



**ANGLOVAAL
GROUP MEDICAL SCHEME**

NOTICE OF THE ANNUAL GENERAL MEETING

TO BE HELD ON 2 JUNE 2026 AT 10H00 AT

THE OFFICES OF AVI LTD,

2 HARRIES ROAD, ILLOVO, SANDTON



ANGLOVAAL GROUP MEDICAL SCHEME

NOTICE OF THE ANNUAL GENERAL MEETING OF THE ANGLOVAAL GROUP MEDICAL SCHEME

The 29th Annual General Meeting of the members of the Anglovaal Group Medical Scheme will take place at 10h00 on 2 June 2026 at the offices of AVI Ltd, 2 Harries Road, Illovo, Sandton.

A quorum for the meeting will be fifteen members of the Scheme, present in person (which includes being present by means of such electronic or other communication facility or media as permits all persons participating in the meeting to communicate with each other simultaneously and instantaneously and persons so participating shall be deemed to be present at such meeting).

Attached please find your copy of the Agenda, the Annual Financial Statements (incorporating the Auditors' Report and the Trustees' Annual Report), and a Proxy Form. AVI reserves the right to refuse entry to any person or to ask any person to leave the premises.

Notice of any motions to be placed before the Annual General Meeting must reach the Principal Officer by no later than 12h00 on 26 May 2026. Such motions must be lodged with or posted to:

The Principal Officer c/o Nadine Naidoo
Anglovaal Group Medical Scheme,
AGM Motions,
P O Box 652509, Benmore, 2010 or
1 Discovery Place, Sandton or
fax to (011) 539-1018 or
email to avgmsagm@discovery.co.za

Please note that you will be required to produce your membership card and identity document when registering for the AGM.

AGENDA

**Annual General Meeting of the Anglovaal Group Medical Scheme
to be held on 2 June 2026 at 10h00 at the offices of AVI Ltd, 2 Harries Road, Illovo,
Sandton.**

1. Welcome and additions to the Agenda
2. Apologies
3. Minutes of the previous meeting
4. Report of the Board of Trustees
5. Annual Financial Statements
6. Appointment of the auditors
7. Submitted motions
8. General
9. Close

**MINUTES OF THE ANNUAL GENERAL MEETING OF THE MEMBERS OF THE
ANGLOVAAL GROUP MEDICAL SCHEME HELD ON 27 MAY 2025 AT 10H00 AT
THE OFFICES OF AVI LIMITED, 2 HARRIES ROAD, ILLOVO, AND
ELECTRONICALLY BY MS TEAMS (IN ACCORDANCE WITH THE SCHEME RULES)**

PRESENT

M Koursaris	(Chairman, Trustee, and member)
V Crystal	(Principal Officer and member)
I Masike	(Trustee and member)
G Bergman	(Trustee)
H de Groot	(Trustee and member)
A Ahmed	(Trustee and member) (MS Teams)
A Mills	(Trustee and member)
M Stevenson	(Trustee and member)
J Laubscher	(Trustee and member) (MS Teams)
A Grobler	(Member) (MS Teams)
H Bruwer	(Member) (MS Teams)
C Engelbrecht	(Member) (MS Teams)
M Ramalata	(Member) (MS Teams)
M Mogoboya	(Member) (MS Teams)
B Makau	(Member) (MS Teams)
L Zimbgwa	(Member) (MS Teams)
R Manchidi	(Member) (MS Teams)
N Mahlangu	(Member) (MS Teams)
K Kepadisa	(Member) (MS Teams)
S Soga	(Member) (MS Teams)
L Hanyane	(Member) (MS Teams)
E Griffiths	(Member) (MS Teams)
D Mashiane	(Member) (MS Teams)
T Bolelwang	(Member) (MS Teams)
T Vadi	(Member)
J Fourie	(Member)
C Coetzee	(Member)
T Murukens	(Member)
S Haffejee	(Member)
M Wright	(Member)
S Scheepers	(Member)

IN ATTENDANCE

N Naidoo	(Discovery Health)
M Buckingham	(Discovery Health)
T Neluvhola	(Discovery Finance)

APOLOGIES

None

1. WELCOME

Mr. Koursaris introduced himself as the Chairman of the Board of Trustees and welcomed all present to the Scheme's 28th Annual General Meeting (AGM). He also requested all members that had joined online to enter their names and membership numbers in the group chat to enable them to be recorded on the attendance register.

With proper notice having been given and a quorum of at least 15 members being present in person (either in the room or electronically), the meeting was declared properly constituted.

The Chairman indicated that copies of the AGM pack and 2024 Annual Financial Statements were available at the back of the room for any members who required a copy.

2. APOLOGIES

There were no apologies.

3. MINUTES OF THE PREVIOUS MEETING

The Chairman took the members through the minutes of the previous AGM held on 24 May 2024, and the minutes were approved without change.

4. REPORT OF THE BOARD OF TRUSTEES

The Chairman referred to pages 64 to 67 of the pack, which contained the report of the Board of Trustees included in the Annual Financial Statements.

The Chairman reported that the Scheme remained a going concern. The trustees monitor the overall performance of the Scheme on a monthly basis and the investment policy is reviewed annually against the expected returns. The Scheme's solvency level as at 31 December 2024 was 57.51%, against the required statutory solvency level of 25%. The trustees do not believe in making short term decisions based on limited information, but to rather take a well-considered, long term view in order to ensure the sustainability of the Scheme. This prudent approach allows the Scheme to be managed through any short term adverse claims experiences, whilst minimising the potential negative impact on the members. As at 31 December 2024 the Scheme's total investments and operating cash stood at R210,7 million.

The Chairman also drew attention to item 16 of the report on pages 62 and 63 of the Annual Financial Statements where the non-compliance matters were outlined and stated that, as advised in previous years, none of these issues were material to the continued operations of the Scheme or its sustainability and arose largely as a result of the highly regulated environment in which the Scheme operates.

The Chairman confirmed that the Trustees were satisfied with the results of the year-end audit. The report of the Board of Trustees, included in the Annual Financial Statements for the period ending 31 December 2024, was approved by the members.

5. ANNUAL FINANCIAL STATEMENTS

The Chairman referred to the Annual Financial Statements for the period under review and advised that the Scheme's financial administrator was present to answer questions from the floor.

With no questions being raised, the Annual Financial Statements for the period ending 31 December 2024 were approved by the members.

6. APPOINTMENT OF THE AUDITORS

The Chairman announced that the Board of Trustees had, after careful consideration, resolved not to recommend PwC for re-appointment as the Scheme's external auditors and, after review of alternative proposals, had resolved to recommend the appointment of BDO, who had made a competitive proposal with a cost savings of approximately R74 000 to the Scheme. The appointment of BDO was approved by the members, subject to approval by the Council for Medical Schemes in terms of section 36(2) of the Medical Schemes Act. The Chairman thanked PwC for their services over the past years.

7. SUBMITTED MOTIONS

No motions were submitted.

8. GENERAL

8.1 Complaints or disputes

The Chairman advised that, as required by the Council for Medical Schemes, members were informed that any member complaints or disputes may be lodged with the Scheme in writing. Should the complaint not be resolved to the member's satisfaction, the Principal Officer would appoint a Disputes Committee and convene a meeting of this Committee to hear and resolve the complaint. The Disputes Committee would consist of three Scheme members, who are not Trustees, employees of Discovery Health, or officers of the Scheme. One of the three members would be a person with legal expertise. Members would have the right to appeal the decision of the Disputes Committee to the Council for Medical Schemes.

8.2 The Chairman then gave members the opportunity to discuss any other items under general. No matters were raised.

9. CLOSING

In conclusion the Chairman thanked everyone present for their attendance and time. In particular he extended thanks to the Board of Trustees, the Principal Officer, the members of the Audit and Investment Committee, the administrator (Discovery Health), as well as the independent service providers, Insight Actuaries and Consultants, for their services during this period.

There being no further matters to discuss, the meeting was closed.

Minutes accepted

M. Koursaris
CHAIRMAN

DATE



ANGLOVAAL
GROUP MEDICAL SCHEME

ANGLOVAAL GROUP MEDICAL SCHEME

ANNUAL FINANCIAL STATEMENTS

31 December 2025

The reports and statements set out below comprise the Annual Financial Statements presented to members:

CONTENTS	Pages
Trustees' responsibility and approval	2
Statement of corporate governance by the Board of Trustees	3
Independent auditor's report	4-7
Statement of Financial Position	8
Statement of Comprehensive Income	9
Statement of Cash Flows	10
Accounting policies	11-24
Notes to the Financial Statements	25-57
Report of the Board of Trustees	58-65

TRUSTEES' RESPONSIBILITY AND APPROVAL

The Trustees are responsible for the preparation and fair presentation of the financial statements of Anglovaal Group Medical Scheme ("the Scheme"), comprising the Statement of financial position as at 31 December 2025, the statements of comprehensive income and cash flows for the year then ended, and the notes to the financial statements, which include a summary of significant accounting policies and other explanatory notes, in accordance with IFRS® Accounting Standards and the requirements of the Medical Schemes Act, of South Africa. In addition, the Trustees are responsible for preparing the report of the Board of Trustees and Statement of Corporate Governance.

The Trustees are also responsible for such internal control as the Trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for maintaining adequate accounting records and an effective system of risk management.

The Trustees have made an assessment of the ability of the Scheme to continue as a going concern and have no reason to believe the Scheme will not be a going concern in the year ahead.

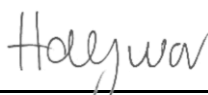
The independent auditor is responsible for reporting on whether the financial statements are fairly presented in accordance with the applicable financial reporting framework.

Approval of the financial statements

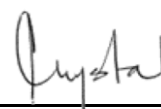
The financial statements of Anglovaal Group Medical Scheme, as identified in the first paragraph, were approved by the Trustees on 30 April 2026 and are signed on their behalf by:



M Koursaris
CHAIRPERSON



H de Groot
TRUSTEE



Vivien Crystal
PRINCIPAL OFFICER

30 April 2026

STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES

The Anglovaal Group Medical Scheme is committed to the principles and practice of fairness, openness, integrity and accountability in all dealings with its stakeholders. The Trustees are either appointed by the respective employers or elected by the members of the Scheme. The Scheme adopts good corporate governance practices in all aspects.

THE BOARD OF TRUSTEES

The Trustees meet regularly and monitor the performance of the Administrator and other service providers. They address a range of key issues and ensure that discussion of items of policy, strategy and performance is critical, informed and constructive.

All Trustees have access to the advice and services of the Principal Officer and consultants and, where appropriate, may seek independent professional advice at the expense of the Scheme.

The Trustees have appointed an audit and investment committee to assist in executing its duties.

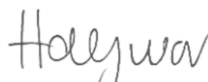
INTERNAL CONTROL

The Scheme and administrator of the scheme maintains internal controls and systems designed to provide reasonable assurance as to the integrity and reliability of the financial statements 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.

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



M Koursaris
CHAIRPERSON



H de Groot
TRUSTEE



Vivien Crystal
PRINCIPAL OFFICER

30 April 2026

INDEPENDENT AUDITOR'S REPORT

To the Members of
 Anglovaal Group Medical Scheme

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Anglovaal Group Medical Scheme (the Scheme), set out on pages 8 to 57, which comprise the statement of financial position as at 31 December 2025; and the statement of comprehensive income; and the statement of cash flows for the year then ended; and notes to the financial statements, including material accounting policy information.

In our opinion, these financial statements present fairly, in all material respects, the financial position of Anglovaal Group Medical Scheme as at 31 December 2025, and its financial performance and cash flows for the year then ended 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.

Basis for Opinion

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the *Auditor's 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 Accountants' *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 year. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	How our audit addressed the key audit matter
Valuation of the Liability for incurred claims (Notes 1.4, 1.6, 4 and 13)	
<p>The valuation of the Liability for Incurred Claims (LIC) component forms part of the Insurance contract liability on the statement of financial position and consists of the estimates of future cash flows for incurred claims but not reported and the risk adjustment for non-financial risk (RA).</p> <p>At 31 December 2025, the LIC included an estimate of future cash flows relating to the claims incurred but not reported amounting to R4.2 million (2024: R5 million), as well as an RA of R0.1 million (2024: R0.2 million).</p>	<p>Our audit procedures for the LIC estimate component included the following:</p> <ul style="list-style-type: none"> We obtained an understanding and documented the LIC estimation process; and We assessed the design and evaluated the implementation of relevant controls over the claims process and the calculation of the LIC estimate. <p>Data</p>

In determining the LIC, the Scheme applies significant judgement and the assessment includes estimation uncertainties, due to the Scheme having to determine claims from healthcare events that have occurred but have not yet been reported. In addition, the Scheme is also required to estimate a run-off period, within which the incurred but not reported claims will be submitted to the Scheme.

Claims incurred but not reported methodology and assumptions:

The most significant assumptions in the determination of the estimates of future cash flows relating to the claims incurred but not reported are:

- Future cashflow projections developed using information about past events, current conditions and forecasts of future conditions;
- Probability weighted average; and
- Timing of the submission and payment, and the level of future claims submitted.

The method used by the Scheme to determine the best estimate of the claims incurred but not reported is the Basic Chain Ladder (BCL) method.

The BCL method involves analysing historical claims development factors and selecting estimated development factors based thereon.

The selected development factors are then applied to cumulative claims data for each period (in the Scheme's case, the four months post-year-end) that is not yet fully developed, to produce an estimated ultimate claims cost for each healthcare year.

RA methodology and assumptions:

The most significant assumptions in the determination of the RA are:

- Variability and level of claims;
- Degree of diversification benefits; and
- Confidence level.

The IFRS 17 Insurance Contracts RA represents the compensation a Scheme requires for bearing the uncertainty in the amount and timing of future cash flows arising from non-financial risk. Because the RA 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.

Management has used the confidence level technique to determine the RA at the reporting date. The Scheme's calibrated risk adjustment is such that the insurance contract liabilities are considered sufficient at the 75th percentile of the ultimate loss distribution.

Due to the significant judgement and estimation uncertainty involved in the Scheme's valuation of the claims incurred but not reported and RA, this area was considered a matter of most significance to our current year audit of the financial statements.

We obtained the claims data from the claims processing system covering the year ended 31 December 2025, which was used in calculating the determination of the claims incurred but not reported and the RA, and performed a reconciliation of the data used in the calculation to the claims data tested as part of the insurance service expense for the year ended 31 December 2025. Based on the results of our reconciliation performed, we did not note material inconsistencies.

Calculations

Making use of our internal actuarial expertise we performed an independent calculation of the estimates of future cashflows relating to the claims incurred but not reported and RA. Our procedures included:

- We considered the appropriateness of the methodology and assumptions applied in determining the estimates of future cashflows relating to the claims incurred but not reported and RA against appropriate industry information;
- We performed an independent calculation of the estimates of future cashflows relating to the claims incurred but not reported and RA using the same methodology and assumptions as that of the Scheme. The independently calculated values were then compared to the Scheme's actuarial calculations. We noted no material differences in this regard; and
- We considered the appropriateness of the confidence level applied for the RA by performing a benchmarking exercise for RA as a percentage of the claims incurred but not reported and confirming that the RA for the Scheme is in range with similar market participants. Based on our work performed, we accepted the Scheme's use of the 75th percentile.

Back testing

The Scheme considers claims processed in the next financial year in respect of services provided during the year ended 31 December 2025 to determine if there is a need to disclose that actual claims are materially different from forecast claims and the LIC component judgement.

We considered the Scheme's assessment of the actual claims processed in the next financial year in respect of services provided during the year ended 31 December 2025 against the relevant requirements of the financial reporting framework, to assess the need for any subsequent events disclosure. Based on the results of our assessment, we accepted the Scheme's assessment, which indicated that such disclosure is not necessary due to the fact that the unutilised portion of the LIC is not material.

Disclosures

We evaluated the presentation of the disclosure relating to the LIC in the current year against the relevant requirements of the IFRS Accounting Standards and appropriate industry guidance.

Other Information

The Scheme's trustees are responsible for the other information. The other information comprises information included in the document title "Anglovaal Group Medical Scheme Annual Financial Statements 31 December 2025", which includes the Trustees' responsibility and approval, Statement of corporate governance by the Board of Trustees, and Report of 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. 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 as a whole 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 ISAs 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 ISAs, 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. 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 year 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 that there are no material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa that have come to our attention during the course of our audit.

Audit Tenure

As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that BDO South Africa Incorporated has been the auditor of Anglovaal Group Medical Scheme for one year.

The engagement partner, Lesego Mafadza, has been responsible for Anglovaal Group Medical Scheme's audit for one year.

BDO South Africa Inc.

BDO South Africa Inc. (May 6, 2026 15:52:25 GMT+2)

BDO South Africa Incorporated

Registered Auditors

Lesego Mafadza

Director

Registered Auditor

06 May 2026

Wanderers Office Park

52 Corlett Drive

Illovo, 2196

	Notes	2025 R	2024 R
ASSETS			
Non-current assets			
Financial assets at fair value through profit or loss	1	226,017,341	188,172,071
		<u>226,017,341</u>	<u>188,172,071</u>
Current assets			
Other financial assets at amortised cost	2	31,971,364	22,563,939
Cash and cash equivalents	3	191,965	285,706
		<u>31,779,399</u>	<u>22,278,233</u>
TOTAL ASSETS		<u>257,988,705</u>	<u>210,736,010</u>
LIABILITIES			
Non-current liabilities			
Liability to members for future benefits	4.3	229,001,156	176,657,146
		<u>229,001,156</u>	<u>176,657,146</u>
Current liabilities			
Insurance contract liability for current members	4.1	28,987,549	34,078,864
Liability to members for future benefits	4.3	28,198,536	27,316,830
Financial liabilities at amortised cost	6	-	5,973,939
		<u>789,013</u>	<u>788,095</u>
TOTAL LIABILITIES		<u>257,988,705</u>	<u>210,736,010</u>

	Notes	2025 R	2024 R
Insurance revenue	7	138,234,795	131,824,620
Insurance service expense		(128,421,225)	(136,199,747)
Net claims incurred*	7	(118,305,128)	(126,303,170)
Accredited managed healthcare services*	7	(2,307,466)	(2,257,337)
Directly attributable insurance services expenses	7	(7,808,631)	(7,639,240)
Net expense from reinsurance contracts held*	7	5,230	35,153
Premiums paid		(519,477)	(1,534,458)
Amounts recovered from reinsurance contracts		524,707	1,569,611
Insurance service result		9,818,800	(4,339,974)
Other income		40,657,293	20,939,274
Investment income	8	1,433,012	1,464,900
Fair value adjustment on financial assets	8	38,522,075	12,912,434
Realised gains on disposal of financial assets	8	702,206	6,561,940
Other expenditure		(4,106,022)	(3,078,860)
Other operating expenses	9	(2,727,011)	(1,841,523)
Asset management fees		(1,379,011)	(1,237,337)
Net surplus for the year before amounts attributable to members for future benefits		46,370,071	13,520,440
Amounts attributable to members for future benefits	4.3	(46,370,071)	(13,520,440)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		-	-
Relevant healthcare expenditure*		(120,607,363)	(128,525,354)

*Relevant healthcare expenditure consists of net claims incurred, accredited managed healthcare services and net expense from reinsurance contracts

	Notes	2025 R	2024 R
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash receipts from members and providers		172,945,514	163,935,497
Cash receipts from members - contributions	4.1	172,945,514	164,311,639
Cash receipts from members and providers - other		-	(376,142)
Cash paid to members and providers		(164,846,272)	(174,413,924)
Cash paid to members and providers - insurance service expense	4.1	(158,974,135)	(168,364,339)
Cash paid to reinsurers	7	(519,477)	(1,534,458)
Cash paid to members and providers - other		(202,118)	-
Cash paid to providers - non-healthcare expenditure		(2,399,145)	(2,288,608)
Cash paid to members - savings plan refunds	4.2	(2,751,397)	(2,226,519)
Net cash generated/(utilised) in operating activities		8,099,242	(10,478,427)
Interest received		1,401,924	1,414,130
Net cash generated/(utilised) in operations		9,501,166	(9,064,297)
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds on disposal of investments	1	-	16,000,000
Net cash generated from investing activities		-	16,000,000
Net increase in cash and cash equivalents		9,501,166	6,935,703
Cash and cash equivalents at beginning of the year		22,278,233	15,342,530
Cash and cash equivalents at end of the year	3	31,779,399	22,278,233

1. GENERAL INFORMATION

Anglovaal Group Medical Scheme (the Scheme) is a medical scheme that offers hospital, chronic illness and day-to-day benefits and is administered by Discovery Health (Pty) Ltd, a wholly owned subsidiary of Discovery Limited, listed in the insurance sector of the Johannesburg Stock Exchange (JSE).

The Scheme is a restricted membership medical scheme registered in terms of the Medical Schemes Act No. 131 of 1998, as amended (the Act), and is domiciled in the Republic of South Africa.

1.1. BASIS OF PREPARATION

The Financial Statements have been prepared in accordance with IFRS[®] Accounting Standards and interpretations issued by IFRS Interpretations Committee (IFRIC[®]), which are set by the International Accounting Standards Board (IASB). The Financial Statements are also prepared in accordance with the Act, which requires additional disclosures for registered medical schemes.

The detailed accounting policies have been set out in the respective Note to the Financial Statements, with the general accounting policies applied in the preparation of these Financial Statements set out below. These policies have been consistently applied to all years presented, except for changes required by the mandatory adoption of new and revised IFRS Accounting Standards and changes in accounting policies.

The preparation of financial statements in conformity with IFRS[®] Accounting Standards requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgement, or areas where estimates are significant to the Financial Statements, are disclosed below.

The Financial Statements are prepared in accordance with the going concern principle using the historical cost basis except for certain assets and liabilities and which include:

- Financial instruments at fair value through profit or loss; and
- Insurance and reinsurance assets and liabilities – measured in terms of IFRS 17.

All monetary information and figures presented in these Financial Statements are stated in South African Rand, which is the Scheme's functional currency, unless otherwise indicated.

The Statement of Financial Position is disclosed as current and non-current assets and current and non-current liabilities as required by IAS 1 as a clear identifiable operating cycle exists.

A Statement of changes in funds and reserves is not presented as the Scheme does not have any financial assets through other comprehensive income. Member funds are disclosed as Liabilities to members for future benefits in the annual financial statements.

1.2. EVENTS AFTER REPORTING DATE

There have been no significant events that have occurred subsequent to the end of the accounting period that effect the Financial Statements, and that the Trustees consider should be brought to the attention of the members of the Scheme.

1.3. IMPLEMENTATION OF NEW STANDARDS

New standards, amendments and interpretations not yet effective and relevant to the Scheme

The following new standards, amendments and interpretations to the existing standards have been published and are not yet effective for the current financial year. The Scheme has not early adopted them and it is not expected that they will have any material impact on the Scheme's assets, liabilities and results but may result in additional disclosure in the Financial Statements.

Standard	Scope	Effective date
Amendments to the Classification and Measurement of Financial Instruments – amendments to IFRS 9 Financial Instruments and IFRS 7 Financial Instruments: Disclosures.	These amendments to IFRS 9 and IFRS 7 address feedback from the post-implementation review of classification and measurement requirements. They clarify the treatment of financial liabilities settled via electronic payment systems and refine the assessment of contractual cash flows, particularly for financial assets with ESG-linked features. Additionally, they enhance disclosure requirements for equity investments designated at fair value through other comprehensive income and introduce new disclosures for financial instruments with contingent features unrelated to basic lending risks and costs. This amendment has no further impact on the Scheme.	1 January 2026
IFRS 18 Presentation and Disclosure in Financial Statement	The Standard was issued in April 2024 and supersedes IAS 1 Presentation of Financial Statements. The Standard provides additional requirements for the presentation and disclosure of information in the primary Financial Statements and the notes to improve transparency and comparability of information. IFRS 18 will impact the Scheme's Income statement and related note disclosures. The Scheme will assess the additional disclosure requirements.	1 January 2027

1.4. SIGNIFICANT JUDGEMENTS AND ESTIMATES

In the application of the Scheme's accounting policies, which are described below and in the notes, the Board of Trustees is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates. The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Following are the significant judgements, apart from those involving estimations (which are dealt with separately below), that have been made in the process of applying the Scheme's accounting policies and that have the most significant effect on the amounts recognised in the Financial Statements.

1.4. SIGNIFICANT JUDGEMENTS AND ESTIMATES (continued)

Significant Judgements

Classification of the Scheme as a mutual entity

A medical scheme is not legally defined as a mutual entity and the classification of the scheme as a mutual entity was done based on the principles set out in IFRS Accounting Standards.

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. As 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 a scheme should be distributed to the members on liquidation if there are any and if the scheme does not amalgamate with another 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 medical 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 terms of IFRS Accounting Standards.

1.4. SIGNIFICANT JUDGEMENTS AND ESTIMATES (continued)

Significant Judgements (continued)

Classification of the Scheme as a mutual entity (continued)

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 profits or losses as part of the Liability attributable to future members (which forms part of the liability to members for future benefits on the face of the Statement of Financial Position).

Consequently, the Statement of Comprehensive Income reflects no total comprehensive income for the year.

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

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.

Unit of account

Judgement has been applied to how the Scheme determined the unit of account for the measurement of its insurance contracts. Management has assessed the portfolio of 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 the option the member will have access to the chronic condition management benefit.
- Reinsurance contracts are based on conditions and not on benefit options.
- Pricing and benefit option changes are determined at a scheme level to manage member migration between different benefit options to ensure each option is sustainable.
- Risk (utilisation and concentration) is managed holistically.

Risk adjustments - liability for incurred claims

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. Because 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.

1.4. SIGNIFICANT JUDGEMENTS AND ESTIMATES (continued)

Significant Judgements (continued)

Risk adjustments - liability for incurred claims (continued)

The risk adjustment was calculated at the portfolio level as the Scheme does not have groups due to laws that constrain the Scheme's ability to set a price based on the individual risk profile of the member. The Risk-Based Solvency methodology was used which calculates the deviations of the recommended provision from the actual using past data and then builds the distribution based on approaches used for Solvency II insurance regulation. The confidence level method was used to derive the overall risk adjustment for non-financial risk. In the confidence level method, the risk adjustment is determined by applying a confidence level to run-off triangles used to calculate the *Liability for incurred claims*. The confidence level is set at 75%.

The Scheme will present the changes in the risk adjustment for non-financial risk in the insurance service result. The bootstrapping method is used to determine the risk adjustment for non-financial risk and was not changed in the current year.

Significant estimates

The preparation of Financial Statements requires the use of accounting estimates, which, by definition, will seldom equal the actual results. This note provides an overview of items that are more likely to be materially adjusted due to changes in estimates and assumptions in subsequent periods. Detailed information about each of these estimates is included in the notes below, together with information about the basis of calculation for each affected line item in the Financial Statements.

In applying IFRS 17 measurement requirements, the following inputs and methods were used that include significant estimates. The present value of future cash flows is estimated using deterministic scenarios.

The sensitivities with regard to the assumptions made that have the most significant impact on measurement under IFRS 17, are detailed in the Insurance Risk Management note in the Financial Statements.

Estimates of future cash flows to fulfil insurance contracts

Included in the measurement of the *Liability for incurred claims* of a 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 a deterministic scenario 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.

1.4. SIGNIFICANT JUDGEMENTS AND ESTIMATES (continued)

Significant estimates (continued)

Method used to measure the insurance contracts

The Scheme estimates insurance liabilities in relation to claims incurred for healthcare contracts.

Judgement is involved in assessing the most appropriate technique to estimate insurance liabilities for the claims incurred. The actuarial methodology used in assessing the estimated claims outcome of insurance liabilities is the chain ladder method. For hospital claims in the latest service month, a blend of the chain ladder method and another method, using the estimated cost per event and pre-authorised admissions is followed.

The chain ladder method involves an analysis of historical claims development factors, and the selection of estimated development factors based thereon. The selected development factors are then applied to cumulative claims data for each period (in the Scheme's case, for the four months post yearend) that is not yet fully developed to produce an estimated ultimate claims cost for each healthcare year. The chain ladder method is the most appropriate for this claim pattern.

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.

The following was taken into account when estimating the *Liability for incurred claims* :

- The homogeneity of the data.
- Changes in pattern of claims.
- Changes in the composition of members and their beneficiaries.
- Changes in benefit limits.
- Changes in the prescribed minimum benefits.

1.5. FINANCIAL INSTRUMENTS

Recognition

The Scheme recognises a financial instrument when, and only when, it becomes a party to the contractual provisions of the instrument. The Scheme classifies its financial instruments into the following categories: financial assets or financial liabilities at fair value through profit or loss, derivatives, and other receivables. Other receivables are receivables other than those arising from insurance contracts and include sundry accounts receivable and interest receivable. Other receivables are disclosed under "Financial assets at amortised cost".

Classification

The classification depends on the purpose for which the financial instruments are acquired. Management determines the classification of financial instruments at initial recognition. All purchases and sales of financial instruments are recognised on the trade date, which is the date on which the Scheme commits to purchase the financial asset or assume financial liability.

1.5. FINANCIAL INSTRUMENTS (continued)

Offsetting financial instruments

This applies where a legally enforceable right to set off exists for recognised financial assets and financial liabilities, and there is an intention and ability to realise the asset and settle the liability simultaneously or to settle on a net basis.

The Scheme will disclose the net asset or liability in the Statement of Financial Position and on a gross basis in the accompanying notes if the above conditions are met.

Derecognition of financial assets and liabilities

The Scheme derecognises a financial asset or part of a financial asset when:

- The contractual right to the cash flows from the asset expires.
- The Scheme retains the contractual right to receive cash flows of the asset, but assumes the obligation to pay one or more third parties the cash flow without material delay.
- The Scheme transfers the asset, while transferring substantially all the risks and rewards of ownership.
- The Scheme neither transfers the financial asset nor retains significant risk and reward of ownership, but has transferred control of the financial asset.

The Scheme derecognises a financial liability when the obligation under the liability is discharged, cancelled or expires.

1.6. INSURANCE CONTRACTS

Definition and classification

Contracts under which the Scheme accepts significant insurance risk from another party (the member) by agreeing to compensate the member or other beneficiary if a specified uncertain future event (the insured event) adversely affects the member or other beneficiary are classified as insurance contracts. In making this assessment, all substantive rights and obligations, including those arising from law or regulation, are considered on a contract-by-contract basis. The Scheme uses judgement to assess whether a contract transfers insurance risk and whether the accepted insurance risk is significant.

Separating components within insurance contracts

IFRS 17 requires an analysis of whether the contract contains components that should be separated from the insurance contract and accounted for under different IFRS Accounting Standards. IFRS 17 requires that cash flows relating to embedded derivatives, cash flows relating to distinct investment components and promises to transfer distinct goods or distinct services, other than insurance contract services, be accounted for separately.

Before the Scheme accounts for an insurance contract it analyses whether the contract contains components that should be separated. There are three categories of components that have to be accounted for separately:

- cash flows relating to embedded derivatives that are required to be separated;
- cash flows relating to distinct investment components; and
- promises to transfer distinct goods or distinct non-insurance services.

1.6. INSURANCE CONTRACTS (continued)

Separating components within insurance contracts (continued)

The Scheme does not have contracts with specified embedded derivatives. Certain of the contracts with members contain a Personal Medical Savings Account (PMSA) component. The PMSA, an investment component, and the insurance component of the insurance contract are highly interrelated.

The PMSA is a non-distinct investment component with the balances included in Insurance contract liabilities in the Statement of Financial Position. While the cash flows are not recorded in the Statement of Comprehensive Income, they are considered in assessing onerous contracts.

The condition whereby the investment component can be separated from the insurance component if not highly interrelated is not met and the PMSA cannot be separated from the insurance component and IFRS 17 is applied to the entire contract including the PMSA.

Amounts relating to the PMSA are transferred from the liability for remaining coverage to the insurance contract liability at each year-end as the underlying medical contract with the member comes to an end at financial year-end.

Level of aggregation

The level of aggregation has a significant impact on accounting for the insurance contract, including the measurement of insurance contracts and the extent of offsetting or cross subsidisation to determine onerous contracts. A portfolio comprises contracts subject to similar risks and managed together. Once the group of insurance contracts has been established, it becomes the unit of account.

The contracts issued by the Scheme are subject to similar risks and managed together thus falling into the same portfolio with no further disaggregation into groups. The level of aggregation is assessed to be at a Scheme level.

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 reassess the risks of the portfolio of insurance contracts and set a price or level of benefits that fully reflects the risks 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.

1.6. INSURANCE CONTRACTS (continued)

Contract boundary (continued)

In assessing the practical ability to reprice, risks transferred from the member to the Scheme are considered.

Cash flows outside the insurance contract boundary relate to future insurance contracts and are recognised when those contracts meet the recognition criteria.

The Scheme has assessed its portfolio of insurance contracts to have a contract boundary of one year, which coincides with the Scheme's financial year.

Recognition and derecognition

The group of insurance contracts issued are initially recognised from the earliest of the following:

- the beginning of the coverage period; or
- the date when the first payment from the member is due or actually received, if there is no due date; or
- when the Scheme determines that a group of contracts becomes 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
- if the terms are modified due to an agreement between the Scheme and its member or by regulation and the modification terms meet the requirements of IFRS 17.

If the modification does not comply with all the requirements of IFRS 17, the Scheme shall treat the changes in cash flow as changes in estimates of fulfilment cash flows.

Initial and subsequent measurement

The coverage period of each contract in the Scheme's portfolio of insurance contracts is one year or less. Therefore, the Scheme has made the accounting policy choice to simplify the measurement of its group of contracts using the Premium Allocation Approach (PAA).

For insurance contracts issued, on initial recognition, the Scheme measures the *Liability for remaining coverage* at the amount of contributions received.

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

- the *Liability for remaining coverage* decreased by any investment component paid or transferred to the *Liability for incurred claims*; and
- the *Liability for incurred claims*, comprising the fulfilment cashflows related to past service at the reporting date.

For insurance contracts issued, at each of the subsequent reporting dates, the *Liability for remaining coverage* is:

- increased for contributions received in the period;
- decreased by any investment component paid or transferred to the *Liability for incurred claims*; and
- decreased for the amounts of expected contributions received recognised as insurance revenue for the services provided in the period.

1.6. INSURANCE CONTRACTS (continued)

Initial and subsequent measurement (continued)

For insurance contracts issued at each of the subsequent reporting dates the *Liability for incurred claims* is:

- the probability weighted estimate of the present value of the future cash flows; and
- the risk adjustment for non-financial risk.

Refer to Judgements and Estimates earlier in this note for the significant judgements and estimates used to determine the *Liability for incurred claims* and the estimates to determine the fulfilment cash flow.

The insurance liability attributable to future members consists of accumulated profits or losses of the Scheme. The funds are mainly held as statutory reserves in lieu of the solvency requirement as required by the Act and

- increased by the net surplus for the period; and
- decreased by the net deficit for the period.

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.

Insurance revenue

As the Scheme provides services under a group of insurance contracts, it reduces the *Liability for remaining coverage* and recognises insurance revenue. 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.

For the group of insurance contracts measured under the PAA, the Scheme recognises insurance revenue based on the passage of time over the coverage period of the group of contracts.

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 fulfilment cashflows relating to the *Liability for incurred claims*);
- changes that relate to future service (i.e. losses/reversals on onerous groups of contracts from changes in the loss components);
- amounts attributable to future members; and
- recoveries from third parties (including reimbursement from the Road Accident Fund).

1.6. INSURANCE CONTRACTS (continued)

Insurance service expenses (continued)

Cash flows that are not directly attributable to a group of insurance contracts are recognised in other operating expenses as incurred.

Other incurred insurance service expenses include:

Accredited administration services

Expenses for accredited administration services are paid to the Scheme's administrator.

Cash flows that are not directly attributable to a group of insurance contracts are recognised in other operating expenses as incurred and include the Scheme's operating expenses and other administration services fees paid to the Scheme's administrator.

Accredited managed care healthcare services (no risk transfer)

Accredited managed healthcare services (no risk transfer) fees comprise amounts paid or payable to a Third-party for managing the utilisation, costs and quality of healthcare services to the members of the Scheme and are expensed as incurred.

Accredited managed healthcare services are part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of the Scheme.

Managed healthcare services are recognised as an expense over the indemnity period on a straight-line basis.

Classification of contribution receivables

The Scheme has accounted for all contribution debtors that relate to insurance services already rendered in Liability for Remaining Coverage (LFRC) at year-end.

Classification of expenditure/income outstanding at year-end that meet the definition of financial liabilities or financial assets

The fulfilment cash flows may include expenditure incurred in accounting standards other than IFRS 17. Where expenditure/income outstanding at year-end meet the definition of financial liabilities or financial assets, the Scheme has an accounting policy choice to either include the payable/receivables in the insurance contract liabilities or to recognise it as a separate IFRS 9 liability/asset such as trade and other payables/receivables. The Scheme has chosen to include these payables in the insurance contract liabilities.

1.7. REINSURANCE CONTRACTS

Definition

Reinsurance contracts are contractual arrangements entered into by the Scheme with a provider. The provider is paid a fixed fee per member to cover the risk of the number of incidents that occur during a specified period and the cost of providing the service. Reinsurance contracts do not reduce the Scheme's primary obligations to its members and their dependants.

1.7. REINSURANCE CONTRACTS (continued)

Unit of account

Groups of reinsurance contracts held are assessed for aggregation separately from groups of insurance contracts issued. Applying the grouping requirements to reinsurance contracts held, the Scheme aggregates reinsurance contracts held concluded within a calendar year (annual cohorts) into groups of contracts for which there is a net gain at initial recognition.

Reinsurance contracts held are assessed for aggregation requirements on an individual contract basis. The Scheme tracks internal management information reflecting historical experiences of such contracts' performance. This information is used for setting pricing of these contracts such that they result in reinsurance contracts held in a net gain position without a significant possibility of a net cost arising subsequently.

Recognition and derecognition

The reinsurance contract held that covers the losses of separate insurance contracts on a proportionate basis is recognised at the later of:

- the beginning of the coverage period of the group; or
- the initial recognition of any underlying insurance contract.

Initial and subsequent measurement

The coverage period of each reinsurance contract in the Scheme's group of reinsurance contracts, is one year or less. Therefore the Scheme has made the accounting policy choice to simplify the measurement of its group of reinsurance contracts using the PAA.

For reinsurance contracts held, on initial recognition the Scheme measures the remaining coverage at the amount of ceding contributions paid.

The carrying amount of a group of reinsurance contracts held at the end of each reporting period is the sum of:

- the *Liability for remaining coverage*; and
- the *Liability for incurred claims*, comprising the fulfilment cashflows related to past service allocated to the group at the reporting date.

Subsequent measurement of the remaining coverage for reinsurance contracts held is:

- increased for the reinsurance fees paid in the period; and
- decreased for the amount of reinsurance fees recognised as reinsurance expenses for the services received in the period.

The Scheme does not adjust the asset for the remaining coverage for reinsurance contracts held for the effect of the time value of money. The reinsurance contributions are due within coverage periods which are one year or less.

Contract boundary

For groups of reinsurance contracts held, cash flows are within the contract boundary if they arise from substantive rights and obligations that exist during the reporting period in which the Scheme is compelled to pay amounts to the reinsurer or in which the Scheme has a substantive right to receive services from the reinsurer.

The Scheme's reinsurance contracts held have a duration of one year or less.

1.7. REINSURANCE CONTRACTS (continued)

Net income/(expense) from reinsurance contracts held

Reinsurance income consists of:

The amount that depicts the value the insurer benefits from entering into a reinsurance contract (i.e. the value of services received from the reinsurance provider).

Reinsurance expenses consist of:

- reinsurance premiums; and
- other incurred directly attributable insurance service expenses;
- effect of changes in risk of reinsurer non-performance.

Reinsurance expenses are recognised similarly to insurance revenue. The amount of reinsurance expenses recognised in the reporting period depicts the transfer of received services at an amount that reflects the portion of ceding contributions the Scheme expects to pay in exchange for those services.

For groups of reinsurance contracts held measured under the Premium Allocation Approach, the Scheme recognises reinsurance expenses based on the passage of time over the coverage period of a group of contracts.

1.8. CONTINGENT LIABILITIES

The Scheme will disclose a contingent liability if one of the following conditions are met:

- A possible obligation arising from past events, the existence of which will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Scheme.
- A present obligation that arises from past events but not recognised because:
 - It is not probable that an outflow of resources will be required to settle an obligation.
 - The amount of the obligation cannot be measured with sufficient reliability.

1.9. LIABILITY TO MEMBERS FOR FUTURE BENEFITS

The insurance liability to future members represents the accumulated funds of the Scheme. The funds are mainly held as statutory reserves in lieu of the solvency requirement as required by the Act.

1.10. FINANCIAL LIABILITIES

Financial liabilities are initially recognised at fair value, net of transaction costs incurred. After initial recognition the financial liabilities are measured at amortised cost, using the effective interest method. In addition, the Scheme is not permitted to borrow, in terms of Section 35 (6)(c) of the Act. The Scheme therefore has no long-term financial liabilities.

1.11. PROVISIONS

The Scheme recognises a provision when the following conditions are met:

- it has a present legal or constructive obligation as a result of past events;
- it is probable that an outflow of resources embodying economic benefits will be required to settle the obligation; and
- a reliable estimate of the amount of the obligation can be made.

Provisions are measured as the present value of management's best estimate of the expenditure required to settle the obligation at the reporting date. Where the effect of discounting to present value is material, provisions are adjusted to reflect the time value of money.

1.12. INCOME TAX

In terms of Section 10 (1)(d) of the Income Tax Act 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax.

1.13. IFRS 12 UNCONSOLIDATED INVESTMENT STRUCTURES

The Scheme has determined that some of its investments in pooled funds and in collective investments ("funds") are investments in unconsolidated structured entities. The objectives include achieving medium to long-term capital growth. The investment strategy does not include the use of leverage.

These funds are managed by independent asset managers who apply various investment strategies to accomplish their respective investment objectives.

The change in fair value of each fund is included in the Statement of Comprehensive Income in "Fair value gains from investments held at fair value through profit or loss".

1.14. UNALLOCATED FUNDS

Unallocated funds arise on the receipt of unidentified deposits in favour of the Scheme.

Unallocated funds that have legally prescribed, that is funds older than three years, are written back and included under Sundry income on the face of the Statement of Comprehensive Income.

A liability for unallocated funds that have not legally prescribed is recognised and disclosed under insurance contract liabilities. The liability is measured in accordance with the requirements of IFRS 17 forming part of the fulfilment cash flows of the related group of insurance contracts.

1. FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS

Accounting policy

The Scheme's investment strategy ("business model objective") is determined by means of an allocation across different asset classes and grouping of financial assets into specific portfolios. Independent asset managers manage these portfolios under fully discretionary, active mandates with performance evaluated at portfolio level on a fair value basis. All asset managers are remunerated based on the fair value of the portfolios under management.

The business model objective is achieved through the selling of assets per the documented strategy for realisation of gains with the collection of contractual cash flows being incidental to the primary business model objective. The financial assets are managed together and grouped into specific portfolios. Based on the business model objective the financial assets are measured at fair value through profit or loss.

Financial assets at fair value through profit or loss are initially recognised at fair value and the transaction costs, if applicable, are expensed in the Statement of Comprehensive Income.

The fair value of the financial instruments traded in an active market is determined by using quoted market prices or dealer quotes. The fair value of financial instruments not traded in an active market is determined by using valuation techniques that maximise the use of observable market data and rely as little as possible on entity specific estimates.

Gains or losses arising from subsequent changes in fair value are recognised under fair value gains from Investments held at fair value through profit or loss in the Statement of Comprehensive Income within the period in which they arise.

The methodology applied to assess assets as non-current or current:

Linked Insurance Policies

The Scheme's intention is not to liquidate these portfolios; however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result, these portfolios have been included as open ended.

Note

The Scheme's Financial assets at fair value through profit or loss are summarised by measurement classes as follows:

	2025 R	2024 R
Linked Insurance Policies	226,017,341	188,172,071
	<u>226,017,341</u>	<u>188,172,071</u>
Reconciliation		
Fair value at the beginning of the year	188,172,071	185,935,034
Proceeds on disposal of investments	(1,379,011)	(17,237,337)
Asset management fees	(1,379,011)	(1,237,337)
Proceeds on disposal of Financial assets at fair value through profit or loss	-	(16,000,000)
Net movement on revaluation of Financial assets at fair value through profit or loss	38,522,075	12,912,434
Realised gains on disposal	702,206	6,561,940
Fair value at the end of the year	<u>226,017,341</u>	<u>188,172,071</u>

2. OTHER FINANCIAL ASSETS AT AMORTISED COST

Accounting policy

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market, other than those the Scheme intends to sell in the short term.

Receivables are initially recognised at fair value, plus transaction costs. The Scheme holds its other receivables with the objective to collect the contractual cash flows and measures them subsequently at amortised cost using the effective interest method.

Impairment of other receivables

The Scheme applies the IFRS 9 simplified approach to measure expected credit losses which uses a lifetime expected loss allowance for other receivables. To measure the expected credit losses, other receivables are grouped based on shared credit risk characteristics and days past due. There are no impairments of other receivables.

<i>Note</i>	2025 R	2024 R
Interest receivable	172,651	141,552
Prepayments	19,314	144,154
	<u>191,965</u>	<u>285,706</u>

At 31 December 2025, the carrying amounts of trade and other receivables approximate their fair values due to the short-term maturities of these assets. Interest is not charged on overdue balances.

3. CASH AND CASH EQUIVALENTS

Accounting policy

Cash and cash equivalents are short-term, highly liquid instruments that are readily convertible to known amounts of cash and are subject to an insignificant risk of changes in value.

In the Statement of Cash Flows, cash and cash equivalents comprise:

- Money market instruments
- Balances with banks.

Cash and cash equivalents only include items held for the purpose of meeting short-term cash commitments rather than for investing or other purposes and are carried at cost, which, due to their short-term nature, approximates fair value.

<i>Note</i>	2025 R	2024 R
Current accounts	2,801,943	3,086,251
Money market instruments	28,977,456	19,191,982
Current assets	<u>31,779,399</u>	<u>22,278,233</u>

The weighted average interest rate on cash and cash equivalents was 7.34% (2024: 7.90%).

The carrying amounts of cash and cash equivalents approximate their fair values due to the short-term maturities of these assets.

4. INSURANCE CONTRACT LIABILITIES

4.1. LIABILITY TO MEMBERS FOR CURRENT BENEFITS

Insurance contracts issued

	2025 R				2024 R			
	Liability for remaining coverage (LFRC)	Liability for incurred claims (LIC)		Total	Liability for remaining coverage (LFRC)	Liability for incurred claims (LIC)		Total
		Present value of future cash flows	Risk adjustment			Present value of future cash flows	Risk adjustment	
Net opening balance	(657,156)	27,809,121	164,865	27,316,830	(64,925)	30,660,753	194,702	30,790,530
Insurance service result	(138,234,795)	128,514,544	(93,319)	(9,813,570)	(131,824,620)	136,229,584	(29,837)	4,375,127
Insurance revenue	(138,234,795)	-	-	(138,234,795)	(131,824,620)	-	-	(131,824,620)
Insurance service expense		128,514,544	(93,319)	128,421,225		136,229,584	(29,837)	136,199,747
Incurred claims	-	115,185,561	-	115,185,561	-	123,073,274	-	123,073,274
Accredited managed healthcare services	-	2,307,466	-	2,307,466	-	2,257,337	-	2,257,337
Directly attributable insurance services expenses	-	7,808,631	-	7,808,631	-	7,639,240	-	7,639,240
Changes in fulfilment cash flows relating to the liability for incurred claims - past service	-	(987,114)	(164,865)	(1,151,979)	-	(1,740,267)	(194,702)	(1,934,969)
Changes in fulfilment cash flows relating to the liability for incurred claims - current service	-	4,200,000	71,546	4,271,546	-	5,000,000	164,865	5,164,865
Total amounts recognised in the Statement of Comprehensive Income	(138,234,795)	128,514,544	(93,319)	(9,813,570)	(131,824,620)	136,229,584	(29,837)	4,375,127
Investment component - MSA	(34,652,474)	34,652,474	-	-	(33,079,253)	33,079,253	-	-
MSA contributions received	(34,507,508)	34,507,508	-	-	(32,809,751)	32,809,751	-	-
Transfers received from other schemes	(144,966)	144,966	-	-	(269,502)	269,502	-	-
Total movement	(172,887,269)	163,167,018	(93,319)	(9,813,570)	(164,903,873)	169,308,837	(29,837)	4,375,127
<i>Cash flows</i>								
Contributions received	172,945,514	-	-	172,945,514	164,311,639	-	-	164,311,639
Claims and other directly attributable expenses paid	-	(158,974,135)	-	(158,974,135)	-	(168,364,339)	-	(168,364,339)
Refunds on death or resignation - MSA	-	(2,751,397)	-	(2,751,397)	-	(2,226,519)	-	(2,226,519)
Claims related to recoveries from reinsurance (Note 5)	-	(524,707)	-	(524,707)	-	(1,569,611)	-	(1,569,611)
Total cash flows	172,945,514	(162,250,239)	-	10,695,275	164,311,639	(172,160,469)	-	(7,848,830)
Net closing balance	(598,911)	28,725,901	71,546	28,198,536	(657,156)	27,809,121	164,865	27,316,830

4. INSURANCE CONTRACT LIABILITIES (continued)

4.1. LIABILITY TO MEMBERS FOR CURRENT BENEFITS (continued)

Notes

2025
R

2024
R

4.1.1. Breakdown of cashflows

Contributions received

Risk contributions	172,945,514	164,311,639
Medical savings contributions	138,234,795	131,824,620
Medical savings transfers	34,507,508	32,809,751
Movement in contribution debt	144,966	269,502
	58,245	(592,234)

Claims and directly attributable expenses paid

Claims and other directly attributable expenses paid	(162,250,239)	(172,160,469)
Medical savings refunds	(158,974,135)	(168,364,339)
Claims related to recoveries from reinsurance	(2,751,397)	(2,226,519)
	(524,707)	(1,569,611)

4.1.2. Breakdown: liability for incurred claims (LIC)

Opening balance	5,164,865	6,400,000
Payments in respect of prior year	(4,012,886)	(4,659,733)
Over provision	1,151,979	1,740,267
Adjustment	3,119,567	3,424,598
Total*	4,271,546	5,164,865

* The liability for incurred claims includes the risk adjustment 71,546 164,865

4.1.3. Included in Liability to members for current benefits

Medical Savings Account monies	4.3	21,700,634	21,732,401
Reported claims not yet paid		2,366,621	754,585
Amounts due to administrator		826,139	804,916
Liability for incurred claims incurred but not yet reported		4,200,000	5,000,000
Risk adjustment		71,546	164,865
Unallocated funds		68,305	-
Less:			
Insurance revenue outstanding		(598,911)	(657,156)
Member and service provider claims debt		(1,132,875)	(1,229,108)
Provision for impairment		808,911	776,286
Forensic receivables		(111,834)	(29,966)
		28,198,536	27,316,823

4. INSURANCE CONTRACT LIABILITIES (continued)

4.2. MEDICAL SAVINGS ACCOUNT LIABILITY

The personal medical savings account (MSA), which is managed by the scheme on behalf of its members, represents savings contributions, and accrued interest thereon in terms of the rules of the scheme, net of any savings claims paid on behalf of members in terms of the scheme's registered rules.

Unspent savings at year end are carried forward to meet future expenses for which the members are responsible. In terms of the Medical Schemes Act 131 of 1998, as amended, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

The personal medical savings accounts are invested (on behalf of members) in fixed deposits and deposits held at call with banks in terms of the rules of the scheme. These monies are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method.

The scheme elected to account for unspent medical savings to be accounted for in the liability for incurred claims.

Reconciliation of personal medical savings accounts

	2025 R	2024 R
Balance at the beginning of the year	21,732,401	21,644,771
Plus:		
Savings contributions received	34,507,508	32,809,751
Transfers received from other schemes	144,966	269,502
Less:		
Savings claims	(31,932,844)	(30,765,104)
Refunds on death or resignation	(2,751,397)	(2,226,519)
	<u>21,700,634</u>	<u>21,732,401</u>

4.3. LIABILITY TO MEMBERS FOR FUTURE BENEFITS

Balance at the beginning of the year	182,631,085	169,110,646
Amounts attributable to members for future benefits	46,370,071	13,520,439
Balance at the end of the year relating to Liability to members for future benefits	<u>229,001,156</u>	<u>182,631,085</u>
Current liability*	<u>-</u>	<u>5,973,939</u>
Non-current liability	<u>229,001,156</u>	<u>176,657,146</u>

* The current liability represents the onerous contract liability projected to be incurred for the following financial year which will be funded from the Liability to members for future benefits.

5. REINSURANCE CONTRACT ASSETS

	2025				2024			
	R				R			
	Remaining coverage component	Incurred claims for contracts under the PAA		Total	Remaining coverage component	Incurred claims for contracts under the PAA		Total
		Present value of future cash flows	Risk adjustment for non-financial risk			Present value of future cash flows	Risk adjustment for non-financial risk	
Healthcare Risk – Reinsurance contracts held								
Net opening balance	-	-	-	-	-	-	-	-
Net expenses/(income) from reinsurance contracts held	519,477	(524,707)	-	(5,229)	1,534,458	(1,569,611)	-	(35,153)
Reinsurance expenses	519,477	-	-	519,477	1,534,458	-	-	1,534,458
Claims recovered	-	(524,707)	-	(524,707)	-	(1,569,611)	-	(1,569,611)
Total amounts recognised in the Statement of Comprehensive Income	519,477	(524,707)	-	(5,229)	1,534,458	(1,569,611)	-	(35,153)
Cash flows								
Premiums paid	(519,477)	-	-	(519,477)	(1,534,458)	-	-	(1,534,458)
Recoveries from reinsurance*	-	524,707	-	-	-	1,569,611	-	-
Total cash flows	(519,477)	524,707	-	5,229	(1,534,458)	1,569,611	-	35,153
Net closing balance	-	-	-	-	-	-	-	-

* Recoveries from reinsurance represent the value of the services provided by the reinsurance contract provider. This represents a non-cash transaction.

6. OTHER FINANCIAL LIABILITIES AT AMORTISED COST

Accounting policy

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. These are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method.

Note

Financial liabilities

	2025 R	2024 R
Related party balances	63,465	61,865
Discovery Health (Pty) Ltd	63,465	61,865
Accruals	725,548	524,112
Unallocated funds	-	202,118
Current liability	789,013	788,095

At 31 December 2025 the carrying amounts of financial liabilities at amortised cost approximate their fair values due to the short-term maturities of these liabilities.

7. INSURANCE REVENUE AND INSURANCE SERVICE EXPENSES

	Notes	2025 R	2024 R
Insurance revenue from contracts measured under the PAA		138,234,795	131,824,620
Gross contributions		172,742,303	164,634,371
Personal Medical Savings Account contributions		(34,507,508)	(32,809,751)
Insurance service expense		(128,421,225)	(136,199,747)
Net claims incurred		(118,305,128)	(126,303,170)
Risk claims		(119,009,783)	(127,080,103)
Third party recoveries		704,655	776,933
Accredited managed healthcare services	7.2	(2,307,466)	(2,257,337)
Directly attributable insurance services expenses		(7,808,631)	(7,639,240)
Accredited administration services	7.1	(7,808,631)	(7,639,240)
Net expense from reinsurance contracts		5,230	35,153
Premiums paid	7.3	(519,477)	(1,534,458)
Amounts recovered from reinsurance contracts	7.3	524,707	1,569,611
Total insurance service result		9,818,800	(4,339,974)

7. INSURANCE REVENUE AND INSURANCE SERVICE EXPENSES (continued)

Detail of accredited administration services, accredited managed healthcare services and net income/(expense) from reinsurance contracts held has been provided below:

	2025 R	2024 R
7.1. Accredited administration services		
Member record management	805,080	787,621
Contribution management	707,643	692,409
Claims management	890,628	871,197
Financial management	28,947	28,299
Information management and data control	1,443,975	1,412,588
Customer services	3,932,358	3,847,126
	<u>7,808,631</u>	<u>7,639,240</u>
7.2. Accredited managed healthcare services (no risk transfer)		
Disease Risk Management	738,141	722,030
Hospital referrals and pre-authorisations	715,656	700,079
Medical provider network management	622,871	609,362
Pharmacy benefit management	230,798	225,866
	<u>2,307,466</u>	<u>2,257,337</u>

7.3. Net income from reinsurance contracts

Accounting policy

Reinsurance contracts held are contractual arrangements entered into by the Scheme and third parties who undertake to indemnify the Scheme against all or part of the loss that the Scheme may incur as a result of carrying on the business of a medical scheme. Reinsurance contracts do not reduce the Scheme's primary obligations to its members and their dependants. The arrangements only decrease the loss the Scheme may incur as a result of carrying on the business of a medical scheme.

Reinsurance contract fees are recognised as an expense over the indemnity period on a straight-line basis.

The claims incurred under member insurance contracts and the equivalent claims recoveries are presented in the Statement of Comprehensive Income on a gross basis. Amounts recoverable under such contracts are therefore recognised in the same year as the related claims. The claims incurred liability under reinsurance contracts and the equivalent receivable are also presented in the Statement of Financial Position on a gross basis.

Assets relating to reinsurance contracts include balances due under reinsurance contracts for outstanding claims provisions, and claims reported not yet paid. Amounts recoverable under reinsurance contracts are estimated in a manner consistent with the outstanding claims provision, claims reported not yet paid, and settled claims associated with the reinsurance contracts.

Amounts recoverable under reinsurance contracts are assessed for impairment at each reporting date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the reinsurance contracts.

7. INSURANCE REVENUE AND INSURANCE SERVICE EXPENSES (continued)

Reinsurance contracts

Reinsurance contracts covering treatment for members diagnosed with diabetes (type I and II)

For their diabetes-related treatment, members have a choice of using the managed care organisation under this reinsurance contracts or not. As the risk profile of the two groups of members are similar, the claims experience of the members who have elected not to use this provider was used to estimate the members' fee-for-service cost for those who elected not to use this provider. The CDE ceased operations and services on 30 April 2025.

As no underlying fee-for-service data is available, the cost of providing the capitated services was estimated as follows:

- Per life per month (PLPM) estimates were calculated for consultations, procedures, medication and hospital admissions to the extent that these services were covered under this reinsurance contracts for the members who have elected not to use this provider.
- The expected fee-for-service cost was calculated by multiplying the calculated PLPM costs by the number of members exposed for the period on this programme.

	2025 R	2024 R
Made up as follows:		
Centre for Diabetes and Endocrinology (Pty) Ltd	5,230	35,153
Reinsurance expense	(519,477)	(1,534,458)
Claims recovered	524,707	1,569,611
	<u>5,230</u>	<u>35,153</u>

8. INVESTMENT INCOME

Accounting policy

Investment income comprise interest received and accrued on Financial assets not measured at fair value through profit or loss.

Investment income received is disclosed as cash flows from operating activities in the Statement of Cash Flows because they enter into the determination of profit or loss. The income from investments are considered operating activities as it generates cash flows to maintain the operating capability of the Scheme.

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

Realised gains and losses represent amounts realised when investments at fair value through profit or loss have been derecognised through disposal. Unrealised gains or losses represent changes in fair value of these investments.

8. INVESTMENT INCOME (continued)

<i>Note</i>	2025 R	2024 R
Interest income from financial assets not measured at fair value through profit or loss	1,433,012	1,464,900
Net gains on investments at fair value through profit or loss	39,224,281	19,474,374
- Fair value adjustment on financial assets	38,522,075	12,912,434
- Realised gains on disposal of financial assets	702,206	6,561,940
Net investment income	<u>40,657,293</u>	<u>20,939,274</u>

9. OTHER OPERATING EXPENSES

Accounting policy

Other operating expenses are expensed as incurred.

<i>Note</i>	2025 R	2024 R
Administration fees	599,869	587,145
Other services		
Internal audit services	119,405	116,900
Forensic investigations and recoveries	149,386	146,257
Governance and compliance	23,778	23,274
Additional services		
Quality management and monitoring services	112,685	110,288
Advanced data analytics	94,335	92,304
Digital service offering	34,891	34,118
Enhanced service offering	18,609	18,249
Enterprise risk management services	18,609	18,249
Legal services	5,686	5,554
Product innovation	22,485	21,952
Association fees	12,088	6,166
Bank charges	51,595	72,885
Consulting fees	461,819	470,891
Council of Medical Schemes	115,416	110,010
Debt collection fees	1,702	538
Emergency call centre fees	13,114	12,756
External audit fees*	1,413,465	524,109
Audit services - current year	1,001,548	524,109
Audit services - prior year under provision	411,917	-
Fidelity guarantee and professional indemnity insurance premium	57,943	57,023
	<u>2,727,011</u>	<u>1,841,523</u>

*This fee relates to the opinions on the annual financial statements, annual statutory returns audit and compliance report in accordance with the requirements of Sections 36(1), 36(5) and 36(8) of the Medical Schemes Act as required by CMS.

10. RELATED PARTY TRANSACTIONS

The Scheme is controlled by the Board of Trustees who are appointed by the employers or elected by the members of the Scheme.

Key management personnel and their close family members

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the non-executive Board of Trustees and the Executive Officers of the Scheme. The disclosure deals with full-time Executive Officers who are compensated on a salary basis, and non-executive Board of Trustees who are compensated on a fee basis.

Close family members include close family members of the Board of Trustees and Executive Officers of the Scheme.

Parties with significant influence over the Scheme

Administrator and managed care organisation

Discovery Health (Pty) Ltd has significant influence over the Scheme, as Discovery Health (Pty) Ltd participates in the Scheme's financial and operating policy decisions, but does not control the Scheme. Discovery Health (Pty) Ltd provides administration and managed care services.

Discovery Third Party Recovery Services Proprietary Limited

The Scheme contracted with Discovery Third Party Recovery Services (Pty) Ltd (DTPRS), a wholly-owned subsidiary of Discovery Health (Pty) Ltd, to manage the identification and collection of third party recoveries from the Road Accident Fund.

Specialist Pharmaceutical Services

The Scheme paid claims for specialist pharmaceutical services to Southern RX Pharmacy, a wholly owned subsidiary of Discovery Health (Pty) Ltd.

Consultants

Mr André Bellingan - Consulting Actuary has significant influence over the Scheme as he participates in the Scheme's financial and operating policy decisions, but does not control the Scheme.

Key management personnel

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the Board of Trustees and the Principal Officer.

Close family members include family members of the Board of Trustees and Principal Officer.

10. RELATED PARTY TRANSACTIONS (continued)

Transactions with related parties

The following provides the total amount in respect of transactions, which have been entered into with related parties for the relevant financial year. All amounts are disclosed as absolute numbers.

Transactions with key management personnel and their close family members which includes Trustees and Executive Officers:

	2025	2024
	R	R
Statement of Comprehensive Income		
Contributions and claims (Trustees and their beneficiaries)		
Insurance revenue	599,004	676,922
Incurred claims	(437,640)	(886,860)
Statement of Financial Position		
Insurance contract liability for current members (Medical savings balances)	24,085	49,892

The terms and conditions of the related party transactions were as follows:

Transactions	Nature of transactions and their terms and conditions
Insurance revenue	This constitutes the contributions paid by the related party as a member of the Scheme, in their individual capacity. All contributions were on the same terms as applicable to other members.
Incurred claims	This constitutes amounts claimed by the related parties, in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme, as applicable to other members.
Medical Savings Accounts	The amounts owing to the related parties relate to Personal Medical Savings Account balances to which the parties have a right. In line with the terms applied to other members, the balances earn monthly interest on an accrual basis, at interest rates determined by the Scheme from time to time at its discretion. The amounts are all current and would need to be payable on demand as applicable to other members.

10. RELATED PARTY TRANSACTIONS (continued)

Transactions with entities that have significant influence over the Scheme

	2025 R	2024 R
Statement of Comprehensive Income		
Discovery Health (Pty) Ltd - administrator		
Total administration fees	(8,408,500)	(8,226,385)
- Accredited administration services (Note 7)	(7,808,631)	(7,639,240)
- Administration fees (Note 9)	(599,869)	(587,145)
Discovery Health (Pty) Ltd - managed care organisation		
Managed care: management services (note 7)	(2,307,466)	(2,257,337)
Southern RX Distributors (Pty) Ltd		
Claims paid from the Scheme	(668,925)	(509,132)
Insight Actuaries and Consultants - Mr André Bellingan		
Consulting fees	(461,819)	(470,891)
Statement of Financial Position		
Discovery Health (Pty) Ltd - administrator		
Balance due to Discovery Health (Pty) Ltd	889,604	866,774

The terms and conditions of the transactions with entities with significant influence over the Scheme were as follows:

Terms and conditions of the administration agreement

The administration agreement is in accordance with instructions given by the Trustees of the Scheme. The agreement is reviewed annually and is renewable depending on fee negotiations. The Scheme and the Administrator shall be entitled to terminate the agreement by giving notice in writing of not less than 90 days and not more than 180 days. The outstanding balance bears no interest and is due within 7 days.

Terms and conditions of the managed care agreements

The managed care agreements are in accordance with instructions given by the Trustees of the Scheme. The agreements are reviewed annually and are renewable depending on fee negotiations. The Scheme and the Managed Healthcare Organisation shall be entitled to terminate the agreement by giving notice in writing of not less than 90 days and not more than 180 days. The outstanding balance bears no interest and is due within 7 days.

11. COMMITMENTS AND OTHER CONTINGENT LIABILITIES

The Scheme does not have any commitments or contingent liabilities outstanding at 31 December 2025.

12. EVENTS AFTER THE REPORTING PERIOD

There have been no other events that have occurred subsequent to the end of the accounting period that materially effect the Financial Statements, and that the Trustees consider should be brought to the attention of the members of the Scheme.

13. INSURANCE RISK MANAGEMENT REPORT

Nature and extent of risks arising from insurance contracts

The Scheme issues contracts that transfer insurance risk. The primary insurance activity carried out by the Scheme indemnifies covered members and their dependants against the risk of loss arising as a result of the occurrence of a health event, in accordance with the Scheme Rules and legislative requirements. Insurance events are, by nature, random and the actual number and size of events during any one year may vary.

This note summarises these risks and the way in which they are managed.

Insurance risk

The risk under any insurance contract can be expressed as the probability that an insured event occurs multiplied by the expected amount of the resulting claim. Insurance events are random and therefore the actual number and size of events during any year are unknown and vary from those estimated. The principal risk that the Scheme faces under its insurance contracts is that the actual claim payments exceed the projected amount of the insurance liabilities. This could occur because the frequency and severity of claims are greater than estimated. A larger number of members will result in smaller variability of the actual claims experience relative to expected levels. This is because an adverse experience is diluted by a larger group of members whose claims are stable and thus predictable.

Factors that aggravate insurance risk include unanticipated demographic movements, adverse experience due to an unexpected epidemic, changes in members' disease profiles, unexpected price increases, prevalence of fraud, supplier induced demand and the cost of new technologies or drugs.

The risks that the Scheme faces can be discussed for the different benefits offered. The types of benefits offered by the Scheme in return for monthly contributions are indicated below:

Prescribed Minimum Benefits (PMBs)

This benefit covers the benefits contemplated in section 29(1)(o) of the Act and consists of the provision of the diagnosis, treatment and care costs of the diagnosis and treatment pairs listed in Annexure A of the Regulations, subject to any limitations specified therein and any emergency medical condition.

The Scheme applies guidelines and protocols for appropriate clinical management under Designated Service Provider (DSP) agreements.

Hospital benefits

The hospital benefits cover medical expenses incurred arising from admission to hospital. This includes accommodation, theatre, professional fees, medication, equipment and consumables.

Clinical protocols and provider contracting are applied to pre-authorisations and the management of the benefit. The Administrator negotiates hospital tariffs annually on behalf of the Scheme to allow for benefit of scale.

13. INSURANCE RISK MANAGEMENT REPORT (continued)

Insurance risk (continued)

Day-to-day benefits

Day-to-day benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines. The Scheme does not carry risk for medical savings benefits.

Chronic benefits

The Chronic Illness Benefit (CIB) covers approved medication and treatment for up to 48 listed conditions, including the 27 Prescribed Minimum Benefit (PMB) chronic conditions. These include conditions such as HIV / AIDS, high blood pressure, cholesterol and asthma. This benefit and approval are managed by an appointed accredited Managed Care Organisation for drug utilisation, medicine management and adherence to compliance with regard to the PMB conditions.

Other services (insured procedure benefits)

These services provide cover for non-hospital expenses, subject to prior approval from the Scheme, which is managed and monitored by an appointed clinical committee.

The risks associated to the Scheme with the types of benefits offered to members are addressed below:

Hospital benefit risk

Frequency and severity of claims

The main factors impacting the frequency and severity of hospital claims are the number of admissions and the cost per event. An increase in the frequency and severity of claims result in an increase in the cost of claims.

An increase or decrease in the admission rate is often linked to increases or decrease in the number of beneficiaries at older ages or with chronic conditions. The increase in cost per event is driven by annual tariff and other cost increases. An increased cost per event can also be caused by an increased case-mix, severity of admissions and the introduction of new hospital-based technologies.

A 2% increase or decrease in the admission rate is estimated to increase or decrease the Scheme's loss ratio by 1.60%. The introduction of new hospital technologies could also increase variability of claims. In some instances, the new technology has a beneficial impact on costs, whether in-hospital or consequent costs. In other instances the new technologies will increase costs.

The change in the admission rate is shown in the following table.

Plan type	2025 Admission rate	2024 Admission rate	% Increase/ (decrease)
Anglovaal Group Medical Scheme	30.3%	30.7%	-1.11%

Other factors that impact on hospital claims are shown

Key indicators	2025	2024	% Increase/ (decrease)
Average length of stay	4.00 days	4.46 days	-10.31%
Average cost per event	R 42,611	R 45,828	-7.02%
Hospital cost per life per month	R 1,078	R 1,172	-8.04%

13. INSURANCE RISK MANAGEMENT REPORT (continued)

Hospital benefit risk (continued)

Initiatives used by the Scheme to manage the risk associated with admission rate include:

- The development of protocols around admissions, including funding protocols for various treatments and procedures;
- The “See Your Doctor First” initiative which requires members to see their doctor prior to an elective admission; and
- The amendment to the pre-authorisation length of stay benchmarks.

Day-to-day benefits risk

Frequency and severity of claims

The risk to the Scheme is limited up to an annual limit per benefit per family via individualised medical savings accounts, as prescribed by the rules of the Scheme.

Chronic Illness Benefit (CIB) risk

Frequency and severity of claims

The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant respectively.

Higher increases in chronic claimants are linked to increases in the number of beneficiaries at older ages. In addition, changes relating to the eligibility for chronic benefits will also impact costs. An increase in the number of items per claimant will drive up the costs of chronic claims per claimant. Increases in the regulated prices for chronic medication, the Single Exit Price, and increases in dispensing fees will also result in an increase in costs per claim. The mix between the various chronic conditions will also have an impact on the frequency and the presence of multiple chronic conditions per person will have an impact on the severity of the claims.

The mix between the various chronic conditions impacts the frequency and severity of claims. The following table shows the change in the chronic prevalence for key measures.

Measures	2025	2024	% Increase/ (decrease)
Cost per claimant	R4,713	R 4,448	5.96%
Claimants per 1000 lives	26.99	26.72	1.01%
Per life per member (PLPM) cost	R 127	R 119	6.88%

Concentration of insurance risk

An annual actuarial valuation is performed, which specifies the contributions to be charged in return for the benefits to be provided given the expected demographic profile.

13. INSURANCE RISK MANAGEMENT REPORT (continued)

Concentration of insurance risk (continued)

The following table summarises the concentration of insurance risk, with reference to the carrying amount of the insurance claims incurred (net of adjustments per beneficiary) for service years 2025 and 2024, by age group and in relation to the type of risk cover/benefits provided.

Claims incurred for 2025 service year per beneficiary

Age grouping (in years)	Avg number of beneficiaries	In-hospital R	Chronic R	Day-to-day R	Total R
< 26	1,306	6,883	180	1,010	8,073
26 – 35	484	9,853	267	1,828	11,948
36 – 50	1,055	13,252	863	2,742	16,857
> 50	1,353	47,594	3,775	11,095	62,464

Claims incurred for 2024 service year per beneficiary

Age grouping (in years)	Avg number of beneficiaries	In-hospital R	Chronic R	Day-to-day R	Total R
< 26	1,350	7,890	115	1,178	9,183
26 – 35	504	10,152	275	1,590	12,017
36 – 50	1,041	14,638	880	2,649	18,167
> 50	1,407	48,483	3,495	11,010	62,988

Contracts with providers are negotiated by the Administrator on behalf of the Scheme to benefit from scale and ultimately the rates. Such contracts are reviewed annually.

Reinsurance contracts held

The Scheme has reinsurance contracts in which suppliers are paid to provide certain minimum benefits to Scheme members, as and when it is required by the members. These arrangements are also known as capitation arrangements and fix the cost to the Scheme of providing these benefits.

The Scheme had a reinsurance contract to cover specific risks. The Scheme was contracted with the Centre for Diabetics and Endocrinology (CDE) for the disease management of registered diabetic patients. The contract ended 30 April 2025.

Risk in terms of reinsurance contracts

The Scheme does, however, remain liable to its members to provide the benefits. If any supplier fails to meet the obligations of the reinsurance contract, the Scheme will cover the cost of the benefit.

When selecting a supplier, the Scheme assesses their ability to provide the relevant service. This is to mitigate against the reputational and operational risks that the Scheme faces should a supplier not meet its obligations. The Scheme also monitors the performance of the suppliers, checks the quality of care provided and has access to data on the underlying fee-for-service claims which are included in the arrangement.

13. INSURANCE RISK MANAGEMENT REPORT (continued)

Reinsurance contracts held (continued)

Claims development

Detailed claims development tables are not presented as the uncertainty regarding the amount and timing of claim payments are typically resolved within one year and in most cases within four months. At year-end, a probability weighted best estimate is made for those claims that have not yet been reported.

The methodology followed in setting the probability weighted best estimate of the claims incurred but not yet reported is the actuarial methodology of chain ladder estimation. This methodology is the most objective, but the accuracy of the estimate is sensitive to changes in the average time from treatment to payment of claims. For hospital claims in the latest service month, a blend of the chainladder method and another method using the estimated cost per event and pre-authorised admissions is also followed.

The December 2025 probability weighted best estimate of future cash flows for claims incurred but not yet reported and risk adjustment was made in accordance with Advisory Practice Note 304 of the Actuarial Society. In accordance with this practice note, the following factors are considered to determine whether they would have any impact on the probability weighted best estimate of the claims incurred but not yet reported and risk adjustment estimates:

- The homogeneity of claims data.
- The credibility of claims data.
- Changes in emergence and settlement patterns.
- The impact of seasonality.
- The impact of re-opened or adjusted claims.
- The impact of benefit limits and changes.
- External influences.
- The demographic profile of the Scheme.

Based on the processing patterns and claims development up to the end of December 2025 in respect of treatment dates during 2025, the recommended probability weighted best estimate of the claims incurred but not yet reported as at December 2025 is R4.2 million (2024: R5 million).

The recommended risk adjustment for non-financial risk, the compensation required for bearing uncertainty about the amount and timing of the cash flows that arise from non-financial risk as the Scheme fulfils insurance contracts, as at 31 December 2025 is R71,546 (2024: R164,865).

13. INSURANCE RISK MANAGEMENT REPORT (continued)

Claims development (continued)

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

	2025		2024	
	R		R	
	LIC as at 31 December	Impact on SOCI*	LIC as at 31 December	Impact on SOCI*
Insurance contract liability	28,198,536		27,316,830	
Change in LIC - 10% movement		420,000		500,000

*Statement of Comprehensive Income

the impact increases the LIC by the same value

Sensitivity of risk adjustment

	2025	2024
	R	R
Risk adjustment with a 75% confidence level - as reported	71,546	164,865
Risk adjustment with a 90% confidence level	306,101	374,580

Liquidity risk

One of the main components of the Scheme's insurance contract liabilities is the probability weighted best estimate of the claims incurred but not yet reported. These are generally settled in a short period of time, approximately 95% of this balance is settled within three months after the claim was incurred and the balance is expected to be settled within six months. The remaining insurance liabilities are generally settled within 30 days from year-end.

The members' savings account contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's savings account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit plan and enrolls in another benefit plan or medical scheme without a savings account or does not enrol in another medical scheme. Therefore, the carrying values of the members' savings account are deemed to be equal to their fair values, which is the amount payable on demand.

Liquidity risk can also arise when the Scheme's investment mix does not match the nature of the liabilities. However, investments are managed by professional asset managers and finance professionals who ensure that investments, including cash and cash equivalents, are always sufficiently liquid to meet current liabilities while excess reserves are invested to maximise investment return within the scope of the Regulations to the Act.

Assumption risk

The Liability to members for future benefits and therefore the Scheme's solvency is sensitive to changes in claims development patterns. Another relevant assumption is medical inflation. Other assumptions that are considered include utilisation trends, the impact of new technology and the expected demographic profile of the Scheme membership.

14. FINANCIAL RISK MANAGEMENT REPORT

Overview

The Scheme is exposed to financial risk through its financial assets, financial liabilities and insurance contract liabilities. In particular the financial risk is that the proceeds, for any reason, from its financial assets are not sufficient to fund the obligations arising from its insurance contracts. The most important components of financial risk include market risk, interest rate risk, credit risk and liquidity 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 that the Scheme holds to meet its obligations to its members.

The Board of Trustees has overall responsibility for the establishment and oversight of the Scheme's risk management framework.

The Scheme manages these risks through various risk management processes. These processes have been developed to ensure that the long-term investment return on assets supporting the insurance liabilities is sufficient to contribute towards funding members' reasonable benefit expectations.

The Scheme manages the financial risks as follows:

- An Audit and Investment Committee has been established by the Board of Trustees to assist in the implementation and monitoring of these risk management processes. The Audit and Investment Committee meets at least quarterly and reports back to the Board of Trustees on the matters included in its terms of reference.
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly.
- The Scheme ensures compliance with Regulation 30, Annexure B of the Act.

Market risk

Market risk is the risk that changes in market variables, such as foreign exchange rates, interest rates and equity prices will affect the Scheme's income or the value of its holdings in financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising the return on risk.

The Scheme's insurance liabilities are settled within one year and the Scheme does not discount insurance liabilities. Consequently, changes in market interest rates would not affect the Scheme's net result arising from changes in the insurance liability.

Currency risk

The Scheme operates in the Republic of South Africa and its cash flows are denominated in South African Rand and therefore the Scheme does not have significant net currency risk.

Price risk

The Scheme is exposed to equity security price risk because of investments held by the Scheme which are classified as financial assets through profit or loss. To manage its price risk arising from investments in equity securities, the Scheme diversifies its portfolio. Diversification of the portfolio is done by the relevant asset manager in accordance with the mandate set by the Scheme.

14. FINANCIAL RISK MANAGEMENT REPORT (continued)

Market risk (continued)

Interest rate risk

The Scheme is exposed to interest rate risk as it places funds at both fixed and floating interest rates. The risk is managed by maintaining an appropriate mix between fixed and floating rate investments within the Scheme's money market investment portfolio.

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 the earlier of contractual repricing or maturity dates:

	Up to 1 month	1 to 3 months	3 months and more	Total
	R	R	R	R
As at 31 December 2025				
Cash and cash equivalents	2,801,943	28,977,456	-	31,779,399
	<u>2,801,943</u>	<u>28,977,456</u>	<u>-</u>	<u>31,779,399</u>
	Up to 1 month	1 to 3 months	3 months and more	Total
	R	R	R	R
As at 31 December 2024				
Cash and cash equivalents	3,086,251	19,191,982	-	22,278,233
	<u>3,086,251</u>	<u>19,191,982</u>	<u>-</u>	<u>22,278,233</u>

The following table below summarises the effective interest rate for monetary financial instruments:

	2025	2024
Current and money market accounts	7.34%	7.90%

Sensitivity analysis for variable rate

Due to the short-term duration of these instruments, a reasonably possible change in interest rates is 100 basis points. At the reporting date, the effect of this change on the Scheme's accumulated funds and deficit is shown below. This analysis assumes that all other variables remain constant. The analysis was performed on the same basis for 2025.

As at 31 December 2025	Surplus or deficit		Accumulated funds	
	100bp Increase R	100bp Decrease R	100bp Increase R	100bp Decrease R
Cash and cash equivalents	195,233	(195,233)	195,233	(195,233)
	<u>195,233</u>	<u>(195,233)</u>	<u>195,233</u>	<u>(195,233)</u>
As at 31 December 2024	Surplus or deficit		Accumulated funds	
	100bp Increase R	100bp Decrease R	100bp Increase R	100bp Decrease R
Cash and cash equivalents	222,782	(222,782)	222,782	(222,782)
	<u>222,782</u>	<u>(222,782)</u>	<u>222,782</u>	<u>(222,782)</u>

14. FINANCIAL RISK MANAGEMENT REPORT (continued)

Legal risk

Legal risk is the risk that the Scheme will be exposed to contractual obligations which have not been provided for. At 31 December 2025, the Scheme did not consider there to be any significant concentration of legal risk and no provision has been raised.

Investment risk

Investment risk is the risk that the investment returns on accumulated assets will not be sufficient to cover future liabilities.

The Scheme's Audit and Investment Committee oversees that the funds are invested in line with the Act.

The investment philosophy is to hold a diversified pool of assets. The assets are selected as being most appropriate given the liquidity and solvency requirements of the Scheme. In contemplating solvency, the return goals of the Scheme, as well as the risk associated with all assets and asset classes are considered. Diversification is across securities, issuers, asset classes, geographic regions as well as managers within asset classes where practical. The Scheme diversifies its investment portfolio by investing in money market instruments and equity portfolios managed by reputable asset managers.

The Audit and Investment Committee monitors the performance of the Scheme's investment portfolio to ensure performance in accordance with the agreed mandates.

The investments for the purposes of the financial statements comprise of financial assets at fair value through profit and loss.

	2025 R	2024 R
Financial assets at fair value through profit and loss are made up of the following:		
Investments in linked insurance policies	226,017,341	188,172,071
	<u>226,017,341</u>	<u>188,172,071</u>

Analysis of carrying amounts of financial assets and financial liabilities per category

The following table compares the fair value and carrying amounts of assets and liabilities per class of assets and liabilities. The carrying amounts approximate the fair value amounts.

	Financial assets at fair value through profit or loss	Financial assets at amortised cost	Insurance contract liability	Financial liabilities at amortised cost
31 December 2025	R	R	R	R
Financial assets at fair value through profit or loss	226,017,341			
Other financial assets at amortised cost		191,965		
Cash and cash equivalents		31,779,399		
Insurance contract liability for current members			28,198,536	
Liability to members for future benefits			229,001,156	
Financial liabilities at amortised cost				789,013
	226,017,341	31,971,364	257,199,692	789,013

14. FINANCIAL RISK MANAGEMENT REPORT (continued)

Investment risk (continued)

	Financial assets at fair value through profit or loss	Financial assets at amortised cost	Insurance contract liability	Financial liabilities at amortised cost
31 December 2024	R	R	R	R
Financial assets at fair value through profit or loss	188,172,071			
Other financial assets at amortised cost		285,706		
Cash and cash equivalents		22,278,233		
Insurance contract liability for current members			27,316,830	
Liability to members for future benefits			182,631,085	
Financial liabilities at amortised cost				788,095
	188,172,071	22,563,939	209,947,915	788,095

Credit risk

Credit risk is the risk of financial loss resulting from a counterparty's failure to meet their contractual obligations. The Scheme does not have significant credit risk arising from reinsurance contract assets or insurance assets. The reinsurance agreements are used to manage insurance risk. This does not, however, discharge the Scheme's liability as the primary insurer. If a reinsurer fails to pay a claim for any reason, the Scheme remains liable for the payment to the member.

Exposures to individual members are managed by adhering to the requirements of Section 26(7) of the Medical Schemes Act 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 all members where contributions have not been received for 60 days. The credit risk is taken into account when the expected contribution is calculated.

The Scheme's principal financial assets are cash and cash equivalents, financial assets at amortised cost and investments. The Scheme's credit risk is primarily attributable to its trade and other receivables.

Insurance contract assets

- Contributions due from members
- Amounts recoverable from members and suppliers in respect of claims debt

Other receivables

Other receivables comprises:

- Interest receivable: and
- Sundry receivables.

The Scheme manages credit risk by:

- Actively pursuing all contributions after 3 days of becoming due, as required by S26(7) of the Medical Schemes Act, of South Africa;
- Suspending benefits on members' accounts whose contributions have not been received for 30 days;
- Terminating benefits on members' accounts whose contributions have not been received for 60 days; and
- Ageing and pursuing unpaid accounts on a monthly basis.

14. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Cash and cash equivalents

The Scheme has no significant concentration of credit risk. Cash transactions are limited to financial institutions with a high credit rating. The Scheme has a policy of limiting the amount of credit exposure to any one financial institution.

Exposure to credit risk

The carrying amount of Insurance contract assets, as included in the Insurance contract liabilities, and Financial assets at amortised cost represents the maximum credit exposure. The maximum exposure to credit risk at the reporting date was:

	Carrying amount	
	2025 R	2024 R
Financial assets at fair value through profit or loss	226,017,341	188,172,071
Financial assets at amortised cost	191,965	285,706
Cash and cash equivalents	31,779,399	22,278,233
	<u>257,988,705</u>	<u>210,736,010</u>

The Scheme ages and pursues unpaid accounts in terms of the Scheme's approved debt policy. The tables below highlight Insurance contract assets which are due, past due (by number of days) and are used to project the insurance contract cash flows that are not recoverable.

	2025	2024
	R	R
Insurance contract asset		
Not past due	816,580	949,802
Past due 1 - 30 days	98,049	126,172
Past due 31 - 60 days	83,726	47,723
Past due 61 - 150 days	142,026	58,850
151 days to more than 1 year	803,143	780,707
Past due, not impaired	156,555	173,895
Past due, expected credit loss	808,911	63,271
	<u>2,908,990</u>	<u>2,200,420</u>

Investments

The Scheme limits its exposure to credit risk by investing in liquid securities and only with counterparties that have high credit ratings. The Trustees do not expect any counterparty to fail to meet its obligations. Annexure B to Regulation 30 to the Medical Schemes Act of South Africa, prescribes the credit limits per institution which reduces the individual risk per institution. The utilisation of these limits are regularly monitored.

14. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Exposure to credit risk (continued)

The table below shows the credit limit and balances of cash and cash equivalents and money market instruments held at five major counterparties at year end which is in compliance with Annexure B of the Regulations. The statutory credit limit is calculated as 35% of the aggregate fair value of liabilities and accumulated funds.

	2025		2024	
	Credit limit	Balance	Credit limit	Balance
	R	R	R	R
Firstrand Bank Limited	90,228,859	8,287,094	73,657,606	9,660,080
ABSA Bank Limited	90,228,859	16,454,196	73,657,606	15,475,593
Standard Bank Limited	90,228,859	7,839,388	73,657,606	6,554,771
Nedbank Limited	90,228,859	14,446,478	73,657,606	18,716,732
Investec Bank Limited	90,228,859	13,018,106	73,657,606	5,892,300

No credit limits were exceeded during the reporting period and the Trustees do not expect any losses from non-performance of these counterparties.

Credit quality of insurance contract assets

The credit quality of insurance contract assets as presented above can be assessed by reference to historical information about counterparty default.

	2025	2024
	R	R
<i>Insurance contract asset</i>		
Counterparties without external credit ratings		
Insurance revenue outstanding	699,165	734,146
Member claims debtors	495,106	523,006
Provider claims debtors	637,418	706,102
Forensic receivables	111,834	29,966
	<u>1,943,523</u>	<u>1,993,220</u>

Insurance revenue outstanding

The Scheme collects over 98% of outstanding contributions in the month following the contributions being due. Therefore, the Scheme can establish that the credit quality of contribution debtors is high and no additional disclosure of the credit quality is provided.

Outstanding contributions arise due to:

- Addition of dependants;
- Non-payment for new members;
- Electronic payment rejection; and
- Change in contribution rates.

The above is managed by applying the approved credit control policy. Members are either suspended or terminated for outstanding contributions. The application thereof assists in that the Scheme's financial risk is managed. The procedures as set out in the policy are communicated to the member prior to suspension or termination of members.

14. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Credit quality of insurance contract assets (continued)

There are no variances in application of policies from the previous years.

Withdrawn member claims debtors

These amounts are due from members that have withdrawn from the Scheme. The Scheme estimates that 95% (2024: 82%) of these receivables are not recoverable. This has been taken into account in the insurance contracts fulfilment cash flows.

The debt may arise due to the following:

- Over-utilisation of benefits;
- Depletion of annual benefits; and
- Termination of member or dependants.

The above is managed by applying the approved credit control policy. The application thereof assists in that the Scheme's financial risk is managed. The procedures as set out in the policy are communicated to the member prior to suspension or termination of members.

There are no variances in application of policies from the previous years.

Service provider claims debtors

These debtors are the healthcare providers of the Scheme. The amounts due to the Scheme are offset against future payments to be made to these providers. The Scheme estimates that 71% (2024: 60%) of these receivables are not recoverable. This has been taken into account in the insurance contracts fulfilment cash flows.

The debt may arise due to the following:

- Reversals done incorrectly;
- Paying the healthcare professional directly instead of the member;
- Overpayment of claims;
- Claims erroneously submitted by healthcare professional (member did not consult doctor);
- Healthcare professional claiming on incorrect membership number or incorrect dependant;
- Duplicated claim;
- Claim paid on incorrect practice number; and
- Incorrect chargeable codes paid;

Forensic receivables

Forensic debt recovery mechanisms primarily include Acknowledgement of Debt (AOD), reversals, and cost adjustments. AOD amounts are recovered through various means such as debit orders, Electronic Fund Transfers (EFTs) or direct deposits into the bank account, which undergo continuous monitoring.

Financial assets held at fair value through profit or loss and cash and cash equivalents

The Scheme manages credit risk on its investment portfolios through the appointment of reputable and appropriate asset managers, extensive diversification and ongoing monitoring and management of credit risk exposures and portfolio holdings.

At 31 December 2025 and 2024, the Scheme only held instruments subject to credit risk with credit ratings between AAA and BBB+ (Moody's).

14. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Financial assets held at fair value through profit or loss and cash and cash equivalents (continued)

These investments are included in Financial assets at fair value through profit or loss in the Statement of Financial Position and no other material risks relating to these investments have been identified other than those already disclosed.

		2025	2024
Counterparties with external credit ratings (Moody's)			
<i>Cash and cash equivalents</i>			
Current accounts	Ba2	2,801,943	3,086,251
Money Market	Ba2	28,977,456	19,191,982
		<u>31,779,399</u>	<u>22,278,233</u>
<i>Financial assets at fair value through profit or loss</i>			
Allan Gray Stable Medical Scheme Portfolio Fund	Not rated	146,259,991	126,568,754
Allan Gray Domestic Equity Portfolio Fund	Not rated	79,757,350	61,603,317
		<u>226,017,341</u>	<u>188,172,071</u>

Cash and cash equivalents are only placed with reputable financial institutions with a high credit quality. The Scheme has a policy of limiting the amount of credit exposure to any one financial institution.

Unconsolidated investment structures

The Scheme has involvement with investment funds in which it invests but it does not consolidate. The investment funds meet the definition of structured entities because:

- The voting rights in the funds are not dominant rights in deciding who controls them because they relate to the administrative tasks only;
- each fund's activities are restricted by prospectus; and
- the funds have narrow and well-defined objectives to provide investment opportunities.

The asset managers invest the Scheme's monies in reputable funds which generate returns for the Scheme. The Scheme views these funds as unconsolidated structured entities. The Scheme monitors the performance of the funds closely to ensure the Scheme earns high returns without unnecessary exposure to risk.

The Scheme has investments in certain pooled portfolios and collective investment schemes (the Funds) as listed in the table below. The exposure the Scheme has to these Funds is also listed in the table. The Scheme's maximum exposure is limited to the total fair value of its investments in the Funds.

Fund	2025		2024	
	Fair value of fund assets held R	% Fund exposure attributable to Scheme	Fair value of fund assets held R	% Fund exposure attributable to Scheme
Allan Gray Stable Medical Scheme Portfolio Fund	146,259,991	4.22%	126,568,754	3.98%
Allan Gray Domestic Equity Portfolio Fund	79,757,350	1.55%	61,603,317	1.57%

14. FINANCIAL RISK MANAGEMENT REPORT (continued)

Liquidity risk

Liquidity risk is the risk that the Scheme will not have sufficient liquid funds available to settle financial obligations as they fall due.

The Scheme's approach to managing liquidity is to ensure, with significant conservative margin, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation.

The Scheme has complied with the requirements regarding the nature and categories of assets as prescribed by Section 35 and Regulation 30 of the Act.

Approximately 99% of the Scheme's insurance liabilities are settled within four months after the claim was incurred and the remaining liability is settled within eight months.

An expected maturity analysis for all assets and liabilities is provided below:

31 December 2025	Up to 1 month R	>1 - 12 months R	> 12 months R	Total R
Assets	2,993,908	254,994,797	-	257,988,705
Financial assets at fair value through profit or loss	-	226,017,341	-	226,017,341
Other financial assets at amortised cost	191,965	-	-	191,965
Cash and cash equivalents	2,801,943	28,977,456	-	31,779,399
Liabilities	(3,297,253)	(2,007,943)	(252,683,508)	(257,988,705)
Liability to members for future benefits	-	-	(229,001,156)	(229,001,156)
Insurance contract liability for current members	(2,508,240)	(2,007,943)	(23,682,352)	(28,198,536)
Financial liabilities at amortised cost	(789,013)	-	-	(789,013)
Net assets/liabilities	(303,345)	252,986,854	(252,683,508)	-

14. FINANCIAL RISK MANAGEMENT REPORT (continued)

Liquidity risk (continued)

31 December 2024	Up to 1 month R	>1 - 12 months R	> 12 months R	Total R
Assets	3,371,957	207,364,053	-	210,736,010
Financial assets at fair value through profit or loss	-	188,172,071	-	188,172,071
Other financial assets at amortised cost	285,706	-	-	285,706
Cash and cash equivalents	3,086,251	19,191,982	-	22,278,233
Liabilities	(3,483,134)	(30,595,730)	(176,657,146)	(210,736,010)
Liability to members for future benefits	-	(5,973,939)	(176,657,146)	(182,631,085)
Insurance contract liability for current members	(2,695,039)	(24,621,791)	-	(27,316,830)
Financial liabilities at amortised cost	(788,095)	-	-	(788,095)
Net assets/liabilities	(111,177)	176,768,323	(176,657,146)	-

Fair value estimation

Financial instruments

The fair value of financial instruments traded in active markets is based on quoted market prices at the reporting date. The quoted market price used for financial assets held by the Scheme is the current closing price.

The fair value of financial instruments that are not traded in an active market is determined by using valuation techniques. These valuation techniques maximise the use of observable market data where it is available and rely as little as possible on entity-specific estimates. Specific valuation techniques used to value financial instruments include quoted market prices or dealer quotes for similar instruments.

The carrying value of Financial assets at amortised cost are assumed to approximate their fair values due to their short-term nature.

Valuation of financial instruments by hierarchy level

The Scheme measures fair values using the following fair value hierarchy that reflects the significance of the inputs used in making the measurements:

Level 1:

Quoted prices (unadjusted) in active markets for identical assets or liabilities. These are readily available in the market and normally obtainable from multiple sources.

Level 2:

Valuation techniques based on observable inputs, either directly (i.e. as prices) or indirectly (i.e. derived from prices). This category includes instruments valued using: quoted prices for identical or similar instruments in markets that are considered less than active, or other valuation techniques where all significant inputs are directly or indirectly observable from market data.

14. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Fair value estimation (continued)

Level 3:

Valuation techniques using significant unobservable inputs. This category includes all instruments where the valuation techniques include inputs not based on observable data and the unobservable inputs have a significant effect on the instruments' valuation. This category includes instruments that are valued based on quoted prices for similar instruments where significant unobservable adjustments or assumptions are required to reflect differences between instruments.

	Level 1 R	Level 2 R	Total R
2025			
Financial assets at fair value through profit or loss			
Linked Insurance Policies	-	226,017,341	226,017,341
	<u>-</u>	<u>226,017,341</u>	<u>226,017,341</u>
	Level 1 R	Level 2 R	Total R
2024			
Financial assets at fair value through profit or loss			
Linked Insurance Policies	-	188,172,071	188,172,071
	<u>-</u>	<u>188,172,071</u>	<u>188,172,071</u>

Level 2 investments are valued using market-based techniques that maximise observable inputs while limiting entity specific assumptions. Interest bearing stocks are valued using the JSE pricing file, which incorporates observable market data such as market yield curves and credit spreads rather than directly observed trade prices, resulting in Level 2 classification. Money market instruments are valued using a discounted cash flow approach that applies observable market interest rate curves; however, because these valuations are not based on directly quoted trading prices of the underlying instruments, they are classified as Level 2. Instrument details and curve yields are used to determine the instrument fair value.

Capital risk management

Capital adequacy risk is the risk that there may be insufficient reserves to provide for adverse variations on actual or expected future experience.

The Scheme's objective is to manage its capital in such a way that the annual contribution increase to members is as low as possible and to remain a going concern. The Scheme therefore uses investment income and the investments to fund any possible deficit that might occur as a result of operational losses.

14. FINANCIAL RISK MANAGEMENT REPORT (continued)

Capital risk management (continued)

The calculation of the regulatory capital requirement is set out below.

	2025 R	2024 R
Liability to members for future benefits per the Statement of Financial Position	229,001,156	182,631,085
Less: cumulative unrealised net gain on remeasurement of investments to fair value	(126,474,540)	(87,952,465)
Accumulated funds per Regulation 29 of the Act	<u>102,526,616</u>	<u>94,678,620</u>
Gross annual contributions	172,742,303	164,634,371
Insurance revenue (Note 4)	138,234,795	131,824,620
Medical savings contributions received (Note 4)	34,507,508	32,809,751
Solvency margin	59.35%	57.51%

The accumulated funds ratio above compares favourably to the minimum prescribed accumulated funds ratio of 25%.

15. NON-COMPLIANCE MATTERS

Circular 11 of 2006 (the Circular) issued by the Council for Medical Schemes (the CMS) deals with issues to be addressed in the audited Financial Statements of medical schemes. This includes the requirement that all instances of non-compliance be disclosed in the audited Financial Statements, irrespective of whether the auditor considers them to be material or not.

During 2025, the Scheme did not comply with the following Sections and Regulations of the Act.

15.1 Non-compliance with Section 26(7) – Late payment of contributions

Nature and impact

In terms of Section 26(7) of the Medical Schemes Act of South Africa (the Act), all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment thereof becoming due.

Causes of failure

Although the majority of contribution payments were made within the stipulated payment deadlines, there were a small number of instances where the Scheme received contributions after three days of becoming due. These contributions equate to less than 0.04% of the gross contributions billed and were received within the month of them becoming due. Such arrear payments are outside the agreed contribution collection agreements with paying parties and are actively addressed as and when they occur.

Corrective action

The procedures that the Scheme follows for collection of these arrear contributions are aligned with its credit risk management policies in Note 14.

15. NON-COMPLIANCE MATTERS (continued)

15.2 Non-compliance with Section 59(2) – Payment of claims within 30 days

Nature and impact

In terms of Section 59(2) of the Medical Schemes Act of South Africa, a medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.

Causes of failure

This usually resulted from members or providers submitting claims without the necessary details required for these payments to be made timeously. These are isolated cases and thus do not have a material effect on the Scheme.

Corrective action

Management have implemented a process to monitor claims made by members and providers on a monthly payment cycle and ensure that payment is performed within 30 days.

15.3 Non-compliance with Section 35(8)(a) – Investments in participating employers

Nature and impact

As at 31 December 2025, the Scheme indirectly through its holdings in the Allan Gray portfolios held shares in AVI Ltd, a participating employer of the Scheme, amounting to R899 928 (2024: R642 117) and R988 919 (2024: R409 080) in African Rainbow Minerals Ltd.

Causes for the failure

Ordinarily this would be in contravention of Section 35(8) of the Act, which, inter alia, prohibits a medical scheme from investing any of its assets in an employer that participates in that scheme. However, as funds in these specific portfolios are structured at the sole discretion of the asset manager in a manner that maximizes the return on investment, and neither the Scheme nor these employers provide input into the structuring of the portfolio, the Scheme has received exemption from the Council for Medical Schemes for compliance with this Section of the Act.

Corrective action

The Scheme applied to the CMS and received an exemption from this section of the Act. The exemption is granted to 31 December 2028.

15.4 Non-compliance with Section 35(8)(c) – Investments in any administrator

Nature and impact

Section 35(8)(c) of the Act states that a medical scheme shall not invest any of its assets in any administrator. During the year the Scheme had exposure to such investments through pooled investment vehicles.

At 31 December 2025, the Scheme indirectly through its holdings in the Allan Gray portfolios held shares in Momentum Metropolitan Holdings Limited R1 034 984 (2024: R1 240 784).

Causes of failure

Ordinarily this would be in contravention of Section 35(8) of the Act which, inter alia, prohibits medical schemes from holding shares in any other medical scheme, any administrator and any person associated with any of these. However, as funds in these portfolios are structured at the sole discretion of the asset manager in a manner that maximises returns and the Scheme provides no input into the structuring of the portfolios, the Scheme has received exemption from the Council for Medical Schemes for compliance with this Section of the Act.

15. NON-COMPLIANCE MATTERS (continued)

15.4 Non-compliance with Section 35(8)(c) – Investments in any administrator (continued)

Corrective action

The Scheme applied to the CMS and received an exemption from this section of the Act. The exemption is granted to 31 December 2028.

15.5 Limitation of assets – Policies of Insurance

Nature and impact

In terms of the explanatory notes and conditions for Annexure B to Regulation 30 of the Act, the Policies of Insurance held in category 6(a)(ii) shall not be more than 90% of the aggregate of the fair value of liabilities and the minimum accumulated funds to be maintained by a medical scheme in accordance with Regulation 29 of the Act. As at 31 December 2025, the Schemes' total investments in Policies of Insurance exceeded the limitation as per category 6(a)(ii) per Annexure B.

Corrective action

Regulation 30(3A) states that a certified statement, from a suitably qualified professional, that indicates that alternative percentages should apply to such assets, can be provided to the Registrar of Medical Schemes. The Scheme will update its annual Regulation 30(3A) certificate in order to include these excess investments in Policies of Insurance.

1. DESCRIPTION OF THE SCHEME

1.1. Terms of registration

The Anglovaal Group Medical Scheme is a not-for-profit restricted membership Scheme registered in terms of the Medical Schemes Act of South Africa ("the Act").

1.2. Benefit options within the Anglovaal Group Medical Scheme

The Scheme offers one (1) benefit option.

1.3. Savings plan

To provide a facility for Scheme members to set funds aside to meet day-to-day and other healthcare costs not covered by the 'risk' benefits in the option, the Trustees have made a personal medical savings account available.

Contributions to the personal medical savings accounts (MSA) are set and the total available amount is based on family size and the member's income level. The amounts contributed to the personal MSA do not exceed 20% (twenty percent) of the member's total medical scheme contribution.

The liability to the members in respect of the savings plan is reflected as part of the insurance contract liability as required by IFRS 17, and is repayable in terms of Regulation 10.

In terms of the rules of the Scheme, the savings plan is underwritten by the Scheme.

2. MANAGEMENT

2.1. Board of Trustees in office during the year and at the date of this report was:

M Koursaris	Chairman - Member Elected Trustee
I Masike	Member Elected Trustee
H de Groot	Employer Appointed Trustee
A Ahmed	Employer Appointed Trustee
O Bergman	Employer Appointed Trustee
A Mills	Member Elected Trustee
M Stevenson	Employer Appointed Trustee
J Laubscher	Member elected trustee

2.2. Principal Officer:

V Crystal

2 Harries Road
Illovo
2196

PO Box 1897
Saxonwold
2132

3. INVESTMENT AND FIXED ASSET POLICY OF THE SCHEME

The Trustees continue to invest funds in line with the requirements of the Act. The Scheme continues to pursue a strategy that maximizes returns on a long-term basis at an acceptable risk.

4. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

4.1. Operational statistics

	2025	2024
Number of members at the end of the accounting period	2,146	2,205
Number of beneficiaries at the end of the accounting period	4,126	4,281
Average number of members for the accounting period	2,186	2,209
Average number of beneficiaries for the accounting period	4,212	4,300
Average age of beneficiaries for the accounting period	40.96	40.68
Pensioner ratio (beneficiaries > 65 years)	20.2%	20.2%
Beneficiary ratio at 31 December	1.92	1.94
Average net insurance revenue pmpm (R)	R 5,270.71	R 4,972.07
Average net insurance revenue pbpm (R)	R 2,735.16	R 2,566.08
Relevant healthcare expenditure as a percentage of net insurance revenue	87.3%	97.5%
Relevant healthcare expenditure pmpm (R)	R 4,598.60	R 4,847.64
Relevant healthcare expenditure pbpm (R)	R 2,435.92	R 2,501.86
Directly attributable insurance service expenses as a percentage of insurance revenue	92.9%	103.3%
Directly attributable insurance service expenses pmpm (R)	R 4,896.53	R 5,137.09
Directly attributable insurance service expenses pbpm (R)	R 2,540.98	R 2,649.53
Administration expenses as a percentage of gross insurance revenue	6.1%	5.8%
Average administration costs pmpm (R)	R 401.71	R 357.59
Average administration costs pbpm (R)	R 208.46	R 184.55
Managed care: Management services as a percentage of gross insurance revenue	1.3%	1.4%
Average managed care: Management services pmpm (R)	R 87.98	R 85.14
Average managed care: Management services pbpm (R)	R 45.66	R 43.75
Accumulated funds per member at 31 December	R 106,710.70	R 82,825.89

* Relevant healthcare expenditure includes all claims and managed care expenditure as defined in the Act.

4.2. Results of operations

The results of the Scheme are set out in the financial statements and the Trustees believe that no further clarification is required.

4. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

4.3. Solvency ratio

The solvency ratio is calculated on the following basis:

Liability to members for future benefits as per Statement of financial position

- Less fair value adjustment on investments held at fair value through profit or loss

Accumulated funds per Regulation 29

Gross annual contributions

Solvency ratio

= Accumulated funds/gross annual contributions x 100

Cumulative net gains on re-measurement to fair value are calculated as follows:

Net cumulative gain at the beginning of the period

Total fair value adjustment on financial assets at fair value through profit or loss

Realised gains on derecognition of financial assets at fair value through profit or loss

Cumulative net gain on remeasurement to fair value of financial assets at fair value through profit or loss in accumulated funds

	2025 R	2024 R
	229,001,156	182,631,085
	(126,474,540)	(87,952,465)
	<u>102,526,616</u>	<u>94,678,620</u>
	<u>172,742,303</u>	<u>164,634,371</u>
	<u>59.35%</u>	<u>57.51%</u>
	2025 R	2024 R
	(87,952,465)	(75,040,031)
	(39,224,281)	(19,474,374)
	702,206	6,561,940
	<u>(126,474,540)</u>	<u>(87,952,465)</u>

4.4. Liabilities for incurred claims

The basis of calculation of the Liability for incurred claims is set out in Note 13 to the Financial statements. There have been no unusual movements which the Trustees believe should be brought to the attention of the members of the Scheme.

5. ACTUARIAL SERVICES

The Scheme's actuaries have been consulted in the determination of the contribution and benefit levels. The Scheme's actuaries also calculate the annual budget and monthly actuarial reports of the Scheme, including the monthly Liability for incurred claims.

6. EVENTS AFTER THE REPORTING DATE

There have been no events that occurred subsequent to the end of the accounting period that affect the statements and that the Trustees consider should be reported.

7. INVESTMENTS IN PARTICIPATING EMPLOYERS AND OTHER RELATED PARTIES

The Scheme had invested in various portfolios, which in turn held shares in African Rainbow Minerals Ltd and AVI Ltd, participating employers of the Scheme.

Discovery Health (Pty) Ltd is the administrator of the Scheme.

Payments are made in terms of the administration and managed care agreements, reviewed for 2025 at the end of 2024, with Discovery Health (Pty) Ltd. Fees were paid as follows:

	2025	2024
	R	R
Discovery Health (Pty) Ltd	10,715,966	10,483,723
Administration fees	8,408,500	8,226,386
Managed care: management services fees	2,307,466	2,257,337

The Scheme appointed consultants to the Scheme and their fees were paid as follows:

Consultation fees		
Insight Actuaries and Consultants	461,819	470,891

8. AUDIT AND INVESTMENT COMMITTEE

An audit and investment committee (the Committee) was established in accordance with the provisions of the Act. The Committee is mandated by the Board of Trustees by means of written terms of reference as to its membership, authority and duties. The Committee consists of five members of which two are members of the Board of Trustees. The Committee met on three occasions during the course of the year as follows:

- 10 April 2025
- 11 September 2025
- 20 November 2025

The Principal Officer, Chairman of the Board of Trustees and the Administrator attend all Committee meetings and have unrestricted access to the Chairman of the Committee. The external auditors of the Scheme attend meetings on invitation only.

In accordance with the provisions of the Act, the primary responsibility of the Committee is to assist the Board of Trustees in carrying out its duties relating to the Scheme's accounting policies, internal control systems and financial reporting practices. The external auditors formally report to the Committee on critical findings arising from audit activities.

This Committee also acts as an investment committee.

The Committee presently comprises: M Koursaris, S Chatrooghoon, J Fourie , I Masike and R van der Laan (Chairman).

9. NON-COMPLIANCE MATTERS

Non-compliance with Section 26(7) – Late payment of contributions

Nature and impact

In terms of Section 26(7) of the Medical Schemes Act of South Africa (the Act), all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment thereof becoming due.

Causes of failure

Although the majority of contribution payments were made within the stipulated payment deadlines, there were a small number of instances where the Scheme received contributions after three days of becoming due. These contributions equate to less than 0.04% of the gross contributions billed and were received within the month of them becoming due. Such arrear payments are outside the agreed contribution collection agreements with paying parties and are actively addressed as and when they occur.

Corrective action

The procedures that the Scheme follows for collection of these arrear contributions are aligned with its credit risk management policies in Note 14.

Non-compliance with Section 59(2) – Payment of claims within 30 days

Nature and impact

In terms of Section 59(2) of the Medical Schemes Act of South Africa, a medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.

Causes of failure

This usually resulted from members or providers submitting claims without the necessary details required for these payments to be made timeously. These are isolated cases and thus do not have a material effect on the Scheme.

Corrective action

Management have implemented a process to monitor claims made by members and providers on a monthly payment cycle and ensure that payment is performed within 30 days.

Non-compliance with Section 35(8)(a) – Investments in participating employers

Nature and impact

As at 31 December 2025, the Scheme indirectly through its holdings in the Allan Gray portfolios held shares in AVI Ltd, a participating employer of the Scheme, amounting to R899 928 (2024: R642 117) and R988 919 (2024: R409 080) in African Rainbow Minerals Ltd.

Causes for the failure

Ordinarily this would be in contravention of Section 35(8) of the Act, which, inter alia, prohibits a medical scheme from investing any of its assets in an employer that participates in that scheme. However, as funds in these specific portfolios are structured at the sole discretion of the asset manager in a manner that maximizes the return on investment, and neither the Scheme nor these employers provide input into the structuring of the portfolio, the Scheme has received exemption from the Council for Medical Schemes for compliance with this Section of the Act.

9. NON-COMPLIANCE MATTERS (continued)

Non-compliance with Section 35(8)(a) – Investments in participating employers (continued)

Corrective action

The Scheme applied to the CMS and received an exemption from this section of the Act. The exemption is granted to 31 December 2028.

Non-compliance with Section 35(8)(c) – Investments in any administrator

Nature and impact

Section 35(8)(c) of the Act states that a medical scheme shall not invest any of its assets in any administrator. During the year the Scheme had exposure to such investments through pooled investment vehicles.

At 31 December 2025, the Scheme indirectly through its holdings in the Allan Gray portfolios held shares in Momentum Metropolitan Holdings Limited R1 034 984 (2024: R1 240 784).

Causes of failure

Ordinarily this would be in contravention of Section 35(8) of the Act which, inter alia, prohibits medical schemes from holding shares in any other medical scheme, any administrator and any person associated with any of these. However, as funds in these portfolios are structured at the sole discretion of the asset manager in a manner that maximises returns and the Scheme provides no input into the structuring of the portfolios, the Scheme has received exemption from the Council for Medical Schemes for compliance with this Section of the Act.

Corrective action

The Scheme applied to the CMS and received an exemption from this section of the Act. The exemption is granted to 31 December 2028.

Limitation of assets – Policies of Insurance

Nature and impact

In terms of the explanatory notes and conditions for Annexure B to Regulation 30 of the Act, the Policies of Insurance held in category 6(a)(ii) shall not be more than 90% of the aggregate of the fair value of liabilities and the minimum accumulated funds to be maintained by a medical scheme in accordance with Regulation 29 of the Act. As at 31 December 2025, the Schemes' total investments in Policies of Insurance exceeded the limitation as per category 6(a)(ii) per Annexure B.

Corrective action

Regulation 30(3A) states that a certified statement, from a suitably qualified professional, that indicates that alternative percentages should apply to such assets, can be provided to the Registrar of Medical Schemes. The Scheme will update its annual Regulation 30(3A) certificate in order to include these excess investments in Policies of Insurance.

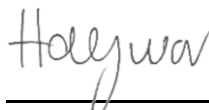
10. MEETING ATTENDANCE

The following schedule sets out trustee meeting attendances where column A indicates the total number of meetings that could have been attended and B the actual number of meetings attended:

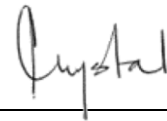
Trustee	Board of Trustees meetings		Audit and Investment Committee meetings		Management Committee meetings	
	A	B	A	B	A	B
V Crystal	4	4	3	3	3	3
M Coursaris	4	4	3	3	3	3
I Masike	4	4	3	3	-	-
H de Groot	4	4	-	-	-	-
O Bergman	4	4	-	-	-	-
A Mills	4	4	-	-	-	-
J Laubscher	4	2	-	-	-	-
A Ahmed	4	4	-	-	-	-
M Stevenson	4	4	-	-	-	-
R van der Laan	-	-	3	3	-	-
J Fourie	-	-	3	3	-	-
S Chatrooghoon	-	-	3	3	-	-



M Coursaris
CHAIRMAN



H de Groot
TRUSTEE



Vivien Crystal
PRINCIPAL OFFICER

30 April 2026

**Anglovaal Group Medical Scheme
Proxy Form for the Annual General
Meeting 2 June 2026**

Membership Number

I (Name in block letters).....

Of Address:

Being a principal member of Anglovaal Group Medical Scheme, hereby appoint:

1.,with member number.....; or failing him/her
2.,with member number.....; or failing him/her
3. The Principal Officer of the Scheme; or failing him/her
4. The Chairman of the Annual General Meeting;

as my proxy to vote for me on my behalf at the Annual General Meeting of the Scheme to be held on 2 June 2026 at 10h00.

Signed at on this day of 2026

Signature:

NOTES

- The person whose name is listed first on the Proxy Form and who is present at the Annual General Meeting will be entitled to act as proxy to the exclusion of those whose names follow.
- The completion and lodging of this Proxy Form will not preclude the relevant member from attending the Annual General Meeting and speaking and voting in person thereat to the exclusion of any proxy appointed in terms hereof, should such members wish to do so.
- Proxy Forms must be lodged at, or posted to the Principal Officer c/o Nadine Naidoo, Anglovaal Group Medical Scheme, AGM Motions, P O Box 652509, Benmore, 2010, faxed to (011) 539-1018, or emailed to avgmsagm@discovery.co.za. Proxies to be received no later than 12h00 on 29 May 2026.