

WITBANK COALFIELDS MEDICAL AID SCHEME

# ANNUAL REPORT 2025





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# 2025 HIGHLIGHTS

## Our Members

Members	10,154
Beneficiaries	26,668
Average age	29.8 yrs
Pensioner ratio	4.9%
Chronic disease ratio	28.4%



## Value Created

Claims paid	R651 million
Hospital authorisations	5,450
Non-healthcare expenses as a % of contributions	5.6%
Managed care savings	R28 million

## Ensuring Sustainability

Insurance liability to future members (reserves)	R725 million
Solvency ratio	79.4%
Investments (excl cash)	R972 million
Investment income	R108 million
Aggregate gross investment return	10.1%



## REPORT OF THE BOARD OF TRUSTEES

The Board of Trustees hereby presents its report for the year ended 31 December 2025.

### 1. ABOUT WCMAS

The Witbank Coalfields Medical Aid Scheme (WCMAS) is a non-profit, restricted membership, self-administered medical scheme governed by the Medical Schemes Act of South Africa, as amended, and regulated by the Council for Medical Schemes. For 90 years, WCMAS has been dedicated to serving its members, affiliated employer groups, and the broader coal mining industry, providing tailored healthcare solutions that prioritize both comprehensive coverage and affordability.

As a specialist scheme catering to a niche market, WCMAS is managed by a Board of Trustees representing key stakeholders and members. The Scheme is designed to address the diverse healthcare needs of coal mining employees across various employment levels, offering exceptional value beyond what is typically available through open medical schemes.

WCMAS distinguishes itself through:

- Tailored healthcare solutions designed for the unique demands of the coal mining sector.
- Personalized service from a dedicated regional team with in-depth industry knowledge.
- Robust financial reserves, ensuring long-term stability and trusted healthcare protection for members.

With a strong foundation in both financial sustainability and service excellence, WCMAS remains a leading medical scheme for the coal mining industry, delivering reliable, high-quality healthcare coverage to its members.

### 2. OPERATIONAL AND BUSINESS REVIEW

As a not-for-profit entity with strong financial reserves, the Scheme budgeted to break even, projecting a marginal surplus of R5 million after investment income for the 2025 financial year. However, the actual financial outcome significantly exceeded expectations, with a net surplus of R144 million. This surplus has been allocated to the liability for future members in the statement of profit or loss, reinforcing the Scheme's long-term sustainability and financial stability.


## 2.1 OPERATIONAL STATISTICS PER BENEFIT OPTION

2025		Comprehensive	Midmas	Ntsika	Scheme
Average number of members during the accounting period		6,577	1414	2,163	10,154
Number of members at 31 December		6,577	1698	2,262	10,537
Average number of beneficiaries during the accounting period		17,303	3,986	5,380	26,668
Number of beneficiaries at 31 December		17,377	4,820	5,494	27,691
Average family size at 31 December		2.6	2.8	2.5	2.6
Average beneficiary age as at 31 December		31.4	26.4	27.8	29.8
Pensioner ratio at 31 December	%	7.4	0.4	1.0	4.9
Insurance revenue per average beneficiary per month (pabpm)	R	2,272	1,337	1,210	1,918
Insurance service expenses pabpm	R	2,362	1,098	1,106	1,920
Relevant healthcare expenditure incurred pabpm	R	2,222	962	957	1,778
Directly attributable insurance service expenses pabpm	R	140	127	147	139
Directly attributable insurance service expenses ratio	%	6.1	9.5	12.1	7.3
Relevant healthcare expenditure ratio	%	97.8	71.9	79.1	92.7
Average members' funds per member as at 31 December*	R				82,433
Return on investments as a percentage of investments*	%				14.8
2024		Comprehensive	Midmas	Ntsika	Scheme
Average number of members during the accounting period		6,608	1065	2,240	9,913
Number of members at 31 December		6,605	1187	2,138	9,930
Average number of beneficiaries during the accounting period		17,384	2,968	5,783	26,135
Number of beneficiaries at 31 December		17,359	3,308	5,464	26,131
Average family size at 31 December		2.6	2.8	2.6	2.6
Average beneficiary age as at 31 December		31.1	25.2	27.0	29.5
Pensioner ratio at 31 December	%	7.3	0.4	0.7	5.1
Insurance revenue per average beneficiary per month (pabpm)	R	2,159	1,303	1,172	1,843
Insurance service expenses pabpm	R	2,079	1,331	1,052	1,767
Relevant healthcare expenditure incurred pabpm	R	1,985	1,182	936	1,662
Directly attributable insurance service expenses pabpm	R	137	129	117	132
Directly attributable insurance service expenses ratio	%	6.4	9.9	10.0	7.1
Relevant healthcare expenditure ratio	%	92.0	90.7	79.9	90.2
Average members' funds per member as at 31 December*	R				72,971
Return on investments as a percentage of investments*	%				10.1

\*Average accumulated funds per member and return on investments are only calculated for the total Scheme and not per option.


## 2.2 BENEFIT OPTIONS

The Scheme’s benefit options remained largely unchanged for the 2025 financial year, ensuring stability and continued value for members. WCMAS offers a range of tailored healthcare solutions designed to meet the diverse needs of its member base.




**COMPREHENSIVE**

The Comprehensive Option provides extensive medical coverage, offering members peace of mind with competitive subsidization for continuation members who retire on this plan. The day-to-day component is primarily funded through a Medical Savings Account (MSA), which accumulates at 25% of contributions, allowing members flexibility in managing their out-of-hospital expenses.



**MIDMAS**

The Midmas Option provides middle-range hospital benefits along with a discretionary Medical Savings Account (MSA) for day-to-day medical expenses, also allocated at 25% of contributions. This option offers a balance between affordability and comprehensive coverage, making it a suitable choice for members seeking flexible healthcare solutions.



**NTSIKA**

The Ntsika Option is designed to provide affordable, primary care-focused healthcare for lower-income employees. Members have access to private healthcare facilities within the Ntsika network. Day-to-day healthcare expenses are funded through insured benefits, ensuring accessibility and cost-effectiveness. Contributions are income-based, offering one of the most affordable private healthcare solutions in the market for this segment.

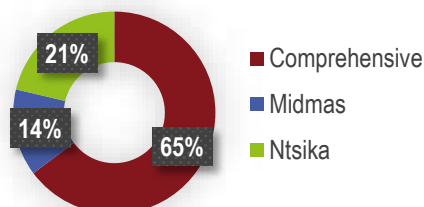
With its diverse benefit options, WCMAS continues to deliver cost-effective and high-quality medical cover, ensuring members receive the best possible healthcare solutions tailored to their needs.

## 2.3 MEMBERSHIP

The Scheme experienced positive growth of 2.4% during the year, with the addition of 241 new members. At the close of the financial year, the average age of beneficiaries remained low at 29.8 years (2024: 29.5), which is significantly lower than the industry average of 34.2 years. Similarly, the pensioner ratio remained stable at 4.9% of total beneficiaries (2024: 5.1%), well below the industry average of 9.6%.

This continued growth and sustained favourable risk profile underscore the exceptional value that WCMAS provides to its members, reinforcing its competitive advantage within the medical scheme industry.

The distribution of membership across benefit options has remained relatively stable, with the Comprehensive Option maintaining its position as the most preferred choice, representing 65% of total membership (2024: 67%).



## 2.4 INSURANCE REVENUE

For the 2025 financial year, the Scheme budgeted for an annual contribution increase of 5.9%. However, the actual contribution increase per beneficiary was 4.1%, reflecting a lower-than-anticipated adjustment. This variance was primarily driven by a shift in membership demographics, with a higher proportion of new members opting to the Midmas benefit option.

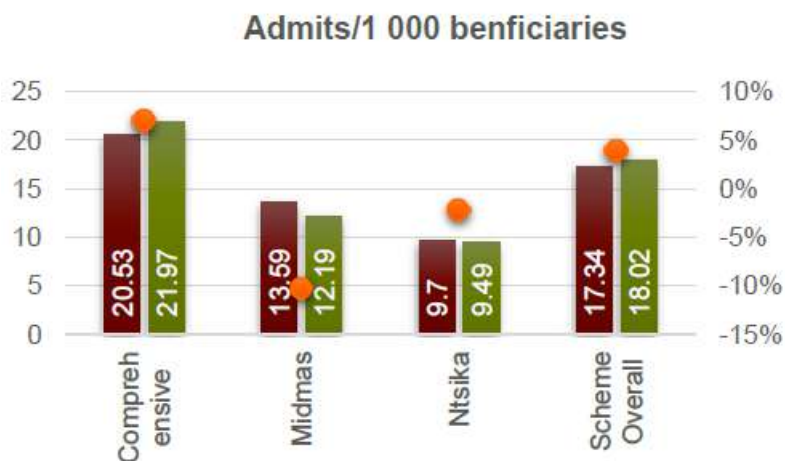
## 2.5 INSURANCE SERVICE EXPENSES

Medical inflation typically outpaces consumer inflation by 1 to 3 percentage points per annum. In anticipation of this trend, the Scheme budgeted for a 7.4% increase in claims expenditure for 2025. However, the actual claims incurred per beneficiary saw an increase of 8.7%, reflecting a higher claims experience than projected.

### 2.5.1 Hospitalization

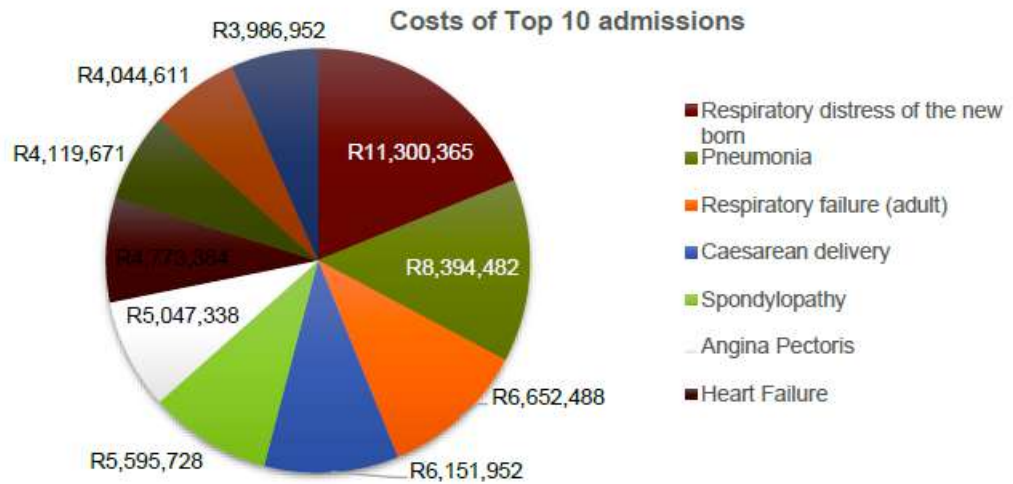
Hospital admission costs are the most substantial and variable of the scheme’s insurance service expenses. These costs include inpatient care, surgical procedures, intensive care, and extended hospital stays for medical conditions, all of which can significantly impact the Scheme’s financial results. Factors such as the frequency of admissions, the severity of medical conditions, and advancements in medical technology influence overall expenditure.

The incidence of hospital admissions is the number of admissions per 1 000 beneficiaries. The incidence of admissions reflects the extent of hospital admissions in WCMAS and is independent of the number of members joining or leaving WCMAS. On this basis, the rate of hospital admissions increase by 3.9% (2024: reduction of 3.9%) year-on-year, reflecting a normalisation to the prior year’s relatively low hospitalisation incidence. The Comprehensive option 7%, while the Midmas and Ntsika options reduced by 10.3% and 2.2% respectively. This hospitalisation incidence trend is illustrated in the graph below:



The overall cost per hospital admission decreased by 4.3% compared to the previous year, This is due in part to a different case mix experience and a reduction in both the number and costs for injuries, maternity deliveries and premature neonates when compared to 2024.

The top ten admission types by cost accounted for 26.1% of the total authorized hospital expenses for the year (2024: 26.7%), reflecting a consistent trend in hospital admission cost drivers:



The Scheme experienced a decrease in the number of high-cost claims during the year. A high-cost claim is defined as claims cost exceeding R350,000 for a single beneficiary within a benefit year. The total value of high-cost claims increased by R10.2 million, now representing 43% of total claims, compared to 42% in 2024. This increase was driven by:

- A 7.5% decrease in the number of high-cost cases.
- A 2.8% reduction in the average cost per case.

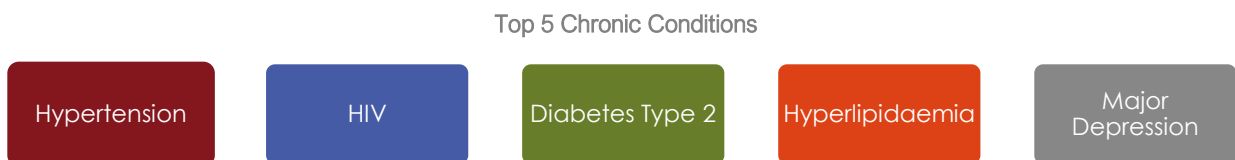
These trends have contributed to higher overall claims expenditure in hospital.

### 2.5.2 Chronic Conditions

Chronic condition expenses represent a significant portion of overall healthcare costs and directly impact financial sustainability. These ongoing medical expenses, associated with conditions such as diabetes, hypertension, and heart disease, require continuous treatment, medication, and management, leading to substantial long-term financial commitments.

The Scheme's chronic medicine costs increased by 10.1%, which was higher than the budgeted estimate of 7.3%. While the cost per patient remained in line with forecast SEP increases at 5.9%, the number of members claiming chronic medication increased by 4%, partly due to the overall increase in membership of 2.4%.

The top five chronic conditions by cost remained unchanged from the previous year, highlighting consistent treatment patterns and member healthcare needs.

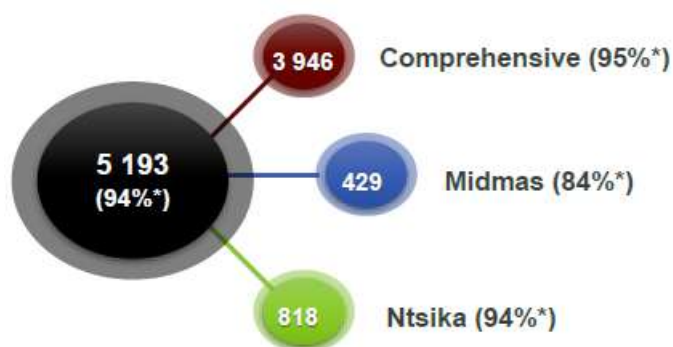


The Scheme continued to strengthen its disease management programmes during the year under review, with a focus on improving health outcomes for members living with chronic conditions, including HIV, hypertension, hyperlipidaemia, and Type 2 diabetes.

In support of members' holistic wellbeing, the Scheme introduced a Mental Wellbeing Programme on 1 January 2025 to assist members in managing mental health conditions such as major depressive disorder. The Trustees also approved the introduction of a Respiratory Disease Management Program to support members living with asthma, chronic obstructive pulmonary disease (COPD) and other respiratory conditions from 1 January 2026.

These initiatives form part of the Scheme's broader clinical risk management strategy aimed at addressing prevalent chronic conditions and promoting appropriate and proactive healthcare interventions

During the year under review, 17.8% of beneficiaries submitted claims relating to a chronic condition (2024: 17.5%). A total of 5,502 beneficiaries (2024: 4,730) were enrolled in disease management programmes, of whom 94% (2024: 96%) received counselling as part of their care plans. The Trustees recognise that effective disease management plays an important role in improving member health outcomes while contributing to the long-term financial sustainability of the Scheme.



As part of its ongoing governance oversight, the Scheme issued a Request for Proposal (RFP) for disease management services during the year. Following a comprehensive evaluation process undertaken by Management, the Clinical Governance Committee and the Board of Trustees, the managed care contracts were awarded to PPS Health Administrators, with effect from 1 January 2026.

The Scheme also participated in the Health Quality Assessment (HQA) survey during 2025. HQA is an independent South African non-profit organisation that conducts annual clinical quality assessments across the healthcare sector and serves as a national benchmarking standard. The results of the survey provided valuable insights and highlighted key areas of focus to further strengthen the Scheme's disease management programmes and clinical quality outcomes.

## 2.6 ADMINISTRATION AND OPERATIVE EXPENSES

The Scheme operates on a self-administered model, with certain administrative and risk management functions outsourced to specialised third-party experts to optimise operational efficiency and to access technical expertise. To ensure maximum value for members, the Board actively monitors administrative and operational expenditure through regular reviews of itemised costs against the approved budget. This oversight supports cost-effectiveness while ensuring alignment with the Scheme's financial sustainability objectives.

Administration expenses that are directly attributable to insurance contracts are classified as insurance service expenses. During the reporting period, these expenses accounted for 7.3% of risk contributions received (2024: 7.1%). On a per-beneficiary-per-month basis, administration expenses increased by 5.7%, from R131,75 in 2024 to R139.23 in 2025.

The most recent available industry benchmark, based on the 2024 financial year, reflects an average administration cost of R194.86 per beneficiary per month, which highlights the Scheme's continued efficiency in managing administrative expenditure.

## 2.7 INVESTMENT PERFORMANCE

The Scheme's accumulated reserves continued to generate sufficient investment income during the year under review to fully offset administrative and operative expenses. As a result, 100% of members' contributions were applied toward funding healthcare benefits. The Trustees regard this outcome as an important indicator of the Scheme's prudent financial management and its commitment to maximising value for members while maintaining long-term sustainability.

Over the three-year period ending 31 December 2025, the Scheme's asset managers delivered a net return of 13.6% (2024: 8.8%), exceeding the performance target of 7.4% (2024: 8.2%). Funds allocated to the money market achieved a 8.8% return over the same period (2024: 9.2%), outperforming the STeFI Composite benchmark of 7.5% (2024: 8.5%).

The Scheme's investment strategy remains focused on achieving a CPI+3% return over a rolling three-year period while maintaining a strong emphasis on capital preservation and responsible risk management. Following a comprehensive review, the Investment Committee confirmed that the current asset managers and the CPI+3% performance objective remain appropriate in supporting the Scheme's long-term financial stability and the sustainability of member benefits.

## 3. SOLVENCY AND FINANCIAL STABILITY

In accordance with Regulation 29(2) of the Medical Schemes Act 131 of 1998, as amended, the Scheme is required to maintain accumulated funds, excluding unrealised investment reserves, at a minimum solvency level of 25%. The solvency ratio for 2025 and 2024 is presented below:

	Note	2025	2024
Insurance contracts liability for future members (members' funds)	10	868,586,642	724,598,316
Less: Cumulative net unrealised non-distributable reserve movements recognised in the statement of income		(225,265,151)	(134,640,554)
Accumulated funds per regulation 29		643,321,491	589,957,762
Gross contributions (including savings contributions)	14	792,225,654	743,416,468
Solvency ratio		81.2%	79.4%

The Scheme significantly exceeds the regulatory solvency requirement, with a solvency ratio of 81.2% in 2024 (2024: 79.4%), reinforcing its strong financial position and ability to meet future member obligations. There were no unusual movements in members' funds that the Trustees believe should be brought to the attention of the members.

## 4. MEDICAL SAVINGS ACCOUNTS

The Scheme offers personal medical savings account options through the Comprehensive and Midmas benefit plans. These savings accounts are designed to help members cover day-to-day healthcare expenses that are not fully covered by the risk pool, providing greater financial flexibility in managing out-of-pocket medical costs.

Personal medical savings are administered on behalf of members in accordance with the Scheme Rules and the Medical Schemes Act, as amended. Unutilized savings amounts accumulate over time for the long-term benefit of the member, with interest applied using the effective interest rate method. In compliance with Regulation 10, the liability associated with members' savings accounts is classified as a current liability in the Scheme's financial statements.

The Scheme also assumes some risk related to the forward allowance of savings account utilization, as outlined in the Scheme Rules. When a member transfers to another benefit option that does not include a personal medical savings account or moves to another medical scheme, any accumulated, unutilized savings balance is refunded or transferred in accordance with the Scheme's rules and regulatory requirements. This ensures that members retain the benefit of their personal medical savings contributions while maintaining financial integrity within the Scheme.

## 5. SCHEME MANAGEMENT AND THIRD-PARTY SERVICE PROVIDERS

### MEMBER ELECTED TRUSTEES

Andile MB Mazibuko

Comfort Mabanga

Letlotlo BM Modise

Nomsa W Mlambo

Nomthandazo SN Ndebele

Zinhle Mothibi

Richard V Mnguni (Chairperson)

Siyanda Lupuwana

### Changes in 2025

Term of office expired on 3 June

Elected on 3 June

Elected on 3 June

Re-elected on 3 June

Reselected as Chair on 29 July

Term of office expired on 3 June

### EMPLOYER APPOINTED TRUSTEES

Caroline IA Maslo

Thungela

Term of office expired on 3 June

Dion M Le Roux

Seriti

Appointed on 4 March

Lebogang S Gumede

Glencore

Re-appointed on 3 June

Masechaba M Makgolane (Vice-Chair)

Thungela

Re-appointed on 3 June

Selected as Vice-chair on 29 July

Nomthandazo Pitjeng

Seriti

Re-appointed on 3 June

Sarah L Kekana

Glencore

Re-appointed on 3 June

Thulisile Ritah Ngwenya

Thungela

Appointed on 3 June

### EXECUTIVE MANAGEMENT

Mereese A Anthony

Principal Officer

Monica DA Perestrelo Javed

Chief Financial Officer

### ACTUARIES

*3One Consulting Actuaries*

52 Grosvenor Road

Bryanston

Sandton

### PRINCIPAL BANKERS

*Nedbank Limited*

### ADMINISTRATION

WCMAS was self-administered for this financial year ending 31 December 2025. Select administration functions and network management for the Ntsika option:

*Universal Healthcare Administrators (Pty) Ltd*

Universal House

15 Tambach Road

Sunninghill Park

Sandton

#### MANAGED HEALTHCARE

*Universal Care (Pty) Ltd*

Universal House  
15 Tambach Road  
Sunninghill Park  
Sandton

*Medikredit Integrated Healthcare Solutions  
(Pty) Ltd (formerly Performance Health)*

10 Kikuyu Road  
Sunninghill  
Sandton

#### ASSET MANAGERS AND CONSULTANTS

*Aluwani Capital Partners*

Aluwani House  
24 Georgian Crescent East  
Bryanston East  
Johannesburg

*Coronation Fund Managers*

7th Floor  
MontClare Place  
Cnr Campground & Main Road  
Claremont  
Cape Town

*NinetyOne Investment Managers*

100 Grayston Drive  
Sandown  
Sandton

*M&G Investments*

*Formerly Prudential Investment Managers*

Loft Offices East  
31 Tyrwhitt Avenue  
Rosebank  
Johannesburg

*Willis Towers Watson*

Illovo Edge  
1 Harries Road  
Illovo  
Sandton

#### EXTERNAL AUDITOR

*Middel & Partners Inc.*

42 Lebombo Road  
Ashlea Gardens  
Pretoria  
0081

#### INTERNAL AUDITOR

*Nexia SAB&T Inc*

119 Witch-Hazel Avenue  
Highveld Technopark  
Centurion

#### WCMAS REGISTERED OFFICE

WCMAS Building  
corner Susanna Street and OR Tambo Road  
Emalahleni

#### WCMAS POSTAL ADDRESS

PO Box 26  
Emalahleni  
1035

## 6. CORPORATE GOVERNANCE

### 6.1 COMMITMENT TO GOVERNANCE

The WCMAS Board of Trustees is committed to upholding the principles of fairness, responsibility, transparency, and accountability in all its interactions with stakeholders. The Board applies Principles and Code of Corporate Practices and Conduct outlined in the King Report on Governance, as applicable to medical schemes.

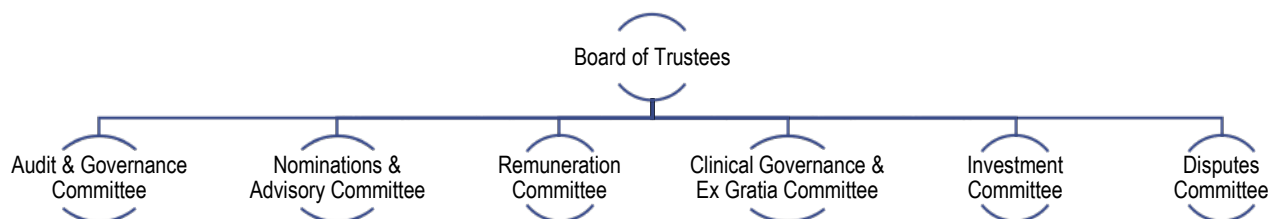
### 6.2 BOARD OF TRUSTEES

The Board of Trustees consists of at least ten members, with an equal split between representatives appointed by participating employer groups and those elected by members of the Scheme at the Annual General Meeting. Trustees serve a two-year term, with a maximum of three successive terms. The Nominations and Advisory Committee reviews all prospective trustees, and the Chairperson and Vice-Chairperson are elected by the Board.

The Board met regularly to monitor Scheme performance, ensuring informed and constructive discussions on policy, strategy, risk management, and service delivery. To enhance decision-making, the Board received actuarial, legal, and investment management advice from experienced professionals. Trustees have direct access to the Executive Management and may seek independent professional advice at the Scheme’s expense when required.

### 6.3 COMMITTEES OF THE BOARD OF TRUSTEES

The Board has established several sub-committees to support its governance duties. These committees meet regularly and include both Trustees and non-trustee members selected for their expertise. Each committee operates under a written charter outlining its responsibilities and authority. The Principal Officer and Chief Financial Officer attend all meetings, and the Committee Chairperson reports to the Board after each session. Committee meeting minutes are circulated to the Board for review.



#### 6.3.1 Audit and Governance Committee

Established in accordance with Section 36 of the Medical Schemes Act, this Committee provides oversight of the Scheme’s accounting policies, internal controls, risk management and financial reporting. It consists of six members, two of whom are Trustees, while the Chairperson is an independent non-trustee member. The Committee liaises with external auditors, internal auditors, and Scheme management to ensure financial integrity. The Committee comprises the following members during the year under review:

Andries J Nienaber		Non-trustee member
Masechaba M Makgolane		Trustee member
Nomthandazo SN Ndebele		Trustee member
Re-ana C Joseph	Chairperson	Non-trustee member
Riaan NM Prinsloo		Non-trustee member
Wilfred L Skhosana		Non-trustee member

During the year, the Committee:

- Fulfilled its duties as required by the Medical Schemes Act and the Board’s Terms of Reference.
- Confirmed the independence of the external auditors.
- Determined that there were no material breakdowns in internal controls.
- Reviewed the risk register and financial statements.
- Recommended the adoption of the Annual Financial Statements by the Board.

#### 6.3.2 Nominations and Advisory Committee

This Committee advises the Board on trustee nominations, diversity, skills assessments, and committee composition. It also evaluates the performance of committees, chairpersons, Trustees, and executive management. It operates under a written Terms of Reference and plays a key role in strengthening Scheme governance.

The Committee comprises the following members during the year under review:

Dion M Le Roux	Appointed on 31 July 2025	Trustee member
Jaqueline Perkes	Chairperson	Non-trustee member
Letlotlo BM Modise		Trustee member
Sunelle Viljoen		Non-trustee member
Zandile Nkosi		Non-trustee member

### 6.3.3 Remuneration Committee

The Remuneration Committee oversees all remuneration matters for Trustees and Scheme employees, ensuring that remuneration strategy aligns with the Scheme's objectives. The Committee recommends appropriate compensation structures to the Board and AGM for approval. The Committee comprises the following members during the year under review:

Carlo Steenkamp	Appointed on 2 September 2025	Non-trustee member
Jaqueline Perkes	Chairperson	Non-trustee member
Letlotlo BM Modise		Trustee member
Siyanda Lupuwana	Appointed on 2 September 2025	Non-trustee member
Sunelle Viljoen		Non-trustee member
Thabo Masike	Term expired on 26 July 2025	Non-trustee member

### 6.3.4 Clinical Governance and Ex Gratia Committee

This Committee provides strategic oversight of the Scheme's clinical risk and managed healthcare activities. It ensures that healthcare services are clinically appropriate, cost-effective, and aligned with best practice. Additionally, it evaluates ex gratia funding requests to ensure equitable support for members in exceptional circumstances. The Committee comprised of the following members during the year under review:

Andile MB Mazibuko	Term expired on 3 June 2025	Trustee member
Dr. Caroline IA Maslo	Chairperson	Non-trustee member
Dr. Fezile Gabellah	Appointed on 31 July 2025	Non-trustee member
Dr. Khulwani Msimeki	Resigned 26 June 2025	Non-trustee member
Dr. Thulisile Ritah Ngwenya		Trustee member
Masechaba Makgolane		Trustee member
Thabo Masike	Appointed on 31 July 2025	Non-trustee member

### 6.3.5 Investment Committee

The Investment Committee is responsible for managing the Scheme's investments in alignment with its long-term financial objectives. Its key mandate includes:

- Achieving CPI +3% annual returns (net of fees) over a three-year period.
- Preserving capital over a 12-month period.
- Investing in highly rated institutions while maintaining moderate risk exposure.
- Ensuring compliance with Medical Schemes Act regulations.

The Committee comprises the following members during the year under review:

Andries J Nienaber		Non-trustee member
Henry M Pearson		Non-trustee member
Re-ana C Joseph		Non-trustee member
Richard V Mnguni		Trustee member
Wilfred L Skosana	Chairperson	Non-trustee member

### 6.3.6 Disputes Committee

This Committee consists of three independent members and convenes only when a formal dispute requires resolution. The disputes committee comprised of the following members during the year under review:

M Botha	Non-trustee member
F Kruger	Non-trustee member
E Wiese	Non-trustee member

### 6.4 TRUSTEES' AND COMMITTEE MEMBERS' REMUNERATION

Trustees and committee members are compensated based on their expertise, skill, and time commitment. The Remuneration Committee ensures that compensation structures remain fair and competitive, subject to approval at the Annual General Meeting. Some members choose to forgo remuneration due to existing employer arrangements. Full remuneration details are disclosed in Note 18 of the Annual Financial Statements.

### 6.5 EVALUATION OF THE BOARD OF TRUSTEES AND COMMITTEES

The Board undergoes annual self-assessments using a structured evaluation questionnaire. This assessment covers leadership, governance, compliance, skill diversity, and effectiveness. The Nominations and Advisory Committee reviews the results, providing recommendations to improve governance and performance.

### 6.6 BOARD AND COMMITTEE MEETINGS

The Board convened seven times during the year, with committee meetings held regularly. Trustees are expected to attend meetings, prepare thoroughly, and contribute constructively. The table below outlines Trustee and committee meeting attendance:

	Board of Trustees	Audit & Governance Committee	Clinical Governance & Ex Gratia Committee	Investment Committee	Nominations & Advisory Committee	Remuneration Committee
Number of meetings	7	2	4	3	2	3
<b>TRUSTEES</b>						
Andile MB Mazibuko	1/4		0/1			
Caroline IA Maslo	4/4		1/1			
Comfort Mabanga	7/7					
Dion M Le Roux	6/7				1/1	
Lebogang S Gumede	6/7					
Letlotlo BM Modise	5				1/2	2/3
Masechaba M Makgolane (Vice-chairperson)	7/7	1/2	4/4			
Nomsa W Mlambo	2/3					
Nomthandazo Pitjeng	7/7					
Nomthandazo SN Ndebele	7/7	2/2				
Zinhle Mothibi	3/3					
Richard V Mnguni (Chairperson)	7/7			2/3		
Sarah L Kekana	6/7					
Siyanda Lupuwana	3/4					1/1
Thulisile Ritah Ngwenya	3/3		3/3			

	Board of Trustees	Audit & Governance Committee	Clinical Governance & Ex Gratia Committee	Investment Committee	Nominations & Advisory Committee	Remuneration Committee
<b>NON TRUSTEES</b>						
Andries Nienaber		1/2		2/3		
Carlo Steenkamp						2/2
Caroline IA Maslo			3/3			
Fezile Gabellah			1/1			
Henry M Pearson				2/3		
Jaqueline Perkes					2/2	3/3
Khulwani Msimeki			1/1			
Re-ana C Joseph		2/2		3/3		
Riaan M Prinsloo		1/2				
Siyanda Lupuwana						2/2
Sunelle Viljoen					2/2	2/3
Thabo Masike			1/1			1/1
Thulisile Ritah Ngwenya			1/1			
Wilfred L Skhosana		1/2		3/3		
Zandile Nkosi					2/2	

## 7 RISK MANAGEMENT

The Board of Trustees understand the importance of sound risk management and remains committed to the principles of ethical leadership and strong corporate governance. These principles serve to protect the long-term sustainability of the Scheme and ensure its continued ability to provide value to its members. To this end, the Board conducts regular reviews of the risks facing the Scheme, actively managing those within its control.

In shaping the Scheme's strategic direction, several key risks have been identified:

### 7.1 MEMBER RETENTION

The Scheme is exposed to the risk of declining membership, particularly due to employer groups reducing their workforce in response to industry changes. To mitigate this risk, the Scheme maintains close engagement with employer groups through dedicated relationship managers and ongoing discussions with key stakeholders. The financial impact of membership fluctuations is carefully assessed during the Board's annual pricing reviews.

### 7.2 MEMBER RISK PROFILE

Sustained growth of a younger, healthier membership base is essential to balance the impact of an ageing population and maintain the competitive value of the Scheme's product offerings. The Board has implemented a responsible growth strategy that ensures strategic growth plans align with the Scheme's eligibility criteria, risk appetite, and risk-based capital tolerance.

### 7.3 REGULATORY CHANGE

Changes in healthcare regulations, including the potential implementation of a National Health Insurance (NHI) system, may impact the Scheme's ability to provide sustainable benefits to its members. The Board actively manages this risk through ongoing engagement with regulators and participation in industry advocacy forums, including the Board of Healthcare Funders.

#### 7.4 RISING HEALTHCARE COSTS

Escalating healthcare costs, particularly in the absence of regulatory cost controls associated with prescribed minimum benefits (PMBs), pose a financial risk to the Scheme and exacerbate affordability constraints for members. Cost-containment initiatives, including clinical outcome monitoring, provider engagement, and ongoing research, are key strategies employed to mitigate this risk. The Scheme also monitors PMB-related claims and engages directly with providers where costs exceed expected thresholds.

#### 7.5 SUSTAINABILITY OF BENEFIT OPTIONS

Setting contribution rates before actual claims experience is realized creates a pricing risk, particularly if contributions are underestimated. Additionally, increased healthcare demand from an ageing membership may drive costs beyond inflation and members' affordability limits. The Scheme mitigates this risk through rigorous risk management policies, including tariff negotiations, pre-authorization, case management, benefit limits, provider networks, and managed care initiatives. Annual pricing reviews and five-year financial projections are conducted to ensure long-term sustainability.

#### 7.6 ECONOMIC CONDITIONS

Adverse economic conditions can affect members' ability to afford contributions or result in shifts to lower-cost benefit options that may not adequately meet their healthcare needs. To address this, the Scheme offers flexible benefit designs that cater to both healthcare needs and affordability, supported by provider networks and managed healthcare initiatives.

#### 7.7 SERVICE DELIVERY FROM KEY SERVICE PROVIDERS

The Scheme relies on service providers for critical managed care functions. Any failure to meet performance expectations could negatively impact member experience, benefit accessibility, and health outcomes. To mitigate this, the Scheme maintains stringent service level agreements with key providers, monitors performance through regular reporting, and holds frequent management discussions to address service issues and operational concerns. Additionally, managed care providers report back to the Clinical Governance and Ex Gratia Committee to ensure accountability and alignment with Scheme objectives.

#### 7.8 RISING BURDEN OF DISEASE

The increasing prevalence of chronic non-communicable diseases, including cancer and mental health conditions, presents a growing challenge. Rising disease burden, coupled with escalating healthcare costs, places additional affordability pressures on members. The Scheme proactively addresses this issue through member education, disease management programmes, and initiatives aimed at improving healthcare literacy and outcomes. Long-term risks, such as the lingering effects of COVID-19 and the health impacts of climate change, are closely monitored to ensure an effective response.

The Board of Trustees remains confident that the Scheme has robust controls in place to effectively manage these risks, ensuring its continued ability to serve its members with financial stability and high-quality healthcare benefits.

### 8 MEDICAL INSURANCE RISK MANAGEMENT

The primary insurance activity undertaken by the Scheme is the assumption of risk related to certain healthcare claims from members and their dependants. Given the inherent uncertainty surrounding the timing and severity of claims, the Scheme continuously evaluates and mitigates its exposure to insurance risk.

To effectively manage medical insurance risk, the Scheme employs a combination of benefit limits and sub-limits, structured approval procedures, pricing guidelines, pre-authorisation requirements, and case management protocols. Additionally, the Scheme engages in negotiations with major service providers and actively monitors emerging industry trends to ensure financial sustainability and member affordability.

The Scheme utilizes various analytical methods to assess and monitor both individual and aggregate risks, including internal risk measurement models, sensitivity analyses, scenario testing, and stress testing. These methodologies provide valuable insights into potential risk exposures and guide strategic decision-making.

The Scheme Rules, registered with the Council for Medical Schemes, define the benefits available under each plan option. The key benefit categories provided by the Scheme include:

- In-hospital benefits – covering costs incurred during hospital admissions.
- Chronic disease benefits – providing medication and consultations for chronic conditions across all plan options, supported by disease management programs that assist, educate, and support members.
- Day-to-day benefits – covering out-of-hospital medical expenses, such as general practitioner and dental visits, acute medication, and over-the-counter medicines, subject to benefit limits and Scheme tariffs; and
- Additional benefits – including preventative wellness benefits, external medical appliances, and access to disease management programs.

In accordance with the Scheme Rules, the Scheme reserves the right to adjust contract terms and conditions to ensure ongoing financial stability and alignment with regulatory requirements. To maintain sound financial governance, management information, including contribution income, expenditure, and claims ratios by option, is reviewed monthly.

## 9 ACTUARIAL REVIEW AND CONTRIBUTION ASSESSMENT

While an actuarial review of the Scheme is not a statutory requirement under the Medical Schemes Act, the Scheme proactively engages independent actuarial expertise to ensure sound financial and benefit planning. For the 2024 and 2025 benefit years, 3One Consulting Actuaries conducted a review of budgeted contributions and key assumptions used in the benefit design process. This assessment confirmed the appropriateness of the contribution increases, ensuring that they remain aligned with the Scheme's financial sustainability and member affordability objectives.

Additionally, the actuaries provided the valuation of the post-retirement employment benefit liability, supporting the Scheme's commitment to prudent financial management and long-term planning. This independent actuarial input strengthens the Scheme's ability to make data-driven decisions, manage risk effectively, and maintain financial stability while delivering comprehensive healthcare benefits to its members.

## 10 OUTSTANDING CLAIMS

The movement on the outstanding claims provision and the methodology used in its calculation are detailed in Note 2 of the Annual Financial Statements. The basis of calculation remains consistent with the prior year, and includes a non-financial risk adjustment, as required under IFRS 17. This adjustment enhances the accuracy of claim provisioning by incorporating non-financial risk factors, ensuring compliance with IFRS® Accounting Standard as issued by the International Accounting Standards Board (IASB®), while maintaining the Scheme's prudent approach to claims liability management. There were no unusual movements in the outstanding claims provision that the Trustees believe require special attention from the Scheme's members. The provision continues to be monitored and evaluated to ensure adequate coverage of incurred but not yet reported claims, supporting the financial stability and claims-paying ability of the Scheme.

## 11 FIDELITY INSURANCE

The Scheme maintains fidelity insurance at a level deemed appropriate by the Board of Trustees. This insurance coverage serves as a safeguard against potential losses arising from fraud, theft, or dishonesty, ensuring the protection of the Scheme's assets and financial integrity. The Board regularly reviews the adequacy of this coverage to align with industry best practices and evolving risk exposures, reinforcing the Scheme's commitment to sound governance and financial security.

## 12 RELATED PARTY TRANSACTIONS

Details of related party transactions are disclosed in Note 20 of the Annual Financial Statements, in accordance with relevant reporting standards and governance requirements. This disclosure includes transactions with parties that have a significant influence over the Scheme. Additionally, Trustee remuneration is detailed in Note 18 of the Annual Financial Statements, providing full disclosure of compensation and allowances in line with the Scheme's governance framework. The Board remains committed to transparent financial management and adherence to regulatory and ethical standards in all related party dealings.

## 13 NON-COMPLIANCE MATTERS

The Scheme is committed to full compliance with the Medical Schemes Act and related regulations. All non-compliance matters identified have been disclosed in this report, regardless of materiality. The following instances of non-compliance were noted during the reporting period:

### LATE RECEIPT OF CONTRIBUTIONS (SECTION 26(7))

Section 26(7) of the Act requires that all contributions be paid directly to a medical scheme within three days of becoming due. In 2025, not all billed contributions were received within this timeframe, which could impact cash flow and interest income. The Scheme actively follows up on outstanding contributions and applies its credit control policy to manage overdue payments effectively.

### CLAIMS PAYMENT DELAYS (SECTION 59(2))

The Act mandates that claims be settled within 30 days of receipt. While the Scheme endeavours to process all claims within this period, occasional delays occur due to validity verification procedures. Claims exceeding the 30-day threshold are investigated by management, ensuring that all outstanding payments are addressed in a timely and compliant manner.

### BENEFIT OPTION SELF-SUFFICIENCY (SECTION 33(2)(b))

Section 33(2)(b) of the Medical Schemes Act requires that each benefit option be financially self-supporting to maintain the financial integrity of the Scheme and prevent cross-subsidisation. In 2025, the Comprehensive option recorded an insurance service deficit of R18,755,239 (refer to Note 19 of the Annual Financial Statements). Persistent deficits on benefit options could potentially lead to cross-subsidisation from surplus-generating options, which may impact the overall financial soundness of the Scheme. To ensure long-term sustainability and regulatory compliance, the Scheme is actively implementing strategic measures, including:

- Contribution adjustments to align pricing with claims experience,
- Benefit design reviews to optimize cost-effectiveness, and
- Ongoing assessments to monitor financial performance and adjust strategies proactively.

### PROHIBITED INVESTMENTS (SECTION 35(8) (a, c & d))

Section 35(8) prohibits medical schemes from holding investments in:

- The business of any medical scheme administrator;
- The holding company of an administrator; or
- Any employer group associated with the Scheme.

As of 31 December 2025, the Scheme held underlying investments amounting to 0.8% in medical scheme administrators or their holding companies (Momentum Metropolitan Holdings, Discovery Holdings and Sanlam Limited) and 0.9% in employer groups (Glencore Plc and Exxaro Resources) of total net asset value. The Scheme has obtained an exemption from the Council for Medical Schemes (CMS) to retain these investments while ensuring compliance with broader regulatory requirements.

#### 14 GOING CONCERN

The Annual Financial Statements have been prepared based on accounting policies applicable to a going concern, which assumes that the Scheme will continue its operations in the foreseeable future. This basis presumes that sufficient funds will be available to finance future operations, and that the realisation of assets and settlement of liabilities, contingent liabilities, and commitments will occur in the ordinary course of business.

The Board of Trustees conducts an annual assessment of the Scheme's business plan, key performance indicators, and strategic targets to ensure that all material risks are comprehensively addressed. This includes maintaining a regular review of the Scheme's risk register and management accounts, ensuring that contingency plans are in place to mitigate potential risks. In reviewing budgets and cash flow projections, along with additional financial data for 2026, the Board of Trustees has determined that the going concern assumption remains appropriate for the next twelve months from the date of approval of the Annual Financial Statements. This assessment underscores the Scheme's financial stability and ability to meet its obligations while continuing to provide sustainable healthcare benefits to its members.

#### 15 EVENTS AFTER THE REPORTING PERIOD

The Board of Trustees confirms that there were no adjusting or non-adjusting events that occurred after the reporting period that would have a material impact on the Annual Financial Statements or require disclosure.

## STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES

The Trustees are responsible for the preparation, integrity and fair presentation of the annual financial statements of Witbank Coalfields Medical Aid Scheme ("the Scheme"), comprising the statement of financial position at 31 December 2025 and the statements of comprehensive income, and cash flows for the year then ended, and the notes to the annual financial statements, which include a summary of significant accounting policies and other explanatory notes required in accordance IFRS Accounting Standards as issued by the International Accounting Standards Board, and the requirements of the Medical Schemes Act of South Africa No. 131 of 1998, as amended ("the Act").

The Trustees consider that, in preparing the annual financial statements, they have used the most appropriate accounting policies consistently applied and supported by reasonable and prudent judgements and estimates.

The Trustees are satisfied that the information contained in the annual financial statements fairly present the results of operations for the year and the financial position of the Scheme at year-end. The Trustees also prepared the other information included in the annual report and are responsible for both its accuracy and its consistency with the financial statements.

The Trustees are responsible for ensuring that accounting records are maintained. The accounting records disclose, with reasonable accuracy, the financial position of the Scheme which enables the Trustees to ensure that the annual financial statements comply with the relevant legislation.

Witbank Coalfields Medical Aid Scheme operates in a well-established control environment which is well documented. This incorporates risk management and internal control procedures which are designed to provide reasonable but not absolute assurance that assets are safeguarded and the risks facing the business are adequately mitigated.


The Trustees, with the support of the independent actuarial advisors, have assessed the ability of the Scheme to continue as a going concern and have no reason to believe, given its solvency position, that the Scheme will not be a going concern in the year ahead.

The Audit and Governance committee functioned effectively throughout the year.

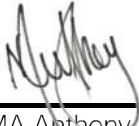
The Scheme's external auditor is responsible for auditing the fair presentation of the financial statements in terms of International Reporting Standards on Auditing in accordance with the applicable financial reporting framework of the Scheme.

### APPROVAL OF FINANCIAL STATEMENTS

The financial statements set out on pages 31 to 79, which have been prepared on the going concern basis, were approved and authorised for issue by the Board of Trustees on 23 April 2026 and were signed on their behalf by:

  
\_\_\_\_\_  
RV Mnguni  
Chairperson

  
\_\_\_\_\_  
M Makgolane  
Vice-chairperson

  
\_\_\_\_\_  
MA Anthony  
Principal Officer

## STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES

The Witbank Coalfields Medical Aid Scheme is committed to upholding the highest standards of fairness, responsibility, transparency, and accountability in its interactions with stakeholders. The Scheme strives to align its corporate governance framework with the principles set forth in the King IV Code of Corporate Governance, as guided by the Council for Medical Schemes.

To ensure compliance with corporate governance requirements, the Board of Trustees, sub-committees, and management have access to governance experts when necessary. This approach is considered sufficient to effectively oversee the affairs of the Scheme.

### 1. ETHICS

The medical schemes industry faces significant challenges, including fraudulent claims and abuse of member benefits by certain healthcare professionals and, in some cases, members. Such unethical practices compromise the financial sustainability of the industry and negatively impact all members. To counter these risks, the Scheme has implemented rigorous fraud prevention policies and detection mechanisms.

The Scheme adopts a zero-tolerance stance on fraud, waste, and abuse. Preventive measures include:

- Raising awareness about fraud and unethical practices.
- Implementing stringent abuse prevention tactics; and
- Utilizing data analytics to detect irregular billing and claiming patterns.

All investigations into suspected fraudulent activities are conducted confidentially, and the identities of whistleblowers are protected.

### 2. CORPORATE CITIZENSHIP

In accordance with the King IV Code, the Scheme recognizes its role as a responsible corporate citizen, acknowledging that it operates as an integral part of broader society. The Scheme and its Trustees are committed to ethical decision-making, ensuring responsible and sustainable operations.

#### 2.1 Stakeholder engagement

The Scheme prioritizes meaningful engagement with stakeholders through:

- Regular communication with key stakeholder groups.
- Ensuring representation of major stakeholder groups on the Board of Trustees.
- Efficient resolution of stakeholder queries; and
- Prompt attention to and escalation of complaints where necessary.

#### 2.2 Responsible business practices

The Scheme is dedicated to maintaining responsible business practices that safeguard its sustainability by:

- Employing skilled and adequately trained staff.
- Upholding high ethical standards, honesty, and integrity; and
- Evaluating the impact of decisions on all relevant stakeholders.

The Scheme enforces strict quality control measures, conducts performance evaluations, and monitors stakeholder feedback to continuously improve its operations.

## 2. BOARD OF TRUSTEES

The Board of Trustees serves as the Scheme's primary governing body, ensuring sound decision-making and strategic oversight. While the Board delegates specific functions to sub-committees and the Principal Officer, it retains ultimate responsibility for the effective operation of the Scheme.

The Board comprises individuals with the requisite expertise, experience, and diversity to govern the Scheme effectively. Trustees are nominated and elected by members and participating employers, operating under defined Terms of Reference. Regular meetings are held to monitor performance and address key strategic and policy matters.

The Board of Trustees believes that the delegation of authority framework contributes to the role clarity and the effective exercise of authority and responsibilities of the Board's duties. All the Trustees have access to the advice and services of the executive leadership and may seek independent professional advice at the expense of the Scheme.

To support governance efficiency, the following sub-committees assist the Board:

- Audit and Governance Committee.
- Clinical Governance and Ex Gratia Committee.
- Disputes Committee.
- Investment Committee.
- Nominations and Advisory Committee; and
- Remuneration Committee.

### 3.1 Performance evaluations

An annual performance review assesses the effectiveness of the Board, sub-committees, and executive leadership. The Nominations and Advisory Committee reviews these assessments, provides feedback, and recommends necessary improvements. The latest review confirmed that the Board and its committees are functioning effectively.

### 3.2 Remuneration

Trustees and committee members receive compensation for their contributions, provided they complete the necessary training as prescribed by the Council for Medical Schemes. The Scheme's remuneration policy aligns with the principles outlined in the King IV report.

Remuneration details, including per-meeting fees and travel cost reimbursements, are disclosed in the Annual Financial Statements (Note 18).

## 3. PRINCIPAL OFFICER

The Principal Officer's responsibilities are defined by a Service Level Agreement, in alignment with the Medical Schemes Act and the Scheme's Rules. The Principal Officer serves in an executive capacity and is fully dedicated to the Scheme. Adequate succession planning ensures continuity in leadership.

## 4. COMPLIANCE AND REGULATORY OVERSIGHT

The Scheme ensures full compliance with relevant medical aid regulations through:

- Ongoing reviews by the Council for Medical Schemes.
- Regular updates to policies in line with legislative changes; and
- Training for staff and Trustees on regulatory requirements.

## 5. RISK MANAGEMENT

The Scheme actively identifies, mitigates, and manages business risks to maintain financial and operational stability. Key risk management activities include:

- Continuous risk identification by management.
- Quarterly risk assessments by the Audit and Governance Committee.
- Implementation of risk-mitigation controls.
- Formal strategic planning processes.
- Annual policy and procedural reviews; and
- Periodic evaluation of committee Terms of Reference.

The Scheme maintains internal controls and systems designed to provide reasonable assurance as to the integrity and reliability of the financial information and to safeguard, verify and maintain accountability for its assets adequately. Such controls are based on established policies and procedures and are implemented by trained personnel with the appropriate segregation of duties.

The Scheme monitors the effectiveness of controls and resultant deficiencies (if any) by:

- Regular quality control reviews.
- Internal audits of control processes; and
- Frequent Audit and Governance Committee meetings to review audit outcomes.

No event or item has come to the attention of the Board of Trustees to indicate that there has been any material breakdown in the functioning of the key internal controls and systems during the year under review.

## 6. INFORMATION TECHNOLOGY, CYBERSECURITY AND DATA PROTECTION

The Scheme's IT infrastructure is managed internally under the oversight of Scheme Management. A reputable administration system is utilized to ensure regulatory compliance and operational efficiency. Stringent change management and cost control measures, including structured incident logging, have been implemented to maintain high service levels.

To protect sensitive member information, the Scheme:

- Implements robust cybersecurity measures.
- Conducts regular IT security audits; and
- Trains employees on data protection best practices.

## 7. INVESTMENT STRATEGY

The Scheme's investment strategy is designed to achieve long-term capital growth while maintaining low risk. The key objectives include:

- Achieving a return exceeding CPI +3.0% per annum (net of fees) over a rolling three-year period.
- Maintaining liquidity levels in accordance with regulatory requirements.
- Investing in highly rated financial institutions with moderate risk exposure.
- Ensuring compliance with legislative and regulatory investment guidelines; and
- Conducting periodic risk assessments with feedback to the Board.

## 8. MEMBER ENGAGEMENT AND SATISFACTION

The Scheme values member feedback and enhances engagement through:

- Regular surveys to assess satisfaction levels.
- A dedicated support team for prompt resolution of member concerns; and
- Transparent communication regarding benefits and changes.

## 9. FUTURE OUTLOOK AND STRATEGIC GOALS

Looking ahead, the Scheme aims to:

- Expand its member support services.
- Strengthen fraud prevention measures.
- Enhance digital services for greater efficiency; and
- Maintain financial stability while improving healthcare access.

This statement has been reviewed and approved by the Board of Trustees, as evidenced by the signatures of the authorized representatives:



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RV Mnguni  
Chairperson



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M Makgolane  
Vice-chairperson



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MA Anthony  
Principal Officer



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## Independent Auditor's Report

*To the Members of The Witbank Coalfields Medical Aid Scheme.*

### Report on the Financial Statements

#### *Unqualified Opinion*

We have audited the financial statements of The Witbank Coalfields Medical Aid Scheme ("The Scheme") set out on pages 31 to 79, which comprise the statement of financial position as at 31 December 2025, and the statement of profit or loss and other comprehensive income and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of material accounting policies.

In our opinion, the financial statements present fairly, in all material respects, the financial position of Witbank Coalfields Medical Aid Scheme as at 31 December 2025, and its financial performance and cash flows for the year then ended in accordance with IFRS<sup>®</sup> Accounting Standards as issued by the International Accounting Standards Board (IASB<sup>®</sup>) and the requirements of the Medical Schemes Act of South Africa.

#### *Basis for Opinion*

We conducted our audit in accordance with International Standards on Auditing (ISA Standards). Our responsibilities under those standards are further described in the Auditors responsibilities for the Audit of the financial statements section of our report. We are independent of "The Scheme" in accordance with the Independent Regulatory Board for Auditors' Code of Professional Conduct for Registered Auditors (IRBA Code) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the corresponding sections of the International Ethics Standards Board for Accountant's International Code of Ethics for Professional Accountants (Including International Independence Standards). We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

#### *Key Audit Matters*

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period. These matters were addressed in the context of our audit of the financial statements, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

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Directors: PA Dames CA(SA)   JJ Marais CA(SA)   WE Westmeier CA(SA)   F Jeeva CA(SA)   JH Krige CA(SA) Associates: HJ Smit AGA(SA)   M Looock AGA(SA)	



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Key Audit Matter	Audit Response
<p><b>Liability for incurred claims</b></p> <p>The Liability for incurred claims (LIC) provision consisting of:</p> <ul style="list-style-type: none"> <li>- Best estimate liability of claims incurred but not reported R 38 203 797 (2024: R 45 308 105);</li> <li>- Risk adjustment R 1 370 008 (2024: R 1 961 679); and</li> <li>- Reported claims not yet paid R 2 383 568 (2024: R 1 042 525),</li> </ul> <p>forms part of the insurance contract liability. The insurance contract liability is described in note 12 to the financial statements. The LIC includes the estimated cost of healthcare benefits that have been incurred by the members before the end of the financial year but that have not been reported to the Scheme by that date, as well as insurance accounts payable and the personal medical savings liability.</p> <p>Per IFRS 17, the Scheme measures the LIC provision as the fulfilment cash flows plus a risk adjustment at year-end. The estimate of the future cash flows in terms of the LIC provision is adjusted to reflect the compensation that the Scheme requires for bearing the uncertainty about the amount and timing of the cash flows arising from non-financial risk including claims risk, membership risk, and expense risk.</p> <p>The rules of the Scheme provide that claims may only be paid if the Scheme is notified of the claim and documentation is submitted within 4 months of the date of the healthcare service.</p> <p>At year-end, the cost of outstanding incurred claims is estimated by the Scheme's actuaries, using the Bornhuetter-Ferguson method (BFM) in the calculation of the Scheme's LIC provision. Considering the IFRS 17 requirements, the LIC estimate shows the LIC provision at various percentiles of the simulated LIC</p>	<p>Our audit procedures for the Liability of incurred claims (LIC) provision included the following:</p> <p>We obtained an understanding of the inherent risk factors in relation to the complexity, subjectivity and the change of the LIC provision estimate;</p> <p>We assessed the appropriateness and timely recognition of the related LIC provision against the requirements of IFRS 17 - Insurance contracts;</p> <p>We have gained a detailed understanding of the end-to-end claims and LIC estimation process and obtained an understanding of the relevant controls.</p> <p>We obtained the report of the Scheme's independent actuary of the LIC provision at year end and tested the appropriateness of the estimate performed as follows:</p> <ul style="list-style-type: none"> <li>- Evaluated the competence, capabilities and objectivity of the Scheme's independent actuary;</li> <li>- Obtained an understanding of the method and models used in calculating the LIC provision estimate and assessed whether it is appropriate in terms of acceptable methodologies, industry standards, and that they meet the measurement objectives of IFRS 17;</li> <li>- Obtained an understanding of the significant assumptions used in the estimate and, challenged whether the assumptions are appropriate for the estimate of the LIC provision and the risk adjustment factors;</li> <li>- Obtained an understanding of the data utilised in the calculation of the estimate;</li> <li>- Assessed the estimate for indicators of possible management bias.</li> </ul>



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<p>estimates, each allowing for a different assumed risk adjustment factor.</p> <p>A LIC provision at the 60<sup>th</sup> percentile (2024 – 50<sup>th</sup> percentile) of the stipulated LIC estimates has been selected by the Scheme.</p> <p>We considered the Liability for incurred claims (Note 12) as a matter of most significance to the current year audit of the financial statements due to the following:</p> <ul style="list-style-type: none"> <li>- the degree of estimation uncertainty and complexity of the fulfilment cash flows;</li> <li>- significant judgment in selecting the related risk adjustment for non-financial risk factors; and</li> <li>- the materiality of this liability.</li> </ul>	<p>We obtained audit evidence from events occurring after the reporting period as a retrospective review of the LIC provision estimate that was set at year end:</p> <ul style="list-style-type: none"> <li>- We assessed the claims received subsequent to year-end for claims incurred relating to the 2025 financial year;</li> <li>- We inspected the records of claims assigned 'audit' status and evaluated whether the claims have been correctly included/excluded from the LIC provision.</li> </ul> <p>Based on our assessment of the events and claims occurring after the reporting period as a retrospective review, we did not identify any matters that would require additional audit procedures to be performed.</p>
<p><b>Validity and accuracy of claims</b></p> <p>The significant expense for the Scheme relates to risk claims incurred. Risk claims incurred is a key driver in determining the sustainability of the Scheme.</p> <p>The payment of valid and accurate risk claims is dependent on the integrity of the Scheme's administration system, as well as the automated claim assessment control.</p> <p>Risk claims incurred was considered a key audit matter due to the significant risk related to the processing of valid claims during the year.</p>	<p>We obtained claims data for the entire period and performed analytical, substantive and control testing in order to verify the validity and accuracy of claims.</p>

*Other Information*

The Scheme's Trustees are responsible for the other information. The other information comprises the information included in the documents titled Report of the Board of Trustees, Statement of Responsibility by the Board of Trustees, and the Statement of Corporate Governance by the Board of Trustees. The other information does not include the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and we do not express an audit opinion or any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the audit, or otherwise appears to be materially misstated.

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<p style="text-align: center; font-size: small;">Middel &amp; Partners Pretoria East Incorporated          Reg. No. 1999/004166/21   Practise no. 946230-0006          Tel: + (27) 12 340 0700          E-mail: info@mdpi.co.za          42 Lebombo Road, Ashlea Gardens 0081          Private Bag 2606, Menlyn 0063</p>	<p style="text-align: center; font-size: small;">Regional Offices          Centurion   Pretoria East   Johannesburg   Rustenburg   Ermelo   Somerset West          Polokwane   Carltonville          www.middel.co.za</p>
<p>Directors:          PA Dames CA(SA)   JJ Marais CA(SA)   WE Westmeier CA(SA)   F Jeeva CA(SA)   JH Krige CA(SA)          Associates:          HJ Smit AGA(SA)   M Looock AGA(SA)</p>	



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If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

#### *Responsibilities of the Scheme's Trustees for the Financial Statements*

The Scheme's Trustees are responsible for the preparation and fair presentation of the financial statements, in accordance with IFRS Accounting Standards as issued by the International Accounting Standards Board and the requirements of the Medical Schemes Act of South Africa, and for such internal control as the Scheme's Trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Scheme's Trustees are responsible for assessing the Scheme's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Scheme's trustees either intend to liquidate the Scheme or to cease operations, or have no realistic alternative but to do so.

#### *Auditor's Responsibilities for the Audit of the Financial Statements*

Our objectives are to obtain reasonable assurance about whether the financial statements are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISA Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISA Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion.

The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's Trustees.
- Conclude on the appropriateness of the Scheme's Trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion.

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<p>Middel &amp; Partners Pretoria East Incorporated Reg. No. 1999/004166/21   Practise no. 946230-0006 Tel: + (27) 12 340 0700 E-mail: info@mdpi.co.za 42 Lebombo Road, Ashlea Gardens 0081 Private Bag 2606, Menlyn 0063</p>	<p>Regional Offices Centurion   Pretoria East   Johannesburg   Rustenburg   Ermelo   Somerset West Polokwane   Carltonville www.middel.co.za</p>
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Directors:  
PA Dames CA(SA) | JJ Marais CA(SA) | WE Westmeier CA(SA) | F Jeeva CA(SA) | JH Krige CA(SA)  
Associates:  
HJ Smit AGA(SA) | M Loock AGA(SA)



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Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Scheme's Trustees regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

From the matters communicated with the Scheme's Trustees, we determine those matters that were of most significance in the audit of the financial statements of the current period and are therefore the key audit matters.

We describe these matters in our auditor's report unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, we determine that a matter should not be communicated in our report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

### Report on Other Legal and Regulatory Requirements

#### *Non-compliance with the Medical Schemes Act of South Africa*

As required by the Council for Medical Schemes, we report the following material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa as amended that have come to our attention during the course of our audit:

1. Non-compliance with section 35(8)(a), (b) and (c) of the Medical Schemes Act 131 of 1998, as amended, of South Africa:

Section 35(8) prohibits medical schemes from holding investments in:

- The business of any medical scheme administrator;
- The holding company of an administrator; or
- Any employer group associated with the Scheme.

As of 31 December 2025, the Scheme held underlying investments amounting to 0.8% in medical scheme administrators or their holding companies (Momentum Metropolitan Holdings, Discovery Holdings and Sanlam Limited) and 0.9% in employer groups (Glencore Plc and Exxaro Resources) of total net asset value. The Scheme has obtained an exemption from the Council of Medical Schemes to retain these investments while ensuring compliance with broader regulatory requirements.

2. Non-compliance with section 26(7) of the Medical Schemes Act 131 of 1998, as amended, of South Africa:

In terms of section 26(7) of the Medical Schemes Act 131 of 1998, all contributions shall be paid to a medical scheme not later than three days after payment thereof becomes due. In 2025, not all billed contributions were received within this timeframe, which could impact cash flow and interest income. The Scheme actively follows up on outstanding contributions and applies its credit control policy to manage overdue payments effectively.



## MIDDEL & PARTNERS

CHARTERED ACCOUNTANTS (SA) · REGISTERED AUDITORS

### 3. Non-Compliance with section 59(2) of the Medical Schemes Act 131 of 1998, as amended, of South Africa:

In terms of section 59(2) of the Medical Schemes Act, accounts must be paid to the member or supplier of the services, any benefit owing to that member or supplier of services within 30 days after the day on which the claim in respect to the benefits was received by the Scheme.

While the Scheme endeavours to process all claims within this period, occasional delays occur due to validity verification procedures. Claims exceeding the 30-day threshold are investigated by management, ensuring that all outstanding payments are addressed in a timely and compliant manner.

### 4. Non-compliance with section 33(2)(b) of the Medical Schemes Act 131 of 1998, as amended of South Africa:

In terms of section 33(2)(b) of the Act, each benefit option shall be self-supporting in terms of membership and financial performance to maintain the financial integrity of the Scheme and prevent cross-subsidisation. At 31 December 2025 the Comprehensive option incurred an insurance service deficit of R 18 755 239 (refer to Note 19 of the Annual Financial Statements).

Persistent deficits on benefit options could potentially lead to cross-subsidisation from surplus-generating options, which may impact the overall financial soundness of the Scheme. To ensure long-term sustainability and regulatory compliance, the Scheme is actively implementing strategic measures, including:

- Contribution adjustments to align pricing with claims experience;
- Benefit design reviews to optimise cost-effectiveness; and
- Ongoing assessments to monitor financial performance and adjust strategies proactively.

### *Audit Tenure*

As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that Middel and Partners has been the auditor of The Witbank Coalfields Medical Aid Scheme for two years.

The engagement partner, Mr Jacques Jean Marais, has been responsible for The Witbank Coalfields Medical Aid Scheme audit for two years.

*Middel & Partners*

Middel & Partners

Per: Jacques Jean Marais

Chartered Accountant (SA)

Registered Auditor

28 April 2026

Pretoria

<p>Middel &amp; Partners Pretoria East Incorporated Reg. No. 1999/004166/21   Practise no. 946230-0006 Tel: + (27) 12 340 0700 E-mail: info@mdpi.co.za 42 Lebombo Road, Ashlea Gardens 0081 Private Bag 2606, Menlyn 0063</p>	<p>Regional Offices Centurion   Pretoria East   Johannesburg   Rustenburg   Ermelo   Somerset West Polokwane   Carltonville www.middel.co.za</p>
<p>Directors: PA Dames CA(SA)   JJ Marais CA(SA)   WE Westmeier CA(SA)   F Jeeva CA(SA)   JH Krige CA(SA) Associates: HJ Smit AGA(SA)   M Loock AGA(SA)</p>	

## STATEMENT OF FINANCIAL POSITION

As at 31 December 2025	Note	2025	2024
<b>ASSETS</b>			
<b>Non-current assets</b>			
Equipment and other fixed assets	4	889,078	1,604,014
Investment properties	5	15,879,456	15,318,525
Investments at fair value through profit or loss	6	847,714,282	708,252,362
		<b>864,482,816</b>	<b>725,174,901</b>
<b>Current assets</b>			
Investments at fair value through profit or loss (ST)	6	268,502,108	248,232,823
Trade and other receivables	7	636,975	475,909
Cash and cash equivalents	8	99,445,941	99,403,561
Assets held for sale	9	86,164	-
		<b>368,671,188</b>	<b>348,112,293</b>
<b>TOTAL ASSETS</b>		<b>1,233,154,005</b>	<b>1,073,287,195</b>
<b>LIABILITIES</b>			
<b>Non-current liabilities</b>			
Insurance contracts liability for future members	10	868,586,642	724,598,316
Retirement benefit obligation	11	2,226,000	1,836,000
		<b>870,812,642</b>	<b>726,434,316</b>
<b>Current liabilities</b>			
Insurance contracts liability for current members	12	361,772,612	346,408,104
Trade and other payables	13	223,751	90,775
Retirement benefit obligation ST	11	345,000	354,000
		<b>362,341,362</b>	<b>346,852,879</b>
<b>TOTAL LIABILITIES</b>		<b>1,233,154,005</b>	<b>1,073,287,195</b>
<b>TOTAL EQUITY</b>		<b>-</b>	<b>-</b>
<b>TOTAL EQUITY AND LIABILITIES</b>		<b>1,233,154,005</b>	<b>1,073,287,195</b>

## STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME

For the year ended 31 December 2025	Note	2025	2024
Insurance revenue	14	613,847,546	578,069,267
Insurance service expenses	15	(614,436,927)	(554,094,284)
<b>INSURANCE SERVICE RESULT</b>		<b>(589,381)</b>	<b>23,974,983</b>
Investment income	17	175,285,486	108,423,205
Gain/(loss) on disposal of equipment		(51,182)	(30,360)
Sundry income		99,518	573,164
<b>OTHER INCOME</b>		<b>175,333,821</b>	<b>108,966,009</b>
Impairment losses on insurance receivables		(70,793)	(456,266)
Insurance finance expenses	12	(20,184,006)	(21,094,514)
Asset management fees		(6,315,271)	(4,573,689)
Costs incurred on rental property		(4,186,045)	(3,452,507)
<b>OTHER EXPENSES</b>		<b>(30,756,114)</b>	<b>(29,576,975)</b>
<b>PROFIT/(LOSS) FOR THE YEAR</b>		<b>143,988,326</b>	<b>103,364,017</b>
Amounts attributable to future members		(143,988,326)	(103,364,017)
<b>TOTAL COMPREHENSIVE INCOME FOR THE YEAR</b>		<b>-</b>	<b>-</b>

**STATEMENT OF CASH FLOWS**

For the year ended 31 December 2025	Note	2025	2024
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>			
Contributions received		795,233,064	765,512,926
Other cash flows from/(to) members and providers		787,218	(1,668,280)
<b>Cash receipts from members and providers</b>		<b>796,020,281</b>	<b>763,844,646</b>
Cash paid to members and providers - Claims		(733,755,365)	(694,728,161)
Cash paid to providers and employees - Directly attributable expenses		(43,035,754)	(42,251,598)
Cash paid to members - Personal medical savings refunds	12.3	(23,851,483)	(15,601,936)
<b>Cash paid to providers, employees and members</b>		<b>(800,642,602)</b>	<b>(752,581,695)</b>
<b>Cash generated from/(utilised in) operations</b>		<b>(4,622,321)</b>	<b>11,262,952</b>
<b>NET CASH (OUTFLOW)/INFLOW FROM OPERATING ACTIVITIES</b>			
		<b>(4,622,321)</b>	<b>11,262,952</b>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>			
Additions to equipment and other assets	4	(201,371)	(1,358,306)
Proceeds on disposals of equipment and other assets		11,100	53,594
Additions to investment properties	5	(1,225,990)	(2,760,641)
Proceeds on disposals of investments at fair value through profit or loss	6	-	15,000,000
Investment income received on investments at amortised cost	15	4,519,851	5,062,747
Investment manager fees paid		(561,660)	(538,200)
Rental income received		5,465,658	5,394,342
Cost incurred in provision of own facilities to external parties		(4,186,045)	(3,452,507)
Non-cash flow item: depreciation on investment property	5	843,157	555,501
<b>NET CASH GENERATED FROM INVESTING ACTIVITIES</b>		<b>4,664,701</b>	<b>17,956,529</b>
<b>NET INCREASE IN CASH AND CASH EQUIVALENTS</b>			
		<b>42,380</b>	<b>29,219,481</b>
Cash and cash equivalents at the beginning of the year	8	99,403,561	70,184,080
<b>CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR</b>	9	<b>99,445,941</b>	<b>99,403,561</b>

## NOTES TO THE ANNUAL FINANCIAL STATEMENTS

For the year ended 31 December 2025

### 1. GENERAL INFORMATION

The Scheme is a registered non-profit, self-administered restricted medical Scheme in terms of the Medical Schemes Act 131 of 1998 ("the Act") and is domiciled in the Republic of South Africa.

### 2. ACCOUNTING POLICIES

#### 2.1 BASIS OF PREPARATION

##### 2.1.1 STATEMENT OF COMPLIANCE

The annual financial statements are prepared in accordance with IFRS Accounting Standards as issued by the International Accounting Standards Board and interpretations issued by the IFRS Interpretations Committees, as applicable in South Africa, and in the manner required by the Act.

##### 2.1.2 BASIS OF MEASUREMENT

These annual financial statements have been prepared on the going concern principle and using the historical cost basis except for fair value through profit or loss financial instruments that are held at fair value and Insurance assets and liabilities that are measured in terms of IFRS 17 current estimates.

Historical cost is generally based on the fair value of the consideration given in exchange for goods and services.

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date, regardless of whether that price is directly observable or estimated using another valuation technique.

In estimating the fair value of an asset or liability, the Scheme considers the characteristics of the asset or liability if market participants would take these characteristics into account when pricing the asset or liability at the measurement date. Fair value for measurement and/or disclosure purposes in these financial statements is determined on such a basis.

##### 2.1.3 STATEMENT OF CASH FLOWS

The Statement of Cash Flow Statement has been prepared using the direct method as prescribed by IAS 7 - Statement of Cash Flows. Under this method, major classes of gross cash receipts and gross cash payments are disclosed separately. Cash flows from operating activities are presented by showing cash receipts from members, cash payments to suppliers and employees, and other operating cash payments.

##### 2.1.4 FUNCTIONAL AND PRESENTATION CURRENCY

The annual financial statements are prepared in Rand which is the Scheme's functional and presentation currency. The amounts presented in these Annual Financial Statements have been rounded to the nearest Rand.

## 2.1.5 NEW STANDARDS, AMENDMENTS TO PUBLISHED STANDARDS AND INTERPRETATIONS

### (a) New standards, amendments and interpretations issued and not yet effective in 2025 and relevant to the Scheme:

The following IFRS Accounting Standards, amendments and interpretations as issued by the International Accounting Standards Board, are not yet effective but relevant to the Scheme's operations:

#### 1. Amendment to IFRS 9, "Financial Instruments" and IFRS 7, "Financial Instruments: Disclosures" - Classification and Measurement of Financial Instruments

*Effective date:* Annual reporting periods beginning on or after 1 January 2026.

*Impact on the Scheme:*

These amendments

- clarify the requirements for the timing of recognition and derecognition of some financial assets and liabilities, with a new exception for some financial liabilities settled through an electronic cash transfer system;
- clarify and add further guidance for assessing whether a financial asset meets the solely payments of principal and interest (SPPI) criterion;
- add new disclosures for certain instruments with
- contractual terms that can change cash flows (such as some instruments with features linked to the
- achievement of environment, social and governance
- (ESG) targets; and
- make updates to the disclosures for equity instruments designated at Fair Value through Other Comprehensive Income (FVOCI).

#### 2. IFRS 18 Presentation and Disclosure in Financial Statements.

*Effective date:* Annual periods beginning on or after 1 January 2027.

*Impact on the Scheme:*

The new IFRS Accounting Standard IFRS 18 Presentation and Disclosure in Financial Statements replaces IAS 1 Presentation of Financial Statements.

IAS 1 Presentation of Financial Statements did not have detailed requirements on:

- classification of income and expenses in the statement of profit or loss.
- presentation of subtotals above 'profit or loss' in the statement of profit or loss; or
- aggregation and disaggregation of information presented in the primary financial statements or disclosed in the notes.

This lack of detailed requirements led to diversity in practice as entities defined their own subtotals and performance measures. Investors found it difficult to analyse and compare companies' financial performance.

IFRS 18 Presentation and Disclosure in Financial Statements, issued by the IASB on 9 April 2024, will improve the quality of financial reporting by:

- requiring defined subtotals in the statement of profit or loss;
- requiring disclosure about management-defined performance measures; and
- adding new principles for aggregation and disaggregation of information.

The IASB expects these improvements will enable investors to make more informed decisions leading to better allocations of capital that will contribute to long-term financial stability.

## 2.2 EVENTS AFTER REPORTING DATE

Recognised amounts in the annual financial statements are adjusted to reflect events arising after reporting date that provide evidence of conditions that existed at the reporting date. Events arising after the reporting date, that are indicative of conditions that arose after the reporting date, are dealt with by way of a note disclosure.

## 2.3 EQUIPMENT AND OTHER FIXED ASSETS

An item of equipment and other fixed assets is recognised as an asset when it is probable that future economic benefits associated with the item will flow to the Scheme, and the cost of the item can be measured reliably.

Equipment and other fixed assets are reflected at historic cost less accumulated depreciation and accumulated impairments. Historical cost includes expenditure that is directly attributable to the acquisition of the items. Subsequent costs are included in the asset's carrying amount, or recognised as a separate asset as appropriate, only when it is probable that future economic benefits associated with the item will flow to the Scheme and the cost of the item can be measured reliably. The carrying amount of the replaced part is derecognised. Maintenance and repairs, which neither materially add to the value of assets, nor appreciably prolong their useful lives, are charged to profit or loss during the financial period in which they are incurred.

Depreciation is charged on the straight-line basis over the estimated useful lives of items of equipment and other fixed assets after considering the assets' residual values. The following are the estimated useful lives of equipment and other fixed assets:

Item	Depreciation method	Estimated useful life
Motor vehicles	Straight line	5 years
Office equipment	Straight line	4 years
Computer equipment	Straight line	3 years
Mailroom equipment	Straight line	5 years
Generator	Straight line	10 years

The assets' residual values and useful lives are reviewed and adjusted, if appropriate, at the end of each reporting period. An asset's carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount.

Surpluses and deficits on disposal of equipment and other assets are determined by comparing the proceeds with the carrying amount and are recognised within other operating income/expenses in the statement of profit or loss and other comprehensive income.

## 2.4 INVESTMENT PROPERTIES

Investment properties are held to earn rental income and for capital appreciation and are initially recognised at cost. Investment properties are carried at historical cost less accumulated depreciation less any accumulated impairment losses. Land and buildings that constitute investment properties are not depreciated.

Transaction costs are included in the initial measurement of investment properties. Costs include costs incurred initially and costs incurred subsequently to add to, or to replace a part of, or service a property. If a replacement part is recognised in the carrying amount of the investment properties, the carrying amount of the replaced part is derecognised.

Depreciation is charged on the straight-line basis over the estimated useful life of the property after taking into consideration the asset's residual value as follows:

- Air conditioners – 5 years
- Lifts – 15 years
- Partitioning and electrical – 5 to 10 years
- Generator – 20 years

Management assesses the fair value of buildings constituting investment properties on an annual basis and as the fair value exceeds carrying value buildings are not depreciated. The residual values and useful lives of the assets are reviewed on an annual basis.

A register of all investment properties is available for inspection at the registered office of the Scheme.

## 2.5 IMPAIRMENT OF NON-FINANCIAL ASSETS

The carrying amounts of the Scheme's property and equipment are reviewed at each reporting date to determine whether there are events or changes in circumstances that indicate that the carrying amount may not be recoverable. If any such indication exists, then the affected asset's recoverable amount is estimated.

The recoverable amount of an asset is the higher of its value in use and its fair value less costs to sell. In assessing value in use, the estimated future cash flows are discounted to their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset.

An impairment loss is recognised if the carrying amount of an asset exceeds its estimated recoverable amount. Impairment losses are recognised in profit or loss.

Impairment losses recognised in prior periods are assessed at each reporting date for any indications that the loss has decreased or no longer exists. An impairment loss is reversed if there has been a change in the estimates used to determine the recoverable amount. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation, if no impairment loss had been recognised.

## 2.6 FINANCIAL INSTRUMENTS

### 2.6.1 CLASSIFICATION, RECOGNITION, AND MEASUREMENT

Regular-way purchases and sales of financial assets and liabilities are recognised on trade date, being the date that the Scheme becomes a party to the contractual rights or obligations of the instrument. The Scheme has the following financial instrument categories: Fair value through profit or loss; Loans and receivables; and Financial liabilities.

The Scheme has classified its financial instruments into the following classes:

- Financial assets held at fair value through profit or loss.
- Trade and other receivables (non-insurance related).
- Cash and cash equivalents; and
- Trade and other payables.

The classification and measurement of the financial instruments depend on the objective of the Scheme's business model whether it is to hold assets only to collect cash flows, or to collect cash flows and to sell and whether the contractual cash flows of an asset give rise to payments on specified dates that are solely payments of principal and interest on the principal amount outstanding. Management applies this assessment on financial instruments at initial recognition and re-evaluates this for financial assets when the objective of the Scheme's business model changes.

Financial instruments are initially measured at fair value plus transaction costs that are directly attributable to acquisition or issue of the financial asset or liability. After initial recognition, these instruments are measured as set out below.

#### 2.6.1.1 Financial assets held at fair value through profit or loss

These financial assets are initially recognised at fair value excluding transaction costs, which are immediately expensed. These financial assets are subsequently measured at fair value. The fair value adjustments are recognised in the statement of profit or loss during the financial period.

#### 2.6.1.2 Loans and receivables

Loans and receivables comprise of 'Trade and other receivables' and 'Cash and cash equivalents'.

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market other than those that the Scheme intends to sell in the short term. Trade and other receivables are classified in this category and are reviewed for impairment as part of the impairment review of loans and receivables. They are included in current assets, except for maturities greater than 12 months after the end of the reporting period. These are classified as non-current assets.

Loans and receivables are subsequently measured at amortised cost using the effective interest method, less impairment losses.

##### *Trade and other receivables*

Trade and other receivables are reviewed for impairment as part of the impairment review conducted on loans and receivables.

##### *Cash and cash equivalents*

Cash and cash equivalents comprise cash on hand, deposits held at call with banks, other short-term liquid investments that are readily convertible to a known amount of cash and are subject to an insignificant risk of change in value and have an original maturity of 90 days or less.

#### 2.6.1.3 Financial liabilities

A financial liability is a liability that is a contractual obligation to deliver cash or another financial asset to another entity or to exchange financial assets or financial liabilities with another entity under conditions that are potentially unfavourable to the entity. They are included in current liabilities, except for maturities greater than 12 months after the end of the reporting period. These are classified as non-current liabilities.

Financial liabilities comprise of 'Trade and other payables'.

Financial liabilities are recognised initially at fair value less any directly attributable transaction costs. After initial recognition, financial liabilities are measured at amortised cost, using the effective interest method.

### *Trade and other payables*

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Accounts payable are classified as current liabilities if payment is due within one year or less (or in the normal operating cycle of the business if longer). If not, they are presented as non-current liabilities. Trade payables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method.

## 2.6.2 IMPAIRMENT OF FINANCIAL ASSETS

### 2.6.2.1 Loans and receivables

The Scheme's loans and receivables do not contain a significant financing component and therefore the loss allowance is measured at initial recognition as expected credit losses that result from all possible default events over the expected life of a financial instrument (ECL) in accordance with IFRS 9. As a practical expedient, IFRS 9 allows a provision matrix to be used to estimate ECL for these financial instruments.

The provision matrix is based on historical observed default rates, adjusted for forward looking estimates. At every reporting date, the historical observed rates are updated. Objective evidence that a financial asset or group of assets is impaired includes observable data that comes to the attention of the Scheme about the following events: the Scheme is unable to collect all amounts due according to the original terms of the receivables; significant financial difficulty of the issuer or debtor; a breach of contract, such as a default or delinquency in payments by the debtor; the disappearance of an active market for that financial asset because of financial difficulties; or national or local economic conditions that correlate with defaults on the assets in the Scheme.

The provision matrix considers contributions receivable, member and service provider debit balances and advances on savings plan accounts to members. The Scheme utilises readily available economic information such as consumer price index, healthcare inflation, national credit rating and unemployment indicators as a basis for determining the future expectations of the observable data.

If it is determined that a possible impairment loss will be incurred on loans and receivables measured at amortised cost, the amount of the loss is measured as the difference between the present value of the cash flows due under the contract and the present value of the cash flows that the entity expects to receive. These losses are recognised at initial recognition in profit or loss and reflected in an allowance account.

If in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised (such as improved credit rating), the previously recognised impairment loss is reversed directly to profit or loss.

### 2.6.3 DERECOGNITION OF FINANCIAL ASSETS

Financial assets are derecognised when the contractual rights to receive the cash flows from the asset expire, or when the Scheme transfers the financial asset and the transfer qualifies for derecognition.

A transfer qualifies for derecognition when the Scheme either:

- transfers substantially all the risks and rewards of ownership of the financial asset; or
- neither transfers nor retains substantially all the risks and rewards of ownership but does not retain control of the financial asset.

If the Scheme retains substantially all the risks and rewards of ownership of a transferred financial asset, the asset continues to be recognised in its entirety and the consideration received is recognised as a financial liability. In subsequent periods, income arising from the transferred asset and expenses incurred on the associated financial liability are recognised in profit or loss.

Where the Scheme neither transfers nor retains substantially all the risks and rewards of ownership, it assesses whether it has retained control of the financial asset. Control is retained if the transferee does not have the practical ability to sell the asset in its entirety to an unrelated third party without imposing additional restrictions.

If control is not retained, the Scheme derecognises the financial asset and recognises separately any rights and obligations created or retained in the transfer.

If control is retained, the Scheme continues to recognise the financial asset to the extent of its continuing involvement.

A financial liability is derecognised when the contractual obligation is discharged, cancelled, or expires.

## 2.7 OFFSET

Financial assets and liabilities are offset, and the net amount reported in the statement of financial position only when there is a legally enforceable right to offset the recognised amounts and there is an intention to settle on a net basis, or to realise the asset and settle the liability simultaneously.

## 2.8 STRUCTURED ENTITIES

A structured entity is an entity that has been designed so that voting or similar rights are not the dominant factor in deciding who controls the entity, such as when any voting rights relate to administrative tasks only, and the relevant activities are directed by means of contractual arrangements.

A structured entity often has some or all the following features or attributes:

- restricted activities.
- a narrow and well-defined objective, such as to provide investment opportunities for investors by passing on risks and rewards associated with the assets of the structured entity to investors.
- insufficient equity to permit the structured entity to finance its activities without subordinated financial support; and
- financing in the form of multiple contractually linked instruments to investors that create concentrations of credit or other risks (tranches).

The Scheme has certain investments in other funds (investee funds), which are investments in unconsolidated structured entities. The Scheme invests in investee funds whose objectives range from achieving medium- to long-term capital growth. The investee funds are managed by unrelated asset managers and apply various investment strategies to accomplish their respective investment objectives.

## 2.9 CASH AND CASH EQUIVALENTS

In the statement of cash flows, cash and cash equivalents includes cash in hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less.

## 2.10 INSURANCE CONTRACTS

### 2.10.1 IDENTIFICATION OF INSURANCE CONTRACTS

The contracts issued by medical schemes (the issuer) indemnify covered members (the policyholder) and their covered dependants against the risk of loss arising from the occurrence of a health event (insured event). The timing, frequency and severity of the health event covered is uncertain. These contracts fall under the scope of IFRS 17.

Whilst the timing, frequency, severity and type of health events are uncertain, the ultimate insurance risk covered by a medical scheme can be defined as a single risk – that of providing cover for a health event that the member may incur. The risk under the insurance contracts issued by medical schemes can be expressed as the probability that an insured event (“health event”) occurs, multiplied by the expected amount of the resulting claim.

### 2.10.2 SEPARATING COMPONENTS FROM AN INSURANCE CONTRACT

An investment component and an insurance component are highly interrelated if, and only if:

- a) the entity is unable to measure one component without considering the other. Thus, if the value of one component varies according to the value of the other, an entity shall apply IFRS 17 to account for the combined investment and insurance component; or
- b) the policyholder is unable to benefit from one component unless the other is also present. Thus, if the lapse or maturity of one component in a contract causes the lapse or maturity of the other, the entity shall apply IFRS 17 to account for the combined investment component and insurance component.

The Personal Medical Savings Account (PMSA) meets the definition of an investment component in IFRS 17 as it requires the Scheme to repay a member in all circumstances, regardless of if an insured event occurred. The investment component is not distinct and has to be accounted for in terms of IFRS 17.

The cash flows relating to the PMSA are not recorded in the statement of comprehensive income but are considered in assessing onerous contracts.

### 2.10.3 LEVEL OF AGGREGATION

The Scheme as a whole was identified as a portfolio. All contracts issued by a Scheme are subject to similar risks and managed together. As the Act specifically constrains the entity’s practical ability to set a different price or level of benefits for members with different characteristics the Scheme as a whole was also identified as the group. The Scheme assesses if the group as a whole is onerous or profitable. Where the following year’s deficit exceeds the value attributable to members – the most residual interest – the contracts written would be onerous and an onerous contract liability raised. Where the amounts attributable to members exceed the following year’s deficit the contracts would not be determined as onerous, and no provision raised as a liability is already recognised. (as the Scheme is regarded as a mutual entity for accounting purposes).

### 2.10.4 CONTRACT BOUNDARY

The Scheme uses the concept of contract boundary to determine what cash flows should be considered in the measurement of groups of insurance contracts. This assessment is reviewed every reporting period.

Cash flows are within the boundary of an insurance contract if they arise from the rights and obligations that exist during the period in which the member is obligated to pay contributions, or the Scheme has a substantive obligation to provide the member with insurance coverage or other services. A substantive obligation ends when both of the following criteria are satisfied:

- The Scheme has the practical ability to re-price the group of contracts so that the price fully reflects the reassessed risk of that portfolio; and
- The pricing of contributions related to coverage to the date when risks are reassessed does not reflect the risks related to periods beyond the reassessment date.

In assessing the practical ability to reprice, risks transferred from the member to the Scheme are considered; other risks, such as lapse or surrender and expense risk, are not included.

IFRS 17(35) Cash flows outside the insurance contracts boundary relate to future insurance contracts and are recognised when those contracts meet the recognition criteria.

The Scheme has assessed all its contracts and determined all contracts have a boundary of one year.

#### 2.10.5 RECOGNITION AND DERECOGNITION

Insurance contracts issued shall be recognised from the earliest of the following:

- The beginning of the coverage period.
- The date when the first payment from a policyholder becomes due; and
- For onerous contracts, when the contracts become onerous.

An insurance contract is derecognised when it is extinguished (i.e. when the obligation specified in the insurance contract expires or is discharged or cancelled).

#### 2.10.6 PREMIUM ALLOCATION APPROACH (PAA)

The contract coverage period for contracts issued does not exceed 12 months and consequently the Scheme elected to apply the PAA.

The classification of medical schemes as mutual entities does not impact the extent of insurance contract services to be provided by the medical scheme in terms of the member contracts and therefore the PAA is still applicable.

In applying the PAA, the Scheme chose to recognise any insurance acquisition cash flows as expenses when it incurs those costs.

The Scheme measures the liability for incurred claims at the fulfilment cash flows relating to incurred claims. The future cash flows are not adjusted for the time value of money and the effect of financial risk as these cash flows are expected to be paid in one year or less from the date the claims are incurred. There is no significant financing component included in the liability for remaining coverage and thus the Scheme is not required to apply a discounted value.

### 2.10.7 INITIAL AND SUBSEQUENT MEASUREMENT

For insurance contracts issued, on initial recognition, the Scheme measures the Liability for remaining coverage (LRC) at the amount of contributions received. The amount of insurance revenue recognised in the reporting period depicts the transfer of promised services at an amount that reflects the portion of consideration the Scheme expects to be entitled to in exchange for those services and increased the LRC. Debtors that paid in advance and for which no service has yet been provided are included in the LRC. Debtors in arrears and for which services and coverage have been provided but not yet paid are included in LRC.

The carrying amount of the group of insurance contracts issued at each reporting period is the sum of:

- the LRC, including a loss component for onerous contracts where applicable; and
- the Liability for incurred claims (LIC), comprising the future fulfilment cash flows related to past service allocated to the group at the reporting date.

For insurance contracts issued, at each of the subsequent reporting dates, the LRC is:

- increased for contributions received in the period; and
- decreased for the amounts of expected contributions received recognized as insurance revenue for the services provided in the period.

For insurance contracts issued at each of the subsequent reporting dates the LIC is:

- best estimate of cash flows and
- non-financial risk adjustment.

Refer to note 3.1 for the significant judgements and estimates used to determine the LIC and the estimates to determine the fulfilment cash flow.

#### Onerous contract assessment:

In the consideration of whether facts and circumstances indicate that a group of insurance contracts is onerous, the Scheme considers whether the expected deficit of the following year exceeds the insurance liability attributable to future members. In the rare scenario where the following year's deficit exceeds the insurance liability attributable to future members – the contracts written would be onerous and an onerous contract liability raised. Where the amounts attributable to future members exceed the following year's deficit the contracts would not be determined as onerous, and no provision raised as a liability is already recognised.

### 2.10.8 INSURANCE REVENUE

Insurance revenue for the period is the amount of expected premium receipts (excluding the PMSA) allocated to the period. The expected contribution receipts include the risk of non-payment by the member. The Scheme allocates the expected premium receipts to each period of insurance contract services based on the passage of time.

### 2.10.9 INSURANCE SERVICE EXPENSES

Insurance service expenses include:

- incurred claims and benefits excluding investment components.
- other incurred directly attributable insurance service expenses.
- changes that relate to past service (i.e., changes in the FCF relating to the LIC); and
- changes that relate to future service (i.e., losses/reversals on onerous groups of contracts from changes in the loss components); and
- amounts attributable to future members.

Cash flows that are not directly attributable to a group of insurance contracts, such as some governance, compliance and training costs, are recognised in other operating expenses as incurred.

The Scheme includes the following acquisition cash flows within the insurance contract boundary that arise from selling, underwriting and starting a group of insurance contracts and that are:

- costs directly attributable to individual contracts and the group of contracts; and
- costs directly attributable to the group of insurance contracts, which are allocated on a reasonable and consistent basis.

Insurance acquisition costs are expensed by the Scheme when it incurs the cost.

## 2.10.10 INSURANCE INTEREST INCOME AND EXPENSES

The non-distinct investment component (PMSA) accrues interest. This is disclosed within the insurance finance expense line item.

## 2.11 EMPLOYEE BENEFITS

### 2.11.1 SHORT-TERM EMPLOYEE BENEFITS

The cost of short-term employee benefits, salaries, and bonuses are recognised in the period in which the related service was delivered. Short-term employee benefit obligations are measured on an undiscounted basis and are expensed as the related service is provided. A liability is recognised for the amount expected to be paid under short-term cash bonuses if the Scheme has a present legal or constructive obligation to pay amounts because of past service provided by the employee and the obligation can be estimated reliably.

### 2.11.2 DEFINED CONTRIBUTION PLANS

Employees all belong to a defined contribution pension fund. Contributions to the fund are recognised in the statement of comprehensive income in the period in which they are incurred.

### 2.11.3 POST-RETIREMENT MEDICAL BENEFITS

On retirement the staff employed by the Scheme as at 31 January 2011, will receive a medical aid subsidy equal to 50% of their contribution for the remainder of their lives. Surviving spouses of employees entitled to the subsidy will continue to receive the benefit. The benefit will cease upon the death of the surviving spouse. Payments in terms of this liability has been effective from 1 January 2012.

The post-retirement medical aid contribution benefit liability is measured at the present value of the amount payable for the remaining lives of the beneficiaries and their surviving spouses. Employees become eligible at retirement age of 60.

An actuarial valuation is performed every second year to determine the value of the liability, and the liability is unfunded. For the year ended 31 December 2025 the Projected Unit Credit discounted cash flow method was used.

## 2.12 INVESTMENT INCOME

Investment income comprises interest on call accounts, current accounts, bonds and money market instruments; dividend income; rental income from investment properties and net fair value gains on financial assets at fair value through profit or loss.

Interest income is recognised using the effective interest method, taking account of the principal amount outstanding and the effective rate over the period to maturity, when it is determined that such income will accrue to the Scheme.

Dividend income is recognised when the right to receive payment is established.

Rental income from investment properties is recognised in profit or loss on a contractual basis over the lease term. All leases with tenants are linked to the Consumer Price Index (CPI) and therefore straight-line recognition of rental income cannot be calculated.

## 2.13 ALLOCATION OF INCOME AND EXPENDITURE TO BENEFIT OPTIONS

The following items are directly allocated to benefit options:

- Insurance revenue.
- Claims incurred.
- Net income/(expense) on risk transfer arrangements.
- Third party claim recoveries.
- Accredited managed healthcare services.
- Attributable expenses incurred.
- Broker fees.
- Finance expenses from insurance contracts issued – PMSA.

Investment income is allocated to an option based on the proportion of that option's gross contribution relative to the Scheme total.

The remaining non-healthcare expenses and income are apportioned based on the average number of members per option divisible by total membership on the Scheme for the financial period:

- Other administration and operative expenditure.
- Other income; and
- Other expenditure.

## 3 USE OF ESTIMATES AND JUDGMENTS

Consistent with other IFRS Accounting Standards as issued by the International Accounting Standards Board, financial reporting under IFRS 17 is, to a larger extent, based on estimates, judgements and models rather than exact depictions. The IFRS Accounting Standards as issued by the International Accounting Standards Board Conceptual Framework establishes the concepts that underlie those estimates, judgements and models. Where an application of a particular standard requires judgments or provides options, it is expected that the preparers of financial information will choose among the alternatives in a way that achieves the objective of financial reporting: to provide financial information about the reporting entity that is useful to the trustees, Council for Medical Schemes (CMS) and members.

In addition to the existing requirement in IFRS Accounting Standards as issued by the International Accounting Standards Board to disclose critical judgements made in applying accounting policies (IAS 1(122)) and major sources of estimation uncertainties (IAS 1(125)), IFRS 17 requires the following specific disclosures with respect to contracts in the scope of the standard:

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- the methods used to measure insurance contracts, and the processes used for estimating inputs to those methods, including quantitative information about those inputs when practicable, and specifically approaches used to determine the risk adjustment for non-financial risk; and
- any changes in the above method and process, together with an explanation of the reason for each change and the type of contracts affected.

If an entity uses a technique other than the confidence-level technique for determining the risk adjustment, it is required to disclose a translation of the result of that technique into a confidence level to allow users of financial statements to see how the entity's own assessment of its risk aversion compares to that of other entities.

### 3.1 SIGNIFICANT JUDGEMENTS AND ESTIMATES FOR INSURANCE CONTRACTS

#### 3.1.1 ASSESSMENT AS TO WHETHER A SCHEME IS A MUTUAL ENTITY

A medical scheme is not legally defined as a mutual entity and the assessment as to whether a medical scheme is a mutual entity was done based on the principles set out in IFRS Accounting Standards as issued by the International Accounting Standards Board.

IFRS 3 defines a "mutual entity" as "An entity, other than an investor-owned entity, that provides dividends, lower costs or other economic benefits directly to its owners, members or participants. For example, a mutual insurance company, a credit union and a co-operative entity are all mutual entities".

IFRS 17 does not define a "mutual entity" however it provides a key characteristic of a mutual entity in the basis of conclusion to the standard. IFRS 17 paragraph BC265 explains that "a defining feature of an insurer that is a mutual entity is that the most residual interest of the entity is due to a policyholder and not a shareholder." The Act is not explicit that members (i.e. policyholders) hold a residual interest or are entitled to the residual interest upon the liquidation of the Medical Scheme. Section 64 of the Act requires the Medical Scheme rules to be followed in the event of liquidation.

The rules of the Scheme do not contain specific guidance on how the assets of the Scheme should be distributed on liquidation. The Act prohibits the disposal of assets of a medical scheme except in limited, listed circumstances, one of them being the liquidation of the Scheme. Members can opt for voluntary liquidation and can distribute the Scheme's remaining assets amongst themselves. Since the Scheme does not have shareholders, the current members will access the reserves through economic benefits such as funding reductions in contributions or deferral of contribution increases.

Although the rules do not specify how the assets should be distributed on liquidation, IFRS 17 states that contracts can be written, oral or implied by an entity's customary business practices. Contractual terms include all terms in a contract, explicit or implied, but an entity shall disregard terms that have no commercial substance (i.e. no discernible effect on the economics of the contract). Implied terms in a contract include those imposed by law or regulation" (IFRS 17.2). Therefore, based on customary business practices, the remaining assets of the Scheme should be distributed to the members on liquidation, if there are any, and if the Scheme does not amalgamate with another medical scheme.

Even if the assets are distributed by a regulator or by the policyholders to an independent third party e.g. another medical scheme, an administrator or a charity, the important aspect is that the choice resides with the members or the regulator acting on behalf of the members, not with an equity holder.

The substance of the legal framework issued regarding insurance contracts and observed practice is that once a contribution is paid to the medical scheme, the contribution is used to provide benefits to members. The benefits are provided by the Scheme (or amalgamated schemes) through insurance coverage, reduced contributions, or payment to members on liquidation (based on votes taken by members).

It is therefore expected that the remaining assets of the Scheme will be used to pay current and future members. Based on the above, the Scheme meets the definition of a mutual entity in IFRS Accounting Standards as issued by the International Accounting Standards Board. The Scheme has therefore developed an accounting policy in terms of the IFRS 17 guidance for mutual entities and the educational material as issued by the IASB and the Scheme recognises any cumulative profit or losses as part of the insurance liability attributable to future members (which forms part of the insurance contract liabilities on the face of the statement of financial position). Consequently, the statement of comprehensive income reflects no total comprehensive income for the year. The movement in the insurance liability attributable to future members are included in other comprehensive income.

Due to the Scheme being a mutual entity, the assessment of onerous contracts are also affected.

### 3.1.2 LEVEL OF AGGREGATION

Judgement has been applied to how the Scheme determined the level of aggregation for the measurement of its insurance contracts. Management has assessed their portfolio as the Scheme as a whole due to the holistic pricing methodologies and risk management strategy that manages the risk on a Scheme level.

The above is demonstrated by the following:

- Hospital claims are managed on a Scheme level.
- Chronic conditions are managed on a Scheme level, i.e., no matter what the option the member will have access to the chronic condition management benefit.
- Risk transfer arrangements are based on conditions and not on benefit options.
- Pricing and benefit option changes are determined at a Scheme level to ensure sustainability for the Scheme overall, given inherent cross-subsidies in the medical scheme environment.
- Risk (utilization and concentration) is managed holistically.

### 3.1.3 RISK ADJUSTMENT – LIABILITY FOR INCURRED CLAIMS (LIC)

The risk adjustment for non-financial risk is applied to the present value of the estimated future cash flows and reflects the compensation the Scheme requires for bearing the uncertainty about the amount and timing of the cash flows from non-financial risk as the Scheme fulfils insurance contracts. As the risk adjustment represents compensation for uncertainty, estimates are made on the degree of diversification benefits and expected favourable and unfavourable outcomes in a way that reflects the Scheme's degree of risk aversion. The Scheme estimates an adjustment for non-financial risk separately from all other estimates.

The biggest risk inherent in run-off models are the run-off assumptions applied. Any processing changes and/or delays between providers and the Scheme (relative to the input assumptions) would impact on the best estimate value of fulfilment cash flow provided. Therefore, provision for such adverse experience is made in the form of a risk adjustment (that is, where the model relies on run-off assumptions).

The risk adjustment was determined by applying sensitivity testing to the run-off input assumptions used to calculate the best estimate reserve value, i.e. a deterministic sensitivity approach. Stochastic claims modelling (based on simulations of multiple prior year outstanding claim reserve distributions of the Scheme) was used to assess this overall risk adjustment value by attaching an upper confidence interval to the value. In other words, it was also stochastically assessed what the required risk adjustment would be to ensure that the Scheme is not under-reserved with a certain confidence level, relative to its unique reserving history and claims run-off patterns. The risk adjustment, relative to this level, was assessed to be 60%.

The risk adjustment reflects the Scheme's risk attitude towards the levels of conservatism considered in its liability reserving, solvency management and pricing practices.

Changes in the risk adjustment for non-financial risk are not disaggregated and included in insurance service result.

#### 3.1.4 ESTIMATES OF FUTURE CASH FLOWS TO FULFIL INSURANCE CONTRACTS

Included in the measurement of the group of contracts are all the future cash flows within the boundary of the group of contracts. The estimates of these future cash flows are based on probability weighted expected future cash flows. The Scheme estimates which cash flows are expected and the probability that they will occur as at the measurement date. In making these expectations, the Scheme uses information about past events, current conditions and forecasts of future conditions. The Scheme's estimate of future cash flows is the mean of a range of scenarios that reflect the full range of possible outcomes. Each scenario specifies the amount, timing and probability of cash flows. The probability weighted average of the future cash flows is calculated using deterministic scenarios representing the probability weighted mean of a full range of scenarios.

The uncertainty in the insurance contracts lies in the number, severity and timing of claims.

Assumptions used to develop estimates about future cash flows are reassessed at each reporting date and adjusted where required.

#### 3.1.5 METHODS USED TO MEASURE THE INSURANCE CONTRACTS

Judgement is involved in assessing the most appropriate technique to estimate insurance liabilities. A generally accepted actuarial methodology used in assessing the estimated claims outcome of insurance liabilities is the chain ladder method. The chain ladder method involves an analysis of historical claims development factors, and the selection of estimated development factors based on historical patterns. Run-off triangles are used in situations where it takes time after the treatment date for the full extent of the claims to become known. It is assumed that payments will emerge in a similar way in each service month. The proportional increase in known cumulative payments from one development month to the next can then be used to calculate payments for future development months.

Run-off factors are most reliable as a predictive tool where outstanding claims are relatively small, and the payment pattern is stable over time. For the most recent treatment months the outstanding claims can be significant, and therefore very sensitive to the run-off assumptions.

A further technique, called the Bornhuetter-Ferguson method, can also be employed for the most recent months, which are the most sensitive to the run-off factors. This method allows for an independent estimate of the expected claims to have an impact on the projected amount and, thus, reduces the sensitivity of the projection to the run-off factors. The Scheme's claims budget is typically used as the original independent estimate. The estimate can be refined as the year progresses based on more recent claims experience (i.e., using an approach called 'credibility theory').

The following was considered when estimating the LIC:

- The level of homogeneity of the data.
- Changes in patterns of claims and claims processing.
- Changes in the composition of the Scheme, i.e., distribution of members and their beneficiaries across various options.
- Changes in benefit limits; and
- Changes in prescribed minimum benefits.

The Scheme is not required to disclose information about the development of claims for which uncertainty about the amount and timing of the claims payments is typically resolved within one year.

### 3.2 FAIR VALUE DETERMINATION

Investments at fair value through profit or loss are measured at fair value and include an estimation component. Fair values have been determined for measurement and disclosure purposes based on the methods listed below.

- Level 1: Inputs are determined directly by reference to published price quotations in an active market for identical assets or liabilities. The fair value of publicly traded financial instruments is based on quoted market prices at the statement of financial position date.
- Level 2: Inputs are observable for the asset, either directly (i.e., prices) or indirectly (i.e., derived from prices). Financial assets classified as level 2 are valued using a discounted cash flow method.
- Level 3: The fair values are determined based on assumptions that are not supported by observable market data. There were level 3 instruments held during the period.

## 4 EQUIPMENT AND OTHER FIXED ASSETS

	2025			2024		
	Cost	Accumulated depreciation	Carrying value	Cost	Accumulated depreciation	Carrying value
Motor vehicles	564,317	(516,037)	48,280	564,317	(516,037)	48,280
Office equipment	3,624,396	(3,461,288)	163,108	3,859,567	(3,631,227)	228,340
Computer equipment	2,328,488	(1,650,798)	677,690	2,148,261	(1,171,158)	977,103
Generator	-	-	-	1,267,594	(917,304)	350,291
<b>Total</b>	<b>6,517,201</b>	<b>(5,628,123)</b>	<b>889,078</b>	<b>7,839,739</b>	<b>(6,235,725)</b>	<b>1,604,014</b>

#### 4.1 RECONCILIATION OF EQUIPMENT AND OTHER FIXED ASSETS

2025	Opening balance	Additions	Disposals	Classified as held for sale (note 9)	Transfers to investment property	Depreciation	Total
Motor vehicles	48,280	-	-	-	-	-	48,280
Office equipment	228,340	6,376	(583)	-	-	(71,026)	163,108
Computer equipment	977,103	194,995	(10,072)	-	-	(484,336)	677,690
Generator	350,291	-	-	(86,164)	(229,726)	(34,401)	-
<b>Total</b>	<b>1,604,014</b>	<b>201,371</b>	<b>(10,655)</b>	<b>(86,164)</b>	<b>(229,726)</b>	<b>(589,763)</b>	<b>889,078</b>

2024	Opening balance	Additions	Disposals	Depreciation	Total
Motor vehicles	105,046	-	-	(56,766)	48,280
Office equipment	57,866	229,697	(225)	(58,998)	228,340
Computer equipment	235,539	1,128,609	(3,180)	(383,866)	977,103
Generator	402,889	-	-	(52,599)	350,291
<b>Total</b>	<b>801,341</b>	<b>1,358,306</b>	<b>(3,404)</b>	<b>(552,228)</b>	<b>1,604,014</b>

#### 5 INVESTMENT PROPERTIES

	2025			2024		
	Cost	Accumulated depreciation	Carrying value	Cost	Accumulated depreciation	Carrying value
Land and buildings	13,140,693	(1,647,475)	11,493,218	13,074,995	(1,647,475)	11,427,520
Partitioning, electrical and fittings	1,564,119	(984,736)	579,383	1,591,534	(895,238)	696,296
Lift	1,486,448	(1,052,924)	433,524	1,486,448	(953,832)	532,615
Air conditioners	5,547,335	(3,386,619)	2,160,716	5,545,848	(2,883,754)	2,662,094
Generator	1,860,260	(647,645)	1,212,615	-	-	-
<b>Total</b>	<b>23,598,855</b>	<b>(7,719,399)</b>	<b>15,879,456</b>	<b>21,698,825</b>	<b>(6,380,300)</b>	<b>15,318,525</b>

#### 5.1 RECONCILIATION OF INVESTMENT PROPERTIES

	Opening balance	Additions	Disposals	Transfers from equipment and other assets	Depreciation	Total
Land and buildings	11,427,520	99,940	(34,242)	-	-	11,493,218
Partitioning, electrical and fittings	696,296	26,071	(7,765)	-	(135,218)	579,383
Lift	532,615	-	-	-	(99,091)	433,524
Air conditioners	2,662,094	65,615	(9,619)	-	(557,373)	2,160,716
Generator	-	1,034,364	-	229,726	(51,474)	1,212,615
<b>Total</b>	<b>15,318,525</b>	<b>1,225,990</b>	<b>(51,626)</b>	<b>229,726</b>	<b>(843,157)</b>	<b>15,879,456</b>

Investment properties comprise the land and buildings on the corner of OR Tambo Road and Susanna Street, erf 5091 and erf 286, Emalahleni (Witbank) and the vacant land in Susanna Street, erf 5090.

The fair value of the properties as valued by a Professional Associated Valuer is R 56,4 million (2024: R56,4 million). Management has assessed the residual value of the building to be R16.5 million. This is greater than the current carrying value of the building and therefore no depreciation has been processed.

Direct operating expenses arising from the property that generated rental income amounted to R3,972,933 (2024: R3,452,507) and which did not generate rental income amounted to R213,112 (2024: R70,154).

## 6 INVESTMENTS AT FAIR VALUE THROUGH PROFIT OR LOSS

Investments are held at fair value through profit and loss and comprise:

	2025	2024
Segregated multiclass portfolio	210,539,729	181,238,890
Linked fund policies	637,174,553	527,013,473
Money market instruments	268,502,108	248,232,823
	<b>1,116,216,390</b>	<b>956,485,185</b>

The underlying asset allocation, on a look-through basis, is as follows:

Cash	401,888,359	357,740,995
Investments in property	25,377,169	16,367,675
Interest-bearing investments, including bonds	363,610,380	309,138,324
Listed equities	325,340,482	273,238,191
	<b>1,116,216,390</b>	<b>956,485,185</b>

The split between the non-current and current portions of investments is as follows:

Non-current assets	847,714,282	708,252,362
Current assets	268,502,108	248,232,823
	<b>1,116,216,390</b>	<b>956,485,185</b>

### 6.1 RECONCILIATION OF FAIR VALUE OF INVESTMENTS

	2025	2024
Balance at the beginning of the year	956,485,185	876,918,435
Proceeds on disposal	-	(15,000,000)
Dividend income capitalised (note 5)	10,958,323	10,566,687
Interest income capitalised (note 5)	43,651,071	44,452,297
Fair value adjustments (note 5)	111,144,791	43,855,799
Management fees	(6,022,980)	(4,308,032)
<b>Balance at the end of the year</b>	<b>1,116,216,390</b>	<b>956,485,185</b>

For financial assets held at fair value, disclosure is required of a fair value hierarchy which reflects the significance of the inputs used to make the measurements. Fair value disclosures are based on the level within which an instrument falls in the fair value hierarchy. The inputs are categorised into three levels, with the highest priority given to unadjusted quoted prices in active markets for identical assets or liabilities and the lowest priority given to unobservable inputs. The three fair value hierarchy levels are:

- Level 1 inputs are unadjusted quoted prices in active markets for identical assets or liabilities.
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are either directly or indirectly (that is, derived from prices) observable for the asset or liability.
- Level 3 inputs for the asset or liability that are not based on observable market data (that is, unobservable inputs).

The following table presents the Scheme's assets held at fair value on a look-through basis:

	Level 1	Level 2	Level 3	Total
<b>2025</b>				
Listed equities	325,340,482	-	-	325,340,482
Bonds	363,610,380	-	-	363,610,380
Listed property holdings	25,377,169	-	-	25,377,169
Money market instruments	-	401,888,359	-	401,888,359
	<b>714,328,031</b>	<b>401,888,359</b>	-	<b>1,116,216,390</b>
<b>2024</b>				
Listed equities	273,238,191	-	-	273,238,191
Bonds	309,138,324	-	-	309,138,324
Listed property holdings	16,367,675	-	-	16,367,675
Money market instruments	-	357,740,995	-	357,740,995
	<b>598,744,190</b>	<b>357,740,995</b>	-	<b>956,485,185</b>

Financial assets held at fair value through profit or loss held by the Scheme categorised as level 2 comprises unlisted money market instruments and valued using discounted cash flows based on applicable interest rates.

## 7 TRADE AND OTHER RECEIVABLES

	2025	2024
<b>Financial assets</b>		
Prepayments	388,678	138,287
Deposits paid	99,666	99,666
Rental income receivable	148,632	237,957
Provision for impairment loss on rental income receivable	-	-
	<b>636,975</b>	<b>475,909</b>
<b>Reconciliation of provision for impairment loss</b>		
Balance at the beginning of the year	-	(1,026,095)
Amounts owing by tenants for rental not recoverable	-	1,022,723
Net impairment gain/(loss) on financial assets	-	3,371
<b>Balance at the end of the year</b>	<b>-</b>	<b>-</b>

The fair value of trade and other receivables approximates their carrying amounts due to the short-term maturities of these assets. Further detail on the Scheme's credit risk related to a customer or other counter party to a financial instrument failing to meet their current obligations to the Scheme is disclosed in note 21.

## 8 CASH AND CASH EQUIVALENTS

	2025	2024
Current accounts	68,224,353	55,130,268
Call accounts	31,221,588	44,273,293
	<b>99,445,941</b>	<b>99,403,561</b>

The effective interest rates on current accounts was 1.1% (2024: 1.2%) and call accounts was 8.6% (2024: 10.1%). The carrying amount of the cash and cash equivalents approximates the fair values due to the short-term maturities of these balances.

## 9 ASSETS HELD FOR SALE

Assets held for sale comprise:

	2025	2024
Generator - at cost	430,820	-
Generator - accumulated depreciation	(344,656)	-
	<b>86,164</b>	<b>-</b>

On 30 September 2025, the Board of Trustees approved the replacement of a generator originally purchased by the Scheme in 2007. Following this approval, the existing generator was classified as held for sale in accordance with IFRS 5.

The generator has been transferred from equipment to non-current assets held for sale. It is measured at the lower of its carrying amount (residual value) and its estimated fair value less costs to sell. At the date of classification, the carrying amount (residual value) was lower than the estimated fair value less costs to sell, and accordingly no impairment loss was recognised.

The generator has reached the end of its estimated useful life and is no longer in use. It has been relocated to a designated sales area and is available for immediate sale in its present condition. Depreciation ceased upon classification as held for sale.

Management considers the sale to be highly probable and expects the transaction to be concluded within twelve months of the date of classification.

## 10 INSURANCE CONTRACT LIABILITIES FOR FUTURE MEMBERS

	2025	2024
Balance of members' funds the beginning of the year	724,598,316	621,234,299
Surplus/deficit on insurance contracts attributable to future members	143,988,326	103,364,017
<b>Balance of members' funds the end of the year</b>	<b>868,586,642</b>	<b>724,598,316</b>

## 11 RETIREMENT BENEFIT OBLIGATION

In 2011, the Board resolved that employees of the Scheme who were in service as at 31 January 2011 and who retire after completing at least 20 years of service are entitled to a post-retirement medical aid subsidy. The subsidy amounts to 50% of the member's monthly medical aid contribution and is payable for the remainder of the retiree's lifetime. Upon the death of the retiree, the subsidy continues to be paid to the surviving spouse. The benefit ceases upon the death of the surviving spouse. Employees become eligible for the subsidy on normal retirement from age 60, provided the minimum service requirement has been met.

An actuarial valuation is performed annually to determine the present value of the defined benefit obligation. The liability is measured as the present value of the expected future payments in respect of the remaining lifetimes of the beneficiaries and their surviving spouses.

The benefit constitutes a defined benefit plan in terms of IAS 19.

The post-retirement medical aid benefit obligation is unfunded. No plan assets have been set aside to meet this obligation. As the plan is unfunded, the Scheme bears full responsibility for meeting benefit payments as they fall due. Accordingly, the Scheme is exposed to liquidity risk and cash flow risk, as future payments will be settled from operating cash flows. The quantum and timing of these payments are inherently uncertain and depend on demographic experience and the financial assumptions applied in the actuarial valuation.

### 11.1 RECONCILIATION OF THE DEFINED BENEFIT OBLIGATION

	2025	2024
Balance at the beginning of the year	2,190,000	1,846,000
Current service cost	108,000	96,000
Interest cost	273,000	265,000
Benefits paid	(26,000)	(24,000)
Remeasurements (actuarial gain/(loss))	26,000	7,000
<b>Balance at the end of the year</b>	<b>2,571,000</b>	<b>2,190,000</b>

#### Amounts Recognized in Surplus or Deficit

Employee costs	26,000	24,000
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### 11.2 SPLIT BETWEEN NON-CURRENT AND CURRENT PORTIONS

Non-current liabilities	2,226,000	1,836,000
Current liabilities	345,000	354,000
<b>Total liability</b>	<b>2,571,000</b>	<b>2,190,000</b>

### 11.3 FIVE-YEAR HISTORY

	2025	2024	2023	2022	2021
Present value of liability	2,571,000	2,190,000	1,846,000	1,808,000	1,629,000
Actuarial gain/(loss)	26,000	7,000	271,000	90,000	93,000

#### 11.4 DEFINED BENEFIT OBLIGATION PROJECTION

The expected future cash flows are projected as follows:

	> 1 year	1-2 years	3-5 years	6-10 years
Projected service costs	114,000	263,000	274,000	686,000
Projected interest costs	259,000	628,000	795,000	2,790,000
Projected employer benefit payments	(28,000)	(66,000)	(181,000)	(1,027,000)
Projected liability at period end	2,916,000	3,741,000	4,629,000	7,078,000

#### 11.5 ACTUARIAL ASSUMPTIONS

An actuarial valuation was performed by independent valuers, 3One Actuaries Inc, on 31 December 2025, using the Projected Unit Credit Method, in accordance with IAS 19. The projections contained in the valuation was consistent with those used in the prior year. The key assumptions used were:

	2025	2024
Consumer Price Inflation (CPI)	5.73%	7.28%
Salary inflation (CPI+1.5%)	7.23%	8.78%
Healthcare cost inflation (CPI+1.5%)	7.23%	8.78%
Discount rate	10.16%	12.54%
Real discount rate	2.73%	3.46%
Retirement age	63 years old	
Mortality rates	Pre-retirement: SA 85-90 (light) with a 3 year age reduction for females Post-retirement: PA(90)	

#### 11.6 SENSITIVITY ANALYSIS

The defined benefit obligation is sensitive to changes in medical inflation. If the assumed future rate of medical cost inflation had been 1% higher, the defined benefit obligation would have increased by R419,073 (2024: R365,730).

The sensitivity analysis above has been prepared by recalculating the defined benefit obligation using a revised assumption while holding all other assumptions constant. In practice, changes in assumptions may be interrelated and the combined effect of changes in multiple assumptions may not be linear.

## 12 INSURANCE CONTRACTS LIABILITY FOR CURRENT MEMBERS

The Scheme as a whole is identified as a portfolio. All the contracts issued by the Scheme are subject to similar risks and are managed together. The breakdown at a portfolio level of the Liability for remaining coverage and Liability for incurred claims are set out below:

2025	Note	Liability for remaining coverage (LFRC)	Liability for incurred (LIC) claims		Total
		Excluding loss component	Best Estimate Liability (BEL)	Risk Adjustment (RA)	
<b>Opening insurance contract liabilities</b>		-	<b>344,446,425</b>	<b>1,961,679</b>	<b>346,408,104</b>
<b>CHANGES IN THE STATEMENT OF COMPREHENSIVE INCOME</b>					
Insurance revenue recognised from contracts measured under the PAA		(613,847,546)	-	-	(613,847,546)
<b>Total insurance revenue</b>	<b>13</b>	<b>(613,847,546)</b>	<b>-</b>	<b>-</b>	<b>(613,847,546)</b>
Incurred claims and other insurance service expenses	14	-	627,554,595	1,370,008	628,924,603
Changes that relate to past service – adjustments to the LIC	15	-	(13,312,555)	(1,961,679)	(15,274,234)
Insurance acquisition cash flows (broker fees)		786,558	-	-	786,558
<b>Total insurance service expenses</b>	<b>15</b>	<b>786,558</b>	<b>614,242,040</b>	<b>(591,671)</b>	<b>614,436,927</b>
<b>Insurance service result</b>		<b>(613,060,988)</b>	<b>614,242,040</b>	<b>(591,671)</b>	<b>589,381</b>
Finance expense from insurance contracts issued	17	-	20,184,006	-	20,184,006
<b>Total amounts recognised in comprehensive income</b>		<b>(613,060,988)</b>	<b>634,426,046</b>	<b>(591,671)</b>	<b>20,773,387</b>
<b>Investment components: PMSA contributions received</b>	<b>12.2</b>	<b>(178,378,108)</b>	<b>178,378,108</b>	<b>-</b>	<b>-</b>
<b>OTHER CHANGES</b>					
<b>Unclaimed PMSA liability written off to Scheme funds</b>	<b>12.2</b>	<b>(99,518)</b>	<b>-</b>	<b>-</b>	<b>(99,518)</b>
<b>Insurance debtors to LIC</b>		<b>(3,007,410)</b>	<b>3,007,410</b>	<b>-</b>	<b>-</b>
<b>CASH FLOWS</b>					
Contributions received		795,233,064	-	-	795,233,064
Claims and other directly attributable expenses paid		-	(776,791,119)	-	(776,791,119)
Other cash flows from/(to) members and providers		-	787,218	-	787,218
Saving plan refunds	12.2	-	(23,851,483)	-	(23,851,483)
Insurance acquisition cash flows (broker fees)		(786,558)	-	-	(786,558)
<b>Total cash flows</b>		<b>794,446,506</b>	<b>(799,855,384)</b>	<b>-</b>	<b>(5,408,879)</b>
<b>Closing insurance contract liabilities</b>		<b>-</b>	<b>360,402,604</b>	<b>1,370,008</b>	<b>361,772,612</b>

2024	Note	LFRC	LIC		Total
		Excluding loss component	BEL	RA	
<b>Opening insurance contract liabilities</b>		-	<b>336,425,945</b>	<b>2,065,387</b>	<b>338,491,332</b>
<b>CHANGES IN THE STATEMENT OF COMPREHENSIVE INCOME</b>					
Insurance revenue recognised from contracts measured under the PAA		(578,069,267)	-	-	(578,069,267)
<b>Total insurance revenue</b>	<b>13</b>	<b>(578,069,267)</b>	<b>-</b>	<b>-</b>	<b>(578,069,267)</b>
Incurred claims and other insurance service expenses	14	-	560,576,775	1,961,679	62,538,454
Changes that relate to past service – adjustments to the LIC	15	-	(6,844,493)	(2,065,387)	8,909,880
Insurance acquisition cash flows (broker fees)		465,710	-	-	465,710
<b>Total insurance service expenses</b>	<b>15</b>	<b>465,710</b>	<b>553,732,282</b>	<b>(103,708)</b>	<b>554,094,284</b>
<b>Insurance service result</b>		<b>(577,603,557)</b>	<b>553,732,282</b>	<b>(103,708)</b>	<b>(23,974,983)</b>
Finance expense from insurance contracts issued	17	-	21,094,514	-	21,094,514
<b>Total amounts recognised in comprehensive income</b>		<b>(577,603,557)</b>	<b>574,826,796</b>	<b>(103,708)</b>	<b>(2,880,469)</b>
<b>Investment components: PMSA contributions received</b>	<b>12.2</b>	<b>(165,347,201)</b>	<b>165,347,201</b>	<b>-</b>	<b>-</b>
<b>OTHER CHANGES</b>					
<b>Unclaimed PMSA liability written off to Scheme funds</b>	<b>12.2</b>	<b>(275,853)</b>	<b>-</b>	<b>-</b>	<b>(275,853)</b>
<b>Insurance debtors to LIC</b>		<b>(22,096,458)</b>	<b>22,096,458</b>	<b>-</b>	<b>-</b>
<b>CASH FLOWS</b>					
Contributions received		765,512,926	-	-	765,512,926
Claims and other directly attributable expenses paid		-	(736,874,349)	-	(736,874,349)
Other cash flows from/(to) members and providers		-	(1,668,280)	-	(1,668,280)
Saving plan refunds	12.2	-	(15,601,936)	-	(15,601,936)
Insurance acquisition cash flows (broker fees)		(465,710)	-	-	(465,710)
<b>Total cash flows</b>		<b>765,047,216</b>	<b>(754,144,566)</b>	<b>-</b>	<b>10,902,651</b>
<b>Closing insurance contract liabilities</b>		<b>-</b>	<b>344,446,425</b>	<b>1,961,679</b>	<b>346,408,104</b>

## 12.1 RECONCILIATION OF NET INSURANCE CONTRACT LIABILITIES BALANCES

The breakdown of the net insurance contract liabilities is set out below:

	LFRC	LIC	Total
<b>2025</b>			
Contributions receivable	(4,573,372)	-	(4,573,372)
Recoveries due from members	1,027,889	-	1,027,889
Recoveries due from service providers	960,343	-	960,343
Contributions received in advance	(1,261,017)	-	(1,261,017)
Insurance debtors to LIC	3,846,157	3,846,157	7,692,315
Reported claims not yet paid	-	2,383,568	2,383,568
Insurance payables for other directly attributable expenditure	-	5,828,629	5,828,629
Personal medical savings accounts liability	-	310,364,203	310,364,203
Best estimate liability - incurred but not reported	-	38,203,797	38,203,797
Risk adjustment	-	1,370,008	1,370,008
	-	<b>361,996,362</b>	<b>361,996,362</b>
<b>2024</b>			
Contributions receivable	443,865	-	443,865
Recoveries due from members	822,403	-	822,403
Recoveries due from service providers	1,946,592	-	1,946,592
Contributions received in advance	(3,270,844)	-	(3,270,844)
Insurances debtors to LIC	57,984	57,984	115,969
Reported claims not yet paid	-	1,042,525	1,042,525
Insurance payables for other directly attributable expenditure	-	4,075,533	4,075,533
Personal medical savings accounts liability	-	294,053,052	294,053,052
Best estimate liability - incurred but not reported	-	45,308,105	45,308,105
Risk adjustment	-	1,961,679	1,961,679
	-	<b>346,498,879</b>	<b>346,498,879</b>

### 12.1.1 Liability for Remaining Coverage (LRC)

During the reporting period, the LRC was reduced by the amount of insurance revenue recognised for the services provided in the period. The composition of insurance revenue is disclosed in the analysis of insurance revenue provided in note 13. The amount of insurance revenue recognised in the reporting period depicts the transfer of promised services at an amount that reflects the portion of consideration the Scheme expects to be entitled to in exchange for those services and increased the LRC. Debtors that paid in advance and for which no service has yet been provided are included in the LRC. Debtors in arrears and for which services and coverage have been provided but not yet paid are included in LRC.

### 12.1.2 Liability for Incurred Claims (LIC)

For insurance contracts issued at each of the subsequent reporting dates the LIC is:

- best estimate of cash flows; and
- risk adjustment.

Members must submit all claims for payment within four months of seeking medical treatment. However, some claims do take significantly longer than four months to settle (i.e. to “run off”).

Run-off patterns are therefore calculated by considering the Scheme's unique experience on the pattern of when claims occur and when they are ultimately settled, categorised into groups for which one can expect a homogenous run-off pattern to emerge.

The best estimate of cash flow provision is based on information available as at the measurement date, which includes amounts already settled (processed) as at the measurement date, the run-off input assumptions outlined above, as well as any other available estimates (for example, budgeted claims or independently estimated hospital amounts from pre-authorisation case estimate models).

#### Risk Adjustment

The biggest risk inherent in run-off models are the run-off assumptions applied. Any processing changes and/or delays between providers and the Scheme (relative to the input assumptions) would impact on the best estimate value of fulfilment cash flow provided. Therefore, provision for such adverse experience is made in the form of a risk adjustment (that is, where the model relies on run-off assumptions).

The risk adjustment was determined by applying sensitivity testing to the run-off input assumptions used to calculate the best estimate reserve value, i.e. a deterministic sensitivity approach. Stochastic claims modelling (based on simulations of multiple prior year outstanding claim reserve distributions of the Scheme) was used to assess this overall risk adjustment value by attaching an upper confidence interval to the value. In other words, it was also stochastically assessed what the required risk adjustment would be to ensure that the Scheme is not under-reserved with a certain confidence level, relative to its unique reserving history and claims run-off patterns. The risk adjustment, relative to this level, was assessed to be 60%. The risk adjustment reflects the Scheme's risk attitude towards the levels of conservatism considered in its liability reserving, solvency management and pricing practices.

#### Claims Sensitivity

Refer to note 23 for the claims sensitivity analysis.

## 12.2 RECONCILIATION OF NET INSURANCE CONTRACT LIABILITIES BALANCES

The PMSA is a non-distinct investment component with the balances included in either insurance contract assets or liabilities in the statement of financial position. The Members' PMSA Reconciliation in line with Regulation 10 of the Act is set out below:

	2025	2024
Balance of the PMSA liability at 1 January	294,053,052	271,352,846
PMSA contributions received or receivable (Note 13)	178,378,108	165,347,201
Transfers from other schemes in terms of Regulation 10(4)	6,455	14,401
Finance expense from insurance contracts	20,184,006	21,094,514
Claims paid to and on behalf of members (Note 14)	(158,306,416)	(147,878,121)
Refunds on death or resignation in terms of regulation 10(5)	(23,851,483)	(15,601,936)
Unclaimed PMSA liability written off to Scheme funds	(99,518)	(275,853)
<b>Balances on PMSA at 31 December</b>	<b>310,364,203</b>	<b>294,053,052</b>

The Comprehensive and Midmas benefit options allow members the facility to pay a 25% percent of their gross contributions into a savings account, to assist members in managing their healthcare costs to their own requirements. Savings are capped at a maximum of 25% of the gross contributions.

The personal medical savings account (PMSA) contains a demand feature in terms of Regulation 10 of the Act that any credit balance on a member's PMSA must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit option and then enrolls in another benefit option or medical scheme without a PMSA or does not enrol in another medical scheme.

Interest is paid to members on PMSA monies at the rate achieved by the Scheme's cash portfolio net of asset management fees. The effective interest rate earned was 6.7% (2024: 7.5%).

### 13 TRADE AND OTHER PAYABLES

	2025	2024
<b>Financial liabilities</b>		
Deposits received from tenants	168,423	54,504
VAT liability	55,327	36,271
	<b>223,751</b>	<b>90,775</b>

The fair value of trade and other payables approximate their carrying amounts due to the short-term maturities of these liabilities.

### 14 INSURANCE REVENUE

	2025	2024
Gross contributions per registered rules	792,225,654	743,416,468
PMSA contributions received or receivable	(178,378,108)	(165,347,201)
<b>Insurance revenue</b>	<b>613,847,546</b>	<b>578,069,267</b>

The personal medical savings account (PMSA) contributions are received by the Scheme in terms of Regulation 10(1) and the Rules of the Scheme.

### 15 INSURANCE SERVICE EXPENSES

	2025	2024
<b>Risk claims per the rules of the Scheme</b>		
Direct benefits for the current period per the registered rules	689,949,334	641,873,737
Direct benefits for the previous period per the registered rules	31,995,550	9,106,793
Claims paid from personal medical savings accounts	(158,306,416)	(147,878,121)
Discount received	(493,661)	(453,559)
Adjustment to the LIC provision	7,578,255	8,250,789
<b>Claims incurred</b>	<b>570,723,062</b>	<b>510,899,640</b>
Accredited managed healthcare services (note 15.1)	13,645,186	10,323,283
Attributable expenses incurred (note 15.2)	44,556,356	41,315,531
<b>Incurred claims and other directly attributable expenses</b>	<b>628,924,603</b>	<b>562,538,454</b>
Changes that relate to past service – adjustment to the LIC	(15,274,234)	(8,909,880)
Broker services	786,558	465,710
<b>Insurance service expenses</b>	<b>614,436,927</b>	<b>554,094,284</b>

### 15.1 ACCREDITED MANAGED HEALTHCARE SERVICES (NO RISK TRANSFER)

	2025	2024
Active risk management services	6,018,939	3,157,701
Hospital benefit management services	4,223,534	3,939,661
Pharmacy benefit management services	1,917,829	1,814,719
Disease risk management support services	963,434	897,134
Managed care network management services and risk management	521,449	514,067
<b>Accredited managed healthcare services</b>	<b>13,645,186</b>	<b>10,323,283</b>

These expenses were incurred for the management of the utilisation, costs and quality of healthcare services of the Scheme.

### 15.2 ATTRIBUTABLE EXPENSES INCURRED

	2025	2024
Actuarial services	695,796	670,266
Administration expenditure: benefit management services (not accredited managed care)	2,478,409	2,508,025
Administration fees in respect of accredited services	1,967,895	1,939,419
Association fees	179,746	94,383
Audit fees	1,293,443	1,952,197
Bank charges	156,292	36,212
Consulting fees	941,528	299,129
Council for Medical Schemes levies	512,664	468,063
Debt collection fees	93,660	78,264
Depreciation, amortisation and impairments	589,762	552,228
Fidelity guarantee insurance	33,178	33,178
Fraud awareness expenses	31,740	52,785
Insurance	220,857	207,011
Internal audit fees	556,387	653,096
ITC expenditure	7,361,254	6,718,618
Legal fees	-	85,068
Marketing	641,793	476,348
Meeting expenses	73,871	52,039
Member communication	543,766	498,307
Motor vehicle expenses	139,435	111,345
Office expenses, repairs and maintenance	164,590	156,584
Operating leases - office equipment	69,761	53,460
Professional indemnity insurance	62,184	62,184
Staff remuneration and employment costs	25,308,281	23,369,869
Travel, accommodation and conferences	357,715	151,150
Trustees' and Committee Members' remuneration and considerations	82,349	36,303
<b>Attributable expenses incurred</b>	<b>44,556,356</b>	<b>41,315,531</b>

## 16 RECLASSIFICATION OF COMPARATIVE INFORMATION

During the current financial year, the Scheme reassessed the presentation of certain expenses in light of the requirements of IFRS 17 – Insurance Contracts and following engagement with the Council for Medical Schemes (CMS) regarding the application of IFRS 17 within the medical schemes industry.

CMS has indicated that, given the legal definition of a medical scheme’s business contained in the Medical Schemes Act, the activities of the Scheme are wholly directed toward the provision and administration of insurance contracts. Accordingly, all expenses incurred in operating the Scheme are considered to be directly attributable to the fulfilment of insurance contracts.

Following this clarification, management concluded that expenses previously presented within “Administration fees and operative expenses” meet the definition of insurance service expenses in terms of IFRS 17.83 and B65, as they relate directly to the fulfilment of the Scheme’s insurance contracts.

As a result, these expenses have been reclassified to “Attributable expenses incurred” within “Insurance service expenses”, refer to note 15.

The reclassification represents a change in presentation only and does not constitute a change in accounting policy. The reclassification has no impact on the net surplus for the year, accumulated funds, total cash flows nor the measurement of insurance contract liabilities.

The effect of the reclassification on the prior year comparative figures is as follows:

	<b>Reclassification</b>	<b>2024 As previously reported</b>	<b>2024 Restated</b>
<b>Statement of Financial Position</b>			
Insurance contracts liability for current members	1,858,741	344,549,363	346,408,104
Trade and other payables	(1,858,741)	1,949,516	90,775
<b>Statement of Profit or Loss and Other Comprehensive Income</b>			
Insurance service expenses	(8,261,191)	(545,833,093)	(554,094,284)
Administration fees and operative expenses	8,261,191	(8,261,191)	-
<b>Statement of Cash Flows</b>			
Cash paid to providers and employees - Directly attributable expenses	(9,265,358)	(32,883,130)	(42,148,488)
Cash paid to providers and employees - Other operative expenditure	9,368,468	(9,368,468)	-

## 17 INVESTMENT INCOME

	2025	2024
Financial assets at amortised cost		
Interest income	4,519,851	5,062,747
Financial assets at fair value through profit or loss		
Dividend income	10,958,323	10,566,687
Interest income	43,381,702	44,452,297
Net fair value gains on financial assets at fair value through profit or loss	111,144,791	43,855,799
Rental income on investment property	5,280,820	4,485,675
<b>Investment income</b>	<b>175,282,487</b>	<b>108,423,205</b>
Interest accrued on PMSA accounts	(20,184,006)	(21,094,514)
<b>Finance expenses from insurance contracts issues</b>	<b>(20,184,006)</b>	<b>(21,094,514)</b>

## 18 TRUSTEES' AND COMMITTEE MEMBERS' REMUNERATION AND CONSIDERATIONS

2025	Fees for meeting attendance	Travelling and other expenses for meetings and conferences	Total
<b>BOARD OF TRUSTEES</b>			
LS Gumedede	-	12,628	12,628
SL Kekana	-	54,068	54,068
D Le Roux	-	42,693	42,693
S Lupuwana	6,990	12,286	19,276
C Mabanga	-	46,464	46,464
M Makgolane	-	46,464	46,464
CIA Maslo	-	46,464	46,464
MB Mazibuko	-	9,728	9,728
RV Mnguni	-	11,083	11,083
BM Modise	-	46,564	46,564
SN Ndebele	-	9,728	9,728
N Pitjeng	-	9,728	9,728
	6,990	347,898	354,888
<b>CLINICAL GOVERNANCE &amp; EX-GRATIA COMMITTEE</b>			
CIA Maslo	16,800	-	16,800
K Msimeki	4,000	-	4,000
	20,800	-	20,800
<b>INVESTMENT COMMITTEE</b>			
A Nienaber	4,180	-	4,180
<b>NOMINATIONS &amp; ADVISORY COMMITTEE</b>			
J Perkes	17,950	6,188	24,138
<b>REMUNERATION COMMITTEE</b>			
S Lupuwana	11,920	-	11,920
J Perkes	17,950	6,188	24,138
	29,870	6,188	36,058
<b>Total</b>	<b>79,790</b>	<b>360,273</b>	<b>440,063</b>

2024		Fees for meeting attendance	Travelling and other expenses for meetings and conferences	Total
<b>BOARD OF TRUSTEES</b>				
S	Lupuwana	-	10,142	10,142
C	Mabanga	-	5,000	5,000
M	Makgolane	-	53,313	53,313
A	Mazibuko	-	27,465	27,465
BM	Modise	-	27,660	27,660
K	Msimeki	-	27,570	27,570
		-	151,150	151,150
<b>AUDIT AND GOVERNANCE COMMITTEE</b>				
AJ	de Klerk	15,368	3,766	19,134
<b>NOMINATIONS AND ADVISORY COMMITTEE</b>				
J	Perkes	8,030	-	8,030
<b>REMUNERATION COMMITTEE</b>				
J	Perkes	9,139	-	9,139
<b>Total</b>		<b>32,537</b>	<b>154,916</b>	<b>187,453</b>

## 19 SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

2025	Comprehensive	Midmas	Ntsika	Scheme
Gross contribution income	628,837,441	85,269,843	78,118,369	792,225,654
Savings contributions	(157,084,631)	(21,293,477)	-	(178,378,108)
<b>Insurance revenue</b>	<b>471,752,810</b>	<b>63,976,367</b>	<b>78,118,369</b>	<b>613,847,546</b>
Claims incurred excluding claims incurred in respect of risk transfer arrangements	(464,297,119)	(45,906,145)	(60,519,798)	(570,723,062)
Accredited managed healthcare expenses	(8,961,362)	(1,542,786)	(3,141,038)	(13,645,186)
Attributable expenses incurred	(28,989,872)	(6,080,827)	(9,485,656)	(44,556,356)
Changes that relate to past service – adjustment to the LIC	11,972,896	1,434,167	1,867,171	15,274,234
Insurance acquisition cash flows (broker fees)	(232,593)	(419,189)	(134,776)	(786,558)
<b>Insurance service expenses</b>	<b>(490,508,050)</b>	<b>(52,514,780)</b>	<b>(71,414,098)</b>	<b>(614,436,927)</b>
<b>INSURANCE SERVICE RESULT</b>	<b>(18,755,239)</b>	<b>11,461,587</b>	<b>6,704,271</b>	<b>(589,381)</b>
Investment income	142,460,216	17,531,300	15,293,969	175,285,486
Gain/(loss) on disposal of equipment	(33,152)	(7,127)	(10,903)	(51,182)
Sundry income	93,846	5,672	-	99,518
<b>Other income</b>	<b>142,520,910</b>	<b>17,529,845</b>	<b>15,283,066</b>	<b>175,333,821</b>
Impairment losses on insurance receivables	(56,849)	(13,102)	(843)	(70,793)
Insurance finance expenses	(19,346,786)	(837,220)	-	(20,184,006)
Asset management fees	(4,090,559)	(879,436)	(1,345,276)	(6,315,271)
Costs incurred on rental property	(2,711,406)	(582,930)	(891,709)	(4,186,045)
<b>Other expenses</b>	<b>(26,205,599)</b>	<b>(2,312,687)</b>	<b>(2,237,828)</b>	<b>(30,756,114)</b>
<b>NET RESULT BEFORE MUTUALISATION</b>	<b>97,560,072</b>	<b>26,678,745</b>	<b>19,749,510</b>	<b>143,988,326</b>

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2024	Comprehensive	Midmas	Ntsika	Scheme
Gross contribution income	600,247,534	61,860,082	81,308,852	743,416,468
Savings contributions	(149,894,815)	(15,452,386)	-	(165,347,201)
<b>Insurance revenue</b>	<b>450,352,719</b>	<b>46,407,696</b>	<b>81,308,852</b>	<b>578,069,267</b>
Claims incurred excluding claims incurred in respect of risk transfer arrangements	(407,226,242)	(41,268,246)	(62,405,152)	(510,899,640)
Accredited managed healthcare expenses	(6,931,557)	(821,498)	(2,570,228)	(10,323,283)
Attributable expenses incurred	(28,614,854)	(4,578,951)	(8,121,727)	(41,315,531)
Changes that relate to past service – adjustment to the LIC	9,271,882	(467,700)	105,698	8,909,880
Insurance acquisition cash flows (broker fees)	(150,764)	(270,664)	(44,282)	(465,710)
<b>Insurance service expenses</b>	<b>(433,651,534)</b>	<b>(47,407,059)</b>	<b>(73,035,691)</b>	<b>(554,094,284)</b>
<b>INSURANCE SERVICE RESULT</b>	<b>16,701,184</b>	<b>(999,363)</b>	<b>8,273,161</b>	<b>23,974,983</b>
Investment income	90,992,671	7,879,232	9,551,303	108,423,205
Gain/(loss) on disposal of equipment	(20,238)	(3,262)	(6,860)	(30,360)
Sundry income	571,428	1,737	-	573,164
<b>Other income</b>	<b>91,543,861</b>	<b>7,877,707</b>	<b>9,544,442</b>	<b>108,966,009</b>
Impairment losses on insurance receivables	(417,944)	(40,936)	2,614	(456,266)
Insurance finance expenses	(20,481,950)	(612,565)	-	(21,094,514)
Asset management fees	(3,048,818)	(491,373)	(1,033,498)	(4,573,689)
Costs incurred on rental property	(2,301,439)	(370,919)	(780,149)	(3,452,507)
<b>Other expenses</b>	<b>(26,250,151)</b>	<b>(1,515,792)</b>	<b>(1,811,033)</b>	<b>(29,576,975)</b>
<b>NET RESULT BEFORE MUTUALISATION</b>	<b>81,994,894</b>	<b>5,362,552</b>	<b>16,006,571</b>	<b>103,364,017</b>

## 20 RELATED PARTIES

### Relationships

Key management personnel:

- Trustees, their close family members, and in the case of appointed Trustees, their employer groups.
- Principal Officer and her close family members

### Balances and transactions

All costs were charged at market related prices in accordance with the provisions of the Act. Related party transactions with key management personnel, other than transactions related to their membership of the medical scheme, are reviewed and preauthorised by the Board of Trustees, and Remuneration Committee where applicable.

	2025	2024
Trustee remuneration (note 18)	354,888	151,150
Contributions received in terms of the Scheme's Rules	1,137,027	1,277,646
Claims paid in terms of the Scheme's Rules	461,157	1,492,407
Savings account balances	463,617	483,284
Principal Officers' remuneration	2,630,886	2,475,234
Principal Officers' travel, accommodation and conferences	39,251	62,184
Rental income received from related parties of trustees	1,595,391	-

## 21 FINANCIAL RISK MANAGEMENT

The Scheme's activities expose it to the following financial risks:

- Credit risk.
- Liquidity risk; and
- Market risk from equity market prices (price risk) and interest rate risk.

The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potentially adverse effects on the financial performance of the investments which the Scheme holds to meet its obligations to its members.

Financial risk management and investment decisions are made under the guidance and policies approved by the Board of Trustees together with the Scheme's Executive Management who establish and oversee the Scheme's financial and non-financial risk management framework.

The Investment Committee is responsible for assisting the Board to manage the investment portfolio in accordance with the agreed policies of the Scheme and to ensure compliance with the regulations of the Act. Refer to the Report of the Board of Trustees for further details on the Scheme's investment strategy.

### 21.1 CREDIT RISK MANAGEMENT

Credit risk refers to the risk that the Scheme will suffer a financial loss if a customer (insurance or trade receivable) or other counter party to a financial instrument fails to meet their current obligations to the Scheme. Credit risk arises principally from the Scheme's investment securities (excluding the equity instruments), cash and cash equivalents and insurance assets.

#### 21.1.1 Exposure to credit risk

The carrying amounts of financial assets represents the maximum credit exposure. The maximum exposure to credit risk at the reporting date was:

	Fair value/ Amortised cost	Impairment	Carrying amount
<b>2025</b>			
Investments (note 6)	1,116,216,390	-	1,116,216,390
Non-insurance receivables (note 7)	636,975	-	636,975
Cash and cash equivalents (note 8)	99,445,941	-	99,445,941
Insurance receivables (note 12)	(2,406,564)	(178,576)	(2,585,140)
	<b>1,213,892,742</b>	<b>(178,576)</b>	<b>1,213,714,166</b>
<b>2024</b>			
Investments (note 6)	956,485,185	-	956,485,185
Non-insurance receivables (note 7)	475,909	-	475,909
Cash and cash equivalents (note 8)	99,403,561	-	99,403,561
Insurance receivables (note 12)	3,450,557	(237,697)	3,212,860
	<b>1,059,815,213</b>	<b>(237,697)</b>	<b>1,059,577,515</b>

#### Investments

Risk is managed by limiting exposure as well as the quality of instruments that the Scheme's assets can be invested in, limiting the impact of a default on the overall portfolio. The following guidelines provide the current limits on each instrument:

## Domestic equity investments:

- Domestic Equity Investments shall be restricted to securities that are actively traded on the Johannesburg Stock Exchange (JSE) and readily marketable.
- Not more than 5% of the total share portfolio may be invested in the share of any one company at the time of purchase.
- For investee companies that have a market capitalization of below R5 billion no more than 2.5% of the total Scheme investment portfolio may be invested in the share instrument of any one investee company; and
- In the case of investments into a pooled fund, the Scheme may invest in accordance with Regulation 30 requirements, in which case the Scheme may waive strict adherence to the guidelines above.

## Domestic fixed-income and cash investments:

- At the time of purchase, debt instruments should have a minimum quality rating of Ba or equivalent as rated by Moody's in accordance with their long-term rating definition. Split-rated issues will be governed by the lower quality designation. Moody's appends numerical modifiers 1, 2, and 3 to each generic rating classification from Aa through Caa. Modifier 1 indicates that the obligation ranks in the higher end of its generic rating category; modifier 2 indicates a mid-range ranking; and modifier 3 indicates a ranking at the lower end of that generic rating category. Obligations rated Ba and Baa are judged to be medium-grade and subject to moderate credit risk and as such may possess certain speculative characteristics.
- Debt instruments which are downgraded for which the asset manager believes should continue to hold the instrument, a report providing reasons should be provided within one month.
- Instruments that are rated Aa and above are limited to no more than 20% per issuer. Instruments below A but not lower than Ba are limited to not more than 10% and no instruments rated below B may be held; and
- Except for those situations involving reorganization of Scheme assets, debt securities should be made only in issuers with an outstanding value of at least R50 million, valued at par, at the time of purchase.

The Scheme defines default in accordance with the Moody's risk management product definition, for which default includes these three types of credit events:

- A missed or delayed disbursement of interest and/or principal, including delayed payments made within a grace period.
- Bankruptcy, administration, legal receivership, or other legal blocks (perhaps by regulators) to the timely payment of interest and/or principal; or
- A distressed exchange occurs where:
  - (i) the issuer offers debt holders new security or package of securities that amount to a diminished financial obligation (such as preferred or common stock, or debt with a lower coupon or par amount, lower seniority, or longer maturity); or
  - (ii) the exchange had the apparent purpose of helping the borrower avoid default.

The quality rating of the domestic fixed income and cash investments held at the reporting date was:

Top 5 holdings at 31 December	Rating (long term)	Risk of default	Percentage of portfolio	
			2025	2024
<b>Current accounts</b>				
Nedbank Ltd	Baa3	Moderate	100.0%	100.0%
<b>Money market accounts</b>				
ABSA Bank Ltd	Baa3	Moderate	25.9%	23.9%
Standard Bank Ltd	Baa3	Moderate	21.9%	20.3%
Nedbank Ltd	Baa3	Moderate	21.3%	24.0%
Investec Bank Ltd	Baa3	Moderate	13.2%	11.8%
FirstRand Bank Ltd	Baa3	Moderate	12.7%	13.2%
			<b>95.0%</b>	<b>93.2%</b>

#### Insurance, trade and other receivables

The Scheme's exposure to credit risk is influenced by the individual characteristics of each member. The demographics of the Scheme's membership base, including the default risk of the industry in which the member operates, has less of an influence on credit risk.

Exposures to individual members are managed by adhering to the requirements of Section 26(7) of the MSA, i.e. actively pursuing all contributions not received within three days of becoming due, suspending benefits for all members where contributions have not been received for 30 days and terminating benefits for all members where contributions have not been received for 60 days. The credit risk is considered when the expected contribution is calculated.

#### Age analysis of insurance receivables

	Gross carrying amount	Impairment	Carrying amount
<b>2025</b>			
Not past due	(4,502,285)	(6,053)	(4,496,232)
Past due 1 - 30 days	59,589	(6,860)	66,450
Past due 31 - 60 days	(49,798)	(6,855)	(42,943)
Past due 61 - 90 days	13,498	(3,757)	17,255
Past due more than 90 days	1,715,279	(155,051)	1,870,330
	<b>(2,763,716)</b>	<b>(178,576)</b>	<b>(2,585,140)</b>
<b>2024</b>			
Not past due	328,718	(11,784)	316,934
Past due 1 - 30 days	332,218	(12,265)	319,953
Past due 31 - 60 days	193,837	(27,749)	166,088
Past due 61 - 90 days	110,870	(21,621)	89,250
Past due more than 90 days	2,484,914	(164,279)	2,320,635
	<b>3,450,557</b>	<b>(237,697)</b>	<b>3,212,859</b>

Age analysis of trade and other receivables

	Gross carrying amount	Impairment	Carrying amount
<b>2025</b>			
Not past due	147,032	-	147,032
Past due 1 - 30 days	-	-	-
Past due 31 - 60 days	-	-	-
Past due 61 - 90 days	-	-	-
Past due more than 90 days	1,600	-	1,600
	<b>148,632</b>	<b>-</b>	<b>148,632</b>
<b>2024</b>			
Not past due	162,080	-	162,080
Past due 1 - 30 days	75,876	-	75,876
Past due 31 - 60 days	-	-	-
Past due 61 - 90 days	-	-	-
Past due more than 90 days	-	-	-
	<b>237,957</b>	<b>-</b>	<b>237,957</b>

With respect to the receivables that are neither impaired nor past due, there are no indications as of the reporting date that the debtors will not meet their payment obligations based on, the nature of the counterparty, the historical information about the counterparty default rates and other information used to assess credit quality.

The Scheme establishes an allowance for impairment that represents its estimate of expected credit losses (IFRS 9) in respect of receivables. The collective loss allowance is determined based on a set policy, while bearing in mind historical data of payment statistics for similar financial assets. The provision for impairment at 31 December 2025 was determined in accordance with the guidelines of the simplified approach (lifetime expected losses) of the expected credit loss model as required by IFRS 9. It is in respect of contributions receivable, member and service provider debit balances and advances from savings plan accounts recoverable by management.

For the Scheme to determine lifetime expected losses, a provision matrix was used. The provision matrix is based on historical observed default rates, adjusted for forward looking estimates. At every reporting date, the historical observed rates are updated. The provision matrix is split for the following categories:

- Active member contributions and savings debtors
- Resigned member contributions and savings debtors
- Provider debtors
- Tenant debtors

The expected credit loss estimates were updated to account for future economic conditions relative to historic conditions. Payment defaults were managed according to the Credit Policy. Scheme management will write off debt on the recommendation of the debt collector following their attempt to recover outstanding amounts.

## 21.2 LIQUIDITY RISK MANAGEMENT

Liquidity risk is the risk that the Scheme will be unable to meet its obligations when they fall due because of member benefit payments, cash requirements from contractual commitments or other cash outflows such as debt maturities. Such outflows would deplete cash resources available to fund insurance activities. In extreme circumstances, lack of liquidity could result in reductions on the Statement of Financial Position and sales of assets, or potentially an inability to fulfil member commitments.

The Scheme's liquidity management process, as carried out within the Scheme and monitored by the Board of Trustees, includes day-to-day funding, managed by monitoring future cash flows to ensure that requirements can be met, maintaining a portfolio of highly marketable assets that can easily be liquidated as protection against any unforeseen interruption to cash flows and monitoring the liquidity ratios against internal and regulatory requirements.

The Scheme manages liquidity risk by maintaining sufficient cash and highly liquid investments to meet anticipated claims liabilities as they fall due. Claims submitted by members are generally settled within 30 days of receipt, and the Scheme therefore maintains a significant portion of its investment portfolio in liquid instruments such as cash and money market investments. Management regularly monitors the matching of liquid assets against short-term insurance liabilities to ensure that the Scheme can meet its obligations to members and service providers as they arise.

The financial liabilities posing a liquidity risk are insurance liabilities and trade and other payables.

There were no significant changes in the Scheme's objectives, policies and processes for managing risk and the methods used to measure risk compared to the previous period.

Members of the Scheme are required to submit their claims within 4 months of the service date. Therefore, the liability attributable to current members is expected to be settled within 12 months. The PMSA balances are payable on demand when a member exits the Scheme.

The Scheme expects to generate a net surplus (before considering amounts attributable to future members) for the year ending 31 December 2026 and therefore does not expect to utilise the liability attributable to future members in the short term, other than the portion relating to insurance premiums received in advance.

The maturity profile of contractual cash flows of non-derivative financial liabilities, and financial assets held to mitigate the risk, are presented in the following table. The cash flows are undiscounted contractual amounts.

Insurance liabilities

	Note	0 - 12 months	+12 months	Total
<b>2025</b>				
Liabilities attributable to current members	12	361,772,612	-	361,772,612
Liabilities attributable to future members	10	-	868,586,642	868,586,642
		<b>361,772,612</b>	<b>868,586,642</b>	<b>1,230,359,254</b>
<b>2024</b>				
Liabilities attributable to current members	12	346,408,104	-	346,408,104
Liabilities attributable to future members	10	-	724,598,316	724,598,316
		<b>346,408,104</b>	<b>724,598,316</b>	<b>1,071,006,419</b>

Trade and other payables

	Note	0 - 12 months	+12 months	Total
<b>2025</b>				
Trade and other payables	13	223,751	-	223,751
		<b>223,751</b>	<b>-</b>	<b>223,751</b>
<b>2024</b>				
Trade and other payables	13	90,775	-	90,775
		<b>90,775</b>	<b>-</b>	<b>90,775</b>

A summary of financial assets available to meet these liabilities is presented below.

	Note	0 - 12 months	+12 months	Total
<b>2025</b>				
Investments	6	268,502,108	847,714,282	1,116,216,390
Cash and cash equivalents	8	99,445,941	-	99,445,941
		<b>367,948,049</b>	<b>847,714,282</b>	<b>1,215,662,331</b>
<b>2024</b>				
Investments	6	248,232,823	708,252,362	956,485,185
Cash and cash equivalents	8	99,403,561	-	99,403,561
		<b>347,636,384</b>	<b>708,252,362</b>	<b>1,055,888,746</b>

The Scheme's liquid financial assets exceed its short-term insurance liabilities and trade and other payables, supporting its ability to meet obligations as they fall due.

### 21.3 INTEREST RATE RISK

The Scheme's investment policy during the year under review was to hold most of investments in interest bearing instruments when assessed on a look-through basis in accordance with Annexure B of Regulation 30 to the Medical Schemes Act. The Scheme's investments were therefore exposed to changes in the market interest rates. Except for the Scheme's investments in interest-bearing instruments, cash and cash equivalents also expose the Scheme to interest rate risk.

The table below summarises the Scheme's exposure to interest rate risks. Included in the table are the Scheme's investments at carrying amounts categorised by earlier of contractual repricing or maturity dates.

	Note	2025	2024
Investments in property	6	25,377,169	16,367,675
Interest-bearing investments, including bonds	6	363,610,380	309,138,324
Cash and cash equivalents	6 and 8	501,334,300	457,144,556
<b>Total variable rate instruments</b>		<b>890,321,849</b>	<b>782,650,555</b>

The money market and cash and cash equivalents are managed on a net returns' basis by the Scheme's asset managers. The balance of fixed and variable instruments being held in these portfolios is adjusted in response to movements in market interest rates to maintain an acceptable level of risk as well as returns. The net returns are benchmarked against the SteFi Composite index.

The carrying amounts of fixed-rate instruments in these portfolios approximate their fair values due to the short period to maturity, and no fair value adjustments are processed to the statement of profit or loss in respect of these instruments. Variable-rate instruments are not linked to one specific market interest rate. The reported returns on these investments will vary in response to movements in market rates.

The Scheme does not discount insurance, trade or other receivables or payables as they are all settled or fall due within one year.

The following sensitivity analysis has been prepared using a sensitivity rate which is used when reporting interest rate risk internally to key management personnel and represents management's assessment of the reasonably possible change in interest rates. All other variables remain constant. The sensitivity analysis includes only financial instruments exposed to interest rate risk which were recognised at the reporting date. No changes were made to the methods and assumptions used in the preparation of the sensitivity analysis compared to the previous reporting period.

	2025		2024	
	Increase	Decrease	Increase	Decrease
Impact of a change in interest rates by 100 basis points on surplus/deficit	8,903,218	(8,903,218)	7,826,506	(7,826,506)

The following table presents analysis of how a possible shift in market interest rates might impact the balances of contracts within the scope of IFRS 17, as well as the net impact on profit or loss and equity. A change in an interest rate would impact the return on the PMSA, which in turn impacts the liability to the policyholders.

	2025		2024	
	Insurance contract liabilities	Profit or loss	Insurance contract liabilities	Profit or loss
Impact of a change in interest rates by 50 basis points	1,551,821	(1,551,821)	1,470,265	(1,470,265)

The analysis is based on a change in an assumption while holding all the assumptions constant. In practice, this is unlikely to occur, and changes in some of the assumptions may be correlated. No changes were made by the Scheme in the methods and assumptions used in preparing the above analysis.

#### 21.4 MARKET PRICE RISK

Market price risk arises from fair value through profit or loss in equity securities held for partially meeting the Scheme's financial obligations. The Scheme is exposed to market price risk because of investments held by the Scheme which are classified as at fair value through profit or loss. The Scheme was not exposed to commodity risk.

The table below summarises the Scheme's exposure to market price risks.

	<i>Note</i>	<b>2025</b>	<b>2024</b>
Listed equities	6	325,340,482	273,238,191

To manage its market price risk arising from investments, the Scheme diversifies its portfolio. The Scheme's assets are managed by various asset managers on behalf of the Scheme. Diversification of the portfolio is done by the asset manager. All buy and sell decisions are measured in terms of the investment mandate of the Scheme.

The Scheme strives to minimise market risk as follows:

- The Scheme has established an investment strategy and in line with this strategy, the Scheme diversifies its investment portfolio by investing in domestic equities, domestic bonds, derivative instruments, and domestic cash to achieve a balanced investment portfolio.
- Diversifying the management of the Schemes investment portfolio to specific specialized mandates thus mitigating the risk through diversification.
- Structuring the investment portfolio so that sufficient cash and cash like securities are available to meet cash requirements for ongoing cash flow needs, thereby avoiding the need to sell securities on the open market during periods of market volatility.

The market price risk sensitivity analysis has been determined based on the exposure to price risks at the reporting date on investments. The analysis assumes that all other variables remain constant. The method remained consistent with the prior period.

The Scheme uses a sensitivity analysis technique for financial market risks that measures the estimated change to profit or loss and accumulated funds. If the equity indexes had been 3% lower, the Scheme's surplus and accumulated funds for the year would reduce by R7.8 million (2024: R8.2 million) because of the change in the market value of instruments.

## 22 CAPITAL RISK MANAGEMENT

The Scheme manages its capital to maintain the capital requirements of the Act. Regulation 29 of the Act requires a minimum ratio of accumulated funds expressed as a percentage of gross annual contribution income to be 25%. The calculation of the regulatory requirement is set out in the Report of the Board of Trustees.

### 23 INSURANCE RISK MANAGEMENT

The Scheme issues healthcare contracts. These contracts compensate members and their beneficiaries in the event of a healthcare event. The Scheme is therefore exposed to the uncertainty of the severity and timing of the healthcare event. Based on the risk the Scheme undertakes to compensate the members and their beneficiaries the Scheme has insurance risk.

The Board of Trustees has developed and documented a policy to manage insurance risk. Included in this policy are:

- The Scheme rules.
- The requirements of the MSA; and
- Acceptance and management of the risk the Scheme is exposed to.

The policy is amended for any changes to the MSA or the Scheme rules.

The Board monitors the adequate application of the policy and reviews the trends in pricing, loss ratios and insurance risks on a regular basis to ensure that the trends fall within the limits of the policy. The Board also monitors the benefit options and approves changes to the benefit options in consultation with the actuaries.

Insurance risk is managed by benefit limits and sub-limits, following the Scheme rules, pre-authorisation, case management and pricing guidelines. The risk is further managed via monitoring emerging legislative, actuarial and environmental issues. The principal risk is that the frequency and the severity of the claims is greater than expected. This risk can be aggravated by unexpected epidemics, price increases and new technologies/research/medicine.

There are several methods the Scheme utilises to assess and monitor insurance risk. These risks are analysed on:

- Average age of the member.
- Category of claims.
- Composition of age per benefit option.
- Geographical area of members; and
- Number of beneficiaries per member.

Probability is applied to the group of insurance contracts. History shows that a highly diversified group is less likely to be affected by a change in the underlying group. However, the inverse is also true, a group that is not diversified is affected by the change in the underlying group. Experience has ensured that underwriting decisions adequately address the risk and the diversification in the group.

#### Expense Risk

Expense risk is the risk of unexpected increases in policy maintenance, claim handling and other costs relating to fulfilment of insurance contracts. The risk is managed through budgeting and periodic cost evaluations.

#### Changes from the Previous Period

There were no significant changes in Scheme's objectives, policies and IFRS Accounting Standards as issued by the International Accounting Standards Board processes for managing risk and the methods used to measure risk.

#### Methods Used and Assumptions Made

Methods used and assumptions made for insurance liabilities assessment are disclosed in note 3.1.

### 23.1 CONCENTRATION OF INSURANCE RISK

The Scheme manages insurance risk through the diversification of its insured population, with the objective of maintaining a balanced portfolio of homogeneous risks. This is achieved by pooling a large number of similar risks over time, which reduces variability in fulfilment cash flows and limits exposure to adverse claims experience.

The Scheme's risk management approach is documented in the annual benefit design plan, which defines the benefit design, target market, and expected demographic composition of the membership base.

The Scheme provides the following main categories of insurance coverage:

- In-hospital benefits: Coverage for the cost of hospitalisation and related healthcare services for pre-authorised medical conditions, in accordance with Scheme rules.
- Chronic benefits: Coverage for the cost of specified prescribed medicines for approved chronic conditions, including, but not limited to, hypertension, hyperlipidaemia, and asthma.
- Day-to-day benefits: Coverage for out-of-hospital healthcare services, up to Scheme tariff limits, including consultations with general practitioners and dentists, as well as prescribed non-chronic medication.

Savings account claims do not give rise to insurance risk, as these represent member-funded arrangements and do not result in the transfer of significant insurance risk to the Scheme.

All insurance contracts issued by the Scheme have a coverage period of one year. The Scheme retains the ability to reprice and amend the terms and conditions of contracts at each annual renewal date, thereby limiting long-term exposure to insurance risk.

The Scheme monitors key indicators of insurance risk on an ongoing basis. Management information, including contribution income, claims ratios, and demographic profiles, is reviewed monthly to assess experience against expectations and to inform risk management actions.

The table below presents an analysis of the concentration of insurance risk, based on the carrying amount of incurred claims, disaggregated by age group and by type of coverage provided.

Age group	Unique claiming beneficiaries	In-hospital		Chronic		Day to day		Total
		PMB	Non-PMB	PMB	Non-PMB	PMB	Non-PMB	
<b>2025</b>								
< 25	9,405	51,117,985	9,000,292	22,023,597	3,496,609	1,892,156	12,554,963	100,085,603
25 - 34	2,558	20,482,057	3,060,932	10,889,060	1,653,993	1,378,963	6,556,834	44,021,838
35 - 49	7,185	63,667,375	9,294,013	42,407,726	9,503,009	3,287,240	18,290,966	146,450,329
50 - 64	3,675	62,323,432	7,100,230	41,534,540	10,508,812	2,047,396	10,963,334	134,477,744
> 65	1,564	73,689,525	4,442,005	39,904,652	12,098,075	510,822	7,957,875	138,602,953
	<b>24,387</b>	<b>271,280,373</b>	<b>32,897,473</b>	<b>156,759,576</b>	<b>37,260,497</b>	<b>9,116,577</b>	<b>56,323,972</b>	<b>563,638,467</b>
<b>2024</b>								
< 25	11,423	45,845,943	5,754,483	18,894,520	4,273,387	1,177,562	12,516,442	88,462,337
25 - 34	2,947	21,110,173	4,123,355	10,011,530	2,197,157	971,000	7,980,744	46,393,959
35 - 49	7,100	66,570,891	8,747,610	34,528,968	10,374,274	2,107,967	18,891,314	141,221,023
50 - 64	3,244	57,629,478	5,673,795	36,510,304	6,457,172	905,139	10,945,674	118,121,563
> 65	1,363	65,346,484	3,412,959	39,305,476	4,637,865	365,690	7,828,080	120,896,553
	<b>26,077</b>	<b>256,502,969</b>	<b>27,712,203</b>	<b>139,250,798</b>	<b>27,939,856</b>	<b>5,527,357</b>	<b>58,162,254</b>	<b>515,095,436</b>

## 23.2 SENSITIVITY ANALYSIS

The following table provides a sensitivity on the insurance contract liabilities. The table provides the sensitivity before and after the impact of the Scheme being a mutual entity. As the Scheme is a mutual entity, the impact of any changes in the insurance liability to current members would impact the insurance liability to future members. The table presents information on how reasonably possible changes in risk confidence level made by the Scheme will impact the risk adjustment.

	2025			2024		
	LIC at 31 December	Impact on LIC	Impact on SOCI	LIC at 31 December	Impact on LIC	Impact on SOCI
<b>Insurance contract liabilities</b>	<b>361,772,612</b>			<b>346,408,104</b>		
Net insurance contract liabilities	361,772,612			346,408,104		
<b>Unpaid claims and expenses</b>						
Insurance contract liabilities (before mutualisation)		18,088,631	(18,088,631)		17,320,405	(17,320,405)
Insurance contract liabilities (after mutualisation)		-	-		-	-
<b>Insurance service expenses</b>	<b>(614,436,927)</b>			<b>(554,094,284)</b>		
Insurance service expenses	(614,436,927)			(554,094,284)		
<b>Expenses - 5% increase</b>						
Insurance service expenses (before mutualisation)			(30,721,846)			(27,704,714)
Insurance service expenses (after mutualisation)			-			-

#### Risk adjustment sensitivities

Any change in the risk adjustment will impact the incurred claims and other directly attributable expenses in insurance service expenses with an equal and opposite impact on the amounts attributable to future members in insurance services expenses. The net impact on profit or loss for any change in the risk adjustment would therefore be nil.

	2025	2024
Risk adjustment with a 60% confidence level - as reported	1,370,008	1,961,679
Risk adjustment with a 65% confidence level	2,051,112	3,069,610

The analysis is based on a change in an assumption while holding all the assumptions constant. In practice, this is unlikely to occur, and changes in some of the assumptions may be correlated. No changes were made by the Scheme in the methods and assumptions used in preparing the above analysis. To further demonstrate the sensitivity to insurance risk, the risk adjustment at a 65% confidence level has also been disclosed.

#### Claims development

Claims development tables have not been presented as the uncertainty regarding the amounts and timing of claims payments is typically resolved within a year. In most cases, claims are resolved within four months from the time they are reported to the Scheme. At year-end, a provision is made for those claims outstanding that have been incurred but not yet been reported.

## 24 STRUCTURED ENTITIES

The Scheme's investments in investee funds are subject to the terms and conditions of the respective investee fund's offering documentation and are susceptible to market price risk arising from uncertainties about future values of those investee funds. The asset manager makes investment decisions after extensive due diligence of the underlying fund, its strategy and the overall quality of the underlying fund's manager.

All investee funds in the investment portfolio are managed by portfolio managers who are compensated by the respective investee funds for their services. Such compensation generally consists of an asset-based fee and a performance-based incentive fee and is reflected in the valuation of the fund's investment in each of the investee funds. These investments are included in investments at fair value through profit or loss as in the statement of financial position.

The exposure of the investments in investee funds at fair value is disclosed in the following table:

	2025	2024
<b>Investee funds</b>		
Coronation Medical Absolute	316,230,573	265,357,102
M&G Medical Aid Inflation Plus 5%	320,943,981	261,656,371
NinetyOne Stable Money Fund	133,044,245	122,847,551
	<b>770,218,798</b>	<b>649,861,023</b>

The strategy of the investee funds is to protect the capital of investors in an absolute sense, whilst providing income in excess of short-term bank deposit rates. The Scheme is not exposed to any further risks of financial loss beyond the fair value of its share in the investee funds as outlined in the preceding table.

## 25 LIABILITY AND ADEQUACY TESTS

The liability adequacy test was considered and concluded not to be material. This is because current estimates of future cash flows relating to the recognised liability equals the recognised liability as a result of the settlement of the recognised liability taking place within four months of report date.

## 26 COMMITMENTS AND CONTINGENCIES

### 26.1 OPERATING LEASE COMMITMENTS

	2025	2024
Minimum lease payments due:		
- within one year	54,165	54,165
- within the second to fifth year inclusive	36,110	90,275
	<b>90,275</b>	<b>144,440</b>

The Scheme entered into an operating lease agreement for printers. The lease is for a period of three years ending 31 July 2027. Low value and short-term leases were recognised in surplus or deficit in accordance with IFRS 16. No contingent rent is payable.

## 26.2 CONTINGENT ASSETS

Claims against the Road Accident Fund for benefits paid on behalf of the Scheme's members are disclosed as a contingent asset as the inflow of economic benefits is probable, but not virtually certain. At the reporting date Road Accident Fund claims of R5,104,593 (2024: R10,117,195) had been submitted but not yet concluded.

## 27 FIDELITY COVER

The Scheme maintains fidelity insurance at a level deemed appropriate by the Board of Trustees. The fidelity cover at 31 December 2025 amounts to R 800,000 (2024: R 800,000). The cover is provided under a group Fidelity Policy covering the scheme. This insurance coverage serves as a safeguard against potential losses arising from fraud, theft, or dishonesty, ensuring the protection of the Scheme's assets and financial integrity. The Board regularly reviews the adequacy of this coverage to align with industry best practices and evolving risk exposures, reinforcing the Scheme's commitment to sound governance and financial security.

## 28 MATTERS OF NON-COMPLIANCE WITH THE ACT

The Scheme is committed to full compliance with the Medical Schemes Act and related regulations. All non-compliance matters identified have been disclosed in this report, regardless of materiality. The following instances of non-compliance were noted during the reporting period:

### 28.1 LATE RECEIPT OF CONTRIBUTIONS (SECTION 26(7))

Section 26(7) of the Act requires that all contributions be paid directly to a medical scheme within three days of becoming due. In 2025, not all billed contributions were received within this timeframe, which could impact cash flow and interest income. The Scheme actively follows up on outstanding contributions and applies its credit control policy to manage overdue payments effectively.

### 28.2 CLAIMS PAYMENT DELAYS (SECTION 59(2))

The Act mandates that claims be settled within 30 days of receipt. While the Scheme endeavours to process all claims within this period, occasional delays occur due to validity verification procedures. Claims exceeding the 30-day threshold are investigated by management, ensuring that all outstanding payments are addressed in a timely and compliant manner.

### 28.3 BENEFIT OPTION SELF-SUFFICIENCY (SECTION 33(2)(b))

Section 33(2)(b) of the Medical Schemes Act requires that each benefit option be financially self-supporting to maintain the financial integrity of the Scheme and prevent cross-subsidisation. In 2025, the Comprehensive option recorded an insurance service deficit of R18,755,239 (refer to Note 19 of the Annual Financial Statements). Persistent deficits on benefit options could potentially lead to cross-subsidisation from surplus-generating options, which may impact the overall financial soundness of the Scheme. To ensure long-term sustainability and regulatory compliance, the Scheme is actively implementing strategic measures, including:

- Contribution adjustments to align pricing with claims experience,
- Benefit design reviews to optimize cost-effectiveness, and
- Ongoing assessments to monitor financial performance and adjust strategies proactively.

### 28.4 PROHIBITED INVESTMENTS (SECTION 35(8) (a, c & d))

Section 35(8) prohibits medical schemes from holding investments in:

- The business of any medical scheme administrator;
- The holding company of an administrator; or
- Any employer group associated with the Scheme.

As of 31 December 2025, the Scheme held underlying investments amounting to 0.8% in medical scheme administrators or their holding companies (Momentum Metropolitan Holdings, Discovery Holdings and Sanlam Limited) and 0.9% in employer groups (Glencore Plc and Exxaro Resources) of total net asset value. The Scheme has obtained an exemption from the Council for Medical Schemes (CMS) to retain these investments while ensuring compliance with broader regulatory requirements.

## 29 GOING CONCERN

The Annual Financial Statements have been prepared based on accounting policies applicable to a going concern, which assumes that the Scheme will continue its operations in the foreseeable future. This basis presumes that sufficient funds will be available to finance future operations, and that the realisation of assets and settlement of liabilities, contingent liabilities, and commitments will occur in the ordinary course of business.

The Board of Trustees conducts an annual assessment of the Scheme's business plan, key performance indicators, and strategic targets to ensure that all material risks are comprehensively addressed. This includes maintaining a regular review of the Scheme's risk register and management accounts, ensuring that contingency plans are in place to mitigate potential risks.

In reviewing budgets and cash flow projections, along with additional financial data for 2026, the Board of Trustees has determined that the going concern assumption remains appropriate for the next twelve months from the date of approval of the Annual Financial Statements. This assessment underscores the Scheme's financial stability and ability to meet its obligations while continuing to provide sustainable healthcare benefits to its members.

## 30 EVENTS AFTER THE REPORTING PERIOD

There were no adjusting or non-adjusting events that occurred after the reporting period that would have a material impact on the Annual Financial Statements or require disclosure.

