AMS ANGLO MEDICAL SCHEME

MEDIBRIEF

THIRD QUARTER | JULY 2026

AMS makes history

Anglo Medical Scheme made a little history at its Annual General Meeting (AGM) on 27 May 2026.

For the first time, the AGM was held in a hybrid format, allowing members to attend either in person or online. The meeting was a great success, with member verification and electronic voting managed seamlessly across both platforms, helping to make participation more convenient and accessible for members.

The AGM also saw the reappointment of Deloitte as the Scheme's external auditor. In addition, the three individuals elected to serve on the AMS Disputes Committee were announced: Bongani Bhengu, David Mbuli and Philip Laubscher.

During the meeting, members heard how AMS continued to deliver excellent service during 2025. On the Managed and Standard Care Plans, AMS' administrator, Discovery Health, processed 502,214 claims, responded to 43,532 emails and handled 30,532 calls, while achieving an impressive 96.96% service level. Members also rated the service they received highly, with an average satisfaction score of 9.58 out of 10.

Another notable achievement was that no complaints were lodged with the Council for Medical Schemes by AMS members during 2025, reflecting the Scheme's commitment to resolving member concerns promptly and effectively.

The AGM also provided insight into the significant healthcare costs funded by the Scheme. The three highest claims paid from the risk pool during the year amounted to almost R11.4 million, which highlights the financial protection that members receive when faced with serious illness or complex medical conditions.

Members were also updated on healthcare costs not fully covered by benefits. For members aged 65 and older on the Managed Care and Standard Care Plans, the average claim shortfall increased by 8%, from R13,590 in 2024 to R14,753 in 2025.

A number of questions were raised by members during the meeting, including the process for lodging a complaint or dispute with the Scheme, when co-payments may apply, and how interest on medical savings accounts is managed. We address these questions in more detail elsewhere in this newsletter.

Thank you to all members who participated in the AGM and who continue to play an active role in the governance of AMS.

How to raise a complaint or dispute

At AMS, our members are at the heart of everything we do. Every decision we make is guided by one principle: acting in the best interests of our members.

We are committed to providing excellent service and ensuring that queries, concerns and complaints are handled fairly, respectfully and efficiently. We also believe that members should have clear channels through which they can raise concerns and have them addressed appropriately. Most enquiries can be resolved quickly by our service team. However, if you have a complaint or dispute, there is a clear process to follow to ensure that your concern receives the attention it deserves and is reviewed at the appropriate level.

1 ***Contact the AMS service team***

If you have a question, concern or complaint, your first point of contact should be the AMS service team via email at member@angloms.co.za for Managed and Standard Care Plan members or ams@kaelo.co.za for Value Care Plan members. They will investigate your enquiry and provide you with a reference number for future correspondence.

2 ***Request escalation***
If you feel that your enquiry or complaint has not been resolved to your satisfaction, you should contact the service team again. Be sure to provide your reference number and request that the matter be escalated within the service team for further review.

3 ***Contact the Principal Officer***
If the matter still remains unresolved, you may contact the Principal Officer's office directly via email at principalofficer@angloms.co.za or on 011 638 5471.

4 ***Refer the matter to the Disputes Committee***
Should you remain dissatisfied after engaging with the Principal Officer's office, you may request the Principal Officer to submit your complaint to the Scheme's Disputes Committee for consideration.

5 ***Contact the Council for Medical Schemes***
If all avenues within the Scheme have been exhausted and your matter remains unresolved, you may lodge a complaint with the Council for Medical Schemes (CMS), the Regulator of medical schemes in South Africa.
Telephone: 0861 123 267 or 012 431 0500
Email: complaints@medicalschemes.co.za
Website: www.medicalschemes.co.za

Please note that the CMS requires members to first exhaust the Scheme's internal complaints and dispute resolution processes before submitting a complaint to the Regulator.

We encourage members to follow each step in the process, as this gives AMS the opportunity to investigate and resolve concerns as efficiently as possible.

Independent benchmarking confirms strong value for AMS members

When belonging to a medical scheme, one of the most important questions is whether you are receiving good value for the contributions you pay.

To help answer that question, AMS commissioned an independent benchmarking analysis by actuarial consulting firm 3ONE. The analysis compared AMS and its benefit options with similar options offered by some of South Africa's largest medical schemes, including Discovery Health, Bonitas, Momentum, Fedhealth, Medshield, Medihelp, Bestmed and Sizwe Hosmed. The findings provide reassuring confirmation that AMS continues to deliver strong value to members across all three benefit options.

Strong value across all options
The analysis used 3ONE's Benefit Value Index (BVI), which measures the value members receive relative to the contributions they pay. Simply put, it assesses how much benefit members can expect to receive for every Rand contributed to their medical scheme.

The results showed that all three AMS options compare favourably with similar options in the market. The AMS Managed Care Plan achieved the highest value score among all comparable options included in the study, while the Standard Care Plan also ranked first in its comparison group. The Value Care Plan delivered better value than most comparable low-cost options available in the market.

Competitive contributions
The benchmarking also found that AMS contributions remain competitive when compared with similar options offered by other medical schemes. The Managed Care and Standard Care Plans were both found to be generally affordable relative to comparable options, while the Value Care Plan remains one of the more affordable options available to members seeking quality cover at a lower contribution level. For many members, this means access to comprehensive benefits without paying significantly more than they would on similar options elsewhere.

Comprehensive benefits matter
Value is about more than contributions alone. The breadth and quality of benefits available to members are equally important. The analysis found that AMS compares strongly in terms of benefit richness.

In particular, the Managed Care Plan was noted for offering a comprehensive range of benefits relative to competing options, while the Standard Care Plan performed well in areas such as chronic medicine benefits, oncology cover, advanced radiology and prostheses. These benefits can make a meaningful difference when members need healthcare the most.

A strong foundation for the future

The report also highlighted AMS's strong financial position. Although medical schemes across South Africa continue to face pressures such as rising healthcare costs and an ageing membership profile, AMS remains supported by exceptionally strong reserves that help safeguard the Scheme's long-term sustainability.

What this means for members

The independent benchmarking confirms that AMS continues to provide members with a compelling combination of competitive contributions, comprehensive benefits and strong value for money. Independent assessments like this help ensure that AMS continues to measure itself against the best in the industry and deliver value where it matters most – to our members.

Understanding co-payments

One of the questions raised by members at the recent AMS AGM was when and why co-payments apply.

A co-payment is the portion of a medical bill that you are responsible for paying yourself. While AMS covers a wide range of healthcare services, there are situations where members may need to contribute towards the cost of treatment.

The most common reason for a co-payment is when a healthcare provider charges more than the amount covered by the Scheme. Co-payments can also apply when members choose not to use a Designated Service Provider (DSP) or network provider for certain services, or for specific procedures where Scheme rules require members to use a particular facility or treatment pathway.

Why do medical schemes apply co-payments?

Co-payments are one of the tools used by medical schemes to manage healthcare costs and ensure the long-term sustainability of benefits for all members. They also encourage the appropriate use of healthcare services and support the use of contracted providers who have agreed to provide quality healthcare at negotiated rates.

AMS carefully selects its network providers to ensure members receive quality healthcare while helping to keep healthcare costs affordable.

Prescribed Minimum Benefits (PMBs)

By law, medical schemes must cover the diagnosis, treatment and care costs of PMBs in full when members use the Scheme's DSPs.

If members choose to obtain PMB treatment from a provider outside the designated network without a valid reason, co-payments may apply.

We're here to help

Healthcare benefits can sometimes be complex, and the circumstances under which co-payments apply differ between benefit options and types of treatment. If you are unsure whether a co-payment may apply, contact AMS before receiving treatment. A quick enquiry can help you avoid unexpected costs and ensure that you make the most of your benefits.

How can you avoid unexpected costs?

Before receiving treatment, it is always a good idea to:

- Ask your healthcare provider whether they charge above the AMS Scheme Reimbursement Rate (SRR).
- Obtain a quotation for planned procedures.
- Use network providers where possible.
- Contact AMS if you are unsure about the level of cover available for a specific treatment.

Understanding the SRR can help you make informed healthcare decisions and avoid unexpected out-of-pocket expenses.

Understanding the AMS Scheme Reimbursement Rate (SRR)

Have you ever wondered how Anglo Medical Scheme determines what it will pay for a medical consultation, procedure or medicine?

The answer lies in the SRR. The SRR is the rate that AMS uses as the basis for paying healthcare claims. In simple terms, it is the maximum amount that the Scheme will reimburse for a particular healthcare service, consultation, procedure or medicine.

To calculate the SRR, AMS uses one of several recognised benchmarks, depending on the type of service being provided. These may include negotiated rates with healthcare providers and networks, the regulated Single Exit Price (SEP) for medicines, or the National Health Reference Price List (NHRPL), adjusted for inflation.

What does this mean for members?

If your healthcare provider charges at or below the SRR, your claim will generally be paid in full according to your benefit rules.

This is often the case when you receive treatment from a provider who participates in an AMS network or when you receive treatment that is covered as a Prescribed Minimum Benefit (PMB).

However, some healthcare providers charge more than the SRR. In these cases, the Scheme will pay up to the SRR and you may be responsible for the difference. This difference is known as a co-payment – paid either from your own pocket, or, where your option allows, from your Medical Savings Account.

A helpful tool for AMS members

Members may be interested to know that Netcare has launched a new mobile app that includes access to Netcare 911, the designated emergency road and air ambulance service provider for members on the Managed Care and Standard Care Plans.

In an emergency, the app can be used to contact Netcare 911 quickly and can share your location with emergency responders, helping them reach you as efficiently as possible.

The app may also be useful for members who are admitted to a Netcare hospital, which is the Designated Service Provider for hospital admissions on the Standard Care Plan. Features include hospital pre-admissions, access to hospital stay information, account information and post-discharge recovery guidance.

While the app is entirely optional, it may be worth downloading and keeping on your phone should you need emergency assistance or a hospital admission in the future.

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 | **Standard and Managed Care Plans:** 0860 222 633 | member@angloms.co.za and claims@angloms.co.za

Visit www.angloms.co.za to learn more about your Scheme and benefits. To read your articles, latest news and more, visit www.angloms.co.za.