



ALLIANCE-MIDMED MEDICAL SCHEME

Registration number 1465

**Annual Board of Trustees Report
and
Audited Financial Statements**

for the year ended 31 December 2025

ALLIANCE-MIDMED MEDICAL SCHEME

FINANCIAL STATEMENTS

for the year ended 31 December 2025

The reports and statements set out below comprise the financial statements presented to members:

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ALLIANCE-MIDMED MEDICAL SCHEME

FINANCIAL STATEMENTS

for the year ended 31 December 2025

STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES

The Board of Trustees ("Board" or "Trustees") is responsible for the preparation, integrity, and fair presentation of the financial statements of Alliance-Midmed Medical Scheme ("the Scheme"). The financial statements presented on pages 11 to 30 have been prepared in accordance with IFRS® Accounting Standards as issued by the International Accounting Standards Board (IASB) and the Medical Schemes Act 131 of 1998, as amended ("the Act") and include amounts based on judgements and estimates.

The Board is satisfied that the information contained in the financial statements fairly presents the results of operations and cash flows for the year and the financial position of the Scheme at year-end. The Board also prepared the additional information included in the Board of Trustees report and are responsible for both its accuracy and its consistency with the financial statements.

The Scheme operates in a well-documented control environment with established policies and procedures to enhance oversight, including reviews that incorporate risk management and internal control procedures, which are designed to provide reasonable assurance that assets are safeguarded and the risks facing the Scheme are controlled. No event or item has come to the attention of the Board of Trustees that indicates any material breakdown in the key internal controls and systems during the year under review.

The going concern basis has been adopted in preparing the financial statements. The Council for Medical Schemes (CMS) announced in 2017 its intention to consolidate Schemes to align with the longer-term funding objectives of the National Health Insurance (NHI) Scheme. This initiative is, however, likely to face delays and challenges before it becomes a reality. We support the principle of Universal Healthcare, but we oppose the stated objective of the NHI to exclude medical Schemes from providing healthcare services in South Africa.

The Board has no reason to believe that the Scheme will not be a going concern for the foreseeable future based on these financial statements, forecasts, and available cash resources.

The Board documented identified risks in a comprehensive risk matrix. The risk matrix forms the basis for the Board's responses to risks and exposures. The Board especially dedicates time to the risks and mitigation strategies at the board meetings.

The Audit Committee includes risk and compliance (committee referred to as ARCC). Its scope broadened from the prescribed mandate and the Scheme's registered rules, constituted in accordance with the provisions of the Act.

Ranrus Incorporated was appointed as external auditor for the period under review.

The Scheme is committed to the principles and practice of fairness, openness, integrity and accountability in its dealings with stakeholders. The Scheme subscribes to the highest standards of governance, following relevant frameworks such as King IV and King V wherever applicable. The Scheme's external auditors have audited the financial statements in terms of IFRS® Accounting Standards as issued by the International Accounting Standards Board (IASB) and their report is presented on pages 7 to 10.

There were no requests for Scheme information under the Promotion of Access to Information Act 2 of 2000.

The Board is committed to, as far as it is practically possible, adhere to non-binding rules, codes, and standards.

The Board meets regularly and monitor the performance of the Scheme and its service providers. The Board addresses a range of key issues and ensure that discussions on items of policy, strategy and performance is critical, informed and constructive.

Member Representative Trustees are elected every three years and comprise 50% of the Board. During 2024 elections were held and new Board members appointed. Board members receive extensive training and all have access to the advice and services of the Principal Officer and in compliance with Scheme policies may seek independent professional advice at the expense of the Scheme.

The Board adheres to a gifts policy and manages potential conflicts of interest through voluntary disclosures and legal checks. Board members are also members of the Scheme. Their contributions and claims are reported and managed at arms-length as for members.

The Board holds an Annual General Meeting, compliant with the notification, agenda, content and disclosure requirements, in terms of its Rules and as specified by the Regulator.

The Board embarked on a compliance project to comply substantially with the good governance requirements contained in the King IV Report and King V Report.

To improve compliance to a level acceptable to the Board and to maintain a service-focused and member-centric responsive medical scheme, the Board commenced self-administration on 1 January 2020. Self-administration will enable the Board to maintain a lower cost structure and enhance our focused management of access to quality healthcare services.

In November 2023, the Board also applied to perform inhouse managed care services, which was approved in March 2024.

The Financial Statements were approved by the Board of Trustees on 26 May 2026 and are signed on its behalf by:

SD Muller
Chairperson

J Nell
Trustee

PDG Theron
Principal Officer

ALLIANCE-MIDMED MEDICAL SCHEME

Registration number: 1465

REPORT OF THE BOARD OF TRUSTEES

for the year ended 31 December 2025

1. DESCRIPTION OF THE MEDICAL Scheme

1.1 Terms of registration

Alliance-Midmed Medical Scheme ("the Scheme") is a non-profit restricted membership medical Scheme registered in terms of the Medical Schemes Act 131 of 1998, as amended ("the Act"). Its membership is restricted to employees and retirees who work / worked for Columbus Stainless (Pty) Ltd and associate companies.

1.2 Benefit options within Alliance-Midmed Medical Scheme

The Scheme offers one benefit option.

1.3 Personal Medical Savings Account (PMSA)

The Scheme offers a 5% (2024: 5%) PMSA, paying the majority of benefits through the Major Risk Pool (MRP).

The PMSA forms part of the Scheme assets, but unexpended savings amounts are accumulated for the benefit of the member. No interest accrues to positive savings balances.

In terms of the Regulations of the Act and the Rules of the Scheme, the PMSA is underwritten by the Scheme.

2. MANAGEMENT

2.1 Board of Trustees in office during the year under review:

SD Muller	Trustee / Chairperson	Member Representative Trustee	Re-elected 1 September 2024
FJ Mabheba	Trustee	Employer Representative Trustee	Re-appointed 1 September 2024
JC van Coller	Trustee	Employer Representative Trustee	Re-appointed 1 September 2024
M van Staden	Trustee	Member Representative Trustee	Elected 1 September 2024
JJ Tharakan	Trustee	Member Representative Trustee	Elected 1 September 2024
J Nell	Trustee	Employer Representative Trustee	Re-appointed 1 September 2024
S Beyer	Alternate	Alternate	Appointed 1 September 2024
A Taljaard	Alternate	Alternate	Elected 1 September 2024
P Monatisa	Alternate	Alternate	Elected 1 September 2024
V Nqwenya	Observer	Alternate	Appointed 1 September 2024

The Trustees took office on 1 September 2024. Three Trustees are appointed, and three Trustees are elected. Four Co-opted persons are invited to attend the Board meetings to ensure continuity should Trustees become unavailable to perform their duties or resign.

Board elections are performed according to the Rules and the Trustee Elections Policy Guidelines, with the objective to appoint knowledgeable and representative Board that acts in the best interest of the Scheme and all its beneficiaries. First there is a call for nominations, followed by a process to obtain the nominee's acceptance and several checks to confirm that the nominees meet the legal requirements. An open election and formal appointment process follows, whereafter the Trustees are provided with comprehensive training.

As the Scheme is a restricted Scheme and Trustees are also members of the Scheme, there tends to be a greater degree of engagement and an interest in its continued success. After the initial training, further training is based on self-assessment.

The Trustees are not remunerated for their services.

2.2 Principal Officer

Appointed 01 February 2025
PDG Theron
25 Robertson
Clubville
Middelburg
1050

Office term ended 31 January 2025
JH Hartzenberg
Postnet Suite
Private Bag X1838
Middelburg
1050

2.3 Registered office address and postal address

Family Wellness Centre
Corner Montagu and Chrome Streets
Middelburg
1055

Postnet Suite MW 765
Private Bag X1838
Middelburg
1050

2.4 Scheme Administrator

The Scheme commenced self-administration effective 1 January 2020, after receiving in-principle approval from the Council for Medical Schemes (CMS).

ALLIANCE-MIDMED MEDICAL SCHEME
Report of the Board of Trustees
for the year ended 31 December 2025

2. MANAGEMENT (continued)

2.5 Consultants

Dr R Odes and Dr Heffer performed the duties of Scheme Medical Advisor.

2.6 Bankers

First National Bank

2.7 Independent Auditors

Ranrus Incorporated
Ground Floor, Building 2
Hyde Park Manor
79 Hyde Lane
Hyde Park
2196
Appointed: 21 September 2022

2.8 Investment managers during the year

Contract commenced 1 November 2024
Sygnia Asset Management (Pty) Ltd
7th Floor, The Foundry
Cardiff Street
Cape Town
8001
Financial Service Provider Number 873

3. INVESTMENT POLICY OF THE SCHEME

The Scheme's long term investment objective is to maximize the return on its investments while exercising prudence. The investment strategy takes into consideration constraints imposed by the Act.

4. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

4.1 Operational statistics

Refer to page 6 of this report for a comparative analysis of the operational statistics of the Scheme.

4.2 Results of operations

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

4.3 Solvency margin

In terms of Regulation 29(2) of the Medical Schemes Act 131 of 1998, as amended, the Scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may not be less than 25%.

	2025 R	2024 R
The accumulated funds ratio is calculated on the following basis:		
Insurance liability for future members	92 536 690	81 300 779
Less: Cumulative unrealised gains on financial assets at fair value through profit and loss	(7 736 318)	-
Accumulated funds per Regulation 29 of the Act	84 800 372	81 300 779
Insurance revenue (note 8)	152 407 412	133 902 882
Solvency margin	55.64%	60.72%

ALLIANCE-MIDMED MEDICAL SCHEME

Report of the Board of Trustees

for the year ended 31 December 2025

4. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES (continued)

4.4 Insurance liability for future members

Movements in the Insurance liability for future members are set out in note 9.6.

4.5 Outstanding claims

Movements in the outstanding claims provision are set out in Note 6.2 to the annual financial statements. 3ONE Consulting Actuaries (3ONE) provided an estimate of the Scheme's required Liability for Incurred Claims (LIC) Provision as at 31 December 2025, taking into consideration of the risk adjustment in respect of non-financial risk introduced by IFRS17.

4.6 Self administration

From 1 January 2020 the Scheme commenced self-administration. The CMS undertook an inspection to assess the Scheme's administration capabilities in April 2022.

The self administration was implemented fully and the Scheme's operations and financial management is running smoothly.

5. INVESTMENTS IN AND LOANS TO EMPLOYERS OF MEMBERS OF THE Scheme AND OTHER RELATED PARTIES

The Scheme holds no investments in participating employers or related parties to Scheme officials or Board members.

6. SELF ADMINISTRATION UPDATE

From 1 January 2020, the Scheme commenced self-administration. The CMS performed an assessment of the Scheme's self-administration processes and control capabilities in 2022. When the Scheme approached CMS initially, there was no pre-accreditation requirement since it is not a third-party administration arrangement but self-administration. However, the Scheme followed the third-party accreditation guidance. The Scheme is awaiting the CMS on-site evaluation.

7. COMPLIANCE MATTERS

The CMS confirmed that the Regulation 10 Directive that was previously issued is invalid and the matter is now closed (refer note 23.)

8. AUDIT, RISK AND COMPLIANCE COMMITTEE

An Audit, Risk and Compliance Committee (ARCC) was established in accordance with the provisions of the Act. The ARCC is mandated by the Board of Trustees by means of written terms of reference as to its membership, authority and duties. The ARCC consists of five members of which two are members of the Board of Trustees. The chairperson and two other members are independent as they are not officers of the Scheme or its service providers. The ARCC met on four occasions during the course of the year as follows:

24 March 2025

22 July 2025

15 September 2025

08 December 2025

The Chairperson of the Scheme (on invitation), the Principal Officer, the financial manager, and the external auditor are invited to attend ARCC meetings. The accountant and external auditor have unrestricted access to the Chairman of the ARCC.

In accordance with the provisions of the Act, the primary responsibility of the ARCC is to assist the Board of Trustees in carrying out its duties relating to the Scheme's accounting policies, internal control systems and financial reporting practices. The independent external auditor formally reports to the ARCC on critical findings arising from their audit activities. The ARCC also ensures that significant matters are identified and appropriately dealt with.

The ARCC comprises Board Members J Nell, M van Staden, and independent Members K Bizana and D Van Der Merwe, under the chairmanship of independent member JP van der Walt.

ALLIANCE-MIDMED MEDICAL SCHEME
Report of the Board of Trustees
for the year ended 31 December 2025

9. DEVIATIONS

The Board of Trustees believe that there are no material deviations from the Act and list the following three matters that presents practical challenges and not wilful non-compliance.

1. Not all billed contributions are received within three days as Section 26(7) of the Act requires. These incidents are exceptional, e.g., when the three-day grace period falls over a weekend. Credit control procedures minimise the risk of non-recoverability, including that about 90% of contributions are collected via deductions from the employers' payroll. The Scheme monitors creditors closely to minimise the incidences.

2. Claims are generally paid within 30 days of receipt, in terms of Section 59(2) of the Act, but due to procedures such as clinical auditing and suspected fraudulent claims, some claims are paid after 30 days of receipt. This could impact on members and providers. Management track claims older than 30-days and monitor progress to minimise delays.

3. Section 35(8)(c) of the Act require that a medical scheme shall not invest its assets in an administrator. Independent third-party asset managers manage the Scheme's investment funds. They have a discretionary mandate to achieve set targets. Given this approach, the Scheme may sometimes be exposed to shares in administrators. As a precaution, the Scheme made an application and was granted an exemption from complying with this requirement by the Council for Medical Schemes. The exemption expires on 31 December 2028. The Scheme invests in Momentum Metropolitan Life Limited, Sanlam Life Insurance Ltd and Discovery Group Limited.

10. KEY MATTERS

The Board of Trustees have identified the following as key matters:

Solvency:

The solvency of the Scheme remains well above the regulated minimum, and within the 40% to 70% target range agreed by the Board.

Management of Claims:

Claims are subjected to a sophisticated screening process. An additional pre-payment Prescribed Minimum Benefit (PMB) claims check was implemented, reducing member exposure progressively since 2018. The total out-of-pocket expense of members was reduced over this period. With the assistance of 3ONE Consulting Actuaries (3ONE), the impact of long-term and chronic illnesses is closely monitored. Based on the data, we developed management programmes, further reducing the cost of care while improving the quality and access.

To accurately report the Scheme's financial position, and because claims must continue to be accepted for payment up to four months after the service date, the Scheme uses the liability for incurred claims provision. 3ONE applied the Bornhuetter-Ferguson method. The BFM produces an estimate that considers a balance between a pure Chain Ladder Method approach, and consideration of expected claims volumes and seasonality. This thereby removes the volatility relative to a pure Chain Ladder approach, where events artificially leading to low claims payments result in turn in a low level of LIC, where the LIC should in fact be increased (and vice versa). Considering IFRS17 requirements, 3ONE has calculated a risk adjustment to allow for compensation required for bearing uncertainty about the timing and amount of cashflows that arise from non-financial risk including claims, membership and expense risk.

Profile of Members:

The member profile has a significant impact on future claims. Membership on 31 December 2025 was 1 813 (2024: 1684). The average age of beneficiaries on 31 December 2025 was 35.80 (2024: 34.79) The membership does not present a sustainability risk. Nevertheless, claims are closely monitored.

Governance:

The Board is committed to strong governance to ensure appropriate and professional management. The Board embarked on the implementation of a robust governance model, which has strengthened several management practices. It includes compliance to relevant aspects of King IV and King V. Underpinning the governance model and structures are stringent internal and external control processes.

The Scheme relies on the skill and experience of human resources. It is important to ensure that the quality and competence of staff are appropriate. This is achieved through continuous training, careful selection of staff and close monitoring by the Principal Officer.

ALLIANCE-MIDMED MEDICAL SCHEME

Report of the Board of Trustees

for the year ended 31 December 2025

Risk Management:

A robust risk management approach is applied operationally, and at clinical, financial and investment management levels. The Board is constantly seeking ways to enhance risk identification and management.

The Scheme utilises the Health Insurance Platform (HiP) System as an integrated platform for processing claims due to the high level of integration of financial, operational, health and management systems. The detailed beneficiary and claims level access and flexible reporting functions, with a plus 99% availability and relatively user-friendly operation, makes it ideal and cost-effective, allowing us to employ fewer staff. HiP is an Oracle-based internationally utilised insurance and healthcare information system. It is highly automated and allows for speedier processing and payment of claims. HiP deploys internationally recognised information security systems and first-class disaster management and recovery processes. The multiple award-winning HiP system underpins the administration of more than 740,000 policyholders in 15 countries.

Impact on the environment:

The Board is continuously looking at ways to further improve its low impact on the environment. The Scheme has effective and efficient systems and processes to minimise its negative impact on the environment (e.g., high automation levels, e-mail communications and a member app to communicate and submit accounts in real-time, electronically). We are working on reducing negative impacts where these are discovered (e.g. a campaign to register providers on the administrator electronic platform for account management and reconciliation).

11. TRUSTEES AND AUDIT, RISK AND COMPLIANCE COMMITTEE MEMBERS MEETING ATTENDANCE

	Board of Trustees meetings		Audit, Risk and Compliance Committee meetings		Annual general meetings	
	A	B	A	B	A	B
Trustees						
SD Muller (Chairperson)	4	4	-	-	1	1
FJ Mabheba	4	3	-	-	1	1
JC van Coller	4	4	-	-	1	1
M van Staden #	4	4	4	1	1	-
J Nell #	4	4	4	3	1	-
J Tharakan	4	3	-	-	1	1
V Ngwenya (Observer)	4	4	-	-	1	1
A Taljaard (Alternate)	4	2	-	-	1	1
S Beyer (Alternate)	4	4	-	-	1	1
P Monatisa (Alternate)	4	4	-	-	1	1
Audit, Risk and Compliance Committee members						
J Van Der Walt (Chairman)	4	3	4	4	1	1
D Van Der Merwe	-	-	4	4	1	1
K Bizana	-	-	4	3	1	
Principal Officer						
PDG Theron	4	4	4	4	1	1

- Trustees serving on the Audit, Risk and Compliance Committee

4 Board Meetings (1 Strategy Session and Budget Meeting not counted)

A = maximum possible attendance

B = actual attendance

12. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

Operational statistics

	2025	2024
Number of members at the end of the year	1 813	1 684
Number of beneficiaries at the end of the year	4 125	3 834
Average number of members for the year	1 745	1 649
Average number of beneficiaries for the year	3 980	3 747
Beneficiaries per member at the end of the year	2.28	2.28
Average age of beneficiaries for the year	35.80	34.79
Pensioner ratio (beneficiaries > 65 years)	9.41%	8.66%
Dependants per member at the end of the accounting period	1.28	1.28
Average insurance revenue per beneficiary per month	R3 031	R2 831
Average insurance service expense per beneficiary per month	R3 263	R2 951
Total insurance service expense as a percentage of insurance revenue	106.11%	99.09%
Average administration fees and other operative expenses per beneficiary per month	R174	R174
Administration fees and other operative expenses as a percentage of gross contributions	5.50%	5.85%
Directly attributable insurance service expenses	R0	R551 535
Directly attributable insurance service expenses ratio	0.00%	0.43%
Relevant healthcare expenditure ratio	94.89%	94.20%
Relevant healthcare expenditure pabpm	R3 028	R2 805
Return on investments as a percentage of closing investments	12.92%	10.10%

Independent Auditors' Report

TO THE MEMBERS OF ALLIANCE-MIDMED MEDICAL SCHEME

Report on Financial Statements

Opinion

We have audited the financial statements of Alliance-Midmed Medical Scheme, set out on pages 11 to 30, which comprise the statement of financial position as at 31 December 2025 and the statement of comprehensive income and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of material accounting policies.

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

Basis for Opinion

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

Key Audit Matter	How our audit addressed the key audit matter
Liability for Incurred Claims – Claims incurred but not yet reported (Note 6)	
The Liability for Incurred Claims (LIC) provision of R56,668,622 (2024: R47,901,980) forms part of the Insurance contract liability. The insurance contract liability is described in note 6 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 have not been reported to the scheme by that date, as well as insurance accounts payable and the personal medical savings liability.	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 LIC provision estimate. • We assessed the appropriateness and timely recognition of the related LIC provisions 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.

IFRS 17 requires that the Scheme measures 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 claims incurred is estimated by the Scheme's actuaries, after considering the Bornhuetter-Ferguson methods 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. A LIC provision at the 75th percentile of the simulated LIC estimates has been selected by the scheme.

We considered the Liability for Incurred Claims – Claims incurred but not yet reported (Note 6) as a matter of most significance to the current year audit of the financial statements due to the following:

- The materiality of liability.
- The degree of estimation uncertainty and complexity of the fulfilment cash flows.
- The significant judgement in selecting the related risk adjustment for non-financial risk factors.

A potential change in the projected claims pattern can cause a material change to the amount of the LIC provision.

- 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 the 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, with the assistance of an auditor expert actuary, challenged whether the assumptions are appropriate for the estimate of the LIC Provision and the risk adjustment factors.
 - Obtained an understanding of the data utilized in the calculation of the estimate and agreed with the source data.
 - 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:
 - We compared the calculations of claims run-off triangles against current and historical claims development patterns to assess the reasonability thereof in comparison to the LIC provision at year end.
 - We assessed the claims received subsequent to year end for claims relating to the 2025 financial year.
 - We inspected the hospital pre-authorization lists as well as confirmations from hospitals for claims incurred up to year end for inclusion in the LIC provision.
 - We inspected the records of claims assigned 'audit' status and evaluated whether the claims have been correctly included/excluded from the LIC provision.
- We evaluated the presentation and disclosure relating to the LIC provision in the current year against the requirements of International Financial Reporting Standards and relevant industry guidance.

	<i>Based on the procedures performed, we are satisfied that the valuation and underlying elements of the LIC have been appropriately valued and that the LIC is appropriate.</i>
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Other Information

The Schemes' trustees are responsible for the other information, which comprises of The Board of Trustees' report as required by the Medical Schemes Act of South Africa. The other information does not include the financial statements and our auditors 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 the other information, we are required to report that fact. We have nothing to report on in this regard.

Responsibilities of the Scheme's Trustees for the Financial Statements

The Scheme's trustees are responsible for the preparation and fair presentation of the financial statements in accordance with IFRS Accounting Standards as issued by the International Accounting Standards Board (IASB) 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.

Auditors' Responsibilities for the Audit of the Financial Statements

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

As part of an audit in accordance with ISAs, we exercise professional judgement and maintain professional skepticism throughout the audit. We are also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks.
- 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 material uncertainty exists, we are required to draw attention in our auditors' 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 auditors' 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.

We also provide the trustees with a statement that we have complied with relevant ethical requirements regarding independence, and to communicate with them all relationships and other matters that may reasonably be thought to bear on our independence and where applicable, related safeguards.

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

Report on Other Legal and Regulatory Requirements

Non-compliance with the Medical Schemes Act of South Africa

As required by the Council for Medical Schemes, we report that no material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa as amended have come to our attention during the course of the audit, other than items of non-compliance set out in note 25 of the notes of the financial statements.

Audit tenure

As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that Ranrus Incorporated has been the auditor of Alliance-Midmed Medical Scheme for four years.

The engagement partner, Mr. JA Barnard CA(SA), has been responsible for Alliance-Midmed Medical Scheme's audit for four years.

Ranrus Incorporated

21 May 2026

Per: J.A Barnard CA(SA)
Director
Registered Auditor

Hyde Park Manor
Building 2, Ground Floor
79 Hyde Lane
Hyde Park
Johannesburg

ALLIANCE-MIDMED MEDICAL SCHEME**STATEMENT OF FINANCIAL POSITION**

as at 31 December 2025

	Notes	2025 R	2024 R
ASSETS			
Non-current assets			
Property and equipment	2	208 205	291 811
Current assets			
		150 100 436	129 813 937
Trade and other receivables	3	85 728	33 737
Cash and cash equivalents	4	21 460 300	18 618 601
Investments held at fair value through profit and loss	5	128 554 408	111 161 599
Total assets		<u>150 308 641</u>	<u>130 105 748</u>
LIABILITIES			
Non-current liabilities			
Insurance liability for future members	6.3	92 536 690	81 300 779
Current liabilities			
		57 771 951	48 804 969
Insurance contract liability	6	56 668 622	47 901 980
Trade and other payables	7	1 103 329	902 989
Total funds and liabilities		<u>150 308 641</u>	<u>130 105 748</u>

ALLIANCE-MIDMED MEDICAL SCHEME

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME

for the year ended 31 December 2025

	Notes	2025 R	2024 R
Insurance revenue	8	144 774 712	127 315 081
Insurance service expense		(155 854 959)	(132 682 882)
Claims incurred	9.1	(138 759 466)	(121 598 080)
Net impairment recovery/ (loss) on healthcare receivables	9.2	-	(13 138)
Accredited managed healthcare services (no risk transfer)	9.3	(5 859 582)	(3 971 905)
Attributable expenses incurred	9.4	-	(551 535)
Third party claim recoveries	9.5	-	-
Amounts attributable to future members	9.6	(11 235 911)	(6 548 224)
Insurance service result		(11 080 247)	(5 367 801)
Other income		19 381 318	13 170 871
Investment income	11	19 381 318	13 109 664
Sundry income		-	61 207
Other expenditure		(8 301 071)	(7 803 070)
Administration fees and other operative expenses	10	(8 301 071)	(7 041 638)
Asset management fees		-	(761 432)
Net surplus for the year		-	-
Total comprehensive income for the year		-	-

ALLIANCE-MIDMED MEDICAL SCHEME

STATEMENT OF CASH FLOWS

for the year ended 31 December 2025

	Notes	2025 R	2024 R
Cash flows from operating activities			
Cash receipts from members – contributions	6	152 569 214	134 063 473
Cash paid for claims and acquisition costs		(139 870 601)	(129 995 315)
Cash paid to providers and employees		(8 049 342)	(6 567 470)
Cash paid to members – savings plan refunds		(3 776 307)	(4 369 926)
Net cash flows from operating activities		872 964	(6 869 239)
Cash flows used in investing activities		1 968 735	6 877 110
Acquisition of medical and computer equipment	2	(19 774)	(88 388)
Acquisition of investments	5	-	(114 630 308)
Proceeds on disposal of investments	5	1 000 000	116 483 608
Interest income	11	988 509	5 442 053
Dividend income	11	-	431 577
Asset management fees		-	(761 432)
Net (decrease) / increase in cash and cash equivalents		2 841 699	7 871
Cash and cash equivalents at the beginning of the year		18 618 601	18 610 730
Cash and cash equivalents at the end of the year	4	21 460 300	18 618 601

ALLIANCE-MIDMED MEDICAL SCHEME

NOTES TO THE ANNUAL STATEMENTS

for the year ended 31 December 2025

1. MATERIAL ACCOUNTING POLICIES

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

The following are the significant accounting policies applied in the preparation of the financial statements. The policies comply with IFRS[®] Accounting Standards as issued by the International Accounting Standards Board (IASB). The policies have been consistently applied to all years presented, unless otherwise stated.

1.1 Basis of preparation

Statement of compliance

The Financial Statements have been prepared in accordance with IFRS[®] Accounting Standards as issued by the International Accounting Standards Board (IASB) and in the manner required by the Medical Schemes Act, 131 of 1998 as amended, which requires additional disclosures for registered medical Schemes.

Basis of measurement

The Financial Statements are prepared in accordance with the going concern principle using the historical cost basis, except for:

- Certain financial assets and liabilities (including derivative instruments) – measured at fair value.
- Insurance and reinsurance assets and liabilities – measured in terms of IFRS 17 estimates.

Functional and presentation currency

These financial statements are presented in South African Rands, which is the Scheme's functional and presentation currency. All the financial information presented in Rand has been rounded to the nearest Rand.

Use of estimates and judgements

Consistent with other IFRS[®] standards, financial reporting under IFRS 17 is, to a larger extent, based on estimates, judgements and models rather than exact depictions. The IFRS[®] Conceptual Framework establishes the concepts that underlie those estimates, judgements and models. Where an application of a particular standard requires judgements 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 users of the information.

In addition to the existing requirement in IFRS 17 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,
- 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.

a. **New standards, amendments and interpretations issued and not yet effective in 2025 and relevant to the Scheme.**

At the date of authorisation of these annual financial statements, the following standard which is relevant to the Scheme, was issued but not yet effective, and has not been adopted early in the annual financial statements. The adoption of this standard in future financial reporting periods may have a significant impact on the medical Scheme's reported results, financial position or cash flows.

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

ALLIANCE-MIDMED MEDICAL SCHEME

NOTES TO THE FINANCIAL STATEMENTS

for the year ended 31 December 2025

MATERIAL ACCOUNTING POLICIES (continued)

Basis of preparation (continued)

1.1.1 Assessment as to whether the 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 by the IFRS Accounting Standards as issued by the International Accounting Standards Board (IASB).

The Scheme meets the definition of a mutual entity in IFRS.

The Scheme has therefore developed its accounting policies 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 profit or loss and other comprehensive income reflects no total comprehensive income for the year. The movement in the insurance liability attributable to future members are included in the insurance service expenses line.

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

1.1.2 Unit of account

Judgement has been applied to how the Scheme determined the unit of account for the measurement of its insurance contracts. Management has assessed their portfolio as the Scheme as a whole due to the holistic pricing methodologies and risk management strategy that manages the risk at Scheme level. The above is demonstrated by the following:

- Hospital claims are managed at Scheme level.
- Chronic conditions are managed at Scheme level, i.e. no matter the option the member will have access to the chronic condition management benefit.
- Pricing and benefit changes are determined at Scheme level.
- Risk (utilisation and concentration) is managed holistically.

1.1.3 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. Because the risk adjustment represents compensation for uncertainty, estimates are made on the degree of diversification benefits and expected favourable and unfavourable outcomes in a way that reflects the Scheme's degree of risk aversion. The Scheme estimates an adjustment for non-financial risk separately from all other estimates.

The risk adjustment was calculated at the portfolio level as the Scheme does not have groups due to laws that constrain the Scheme's ability to set a price for different members. The confidence level method was used to derive the overall risk adjustment for non-financial risk. In the confidence level method, the risk adjustment is determined by applying a confidence level to run-off triangles used to calculate the LIC. The confidence level is set at 75%.

The methods and assumptions used to determine the risk adjustment for non-financial risk were not changed in 2024 and 2025.

1.1.4 Initial recognition

The Scheme coverage period aligns to the financial reporting year as both begin on 1 January each year and conclude on 31 December of the same year.

The contracts with members will be recognised from 1 January, or from inception of cover should the member join the Scheme after 1 January.

1.1.5 Contract boundary

The contract boundary for the Scheme is one year from 1 January to 31 December each year.

1.1.6 Measurement model

The coverage period for the Scheme is one year or less (as discussed in the contract boundary section above), therefore the Premium Allocation Approach (PAA) will be applied.

ALLIANCE-MIDMED MEDICAL SCHEME

NOTES TO THE FINANCIAL STATEMENTS

for the year ended 31 December 2025

MATERIAL ACCOUNTING POLICIES (continued)

1.2 Financial instruments

Financial assets and liabilities are recognised on the Scheme's statement of financial position on the trade date when it becomes a party to the contractual provisions of the instrument.

Derecognition

Financial assets are derecognised when the rights to receive cash flows from the financial assets have expired or have been transferred and the Scheme has substantially transferred all the risks and rewards of ownership.

Measurement

Financial instruments are initially measured at fair value less any attributable transaction costs. Subsequent to initial recognition, these instruments are measured as set out below.

The carrying value of short-term financial assets and liabilities approximates fair value.

Cash and cash equivalents

Cash and cash equivalents comprise the current bank accounts, deposits held on call with banks, and other short-term liquid investments that are readily convertible to a known amount of cash, which are subject to an insignificant risk of change in value with original maturities of three months or less.

Investments held at fair value through profit and loss

All purchases and sales of investments are recognised on the trade date, which is the date that the Scheme commits to purchase or sell the asset. The cost of purchases includes transaction costs. Investments held at fair value through reflected in the statement of comprehensive income are subsequently carried at fair value. Realised and unrealised gains and losses arising from changes in the fair value of the investments are included in the statement of comprehensive income in the year in which they arise. The fair value of financial instruments is determined by reference to an exit price on measurement date.

Investments are held conservatively as current assets because of the volatility inherent in the size of the Scheme, and the Trustees must ensure sufficient liquidity to ensure reasonable access to cash in the event of major expenses. Within the current arrangement we aim to access the majority of the investments within 30-days without significant risk of loss, and all within 180 days.

The Scheme assets are held in such a manner to account for several challenges that may or may not materialise in the next six to 24 months. For one, the Scheme was served with a Regulation 10 Directive to pay more than R36 million to members in their PMSA in lieu of PMB payments that the Regulator allege that the Scheme made from members' PMSA instead of the Major Risk Pool. The Scheme objected and is still awaiting the outcome of the objection. The Directive, at the time, instructed the refund to be effective within two weeks. In addition, the government has expressed the intention to expedite the National Health Insurance Scheme, and a prominent element is to consolidate small Schemes. This threat has been declared in the Scheme's Annual Financial Statements AFS since 2018, and recently government intensified their attempts, under the COVID-19 response, to expedite this initiative.

On disposal of an investment, the difference between the net disposal proceeds and carrying amount is recognised in the surplus/deficit for the year.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. 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.

Subsequent to initial recognition, they are measured at amortised cost using the effective interest rate method.

1.3 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 of the following features or attributes: (a) restricted activities; (b) 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; (c) insufficient equity to permit the structured entity to finance its activities without subordinated financial support; and (d) financing in the form of multiple contractually linked instruments to investors that create concentrations of credit or other risks (tranches).

The Scheme has determined that some of its investments in pooled funds and collective investment schemes ("funds") are investments in unconsolidated structured entities. The Scheme invests in these funds, whose objectives range from achieving medium- to long-term capital growth and whose investment strategy do not include the use of leverage. The funds are managed by unrelated asset managers and apply various investment strategies to accomplish their respective investment objectives.

The change in fair value of each fund is included in the statement of profit and loss and other comprehensive income in 'Net gains/ (losses) on financial instruments held at fair value through profit or loss.

1.4 Impairment losses

Impairment of insurance receivables

The Scheme's assets are reviewed at the reporting date to determine whether there is possible impairment. Impairment losses are incurred only if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset (a 'loss event') and that loss event (or events) has an impact on the estimated future cash flows of the financial asset or group of financial assets that can be reliably estimated.

An impairment loss in terms of Insurance revenue is recognised whenever the value of a listed asset is less than the recoverable amount. Impairment losses are recognised in the statement of profit or loss and other comprehensive income. Based on our history, we estimate a loss of less than one per cent of cash flows, thus a stable cash position.

In assessing value in use of investment income, the estimated future cash flows are discounted to their present value using the effective interest rate computed at the initial recognition of the asset. Receivables due within the same operating cycle are not discounted.

For loans and receivables, the value of the value in use is the difference between the value of the loans or receivables at the reporting period end and the expected value to be recovered after future interest is discounted. Subsequent recoveries of amounts previously written off are credited as other income or against operating expenses in profit or loss. 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 an improvement in the debtor's statement of comprehensive income), the movement in the impairment loss will be written back through the Statement of Comprehensive income.

ALLIANCE-MIDMED MEDICAL SCHEME

NOTES TO THE FINANCIAL STATEMENTS

for the year ended 31 December 2025

MATERIAL ACCOUNTING POLICIES (continued)

1.5 Personal Medical Savings Account liability (PMSA)

The personal medical savings account, which is managed by the Scheme on behalf of its members, represents savings Insurance revenue (which are a deposit component of the insurance contracts) and accrued interest thereon in terms of the Rules of the Scheme, net of any savings claims paid on behalf of members in terms of the Scheme's registered rules.

Medical Schemes generally do not have any contracts with specified embedded derivatives. Certain contracts contain a PMSA which, under IFRS 4 were separated from the insurance contract and accounted for as a financial instrument. Medical Schemes need to assess the PMSA based on their Rules and IFRS 17's requirements for distinct investment components, to assess whether the PMSA meets the definition of a distinct investment component. Under IFRS 4, PMSAs generally met the IFRS 4 criteria for unbundling and the PMSA were unbundled and accounted for as financial instruments. Matters to be considered to assess whether the PMSAs can be separated from the insurance contract under IFRS 17 are presented below.

The condition to be met under IFRS 17 is that the investment component and the insurance component are not highly interrelated.

The investment component and the insurance component are highly interrelated where the one component cannot be measured without considering the other. The PMSA can be measured separately; however, there is a risk component that is available once the PMSA has been exhausted and once certain conditions are met. This indicates that the level of certain risk benefits available is dependent on the PMSA, meaning that the value of risk benefits cannot be measured without considering the PMSA resulting in the two components being highly interrelated.

The PMSA component and the insurance component are a function of the benefit design and the PMSA is not highly interrelated, especially since for the Scheme, the risk component covers all the Scheme liabilities. The PMSA can be measured separately.

The second indicator is that the Scheme benefit design include both a risk and PMSA part, which is not optional. It is thus a function of benefit design as opposed to interdependency. To cancel a component of the contract, the member has to cancel the entire contract (both components).

The condition whereby an investment component can be separated from the insurance component if not highly interrelated is not met when considering the PMSA component. Where the above condition apply, PMSAs cannot be separated from the insurance component, and IFRS 17 shall be applied to the entire contract including the PMSA.

The PMSA is a non-distinct investment component with the balances included in Insurance Contract Liabilities in the Statement of Financial Position.

1.6 Risk claims provisions

Provisions are recognised when the Scheme has a present legal or constructive obligation as a result of past events, for which it is probable that an outflow of economic benefits will be required to settle the obligation, and a reliable estimate can be made of the obligation amount.

Outstanding risk claims provision

The outstanding claims provision is the estimated cost of healthcare benefits that have occurred before the reporting date but have not been reported to the Scheme by that date. This provision is determined according to, amongst others, previous claims experience, claims settlement patterns, membership changes, claims frequency changes, claims processing cycles and variations, and average claims costs. The outstanding claims provision is reduced by the estimated recoveries from members for co-payments, and PMSA member payments.

Liabilities and related assets under the liability adequacy test

The Scheme does not discount its provision for outstanding risk claims, since the effect of the time value of money is not considered material.

Liability adequacy tests are performed to ensure the adequacy of the member insurance contract liabilities as at the reporting date.

The liability for insurance contracts is tested for adequacy by discounting current estimates of all future contractual cash flows and comparing this amount to the carrying value of the liability net of any related assets (i.e. the value of business acquired). Where a shortfall is identified, an additional provision is made and the Scheme recognises the deficiency in income for the year.

1.7 Investment income

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

Dividends are recognised when the Scheme's right to receive payment is established.

1.8 Medical insurance contracts

Insurance contracts are contracts under which the Scheme accepts significant insurance risk from a member by agreeing to compensate the member if a specified uncertain future event adversely affects the member. In making this assessment, all substantive rights and obligations, including those arising from law or regulation, are considered on a contract-by-contract basis. The Scheme uses judgement to assess whether a contract transfers insurance risk (i.e., if there is a scenario with commercial substance in which the Scheme has the possibility of a loss on a present value basis) and whether the accepted insurance risk is significant.

The Scheme has assessed their portfolio to be at a Scheme level as a whole.

Before the Scheme accounts for an insurance contract based on the guidance in IFRS 17, it analyses whether the contract contains components that should be separated. IFRS 17 distinguishes three categories of components that have to be accounted for separately

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

The Scheme applies IFRS 17 to all remaining components of the contract.

1.9 Insurance revenue

As the Scheme provides services under the group of insurance contracts, it reduces the Liability for Remaining Coverage (LFRC) and recognises insurance revenue. The amount of insurance revenue recognised in the reporting period depicts the transfer of promised services at an amount that reflects the portion of consideration the Scheme expects to be entitled to in exchange for those services.

For the group of insurance contracts measured under the Premium Allocation Approach (PAA), the Scheme recognises insurance revenue based on the expected pattern of release of risk over the coverage period of the group of contracts.

ALLIANCE-MIDMED MEDICAL SCHEME

NOTES TO THE FINANCIAL STATEMENTS

for the year ended 31 December 2025

MATERIAL ACCOUNTING POLICIES (continued)

1.10 Insurance service expense

Insurance service expense comprise:

- incurred claims and benefits excluding investment components;
- other incurred directly attributable insurance service expenses;
- changes that relate to past service (i.e. changes in the fulfilment Cash Flows (FCF) relating to the Liability for Incurred Claims (LIC);
- changes that relate to future service (i.e. losses/reversals on onerous group 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 product development 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.

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

1.11 Claims incurred

Claims incurred comprise the total estimated cost of all claims arising from healthcare events that have occurred in the year and for which the Scheme is responsible, whether reported by the end of year. Net claims incurred comprise:

- Accredited managed healthcare services (no transfer of risk);
- claims submitted and accrued for services rendered during the year, net of recoveries from members for co-payments and PMSA liabilities;
- claims for services rendered during the previous year not included in the outstanding claims provision for that year, net of recoveries from members for co-payments, and PMSA member liabilities; and
- movement in the provision for outstanding claims.

1.12 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. If not, they are presented as non-current liabilities.

1.13 Property and equipment

Property and equipment comprise mainly office and computer equipment. Property and equipment is reflected at historical cost less accumulated depreciation and accumulated impairments. Historical cost includes expenditure that is directly attributable to the acquisition of the items. Depreciation on all assets is calculated using the straight-line method to allocate their cost to their residual values over their estimated useful lives. The Scheme purchased computer equipment to deal with remote working and medical equipment to manage home-based care during the COVID-19 pandemic in this period. Ad-hoc purchases are for new staff, replacements and self-administration functions. The useful life of office and computer equipment is 1-3 years.

ALLIANCE-MIDMED MEDICAL SCHEME
NOTES TO THE FINANCIAL STATEMENTS (Continued)

for the year ended 31 December 2025

	2025 R	2024 R
2. PROPERTY AND EQUIPMENT		
Cost		
At beginning of year	489 237	400 849
Additions	19 774	88 388
At end of year	509 011	489 237
Accumulated depreciation		
At beginning of year	(197 426)	(115 790)
Depreciation	(103 380)	(81 636)
At end of year	(300 806)	(197 426)
Carrying amount at end of year	208 205	291 811
3. TRADE AND OTHER RECEIVABLES		
Non-insurance receivables		
Prepaid expenses	33 736	33 737
Sundry receivable	51 992	-
Accrued interest	-	-
	85 728	33 737
4. CASH AND CASH EQUIVALENTS		
Current accounts	21 460 300	18 618 601
	21 460 300	18 618 601
5. INVESTMENTS HELD AT FAIR VALUE THROUGH PROFIT AND LOSS		
Fair value at the beginning of the year	111 161 599	105 778 865
Additions and income capitalised	-	114 630 308
Disposals	(1 000 000)	(116 483 608)
Net unrealised gains on revaluation recognised through the statement of comprehensive income	18 392 809	7 236 034
Fair value at the end of the year	128 554 408	111 161 599
The investments included above represent:		
Cash and equivalents	60 864 421	58 350 300
Bonds	37 132 458	31 367 368
Equities	30 557 529	21 443 931
Fair value at the end of the year	128 554 408	111 161 599

Effective 1 November 2024, the Scheme changed its investment managers and investment portfolio.

ALLIANCE-MIDMED MEDICAL SCHEME
NOTES TO THE FINANCIAL STATEMENTS

for the year ended 31 December 2025

6. INSURANCE CONTRACT LIABILITY

2025	Liability for remaining coverage (LRC)	Liability for incurred claims (LIC)		Total 2025
		Best estimate liability	Risk adjustment	
Opening insurance contract assets	(603 481)	(78 322)	-	(681 803)
Opening insurance contract liabilities	247 196	46 847 225	1 489 362	48 583 783
Net opening balance as at 1 January 2024	(356 285)	46 768 903	1 489 362	47 901 980
Changes in the statement of comprehensive income				
Insurance revenue	(144 774 712)	-	-	(144 774 712)
Insurance revenue from contracts measured under the PAA	(144 774 712)	-	-	(144 774 712)
Insurance service expense	-	144 729 078	(110 030)	144 619 048
Incurred claims and other insurance service expenses	-	144 729 078	1 379 332	146 108 410
Adjustment to liabilities for incurred claims - past events	-	-	(1 489 362)	(1 489 362)
Total changes in the statement of comprehensive income	(144 774 712)	144 729 078	(110 030)	(155 664)
Investment components	(7 640 556)	7 640 556	-	-
Cash flows				
Contributions received	152 569 214	-	-	152 569 214
Claims and other directly attributable expenses paid	-	(143 646 908)	-	(143 646 908)
Insurance acquisition cash flows paid	-	-	-	-
Total Cash flows	144 928 658	(136 006 352)	-	8 922 306
Net closing balance as at 31 December 2025	(202 339)	55 491 629	1 379 332	56 668 622
Notes for 2025:				
Savings contributions received	7 640 556			
Contributions received	152 569 214			
Risk contributions	144 928 658			
PMSA contributions	7 640 556			
Claims and other directly attributable expenses paid	(143 646 908)			
Risk claims	(138 404 678)			
PMSA claims and refunds	(5 242 230)			
Expenses	-			

	2025 R	2024 R
INSURANCE CONTRACT LIABILITY		
Insurance contract assets	612 812	681 803
Recoveries from members for co-payments outstanding	44 657	52 396
Risk contributions outstanding	464 578	641 212
Provider debt outstanding	377 643	256 846
PMSA advances (note 5.2)	7 856	13 271
Provision for impairment losses on healthcare receivables	(281 922)	(281 922)
Insurance contract liabilities	57 281 434	48 583 783
Reported risk claims not yet paid	12 544 600	8 036 639
Contributions received in advance	224 508	247 196
Outstanding risk claims provision	8 186 793	6 372 741
PMSA liability	36 325 533	33 927 207
Net insurance contract liabilities	56 668 622	47 901 980

ALLIANCE-MIDMED MEDICAL SCHEME
NOTES TO THE FINANCIAL STATEMENTS

for the year ended 31 December 2025

6. INSURANCE CONTRACT LIABILITY CONTINUED

2024	Liability for remaining coverage (LRC)	Liability for incurred claims (LIC)		Total 2024
		Best estimate liability	Risk adjustment	
Opening insurance contract assets	(624 777)	(34 511)	-	(659 288)
Opening insurance contract liabilities	121 172	47 551 418	2 370 870	50 043 460
Net opening balance as at 1 January 2024	(503 605)	47 516 907	2 370 870	49 384 172
Changes in the statement of comprehensive income				
Insurance revenue	(127 315 081)	-	-	(127 315 081)
Insurance revenue from contracts measured under the PAA	(127 315 081)	-	-	(127 315 081)
Insurance service expense	-	127 016 166	(881 508)	126 134 658
Incurred claims and other insurance service expenses	-	127 016 166	1 489 362	128 505 528
Adjustment to liabilities for incurred claims - past events	-	-	(2 370 870)	(2 370 870)
Total changes in the statement of comprehensive income	(127 315 081)	127 016 166	(881 508)	(1 180 423)
Investment components	(6 601 072)	6 601 072	-	-
Cash flows				
Contributions received	134 063 473	-	-	134 063 473
Claims and other directly attributable expenses paid	-	(134 365 241)	-	(134 365 241)
Insurance acquisition cash flows paid	-	-	-	-
Total Cash flows	127 462 401	(127 764 169)	-	(301 769)
Net closing balance as at 31 December 2024	(356 285)	46 768 903	1 489 362	47 901 980
Notes for 2024:				
Savings contributions received	6 601 072			
Contributions received	134 063 473			
Risk contributions	127 462 401			
PMSA contributions	6 601 072			
Claims and other directly attributable expenses paid	(134 365 241)			
Risk claims	(128 252 269)			
PMSA claims and refunds	(5 561 438)			
Expenses	(551 535)			

ALLIANCE-MIDMED MEDICAL SCHEME**NOTES TO THE FINANCIAL STATEMENTS (Continued)**

for the year ended 31 December 2025

	2025 R	2024 R
6.1 PERSONAL MEDICAL SAVINGS ACCOUNT		
Balance of Personal Medical Savings Accounts at beginning of the year	33 927 207	32 887 573
Less: Prior year advances on Personal Medical Savings Account	<u>(13 271)</u>	<u>(1 238)</u>
Net balance on Personal Medical Savings Account at the beginning of the year	33 913 936	32 886 335
Personal Medical Savings Account Insurance revenue received	7 645 971	6 589 039
- for the current year (note 8)	7 632 700	6 587 801
- allocated to settle prior year advances	<u>13 271</u>	<u>1 238</u>
Less:		
Transfers to other Schemes and repayments on death or resignation	(3 776 307)	(4 369 926)
Claims paid on behalf of members (note 9.1)	<u>(1 465 923)</u>	<u>(1 191 512)</u>
Net balance on Personal Medical Savings Account liability at the end of the year	36 317 677	33 913 936
Add: Advances on Personal Medical Savings Account included in trade and other receivables	7 856	13 271
Amounts due to members on Personal Medical Savings Account at the end of the year	<u><u>36 325 533</u></u>	<u><u>33 927 207</u></u>

The Personal Medical Savings Account (PMSA) liability contains a demand feature in terms of regulation 10 of the Act that any credit on a member's PMSA must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit option and then enrolls in another benefit option or medical Scheme without a PMSA or does not enrol in another medical Scheme.

Advances on Personal Medical Savings Accounts are funded by the Scheme and are included in trade and other receivables. The Scheme does not charge interest on advances on PMSA.

6.2 LIABILITY FOR INCURRED CLAIMS**Analysis of movements in liability for incurred claims**

Balance at beginning of year	6 372 741	8 673 274
Payments in respect of prior year	<u>(3 083 574)</u>	<u>(2 829 841)</u>
Over provision in prior year	3 289 167	5 843 433
Adjustment to income statement	(3 289 167)	(5 843 433)
Raised in the current year	8 186 793	6 372 741
Balance at end of year	<u><u>8 186 793</u></u>	<u><u>6 372 741</u></u>

The over-provision relates to an out-of-pattern reduction in claims in the last quarter of the year. No specific reasons were identified for this change in claiming pattern.

Analysis of liability for incurred claims

Estimated gross claims	8 186 793	6 372 741
Balance at end of year	<u><u>8 186 793</u></u>	<u><u>6 372 741</u></u>

Basis for determination of the liability for incurred claims

3ONE Consulting Actuaries (3ONE) performed the outstanding claims provision calculation in accordance with the principles and guidelines included within the Actuarial Society of South Africa's "Advisory Practice Note 304: Liability Valuations of South African Medical Schemes".

3ONE provide an estimate of the Scheme's required Liability for Incurred Claims (LIC) Provision as at 31 December 2025, taking into consideration of the risk adjustment in respect of non-financial risk introduced by IFRS17.

ALLIANCE-MIDMED MEDICAL SCHEME**NOTES TO THE FINANCIAL STATEMENTS (Continued)**

for the year ended 31 December 2025

6.2 LIABILITY FOR INCURRED CLAIMS (continued)**Process used to determine the assumptions**

3ONE applied the Bornhuetter Ferguson Method to calculate the Scheme's liability for incurred claims.

The BFM produces an estimate that considers a balance between a pure Chain Ladder Method approach, and consideration of expected claims volumes and seasonality. This thereby removes the volatility relative to a pure Chain Ladder approach, where events artificially leading to low claims payments result in turn in a low level of LIC, where the LIC should in fact be increased (and vice versa).

Considering IFRS17 requirements, 3ONE shows the LIC provision at various percentiles of the simulated LIC estimates, each allowing for a different assumed risk adjustment. The risk adjustment has been introduced to allow for compensation that the Scheme requires for bearing the uncertainty about the timing and amount of cashflows that arises from non-financial risk including claims risk, membership risk, and expense risk. However, it is not expected that membership risk and expense risk would have a significant impact on the risk adjustment given the nature of these risks.

In addition to consideration of claims, the SAICA guidelines reference expense risk and lapse risk to be allowed for by the Risk Adjustment. However, given that the medical Scheme benefit year, financial year and contract boundary align, at the reporting date all contracts entered into during the reporting period would have expired with the primary area of uncertainty being related to the incurred claims.

3ONE did not only produce a point-estimate of LIC, but also produced a distribution of results based on a stochastic statistical process named bootstrapping. 1,000 simulated estimates were produced. This allows for an enhanced understanding of the probable range of LIC results in addition to the calculation of a reasonable estimate.

The quantum of non-healthcare expenses (eg. administration costs, salaries, property rental, etc) is significantly lower than healthcare expenses. These expenses are highly certain and managed closely by the Scheme management. The extent of any unknown non-healthcare expenses arising after the effective reporting date, that have not yet been reported, is expected to be immaterial.

2025	2024
R	R

6.3 INSURANCE CONTRACT LIABILITIES - LIABILITY ATTRIBUTABLE TO FUTURE MEMBERS**Reconciliation of the insurance liability attributable to future members****Opening balance**

Movement in insurance liability attributable to future members (note 9.6)

Closing balance

81 300 779	74 752 555
11 235 911	6 548 224
92 536 690	81 300 779

7. TRADE AND OTHER PAYABLES**Non-insurance liabilities**

Investment management fees

Audit fee provision

Payroll provisions

Sundry accounts payable

-	63 195
405 245	384 118
246 187	44 306
451 897	411 370
1 103 329	902 989

8. INSURANCE REVENUE

Gross Insurance revenue

Less: Savings Insurance revenue (note 6.1)

Total insurance revenue

152 407 412	133 902 882
(7 632 700)	(6 587 801)
144 774 712	127 315 081

ALLIANCE-MIDMED MEDICAL SCHEME

NOTES TO THE FINANCIAL STATEMENTS (Continued) for the year ended 31 December 2025

	2025 R	2024 R
9. INSURANCE SERVICE EXPENSE		
9.1 Claims Incurred		
Current year claims	135 327 763	122 260 284
Movement in outstanding claims provision	4 897 626	529 308
- Over provision in prior year (note 6.2)	(3 289 167)	(5 843 433)
- Current year provision	8 186 793	6 372 741
- Claims paid from Personal Medical Savings Account (note 6.1)	(1 465 923)	(1 191 512)
	<u>138 759 466</u>	<u>121 598 080</u>
9.2 Net impairment recovery / (loss) on healthcare receivables		
Trade and other receivables:		
Movement in advances from PMSA accounts that are not recoverable	-	(3 630)
- Impairment losses	-	(3 630)
Members' and service providers' portions that are not recoverable	-	16 768
- Impairment losses	-	16 768
Previous impaired losses recovered	-	-
	<u>-</u>	<u>13 138</u>
9.3 Accredited managed healthcare services - (no transfer of risk)		
Rx Health (Pty) Ltd	-	669 829
Nursecare Agency	40 698	78 533
Mediscor PBM (Pty) Ltd	617 827	554 807
Staff remuneration	3 958 859	1 916 044
Medical Advisors	1 242 198	752 692
	<u>5 859 582</u>	<u>3 971 905</u>
9.4 Attributable expenses incurred		
Benefit management fee - not accredited managed care		
- Paid to Health Portfolio Managers	-	63 068
- Paid to Smart Client Services	-	11 360
- Staff remuneration	-	477 107
	<u>-</u>	<u>551 535</u>
9.5 Third party claims recoveries		
Road accident fund claims recoveries	-	-
9.6 Amounts attributable to future members		
Movement in insurance liability attributable to future members (note 6.3)	<u>11 235 911</u>	<u>6 548 224</u>
TOTAL INSURANCE SERVICE EXPENSE	<u>155 854 959</u>	<u>132 682 882</u>
10. ADMINISTRATION EXPENSES		
Audit fees	387 914	368 418
Consultant fees	3 615 871	3 287 098
Legal fees	660 215	219 570
Depreciation	103 381	81 634
Fidelity guarantee and professional indemnity insurance premium	33 737	32 130
Registrar's levies	89 901	83 576
Travel expenses	103 310	155 905
Europ Assistance	135 769	97 854
IT Expenses **	2 320 005	1 799 679
Bank charges	161 275	148 866
Subscriptions	112 004	124 063
Other expenses	577 689	642 845
	<u>8 301 071</u>	<u>7 041 638</u>
** Due to the Scheme being accredited as a MCO in 2024, monthly IT charges relating to administration system was incurred. In prior years these system IT charges formed part of the fees paid to outsourced service providers.		
11. INVESTMENT INCOME		
Interest income earned on cash and cash equivalents	988 509	1 806 302
Investments held at fair value through profit and loss		
-Interest income	-	3 635 751
-Dividend income	-	431 577
-Net gain on investments held at fair value through profit and loss	18 392 809	7 236 034
	<u>19 381 318</u>	<u>13 109 664</u>

ALLIANCE-MIDMED MEDICAL SCHEME**NOTES TO THE FINANCIAL STATEMENTS (Continued)**
for the year ended 31 December 2025

	2025	2024
	R	R
11.1 NET FAIR VALUE GAINS		
Net fair value gains on investments held at fair value through profit and loss		
-Net realised gain on disposals	16 248	41 520 581
-Net unrealised gains on revaluation	18 376 561	(34 284 547)
	<u>18 392 809</u>	<u>7 236 034</u>

12. FIDELITY COVER

In terms of section 33(3) of the Medical Schemes Act 131 of 1998, as amended, the Scheme took out a fidelity policy through ITOO underwritten by Hollard which, at 31 December 2025, provided cover of R15 million (2024: R15 million).

13. RELATED PARTY TRANSACTIONS

Client Success Consulting Services provides Scheme management support, systems optimisation, and data analytics/reporting services. The service cost R1 332 726 for the year (2024: R1 272 659).

The participating employers' payroll system is primarily utilised to collect both the member's and the employer's proportionate share of the Insurance revenue.

The Trustees are considered to be key management personnel since they have authority and responsibility for planning, directing, and controlling the activities of the Scheme. Insurance revenue of R522 684 (2024: R869 112) were received and claims of R329 522 (2024: R747 345) were paid in respect of the Trustees who are members of the Scheme. All Insurance revenue were at the same terms as applicable to other members. All claims were paid in accordance with the Rules of the Scheme.

The Principal Officer received R Nil remuneration from the Scheme to attend to the duties as the Principal Officer in 2025 (2024: R Nil). The Principal Officer is remunerated by the employer group Columbus Stainless (Pty) Ltd.

On 31 December 2025, the Trustees had positive savings balances of R173 040 (2024: R211 820). The amounts are current and payable on demand should an appropriate claim be issued, or the member exits the Scheme.

14. CRITICAL ACCOUNTING JUDGEMENTS

While applying the Scheme's accounting policies, the following judgements have the most significant effect on the amounts recognised in the annual financial statements:

Liability for Incurred Claims

Details of assumptions and judgements used in determining the outstanding claims provision are outlined under Note 6.2.

Expected Credit Loss (ECL)

The Scheme, after the initial recognition of contribution income, is exposed to credit risk over the remainder of the financial year. The Scheme manages this (bad debt) risk monthly in terms of its policy, and we suspend benefits where the premiums are not regularly settled. Credit risk is limited since most of our Insurance revenue are collected via employer payrolls. We provided for less than zero-point-five percent of Insurance Revenue to become irrecoverable.

There are no other key areas of estimation uncertainty at the reporting date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities in the next financial year.

ALLIANCE-MIDMED MEDICAL SCHEME

NOTES TO THE FINANCIAL STATEMENTS (Continued) for the year ended 31 December 2025

15. MEDICAL INSURANCE RISK MANAGEMENT

Risk management objectives and policies for mitigating medical insurance risk

The primary insurance activity carried out by the Scheme is assuming the expense of medical services provided to members and their dependants that are directly attributable to the insured benefit, as defined in the Rules. As such the Scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract. The Scheme also has exposure to market risk through its insurance and investment activities.

The Scheme manages its insurance risk through benefit limits and sub-limits, benefit access pre-approval procedures, pricing guidelines, case management, contracting with providers, service provider profiling, technology, centralised risk transfer arrangements as well as the close monitoring of emerging health risk management options. The services of an actuarial consultant are contracted in this regard.

The Scheme uses several methods to assess and monitor insurance risk exposures both for individual types of risks insured and overall risks. These methods include internal risk measurement models, sensitivity analyses, scenario analyses and stress testing. The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts. The three principal risks are a greater than expected frequency and severity of claims, cybercrime incidents (involving the theft of Scheme data/assets), and legislator/legislative changes that significantly change the Scheme's financial position.

Insurance events are, by their nature, random, and the actual number and size of events during any one year may vary from those estimated.

The following table summarises the concentration of insurance risk at a beneficiary level, with reference to the net carrying amount of 2025 medical insurance claims paid in the 2025 financial year, by age group and in relation to the type of risk covered or benefits provided. Where appropriate prescribed minimum benefits (PMB) and non-PMB claims have been split.

		Hospital (major medical)		Chronic		Day-to-day	Total
		PMB	Non-PMB	PMB	Non-PMB		
		R	R	R	R	R	R
2024							
Age grouping (in years)							
< 26	-Gross	4 234 630	7 178 176	30 588	5 520	7 519 042	18 967 956
	-Net	3 761 378	6 793 411	30 564	5 520	7 998 419	18 589 292
26 - 35	-Gross	1 354 913	3 409 150	27 985	29 484	4 071 348	8 892 880
	-Net	1 346 178	3 278 197	27 977	29 480	4 304 618	8 986 450
36 - 50	-Gross	6 819 799	11 884 873	461 520	132 601	10 845 535	30 144 328
	-Net	6 739 494	11 365 375	461 402	132 560	11 689 944	30 388 775
51 - 65	-Gross	10 693 345	19 299 816	827 208	93 971	13 812 853	44 727 193
	-Net	10 636 323	18 549 600	826 566	93 650	14 523 067	44 629 206
> 65	-Gross	10 503 425	13 264 169	627 942	20 394	7 503 889	31 919 819
	-Net	10 379 288	12 583 133	623 921	19 989	6 986 199	30 592 530
Total	-Gross	33 606 112	55 036 184	1 975 243	281 970	43 752 667	134 652 176
	-Net	32 862 661	52 569 716	1 970 430	281 199	45 502 247	133 186 253

		Hospital (major medical)		Chronic		Day-to-day	Total
		PMB	Non-PMB	PMB	Non-PMB		
		R	R	R	R	R	R
2024							
Age grouping (in years)							
< 26	-Gross	3 891 940	7 489 211	27 719	8 682	7 118 718	18 536 270
	-Net	3 872 461	7 149 968	27 072	7 599	7 328 608	18 385 708
26 - 35	-Gross	1 069 510	2 778 333	27 387	49 230	3 739 193	7 663 653
	-Net	1 065 794	2 703 960	27 382	48 799	3 866 130	7 712 065
36 - 50	-Gross	4 572 136	10 286 627	405 269	110 214	9 862 479	25 236 725
	-Net	4 567 323	9 972 848	404 525	109 691	10 207 847	25 262 234
51 - 65	-Gross	4 921 734	19 655 709	697 816	71 737	12 831 384	38 178 380
	-Net	4 896 987	18 862 827	696 332	71 165	13 060 113	37 587 424
> 65	-Gross	8 725 609	15 588 802	616 745	12 754	7 059 222	32 003 132
	-Net	8 610 620	15 172 228	614 169	12 218	7 069 982	31 479 217
Total	-Gross	23 180 929	55 798 682	1 774 936	252 617	40 610 996	121 618 160
	-Net	23 013 185	53 861 831	1 769 480	249 472	41 532 680	120 426 648

Reconciliation of net claims to current year claims paid:

	2025	2024
	R	R
Total net claims as above	133 186 253	120 426 648
Claim adjustments	60 797	10 934
Claims paid via Europ Assistance	614 790	631 190
Claims paid from Personal Medical Savings Accounts (note 6.1)	1 465 923	1 191 512
Claims paid (note 9.1)	135 327 763	122 260 284

Hospital (major medical) benefits cover costs incurred by members whilst they are in hospital receiving pre-authorised and emergency treatment for medical conditions.

Chronic benefits cover the cost of approved prescribed medicines consumed by members for chronic conditions/diseases, such as high blood pressure, cholesterol, and asthma.

Day-to-day benefits (which are paid from the major medical pool) cover the cost of out of hospital medical care, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines.

Contracts are annual in nature and the Scheme has the right to change the terms and conditions of the contract under certain conditions. Management information including contribution income and claims ratios, target market and demographic split, is reviewed monthly. There is also a review program that regularly reviews contractual premium and benefit data.

ALLIANCE-MIDMED MEDICAL SCHEME

NOTES TO THE FINANCIAL STATEMENTS (Continued)

for the year ended 31 December 2025

16. FINANCIAL RISK MANAGEMENT

Several activities expose the Scheme to various financial risks, including changes in bond and equity market prices and interest rates. The Scheme's overall risk management programme focuses on the unpredictability of investment returns. It seeks to minimise potential adverse effects on the financial performance of the investments held by the Scheme. The Scheme's investments are managed according to agreed mandates.

Financial risk factors

Market risk

Market risk is the risk that the value of a financial instrument will fluctuate as a result of changes in the marketplace.

Equities and bonds are reflected at market values, which are susceptible to fluctuations. The Scheme manages its market risk by employing the following procedures:

- mandating a specialist fund manager to invest in equities and bonds, where there is an active market and where access is readily available to a broad spectrum of financial information relating to the institutions invested in;
- diversifying across a large pool of securities to reduce risk. Investments are according to prescription; and
- considering the risk-reward profile of holding equities and bonds and bearing the risk in order to improve returns on assets.

Should the South African bond and equities move by 2%, assuming all other variables remain constant, and the recent past is predictive of the future, the impact on investment returns and accumulated funds of the Scheme would be as follows:

	Market value as a percentage of Scheme assets		Impact	
	2025 %	2024 %	2025 R	2024 R
Bonds	24.70%	24.11%	597 767	535 364
Equities including property unit trusts	20.33%	16.48%	858 332	756 141
Total change in accumulated funds			<u>1 456 099</u>	<u>1 291 505</u>

Interest Rate Risk

Interest rate risk is the exposure to movements in interest rates. The Scheme's exposure to interest rate risk is reduced by the fact that the Scheme holds no interest bearing debt.

The Scheme places funds at both fixed and floating interest rates. The specialist manager manages the risk by maintaining an appropriate mix between fixed and floating rate placings within market expectations and determined mandates. The table below summarises the Scheme's exposure to interest rate risks in terms of the contractual maturity dates of the underlying investments. Included in the table are the Scheme's investments in interest-bearing instruments at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

	Up to 1 month R	2 - 3 months R	4 - 12 months R	1 - 5 years R	Over 5 years R	Total R
As at 31 December 2025						
Cash and cash equivalents	21 460 300	-	-	-	-	21 460 300
Investments held at fair value through profit and loss	-	97 996 879	-	-	-	97 996 879
Total	21 460 300	97 996 879	-	-	-	119 457 179
As at 31 December 2024						
Cash and cash equivalents	18 618 601	-	-	-	-	18 618 601
Investments held at fair value through profit and loss	-	89 717 668	-	-	-	89 717 668
Total	18 618 601	89 717 668	-	-	-	108 336 269

If interest rates changed by 2%, assuming all other variables remain constant, and the recent past is predictive of the future, the impact on return on investment and the resulting impact on the net results of the Scheme is as follows:

	2025 R	2024 R
Change in investment income	<u>1 132 968</u>	<u>897 252</u>

ALLIANCE-MIDMED MEDICAL SCHEME

NOTES TO THE FINANCIAL STATEMENTS (Continued) for the year ended 31 December 2025

17. FINANCIAL RISK MANAGEMENT (continued)

Credit Risk

Credit risk is the risk of loss arising from the inability of a member or a third party to service their debt obligations.

The Scheme's principal financial assets are cash, cash equivalents, and investments and trade and other receivables. The Scheme's credit risk is attributable primarily to its trade and other receivables. The amounts presented in the statement of financial position are net of allowances for impaired receivables. An allowance for impairment is made where there is an identified event which, based on previous experience is evidence of a reduction in the recoverability of the cash flows. Cash balances are held at high credit quality financial institutions, with a minimum credit rating of AA. The Scheme has no significant concentration of credit risk, with exposure spread over a number of counterparties and members.

	2025 R	2024 R
Trade and other receivables		
Fully performing	85 728	33 737
Past due and impaired	-	-
	85 728	33 737
Provision for impairment of trade and other receivables	-	-
	85 728	33 737
Trade and other receivables (note 3)		

In order to mitigate this risk, there is a formal policy in place for the treatment of any debt that becomes past due.

A subset of credit risk is counterparty risk which is the risk that a counterparty is unable to meet its financial and or contractual obligations during the period of a transaction. The financial exposure has been addressed above. Contractual exposure exists with regards to managed care agreements, administration agreements and investment mandates. Each of these risk exposures is managed in the ordinary course of business. Where appropriate, contractual rights, service level agreements and performance management interventions are in place. It is also relevant to note that the counterparty risk is limited.

Liquidity Risk

Prudent liquidity risk management implies maintaining sufficient cash and marketable securities. By monitoring the availability of funding through liquid holding cash positions with various financial institutions, management ensures that the Scheme has the ability to fund its day-to-day operations. Liquidity is further managed by monitoring forecast cash flows and ensuring adequate liquid resources to meet its short-term commitments.

The table below analyses the assets and liabilities of the Scheme into relevant maturity groupings based on the remaining period at statement of financial position date to the contractual maturity date:

	Up to 1 month R	2 - 3 months R	4 - 12 months R	1 - 5 years R	Over 5 years R	Total R
As at 31 December 2025						
Current assets	150 100 436	-	-	-	-	150 100 436
Trade and other receivables	85 728	-	-	-	-	85 728
Cash and cash equivalents	21 460 300	-	-	-	-	21 460 300
Investments held at fair value	128 554 408	-	-	-	-	128 554 408
Current liabilities	51 655 594	3 187 555	2 928 802	-	-	57 771 951
Insurance contract liability	50 552 265	3 187 555	2 928 802	-	-	56 668 622
Trade and other payables	1 103 329	-	-	-	-	1 103 329
Net positive / (negative) liquidity	98 444 842	(3 187 555)	(2 928 802)	-	-	92 328 485
As at 31 December 2024						
Current assets	129 813 937	-	-	-	-	129 813 937
Trade and other receivables	33 737	-	-	-	-	33 737
Cash and cash equivalents	18 618 601	-	-	-	-	18 618 601
Investments held at fair value	111 161 599	-	-	-	-	111 161 599
Current liabilities	40 346 754	2 936 791	5 521 424	-	-	48 804 969
Insurance contract liability	39 443 765	2 936 791	5 521 424	-	-	47 901 980
Trade and other payables	902 989	-	-	-	-	902 989
Net positive liquidity	89 467 183	(2 936 791)	(5 521 424)	-	-	81 008 968

ALLIANCE-MIDMED MEDICAL SCHEME**NOTES TO THE FINANCIAL STATEMENTS (Continued)**
for the year ended 31 December 2025**18. FINANCIAL RISK MANAGEMENT (continued)****Fair value estimation**

The fair value of publicly traded financial instruments is based on quoted market prices at the reporting date.

		2025		2024	
		Carrying amount	Fair Value	Carrying amount	Fair Value
		R	R	R	R
Cash and cash equivalents	(note 4)	21 460 300	21 460 300	18 618 601	18 618 601
Trade and other receivables	(note 3)	85 728	85 728	33 737	33 737
Investments held at fair value	(note 5)	128 554 408	128 554 408	111 161 599	111 161 599
Insurance contract liability	(note 6)	(56 668 622)	(56 668 622)	(47 901 980)	(47 901 980)
Trade and other payables	(note 7)	(1 103 329)	(1 103 329)	(902 989)	(902 989)

All financial assets are classified as level 2 (level 2 is unitised holdings and level 1 is direct equity holdings). Level 2 financial assets are financial assets whose fair value is determined by directly observable market inputs other than Level 1 inputs, these being referenced to published price quotations in an active market for the underlying assets.

Breakdown of investments

The investments managed by the Scheme's investment manager are split between investments held at fair value through the profit and loss and cash and cash equivalents categories in the annual financial statements.

Investments held at fair value through profit and loss consist of the following:

	2025	2024
	R	R
Syqnia	128 554 408	111 161 599
Total	128 554 408	111 161 599

19. CAPITAL ADEQUACY RISK MANAGEMENT

The Scheme defines its capital as accumulated funds detailed in the statement of changes in funds and reserves. The Scheme manages its capital to ensure that it will be able to continue as a going concern as well as meet the minimum solvency ratio of 25%, as regulated in the Act.

The Schemes' solvency at the end of 2025 was 55.64% (2024: 60.72%).

The Scheme manages its funds by utilising the expertise of investment managers to maximise returns on investments and maintain an acceptable level of risk. Investment managers are guided by mandates, subject to the Scheme's Investment Policy, issued by the Board of Trustees. In addition, careful consideration is given to the impact on accumulated funds when preparing future year benefit options.

20. COMMITMENTS

There were no capital commitments as at 31 December 2025 (2024: nil).

21. GUARANTEES

No guarantees either from or to third parties existed at 31 December 2025 (2024: nil).

22. CONTINGENT ASSETS

The Scheme has approximately R4.2m (2024: R3.5m) in recoveries outstanding from the Road Accident Fund (RAF) for claims paid on behalf of members. The likelihood of recovery of these amounts is uncertain, and the Board have elected not to recognise a receivable on the statement of financial position as any future recoveries are highly contingent on multiple factors. Based on past experience, the Board consider that the receivable were it to be recognised, would be substantially impaired.

ALLIANCE-MIDMED MEDICAL SCHEME

NOTES TO THE FINANCIAL STATEMENTS (Continued)

for the year ended 31 December 2025

23. CONTINGENT LIABILITIES

In September 2019, the Council for Medical Schemes (CMS) requested information alleging that in 2016, 2017 and 2018 benefit years, the Scheme paid R37.28 million from member's Personal Medical Savings Accounts (PMSA) for claims that the Scheme is liable to pay from the Major Risk Pool. In May 2020, the Scheme received a Regulation 10(6) Non-Compliance Directive, instructing the Scheme to refund the claimed amounts to member's savings accounts.

The Scheme objected to the Directive, stating that, amongst others, CMS may have included amounts for consumables, amounts that providers have written off and codes that was used for non-PMB claims, but that could be used for either PMB or non-PMB claims as well as co-payments for services provided by non-DSP's. In addition, the fact that CMS performed an accreditation audit on the Administrator in 2015/16, including a check on the savings payments and the Scheme was not informed that there were any findings in this regard. The Scheme also queried the amounts because Alliance-Midmed reconciles PMB claims prior to claims payment runs, and the Scheme would have been aware of the differences.

CMS directed that the Scheme refund the said amount to members, that they allege the Scheme paid from savings for PMB claims. During the period that the Directive applied, the Scheme had an 8% savings benefit, total contribution income for the 2016 benefit year was R80.40 Million, the savings opening balance was R25.21 Million and year-end savings amounted to R28.07 million. It is therefore, given the movement in the savings liability, an impossibility to have paid claims to this value from the savings accounts.

Alliance-Midmed also requested the data and methodology from CMS to check and verify the claim made in the directive. The Scheme have also requested from the administrator at the time, the data that they originally submitted. The Scheme engaged a clinical auditor to work through the data and have also engaged with Bowmans Law to provide legal advice on the matter. One of the items on the legal check is to ensure that the Scheme can submit a claim against the administrator's indemnity insurer, should there be a liability.

Upon in-depth investigation by the Clinical Auditor, it appears that the CMS may have used another Scheme's data in their assessments. The Scheme provided this feedback on two occasions in the form of an Objection.

The Scheme informed CMS that there could have been a potential liability of around R1.0 million as per the original letter that arose over the three years in question - noting that the Scheme processed around R200.0 million worth of claims. This is due to the nature of the PMB's including the requirement for interpretation and judgement. This is especially challenging in the medical environment. However due to the Scheme's unique internal control processes, this amount was also disputed.

24. SELF ADMINISTRATION UPDATE

From 1 January 2020, the Scheme commenced self-administration. The CMS performed an assessment of the Scheme's self-administration processes and control capabilities in 2022. When the Scheme approached CMS initially, there was no pre-accreditation requirement since it is not a third-party administration arrangement but self-administration. However, the Scheme followed the third-party accreditation guidance. The Scheme is awaiting the CMS on-site evaluation.

25. NON-COMPLIANCE WITH THE MEDICAL SCHEMES ACT

1. Not all billed contributions are received within three days as Section 26(7) of the Act requires. These incidents are exceptional, e.g., when the three-day grace period falls over a weekend. Credit control procedures minimise the risk of non-recoverability, including that about 90% of contributions are collected via deductions from the employers' payroll. The Scheme monitors creditors closely to minimise the incidences.

2. Claims are generally paid within 30 days of receipt, in terms of Section 59(2) of the Act, but due to procedures such as clinical auditing and suspected fraudulent claims, some claims are paid after 30 days of receipt. This could impact on members and providers. Management track claims older than 30-days and monitor progress to minimise delays.

3. Section 35(8)(c) of the Act require that a medical scheme shall not invest its assets in an administrator. Independent third-party asset managers manage the Scheme's investment funds. They have a discretionary mandate to achieve set targets. Given this approach, the Scheme may sometimes be exposed to shares in administrators. As a precaution, the Scheme made an application and was granted an exemption from complying with this requirement by the Council for Medical Schemes. The exemption expires on 31 December 2028. The Scheme invests in Momentum Metropolitan Life Limited, Sanlam Life Insurance Ltd and Discovery Group Limited.

26. GOING CONCERN

The Council for Medical Schemes announced in 2017 that it intends to consolidate smaller schemes into bigger risk pools to align with the longer-term funding objectives of the National Health Insurance Scheme. This is, however, likely to face challenges before it becomes reality and there is no indication that this will occur in the short to medium term. The Scheme remains financially sound.

The subsequent Directives issued by the Registrar, following the investigation into the Scheme's affairs, were addressed in a written response to the Registrar. An outcome is still awaited.

Based on the information contained in these annual financial statements, available cash resources and forecasts, the Board firmly believes that the Scheme will continue as a going concern in the foreseeable future.