

AMS reminders A-Z

This first edition of 2023 provides you with a few important reminders. Please inform yourself about the topics below. More information to each topic is available in your Benefit Guide or on www.angloms.co.za.



- A Authorisations** (see article below).
- B Benefits** – familiarise yourself with your available benefits for 2023 and which medical costs AMS is funding.
- C Claims** are your payment requests to the Scheme for qualifying healthcare services. Find out what information needs to be included on your claims and how we process and pay them.
- D Day clinics** are the preferred place of service for certain surgical or diagnostic procedures (e.g. cataracts, colonoscopies, gastroscopies) etc. By choosing day clinics, you avoid hospital co-payments.
- E Ex gratia** (Latin) means 'by virtue of grace' or 'by favour'. It is a discretionary benefit where the Scheme may consider funding in cases of financial hardship and/or in cases of exceptional clinical circumstances.
- F Frail care** benefits are only available on the Managed Care Plan. Medically related frail care services, where clinically appropriate, will be funded according to Scheme protocols. Only claims received from a Board of Healthcare Funder registered facility or Registered Nurse providing services at home, will be considered for payment. Authorisation is required.
- G Generics** are medicines with the same active ingredients as original brand-name medicines, usually at a lower cost.
- H Hospitalisation** must always be authorised. On the Value Care Plan, you need to use Prime Cure hospitals, you have a Family Hospital Limit and private hospital sublimit*. On the Standard Care Plan, you need to use a facility on the network to avoid co-payments, but you have an unlimited hospital benefit*. On the Managed Care Plan, you have an unlimited hospital limit* and you can use any hospital; co-payments for non-PMB conditions apply.
*Claims paid at SRR (see below).
- I International claims.** There are certain rules for paying international claims on the Standard and Managed Care plan. Before you travel, please learn about them, and take out travel insurance.
- J Joining the Scheme** is, according to our Rules, only possible for active employees of our participating employers. If you want to add beneficiaries to your membership, you need to do so during the first 30 days of them becoming part of your family (e.g. birth, marriage or when you join the Scheme). If you retire and leave the Scheme, or terminate your membership as a retiree, you cannot re-join.
- K Keep your details up to date!** It is your responsibility to inform us if your contact details are changing. If we cannot contact you, it might affect our ability to service you and to provide benefits.
- L Limits** – some benefits are subject to annual limits. Track your benefit usage on your statement or by logging onto the AMS website or app.
- M Medical emergencies** are not any emergency situation. They are clearly defined in the Medical Schemes Act (as per below article).
- N Networks** of healthcare providers are put in place to manage cost through agreed rates so we can keep contributions low.
- O Oncology** (cancer) benefits, after authorisation and registration on the Oncology management programme, will be paid against specific rules and limits. On the Value Care Plan, they are allocated to your available Family Hospital Limit unless PMB; services to be obtained from a state facility. The Standard Care Plan has a limit per beneficiary per 12-month period for treatment with a 20% co-payment once the benefit is depleted; hospitalisation in network facility. Benefits on the Managed Care Plan are unlimited if PMB.
- P Prescribed Minimum Benefits** (PMBs) are the benefits all schemes have to pay for a set list of conditions. You need to register the condition to qualify for benefits and might need to use a Designated Service Provider.
- Q Queries** on any of these topics? Call us on 0860 222 633.
- R Retirement** approaching? You can stay on AMS if you retire from one of our participating employers. Discuss with your HR department how it will affect your subsidies and contribution payments.
- S SRR** stands for Scheme Reimbursement Rate and is the set rate the Scheme pays for services rendered by healthcare providers. This rate is what the Scheme considers to be affordable for its membership and might be lower or higher than what the provider charges.

- T Travel insurance** is highly recommended when you go overseas for you to be covered for medical emergencies. According to our Rules, we cannot pay providers outside South Africa.
- U Upload your claims** on the Anglo Medical Scheme app, in the member area of www.angloms.co.za or email them to claims@angloms.co.za.
- V Vitality** is not a Scheme product, but you may join this wellness programme offered by our administrator independently.
- W www.angloms.co.za** is the Scheme website and provides

you with detailed information on all of these topics, as well as a member self-administration area.

- X XXX** – protect your personal information! We do everything in our power to protect your personal information; please play your part and be mindful where and how you share it.
- Y Your responsibilities** as a member are to know and comply with the Scheme Rules.
- Z Zero co-payment** wanted? There are ways to avoid most co-payments for medicine or healthcare services. Call us for assistance.

All about authorisation

The Benefit Guide specifies, for every benefit, whether you need an authorisation to access the benefit. We usually refer to ‘authorisation’, but authorisation can be either pre-authorisation or retrospective authorisation.

Pre-authorisation is to be obtained before planned procedures in hospitals, day clinics and doctor’s rooms, including tests such as MRI and CT scans and inter-hospital ambulance transfers, to mention a few.

Retrospective authorisation can be given for an event that has already occurred. This event would have required authorisation, but it could not have been, for various reasons, obtained at the time. Without authorisation, the payment of the healthcare services will be rejected for ‘no authorisation’, or paid from your day-to-day benefits, even if you have a benefit for these services. Some Scheme-specified procedures will be considered for payment from the Scheme ‘Risk’, not from your limited benefits or MSA. Other procedures might need a retrospective review as they are initially not considered as payable from ‘Risk’.

What happens in the case of emergency?

The Medical Schemes Act 131 of 1998 defines an “emergency medical condition” as “the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a body organ or part, or would place the person’s life in serious jeopardy”, i.e. a heart attack, stroke, a motor vehicle accident, broken femur after a fall, etc.

To get authorisation for a medical emergency, call us the next working day or within 48–72 hours. We will assess the circumstances and advise whether the event will be authorised.

Authorisation rules to note:

- Authorisation for a hospital admission is only valid for 4 months
- You can’t get an authorisation for a hospital admission or procedure for the following year
- Unless specifically indicated, an authorisation for benefits will only be valid for the current year as benefits and co-payments can change from year to year
- Always ask which benefits will be used for your authorised event. Authorisation does not mean ‘payment (in full) by the Scheme’. Benefit rules, limits and co-payments still apply

Claims procedures:

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, i.e. the Medical Savings Account or limited benefits, ask us for a re-evaluation.

Authorisation vs registration:

Your benefit guide also shows if you need to register your condition for your claims to be paid from a dedicated benefit. If you don’t register your condition, claims will be paid from your limited benefits or MSA.

For both authorisations of healthcare services and registrations of conditions, or any question you might have on the topic, please call us on 0860 222 633.

Do you have further questions on the articles in this edition? Contact us on the numbers and addresses listed here:

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

Visit www.angloms.co.za to learn more about your Scheme and benefits.

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