility for your child is confirmed, the adult dependant contribution rate would apply.
- Your child is permanently disabled.

Depending on your employer, there might be different subsidies, or none, for the contribution for your child dependant after the age of 21 or 24.

Can I obtain the services of a specialist i.e. paediatrician, specialist physician, cardiologist, etc. on the Value Care Plan?

Yes, you can. You need a referral from a Prime Cure Network GP and you also need to obtain authorisation before you see a specialist. Without authorisation and referral, you would be liable for the full amount of your claim or, if your claim is 'Prescribed Minimum Benefit (PMB)' related, a co-payment of 30%. You may have to pay for the services upfront and submit the claim to request a refund. The Prime Cure Network might have an agreed rate with certain specialists. These specialists can, however, charge their normal rates, which might result in a co-payment. Ask your specialist for a quote before you phone Prime Cure for an authorisation (0861 665 665). The call centre agent will also be able to assist you with the amount you may be required to pay in if the specialist charges above the Prime Cure Rate.

More FAQs for members of the Value Care Plan are available on www.angloms.co.za under Plans & Products > Value Care Plan.

Chronic medicine and the consequences of not taking it as prescribed

What is considered chronic medication and how does the Scheme fund it?

If you take medication for a condition for longer than 3 months, it is considered 'chronic'. The Standard Care Plan (SCP) and Managed Care Plan (MCP) provide a separate benefit for certain chronic medication. These benefits are not automatic, but are subject to the Scheme Rules, clinical entry criteria and protocols. For a list of these conditions, please refer to the Benefit Guide. There are Prescribed Minimum Benefit (PMB) chronic conditions and non-PMB chronic conditions. To access these benefits, your pharmacist or doctor needs to register your chronic condition with the Scheme. In most cases a telephone call is sufficient.

Once your chronic condition is registered, the medication will be paid for from a separate chronic medicine benefit or by the Scheme and not from the Out of Hospital benefit on SCP or your Medical Savings Account (MSA) on the MCP. For PMB chronic conditions, you will also have access to a 'basket of care'. This includes certain healthcare services necessary to treat your condition, for example, pathology tests or consultations.

Non-compliance and the effect on your benefits

Our medicine management team regularly reviews whether members registered for chronic condition/s use their medication. If the claims history suggests that the member is not using the relevant medication, the registration of the condition will be terminated, and the member will be informed. If the chronic condition is a PMB condition, the 'basket of care' will be terminated as well and healthcare services for this condition will then be paid out of the members' day-to-day benefits or MSA and not by the Scheme.

Negative consequences for your health

The effect on your health of not taking your medication as prescribed might not be visible to you immediately. It might result in poor medical outcomes, considerable health risks and potentially higher healthcare costs for you and the Scheme, such as avoidable hospitalisation. Do not take more or less of the dose prescribed, don't skip or double up on doses, and don't stop or start medication without consulting your doctor.

Practical tips to help you comply with the treatment for your condition

- Educate yourself about your condition and the treatment prescribed.
- Follow your doctor's recommendation on how to monitor your treatment outcome. This can be consultations with your doctor, examinations, blood and/or other investigative tests.
- Inform your doctor if you feel different and don't take your own measures to change your treatment.
- If you change to a generic medication, let the pharmacist write on the package which medication it replaces so that you do not to confuse when and how much medication to take.
- Simplify your medicine where possible. Ask for once-daily doses and create a daily routine for when you take them.
- Keep your medication in a dry, dark place for it to stay effective and don't use it past its expiry date.
- Fill your prescriptions early enough and set reminders when to get a new prescription from your doctor. The law requires patients to obtain a new prescription every 6 months. It also serves to ensure that regular monitoring takes place to measure the effectiveness of the treatment.
- For any question about your medication or condition, consult your pharmacist or doctor. For questions about your medication benefits, please call our medicine management team on 0860 222 633.

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

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