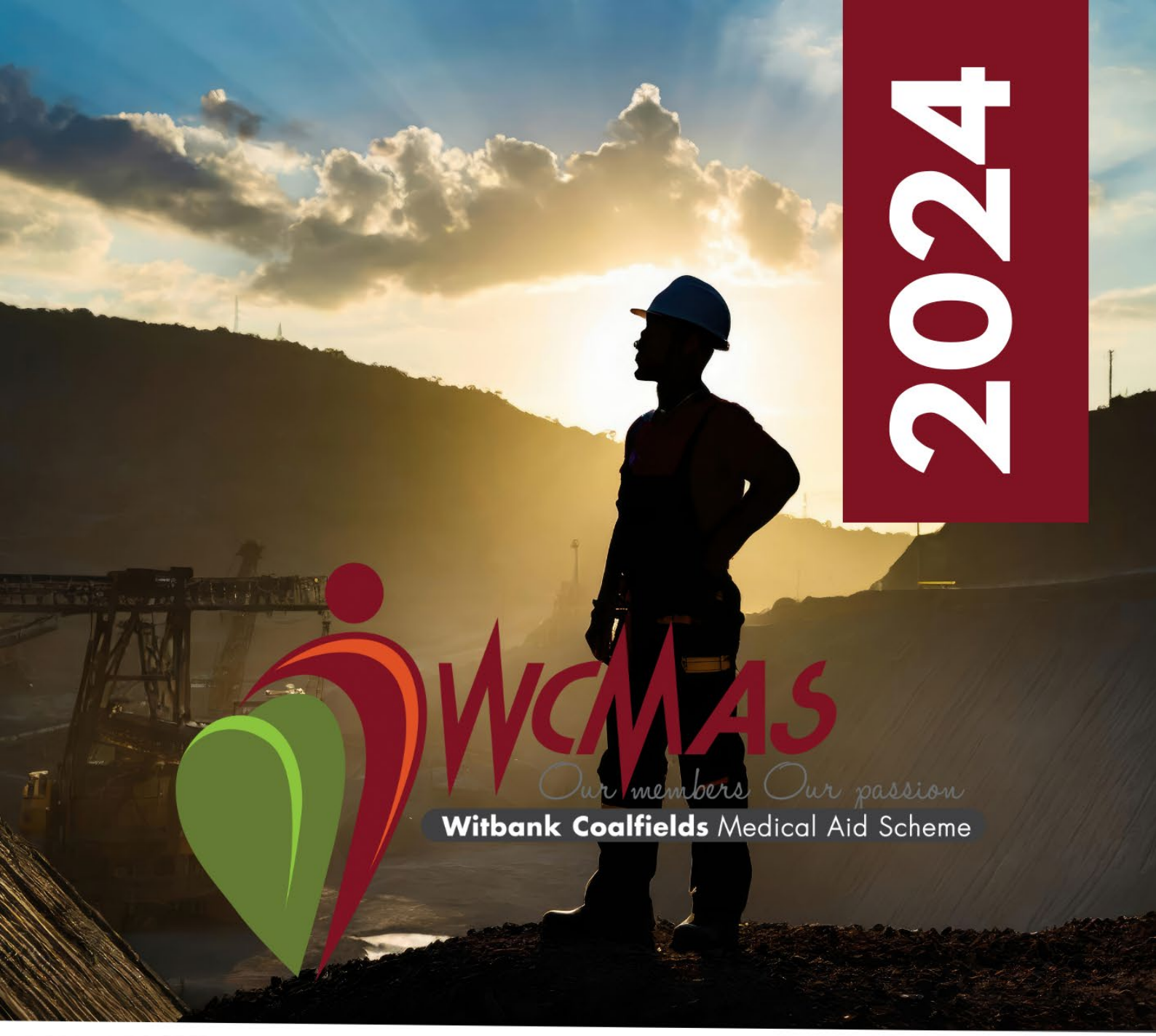


ANNUAL REPORT

CELEBRATING 90 years 2025

CONTENTS

WCMAS
Our members Our passion
Witbank Coalfields Medical Aid Scheme

PERFORMANCE SNAPSHOT

MEMBERSHIP TRENDS

- Principal members: **9,913** (2023: 9,538) ↑
- Total beneficiaries: **26,135** (2023: 25,085) ↑
- Average beneficiary age: **29.5** (2023: 29.5)
- Dependants per principal member: **1.6**
- Pensioner ratio: **5.1%** (2023: 5.1%)
- Chronic profile: **17.5%** (2023: 17.8%) ↓

VALUE CREATED FOR MEMBERS

- Claims paid: **R651million** (2023: R677million)
- Hospital authorisations: **5,450** (2023: 5,397)
- Non-healthcare expenses as a percentage of contributions: **5.6%** (2023: 6.2%)
- Managed care savings: **R28million** (2023: R20million)

ENSURING SUSTAINABILITY

- Insurance liability for future members: **R725million** (2023: R621million)
- Solvency ratio: **79.4%** (2023: 78.3%)
- Total investment portfolio excl cash: **R972million** (2023: R890million)
- Investment income: **R108million** (2023: R92million)
- Aggregate gross investment return: **10.1%** (2023: 9.5%)

REPORT OF THE BOARD OF TRUSTEES

The Board of Trustees hereby presents its report for the year ended 31 December 2024.

1. ABOUT WCMAS

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

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

WCMAS distinguishes itself through:

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

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

2. OPERATIONAL AND BUSINESS REVIEW

As a not-for-profit entity with strong financial reserves, the Scheme budgeted to break even, projecting a marginal surplus of R1.2 million after investment income for the 2024 financial year. However, the actual financial outcome significantly exceeded expectations, with a net surplus of R103 million. This surplus has been allocated to the liability for future members in the statement of profit or loss, reinforcing the Scheme's long-term sustainability and financial stability.

2.1 OPERATIONAL STATISTICS PER BENEFIT OPTION

2024		Comprehensive	Midmas	Ntsika	Scheme
Average number of members during the accounting period		6,608	1065	2,240	9,913
Number of members at 31 December		6,605	1187	2,138	9,930
Average number of beneficiaries during the accounting period		17,384	2,968	5,783	26,135
Number of beneficiaries at 31 December		17,359	3,308	5,464	26,131
Average family size at 31 December		2.6	2.8	2.6	2.6
Average beneficiary age as at 31 December		31.1	25.2	27.0	29.5
Pensioner ratio at 31 December	%	7.3	0.4	0.7	5.1
Insurance revenue per average beneficiary per month (pabpm)	R	2,159	1,303	1,172	1,843
Insurance service expenses pabpm	R	2,052	1,306	1,026	1,740
Relevant healthcare expenditure incurred pabpm	R	1,985	1,182	936	1,662
Directly attributable insurance service expenses pabpm	R	111	104	90	105
Insurance service expenses as a percentage of insurance revenue	%	95.1	100.2	87.5	94.4
Relevant healthcare expenditure ratio	%	92.0	90.7	79.9	90.2
Average members' funds per member as at 31 December*	R		72,971		
Return on investments as a percentage of investments*	%		10.1		

2023		Comprehensive	Midmas	Ntsika	Scheme
Average number of members during the accounting period		6,630	639	2,269	9,538
Number of members at 31 December		6,652	686	2,257	9,595
Average number of beneficiaries during the accounting period		17,457	1,804	5,823	25,085
Number of beneficiaries at 31 December		17,544	1,911	5,861	25,316
Average family size at 31 December		2.6	2.8	2.6	2.6
Average beneficiary age as at 31 December		30.9	25.3	26.4	29.5
Pensioner ratio at 31 December	%	7.2	0.3	0.5	5.1
Insurance revenue per average beneficiary per month (pabpm)	R	2,024	1,273	1,093	1,754
Insurance service expenses pabpm	R	2,252	1,295	1,168	1,931
Relevant healthcare expenditure incurred pabpm	R	2,178	1,180	1,047	1,844
Directly attributable insurance service expenses pabpm	R	102	92	105	102
Insurance service expenses as a percentage of insurance revenue	%	111.3	101.7	106.8	110.1
Relevant healthcare expenditure ratio	%	107.6	92.7	95.8	105.1
Average members' funds per member as at 31 December*	R		64,746		
Return on investments as a percentage of investments*	%		9.5		

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

2.2 BENEFIT OPTIONS

The Scheme's benefit options remained largely unchanged for the 2024 financial year, ensuring stability and continued value for members. WCMAS offers a range of tailored healthcare solutions designed to meet the diverse needs of its member base.

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

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

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

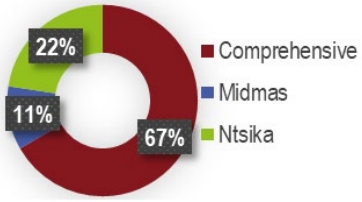
With its diverse benefit options, WCMAS continues to deliver cost-effective and high-quality medical cover, ensuring members receive the best possible healthcare solutions tailored to their needs.

2.3 MEMBERSHIP

The Scheme experienced positive organic growth of 3.5% during the year, with the addition of 335 new members. At the close of the financial year, the average age of beneficiaries remained at 29.5 years (2023: 29.5), which is significantly lower than the industry average of 34.0 years. Similarly, the pensioner ratio remained stable at 5.1% of total beneficiaries (2023: 5.1%), well below the industry average of 9.4%.

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

The distribution of membership across benefit options has remained relatively stable, with the Comprehensive Option maintaining its position as the most preferred choice, representing 67% of total membership (2023: 69%).



2.4 INSURANCE REVENUE

For the 2024 financial year, the Scheme budgeted for an annual contribution increase of 6.3%. However, the actual contribution increase per beneficiary was 5.1%, reflecting a lower-than-anticipated adjustment. This variance was primarily driven by a shift in membership demographics, with a higher proportion of child dependants, which resulted in a lower average contribution per beneficiary.

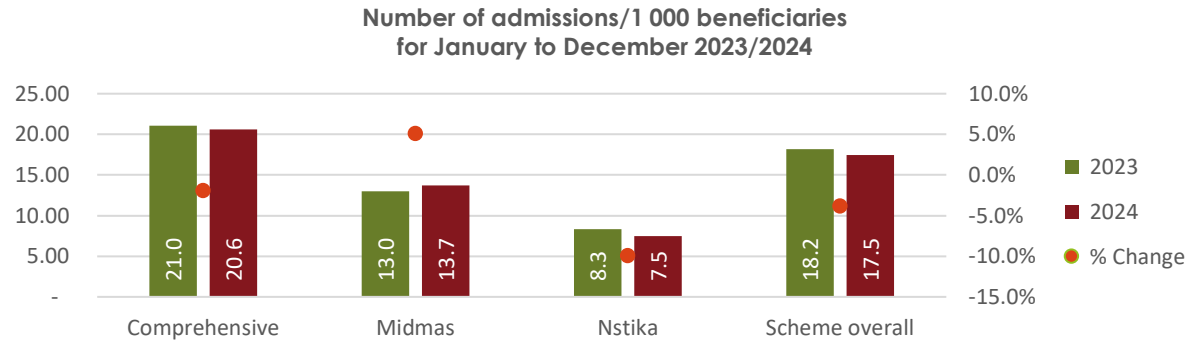
2.5 INSURANCE SERVICE EXPENSES

Medical inflation typically outpaces consumer inflation by 1 to 3 percentage points per annum. In anticipation of this trend, the Scheme budgeted for a 7.2% increase in claims expenditure for 2024. However, the actual claims incurred per beneficiary saw a notable decrease of 9.9%, reflecting a more favourable claims experience than projected.

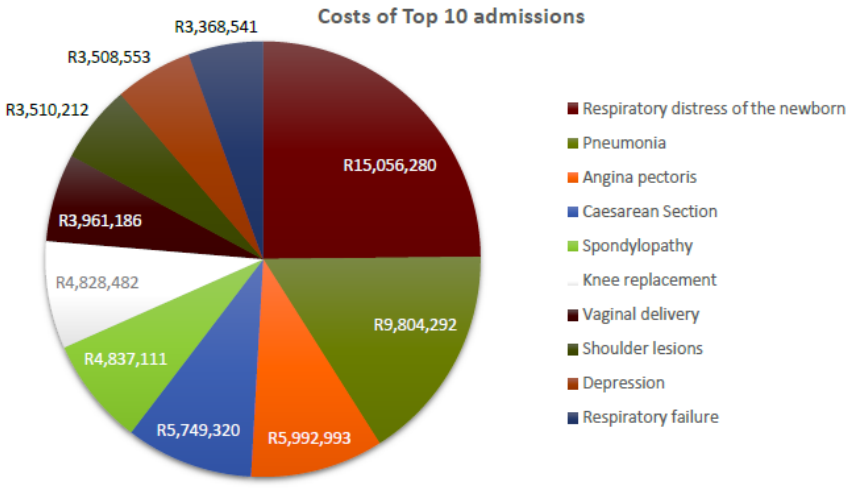
2.5.1 Hospitalization

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

The rate of hospital admissions declined by 3.9% year-on-year, contributing to the overall reduction in claims expenditure. This positive trend is illustrated in the graph below:



The overall cost per hospital admission increased by 6.3% compared to the previous year, remaining below the budgeted estimate of 7.2%. The top ten admission types by cost accounted for 26.7% of the total authorized hospital expenses for the year (2023: 27.1%), reflecting a consistent trend in hospital admission cost drivers:



The Scheme experienced a decrease in the number of high-cost claims during the year. A high-cost claim is defined as claims cost exceeding R350,000 for a single beneficiary within a benefit year. The total value of high-cost claims decreased by R22.4 million, now representing 41% of total claims, compared to 45% in 2023. This reduction was driven by:

- A 2.5% decrease in the number of high-cost cases.
- A 15.3% reduction in the average cost per case.

These positive trends have contributed to lower overall claims expenditure in hospital.

2.5.2 Chronic Conditions

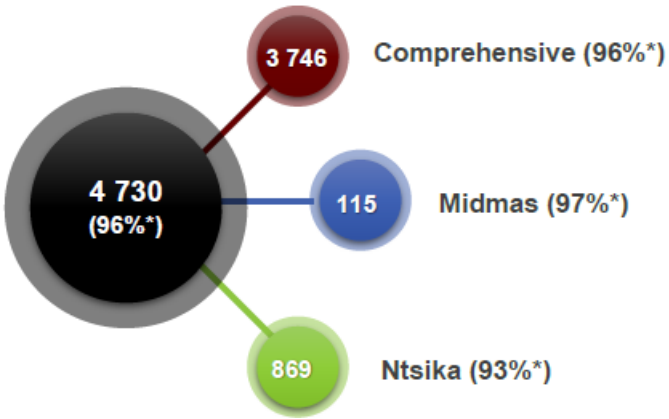
Chronic condition expenses represent a significant portion of overall healthcare costs and directly impact financial sustainability. These ongoing medical expenses, associated with conditions such as diabetes, hypertension, and heart disease, require continuous treatment, medication, and management,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

The Scheme's chronic medicine costs increased by 5.8%, which was significantly lower than the budgeted estimate of 7%. This controlled increase reflects effective cost management strategies and stable utilization trends.

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

Top 5 Chronic Conditions

In 2024, the Scheme continued to implement disease management programmes designed to enhance health outcomes for members living with chronic conditions, including HIV, Hypertension, Hyperlipidaemia, and Type 2 Diabetes. To further support members, the Scheme introduced a Mental Wellbeing Programme on 1 January 2025, aimed at managing mental health conditions such as Major Depression. These initiatives contribute to the Scheme's clinical risk management strategy by addressing prevalent chronic conditions and promoting proactive healthcare interventions.
During the year, 17.5% of beneficiaries were diagnosed with a chronic condition (2023: 17.8%). A total of 4,730 beneficiaries (2023: 4,547) were enrolled in a disease management programme, with 96% (2023: 95%) having received counselling from the programme as part of their care plan. These programmes play a vital role in improving member health outcomes while supporting the financial sustainability of the Scheme.



2.6 ADMINISTRATION AND OPERATIVE EXPENSES

The Scheme operates on a self-administered model, with certain administrative and risk management functions outsourced to third-party experts to optimize efficiency and expertise. To ensure maximum value for members, the Board actively monitors administrative and operational expenses through a rigorous review of itemized costs against the approved budget. This oversight ensures cost-effectiveness and alignment with the Scheme's financial sustainability objectives.

Administration expenses that are directly attributable to insurance contracts are classified under insurance service expenses. During the reporting period, these expenses decreased by 1.4% year-on-year and accounted for 5.6% (2023: 6.2%) of contributions received. On a per-beneficiary-per-month basis, administration expenses declined by 5.4%, from R139.24 in 2023 to R131.75 in 2024. The most recent industry benchmark, based on the 2022 financial year, reflects an industry average of R174.04 per beneficiary per month, highlighting the Scheme's continued efficiency in managing administrative costs.

		2024	2023
	Note	R	R
Attributable expenses incurred	14	33,054,340	30,761,112
Administration fees and operative expenses	16	8,261,191	11,150,277
		41,317,555	**41,913,413**

2.7 INVESTMENT PERFORMANCE

The Scheme's strong accumulated reserves generated sufficient investment income to fully offset administrative and operative expenses, ensuring that 100% of members' contributions were directed toward healthcare expenses. This prudent financial management approach enhances the Scheme's long-term sustainability while maximizing value for members.

Over the three-year period ending 31 December 2024, the Scheme's asset managers achieved a net return of 8.8% (2023: 9.2%), exceeding the target of 8.2% (2023: 9.1%). Additionally, funds allocated to the money market delivered a 9.2% return, outperforming the STEFI composite benchmark of 8.5%.

The Scheme's investment strategy remains centred on achieving a CPI+3% return over a rolling three-year period while prioritizing capital preservation. Following a comprehensive review, the Investment Committee has reaffirmed that the current asset managers and the CPI+3% target continue to be appropriate in supporting the Scheme's long-term financial stability and sustainable member benefits.

3. SOLVENCY AND FINANCIAL STABILITY

In accordance with Regulation 29(2) of the Medical Schemes Act 131 of 1998, as amended, the Scheme is required to maintain accumulated funds, excluding unrealised investment reserves, at a minimum solvency level of 25%. The solvency ratio for 2024 and 2023 is presented below:

		2024	2023
	Note	R	R
Insurance contracts liability for future members (members' funds)	9	724,598,316	621,234,299
Less: Cumulative net unrealised non-distributable investment reserves		(134,640,554)	(90,784,755)
Accumulated funds per regulation 29		589,957,762	530,449,544
Gross contributions (including savings contributions)	13	743,416,468	677,047,537
Solvency ratio		79.4%	78.3%

The Scheme significantly exceeds the regulatory solvency requirement, with a solvency ratio of 79.4% in 2024 (2023: 78.3%), reinforcing its strong financial position and ability to meet future member obligations. There were no unusual movements in members' funds that the Trustees believe should be brought to the attention of the members.

4. MEDICAL SAVINGS ACCOUNTS

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

Personal medical savings are administered on behalf of members in accordance with the Scheme Rules and the Medical Schemes Act, as amended. Unutilized savings amounts accumulate over time for the long-term benefit of the member, with interest applied using the effective interest rate method. In compliance with Regulation 10, the liability associated with members' savings accounts is classified as a current liability in the Scheme's financial statements. The Scheme also assumes some risk related to the forward allowance of savings account utilization, as outlined in the Scheme Rules. When a member transfers to another benefit option that does not include a personal medical savings account or moves to another medical scheme, any accumulated, unutilized savings balance is refunded or transferred in accordance with the Scheme's rules and regulatory requirements. This ensures that members retain the benefit of their personal medical savings contributions while maintaining financial integrity within the Scheme.

5. SCHEME MANAGEMENT AND THIRD-PARTY SERVICE PROVIDERS

MEMBER ELECTED TRUSTEES

	Changes in 2024
Richard V Mnguni (Chairperson)	
Siyanda Lupuwana	
Comfort Mabanga	Elected 28 August 2024
Andile MB Mazibuko	
Letlotlo BM Modise	Re-elected 28 August 2024
Nomthandazo SN Ndebele	Elected 28 August 2024
Riaan M Prinsloo	Term of office expired 28 August 2024
Johan L Snyman	Passed away 5 August 2024

EMPLOYER APPOINTED TRUSTEES

Caroline IA Maslo (Vice-Chairperson)	Thungela	
Lebogang S Gumede	Glencore	
Sarah L Kekana	Glencore	
Dion Le Roux	Seriti	Appointed 5 March 2025
Masechaba M Makgolane	Thungela	
Khawulani Msimeki	Seriti	Resigned 15 November 2024
Nomthandazo Pitjeng	Seriti	

NON-VOTING STAKEHOLDER REPRESENTATIVES INVITED TO OBSERVE BOARD MEETINGS:

S Matthews of the South African Colliery Managers' Association (SACMA)

EXECUTIVE MANAGEMENT

Mereese A Anthony	Principal Officer
Monica DA Perestrelo Javed	Chief Financial Officer

ACTUARIES

3One Consulting Actuaries
52 Grosvenor Road
Bryanston
Sandton

PRINCIPAL BANKERS

Nedbank Limited

ADMINISTRATION

WCMAS was self-administered for this financial year ending 31 December 2024. Select administration functions and network management for the Ntsika option:

Universal Healthcare Administrators (Pty) Ltd
Universal House
15 Tambach Road
Sunninghill Park
Sandton

MANAGED HEALTHCARE

Universal Care (Pty) Ltd
Universal House
15 Tambach Road
Sunninghill Park
Sandton

Medikredit Integrated Healthcare Solutions (Pty) Ltd (formerly Performance Health)
10 Kikuyu Road
Sunninghill
Sandton

ASSET MANAGERS AND CONSULTANTS

Aluwani Capital Partners
Aluwani House
24 Georgian Crescent East
Bryanston East
Johannesburg

NinetyOne Investment Managers
100 Grayston Drive
Sandown
Sandton

Willis Towers Watson
Illovo Edge
1 Harries Road
Illovo
Sandton

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

M&G Investments
Formerly Prudential Investment Managers
Loft Offices East
31 Tyrwhitt Avenue
Rosebank
Johannesburg

EXTERNAL AUDITOR

Middel & Partners Inc.
25 Sovereign Drive
Milestone Place
Block B, 1st Floor
Route 21 Corporate Park
Irene

INTERNAL AUDITOR

Nexia SAB&T Inc
119 Witch-Hazel Avenue
Highveld Technopark
Centurion

WCMAS REGISTERED OFFICE

WCMAS Building
corner Susanna Street and OR Tambo Road
Emalahleni

WCMAS POSTAL ADDRESS

PO Box 26
Emalahleni
1035

6. CORPORATE GOVERNANCE

6.1 COMMITMENT TO GOVERNANCE

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

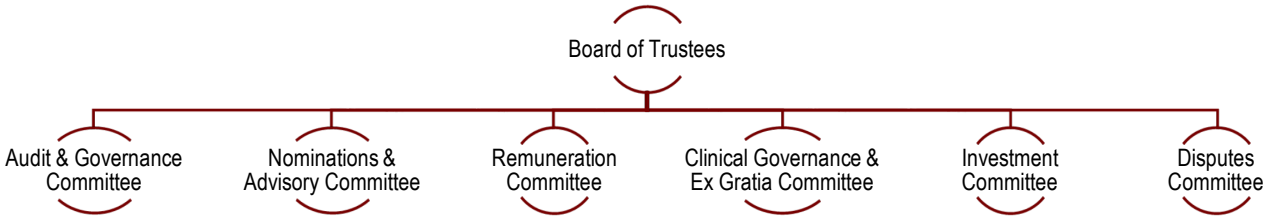
6.2 BOARD OF TRUSTEES

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

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

6.3 COMMITTEES OF THE BOARD OF TRUSTEES

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



6.3.1 Audit and Governance Committee

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

Johan A De Klerk	Chairperson Term of office expired 7 December 2024	Non-trustee member
Re-ana C Joseph	Vice-chairperson	Non-trustee member
Masechaba M Makgolane		Trustee member
Nomthandazo Ndebele	Appointed 22 November 2024	Trustee member
Andries Nienaber		Non-trustee member
R Prinsloo	Trustee term of office expired 28 August 2024	Trustee member
R Prinsloo	Appointed 22 November 2024	Non-trustee member
W Skhosana	Appointed 22 November 2024	Non-trustee member

During the year, the committee:

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

6.3.2 Nominations and Advisory Committee

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

Jaqueline Perkes	Chairperson	Non-trustee member
Letlotlo BM Modise		Trustee member
Zandile Nkosi	Appointed 22 November 2024	Non-trustee member
Sunelle Viljoen		Non-trustee member

6.3.3 Remuneration Committee

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

Jaqueline Perkes	Chairperson	Non-trustee member
Siyanda Lupuwana		Trustee member
Thabo Masike		Non-trustee member
Letlotlo BM Modise		Trustee member
Sunelle Viljoen		Non-trustee member

6.3.4 Clinical Governance and Ex Gratia Committee

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

Dr. Caroline IA Maslo	Chairperson	Trustee member
Masechaba Makgolane		Trustee member
Dr. Thulisile R Ngwenya Makhado	Appointed 22 November 2024	Non-trustee member
Dr. Khawulani Msimeki		Trustee member
Andile MB Mazibuko		Trustee member

6.3.5 Investment Committee

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

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

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

Wilfred L Skosana	Chairperson	Non-trustee member
Re-ana C Joseph		Non-trustee member
Richard V Mnguni	Appointed 22 November 2024	Trustee member
Andries Nienaber		Non-trustee member
Henry M Pearson		Non-trustee member
R Prinsloo	Trustee term of office expired 28 August 2024	Trustee member

6.3.6 Disputes Committee

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

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

6.4 TRUSTEES' AND COMMITTEE MEMBERS' REMUNERATION

Trustees and committee members are compensated based on their expertise, skill, and time commitment. The Remuneration Committee ensures that compensation structures remain fair and competitive, subject to approval at the Annual General Meeting. Some members choose to forgo remuneration due to existing employer arrangements. Full remuneration details are disclosed in Note 17 of the Annual Financial Statements.

6.5 EVALUATION OF THE BOARD OF TRUSTEES AND COMMITTEES

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

6.6 BOARD AND COMMITTEE MEETINGS

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

	Board of Trustees	Audit and Governance Committee	Clinical Governance and Ex Gratia Committee	Investment Committee	Nominations and Advisory Committee	Remuneration Committee
Number of meetings	6	3	4	4	3	3
TRUSTEES						
Richard V Mnguni (Chairperson)	6					
Caroline IA Maslo (Vice-Chairperson)	6		4			
Lebogang S Gumede	2					
Sarah L Kekana	4					
Siyanda Lupuwana	3					2
Comfort Mabanga	1					
Masechaba M Makgolane	6	3	4			
Andile MB Mazibuko	6		3			
Letlotlo BM Modise	6				2	2
Khawulani Msimeki	6		3			
Nomthandazo SN Ndebele	1					
Nomthandazo Pitjeng	3					
Riaan M Prinsloo	3	2		3		
Johan L Snyman	2		1			
NON-TRUSTEE MEMBERS						
Johan A De Klerk		3				
Re-ana C Joseph		1		4		
Thabo Masike						3
Andries Nienaber		2		2		
Henry M Pearson				3		
Jaqueline Perkes					3	3
Wilfred L Skhosana				4		
Sunelle Viljoen					1	3

6.7 CMS INSPECTION UPDATE

In 2020, the Council for Medical Schemes (CMS) initiated an investigation into the Scheme's governance under Section 44(4)(a) of the Medical Schemes Act. As a result, CMS recommended the appointment of a Statutory Manager under Section 5A of the Financial Institutions (Protection of Funds) Act, 28 of 2001.

The Statutory Manager, Mr. Juanito Damons, was jointly appointed by the Scheme and CMS on 18 July 2022. He attended all Board of Trustees and Audit & Governance Committee meetings, holding additional ad hoc meetings with Scheme officials as needed.

The Scheme successfully implemented governance improvements by 31 July 2023, leading to the conclusion of the Statutory Manager's role. CMS submitted a court application for the removal of the Statutory Manager, and on 25 November 2024, the court terminated statutory management, signifying a return to normal governance.

7 RISK MANAGEMENT

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

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

7.1 MEMBER RETENTION

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

7.2 MEMBER RISK PROFILE

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

7.3 REGULATORY CHANGE

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

7.4 RISING HEALTHCARE COSTS

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

7.5 SUSTAINABILITY OF BENEFIT OPTIONS

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

7.6 ECONOMIC CONDITIONS

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

7.7 SERVICE DELIVERY FROM KEY SERVICE PROVIDERS

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

7.8 RISING BURDEN OF DISEASE

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

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

8 MEDICAL INSURANCE RISK MANAGEMENT

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

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

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

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

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

to benefit limits and Scheme tariffs; and
- Additional benefits – including preventative wellness benefits, external medical appliances, and access to disease management programs.

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

9 ACTUARIAL REVIEW AND CONTRIBUTION ASSESSMENT

While an actuarial review of the Scheme is not a statutory requirement under the Medical Schemes Act, the Scheme proactively engages independent actuarial expertise to ensure sound financial and benefit planning. For the 2023 and 2024 benefit years, 3One Consulting Actuaries conducted a review of budgeted contributions and key assumptions used in the benefit design process. This assessment confirmed the appropriateness of the contribution increases, ensuring that they remain aligned with the Scheme's financial sustainability and member affordability objectives.

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

10 OUTSTANDING CLAIMS

The movement on the outstanding claims provision and the methodology used in its calculation are detailed in Note 2 of the Annual Financial Statements. The basis of calculation remains consistent with the prior year, and includes a non-financial risk adjustment, as required under IFRS 17. This adjustment enhances the accuracy of claim provisioning by incorporating non-financial risk factors, ensuring compliance with IFRS Accounting Standards as issued by the International Accounting Standards Board, while maintaining the Scheme's prudent approach to claims liability management.

There were no unusual movements in the outstanding claims provision that the Trustees believe require special attention from the Scheme's members. The provision continues to be monitored and evaluated to ensure adequate coverage of incurred but not yet reported claims, supporting the financial stability and claims-paying ability of the Scheme.

11 FIDELITY INSURANCE

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

12 RELATED PARTY TRANSACTIONS

Details of related party transactions are disclosed in Note 19 of the Annual Financial Statements, in accordance with relevant reporting standards and governance requirements. This disclosure includes transactions with parties that have a significant influence over the Scheme. Additionally, Trustee remuneration is detailed in Note 17 of the Annual Financial Statements, providing full disclosure of compensation and allowances in line with the Scheme's governance framework.

The Board remains committed to transparent financial management and adherence to regulatory and ethical standards in all related party dealings.

13 SIGNIFICANT EVENTS

In 2019, the Scheme reported a significant event involving alleged fraudulent activities by a senior management member. These activities included misuse of Scheme property, unauthorised expenses, non-compliance with internal procurement policies, and theft of monetary assets. Following an independent forensic investigation, the Scheme took legal action and successfully recovered a portion of the misappropriated funds. A criminal complaint was also lodged to address the matter.

In 2020, the Council for Medical Schemes (CMS) initiated an investigation into the Scheme's governance under Section 44(4)(a) of the Medical Schemes Act. Based on the findings, CMS recommended the appointment of a Statutory Manager under Section 5A of the Financial Institutions (Protection of Funds) Act, 28 of 2001, to oversee governance improvements and ensure compliance with regulatory requirements.

Under an agreement between CMS, the Registrar, and the Board of Trustees, Mr. Juanito Damons was appointed as the Statutory Manager on 18 July 2022. His role included attending all Board of Trustees and Audit & Governance Committee meetings, as well as conducting ad hoc engagements with Scheme officials to monitor progress.

By 31 July 2023, the Scheme had successfully implemented the governance enhancements recommended by the Statutory Manager. As a result, CMS applied to the High Court to remove the Scheme from Statutory Management. On 25 November 2024, the court officially terminated statutory management, marking the Scheme's return to normal governance operations and reaffirming its commitment to strong governance, transparency, and regulatory compliance.

14 NON-COMPLIANCE MATTERS

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

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

Section 26(7) of the Act requires that all contributions be paid directly to a medical scheme within three days of becoming due. In 2024, not all billed contributions were received within this timeframe, which could impact cash flow and interest income. The Scheme actively follows up on outstanding contributions and applies its credit control policy to manage overdue payments effectively.

14.2 CLAIMS PAYMENT DELAYS (SECTION 59(2))

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

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

Section 33(2)(b) of the Medical Schemes Act requires that each benefit option be financially self-supporting to maintain the financial integrity of the Scheme and prevent cross-subsidisation.

In 2024, the Midmas option recorded a minor insurance service deficit of R111,824 (refer to Note 18 of the Annual Financial Statements). While this deficit is not material, persistent deficits on

benefit options could potentially lead to cross-subsidisation from surplus-generating options, which may impact the overall financial soundness of the Scheme.

To ensure long-term sustainability and regulatory compliance, the Scheme is actively implementing strategic measures, including:

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

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

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

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

As of 31 December 2024, the Scheme held underlying investments amounting to 0.6% in medical scheme administrators or their holding companies (Momentum Metropolitan Holdings, Discovery Holdings and Sanlam Limited) and 0.6% in employer groups (Glencore Plc and Exxaro Resources) of total net asset value. The Scheme has obtained an exemption from the Council for Medical Schemes (CMS) to retain these investments while ensuring compliance with broader regulatory requirements.

15 GOING CONCERN

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

The Board of Trustees conducts an annual assessment of the Scheme's business plan, key performance indicators, and strategic targets to ensure that all material risks are comprehensively addressed. This includes maintaining a regular review of the Scheme's risk register and management accounts, ensuring that contingency plans are in place to mitigate potential risks. In reviewing budgets and cash flow projections, along with additional financial data for 2025, the Board of Trustees has determined that the going concern assumption remains appropriate for the next twelve months from the date of approval of the Annual Financial Statements. This assessment underscores the Scheme's financial stability and ability to meet its obligations while continuing to provide sustainable healthcare benefits to its members.

16 EVENTS AFTER THE REPORTING PERIOD

On 20 January 2025, the United States President's Emergency Plan for AIDS Relief (PEPFAR) funding in South Africa was paused for 90 days pending a final decision on future funding. The termination of PEPFAR funding would have significant repercussions on the nation's HIV/AIDS response in the public health services sector and NGOs directly involved in HIV prevention and treatment. The impact on the Scheme, whose members are mostly claiming from the private sector already, is not considered significant enough to require a policy adjustment or a change in claims estimates.

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

STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES

The Trustees are responsible for the preparation, integrity and fair presentation of the annual financial statements of Witbank Coalfields Medical Aid Scheme ("the Scheme"), comprising the statement of financial position at 31 December 2024 and the statements of comprehensive income, and cash flows for the year then ended, and the notes to the annual financial statements, which include a summary of significant accounting policies and other explanatory notes required in accordance IFRS Accounting Standards as issued by the International Accounting Standards Board, and the requirements of the Medical Schemes Act of South Africa No. 131 of 1998, as amended ("the Act").

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

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

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

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

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

The Audit and Governance committee functioned effectively throughout the year.

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

APPROVAL OF FINANCIAL STATEMENTS

The financial statements set out on pages 32 to 76, which have been prepared on the going concern basis, were approved and authorised for issue by the Board of Trustees and on 16 April 2025 and were signed on their behalf by:

RV Mnguni
Chairperson

CIA Maslo
Vice-chairperson

MA Anthony
Principal Officer

STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES

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

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

1. ETHICS

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

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

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

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

2. CORPORATE CITIZENSHIP

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

2.1 Stakeholder engagement

The Scheme prioritizes meaningful engagement with stakeholders through:

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

2.2 Responsible business practices

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

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

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

2. BOARD OF TRUSTEES

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

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

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

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

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

3.1 Performance evaluations

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

3.2 Remuneration

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

Remuneration details, including per-meeting fees and travel cost reimbursements, are disclosed in the Annual Financial Statements (Note 17).

3. PRINCIPAL OFFICER

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

4. COMPLIANCE AND REGULATORY OVERSIGHT

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

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

5. RISK MANAGEMENT

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

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

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

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

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

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

6. INFORMATION TECHNOLOGY, CYBERSECURITY AND DATA PROTECTION

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

To protect sensitive member information, the Scheme:

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

7. INVESTMENT STRATEGY

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

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

8. MEMBER ENGAGEMENT AND SATISFACTION

The Scheme values member feedback and enhances engagement through:

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

9. FUTURE OUTLOOK AND STRATEGIC GOALS

Looking ahead, the Scheme aims to:

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

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

RV Mnguni
Chairperson

CIA Maslo
Vice-chairperson

MA Anthony
Principal Officer

Independent Auditor's Report

To the Members of The Witbank Coalfields Medical Aid Scheme.

Report on the Financial Statements

Unqualified Opinion

We have audited the financial statements of The Witbank Coalfields Medical Aid Scheme ("The Scheme") set out on pages 27 to 70, which comprise the statement of financial position as at 31 December 2024, and the statement of profit or loss and other comprehensive income and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of material accounting policies.

In our opinion, the financial statements present fairly, in all material respects, the financial position of Witbank Coalfields Medical Aid Scheme as at 31 December 2024, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards 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 (ISA Standards). Our responsibilities under those standards are further described in the Auditors responsibilities for the Audit of the financial statements section of our report. We are independent of "The Scheme" in accordance with the Independent Regulatory Board for Auditors' Code of Professional Conduct for Registered Auditors (IRBA Code) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the corresponding sections of the International Ethics Standards Board for Accountant's International Code of Ethics for Professional Accountants (Including International Independence Standards). We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Key Audit Matters

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

Key Audit Matter	Audit Response
Liability for incurred claims The Liability for incurred claims (LIC) provision consisting of: - Best estimate liability of claims incurred but not reported R 45 308 105 (2023: R 45 863 488); - Risk adjustment R 1 961 679 (2023: R 2 065 387); and - Reported claims not yet paid R 1 042 525 (2023: R 34 920 430), forms part of the insurance contract liability. The insurance contract liability is described in note 11 to the financial statements. The LIC includes the estimated cost of healthcare benefits that have been incurred by the members before the end of the financial year but that have not been reported to the Scheme by that date, as well as insurance accounts payable and the personal medical savings liability. Per IFRS 17, the Scheme measures the LIC provision as the fulfilment cash flows plus a risk adjustment at year-end. The estimate of the future cash flows in terms of the LIC provision is adjusted to reflect the compensation that the Scheme requires for bearing the uncertainty about the amount and timing of the cash flows arising from non-financial risk including claims risk, membership risk, and expense risk. The rules of the Scheme provide that claims may only be paid if the Scheme is notified of the claim and documentation is submitted within 4 months of the date of the healthcare service. At year-end, the cost of outstanding incurred claims is estimated by the Scheme's actuaries, using the Bornhuetter-Ferguson method (BFM) in the calculation of the Scheme's LIC provision. Considering the IFRS 17 requirements, the LIC estimate shows the LIC provision at various percentiles of the simulated LIC estimates, each allowing for a different assumed risk adjustment factor.	Our audit procedures for the Liability of incurred claims (LIC) provision included the following: We obtained an understanding of the inherent risk factors in relation to the complexity subjectivity and the change of the LIC provision estimate; We assessed the appropriateness and timely recognition of the related LIC provision against the requirements of IFRS 17 - Insurance contracts; We have gained a detailed understanding of the end-to-end claims and LIC estimation process and obtained an understanding of the relevant controls. We obtained the report of the Scheme's independent actuary of the LIC provision at year end and tested the appropriateness of the estimate performed as follows: - Evaluated the competence, capabilities and objectivity of the Scheme's independent actuary; - Obtained an understanding of the method and models used in calculating the LIC provision estimate and assessed whether it is appropriate in terms of acceptable methodologies, industry standards, and that they meet the measurement objectives of IFRS 17; - Obtained an understanding of the significant assumptions used in the estimate and, challenged whether the assumptions are appropriate for the estimate of the LIC provision and the risk adjustment factors; - Obtained an understanding of the data utilised in the calculation of the estimate; - Assessed the estimate for indicators of possible management bias. We obtained audit evidence from events occurring after the reporting period as a retrospective review of the LIC provision estimate that was set at year end:

A LIC provision at the 50th percentile (2023 – 50th percentile) of the stipulated LIC estimates has been selected by the Scheme. We considered the Liability for incurred claims (Note 11) as a matter of most significance to the current year audit of the financial statements due to the following: - the degree of estimation uncertainty and complexity of the fulfilment cash flows; - significant judgment in selecting the related risk adjustment for non-financial risk factors; and - the materiality of this liability.	- We assessed the claims received subsequent to year-end for claims incurred relating to the 2024 financial year; - We inspected the records of claims assigned 'audit' status and evaluated whether the claims have been correctly included/ excluded from the LIC provision. Based on our assessment of the events and claims occurring after the reporting period as a retrospective review, we did not identify any matters that would require additional audit procedures to be performed.
Validity and accuracy of claims The significant expense for the Scheme relates to risk claims incurred. Risk claims incurred is a key driver in determining the sustainability of the Scheme. The payment of valid and accurate risk claims is dependent on the integrity of the Scheme's administration system, as well as the automated claim assessment control. Risk claims incurred was considered a key audit matter due to the significant risk related to the processing of valid claims during the year.	We obtained claims data for the entire period and performed analytical, substantive and control testing in order to verify the validity and accuracy of claims.

Other Information

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

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the audit, or otherwise appears to be materially misstated. 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 International Financial Reporting Standards Accounting Standards as issued by the International Accounting Standards Board and the requirements of the Medical Schemes Act of South Africa, and for such internal control as the Scheme's Trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

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

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's Trustees.

- Conclude on the appropriateness of the Scheme's Trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion.

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

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

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

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

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

Report on Other Legal and Regulatory Requirements

Non-compliance with the Medical Schemes Act of South Africa

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

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

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

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

   As of 31 December 2024, the Scheme held underlying investments amounting to 0.6% in medical scheme administrators or their holding companies (Momentum Metropolitan Holdings, Discovery Holdings and Sanlam Limited) and 0.6% in employer groups (Glencore Plc and Exxaro Resources) of total net asset value. The Scheme has obtained an exemption from the Council of Medical Schemes to retain these investments while ensuring compliance with broader regulatory requirements.

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

   In terms of section 26(7) of the Medical Schemes Act 131 of 1998, all contributions shall be paid to a medical scheme not later than three days after payment thereof becomes due.

   In 2024, not all billed contributions were received within this timeframe, which could impact cash flow and interest income. The Scheme actively follows up on outstanding contributions and applies its credit control policy to manage overdue payments effectively.

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

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

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

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

   In terms of section 33(2)(b) of the Act, each benefit option shall be self-supporting in terms of membership and financial performance to maintain the financial integrity of the Scheme and prevent cross-subsidisation. At 31 December 2024 the Midmas option incurred a minor insurance service deficit of R 111 824 (refer to Note 18 of the Annual Financial Statements).

   While this deficit is not material, persistent deficits on benefit options could potentially lead to cross-subsidisation from surplus-generating options, which may impact the overall financial soundness of the Scheme. To ensure long-term sustainability and regulatory compliance, the Scheme is actively implementing strategic measures, including:

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

Audit Tenure

As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that Middel and Partners has been the auditor of The Witbank Coalfields Medical Aid Scheme for the first time for the reporting date 31 December 2024.

The engagement partner, Mr Jacques Jean Marais, has been responsible for The Witbank Coalfields Medical Aid Scheme audit for the first time for the reporting date 31 December 2024.

Middel & Partners

Per: Jacques Jean Marais

Chartered Accountant (SA)

Registered Auditor

29 April 2025

Pretoria

STATEMENT OF FINANCIAL POSITION
As at 31 December 2024

	Note	2024	2023
ASSETS			
Non-current assets			
Equipment and other fixed assets	4	1,604,014	801,341
Investment properties	5	15,318,525	13,193,933
Investments at fair value through profit or loss	6	708,252,362	649,578,532
		725,174,901	**663,573,806**
Current assets			
Investments at fair value through profit or loss	6	248,232,823	227,339,903
Trade and other receivables	7	475,909	459,207
Cash and cash equivalents	8	99,403,561	70,184,080
		348,112,293	**297,983,190**
TOTAL ASSETS		**1,073,287,195**	**961,556,996**
LIABILITIES			
Non-current liabilities			
Insurance contracts liability for future members	9	724,598,316	621,234,299
Retirement benefit obligation	10	1,836,000	1,510,000
		726,434,316	**622,744,299**
Current liabilities			
Insurance contracts liability for current members	11	344,549,363	335,801,166
Trade and other payables	12	1,949,516	2,675,531
Retirement benefit obligation	10	354,000	336,000
		346,852,879	**338,812,697**
TOTAL LIABILITIES		**1,073,287,195**	**961,556,996**
TOTAL EQUITY		**-**	**-**
TOTAL EQUITY AND LIABILITIES		**1,073,287,195**	**961,556,996**

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME

For the year ended 31 December 2024

	Note	2024	2023
Insurance revenue	13	578,069,267	527,865,620
Insurance service expenses	14	(545,833,093)	(581,343,801)
INSURANCE SERVICE RESULT		**32,236,174**	**(53,478,181)**
Investment income	15	108,423,205	91,542,440
Gain/(loss) on disposal of equipment		(30,360)	160,611
Sundry income		573,164	257,357
OTHER INCOME		**108,966,009**	**91,960,408**
Impairment losses on insurance receivables		(456,266)	(288,777)
Insurance finance expenses	12	(21,094,514)	(20,561,012)
Administration fees and operative expenses	16	(8,261,191)	(11,150,277)
Asset management fees		(4,573,689)	(4,888,717)
Costs incurred on rental property		(3,452,507)	(3,444,807)
OTHER EXPENSES		**(37,838,166)**	**(40,333,590)**
PROFIT FOR THE YEAR		**103,364,017**	**(1,851,362)**
Amounts attributable to future members		(103,364,017)	**1,851,362**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**-**	**-**

STATEMENT OF CASH FLOWS

For the year ended 31 December 2024

	Note	2024	2023
CASH FLOWS FROM OPERATING ACTIVITIES			
Contributions received		765,512,926	654,661,302
Other cash flows from/(to) members and providers		(1,668,280)	247,921
Cash receipts from members and providers		763,844,646	654,909,223
Cash paid to members and providers - Claims		(694,728,161)	(666,377,515)
Cash paid to providers and employees - Directly attributable expenses		(32,883,130)	(31,008,466)
Cash paid to providers and employees - Other operative expenditure		(9,368,468)	(10,898,837)
Cash paid to members - Personal medical savings refunds	12.3	(15,601,936)	(19,396,868)
Cash paid to providers, employees and members		(752,581,694)	(727,681,685)
Cash generated from/ (utilised in) operations		**11,262,952**	**(72,772,463)**
NET CASH (OUTFLOW)/INFLOW FROM OPERATING ACTIVITIES		**11,262,952**	**(72,772,463)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Additions to equipment and other assets	4	(1,358,306)	(196,912)
Proceeds on disposals of equipment and other assets		53,594	160,611
Additions to investment properties	5	(2,760,641)	(10,589)
Proceeds on disposals of investments at fair value through profit or loss	6	15,000,000	78,000,000
Investment income received on investments at amortised cost	15	5,062,747	2,730,114
Investment manager fees paid		(538,200)	(510,600)
Receipts from sundry debtors		-	249,872
Rental income received		5,394,342	4,184,996
Cost incurred in provision of own facilities to external parties		(3,452,507)	(3,444,807)
Non-cash flow item: depreciation on investment property	5	555,501	527,400
NET CASH GENERATED FROM INVESTING ACTIVITIES		**17,956,529**	**81,690,084**
NET INCREASE IN CASH AND CASH EQUIVALENTS		**29,219,481**	**8,917,621**
Cash and cash equivalents at the beginning of the year	8	70,184,080	61,266,459
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR	9	**99,403,561**	**70,184,080**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
For the year ended 31 December 2024

1. GENERAL INFORMATION

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

2. ACCOUNTING POLICIES

2.1 BASIS OF PREPARATION

2.1.1 STATEMENT OF COMPLIANCE

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

2.1.2 BASIS OF MEASUREMENT

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

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

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

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

2.1.3 STATEMENT OF CASH FLOWS

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

2.1.4 FUNCTIONAL AND PRESENTATION CURRENCY

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

2.1.5 NEW STANDARDS, AMENDMENTS TO PUBLISHED STANDARDS AND INTERPRETATIONS

(a) New standards, amendments to published standards and interpretations issued and effective in 2024 and relevant to the Scheme:

Effective date	Standard, Amendment or Interpretation	Impact on the Scheme
Annual reporting periods beginning on or after 1 January 2024	IAS 1 Presentation of Financial Statements	Classification of Liabilities as Current or Non-current: Under existing IAS 1 requirements, companies classify a liability as current when they do not have an unconditional right to defer settlement of the liability for at least twelve months after the end of the reporting period. As part of its amendments, the Board has removed the requirement for a right to be unconditional and instead, now requires that a right to defer settlement must have substance and exist at the end of the reporting period. There is limited guidance on how to determine whether a right has substance and the assessment may require management to exercise interpretive judgement. The existing requirement to ignore management's intentions or expectations for settling a liability when determining its classification is unchanged. Disclosure of Accounting Policies: The amendments require Schemes to disclose their material accounting policy information rather than their significant accounting policies, with additional guidance added to the Standard to explain how an entity can identify material accounting policy information with examples of when accounting policy information is likely to be material.

(b) New standards, amendments and interpretations issued and not yet effective in 2024 and relevant to the Scheme:

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

Effective date	Standard, Amendment or Interpretation	Impact on the Scheme
Annual reporting periods beginning on or after 1 January 2026.	Amendments IFRS 9 and IFRS 7 regarding the classification and measurement of financial instruments.	The amendments address matters identified during the post-implementation review of the classification and measurement requirements of IFRS 9 Financial Instruments.
Annual periods beginning on or after 1 January 2027.	IFRS 18 Presentation and Disclosures in Financial Statements.	IFRS 18 includes requirements for all entities applying IFRS for the presentation and disclosure of information in financial statements.

2.2 EVENTS AFTER REPORTING DATE

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

2.3 EQUIPMENT AND OTHER FIXED ASSETS

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

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

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

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

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

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

2.4 INVESTMENT PROPERTIES

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

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

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

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

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

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

2.5 IMPAIRMENT OF NON-FINANCIAL ASSETS

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

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

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

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

2.6 FINANCIAL INSTRUMENTS

2.6.1 CLASSIFICATION, RECOGNITION, AND MEASUREMENT

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

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

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

and re-evaluates this for financial assets when the objective of the Scheme's business model changes.

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

2.6.1.1 Financial assets held at fair value through profit or loss

These financial assets are initially recognised at fair value excluding transaction costs, which are immediately expensed.

These financial assets are subsequently measured at fair value. The fair value adjustments are recognised in the statement of profit or loss during the financial period.

2.6.1.2 Loans and receivables

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

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

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

Trade and other receivables

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

Cash and cash equivalents

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

2.6.1.3 Financial liabilities

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

Financial liabilities comprise of 'Trade and other payables'.

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

Trade and other payables

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

2.6.2 IMPAIRMENT OF FINANCIAL ASSETS

2.6.2.1 Loans and receivables

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

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

The provision matrix considers contributions receivable, member and service provider debit balances and advances on savings plan accounts to members. The Scheme utilises readily available economic information such as consumer price index, healthcare inflation, national credit rating and unemployment indicators as a basis for determining the future expectations of the observable data.
If it is determined that a possible impairment loss will be incurred on loans and receivables measured at amortised cost, the amount of the loss is measured as the difference between the present value of the cash flows due under the contract and the present value of the cash flows that the entity expects to receive. These losses are recognised at initial recognition in profit or loss and reflected in an allowance account.

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

2.6.3 DERECOGNITION OF FINANCIAL ASSETS

Financial assets are derecognised when the rights to receive cash flows from the assets have expired, the right to receive cash flows has been retained but an obligation to pay them in full without material delay has been assumed or the right to receive cash flows has been transferred together with substantially all the risks and rewards of ownership.

If a transfer does not result in derecognition because the Scheme has retained substantially all the risks and rewards of ownership of the transferred asset, the Scheme continues to recognise the transferred asset in its entirety and recognises a financial liability for the consideration received. In subsequent periods, the Scheme recognises any income on the transferred asset and any expense incurred on the financial liability.

Where the Scheme neither transfers nor retains substantially all the risks and rewards of ownership of the financial asset, the Scheme determines whether it has retained control of the financial asset. If the Scheme has not retained control, it derecognises the financial asset and recognises separately as assets or liabilities any rights and obligations created or retained in the transfer; and if the Scheme has retained control, it continues to recognise the financial asset to the extent of its continuing involvement in the financial asset.

The Scheme derecognises a financial liability when the contractual obligations are discharged, cancelled, or expire.

2.7 OFFSET

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

2.8 STRUCTURED ENTITIES

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

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

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

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

2.9 CASH AND CASH EQUIVALENTS

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

2.10 INSURANCE CONTRACTS

2.10.1 IDENTIFICATION OF INSURANCE CONTRACTS

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

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

2.10.2 SEPARATING COMPONENTS FROM AN INSURANCE CONTRACT

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

a) the entity is unable to measure one component without considering the other. Thus, if the value of one component varies according to the value of the other, an entity shall apply IFRS 17 to account for the combined investment and insurance component; or

b) the policyholder is unable to benefit from one component unless the other is also present. Thus, if the lapse or maturity of one component in a contract causes the lapse or maturity of the other, the entity shall apply IFRS 17 to account for the combined investment component and insurance component.

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

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

2.10.3 LEVEL OF AGGREGATION

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

2.10.4 CONTRACT BOUNDARY

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

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

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

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

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

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

2.10.5 RECOGNITION AND DERECOGNITION

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

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

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

2.10.6 PREMIUM ALLOCATION APPROACH (PAA)

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

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

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

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

2.10.7 INITIAL AND SUBSEQUENT MEASUREMENT

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

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

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

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

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

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

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

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

Onerous contract assessment:

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

2.10.8 INSURANCE REVENUE

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

2.10.9 INSURANCE SERVICE EXPENSES

Insurance service expenses include:

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

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

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

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

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

2.10.10 INSURANCE INTEREST INCOME AND EXPENSES

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

2.11 EMPLOYEE BENEFITS

2.11.1 SHORT-TERM EMPLOYEE BENEFITS

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

2.11.2 DEFINED CONTRIBUTION PLANS

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

2.11.3 POST-RETIREMENT MEDICAL BENEFITS

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

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

An actuarial valuation is performed every second year to determine the value of the liability, and the liability is unfunded. For the year ended 31 December 2024 the Projected Unit Credit discounted cash flow method was used.

2.12 INVESTMENT INCOME

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

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

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

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

2.13 ALLOCATION OF INCOME AND EXPENDITURE TO BENEFIT OPTIONS

The following items are directly allocated to benefit options:

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

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

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

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

3 USE OF ESTIMATES AND JUDGMENTS

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

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

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

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

3.1 SIGNIFICANT JUDGEMENTS AND ESTIMATES FOR INSURANCE CONTRACTS

3.1.1 ASSESSMENT AS TO WHETHER A SCHEME IS A MUTUAL ENTITY

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

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

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

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

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

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

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

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

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

3.1.2 LEVEL OF AGGREGATION

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

The above is demonstrated by the following:

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

3.1.3 RISK ADJUSTMENT – LIABILITY FOR INCURRED CLAIMS (LIC)

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

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

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

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

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

3.1.4 ESTIMATES OF FUTURE CASH FLOWS TO FULFIL INSURANCE CONTRACTS

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

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

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

3.1.5 METHODS USED TO MEASURE THE INSURANCE CONTRACTS

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

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

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

the year progresses based on more recent claims experience (i.e., using an approach called 'credibility theory').

The following was considered when estimating the LIC:

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

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

3.2 FAIR VALUE DETERMINATION

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

- Level 1: Inputs are determined directly by reference to published price quotations in an active market for identical assets or liabilities. The fair value of publicly traded financial instruments is based on quoted market prices at the statement of financial position date.

- Level 2: Inputs are observable for the asset, either directly (i.e., prices) or indirectly (i.e., derived from prices). Financial assets classified as level 2 are valued using a discounted cash flow method.

- Level 3: The fair values are determined based on assumptions that are not supported by observable market data. There were level 3 instruments held during the period.

4 EQUIPMENT AND OTHER FIXED ASSETS

	2024			2023		
	Cost	Accumulated depreciation	Carrying value	Cost	Accumulated depreciation	Carrying value
Motor vehicles	564,317	(516,037)	48,280	564,317	(459,271)	105,046
Office equipment	3,859,567	(3,631,227)	228,340	4,252,617	(4,194,751)	57,866
Computer equipment	2,148,261	(1,171,158)	977,103	4,085,172	(3,849,632)	235,539
Generator	1,267,594	(917,304)	350,291	1,267,594	(864,705)	402,889
Total	**7,839,739**	**(6,235,725)**	**1,604,014**	**10,169,700**	**(9,368,359)**	**801,341**

4.1 RECONCILIATION OF EQUIPMENT AND OTHER FIXED ASSETS

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

2023	Opening balance	Additions	Depreciation	Total
Motor vehicles	190,196	-	(85,149)	105,047
Office equipment	747,480	44,978	(734,592)	57,866
Computer equipment	199,596	151,933	(115,990)	235,539
Generator	455,578	-	(52,689)	402,889
Total	**1,592,850**	**196,911**	**(988,420)**	**801,341**

5 INVESTMENT PROPERTIES

	2024			2023		
	Cost	Accumulated depreciation	Carrying value	Cost	Accumulated depreciation	Carrying value
Land and buildings	13,074,995	(1,647,475)	11,427,520	13,139,815	(1,647,475)	11,492,340
Partitioning, electrical and fittings	1,591,534	(895,238)	696,296	1,530,967	(821,316)	709,652
Lift	1,486,448	(953,832)	532,615	1,486,448	(854,741)	631,707
Air conditioners	5,545,848	(2,883,754)	2,662,094	4,113,549	(3,753,314)	360,235
Total	**21,698,825**	**(6,380,300)**	**15,318,525**	**20,270,779**	**(7,076,846)**	**13,193,933**

5.1 RECONCILIATION OF INVESTMENT PROPERTIES

2024	Opening balance	Additions	Disposals	Depreciation	Total
Land and buildings	11,492,340	-	(64,820)	-	11,427,520
Partitioning, electrical and fittings	709,652	150,916	(17,976)	(146,296)	696,296
Lift	631,707	-	-	(99,091)	532,615
Air conditioners	360,235	2,609,725	2,247	(310,114)	2,662,094
Total	**13,193,933**	**2,760,641**	**(80,549)**	**(555,501)**	**15,318,525**

2023	Opening balance	Additions	Depreciation	Total
Land and buildings	11,492,340	-	-	11,492,340
Partitioning, electrical and fittings	836,423	10,589	(137,360)	709,652
Lift	730,798	-	(99,091)	631,707
Air conditioners	651,184	-	(290,949)	360,235
Total	**13,710,744**	**10,589**	**(527,400)**	**13,193,933**

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

The fair value of the properties as valued by a Professional Associated Valuer is R 56,4 million (2023: R56,4 million). Management has assessed the residual value of the building to be R16.5 million. This is greater than the current carrying value of the building and therefore no depreciation has been processed.

Direct operating expenses arising from the property that generated rental income amount to R3 452 507 (2023: R3 371 497) and which did not generate rental income amount to R70 154 (2023: R69 998).

6 INVESTMENTS AT FAIR VALUE THROUGH PROFIT OR LOSS

6.1 INVESTMENTS ARE HELD AT FAIR VALUE THROUGH PROFIT AND LOSS AND COMPRISE:

	2024	2023
Segregated multiclass portfolio	181,238,890	166,643,173
Linked fund policies	527,013,473	482,935,359
Money market instruments	248,232,823	227,339,903
	956,485,185	**876,918,435**

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

Cash	357,740,995	348,734,353
Investments in property	16,367,675	10,588,774
Interest-bearing investments, including bonds	309,138,324	291,850,006
Listed equities	273,238,191	225,745,301
	956,485,185	**876,918,434**

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

Non-current assets	708,252,362	649,578,532
Current assets	248,232,823	227,339,903
	956,485,185	**876,918,435**

Refer to note 2.5 Financial Instruments and note 3.2 for details of fair values.

6.1 RECONCILIATION OF FAIR VALUE OF INVESTMENTS

	2024	2023
Balance at the beginning of the year	876,918,435	874,497,567
Proceeds on disposal	(15,000,000)	(78,000,000)
Dividend income capitalised (note 15)	10,566,687	10,193,829
Interest income capitalised (note 15)	44,452,297	44,136,039
Fair value adjustments (note 15)	43,855,799	30,299,569
Management fees	(4,308,032)	(4,208,570)
Balance at the end of the year	**956,485,185**	**876,918,435**

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

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

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

2024	Level 1	Level 2	Level 3	Total
Assets				
Financial assets held at fair value through profit or loss (note 6)				
Listed equities	273,238,191			273,238,191
Bonds	309,138,324			309,138,324
Listed property holding	16,367,675			16,367,675
Money market instruments		357,740,995		357,740,995
Total assets	**598,744,190**	**357,740,995**	**-**	**956,485,185**

2023				
Assets				
Financial assets held at fair value through profit or loss (note 6)				
Listed equities	225,745,301			225,745,301
Bonds	291,850,006			291,850,006
Listed property holding	10,588,774			10,588,774
Money market instruments		348,734,353		348,734,353
Total assets	**528,184,081**	**348,734,353**	**-**	**876,918,434**

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

7 TRADE AND OTHER RECEIVABLES

FINANCIAL ASSETS	2024	2023
Prepayments	138,287	239,012
Deposits paid	99,666	99,666
Rental income receivable	237,957	1,146,624
Provision for impairment loss on rental income receivable	-	(1,026,095)
	475,909	**459,207**
RECONCILIATION OF PROVISION FOR IMPAIRMENT LOSS		
Balance at the beginning of the year	(1,026,095)	(1,022,783)
Amounts owing by tenants for rental not recoverable	1,022,723	-
Net impairment gain/(loss) on financial assets	3,371	(3,312)
Balance at the end of the year	**-**	**(1,026,095)**

The fair value of trade and other receivables approximates their carrying amounts due to the short-term maturities of these assets. Further detail on the Scheme's credit risk related to a customer or other counter party to a financial instrument failing to meet their current obligations to the Scheme is disclosed in note 20.1.

8 CASH AND CASH EQUIVALENTS

Current accounts	55,130,268	34,529,497
Call accounts	44,273,293	35,654,584
	99,403,561	**70,184,080**

The effective interest rates on current accounts was 1.2% (2023: 1.1%) and call accounts was 10.1% (2023: 10.6%). The carrying amount of the cash and cash equivalents approximates the fair values due to the short-term maturities of these balances.

9 INSURANCE CONTRACT LIABILITIES FOR FUTURE MEMBERS

	2024	2023
Balance of members' funds the beginning of the year	621,234,299	623,085,661
Surplus/(deficit) on insurance contracts attributable to future members	103,364,017	(1,851,362)
Balance of members' funds the end of the year	**724,598,316**	**621,234,299**

10 RETIREMENT BENEFIT OBLIGATION

10.1 POST-RETIREMENT MEDICAL AID BENEFIT

In 2011, the Board resolved that the staff employed by the Scheme as at 31 January 2011 and who had retired after at least 20 years of service, will receive a medical aid subsidy equal to 50% of their medical aid contribution per month for the remainder of their lives. Surviving spouses of employees entitled to the subsidy will continue to receive the benefit. The benefit will cease upon the death of the surviving spouse. The actuarial valuation to determine the liability is performed every year and the liability is unfunded. The post-retirement medical aid benefit liability is measured at the present value of the amount payable for the remaining lives of the beneficiaries and their surviving spouses. Employees become eligible for the medical aid subsidy on normal retirement at any age after 60.

10.2 MOVEMENTS IN THE POST-RETIREMENT MEDICAL AID BENEFIT FOR THE YEAR

	2024	2023
Balance at the beginning of the year	1,846,000	1,808,000
Expenses in respect of the current year:		
Service cost	96,000	99,000
Interest cost	265,000	233,000
Benefits paid	(24,000)	(23,000)
Remeasurements	7,000	(271,000)
	2,190,000	**1,846,000**
Employee costs	**24,000**	**23,000**
Non-current liabilities	1,836,000	1,510,000
Current liabilities	354,000	336,000
	2,190,000	**1,846,000**

If the assumed future rate of medical inflation was 1% higher, the liability would have been R365,730 (2023: R341,510) higher. The five-year summary of the post-retirement medical aid benefit liability as at 31 December 2024 is as follows:

	2024	2023	2022	2021	2020
Present value of liability	2,190,000	1,846,000	1,808,000	1,629,000	1,478,000
Actuarial gain/(loss)	7,000	271,000	90,000	93,000	189,000

10.3 POST RETIREMENT BENEFIT LIABILITY PROJECTION

	> 1 year	1-2 years	3-5 years	6-10 years
Projected service costs for the period	108,000	259,000	311,000	883,000
Projected interest costs for the period	273,000	687,000	923,000	3,632,000
Projected employer benefit payments for the period	(27,000)	(60,000)	(111,000)	(930,000)
Projected liability at the end for the period	2,544,000	3,430,000	4,553,000	8,138,000

10.4 KEY ASSUMPTIONS USED

An actuarial valuation was performed by independent valuators, 3One Actuaries Inc, on 31 December 2024, using the Projected Unit Credit discounted cashflow method. The projections contained in the valuation was consistent with those used in the prior year. The key assumptions used were:

	2024	2023
Discount rate	12.54%	14.43%
Real discount rate	3.46%	3.58%
Health care cost inflation	8.78%	10.48%
Long-term price inflation	7.28%	8.98%
Expected increase in salaries	8.78%	10.48%
Retirement age	63 years old	
Mortality rates	Pre-retirement: SA 85-90 (light) with a 3-year age reduction for females Post-retirement: PA(90)	

11 INSURANCE CONTRACTS LIABILITY FOR CURRENT MEMBERS

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

2024	Note	LFRC	LIC		Total
		Excl. loss component	BEL	RA	
Opening insurance contract liabilities		**-**	**333,735,779**	**2,065,387**	**335,801,166**
Changes in the statement of comprehensive income					
Insurance revenue recognised from contracts measured under the PAA	13	(578,069,267)	-	-	(578,069,267)
Total insurance revenue	**13**	**(578,069,267)**	**-**	**-**	**(578,069,267)**
Incurred claims and other insurance service expenses	14	-	552,315,584	1,961,679	554,277,263
Changes that relate to past service – adjustments to the LIC	14	-	(6,844,493)	(2,065,387)	(8,909,880)
Broker fees		465,710	-	-	465,710
Total insurance service expenses	**14**	**465,710**	**545,471,091**	**(103,708)**	**545,833,093**
Insurance service result		**(577,603,557)**	**545,471,091**	**(103,708)**	**(32,236,174)**
Finance expense from insurance contracts issued	15	-	21,094,514	-	21,094,514
Total amounts recognised in comprehensive income		**(577,603,557)**	**566,565,605**	**(103,708)**	**(11,141,660)**
Investment components: PMSA contributions received	**11.2**	**(165,347,201)**	**165,347,201**	**-**	**-**
Other changes					
Unclaimed PMSA liability written off to Scheme funds	**11.2**	**-**	**(275,853)**	**-**	**(275,853)**
Insurance debtors to LIC		**(22,096,458)**	**22,096,458**	**-**	**-**
Cash flows					
Contributions received		765,512,926	-	-	765,512,926
Claims and other directly attributable expense paid		-	(727,611,290)	-	(727,611,290)
Other cash flows from/(to) members and providers		-	(1,668,280)	-	(1,668,280)
Saving plan refunds	11.2	-	(15,601,936)	-	(15,601,936)
Broker fees		(465,710)	-	-	(465,710)
Total cash flows		**765,047,216**	**(744,881,507)**	**-**	**20,165,710**
Closing insurance contract liabilities		**-**	**342,863,536**	**1,961,679**	**344,549,363**

2023	Note	LFRC Excl. loss component	LIC BEL	LIC RA	Total
Opening insurance contract liabilities		**-**	**321,511,066**	**2,306,424**	**323,817,490**
Changes in the statement of comprehensive income					
Insurance revenue recognised from contracts measured under the PAA	13	(527,865,620)	-	-	(527,865,620)
Total insurance revenue	**13**	**(527,865,620)**	**-**	**-**	**(527,865,620)**
Incurred claims and other insurance service expenses	14	-	577,147,413	2,065,387	579,212,800
Changes that relate to past service – adjustments to the LIC	14	-	4,255,535	(2,306,424)	1,949,111
Broker fees		181,890	-	-	181,890
Total insurance service expenses	**14**	**181,890**	**581,402,948**	**(241,037)**	**581,343,801**
Insurance service result		**(527,683,730)**	**581,402,948**	**(241,037)**	**53,478,181**
Finance expense from insurance contracts issued	15	-	20,561,012	-	20,561,012
Total amounts recognised in comprehensive income		**(527,683,730)**	**601,963,959**	**(241,037)**	**74,039,193**
Investment components: PMSA contributions received	**11.2**	**(149,181,917)**	**149,181,917**	**-**	**-**
Other changes					
Insurance debtors to LIC		**22,386,235**	**(22,386,235)**	**-**	**-**
Cash flows					
Contributions received		654,661,302	-	-	654,661,302
Claims and other directly attributable expense paid		-	(697,385,981)	-	(697,385,981)
Other cash flows from/(to) members and providers		-	247,921	-	247,921
Saving plan refunds	11.2	-	(19,396,868)	-	(19,396,868)
Broker fees		(181,890)	-	-	(181,890)
Total cash flows		654,479,412	(716,534,928)	-	(62,055,516)
Closing insurance contract liabilities		-	333,735,779	2,065,387	335,801,166

11.1 RECONCILIATION OF NET INSURANCE CONTRACT LIABILITIES BALANCES

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

2024	LFRC	LIC	Total
Contributions receivable	443,865	-	443,865
Recoveries due from members	822,403	-	822,403
Recoveries due from service providers	1,946,592	-	1,946,592
Contributions received in advance	(3,270,844)	-	(3,270,844)
Insurance debtors to LIC	57,984	57,984	115,969
Reported claims not yet paid	-	1,042,525	1,042,525
Insurance payables for other directly attributable expenditure	-	2,126,017	2,126,017
Personal medical savings accounts liability	-	294,053,052	294,053,052
Best estimate liability (BEL) of claims incurred but not reported	-	45,308,105	45,308,105
Risk adjustment (RA)	-	1,961,679	1,961,679
	-	**344,549,363**	**344,549,363**

2023	LFRC	LIC	Total
Contributions receivable	21,625,716	-	21,625,716
Recoveries due from members	1,020,384	-	1,020,384
Recoveries due from service providers	65,929	-	65,929
Contributions received in advance	(2,356,237)	-	(2,356,237)
Insurance debtors to LIC	(20,355,793)	(20,355,793)	(40,711,585)
Reported claims not yet paid	-	34,920,430	34,920,430
Insurance payables for other directly attributable expenditure	-	1,954,807	1,954,807
Personal medical savings accounts liability	-	271,352,846	271,352,846
Best estimate liability (BEL) of claims incurred but not reported	-	45,863,488	45,863,488
Risk adjustment (RA)	-	2,065,387	2,065,387
	-	**335,801,166**	**335,801,166**

LIABILITY FOR REMAINING COVERAGE (LRC)

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

LIABILITY FOR INCURRED CLAIMS (LIC)

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

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

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

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

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

Risk Adjustment:

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

The risk adjustment was determined by applying sensitivity testing to the run-off input assumptions used to calculate the best estimate reserve value, i.e. a deterministic sensitivity

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

Claims Sensitivity:

Refer Note 22.2 for the claims sensitivity analysis.

11.2 RECONCILIATION OF NET INSURANCE CONTRACT LIABILITIES BALANCES

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

	2024	2023
Balance of the PMSA liability at 1 January	271,352,846	252,853,636
PMSA contributions received or receivable (Note 13)	165,347,201	149,181,917
Transfers from other schemes in terms of Regulation 10(4)	14,401	41,116
Finance expense from insurance contracts	21,094,514	20,561,012
Claims paid to and on behalf of members (Note 14)	(147,878,121)	(131,887,966)
Refunds on death or resignation in terms of regulation 10(5)	(15,601,936)	(19,396,868)
Unclaimed PMSA liability written off to Scheme funds	(275,853)	-
Balances on PMSA at 31 December	**294,053,052**	**271,352,846**

The Comprehensive and Midmas benefit options allow members the facility to pay a 25% percent of their gross contributions into a savings account, to assist members in managing their healthcare costs to their own requirements. Savings are capped at a maximum of 25.0% of the gross contributions.

The personal medical savings account (PMSA) contains a demand feature in terms of Regulation 10 of the Act that any credit balance on a member's PMSA must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit option and then enrols in another benefit option or medical scheme without a PMSA or does not enrol in another medical scheme. Interest is paid to members on PMSA monies at the rate achieved by the Scheme's cash portfolio net of asset management fees. The effective interest rate earned was 7.5% (2023: 7.8%).

12 TRADE AND OTHER PAYABLES

	2024	2023
Financial liabilities		
Provision for audit fees	870,088	616,744
Provision for employee costs	711,832	632,390
Accruals	276,821	1,337,923
Deposits received from tenants	54,504	54,504
VAT liability	36,271	33,971
	1,949,516	**2,675,531**

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

13 INSURANCE REVENUE

Gross contributions per registered rules	743,416,468	677,047,537
PMSA contributions received or receivable	(165,347,201)	(149,181,917)
	578,069,267	**527,865,620**

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

14 INSURANCE SERVICE EXPENSES

	2024	2023
Risk claims per the rules of the Scheme:		
Direct benefits for the current period per the registered rules	641,873,737	622,028,925
Direct benefits for the previous period per the registered rules	9,106,793	54,550,185
Claims paid from personal medical savings accounts	(147,878,121)	(131,887,966)
Discount received	(453,559)	(256,802)
Adjustment to the LIC provision	8,250,789	(4,672,199)
Claims incurred	510,899,640	539,762,143
Third party claims recoveries	-	(836,462)
Accredited managed healthcare services (note 14.1)	10,323,283	9,526,006
Attributable expenses incurred (note 14.2)	33,054,340	30,761,112
Incurred claims and other directly attributable expenses	554,277,263	579,212,800
Changes that relate to past service – Adjustment to the LIC	(8,909,880)	(1,753,614)
Insurance acquisition costs - Broker fees	465,710	181,890
Amounts attributable to future members	(103,364,017)	1,851,362
	442,469,076	**579,492,438**

14.1 ACCREDITED MANAGED HEALTHCARE SERCIVES (NO RISK TRANSFER)

Active risk management services	3,157,701	2,910,808
Hospital benefit management services	3,939,661	3,616,493
Pharmacy benefit management services	1,814,719	1,683,598
Disease risk management support services	897,134	821,918
Managed care network management services and risk management	514,067	493,190
	10,323,283	**9,526,006**

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

14.2 ATTRIBUTABLE EXPENSES INCURRED

Actuarial fees	670,266	635,973
Administration expenditure: benefit management services (not accredited managed care)	2,508,025	2,128,853
Administration fees in respect of accredited services	1,939,419	1,872,134
ITC expenditure	6,718,618	5,894,420
Member communication	498,307	594,863
Staff remuneration and employment costs	20,719,705	19,517,295
Third party claims recovery administration fees	-	117,575
	33,054,340	**30,761,112**

15 INVESTMENT INCOME

	2024	2023
Financial assets at fair value though profit or loss		
Dividend income	10,566,687	10,193,829
Interest income	44,452,297	44,136,039
Financial assets at amortised cost		
Interest income	5,062,747	2,730,114
Net fair value gains on financial assets at fair value though profit or loss	43,855,799	30,299,569
Rental income on investment property	4,485,675	4,182,890
	108,423,205	**91,542,440**

16 ADMINISTRATION FEES AND OPERATIVE EXPENSES

Association fees	94,383	70,787
Audit fees	1,952,197	1,033,973
Bank charges	36,212	154,647
Consulting fees	299,129	539,371
Council for Medical Schemes levies	468,063	435,731
Debt collection fees	78,264	84,930
Depreciation, amortisation and impairments	552,228	988,421
Fidelity guarantee insurance	33,178	32,691
Fraud awareness expenses	52,785	-
Insurance	207,011	158,225
Internal audit fees	653,096	625,101
Legal fees	85,068	1,056,590
Marketing	476,348	442,420
Meeting expenses	52,039	70,123
Motor vehicle expenses	111,345	97,015
Office expenses, repairs and maintenance	156,584	249,512
Operating leases - office equipment	53,460	71,470
Principal officers' conference and travel costs	36,185	-
Principal officers' remuneration	2,475,234	2,678,232
Professional indemnity insurance	62,184	59,223
Recruitment and selection	5,578	66,952
Statutory manager's fees	-	1,954,000
Training and development	212,310	218,158
Travel, accommodation and conferences	8,585	650
Trustees' and Committee Members' remuneration and considerations	99,724	62,052
	8,261,191	**11,150,277**

17 TRUSTEES' AND COMMITTEE MEMBERS' REMUNERATION AND CONSIDERATIONS

2024	**Fees for meeting attendance**	**Travelling and other expenses for meetings and conferences**	**Total**
BOARD OF TRUSTEES			
S Lupuwana	-	5,143	**5,143**
M Makgolane	-	15,185	**15,185**
A Mazibuko	-	14,265	**14,265**
BM Modise	-	14,460	**14,460**
K Msimeki	-	14,370	**14,370**
	-	63,422	**63,422**

2024	Fees for meeting attendance	Travelling and other expenses for meetings and conferences	Total
AUDIT AND GOVERNANCE COMMITTEE			
AJ de Klerk (non-trustee)	15,368	3,766	**19,134**
NOMINATIONS AND ADVISORY COMMITTEE			
J Perkes (non-trustee)	8,030	-	**8,030**
REMUNERATION COMMITTEE			
J Perkes (non-trustee)	9,139	-	**9,139**
	32,537	**67,187**	**99,724**
2023			
BOARD OF TRUSTEES			
JC de Carvalho	10,375	-	**10,375**
R Mnguni	-	9,002	**9,002**
BM Modise	-	9,002	**9,002**
	10,375	18,005	**28,380**
AUDIT AND GOVERNANCE COMMITTEE			
AJ de Klerk (non-trustee)	12,882	1,684	**14,566**
REMUNERATION COMMITTEE			
J Perkes (non-trustee)	19,106	-	**19,106**
	42,363	**19,689**	**62,052**

18 SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

2024	Comprehensive	Midmas	Ntsika	Scheme
Gross contribution income	600,247,534	61,860,082	81,308,852	743,416,468
Savings contributions	(149,894,815)	(15,452,386)	-	(165,347,201)
Insurance revenue	450,352,719	46,407,696	81,308,852	578,069,267
Claims incurred excluding claims incurred in respect of risk transfer arrangements	(407,226,242)	(41,268,246)	(62,405,152)	(510,899,640)
Accredited managed healthcare expenses	(6,931,557)	(821,498)	(2,570,228)	(10,323,283)
Attributable expenses incurred	(23,107,949)	(3,691,412)	(6,254,979)	(33,054,340)
Changes that relate to past service – adjustment to the LIC	9,271,882	(467,700)	105,698	8,909,880
Insurance acquisition cash flows (broker fees)	(150,764)	(270,664)	(44,282)	(465,710)
Insurance service expenses	(428,144,629)	(46,519,520)	(71,168,944)	(545,833,093)
INSURANCE SERVICE RESULT	**22,208,090**	**(111,824)**	**10,139,909**	**32,236,174**
Investment income	90,992,671	7,879,232	9,551,303	108,423,205
Gain/(loss) on disposal of equipment	(20,238)	(3,262)	(6,860)	(30,360)
Sundry income	571,428	1,737	-	573,164
OTHER INCOME	**91,543,860**	**7,877,707**	**9,544,442**	**108,966,009**
Impairment losses on insurance receivables	(417,944)	(40,936)	2,614	(456,266)
Insurance finance expenses	(20,481,950)	(612,565)	-	(21,094,514)
Asset management fees	(3,048,818)	(491,373)	(1,033,498)	(4,573,689)
Costs incurred on rental property	(2,301,439)	(370,919)	(780,149)	(3,452,507)
Administration fees and operative expenses	(5,506,905)	(887,538)	(1,866,747)	(8,261,191)
OTHER EXPENSES	**(31,757,056)**	**(2,403,331)**	**(3,677,780)**	**(37,838,166)**
NET RESULT BEFORE MUTUALISATION	**81,994,894**	**5,362,552**	**16,006,571**	**103,364,017**

2023	Comprehensive	Midmas	Ntsika	Scheme
Gross contribution income	565,110,881	35,559,039	76,377,617	677,047,537
Savings contributions	(141,183,817)	(7,998,100)	-	(149,181,917)
Insurance revenue	423,927,064	27,560,939	76,377,617	527,865,620
Claims incurred excluding claims incurred in respect of risk transfer arrangements	(450,580,864)	(25,086,155)	(70,716,434)	(546,383,453)
Third party claim recoveries	836,462	-	-	836,462
Accredited managed healthcare expenses	(6,592,792)	(467,521)	(2,465,693)	(9,526,006)
Attributable expenses incurred	(21,449,731)	(1,986,723)	(7,324,658)	(30,761,112)
Movement in the liability for incurred claims provision	6,131,767	(409,448)	(1,050,120)	4,672,199
Insurance acquisition cash flows (broker fees)	(68,789)	(89,733)	(23,370)	(181,892)
Insurance service expenses	(471,723,947)	(28,039,580)	(81,580,275)	(581,343,802)
INSURANCE SERVICE RESULT	**(47,796,883)**	**(478,641)**	**(5,202,658)**	**(53,478,182)**
Investment income	79,537,222	3,997,816	8,007,403	91,542,440
Gain/(loss) on disposal of equipment	111,643	10,760	38,208	160,611
Sundry income	178,892	17,242	61,223	257,357
OTHER INCOME	**79,827,757**	**4,025,818**	**8,106,834**	**91,960,408**
Impairment losses on insurance receivables	(233,016)	(55,017)	(743)	(288,775)
Insurance finance expenses	(20,291,194)	(269,818)	-	(20,561,012)
Asset management fees	(3,398,217)	(327,520)	(1,162,980)	(4,888,717)
Costs incurred on rental property	(2,394,535)	(230,785)	(819,487)	(3,444,807)
Administration fees and operative expenses	(7,750,716)	(747,015)	(2,652,546)	(11,150,277)
Other income and expenses	**(34,067,678)**	**(1,630,155)**	**(4,635,756)**	**(40,333,588)**
NET RESULT BEFORE MUTUALISATION	**(2,036,804)**	**1,917,022**	**(1,731,580)**	**(1,851,362)**

19 RELATED PARTIES

Relationships

Key management personnel	Trustees and their close family members
	Principal Officer and her close family members

Balances and transactions

	2024	2023
Trustee Remuneration (note 17)	63,422	28,380
Payments to related parties of trustees	-	314,242
Contributions received in terms of the Scheme's Rules	1,277,646	2,626,800
Claims paid in terms of the Scheme's Rules	1,492,407	1,586,946
Savings account balances	483,284	667,527
Principal officers' remuneration (note 16)	2,475,234	2,678,232
Principal officers' travel, accommodation and conferences (note 16)	62,184	-
Statutory Manager's Fees (note 16)	-	1,954,000

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

20 FINANCIAL RISK MANAGEMENT

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

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

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

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

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

20.1 CREDIT RISK

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

20.1.1 Exposure to credit risk

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

	Fair value/ Amortised cost	Impairment	Carrying amount
2024			
Investments (note 6)	956,485,185	-	956,485,185
Non-insurance receivables (note 7)	475,909	-	475,909
Cash and cash equivalents (note 8)	99,403,561	-	99,403,561
Insurance receivables (note 11)	3,450,557	(237,697)	3,212,860
	1,059,815,213	**(237,697)**	**1,059,577,515**
2023			
Investments (note 6)	876,918,435	-	876,918,435
Non-insurance receivables (note 7)	1,485,302	(1,026,095)	459,207
Cash and cash equivalents (note 8)	70,184,080	-	70,184,080
Insurance receivables (note 11)	23,030,534	(318,504)	22,712,030
	971,618,350	**(1,344,599)**	**970,273,752**

Investments

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

Domestic equity investments

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

Domestic fixed-income and cash investments

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

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

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

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

Top 5 holdings at 31 December	Rating (long term)	Risk of default	Percentage of portfolio 2024	2023
Current accounts				
Nedbank Ltd	Baa3	Moderate	100.0%	100.0%
Money market accounts				
Nedbank Ltd	Baa3	Moderate	24.0%	29.8%
ABSA Bank Ltd	Baa3	Moderate	23.9%	21.9%
Standard Bank Ltd	Baa3	Moderate	20.3%	21.6%
FirstRand Bank Ltd	Baa3	Moderate	13.2%	14.0%
Investec Bank Ltd	Aa1	Very low	11.8%	8.7%
			93.2%	96.0%

Insurance, trade and other receivables

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

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

Age analysis of insurance receivables

	Gross carrying amount	Impairment	Carrying amount
2024			
Not past due	328,718	(11,784)	316,934
Past due 1 - 30 days	332,218	(12,265)	319,953
Past due 31 - 60 days	193,837	(27,749)	166,088
Past due 61 - 90 days	110,870	(21,621)	89,250
Past due more than 90 days	2,484,914	(164,279)	2,320,635
	3,450,557	**(237,697)**	**3,212,859**
2023			
Not past due	21,267,945	-	21,267,945
Past due 1 - 30 days	303,257	-	303,257
Past due 31 - 60 days	57,280	-	57,280
Past due 61 - 90 days	308,445	-	308,445
Past due more than 90 days	1,093,607	(318,504)	775,103
	23,030,534	**(318,504)**	**22,712,030**

Age analysis of trade and other receivables

	Gross carrying amount	Impairment	Carrying amount
2024			
Not past due	162,080	-	162,080
Past due 1 - 30 days	75,876	-	75,876
Past due 31 - 60 days	-	-	-
Past due 61 - 90 days	-	-	-
Past due more than 90 days	-	-	-
	237,957	**-**	**237,957**

	Gross carrying amount	Impairment	Carrying amount
2023			
Not past due	212,489	-	212,489
Past due 1 - 30 days	11,078	(3,371)	7,707
Past due 31 - 60 days	-	-	-
Past due 61 - 90 days	-	-	-
Past due more than 90 days	1,022,723	(1,022,723)	-
	1,246,290	**(1,026,094)**	**220,196**

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

The Scheme establishes an allowance for impairment that represents its estimate of expected credit losses (IFRS 9) in respect of receivables. The collective loss allowance is determined based on a set policy, while bearing in mind historical data of payment statistics for similar financial assets. The provision for impairment at 31 December 2024 was determined in accordance with the guidelines of the simplified approach (lifetime expected losses) of the expected credit loss model as required by IFRS 9. It is in respect of contributions receivable, member and service provider debit balances and advances from savings plan accounts recoverable by management.

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

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

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

20.2 LIQUIDITY RISK

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

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

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

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

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

The Scheme expects to achieve a net surplus (before considering amounts attributable to future members) for the period ending 31 December 2025 and therefore does not expect to utilise the liability attributable to future members within the next months, other than the portion relating to insurance premiums received in advance.

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

Insurance liabilities

2024	**0 - 12 months**	**+12 months**	**Total**
Liabilities attributable to current members (note 11)	344,549,363	-	344,549,363
Liabilities attributable to future members (note 9)	-	724,598,316	724,598,316
	344,549,363	**724,598,316**	**1,069,147,678**
2023			
Liabilities attributable to current members (note 11)	335,801,166	-	335,801,166
Liabilities attributable to future members (note 9)	-	621,234,299	621,234,299
	335,801,166	**621,234,299**	**957,035,465**

Trade and other payables

2024	**0 - 12 months**	**+12 months**	**Total**
Trade and other payables (note 12)	1,949,516	-	1,949,516
2023			
Trade and other payables (note 12)	2,675,531	-	2,675,531

20.3 INTEREST RATE RISK

The Scheme's investment policy during the year under review was to hold most of investments in interest bearing instruments when assessed on a look-through basis in accordance with Annexure B of Regulation 30 to the Medical Schemes Act. The Scheme's investments were therefore exposed to changes in the market interest rates. Except for the Scheme's investments in interest-bearing instruments, cash and cash equivalents also expose the Scheme to interest rate risk. The table below summarises the Scheme's exposure to interest rate risks. Included in the table are the Scheme's investments at carrying amounts categorised by earlier of contractual repricing or maturity dates.

	2024	2023
Investments in property (note 6)	16,367,675	10,588,774
Interest-bearing investments, including bonds (note 6)	309,138,324	291,850,006
Cash and cash equivalents (notes 6 and 8)	457,144,556	418,918,433
Total variable rate instruments	**782,650,555**	**721,357,213**

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

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

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

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

	2024		2023	
	Increase	**Decrease**	**Increase**	**Decrease**
Impact of a change in interest rates by 100 basis points on surplus/deficit	7,826,506	(7,826,506)	7,213,572	(7,213,572)

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

	2024		2023	
	Insurance contract liabilities	**Profit or loss**	**Insurance contract liabilities**	**Profit or loss**
0.5% increase in interest rates: Insurance contract liabilities	14,702,653	(14,702,653)	13,567,642	(13,567,642)

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

20.4 MARKET PRICE RISK

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

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

The Scheme strives to minimise market risk as follows:

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

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

The Scheme uses a sensitivity analysis technique for financial market risks that measures the estimated change to profit or loss and accumulated funds. If the equity indexes had been 3% lower, the Scheme's surplus and accumulated funds for the year would reduce by R8.2 million (2023: R6.8 million) because of the change in the market value of instruments.

21 CAPITAL RISK MANAGEMENT

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

22 INSURANCE RISK MANAGEMENT

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

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

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

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

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

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

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

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

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

22.1 EXPENSE RISK

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

22.2 CHANGES FROM THE PREVIOUS PERIOD

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

22.3 METHODS USED AND ASSUMPTIONS MADE

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

22.4 CONCENTRATION OF INSURANCE RISK

The Scheme's strategy seeks diversity to ensure a balanced portfolio and is based on a large portfolio of similar risks over several years and, as such, it is believed that this reduces the volatility of the outcome. The strategy is set out in the annual business plan, which specifies the benefits to be provided, the preferred target market and demographic split thereof.

In-hospital benefits cover all cost incurred by members, whilst they are in hospital to receive pre-authorised treatment for certain medical conditions. Chronic benefits cover the cost of

certain prescribed medicines consumed by members for chronic conditions/diseases, such as high blood pressure, cholesterol and asthma. Day-to-day benefits cover the cost (up to 100% of the Scheme tariff) of all out of hospital medical attention, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines. Savings account claims are excluded. All the contracts are annual in nature and the Scheme has the right to change the terms and conditions of the contract at renewal. Management information, including contribution income, claims ratios and demographic split, is reviewed monthly.

The following table summarises the concentration of insurance risk, with reference to the carrying amount of the insurance claims incurred, excluding capitation fees, by age group in relation to the type of risk covered / benefits provided.

Age group	Unique claiming beneficiaries	In-hospital		Chronic		Day to day		Total
		PMB	Non-PMB	PMB	Non-PMB	PMB	Non-PMB	
2024								
< 25	11,423	45,845,943	5,754,483	18,894,520	4,273,387	1,177,562	12,516,442	88,462,337
25 - 34	2,947	21,110,173	4,123,355	10,011,530	2,197,157	971,000	7,980,744	46,393,959
35 - 49	7,100	66,570,891	8,747,610	34,528,968	10,374,274	2,107,967	18,891,314	141,221,023
50 - 64	3,244	57,629,478	5,673,795	36,510,304	6,457,172	905,139	10,945,674	118,121,563
> 65	1,363	65,346,484	3,412,959	39,305,476	4,637,865	365,690	7,828,080	120,896,553
	26,077	**256,502,969**	**27,712,203**	**139,250,798**	**27,939,856**	**5,527,357**	**58,162,254**	**515,095,436**
2023								
< 25	8,660	40,909,722	-	19,509,625	242,971	14,398	15,430,769	76,107,485
25 - 34	1,361	72,961,238	14,448	42,148,163	2,791,410	6,542	14,273,472	132,195,273
35 - 49	2,594	20,920,004	-	9,756,244	1,357,596	10,161	9,013,178	41,057,183
50 - 64	6,289	58,986,357	1,537	38,373,935	3,282,672	44,373	22,014,626	122,703,500
> 65	3,049	51,025,187	9,839	34,834,786	2,405,651	22,909	15,575,894	103,874,266
	21,953	**244,802,508**	**25,824**	**144,622,753**	**10,080,300**	**98,383**	**76,307,939**	**475,937,707**

22.5 SENSITIVITY ANALYSIS

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

22.5.1 If unpaid claims and insurance expenses increase by 5%

	LIC as at 31 December	Impact on LIC	Impact on SOCI*
2024			
Insurance contract liabilities	344,549,363	17,227,468	(17,227,468)
2023			
Insurance contract liabilities	335,801,166	16,790,058	(16,790,058)

*Statement of Profit or Loss and Comprehensive Income

22.5.2 Risk adjustment sensitivities

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

	2024	2023
Risk adjustment with a 60% confidence level - as reported	1,961,679	2,065,387
Risk adjustment with a 65% confidence level	3,069,610	3,535,042

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

22.5.3 Claims development

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

23 STRUCTURED ENTITIES

The Scheme's investments in investee funds are subject to the terms and conditions of the respective investee fund's offering documentation and are susceptible to market price risk arising from uncertainties about future values of those investee funds. The asset manager makes investment decisions after extensive due diligence of the underlying fund, its strategy and the overall quality of the underlying fund's manager. All investee funds in the investment portfolio are managed by portfolio managers who are compensated by the respective investee funds for their services. Such compensation generally consists of an asset-based fee and a performance-based incentive fee and is reflected in the valuation of the fund's investment in each of the investee funds. These investments are included in investments at fair value through other profit or loss as in the statement of financial position.

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

Investee funds	2024	2023
Coronation Medical Absolute	265,357,102	241,993,524
M&G Medical Aid Inflation Plus 5%	261,656,371	240,941,835
NinetyOne Stable Money Fund	122,847,551	112,198,503
	649,861,023	**595,133,862**

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

24 LIABILITY AND ADEQUACY TESTS

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

25 COMMITMENTS AND CONTINGENCIES

25.1 OPERATING LEASE COMMITMENTS

	2024	2023
Minimum lease payments due:		
- within one year	54,165	29,620
- in the second to the fifth year inclusive	90,275	-
	144,440	**29,620**

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

25.2 CONTINGENT ASSETS

Claims against the Road Accident Fund for benefits paid on behalf of the Scheme's members are disclosed as a contingent asset as the inflow of economic benefits is probable, but not virtually certain. At the reporting date Road Accident Fund claims of R10 117 195 (2023: R8 681 333) had been submitted but not yet concluded.

26 FIDELITY COVER

The Scheme maintains fidelity insurance at a level deemed appropriate by the Board of Trustees. The fidelity cover at 31 December 2024 amounts to R 800,000 (2023: R 800,000). The cover is provided under a group Fidelity Policy covering the scheme.

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

27 MATTERS OF NON-COMPLIANCE WITH THE ACT

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

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

Section 26(7) of the Act requires that all contributions be paid directly to a medical scheme within three days of becoming due. In 2024, not all billed contributions were received within this timeframe, which could impact cash flow and interest income. The Scheme actively follows up on outstanding contributions and applies its credit control policy to manage overdue payments effectively.

27.2 CLAIMS PAYMENT DELAYS (SECTION 59(2))

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

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

Section 33(2)(b) of the Medical Schemes Act requires that each benefit option be financially self-supporting to maintain the financial integrity of the Scheme and prevent cross-subsidisation.

In 2024, the Midmas option recorded a minor insurance service deficit of R111,824 (refer to Note 18 of the Annual Financial Statements). While this deficit is not material, persistent deficits on benefit options could potentially lead to cross-subsidisation from surplus-generating options, which may impact the overall financial soundness of the Scheme.
To ensure long-term sustainability and regulatory compliance, the Scheme is actively implementing strategic measures, including:

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

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

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

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

As of 31 December 2024, the Scheme held underlying investments amounting to 0.6% in medical scheme administrators or their holding companies (Momentum Metropolitan Holdings, Discovery Holdings and Sanlam Limited) and 0.6% in employer groups (Glencore Plc and Exxaro Resources) of total net asset value. The Scheme has obtained an exemption from the Council for Medical Schemes (CMS) to retain these investments while ensuring compliance with broader regulatory requirements.

28 GOING CONCERN

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

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

In reviewing budgets and cash flow projections, along with additional financial data for 2025, the Board of Trustees has determined that the going concern assumption remains appropriate for the next twelve months from the date of approval of the Annual Financial Statements. This assessment underscores the Scheme's financial stability and ability to meet its obligations while continuing to provide sustainable healthcare benefits to its members.

29 SIGNIFICANT EVENTS

In 2019, the Scheme reported a significant event involving alleged fraudulent activities by a senior management member. These activities included misuse of Scheme property, unauthorised expenses, non-compliance with internal procurement policies, and theft of monetary assets. Following an independent forensic investigation, the Scheme took legal action and successfully recovered a portion of the misappropriated funds. A criminal complaint was also lodged to address the matter.

In 2020, the Council for Medical Schemes (CMS) initiated an investigation into the Scheme's governance under Section 44(4)(a) of the Medical Schemes Act. Based on the findings, CMS recommended the appointment of a Statutory Manager under Section 5A of the Financial Institutions (Protection of Funds) Act, 28 of 2001, to oversee governance improvements and ensure compliance with regulatory requirements.

Under an agreement between CMS, the Registrar, and the Board of Trustees, Mr. Juanito Damons was appointed as the Statutory Manager on 18 July 2022. His role included attending all Board of Trustees and Audit & Governance Committee meetings, as well as conducting ad hoc engagements with Scheme officials to monitor progress.

By 31 July 2023, the Scheme had successfully implemented the governance enhancements recommended by the Statutory Manager. As a result, CMS applied to the High Court to remove the Scheme from Statutory Management. On 25 November 2024, the court officially terminated statutory management, marking the Scheme's return to normal governance operations and reaffirming its commitment to strong governance, transparency, and regulatory compliance.

30 EVENTS AFTER THE REPORTING PERIOD

On 20 January 2025, the United States President's Emergency Plan for AIDS Relief (PEPFAR) funding in South Africa was paused for 90 days pending a final decision on future funding. The termination of PEPFAR funding would have significant repercussions on the nation's HIV/AIDS response in the public health services sector and NGOs directly involved in HIV prevention and treatment. The impact on the Scheme, whose members are mostly claiming from the private sector already, is not considered significant enough to require a policy adjustment or a change in claims estimates.

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