

## AGM Spotlight

### 1. Highlights from our 56th Annual General Meeting (AGM)

Anglo Medical Scheme held its 56th AGM virtually in May, with good attendance and strong member engagement.

The Chairperson's report reflected on the Scheme's robust financial health and continued commitment to member value. Notably, the Scheme's benefit options were independently assessed and found to offer value for money between 7% and 21% above industry averages. Despite the Scheme's older average age profile, members continue to benefit from high-performing investment returns, carefully considered contribution increases and benefit enhancements.

Financial results for the year showed a strong overall surplus of R272 million, thanks to prudent investment performance.

As part of good governance practice, the Board initiated a review of the external auditor. Following a competitive process, Deloitte & Touche was appointed as the Scheme's new auditor for the 2025/26 financial year, with the resolution passed unanimously by members.

### 2. Understanding out-of-pocket (OOP) costs and member value

At the AGM, a member raised a question about the extent to which claims submitted by pensioners were not paid by the Scheme. This followed a figure published in the Scheme's Annual Financial Statements, which noted that members over the age of 65 cost the Scheme an average of R90 999 per member in 2024 – reflecting the total value of claims paid on behalf of each pensioner member.

The issue of OOP expenses – the difference between what a provider charges and what the Scheme reimburses – is relevant to all members, not just pensioners. In response, the Principal Officer explained that an analysis of the Managed Care and Standard Care Plans showed that, in 2024, members over 65 paid an average of:

- R5 881 in OOP costs for in-hospital claims.
- R7 709 in OOP costs for out-of-hospital claims.

As part of the Scheme's annual benefit review process, AMS closely monitors how benefits are being used and, where appropriate, adjusts them to improve member value. OOP expenses can vary depending on the benefit option you're on and the types of services accessed.

In some cases, OOP costs arise when members choose items or services that exceed the benefit limits. For example, spectacles can be a source of additional expense.



While your plan may include an optical benefit, it might not cover the full cost of higher-end frames or lenses, resulting in a shortfall that the member must pay.

OOP expenses can often be avoided by using providers within the Scheme's network. AMS carefully selects these providers based on quality and value and agrees on standardised rates for services. This means that when you use a network provider, you are far less likely to face shortfalls or unexpected costs.

On the topic of quality, AMS is now a proud participant in the Health Quality Assessment (HQA) programme. This initiative helps benchmark what we spend healthcare funds on and the outcomes members experience – reinforcing our commitment to providing access to quality, evidence-based care across the board.

### 3. Why doesn't the Scheme use its reserves to pay for more benefits?

In a similar vein, a question raised at this year's AGM was why the Scheme doesn't use its surplus reserves, which are above the statutory minimum, to fund benefits that are currently not paid in full or at all. The short answer is that it already does.

Thanks to the Employer's historical pre-funding of pensioners, AMS holds strong reserves. These reserves were specifically created to protect the Scheme from the financial impact of its high pensioner ratio, which currently stands at 23.2%, significantly higher than the industry average of 9.4%. As more members retire and fewer younger members join, this ratio is expected to grow further.

The reserves help cushion members from steep contribution increases that would otherwise result from an older membership profile. In fact, all members already benefit from the reserves through lower contributions than would be required in the absence of this financial buffer. For example, in 2024, the Scheme recorded an operating deficit of R96.1 million before investment income, primarily driven by the Managed Care Plan's older demographic. Reserves are used to absorb this gap.

The Trustees also continue to use the Scheme's strong financial position to enhance benefits where appropriate. In 2024, this included increasing the dentistry limit on the Managed Care Plan and introducing an optometry risk benefit. Further out-of-hospital benefit increases have been approved for 2025.

An independent analysis confirmed that all AMS plans deliver above-average value for money when compared to similar options in the market – with up to 21% more benefit per contribution Rand spent.

#### 4. What were the highest claims paid in 2024?

Medical emergencies can happen unexpectedly, and when they do, your medical scheme is there to provide financial

protection. In 2024, AMS paid out significant amounts from risk for members facing serious health events.

The top three highest individual claims paid from the Scheme's risk pool were:

- R3.4 million for septicaemia (member aged 79).
- R3.3 million for an ischaemic stroke (member aged 60).
- R2.5 million for septicaemia (member aged 45).

Together, the top 20 claims paid from the risk pool totalled R34.7 million. These figures are a powerful reminder of the value of medical scheme cover particularly when facing complex or prolonged hospitalisation. AMS's strong financial position and commitment to quality care ensure that members are supported when it matters most.

## Tax certificates

If you have not yet received your AMS tax certificate for the year ending 28 February 2025, please rest assured – it is currently on its way. You will receive it via email or post, depending on your preferred method of statement delivery. Alternatively, you can download it by logging into the member portal at [www.angloms.co.za](http://www.angloms.co.za), using the AMS app, requesting it via WhatsApp (Ask AMS at 011 292 8797), or by contacting the Call Centre.

## Was your chronic condition registration and related funding terminated? You may need to re-register

If you've received a letter informing you that your chronic condition registration and related funding has been terminated, it's because no claims were received for your chronic medication over the past 12 months. Chronic benefits remain active only if you are using them regularly – which includes consistently taking your prescribed medication.

In addition to medication, some chronic conditions come with a dedicated treatment basket, which may include doctor consultations, blood tests, x-rays, and other healthcare services. These services are paid from your chronic benefit and not from your available day-to-day benefits (on the Standard Care Plan) or Medical Savings Account (MSA) (on the Managed Care Plan).

If your chronic condition registration/s have been terminated, you'll no longer have access to this condition registration/s. Your doctor or pharmacist can contact Anglo Medical Scheme on **0860 222 633** should you need to re-register the condition/s.

### Why taking chronic medication matters?

Taking your medication as prescribed is vital for managing chronic conditions and maintaining long-term health. Stopping your medicine, even if you feel better, can worsen your condition and may lead to hospitalisation or serious health risks.

Never stop chronic medication without consulting your doctor. These treatments are often lifelong and are designed to manage your condition over time. If you've fallen behind on your routine screenings or check-ups, now is a good time to get back on track.

**Do you have membership or Scheme questions? Contact us on the numbers and addresses listed here:**

Value Care Plan: 0861 665 665 | [support@kaelo.co.za](mailto:support@kaelo.co.za) | Standard and Managed Care Plans: 0860 222 633 | [member@angloms.co.za](mailto:member@angloms.co.za) and [claims@angloms.co.za](mailto:claims@angloms.co.za)

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