ALLIANCE-MIDMED MEDICAL SCHEME

Registration number 1465

Annual Board of Trustees Report
and
Audited Financial Statements

for the year ended 31 December 2024

ALLIANCE-MIDMED MEDICAL SCHEME

FINANCIAL STATEMENTS
for the year ended 31 December 2024

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

	Page
Statement of responsibility by the Board of Trustees	1
Report of the Board of Trustees	2 - 6
Report of the Independent Auditor	7 - 10
Statement of financial position	11
Statement of profit or loss and other comprehensive income	12
Statement of cash flows	13
Notes to the financial statements	14 - 30

ALLIANCE-MIDMED MEDICAL SCHEME

FINANCIAL STATEMENTS
for the year ended 31 December 2024

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 annual strategy meeting.

The Audit Committee includes risk and compliance. 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 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 III Report and then the King IV Report by 2025.

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 12 May 2025 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 2024

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% (2023: 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 Mabhena	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
V Ngwenya	Alternate	Alternate	Appointed 9 April 2023
P Monatisa	Alternate	Alternate	Elected 1 September 2024

The Trustees took office on 1 September 2024. Three Trustees are appointed, and three Trustees are elected. Three 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
3 Jasmyn Street
Kanonkop
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).

2. MANAGEMENT (continued)

2.5 Consultants

Dr R Odes performed the duties of Scheme Medical Advisor.

2.6 Bankers

First National Bank

2.7 Independent Auditors

Ranrus Incorporated
1 Mowbray Road
Greenside
Johannesburg
2193
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

Contract ended 31 October 2024
Old Mutual Wealth
No1 Mutual Place
107 Rivonia Road
Sandton
2196
Financial Service Provider Number 588

Contract ended 31 October 2024
MandG Investments Life South Africa (RF) Ltd
P.O. Box 23167
Claremont
7735
Financial Service Provider Number 615

Contract ended 31 October 2024
Stanlib Collective Investments
17 Melrose Boulevard
Cnr Campground & Main Roads
Melrose Arch
2196

Contract ended 31 October 2024
Allan Gray Life Ltd
1 Silo Square
V & A Waterfront
Cape Town
8001

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%.

	2024 R	2023 R
The accumulated funds ratio is calculated on the following basis:		
Insurance liability for future members	81 300 779	74 752 555
Less: Cumulative unrealised gains on financial assets at fair value through profit and loss	-	(23 644 304)
Accumulated funds per Regulation 29 of the Act	81 300 779	51 108 251
Insurance revenue (note 8)	133 902 882	121 448 866
Solvency margin	60.72%	42.08%

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 2024, 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. SUBSEQUENT EVENTS

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 we 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. We are yet to receive feedback regarding the assessment.

The Board is also dealing with an investigation into the Scheme's affairs, subsequent to concerns raised by the inspector during a remote "routine inspection" by the CMS. We have commented on the draft report by the investigators in February 2022, and await their final report. The investigation had a major impact on our resources and finances. Further discussions has taken place with CMS, after year end, to resolve the matter.

Effective 31 January 2025, J Hartzenberg's term as Principal Officer ended and PDG Theron was appointed as the Principal Officer effective 01 February 2025.

7. COMPLIANCE MATTERS

According to CMS calculations, a potential contingent liability arose through a directive from CMS received on 16 April 2020 to refund about R37.28 million to members. CMS alleged that the Scheme used Member Savings to pay for Prescribed Minimum Benefit (PMB) claims, which claims should have been paid from the Major Risk Pool (MRP). We objected to the directive on the basis thereof, as explained in Note 23. The CMS confirmed that they have not yet finalised the objection against the Regulation 10 Directive and our submitted evidence that the CMS used another Scheme's data and that the Regulation 10 Directive is therefore invalid (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:

18 March 2024
18 June 2024
16 September 2024
09 December 2024

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 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 and M van Staden, and independent Members K Bizana and D van der Merwe, under the chairmanship of independent member JP van der Walt.

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 member 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 30 November 2025. 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. We implemented an additional pre-payment Prescribed Minimum Benefit (PMB) claims check, reducing member exposure progressively since 2018, when we first implemented this process. The total out-of-pocket expense of members was reduced over this period. With the assistance of 3ONE Consulting Actuaries (3ONE), we closely evaluate the impact of long-term and chronic illnesses, including COVID-19. 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 chain ladder method (CLM). The CLM uses run-off triangles to calculate the expected outstanding claims amount. Primarily this methodology assumes that previous claims patterns represent current run-off expectations. 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 2024 was 1 684 (2023: 1 594). The average age of beneficiaries on 31 December 2024 was 34.79 (2023: 35.77) 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 and we expect this project to be completed in 2025. It includes compliance to relevant aspects of King III and King IV. 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.

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 administraiton 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	3	4	3	1	1
FJ Mabhena	4	4	-	-	1	1
JC van Coller	4	4	-	-	1	1
D Martin (term ended 31 October 2024) #	2	2	1	1	1	-
J Nell #	4	3	4	3	1	1
EC Jordaan (term ended 31 October 2024) #	2	1	2	1	1	1
M van Staden #	2	2	1	1	1	1
JJ Tharakan	2	2	-	-	1	1
S Beyer (Co-opted Trustee)	4	4	-	-	1	1
V Ngwenya (Observer)	4	3	-	-	1	1
A Taljaard	2	2	-	-	-	-
P Monatisa	2	2	-	-	-	-
Audit, Risk and Compliance Committee members						
J Van Der Walt (Chairman)	4	4	4	4	1	1
D Van Der Merwe			4	3	1	1
K Bizana			4	1	1	
Principal Officer						
J Hartzenberg	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

	2024	**2023**
Number of members at the end of the year	1 684	1 594
Number of beneficiaries at the end of the year	3 834	3 624
Average number of members for the year	1 649	1 600
Average number of beneficiaries for the year	3 747	3 615
Beneficiaries per member at the end of the year	2.28	2.27
Average age of beneficiaries for the year	34.79	35.77
Pensioner ratio (beneficiaries > 65 years)	8.66%	9.33%
Dependants per member at the end of the accounting period	1.28	1.27
Average insurance revenue per beneficiary per month	R2 831	R2 659
Average insurance service expense per beneficiary per month	R2 951	R2 772
Total insurance service expense as a percentage of insurance revenue	99.09%	99.01%
Average administration fees and other operative expenses per beneficiary per month	R174	R128
Administration fees and other operative expenses as a percentage of gross contributions	5.85%	4.58%
Directly attributable insurance service expenses	R551 535	R3 499 127
Directly attributable insurance service expenses ratio	0.43%	3.03%
Return on investments as a percentage of closing investments	10.10%	8.39%

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 32, which comprise the statement of financial position as at 31 December 2024 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 significant 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 2024 and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa, as amended.

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. The IRBA Code is consistent with the International Ethics Standards Board for Accountants Code of Ethics for Professional Accountants (Parts A and B). 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 R47,901,980 (2023: R49,384,172) 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

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 incurred claims is estimated by the Scheme's actuaries, after considering the Traditional Chain Ladder Techniques and 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.	process and obtained an understanding of the relevant controls. • We obtained the report of the Scheme's independent actuary of the LIC provision at year end and tested the appropriateness of the estimate performed as follows: o Evaluated the competence, capabilities and objectivity of the Scheme's independent actuary. o 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. o 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. o Obtained an understanding of the data utilized in the calculation of the estimate and agreed with the source data. o 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: o 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. o We assessed the claims received subsequent to year end for claims relating to the 2024 financial year. o 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. o 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.

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 International Financial Reporting Standards 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 3 years.

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

Ranrus Incorporated

Jarred Barnard
Ranrus Inc.
Signed by Jarred Barnard, jbarnard@ranrus.co.za
13/06/2025 09:58:40(UTC+02:00) SIGNIFLOW

Per: JA Barnard CA(SA)
Director
Registered Auditor

13 June 2025

1 Mowbray Road
Greenside
Johannesburg
South Africa
2193

ALLIANCE-MIDMED MEDICAL SCHEME

STATEMENT OF FINANCIAL POSITION
as at 31 December 2024

	Notes	2024 R	2023 R
ASSETS			
Non-current assets			
Property and equipment	2	291 811	285 058
Current assets		129 813 937	124 421 725
Trade and other receivables	3	33 737	32 130
Cash and cash equivalents	4	18 618 601	18 610 730
Investments held at fair value through profit and loss	5	111 161 599	105 778 865
Total assets		130 105 748	124 706 783
LIABILITIES			
Non-current liabilities		81 300 779	74 752 555
Insurance liability for future members	6.3	81 300 779	74 752 555
Current liabilities		48 804 969	49 954 228
Insurance contract liability	6	47 901 980	49 384 172
Trade and other payables	7	902 989	570 056
Total funds and liabilities		130 105 748	124 706 783

ALLIANCE-MIDMED MEDICAL SCHEME

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME
for the year ended 31 December 2024

	Notes	2024 R	2023 R
Insurance revenue	8	127 315 081	115 361 975
Insurance service expense		(132 682 882)	(120 250 188)
Claims incurred	9.1	(121 598 080)	(115 472 613)
Net impairment recovery/ (loss) on healthcare receivables	9.2	(13 138)	(22 460)
Accredited managed healthcare services (no risk transfer)	9.3	(3 971 905)	(2 062 451)
Attributable expenses incurred	9.4	(551 535)	(3 499 127)
Third party claim recoveries	9.5	-	-
Amounts attributable to future members	9.6	(6 548 224)	806 463
Insurance service result		(5 367 801)	(4 888 213)
Other income		13 170 871	10 447 676
Investment income	11	13 109 664	10 439 291
Sundry income		61 207	8 385
Other expenditure		(7 803 070)	(5 559 463)
Administration fees and other operative expenses	10	(7 041 638)	(4 782 541)
Asset management fees		(761 432)	(776 922)
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 2024

	Notes	2024 R	2023 R
Cash flows from operating activities			
Cash receipts from members – contributions	6	134 063 473	121 326 881
Cash paid for claims and acquisition costs		(129 995 315)	(121 799 727)
Cash paid to providers and employees		(6 567 470)	(4 423 941)
Cash paid to members – savings plan refunds		(4 369 926)	(1 306 268)
Net cash flows from operating activities		**(6 869 239)**	**(6 203 055)**
Cash flows used in investing activities		**6 877 110**	**739 041**
Acquisition of medical and computer equipment	2	(88 388)	(270 166)
Acquisition of investments	5	(114 630 308)	(5 250 410)
Proceeds on disposal of investments	5	116 483 608	179 605
Interest income	11	5 442 053	6 356 215
Dividend income	11	431 577	500 719
Asset management fees		(761 432)	(776 922)
Net (decrease) / increase in cash and cash equivalents		**7 871**	**(5 464 014)**
Cash and cash equivalents at the beginning of the year		18 610 730	24 074 744
Cash and cash equivalents at the end of the year	4	**18 618 601**	**18 610 730**

ALLIANCE-MIDMED MEDICAL SCHEME

NOTES TO THE ANNUAL STATEMENTS
for the year ended 31 December 2024

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 (FS). 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 FS have been prepared in accordance withIFRS 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 FS 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, 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 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 2024 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	**Standard,**	**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.

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).

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

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

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

Although the Rules do not specify how the assets should be distributed on liquidation, IFRS 17 states that "contracts can be written, oral or implied by an entity's customary business practices. Contractual terms include all terms in a contract, explicit or implied, but an entity shall disregard terms that have no commercial substance (i.e. no discernible effect on the economics of the contract). Implied terms in a contract include those imposed by law or regulation" (IFRS 17.2). Therefore, based on customary business practices, the remaining assets of the Scheme should be distributed to the members on liquidation if there are any and if the Scheme does not amalgamate with another Scheme. Even if the assets are distributed by a regulator or by the policyholders to an independent third party e.g. another medical Scheme, an administrator or a charity, the important aspect is that the choice resides with the members or the regulator acting on behalf of the members, not with an equity holder.

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

IFRS17.B71 It is therefore expected that the remaining assets of the Scheme will be used to pay current and future members.

Based on the above, the Scheme meets the definition of a mutual entity in IFRS.

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 2022 and 2023.

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.

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, because 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 intentio to expedite the National Health Insurance Scheme, and a prominent element is to consolidate small Schemes. This threat has been declared in the Sch Annual Financial Statements AFS since 2018, and recently government intensified their attempts, under the COVID-19 response, to expedite this initiat

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 multip 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 unconsolidat structured entities. The Scheme invests in these funds, whose objectives range from achieving medium- to long-term capital growth and whose investn strategy do not include the use of leverage. The funds are managed by unrelated asset managers and apply various investment strategies to accomplis 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 astable 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.

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. Unde 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 he 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 interdependancy. 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 amou 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.

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 Ful-fil-ment 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.

		2024 R	2023 R
2.	**PROPERTY AND EQUIPMENT**		
	Cost		
	At beginning of year	400 849	130 683
	Additions	88 388	270 166
	At end of year	489 237	400 849
	Accumulated depreciation		
	At beginning of year	(115 790)	(60 221)
	Depreciation	(81 636)	(55 569)
	At end of year	(197 426)	(115 790)
	Carrying amount at end of year	291 811	285 058
3.	**TRADE AND OTHER RECEIVABLES**		
	Non-insurance receivables		
	Prepaid expenses	33 737	32 130
		33 737	32 130

		2022 R	2021 R
4.	**CASH AND CASH EQUIVALENTS**		
	Current accounts	18 618 601	422 106
	Deposits on call	-	18 188 625
		18 618 601	18 610 731

The overall weighted average effective interest rate on cash resources at year end was 8.28% (2023: 8.51%).

5.	**INVESTMENTS HELD AT FAIR VALUE THROUGH PROFIT AND LOSS**	
Fair value at the beginning of the year	105 778 865	97 305 309
Additions and income capitalised	114 630 308	5 250 410
Disposals	(116 483 608)	(179 605)
Net unrealised gains on revaluation recognised through the statement of comprehensive income	7 236 034	3 402 752
Fair value at the end of the year	111 161 599	105 778 865
The investments included above represent:		
Cash and equivalents	58 350 300	21 006 305
Bonds	31 367 368	56 241 090
Equities	21 443 931	28 531 470
Fair value at the end of the year	111 161 599	105 778 865

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

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**
Closing insurance contract assets	(603 481)	(78 322)	-	(681 803)
Closing insurance contract liabilities	247 196	46 847 225	1 489 362	48 583 783
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)			

6. INSURANCE CONTRACT LIABILITY

		2024 R	2023 R
Insurance contract assets		**681 803**	**659 288**
Recoveries from members for co-payments outstanding		52 396	27 239
Risk contributions outstanding		641 212	667 249
Provider debt outstanding		256 846	255 906
PMSA advances (note 5.2)		13 271	1 238
Provision for impairment losses on healthcare receivables		(281 922)	(292 344)
Insurance contract liabilities		**48 583 783**	**50 043 460**
Reported risk claims not yet paid		8 036 639	8 361 441
Contributions received in advance		247 196	121 172
Outstanding risk claims provision	6.2	6 372 741	8 673 274
PMSA liability	6.1	33 927 207	32 887 573
Net insurance contract liabilities		**47 901 980**	**49 384 172**

6. INSURANCE CONTRACT LIABILITY

Reconciliation of liability for remaining coverage and liability for incurred claims

2023	Liability for remaining coverage (LRC)	Liability for incurred claims (LIC)		Total 2023
		Best estimate liability	Risk adjustment	
	R	R	R	R
Opening insurance contract assets	(595 563)	(79 133)	-	(674 696)
Opening insurance contract liabilities	215 181	44 340 016	1 588 109	46 143 306
Net opening balance as at 1 January 2023	**(380 382)**	**44 260 883**	**1 588 109**	**45 468 610**
Changes in the statement of comprehensive income				
Insurance revenue	**(115 361 975)**	**-**	**-**	**(115 361 975)**
Insurance revenue from contracts measured under the PAA	(115 361 975)	-	-	(115 361 975)
Insurance service expense	**-**	**120 273 890**	**782 761**	**121 056 651**
Incurred claims and other insurance service expenses	-	120 273 890	2 370 870	122 644 760
Adjustment to liabilities for incurred claims - past events	-	-	(1 588 109)	(1 588 109)
Total changes in the statement of comprehensive income	**(115 361 975)**	**120 273 890**	**782 761**	**5 694 676**
Investment components*	(6 088 129)	6 088 129	-	-
Cash flows				
Contributions received**	121 326 881	-	-	121 326 881
Claims and other directly attributable expenses paid***	-	(123 105 995)	-	(123 105 995)
Insurance acquisition cash flows paid				-
Total Cash flows	**115 238 752**	**(117 017 866)**	**-**	**(1 779 114)**
Net closing balance as at 31 December 2023	**(503 605)**	**47 516 907**	**2 370 870**	**49 384 172**
Closing insurance contract assets	(624 777)	(34 511)	-	(659 288)
Closing insurance contract liabilities	121 172	47 551 418	2 370 870	50 043 460
Net closing balance as at 31 December 2023	**(503 605)**	**47 516 907**	**2 370 870**	**49 384 172**

Notes for 2023:

Savings contributions received*	6 088 129
Contributions received**	**121 326 881**
Risk contributions	115 238 752
PMSA contributions	6 088 129
Claims and other directly attributable expenses paid ***	**(123 105 995)**
Risk claims	(114 074 673)
PMSA claims and refunds	(5 532 195)
Expenses	(3 499 127)

	2024 R	2023 R
6.1 PERSONAL MEDICAL SAVINGS ACCOUNT		
Balance of Personal Medical Savings Accounts at beginning of the year	32 887 573	32 331 639
Less: Prior year advances on Personal Medical Savings Account	(1 238)	(5 565)
Net balance on Personal Medical Savings Account at the beginning of the year	32 886 335	32 326 074
Personal Medical Savings Account Insurance revenue received	6 589 039	6 092 456
- for the current year (note 8)	6 587 801	6 086 891
- allocated to settle prior year advances	1 238	5 565
Less:		
Transfers to other Schemes and repayments on death or resignation	(4 369 926)	(1 306 268)
Claims paid on behalf of members (note 9.1)	(1 191 512)	(4 225 927)
Net balance on Personal Medical Savings Account liability at the end of the year	33 913 936	32 886 335
Add: Advances on Personal Medical Savings Account included in trade and other receivables	13 271	1 238
Amounts due to members on Personal Medical Savings Account at the end of the year	33 927 207	32 887 573

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 enrols 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	8 673 274	6 792 047
Payments in respect of prior year	(2 829 841)	(2 431 263)
Over provision in prior year	5 843 433	4 360 784
Adjustment to income statement	(5 843 433)	(4 360 784)
Raised in the current year	6 372 741	8 673 274
Balance at end of year	6 372 741	8 673 274 -

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	6 372 741	8 673 274
Balance at end of year	6 372 741	8 673 274

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 2024, taking into consideration of the risk adjustment in respect of non-financial risk introduced by IFRS17.

6.2 LIABILITY FOR INCURRED CLAIMS (continued)

Process used to determine the assumptions

3ONE applied the Chain Ladder Method (CLM) to calculate the Scheme's liability for incurred claims.

The CLM uses run-off triangles to calculate the expected outstanding claims amount. The primary assumption is that past claims patterns will continue in the future.

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.

	2024 R	2023 R
6.3 INSURANCE CONTRACT LIABILITIES - LIABILITY ATTRIBUTABLE TO FUTURE MEMBERS		
Reconciliation of the insurance liability attributable to future members		
Opening balance	74 752 555	75 559 018
Movement in insurance liability attributable to future members (note 9.6)	6 548 224	(806 463)
Closing balance	81 300 779	74 752 555
7. TRADE AND OTHER PAYABLES		
Non-insurance liabilities		
Investment management fees	63 195	65 207
Audit fee provision	384 118	364 093
Payroll provisions	44 306	(0)
Sundry accounts payable	411 370	140 757
	902 989	570 057
8. INSURANCE REVENUE		
Gross Insurance revenue	133 902 882	121 448 866
Less: Savings Insurance revenue (note 6.1)	(6 587 801)	(6 086 891)
Total insurance revenue	127 315 081	115 361 975

		2024 R	2023 R
9.	**INSURANCE SERVICE EXPENSE**		
9.1	**Claims Incurred**		
	Current year claims	122 260 284	115 386 050
	Movement in outstanding claims provision	529 308	4 312 490
	- Over provision in prior year (note 6.2)	(5 843 433)	(4 360 784)
	- Current year provision	6 372 741	8 673 274
	- Claims paid from Personal Medical Savings Account (note 6.1)	(1 191 512)	(4 225 927)
		121 598 080	115 472 613
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)	2 690
	- Impairment losses	(3 630)	2 690
	Members' and service providers' portions that are not recoverable	16 768	19 770
	- Impairment losses	16 768	19 770
	Previous impaired losses recovered	-	-
		13 138	22 460
9.3	**Accredited managed healthcare services - (no transfer of risk)**		
	Rx Health (Pty) Ltd	669 829	1 453 713
	Nursecare Agency	78 533	-
	Mediscor PBM (Pty) Ltd	554 807	608 738
	Staff remuneration	1 916 044	-
	Medical Advisors	752 692	-
		3 971 905	2 062 451
9.4	**Attributable expenses incurred**		
	Benefit management fee - not accredited managed care		
	- Paid to Health Portfolio Managers	63 068	1 773 398
	- Paid to Smart Client Services	11 360	1 116 184
	- Staff remuneration	477 107	609 545
		551 535	3 499 127
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)	6 548 224	(806 463)
	TOTAL INSURANCE SERVICE EXPENSE	132 682 882	120 250 188
10.	**ADMINISTRATION EXPENSES**		
	Audit fees	368 418	330 319
	Consultant fees	3 287 098	2 928 374
	Legal fees	219 570	444 441
	Depreciation	81 634	55 570
	Fidelity guarantee and professional indemnity insurance premium	32 130	20 400
	Registrar's levies	83 576	76 746
	Travel expenses	155 905	139 911
	Europ Assistance	97 854	93 239
	IT Expenses **	1 799 679	-
	Bank charges	148 866	138 978
	Subscriptions	124 063	146 730
	Other expenses	642 845	407 833
		7 041 638	4 782 541

** 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	1 806 302	1 473 222
	Investments held at fair value through profit and loss		
	-Interest income	3 635 751	4 882 993
	-Dividend income	431 577	500 719
	-Net gain on investments held at fair value through profit and loss	7 236 034	3 582 357
		13 109 664	10 439 291

	2024 R	2023 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	41 520 581	179 605
-Net unrealised gains on revaluation	(34 284 547)	3 402 752
	7 236 034	3 582 357

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 underwitten by Hollard which, at 31 December 2024, provided cover of R10 million (2023: R10 million).

13. RELATED PARTY TRANSACTIONS

Health Portfolio Management provides systems and infra-structure services to the Scheme at arms-length. The cost to the Scheme was R63 068 for the year (2023: R1 773 398). Contract ended January 2024.

Smart Client Services provides Member and Provider Communication services to the Scheme at arms-length. The cost to the Scheme was R11 360 for the year (2023: R1 116 184). Contract ended January 2024.

Client Success Consulting Services provides Scheme management support, systems optimisation, and data analytics/reporting services.The service cost R1 272 659 for the year (2023: R949 032).

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 R869 112 (2023: R562 452) were received and claims of R747 345 (2023: R293 830) 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 2024 (2023: R Nil). The Principal Officer is remunerated by the employer group Columbus Stainless (Pty) Ltd.

On 31 December 2024, the Trustees had positive savings balances of R211 820 (2023: R159 292). 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:

Liabilitiy 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.

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 2023 medical insurance claims paid in the 2023 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		
2024		R	R	R	R	R	R
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

		Hospital (major medical)		Chronic		Day-to-day	Total
		PMB	Non-PMB	PMB	Non-PMB		
2023		R	R	R	R	R	R
Age grouping (in years)							
< 26	-Gross	2 946 604	4 839 296	36 556	-	9 098 364	16 920 820
	-Net	2 941 934	4 783 731	36 373	-	8 411 480	16 173 518
26 - 35	-Gross	1 540 301	2 516 114	47 379	29 437	4 236 832	8 370 063
	-Net	1 535 371	2 484 283	47 282	29 286	3 949 180	8 045 402
36 - 50	-Gross	4 336 923	7 636 898	417 191	79 638	11 427 793	23 898 443
	-Net	4 324 887	7 512 103	414 553	78 992	10 751 311	23 081 846
51 - 65	-Gross	9 107 249	10 810 159	770 721	36 699	14 584 830	35 309 658
	-Net	8 994 381	10 583 221	768 469	35 994	13 560 553	33 942 618
> 65	-Gross	11 992 587	9 473 072	579 651	10 770	8 364 607	30 420 687
	-Net	11 954 692	9 329 283	576 398	10 768	7 579 219	29 450 360
Total	**-Gross**	29 923 664	35 275 539	1 851 498	156 544	47 712 426	114 919 671
	-Net	29 751 265	34 692 621	1 843 075	155 040	44 251 743	110 693 744

Reconciliation of net claims to current year claims paid:

	2024	2023
	R	R
Total net claims as above	120 426 648	110 693 744
Claim adjustments	10 934	50 974
Claims paid via Europ Assistance	631 190	415 405
Claims paid from Personal Medical Savings Accounts (note 6.1)	1 191 512	4 225 927
Claims paid (note 9.1)	122 260 284	115 386 050

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.

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	
	2024	2023	2024	2023
	%	%	R	R
Bonds	24.11%	45.10%	535 364	1 025 368
Equities including property unit trusts	16.48%	22.88%	756 141	522 299
Total change in accumulated funds			1 291 505	1 547 667

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 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
As at 31 December 2023						
Cash and cash equivalents	18 610 730	-	-	-	-	18 610 730
Investments held at fair value through profit and loss	25 382 510	51 864 885	-	-	-	77 247 395
Total	43 993 240	51 864 885	-	-	-	95 858 125

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:

	2024 R	2023 R
Change in investment income	897 252	733 066

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.

	2024 R	2023 R
Trade and other receivables		
Fully performing	33 737	32 130
Past due and impaired	-	-
	33 737	32 130
Provision for impairment of trade and other receivables	-	-
Trade and other receivables (note 3)	33 737	32 130

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 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 / (negative) liquidity	89 467 183	(2 936 791)	(5 521 424)	-	-	81 008 968
As at 31 December 2023						
Current assets	124 421 725	-	-	-	-	124 421 725
Trade and other receivables	32 130	-	-	-	-	32 130
Cash and cash equivalents	18 610 730	-	-	-	-	18 610 730
Investments held at fair value	105 778 865	-	-	-	-	105 778 865
Current liabilities	43 351 148	1 394 411	5 208 669	-	-	49 954 228
Insurance contract liability	42 781 092	1 394 411	5 208 669	-	-	49 384 172
Trade and other payables	570 056	-	-	-	-	570 056
Net positive liquidity	81 070 577	(1 394 411)	(5 208 669)	-	-	74 467 497

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.

		2024		2023	
		Carrying amount	Fair Value	Carrying amount	Fair Value
		R	R	R	R
Cash and cash equivalents	(note 4)	18 618 601	18 618 601	18 610 730	18 610 730
Trade and other receivables	(note 3)	33 737	33 737	32 130	32 130
Investments held at fair value	(note 5)	111 161 599	111 161 599	105 778 865	105 778 865
Insurance contract liability	(note 6)	(47 901 980)	(47 901 980)	(49 384 172)	(49 384 172)
Trade and other payables	(note 7)	(902 989)	(902 989)	(570 056)	(570 056)

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:	2024 R	2023 R
Prudential Inflation Plus 5% Fund	-	42 767 357
Stanlib Income Fund	-	25 382 510
Allan Gray Medical Schemes Portfolio	-	37 628 998
Sygnia	111 161 599	-
Total	111 161 599	105 778 865

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 2024 was 60.72% (2023: 42.08%).

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 2024 (2023: nil).

21. GUARANTEES

No guarantees either from or to third parties existed at 31 December 2024 (2023: nil).

22. CONTINGENT ASSETS

The Scheme has approximately R3.5m (2023: 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.

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.

We 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 we were not informed that there were any findings in this regard. We also queried the amounts because Alliance-Midmed reconciles PMB claims prior to claims payment runs, and we 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. We have also requested from the administrator at the time, the data that they originally submitted. We engaged a clinical auditor to work through the data and we 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 we 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. We provided this feedback on two occasions in the form of an Objection.

The Scheme infomred 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 we 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 our unique internal control processes, we have disputed this amount as well.

24. SUBSEQUENT EVENTS

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 we 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. We are yet to receive feedback regarding the assessment.

The Board is also dealing with an investigation into the Scheme's affairs, subsequent to concerns raised by the inspector during a remote "routine inspection" by the CMS. We have commented on the draft report by the investigators in February 2022, and await their final report. The investigation had a major impact on our resources and finances. Further discussions has taken place with CMS, after year end, to resolve the matter.

Effective 31 January 2025, J Hartzenberg's term as Principal Officer ended and PDG Theron was appointed as the Principal Officer effective 01 February 2025.

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 member 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 30 November 2025. 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 investigaion into the Scheme's affairs, were addressed in a written response to the Registrar. We are still awaiting a further response.

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.