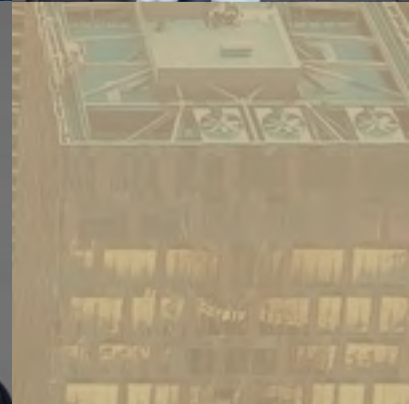
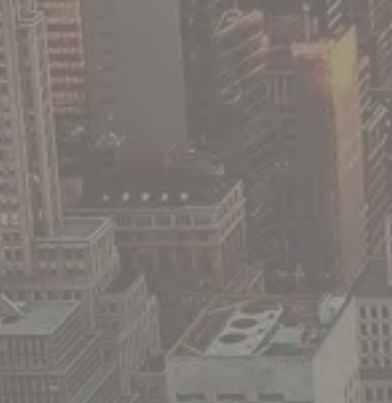
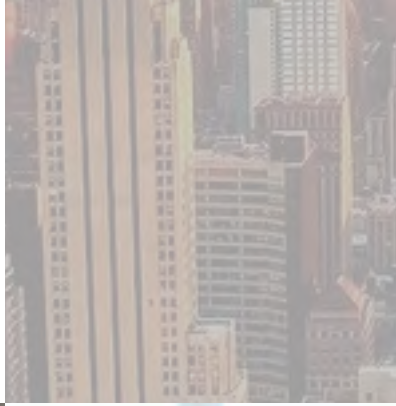


PROFMED



PROFMED ANNUAL INTEGRATED REPORT 2025

Registration No 1194





PROFMED Annual Integrated Report
For the year ended 31 December 2025

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Glossary

ALBI	All Bond Index
ALPI	All Property Index
BBBEE	Broad-Based Black Economic Empowerment Chronic
CDL	Disease List
CMS	Council for Medical Schemes
CPI	Consumer Price Index
EDO	Efficiency Discount Option
FCF	Free Cash Flows
FVOCI	Fair value through other comprehensive income
FVPL	Fair value through profit or loss
FWA	Fraud, Waste and Abuse
HMI	Health Market Inquiry
IAS	International Accounting Standard
ISA	International Standard on Auditing
IFRS	International Financial Reporting Standards
IGOV	Inflation-linked Government Bond Index Low-cost
LCBO	Benefit Option
LIC	Liability for incurred claims
LRC	Liability for remaining coverage
MSA	Medical Schemes Act
NHI	National Health Insurance
PAA	Premium Allocation Approach
PMB	Prescribed Minimum Benefits
PPSHA	PPS Healthcare Administrators
RAF	Road Accident Fund
SAICA	South African Institute of Chartered Accountants
SAPY	South African Property Yield Index
SARS	South African Revenue Services
SME	Small and Medium-sized Enterprises
SPPI	Solely payments of principal and interest Short-term
STEFI	Fixed Interest Index
SWIX	Shareholder Weighted Index
WGBI	World Government Bond Index

OUR CHAIRPERSON'S REPORT

The 2025 financial year brought both challenges and opportunities to Profmed which was met with the resilience and vision for which the Scheme is known.

In the year under review, we saw increased complexity in the operating landscape in which the Scheme pursues its core objectives: To provide its members and beneficiaries with affordable access to appropriate healthcare, while managing the escalating costs of healthcare and ensuring the sustainability of the Scheme.

The year was characterised by several material challenges, including a sustained rise in chronic disease prevalence; above-inflation increases in the cost of healthcare; affordability pressures driven by broader macroeconomic conditions; and ongoing regulatory uncertainty associated with National Health Insurance (NHI).

The Board and management responded to these challenges with appropriate strategic agility, adaptability and innovation, ensuring the Scheme remained resilient and well positioned for the future.



INVESTMENT

It has been an exceptional year for South African (SA) asset classes, with SA equities being the standout performer delivering a return of 42.6% over the period. SA listed property (30.6%) and SA nominal bonds (24.2%) were the second and third best performing mainstream asset classes for the 2025 calendar year.

The Rand appreciated by 12.2% against the US dollar in 2025, which naturally had the effect of reducing the South African rand return of the global asset classes. Global equities were up 22.3% in US dollar, once again driven by the strong performance of large cap United States technology companies. Medical Schemes are however only permitted to invest in global fixed income assets (no global equities allowed) and global bonds performed

poorly amid elevated global inflation and high debt levels while the strengthening Rand has also reduced returns in global bonds.

It is somewhat ironic that the inconsistent and belligerent policies followed by the Trump Administration spurred the sharp increase in the gold price and a weakening of the US\$, all of which turned out extremely positive for the South African equity and bond markets and in turn Profmed's Investment portfolio in 2025.

OUR CHAIRPERSON'S REPORT CONTINUED

FINANCIAL STRENGTH SOLVENCY

While financial markets played a role, we are especially proud of our strong operational profit. The Scheme's current position puts it on a stable financial trajectory. For the period under review, the Scheme reported a net surplus (amounts attributable to future members) of R356.6 million. The surplus is mainly attributed to positive claims result and significant investment returns. As a result, the solvency ratio exceeded the target range of 35% - 40% and ended 2025 at 43.4%.

Profmed has over many years had a declining solvency ratio due to escalating claims costs driven by healthcare inflation and ageing membership. Healthcare inflation has typically averaged at 9% over the past 10 years and the Board's key strategy has been to stabilise the solvency ratio which was previously above 50% to a more reasonable target range. The decline in the solvency has, since 2019, necessitated stronger claims management interventions and the introduction of hospital and day procedure networks. In 2024 and 2025 the positive operating surplus indicates that claims and specifically negotiations with providers have resulted in a more stable reserve level and in 2025 a growing reserve level. Much of the improved solvency ratio is attributed to significant out of the ordinary investment returns for 2025. Markets have been typically strong this past year and the 43.4% solvency ratio at year end is mostly driven by the unexpected investment returns while the better claim outcomes also contributed in a small way to the improvement. While the 43.4% solvency ratio is a strong position for Profmed, all reserves within the Scheme provide a good foundation to benefit members in future years through lower premium increases and where possible added benefits.

The healthcare industry continues to experience significant pressure from an ageing population and rising costs of care. As life expectancy increases, demand-side pressures are intensifying due to the growing prevalence of lifestyle-related and chronic conditions, including mental health disorders and cancer. This demographic shift, challenges access to appropriate care, requiring healthcare systems to balance affordability with long-term sustainability.

Costs of care are escalated by both demand-side factors, such as increased utilisation, and supply-side factors, including high-cost medical technologies and medicines. Profmed's reserve strategy remains central to its approach, ensuring that member contributions align with actual healthcare utilisation while providing a buffer against escalating costs. Maintaining these reserves is critical to protecting members against healthcare inflation and ensuring the Scheme's continued financial resilience.

In 2025, the Scheme implemented targeted strategies to contain costs and optimise outcomes. These included well-managed hospital negotiations and enhanced networks, the strengthening of managed care interventions and protocols.

Such initiatives are essential not only to improve health outcomes for members on a sustained basis and ensuring the timely payment of all valid claims, but also to contain cost escalation and safeguard the Scheme's long-term financial stability. Through these strategies, Profmed remains well-positioned to deliver affordable, appropriate, and high-quality healthcare to its members. Our sustainable value cycle allows for the surplus to be shared with members through enhanced benefits and continued low contribution rates.



OUR CHAIRPERSON'S REPORT CONTINUED

OPPORTUNITIES VIA PARTNERSHIPS

One of the most powerful things about Profmed is that we don't just stop at medical cover. We look at the whole professional journey, and then ask: Who can we partner with to make that journey easier?

Profmed's partnership strategy focuses on aligning with professionally focused institutions to strengthen its value proposition and support sustainable membership growth. As a restricted medical scheme for graduate professionals, growth is driven by access to trusted distribution channels and ecosystem partners that deliver high quality, professionally aligned member pools. Strategic partnerships enhance Profmed's value proposition through integrated financial, advisory and wellness offerings, while supporting consistent new member inflows and longterm retention. Key relationships with Rand Merchant Bank (RMB), PPS Financial Services (PPS) and FinDR serve as strategic growth levers that reinforce market reach, member quality and long-term sustainability.

BENEFITS

Profmed continues to offer plans tailored to professionals at every stage of life, whether young professionals seeking affordable entry-level cover, growing families balancing multiple priorities, or retirees looking for stability and peace of mind. The Scheme has maintained its reputation for competitive pricing, ensuring that members across income levels can access options that meet their needs without unnecessary complexity. Its strong financial and operational performance provides the stability to manage low contribution adjustments responsibly while introducing enhancements that deliver greater value.

In 2025, all benefit adjustments were guided by robust data related to member health needs. By analysing utilisation and claims patterns, the Scheme aligned its offerings with the care members require, shifting from reactive insights to proactive health management. This approach enabled the introduction of an AI-driven, non-invasive facial scan and digital health assessment, helping members stay healthier while reducing out-of-pocket costs and the long-term impact of chronic conditions.

Preventative and wellness care remained a priority in 2025. In response to breast cancer being the most common cancer among women globally, the mammogram cycle was amended from biennial to annual for women aged 40 to 55 years. To further support and encourage screening, the **Amplifire Health Booster** benefit an innovative, incentivised enabler was enhanced to offer even more day-to-day benefits. Amplifire incentivises members to take control of their wellbeing through proactive health actions and measurable personal health outcomes. This forward-thinking approach reflects the Scheme's unwavering commitment to strengthening care where it matters most, each member is recognised as a completely unique individual with distinct health needs. We strengthened the dental benefit by introducing a family limit, giving your household more funds for dental care rather than being restricted to individual beneficiary limits. Complementing this approach, the Scheme continues to advance both efficiency and clinical outcomes through coordinated care programmes for chronic conditions, short stay hospital options, and home-based care initiatives such as **Healing at Home**.

The Healing at Home initiative enhances member care by providing hospital level treatment in the home for suitable conditions, improving both comfort and convenience. Delivered through contracted service providers, the programme is demonstrating positive clinical outcomes. The focus moving forward is on expanding its reach and increasing member awareness to maximise its impact.

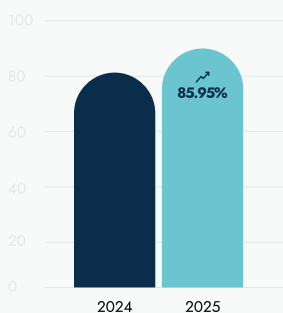


OUR CHAIRPERSON'S REPORT CONTINUED

SERVICE

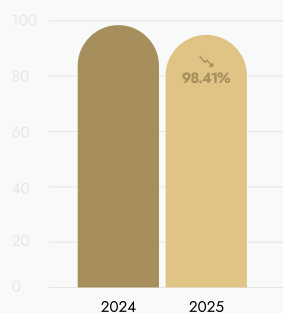
In 2025, we examined our service delivery level arrangements, and this renewed attention has resulted in improved member satisfaction scores

First time Call Resolution (Client Service)



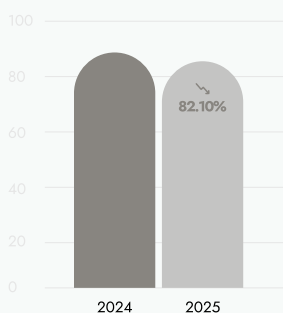
From 74.29% in 2024 to 80.95% in 2025

Stable Customer Satisfaction on Calls



with 98.44% in 2024 and 98.41% in 2025.

Total Number of Calls Answered in less than 20 seconds



in 2024 was 86.50% and 2025 82.10%

The claims' processing performance has remained stable and largely in-line with contracted service levels. Total claim lines processed in 2024 were 5 400 068 and 5 555 233 in 2025.

NHI

Profmed continues to monitor the implementation of the NHI Act and its potential implications for the healthcare system. While full impact on medical scheme members may take several years, concerns around affordability, funding mechanisms, and regulatory detail remain significant. The Scheme is actively participating in industry led engagements, including the Health Funders Association led legal challenge, while advocating for amendments that address critical concerns and protracted disputes.

Several legal challenges to NHI will continue to play out over the coming few years and many have seen little progress since they were lodged more than a year ago. While this continues the necessary reforms required to improve affordability and sustainability of medical schemes has also been relegated. Profmed remains committed to strategic engagement and collaboration to safeguard our members and their reserves, by ensuring sustainable and equitable access for all members.

LOW-COST BENEFIT OPTION (LCBO)

One of the more important regulatory matters remains the long-awaited LCBO reforms. A report was released by the Council for Medical Schemes (CMS) for public comment; however, implementation has not progressed, as the Minister of Health has indicated a preference for prioritising the National Health Insurance (NHI), citing potential overlap between the two initiatives.

As a result, the CMS has continued to extend exemptions that allow health insurers to offer low-cost insurance products, while medical schemes are not permitted to compete in this market on an equal footing. A number of industry-led legal processes are ongoing, and Profmed continues to monitor developments closely. In recent years, there has been a delay in young professionals taking up medical scheme cover, with some opting for limited health insurance products or remaining uninsured.



APPRECIATION

In closing, I extend my sincere appreciation to the Profmed Trustees, the Independent Committee Members, Mr Craig Comrie and his team, as well as our primary contracted partner, PPS Healthcare Administrators, for their continued stewardship and unwavering commitment to the Scheme. Their collective expertise, sound judgment and responsiveness to an evolving healthcare and regulatory landscape remain invaluable in safeguarding the Scheme's sustainability and its ability to meet members' needs.

I would also like to thank our members for their continued trust and confidence in Profmed. We remain committed to acting in their best interests and to ensuring access to quality, affordable healthcare, now and into the future.



Adv JJ Crouse
Chairperson

15 April 2026

REPORT SCOPE AND BOUNDARIES

This Report aims to provide a concise overview of the Scheme, integrating and connecting important information about strategy, risks and opportunities and relating them to the financial, economic, social and environmental performance for the reporting period 1 January 2025 to 31 December 2025. Material and relevant issues that affect the Scheme have been identified in this Report.

USE OF GUIDELINES

Profmed's policies comply with the Medical Schemes Act 131 of 1998 (MSA) and the recommendations set out in the King Report on Governance for South Africa (King IV) and incorporate guidance from the International Integrated Reporting Council.

The Board adopted King IV and discloses its compliance with the King IV practices and principles for 2025. The financial accounting policies are in accordance with International Financial Reporting Standards (IFRS), with guidance from the Medical Schemes Accounting Guide, issued by the South African Institute of Chartered Accountants (SAICA). King V is effective from 1 January 2026 and has made significant improvements in the framework of disclosures that will be made in Profmed's 2026 Annual Integrated Report.

MATERIALITY

Material topics are defined as those reflecting significant economic, environmental and social impacts or those that would influence the decisions of the Scheme's stakeholders such as discussions on broader healthcare, product and benefit enhancement opportunities. Regulatory obligations, internal financial and non-financial reports and voluntary disclosure standards inform the material topics disclosed in this Report.

STAKEHOLDER INCLUSIVENESS

The principle of stakeholder inclusiveness ensures that disclosures are material and relevant to the legitimate interests of Profmed's stakeholders. The Scheme's main

stakeholders are current Profmed members, future Profmed members, brokers, healthcare service providers, the third-party administrator, managed care service providers, employees, contracted outsourced providers, and the Council for Medical Schemes (CMS).

The Scheme utilises a range of primary channels to engage effectively with stakeholders. These include virtual conferencing and meeting platforms, an interactive website, the Profmed mobile App, the Scheme Rules, claims statements, and targeted individual communications where required. Member communication encompasses governance communication as required by the MSA, as well as information relating to benefits, contributions, and any other matters that may impact members. The Profmed mobile App enhances member engagement by providing convenient access to Scheme information and personalised data. It also offers practical functionality designed to improve accessibility, streamline interactions, and add meaningful value to the overall member experience.

DATA MEASUREMENT

Data measurement techniques are replicable, and the data warehouse is used extensively to identify trends and risks. This information is used to make informed decisions about the Scheme's performance against predetermined budgets and health-related outcomes. Measurement techniques, estimates and underlying assumptions are described where it is materially necessary to do so.

ASSURANCE

Deloitte & Touche, the Scheme's external auditor, has audited the annual financial statements and their report is presented on page 38. The Scheme's independent actuaries have been consulted where estimates and projections are presented.

The global credit rating remained the same at a financial rating of AA with stable outlook. The rating is underpinned by improved investment returns and claims management in 2024 and 2025. As such, the capital adequacy ratio (CAR) improved to 2.0x compared to 1.9x in previous years. The expectation is that a positive outlook is a real possibility where statutory solvency is forecast above 40% in the coming years in line with the Board decision to target a long-term solvency range of between 35% and 40%.

ORGANIZATIONAL OVERVIEW & EXTERNAL ENVIRONMENT

1. About Profmed

Profmed is a not-for-profit organisation exclusively for graduate professionals. It provides a risk-pooling arrangement to fund members' medical costs and also assists in the control, management and administration of medical services provided to its members.

1.1 Our Terms of Registration

Profmed is a restricted medical scheme registered in terms of the Medical Schemes Act No. 131 of 1998, as amended. Our registration number is 1194.

1.2 The Healthcare Options we offer

During the year, the following Premium healthcare options were available:

▶ **ProPinnacle**

▶ **ProSecure Plus**

▶ **ProSecure**

▶ **ProActive Plus**

▶ **ProSelect**

The Savvy options offer the same benefits as the Premium options listed above with the exception that members on the Savvy options are required to make use of network hospitals. By selecting to belong to a Savvy option, members enjoy a reduction in their contributions. Due to the nature of the Savvy options, which are classified as Efficiency Discount Options (EDOs), their performance is not reported per option but is included in the performance reporting of the Premium equivalent options.

2. Our External Environment

Profmed operates in a dynamic, complex and competitive environment. This environment is exacerbated by the highly legislated framework in which medical schemes operate.

The Scheme continually scans the internal and external environment to assess risks and opportunities associated with our material matters. This process enables us to identify risks to the financial, operational and relational wellbeing of the Scheme and opportunities arising from effectively managing these risks.

The introduction of the MSA in 1998 required medical schemes to admit members irrespective of their health status or age. The intention was to introduce mechanisms, namely, risk equalisation and mandatory medical scheme cover, to assist medical schemes to mitigate their claims risk. Risk equalisation was intended to spread the risk of the burden of disease across all medical schemes, and mandatory membership of a medical scheme by individuals earning above a certain threshold was meant to enlarge the risk pool and thereby stabilise necessary cross-subsidisation. These mechanisms would have relieved the State of the burden of disease of the employed population and were the reason the income tax subsidy was granted on medical scheme contributions.

Neither risk equalisation nor mandatory medical scheme cover have been implemented, which results in schemes being exposed to anti-selection that increases the age and risk of the Scheme and makes healthcare less affordable for younger members.

ORGANIZATIONAL OVERVIEW & EXTERNAL ENVIRONMENT CONTINUED

This situation has been exacerbated by the requirements of the legislation in terms of the PMBs, which requires medical schemes to cover, in full, the diagnosis, treatment and care costs of 271 conditions.

2.1 Economic Environment

The Scheme operated in a constrained economic environment, requiring a careful balance between contribution affordability and long-term sustainability. Medical inflation continues to exceed overall CPI, placing pressure on contribution levels. Contributions are therefore set to meet projected claims, utilisation trends, and regulatory solvency requirements, while maintaining an appropriate reserve buffer. Profmed manages affordability through prudent benefit design and moderated contribution increases, supported by the responsible investment of reserves. Income is derived solely from member contributions and investment returns, with surplus funds retained to strengthen the Scheme's financial position in line with non-profit principles.

2.2 Regulatory Environment

Update - NHI and LCBO Framework

Although enacted, the NHI Act faces significant delays due to nine court challenges citing procedural flaws, insufficient public consultation, an unsustainable tax-based funding model, and disputes over the role of medical schemes. Members are advised that, irrespective of whether the Act is amended, medical schemes will, for the foreseeable future, continue to provide cover for the healthcare services presently funded. This position arises from the phased implementation framework contemplated in the Act, which requires the establishment and operationalisation of the necessary institutional, administrative, and funding mechanisms prior to the enforcement of substantive changes. It is further anticipated that the Act will remain the subject of protracted litigation. As a result, the practical implementation and enforcement of its material provisions are likely to be deferred.

With regards to the LCBO framework, the CMS has finalised and published its report on LCBOs. The report's key findings include, escalating healthcare costs disproportionately affecting low-income populations, insurance products functioning under temporary exemptions, yet not fully

compliant with applicable regulatory requirements and thirdly concerns that LCBOs may undermine PMBs and principles of equity. The CMS formally opposes the introduction of new LCBOs and recommends a structured transition framework aimed at achieving comprehensive and equitable coverage, consistent with the objectives of NHI.

2.3 Competitive Environment

The medical scheme industry remains highly competitive, with overall growth in insured membership largely stagnant over recent years. Where growth has occurred, it has predominantly been achieved through amalgamations rather than organic expansion. The accompanying graph illustrates the trend in the average change in beneficiaries across the main competitor schemes and reflects that, over the past eleven years, overall beneficiary numbers in the industry have remained broadly unchanged.

The drivers of healthcare inflation are complex and multifaceted. The trends noted an increase in the costs of healthcare services, a growing prevalence of chronic illnesses, and the impact of an ageing economically active population. These factors are not just abstract economic data points; they represent real challenges that affect every person in need of healthcare. Profmed stands out with a strategic advantage as a closed scheme. By targeting individuals who have a professional qualification means that Profmed's members are uniquely empowered to actively manage their health, leading to fewer claims and more stable costs over time. Our ability to maintain a lower contribution increase is a testament to the effectiveness of these targeted initiatives.

Healthcare inflation continues to be driven by a complex and interrelated set of factors. Key contributors include sustained increases in the cost of healthcare services, a rising prevalence of chronic conditions, and the growing impact of an ageing economically active population. These dynamics place ongoing pressure on medical schemes and directly affect members who rely on affordable access to quality healthcare.

Against this backdrop, Profmed benefits from a distinct strategic advantage as a closed scheme. By focusing on professionally qualified individuals, Profmed's membership base is characterised by higher levels of health awareness and proactive health management.

ORGANIZATIONAL OVERVIEW & EXTERNAL ENVIRONMENT CONTINUED

This contributes to more appropriate utilisation of benefits, comparatively lower claims volatility, and greater cost stability over time. The Scheme's ability to sustain lower contribution increases reflects the effectiveness of this targeted membership strategy and disciplined cost management approach.

The contribution increases are set at levels that achieve a balance between financial sustainability, member affordability and market competitiveness, which envisions expected membership growth for the year. Profmed's contribution increases for 2025 were lower than the industry and remain very competitive. This, together with Profmed's comprehensive benefits, sound governance and excellent

service, has attracted members from competitor schemes. Profmed remains the intelligent choice for professionals seeking value-based healthcare benefits.

Our long-term strategic objectives remain fundamentally unchanged. The Board meets annually to determine the strategy of the Scheme. Risks that could impact the Scheme are considered when setting the strategy. The Board has an oversight role in the implementation of the strategy by the management team and regularly assesses performance against the defined strategy.





Strategy, Risk And Business Model

STRATEGY, RISK AND BUSINESS MODEL

STRATEGY

Profmed's key long-term strategy is to grow the membership of the Scheme. By growing the membership, the risk pool will be enlarged, which, in turn, will reduce the effects of high-impact claims.

The table below outlines the movement in the number of principal members for the period under review.

	2025	2024
Opening balance	33 968	34 691
New Members Joining	2 255	1 901
Members resigning	(2 178)	(2 624)
Closing Balance	34 045	33 968
Joining rate	6.6%	5.5%
Resignation rate	6.4%	7.6%
Net growth rate	0.2%	(2.1%)

RISK

Profmed has a robust risk-identification and monitoring process. Identified risks are evaluated and monitored by the Board as well as the Audit and Risk Committee. Both these forums provide input to the Risk Register relating to their spheres of responsibility. The Medical Committee and Investment Committee provide input to the register on any matters of risk pertaining to their respective scopes of responsibility.

The Board and the Audit and Risk Committee assess the mitigating controls of each risk to ascertain the impact of the risk on the Scheme. Internal Audit also assesses the effectiveness of the mitigating controls.

The private healthcare industry in South Africa is highly sophisticated and is ranked as one of the best internationally in terms of access to care, healthcare outcomes and the use of advanced technology. However, despite these advantages, various risks could threaten the achievement of our strategy.

The cost of providing this world-class quality care, as well as the increasing burden of disease, is a major challenge for the healthcare funding industry globally.

Medical inflation has outpaced consumer inflation for many years, driven by various supply and demand factors. Oligopolies within the private hospital and pharmaceutical industries have restricted competition and make it difficult to negotiate rates and manage costs.

The **average age** of beneficiaries increased from 42.3 years in 2024 to 42.8 years in 2025. This ageing results in increases in benefit utilisation and increases in the burden of disease which poses risks to the sustainability of the Scheme. However, Profmed continues to target membership growth within the young graduate population in an effort to improve the overall health risk of the Scheme. The Board of Trustees continue to monitor membership movements, and the matter is receiving the necessary attention in terms of both risk management and future strategic options.

Medical scheme membership is voluntary in South Africa. The nature of medical schemes is that young members and healthy members subsidise those who are ill or ageing. The risk is that the young and healthy do not join medical schemes until they are older or become ill. This compromises the necessary cross-subsidisation in the industry and drives above inflation annual increases in contributions.

STRATEGY, RISK & BUSINESS MODEL CONTINUED

Monitoring and managing risk

Profmed is in the fortunate position that its Board and executive management have a wealth of knowledge and experience in the healthcare and related industries. The Scheme has specialised data-mining tools and, together with its Administrator, carefully monitors these risks. The Scheme's actuaries are specialists in the healthcare industry, further enhancing the Board's ability to monitor and manage risk.

BUSINESS MODEL

Profmed creates value for stakeholders without a motive to derive profit.

Profmed's business model is that of a restricted medical scheme which operates in terms of the provisions of the MSA and takes risk by providing healthcare benefits in return for contributions. Administration, managed healthcare services, investment management, actuarial, legal, internal audit and marketing services are outsourced. These services are outsourced to experts in their field, which is more cost-effective and provides for greater accountability. These services are managed by a competent and experienced Profmed executive management team, which reports to the Board.

The success of the Scheme's business model depends on healthcare product differentiation, affordability and service excellence.

Profmed's philosophy is to provide our discerning members with cost-effective, evidence-based and clinically appropriate treatment at the most appropriate facilities, and to provide peace of mind that their contributions are utilised appropriately and effectively.

The five Premium options are supplemented with five EDO options, known as the Savvy options. The Savvy options offer the same benefits as those of the Premium options, except that members on these options are required to make use of certain network hospitals. In 2025, the following are the main features of the benefit options available:

- **ProPinnacle:** Unlimited in-hospital cover in private wards, comprehensive chronic and day-to-day cover and cover over and above the PMBs. In-and out-of-hospital GP and specialist costs, i.e. consultations and procedures, were covered at 300% Profmed Tariff. Dental consultations and procedures, were covered at 135% Profmed Tariff.
- **ProSecure Plus:** Unlimited in-hospital cover in general wards, private ward rates for maternity (post delivery) as well as cover for chronic and day-to-day medical expenses and cover over and above the PMBs.
 - In-hospital GP and specialist costs, i.e. consultations and procedures, were covered at 200% Profmed Tariff. Out-of-hospital GP and specialist consultations were covered at specified Rand values, and procedures were covered at 100% Specific Tariff. Dental consultations and procedures, were covered at 135% Profmed Tariff.
 -
- **ProSecure:** Unlimited in-hospital cover in general wards, as well as chronic and day-to-day medical expenses and cover over and above the PMBs. In- and out-of-hospital GP and specialist consultations were covered at specified Rand values, and procedures were covered at 100% Specific Tariff. Dental consultations and procedures were covered at 135% Profmed Tariff.
 -
- **ProActive Plus:** Unlimited in-hospital cover in general wards, and cover for PMBs. In-hospital GP and specialist costs, i.e. consultations and procedures, were covered at 175% Profmed Tariff. Out-of-hospital GP and specialist consultations are covered at specified Rand values, and procedures were covered at 100% Specific Tariff. Dental consultations and procedures were covered at 135% Profmed Tariff.
- **ProSelect:** Unlimited in-hospital cover in general wards via a wide network of hospitals, and cover for PMBs. In-hospital GP and specialist costs, i.e. consultations and procedures, were covered at 100% Specific Tariff. Dental consultations and procedures were covered at 135% Profmed Tariff.

The Profmed Tariff is calculated using the 2006 National Health Reference Price List with annual inflationary increases.



Corporate Governance

CORPORATE GOVERNANCE

BOARD OF TRUSTEES IN OFFICE DURING 2025

Mr GS Harvey (Outgoing Chairperson)	BSc (Hons) Comp. Sciences (Term expired 11 June 2025)
Adv JJ Crouse (Incoming Chairperson)	BCom, LLB, PG Cert Medicine and Law (Appointed 12 June 2025)
Mr HP du Toit	BSc, FASSA
Ms NE Curry-Jandrell	BCom (Hons) Actuarial Science, MCom Mathematical Statistics, FASSA (Term expired 11 June 2025)
Prof CA Joseph	M.B., B.Ch. (Wits), F.R.C.S. (Eng), F.C.S. (SA), M.Med. (Wits)
Ms ND Maidi	BCom (Hons), CA (SA), LLB
Ms KPM Simelane	BA (Social Work), HDPM, M.Phil
Dr J Welgemoed	BChD, Hons. Business Administration
Dr H Woermann	BBusSC (UCT), MBChB (UCT) (Appointed 12 June 2025)
Mr AHG Wright	BCom, LLB, CA(SA), FB(SA), (Appointed 12 June 2025)

In line with Profmed's status as a restricted medical scheme for professionals, the Board comprises suitably qualified individuals with extensive expertise across clinical, IT, financial, legal, investment, actuarial, governance and business disciplines. This collective depth of experience ensures effective governance and provides members with assurance that the Scheme is managed by highly competent professionals.

1. MANAGEMENT

1.1 Principal Officer

Mr Craig Comrie is a Chartered Accountant with a wealth of experience in corporate finance, healthcare administration and the running of medical schemes. Profmed benefits significantly from his extensive experience and knowledge of both the restricted and open medical scheme markets.

Mr Craig Comrie's skill and strong leadership continues to be an asset to Profmed.

1.2 Corporate governance

The pillars upholding the Scheme's governance are:

- the Medical Schemes Act 131 of 1998 (as amended);
- the Rules of the Scheme;
- the Profmed Charter, incorporating
- the Code of Conduct and Conflict of Interest Policy; and
- the King Report IV on Governance for South Africa.

The Board reviews these documents annually to ensure their relevance and alignment with new legislation and corporate governance.

The criteria for trustees and key office bearers and the ethics requirements for trustees and employees are addressed in the Profmed Charter, Code of Conduct and Conflict of Interest Policy.

The Nominations Committee, which is an ad hoc committee of the Board, scrutinises nominations received by the Scheme for both appointed and elected trustees in accordance with these policies.

The Board annually undertakes a self-evaluation, and the results are shared with the Board with a view to engaging constructively to resolve any challenges or weaknesses highlighted in the evaluation.

CORPORATE GOVERNANCE CONTINUED

Internal control

Profmed has outsourced the administration of the Scheme to PPS Healthcare Administrators (PPSHA). The Internal Audit Division of the Administrator reports functionally to Profmed's Audit and Risk Committee which is of the view that the internal financial controls provide a sound basis for the preparation of reliable financial statements.

The Board has reviewed the Committee's assessment and concurs with its conclusions. The Board retains overall responsibility for risk governance and ensures that material and manageable risks are appropriately identified, assessed, and effectively managed through the implementation of suitable mitigating controls. Risks that fall outside the direct control of the Scheme are subject to ongoing monitoring. The management team is responsible for the day-to-day identification, management, and reporting of risks within an approved risk management framework. Refer to page 12 for further details on the Scheme's approach to the risk.

The Board ensures that manageable risks are managed effectively, that mitigating controls are implemented and that risks which fall outside the control of the Scheme are monitored closely. The management team is responsible for the management of risk. Refer to page 12 for further details on the Scheme's approach to risk.

Fraud, waste and abuse

The impact of fraud is far-reaching and affects all members of Profmed. The Scheme has implemented advanced analytical capabilities to proactively detect and prevent fraudulent

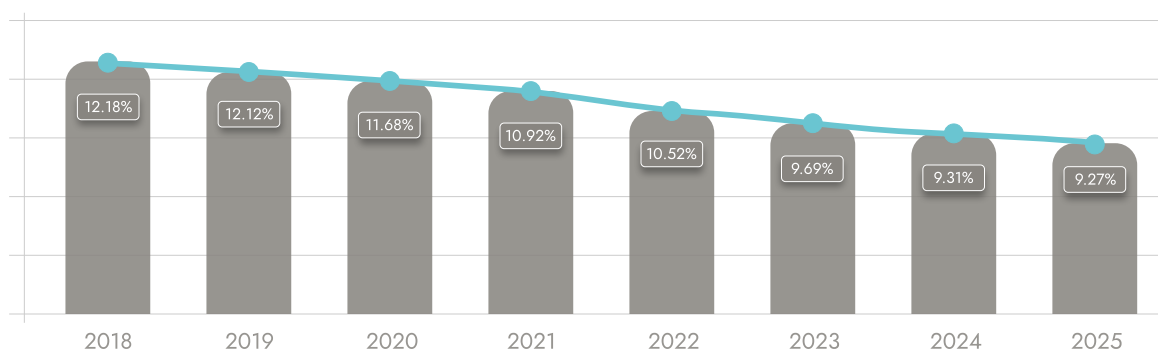
activities. Members are encouraged to report any suspected fraudulent claims or irregular conduct through established reporting channels.

The internal forensic investigation unit managed by PPSHA has been strengthened, with enhanced capacity. Notable progress has been achieved in the development and implementation of the Fraud and Corruption Strategy, Policy, and Implementation Plan. In addition, a comprehensive fraud risk assessment is currently underway to further reinforce the control environment. The independent whistleblowing service remains fully operational and continues to support the early identification and reporting of unethical or unlawful conduct.

Non-healthcare expenditure

The Board has, over the past few years, implemented a strategy to reduce non-healthcare expenditure over time while still maintaining superior governance over the Scheme and improving the service provided to members and stakeholders. The Scheme consistently works to enhance operational efficiency and minimise operating expenses. Effective cost control under the leadership of Mr Craig Comrie ensured that member contributions were predominantly allocated to healthcare-related expenses rather than administrative overheads. As illustrated in the graph below, Profmed's operating expenses over the past eight years show a consistent downward trend, demonstrating sustained improvements in operational efficiency and financial management.

NON HEALTHCARE EXPENDITURE AS A PERCENTAGE OF CONTRIBUTIONS



CORPORATE GOVERNANCE CONTINUED

2. ATTENDANCE AT TRUSTEE AND COMMITTEE MEETINGS

The following schedule sets out trustee meeting attendances where column A indicates the total number of meetings held and B the actual number of meetings attended. Trustee remuneration is disclosed in Note 17.

Name	Board of Trustees		Board Strategy Session		Audit & Risk Committee		Investment Committee		Medical Committee		Recommendation Committee		Nomination Committee		Ad Hoc Meetings
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	
Adv JJ Crouse	5	5	1	1	2	2	1	-	3	3	1	1	1	1	4
Mr HP du Toit	5	5	1	1	-	-	2	2	-	-	-	-	-	-	1
Mr GS Harvey	2	2	0	0	1	1	1	1	1	1	1	1	1	1	3
Ms NE Curry-Jandrell	2	2	0	0	1	1	1	1	-	-	-	-	-	-	1
Prof CA Joseph	5	5	1	1	-	-	-	-	3	3	-	-	-	-	3
Ms N D Madi	5	5	1	1	3	3	-	-	-	-	-	-	-	-	1
Mr PL Marais*	-	-	-	-	-	-	-	-	-	-	2	2	-	-	1
Ms K Naidu	-	-	-	-	-	-	-	-	-	-	2	2	-	-	2
Dr Y Omar Carrim*	-	-	-	-	3	3	-	-	-	-	-	-	-	-	0
Mr J Prinsloo*	-	-	-	-	3	3	-	-	-	-	-	-	-	-	0
Ms KPM Simelane	5	5	1	1	-	-	-	-	-	-	-	-	1	1	1
Mr E Steenkamp	-	-	-	-	-	-	-	-	-	-	2	2	-	-	1
Mr RN Theunissen*	-	-	-	-	3	3	-	-	-	-	-	-	-	-	2
Dr J Welgemoed	5	5	1	1	-	-	-	-	3	3	-	-	1	1	3
Dr HJ Woermann	3	3	1	1	-	-	-	-	2	2	-	-	-	-	2
Mr AHG Wright	3	3	1	1	2	2	1	1	-	-	-	-	-	-	2

* - Independent committee member

(-) Non – committee member

CORPORATE GOVERNANCE CONTINUED

3. AUDIT AND RISK COMMITTEE

The Audit and Risk Committee, established in accordance with the MSA, is mandated by the Board to assist it in carrying out its duties relating to monitoring the Scheme's risk and governance function, accounting policies, internal control systems and financial reporting practices.

The Audit and Risk Committee has satisfied itself that the Scheme has optimised the assurance from the combined assurance model obtained from, inter alia, management and internal and external assurance providers.

There is an effective risk management process in place, which includes implementing and monitoring mitigating controls and ongoing risk management activities.

The Scheme has cybercrime insurance to mitigate the effects of an attack on the Scheme and the Committee considers that the measures currently in place, as determined by management, are appropriate to protect the Scheme

continuity, stability and the retention of appropriate level of expertise on the Committee. Trustee members are appointed annually by the Board.

The Chairperson of the Board attends Committee meetings by invitation, together with the internal and external auditors. The Principal Officer and Chief Financial Officer of the Administrator also attend meetings to provide input and respond to queries.

All these parties have unrestricted access to the Chairperson of the Committee.

The Committee's effectiveness both collectively and individually is assessed annually. During the year, the external and internal auditors meet separately with the Committee without management present. Similarly, management met with the Committee without the presence of the external and internal auditors ensuring open and independent dialogue.

The Audit and Risk Committee discharged its responsibilities for the year under review in accordance with its Charter, the Medical Schemes Act, and King IV. Key activities included:

- Reviewing the Scheme's Annual Integrated Report, including the annual financial statements and sustainability disclosures, prior to submission and approval by the Board;
- Assessing the effectiveness of internal controls, including financial, operational and IT controls;
- Recommending to the annual general meeting, with the approval of the Board, the appointment of the independent external auditor;
- Approved the external auditor's terms of engagement, the audit plan and audit fees;
- Evaluating the adequacy and effectiveness of the Scheme's compliance monitoring processes and adherence to applicable laws and regulations.
- Reviewing the performance and independence of internal audit.
- Considering the effectiveness of the finance function, including resourcing and capability.
- Reviewing and confirming compliance with the Audit and Risk Committee Charter.
- Providing independent oversight of financial, operational, and strategic risks, including review of the risk management plan and monitoring adherence to it.

Composition of the Audit and Risk Committee:

Independent Members

Mr RN Theunissen (Chairperson)	BAcc, CA (SA), Dip CJ & FA
Dr Y Omar Carrim	MBChB, Bcomm Acc (Hons), CTA, Dip.Sleep Med (SA) FC Rad (SA)DIAG,MMed Rad (SA)
Mr J Prinsloo	Bcom Acc (Hons),CA (SA)

Trustee Members

Ms NE Curry- Jandrel	Re-appointed 06 June 2024 (Term expired 11 June 2025)
Ms ND Maidi	Re-appointed 12 June 2025
Mr AHG Wright	Appointed 12 June 2025

The independent members of the Audit and Risk Committee serve a renewable four-year term of office to ensure

CORPORATE GOVERNANCE CONTINUED

- Ensuring that a register of key sustainability risks is maintained and that appropriate mitigation measures are in place.
- Considering the results of internal and external penetration testing of the Scheme's IT systems. The Committee concluded that the findings indicated no compromise of the Scheme's system security.

4. MEDICAL COMMITTEE

The Scheme has an established Medical Committee. The Board mandates the Committee to assist it in providing appropriate and cost-effective funding of members' benefits by considering changes to benefits and clinical protocols and recommending these to the Board. The Committee also considers ex gratia requests from members and reports to the Board on requests granted.

Composition of the Medical Committee

Trustee Members

Adv JJ Crouse
(Outgoing Chairperson)

Dr J Welgemoed Appointed 12 June 2025
(Incoming Chairperson)

Prof CA Joseph Re-appointed 12 June 2025

Dr H Woermann Appointed 12 June 2025

The Chairperson of the Board of Trustees attends meetings ex officio. Trustee members are appointed annually by the Board. The Principal Officer and Clinical Executive of the Scheme attend meetings, and relevant staff from the Scheme and Administrator attend meetings by invitation.

The Medical Committee discharged its responsibilities for the year under review as follows:

- Reviewed the performance and quarterly reports of the managed healthcare providers;

- Delegated Committee members participated in the benefit design to ensure clinical appropriateness, quality of care and cost-effectiveness;
- Provided support to the medical advisor and clinical executive;
- Attended to any other relevant matters referred to it.

No ex-gratia requests were submitted to or approved by the Committee during the year under review. The Committee considered and recommended to the Board the adjusted Rand value of the tariff paid to healthcare providers for procedures and consultations on certain options for the 2025 benefit year.

5. REMUNERATION COMMITTEE

The Board of Trustees oversees governance per the Medical Schemes Act 131 of 1998 (MSA). Profmed has established a Remuneration Committee to assist the Board in setting and recommending remuneration policies.

The Committee promotes transparency and fairness in the remuneration of Trustees, independent committee members, the Principal Officer, and executive staff of Profmed. Remuneration supports ethical governance, attracts and retains skilled individuals, and protects member funds in this medica

The Remuneration Committee comprises independent members with relevant expertise to ensure objectivity:

Independent Members

Mr PL Marais Master of Arts (HES) (UFS),
Strategic Human Resources
Management Programme
Graduate School of Business
(UCT), Postgraduate Diploma in
Labour Law (UJ), Certified Global
Remuneration Professional (GRP),
Fellow of the Institute of Directors
(IoDSA), (Appointed Chairperson
re-appointed 12 June 2025)

Ms K Naidu Cert. Dir. (IODSA), MBA
(DMU.UK)

Mr E Steenkamp CA (SA), MBA

CORPORATE GOVERNANCE CONTINUED

Independent members serve a four-year term for continuity and retention of expertise. The Chairperson of the Board of Trustees attends meetings as a non-voting member of the Committee. Principal Officer participates and a remuneration consultant attends by invitation. Pricewaterhouse Coopers (PwC) has served as the appointed advisors to the Committee and have also provided advice on benchmarking and policy matters throughout 2025.

The Committee has fulfilled all its responsibilities as mandated by the Board which include:

- Recommend the general policy on Board and Board committee remuneration.
- Recommend the remuneration package for the Principal Officer.
- Recommend fees, allowances, and reimbursement policies for Board and committee members.
- Recommend implementation of short-term and long-term incentive schemes for the Principal Officer and senior staff.
- Recommend remuneration increases for Scheme employees.

The Remuneration Strategy and Policy are regularly reviewed by the Committee, with recommendations submitted to the Board for approval. All conflicts of interests are noted in the minutes of each remuneration meeting. There have been no material shifts in remuneration policies or processes in 2025.

The Remuneration policies are guided by:

- MSA Section 57(8) and Regulation 6A and mandatory disclosure of trustee remuneration and the Principal Officer are included in the annual integrated report.
- CMS does not regulate the amount or structure of remuneration applicable to medical scheme however have provided some guidelines in Circular 45 of 2011 and Circular 41 of 2014 requiring careful disclosure of all fees and paying reasonable and fair remuneration.
- King IV requirement relating to report on Corporate Governance Principle 14 also focusses on fair, responsible, and transparent remuneration; and is recommended for medical schemes via IoDSA guidance.

The Remuneration Committee has noted that key information relating to the conduct and performance of the Scheme are disclosed in detail throughout the Annual Integrated Report 2025.

Trustee and Chairperson Remuneration

Remuneration for the Board and Committees recognises that trustees often forego professional income. Remuneration is structured to be reasonable, fair, and market-related to attract skilled individuals for effective fiduciary duties, while remaining cost-effective and aligned with non-profit objectives (no profit incentives).

All business costs incurred by employees and trustees including travel, accommodation and related costs are reimbursed based on a structured approval process. All travel and accommodation costs relating to trustees are disclosed as part of the annual integrated report.

Trustee remuneration is independently benchmarked biennially against the broader market which considers hourly remuneration for senior professional roles. This hourly rate is then discounted appropriately considering the nonprofit nature of medical schemes.

The Chairperson's remuneration reflects additional governance responsibilities (e.g., multiple committee attendances, strategy oversight). The Committee reviews time commitment and deems current levels appropriate and fair.

Principal Officer Remuneration

The Principal Officer's remuneration is benchmarked biennially against comparative roles of Chief Executive Officers and Principal Officers. Total package is targeted at the 60th percentile of market practices for comparable roles according to independent surveys conducted by the remuneration advisors, PwC. The total package balances fixed and variable elements:

- Guaranteed or fixed component.
- A variable component or incentive-based remuneration is calculated as a percentage of the fixed component is performance-based and measured against strategic targets. This variable incentive is split as 70% short-term and 30% long-term incentive which promotes long term retention.

CORPORATE GOVERNANCE CONTINUED

Executive Office Staff

All permanent employees receive a market-related guaranteed package (fixed cash + compulsory benefits like medical scheme and retirement fund membership). Increases align with market trends; exceptional performers may receive above-average adjustments via individual performance reviews

Short-Term Incentive for Executive Office Staff

Annual performance-based incentives reward achievement of specific objectives. Sales function employees receive monthly variable incentives tied to established performance targets.

Long-Term Incentive for Executive Office Staff

Used for retention of senior key employees; linked to individual and Scheme strategic performance.

Governance Process

- Annual benchmarking (trustees, Principal Officer and Senior staff are bench-marked biennially).
- Committee recommendations are considered for Board approval.

After a careful benchmarking process and reporting provided by PWC (external remuneration advisors), the Committee proposed market related increases for Trustees and Chairpersons effective 1 June 2025 and proposed market related increases to the total remuneration paid to the Principal Officer and Senior staff. These were appropriately budgeted for in the 2025/2026 year. The Board of Trustees accepted these proposals which have since been implemented.

The committee is satisfied that it has effectively, fairly and responsibly fulfilled its duties as prescribed by its terms of reference, ensuring that recommendations made to the board are well informed and comply with all statutory requirements and align with current best practice.

6. INVESTMENT COMMITTEE

The Scheme has an established Investment Committee, which includes the Principal Officer. The Committee is mandated by the Board to assist it in setting the Scheme's

investment policy, the appointment of the investment advisor and portfolio managers, and monitoring of investment performance.

Composition of the Investment Committee:

Committee members

Mr HP du Toit (Chairperson)	Re-appointed 12 June 2025
Ms NE Curry- Jandrell	Re-appointed 06 June 2024 (Term expired 11 June 2025)
Mr AHG Wright	Appointed 12 June 2025
Mr CW Comrie	Principal Officer and Chief Executive

The Chairperson of the Board of Trustees attends meetings *ex officio*.

The Investment Committee discharged its responsibilities for the year under review as follows:

The Committee monitored, reviewed and assessed:

- Profmed's investments in accordance with:
 - the Investment Policy approved by the Board;
 - Section 35 of the Medical Schemes Act;
 - Regulation 30, read with Annexure B to the Medical Schemes Act;
- the performance of investments (cash, cash equivalents, property, equities) against the performance benchmarks and against peer managers within each asset class;
- the performance of portfolio managers and the investment advisor;
- the performance of peer-group asset managers in the broader investment management market;
- the allocation of funds between categories of assets and asset managers;
- the fees charged by the portfolio managers and investment advisor;
- the ongoing appropriateness of Profmed's investment policy.

CORPORATE GOVERNANCE CONTINUED

7. MANAGEMENT OF THE SCHEME'S INVESTMENTS

The Scheme's investments are subject to Regulation 30 of the MSA, read in conjunction with Annexure B to the Regulations, and the Scheme's investment strategy complies with these regulations. The Board regularly reviews the investment strategy and performance against the strategy.

The Scheme's primary investment objective is to achieve an investment return of CPI + 4.25% (net of investment costs) over any rolling five-year period, with a risk budget as measured by standard deviation of 10% per annum.

The objective of the Investment Committee, in conjunction with the investment advisor, is to outperform the composite benchmark as set out in the table below. This composite benchmark has been aligned with the objectives of the Scheme and the regulatory parameters within which the Scheme must operate. Outperformance of the composite benchmark is expected to be achieved by:

- selecting portfolio managers that outperform the relevant mandate's benchmark index by means of superior stock selection within each asset class; and
- altering the asset class composition allocation relative to the benchmark within the bands indicated.

Asset class	Index	Proportion of composite index	Bands
Equities	Capped All Share Index	40.0%	25 – 50%
Fixed income	ALBI	24.0%	15 – 60%
	IGOV	5.0%	0 – 10%
	JP Morgan WGBI	8.5%	2.5 – 12.5%
Cash	STEFI Composite	19.0%	10 – 75%
Property ¹	SAPY/ALPI from 1 April 2019	3.5%	0 – 7.5%

Notes:

1. Included in the property investment portfolio is the building in which the Executive Office of the Scheme is housed. As the property was intended to be a long-term investment, the building has been modernised, which attracted long-term tenants. The property remains a sound investment.

7. MANAGEMENT OF INSURANCE RISK

The primary insurance activity carried out by the Scheme is taking on the risk of paying healthcare costs on behalf of members and their dependents. The risk the Scheme is exposed to is the uncertainty surrounding the timing and quantum of claims.

The Scheme manages its insurance risk through: benefit limits and sub-limits;

- approval procedures for transactions that involve pricing guidelines;
- pre-authorisation and case management;
- protocols; and
- monitoring of emerging events and trends.

CORPORATE GOVERNANCE CONTINUED

The Scheme uses several methods to assess and monitor insurance risk exposure, 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 principal risk is that the frequency and severity of claims are greater than expected. Insurance events are, by their nature, random and the actual number and size of events during any one year may vary from those estimated with established statistical techniques. There have been no changes to assumptions used to measure insurance assets and liabilities that have a material effect on the annual financial statements and there are no terms and conditions of insurance contracts that have a material effect on the amount, timing and uncertainty of the Scheme's cash flows.

Medical schemes are required to fund PMB in full at invoice price in terms of Regulation 8 of the Regulations to the MSA. This poses a financial risk to the Scheme as there is no regulated tariff for providers.

9. SECTION 59 INVESTIGATION INTO ALLEGED RACIAL PROFILING

An independent panel appointed by the CMS found that fraud, waste and abuse (FWA) investigations conducted under Section 59 between 2012 and 2019 disproportionately targeted black healthcare practitioners. While no explicit evidence of intentional racial discrimination was identified, the panel concluded that systemic bias and flawed risk-scoring methodologies resulted in discriminatory outcomes. It recommended investigative algorithms and audit processes, strengthening oversight and appeal mechanisms, standardising procedures, improving data governance, refining legislative safeguards, and considering remedial measures for affected practitioners.

Although the Minister Health and Parliament's Portfolio Committee on Health are considering legal and policy

reforms, no formal amendments or enforcement actions have yet been implemented.

10. BROAD-BASED BLACK ECONOMIC EMPOWERMENT (BBBEE)

Profmed is not required to comply with the Broad-Based Black Economic Empowerment Act, No. 53 of 2003, due to the restrictions of the MSA. The construct of a medical scheme is such that the key aspects of ownership and management make it difficult to align with the most recent BBBEE scorecard. Nevertheless, the Board fully subscribes to the principles of transformation and the ethos of the Act. Profmed implements the principles regarding Board composition in respect of appointed trustees, staff complement and procurement.

11. ADHERENCE TO THE MEDICAL SCHEMES ACT 131 OF 1998 AND REGULATIONS

11.1 Contribution income must be received within three days of becoming due

The MSA requires that contributions shall be received within three days of becoming due. There were instances where the Scheme did not receive all contributions as required. This is mainly due to:

- members paying contributions after the third day of becoming due;
- members having insufficient funds in their bank accounts at the time of collection; and
- members exiting without informing the Scheme

Profmed actively pursues contributions not received within three days.

11.2 Financial soundness of benefit options

The Scheme offers five benefit options, each with an equivalent efficiency discount option (EDO), effectively creating ten benefit options. All the options performed better than originally budgeted in 2025. The Board of Trustees has noted the operational deficit (amounts attributable to future members less other income and asset management fees) on the ProSecure and ProPinnacle options. The Scheme remains financially sound.

CORPORATE GOVERNANCE CONTINUED

11.3 Investment in medical scheme administrators

The MSA requires that no medical scheme shall invest any of its assets in a medical scheme administrator. The Scheme, through its collective investments, has indirect investments in medical scheme administrators and has received exemption from the CMS.

11.4 Payment of claims within 30 days of receipt

The MSA requires that a valid claim submitted to the Scheme must be paid within 30 days after the day on which the claim is received. In limited instances, due to a technical system issue, claims were paid after this timeframe.

PROF MED





Performance

PERFORMANCE

1. FINANCIAL PERFORMANCE

1.1 Financial health of the Scheme

Profmed is the medical scheme of choice for professionals, and its core focus is to provide funding for quality healthcare when members need medical attention. Funding quality healthcare in a sustainable and affordable manner is achieved through appropriate benefit design, sound financial and risk management as well as through effective governance structures.

Profmed's financial strength and claims-paying ability are supported by strong reserves and investment returns. The credit rating remains unchanged for the reporting year. The results of the Scheme's operations are set out in the Statement of Comprehensive Income.

The annual financial statements are prepared in compliance with International Financial Reporting Standards.

Below are the Scheme's performance indicators:

Measure	Results	
	2025	2024
Claims ratio	90.6%	90.5%
Insurance service result	R81.1 million	R74.6 million
Net surplus	R356.6 million	R180.6 million
Asset growth	30.5%	11.7%
Solvency ratio	43.41%	41.5%
Investment return	24.6%	13.7%
New membership growth	6.6%	5.5%
Member resignations	6.1%	7.6%
Net membership growth	0.2%	(2.1%)

PERFORMANCE CONTINUED

ACCUMULATED FUNDS RATIO (SOLVENCY RATIO)

The accumulated funds percentage is calculated as follows:

	2025 R'000	2024 R'000
Total Insurance contract liability to members (members' funds) per Statement of Financial Position	1 626 210	1 269 581
Less: Cumulative unrealised investment gains	(459 555)	(219 666)
Accumulated funds per Regulation 29 of the Regulations to the MSA	1 166 655	1 049 915
Annual insurance revenue per Statement of Comprehensive Income	2 687 758	2 528 336
Accumulated funds ratio calculated as the ratio of accumulated funds/gross insurance revenue x 100	43.4%	41.5%
Minimum ratio required by Regulation 29 of the Regulations to the MSA	25.0%	25.0%



PERFORMANCE

CONTINUED

1.2 OPERATIONAL STATISTICS PER BENEFIT OPTION

2025	ProPinnacle	ProSecure Plus	ProSecure	ProActive Plus	ProSelect	Total Scheme
Non-financial highlights						
Number of members at year-end	1 048	1 891	5 982	13 510	11 614	34 045
Average number of members for the year	1 062	1 915	6 067	13 479	11 553	34 077
Number of beneficiaries at year-end	1 616	3 246	11 197	28 512	24 175	68 746
Average number of beneficiaries for the year	1 645	3 294	11 397	28 397	24 166	68 898
Dependant ratio at year-end	0.54	0.72	0.87	1.11	1.08	1.02
Average age of beneficiaries	64.97	59.57	54.13	37.61	39.96	42.81
Pensioner ratio (65 years and older)	66.21%	55.05%	43.28%	14.56%	15.50%	22.70%
Financial highlights						
Insurance revenue per average beneficiary per month	12 184	6 406	5 019	2 608	2 134	3 251
Insurance service expense (ISE) pabpm	13 067	6 500	5 187	2 473	1 861	3 153
Relevant healthcare expenditure incurred pabpm	12 794	6 254	4 962	2 272	1 659	2 944
Directly attributable insurance service expenses (DAE) pabpm	273	246	225	201	202	209
Insurance Service Expense (ISE) ratio	107%	101%	103%	95%	87%	97%
Relevant healthcare expenditure ratio	105%	98%	99%	87%	78%	91%
Directly attributable insurance service expenses (DAE) ratio	2%	4%	4%	8%	9%	6%

* Relevant healthcare expenditure is the aggregation of claims incurred, third-party claim recoveries and accredited managed healthcare services

PERFORMANCE

CONTINUED

1.2 OPERATIONAL STATISTICS PER BENEFIT OPTION *(Continued)*

2024	ProPinnacle	ProSecure Plus	ProSecure	ProActive Plus	ProSelect	Total Scheme
Non-financial highlights						
Number of members at year-end	1 124	1 923	6 261	13 051	11 609	33 968
Average number of members for the year	1 131	1 952	6 346	27 592	11 692	34 292
Number of beneficiaries at year-end	1 765	3 358	11 928	27 592	24 530	69 173
Average number of beneficiaries for the year	1 808	3 433	12 124	27 724	24 732	69 820
Dependant ratio at year-end	0.57	0.75	0.91	1.11	1.11	1.04
Average age of beneficiaries	64.51	58.11	52.70	37.04	39.43	42.31
Pensioner ratio (65 years and older)	64.36%	51.94%	40.11%	13.52%	14.49%	21.61%
Financial highlights						
Insurance revenue per average beneficiary per month	10 815	5 776	4 544	2 409	1 999	3 018
Insurance service expense (ISE) pabpm	12 478	5 756	4 937	2 108	1 773	2 929
Relevant healthcare expenditure incurred pabpm	12 225	5 527	4 726	1 917	1 583	2 731
Directly attributable insurance service expenses (DAE) pabpm	252	229	211	191	190	198
Insurance Service Expense (ISE) ratio	115%	100%	109%	88%	89%	97%
Relevant healthcare expenditure ratio	113%	96%	104%	80%	79%	90%
Directly attributable insurance service expenses (DAE) ratio	2%	4%	5%	8%	10%	7%

* Relevant healthcare expenditure is the aggregation of claims incurred, third-party claim recoveries and accredited managed healthcare services

PERFORMANCE

CONTINUED

1.3 OPERATIONAL STATISTICS FOR THE SCHEME

	2025	2024
Insurance contract liability to members (accumulated funds) per member	R47 766	R37 022
Investment return	24.6%	13.7%

The value created by administration and managed care providers is a topic of debate in the healthcare industry. Profmed monitors this quarterly to ensure that these interventions are cost-effective. The table below illustrates the favourable intervention of the Administrator and the managed healthcare providers by correctly applying the Rules of the Scheme, and reflects the value added by third-party service providers.

2025	PPSHA R'000	MediKredit R'000	Opticlear R'000	Total R'000
Total claims received	2 047 871	953 910	262 186	3 263 967
Favourable impact of intervention	391 278	361 782	235 036	988 096
Intervention (% of total)	19.1%	37.9%	89.6%	30.3%
Cost to provide intervention	56 884	13 381	571	70 836

1.4 INSURANCE CONTRACT LIABILITY TO FUTURE MEMBERS (MEMBERS' FUNDS)

Insurance contract liability to future members represents the cumulative amounts required to provide coverage to future members of the Scheme.

1.5 LIABILITY FOR INCURRED CLAIMS

The liability for incurred claims is a provision made for the estimated cost of healthcare benefits incurred before the year-end, but that had not been reported to the Scheme by that date. It also includes claims reported but not yet settled. Additionally, under IFRS 17, the risk adjustment reflects the compensation that an entity requires for bearing the uncertainty, with respect to the amount and timing of the cashflows that arise from non-financial risks. This provision is determined as accurately as possible based on several factors, which include previous experience in claims patterns,

claims settlement patterns, changes in the nature and number of members according to trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim.

1.6 ACTUARIAL SERVICES

The Scheme's actuaries were consulted regarding the determination of the contribution and benefit levels. They also assisted in determining the assumptions used in the calculation of the liability for incurred claims noted in 1.5 above. This is fully explained in the notes to the financial statements.

1.7 SUBSEQUENT EVENTS

No adjusting or non-adjusting events have occurred between the accounting date and the date of this Report that would have affected the 2025 results.

PERFORMANCE CONTINUED

1.8 GOING CONCERN

The financial statements have been prepared on the basis of accounting policies applicable to a going concern. This basis presumes that funds will be available to finance future operations and that the realisation of assets and settlement of liabilities and commitments will occur in the ordinary course of business.

2. CONTRIBUTING TO SUSTAINABILITY

2.1 ECONOMIC SUSTAINABILITY

Stress Index Participation and Social Impact

More than 4 000 members took part in the 2025 Profmed Stress Index survey, reinforcing Profmed's commitment to understanding the realities facing South African professionals. For every completed survey, Profmed donated R10 to Rock of Hope Place of Safety, a home that provides care, protection and daily support to abandoned and vulnerable children. In doing so, members not only contributed to valuable insights on stress and wellbeing but also helped extend meaningful support to a community in need. The initiative reflects Profmed's belief that advancing conversations around mental health should go hand in hand with tangible action that uplifts and protects the most vulnerable.

Pink Bra Drive and Knitted Knockers Support

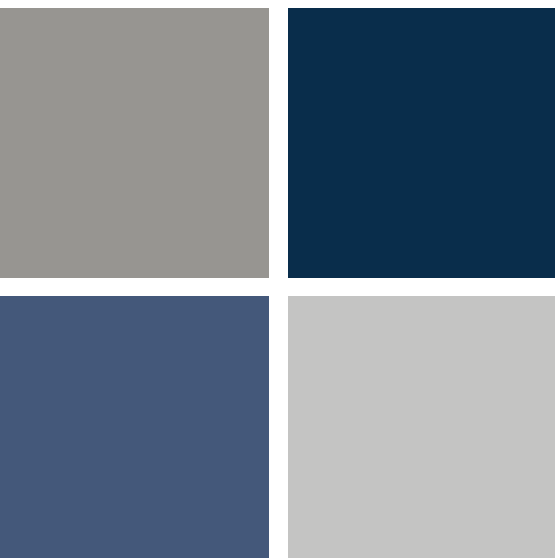
Profmed's Pink Bra Drive encouraged community members to donate new or gently used bras, offering a simple yet meaningful way to support women's health and dignity.

Building on the momentum of this initiative, Profmed contributed R100 000 to Knitted Knockers South Africa, an organisation that creates soft, handmade breast forms for individuals who have undergone mastectomy surgery. The contribution reflects Profmed's holistic approach to healthcare, one that extends beyond clinical treatment to encompass recovery, confidence and overall wellbeing. By investing in initiatives that respond to real, lived needs, Profmed continues to make a tangible difference in the lives of those navigating significant health journeys.

2.2 ENVIRONMENTAL SUSTAINABILITY

While our first priority is to ensure the financial sustainability of the Scheme in the best interests of our members, we also recognise the effect of environmental sustainability and responsible corporate citizenship on the Scheme and our members. Profmed contributes to environmental sustainability by making optimal use of water. A reverse osmosis system installed at our premises that house the Executive Office of the Scheme allows for the appropriate use of grey water, thereby optimising the use of this scarce commodity.

The implementation of the solar installation resulted in the Scheme reducing electricity bills by 60%. A hybrid working model and the use of virtual meeting platforms continue to create efficiencies by reducing travel time, costs and increasing productivity. These factors contribute to conserving the environment by lowering air and road travel carbon emissions, which in turn creates a healthier community.



PROFMED



Outlook

OUTLOOK

We will ensure our future sustainability through the creation and protection of value for all stakeholders by effectively managing financial and non-financial factors impacting the Scheme's clinical outcomes and economic performance.

The goal of the Board is to sustain the Scheme's business model. This will be achieved by:

1. providing excellent service;
2. appropriate benefit design;
3. growing our membership;
4. close monitoring of external factors.

The Scheme will continue to take appropriate steps to limit the rise in healthcare costs by way of negotiation with healthcare providers and contracted outsourced providers, and through the implementation of managed healthcare principles.

We will continue to structure benefit options appropriately with the objective of providing quality healthcare when it is most needed.

The investments of the Scheme will continue to be managed by professional fund managers to provide the maximum benefit for members, without incurring undesirable risks.

Growth in membership will be achieved by providing benefits appropriate to the Scheme's target market, and by providing outstanding service.

We will continually strive to improve service to our members and implement sound marketing and brand management.

Our future sustainability will be achieved by:

1. SCHEME ADMINISTRATION

Profmed will ensure that the administration of the Scheme is effective and that the Administrator performs in line with strict service level agreements. To achieve this:

- service levels will be monitored weekly by the Principal Officer and quarterly by the Board;
- the Scheme will ensure that the administration IT platform remains robust and adaptable to enable the Scheme to be agile in navigating the challenging healthcare

landscape and in supporting the Scheme to achieve its strategic objectives.

The Board has an IT governance policy to ensure that the IT systems of the Scheme's Administrator and the contracted outsourced partners remain relevant, secure and adaptable, and that service level agreements are strictly

2. BENEFIT DESIGN

Profmed's benefits are designed using an appropriate and effective two-pronged approach:

2.1 To be pre-emptive in providing primary healthcare, which includes, among others, preventative care and diagnostic benefits, in an endeavour to proactively prevent the onset of illness and disease and to ensure better treatment outcomes.

2.2 To be responsive by providing comprehensive cover for catastrophic illness and for trauma and injuries, as well as unlimited hospitalisation.

To support this approach, the Scheme employs managed healthcare protocols to ensure that members receive best practice treatment, resulting in better outcomes and reducing down-stream medical costs for both our members and the Scheme.

Profmed has a traditional benefit design where benefits are transparent and clearly defined, providing members with peace of mind in times of trauma and severe illness. Profmed does not offer medical savings accounts as contemplated in the Medical Schemes Act.

3. MEMBERSHIP

While the continued emigration of skilled professionals from South Africa is not the primary factor limiting the Scheme's growth, the resulting contraction of the workforce in key industries does constrain expansion and the acquisition of new

OUTLOOK CONTINUED

members. This dynamic highlights the importance of strengthening retention strategies, enhancing the Scheme's value proposition, and introducing innovative benefit solutions and partnerships to sustain long-term growth

The most important challenge for the Scheme is to attract younger members to reduce the average age of our membership. Using an aggressive and innovative growth strategy, Profmed aims to continually accelerate growth with a view to lowering the age profile and growing the risk pool of the Scheme. This will mitigate the risk of the Scheme ageing and reduce the Scheme's burden of disease.

4. EXTERNAL FACTORS

Medical schemes face a plethora of legislative and industry factors that could impact the landscape in which they operate.

These factors include:

- the revision of the PMB benefit package;
- the delay in implementing the findings of the HMI;
- the reforms and regulations related to the NHI Act;
- the uncertainty of the Medical Schemes Amendment Bill;
- the delay in the introduction of a Low-Cost Benefit option; and
- the uncertainty of the proposed consolidation framework by the CMS.

The lack of any meaningful developments with regard to these factors for the year under review, creates an inability for medical schemes to innovate and proactively meet the challenges for the future.



STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES

The trustees are responsible for the preparation, integrity, and fair presentation of the Annual Integrated Report of Profmed. The annual financial statements, presented on pages 43 to 88 have been prepared in accordance with International Financial Reporting Standards and the Medical Schemes Act of South Africa, and include amounts based on judgements and estimates made by management.

The trustees consider that, in preparing the annual financial statements, the most appropriate accounting policies have been used, consistently applied and supported by reasonable and prudent judgements and estimates, and that all the standards in the International Financial Reporting Standards that the trustees consider to be applicable have been followed.

The trustees are satisfied that the information contained in the annual 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 trustees are also responsible for the other information included in the Annual Integrated Report and are responsible for both its accuracy and its consistency with the annual financial statements.

The trustees are responsible for ensuring the effectiveness of internal controls and that proper accounting records are kept. The accounting records disclose with reasonable accuracy the financial position of the Scheme to enable the trustees to ensure that the annual financial statements comply with the relevant legislation.

The trustees of the Scheme are responsible for the controls over, and the security of the website and, where applicable, for establishing and controlling the process for electronically distributing annual reports and other financial information to members and to the CMS.

The going-concern basis has been adopted in preparing the annual financial statements. The trustees have no reason to believe that the Scheme will not be a going concern in the foreseeable future, based on forecasts and available cash resources. This view is endorsed by the Audit and Risk Committee. These annual financial statements confirm the viability of the Scheme.

The Scheme's external auditor, Deloitte, has audited the annual financial statements and their report is presented on page 38.

The annual financial statements were approved by the Board of Trustees on 15 April 2026 and are signed on its behalf by:



Adv JJ Crouse
Chairperson



KPM Simelane
Trustee



Mr C Comrie
Principal Officer

15 April 2026

REPORT OF THE PROFMED AUDIT AND RISK COMMITTEE

The Audit and Risk Committee operate in terms of formal terms of reference, which are approved annually by the Board. The terms of reference were reviewed and approved by the Board during 2025. The Committee conducted its affairs and discharged its responsibilities in compliance with its terms of reference.

External auditor

- The Committee satisfied itself that the external auditor was independent.
- In consultation with management, the Committee accepted the engagement letter, audit plan and audit fees for the 2025 audit.
- The Committee approved the terms of an agreement for the predecessor auditor to perform a non-audit service, viz. a benchmarking exercise for the Remuneration Committee.
- During the year, the Committee met with the external auditor without management being present.

Financial statements and accounting policies and practices

- The Committee reviewed the accounting policies and practices and the financial statements and is satisfied that they are appropriate and comply with International Financial Reporting Standards (IFRS) and the requirements of the Medical Schemes Act No. 131 of 1998, as amended.

Integrated reporting

- At the meeting on 18 March 2026, the Committee agreed to recommend to the Board the approval of the Annual Integrated Report, which Report includes the annual financial statements.
- The Committee endorsed the Board's affirmation of the going concern status of the Scheme, which appears in the Statement of Responsibility on page 36.

Governance of risk

- The Board has assigned oversight of the Scheme's risk management function to the Committee.
- The Committee concluded that the Scheme has implemented an effective policy and plan for risk management.

Internal audit

- The Committee determined that the outsourced internal audit function operated effectively.
- The Committee approved the annual audit plan and the three-year rolling plan relating to the Scheme.
- During the year, the Committee met with the chief internal audit executive of the Administrator without management being present.

Finance function

- The Committee considered the expertise, adequacy of resources and experience of senior members of management of the Scheme and of the management of the Administrator responsible for the finance function and concluded that these were appropriate.

Internal financial controls

- The Committee considered the internal financial controls, both at the Administrator and at the Executive Office of the Scheme and deemed them to be effective.

Information regarding the composition, attendance and responsibilities of the Audit and Risk Committee, together with the other information relating to its activities, is provided on page 19.



Mr RN Theunissen

Chairperson: Audit and Risk Committee
18 March 2026



Private Bag X6
Gallo Manor 2052
South Africa

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Independent Auditor's Report

To the Members of Profmed

Report on the Financial Statements

Opinion

We have audited the financial statements of Profmed (the Scheme), set out on pages 38 to 81, which comprise the statement of financial position as at 31 December 2025, and the statement of comprehensive income, the statement of changes in members' funds and reserves and the statement of cash flows for the year then ended, and notes to the financial statements, including material accounting policy information.

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

Basis for Opinion

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



Managing Partner: ML Tshabalala

A full list of partners and directors is available on request

B-BBEE rating: Level 1 contribution in terms of the DTI Generic Scorecard as per the amended Codes of Good Practice

Associate of Deloitte Africa, a Member of Deloitte Touche Tohmatsu Limited

Key Audit Matters

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

Key audit matter	How the key audit matter was addressed during the audit
<i>Insurance contract liability</i> As disclosed in note 8 to the financial statements, the carrying amount of the Insurance Contract Liability to Current Members is R225 million as at 31 December 2025 (2024: R149.4 million). The Insurance Contract Liability consists of the Liability for incurred claims (LIC) of R214.2 million (2024: R141.6 million), the Risk Adjustment (RA) of R6.6 million (2024: R4.5 million) and Liability for remaining coverage (LRC) of R3.9 million (2024: R3.3 million). The LIC includes the component recognised for the estimated cost of healthcare benefits that have been incurred prior to year-end but are only reported to the Scheme after year-end. The LIC also includes a risk adjustment for non-financial risk. Included in the LIC is a provision for the estimated costs of healthcare benefits that have occurred before the year end but have not been reported to the Scheme by that date, which requires the Schemes Trustees to make assumptions in the valuation thereof, which is determined with reference to an estimation of the ultimate cost of settling all claims incurred but not yet reported at the Statement of Financial Position date. • The calculation is based on a number of factors which include: • Previous experience in claims patterns; • Claims settlement patterns; • Changes in the nature and number of members according to gender and age; • Trends in claims frequency; • Changes in the claims processing cycle; • Variations in the nature and average cost per claim; and • Other factors such as expectations of future events that are believed to be reasonable to be taken into account in the valuation of the provision for the estimated costs of healthcare benefits that have occurred before the yearend but have not been reported to the scheme by that date.	We obtained an understanding from the Scheme's actuaries regarding the process followed in calculating the provision for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme and Risk Adjustment for Non-financial Risk. The actuarial method applied by the Scheme is one that is generally applied within the medical scheme industry. In evaluating the valuation of the provision for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme, we audited the calculations and performed various procedures including the following: • Assessed the design and implementation of key controls within the provision for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme process; • Tested the integrity of the information used in the calculation of the provision by performing substantive procedures to ensure the completeness and accuracy of the information; • With the assistance of our internal actuarial specialists, we performed an independent calculation of the estimated future cash flows included in the LIC using historical claims data and trends, and using this estimate as a basis of assessing the reasonableness of the Scheme's estimate of the provision; • Assessed the presentation and disclosure and considered whether the disclosures reflect the risks inherent in the accounting for the provision for the estimated costs of healthcare benefits that have occurred before the year end but have not been reported to the scheme by that date.

Under IFRS 17, Insurance Contracts (“IFRS 17”), a risk adjustment reflects the compensation that the entity requires for bearing the uncertainty for the amount and the timing of the cashflows that arise from non-financial risk during the coverage period. The RA is principle based and exhibits the following main properties:

- Reflects risks and uncertainty as viewed by the Scheme;
- Considers all aspects of non-financial risk and uncertainty; and
- Excludes financial risks, such as investment returns (cash flows not directly tied to contract).
- The abovementioned factors require judgement and assumptions to be made by the Scheme’s Trustees and therefore accordingly, for the purposes of our audit, we identified the valuation of the provision for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme and the Risk Adjustment for Non-financial Risk as representing a key audit matter.

In evaluating the valuation of the Risk Adjustment for Non-financial Risk, we performed various procedures including the following:

- With the assistance of our internal actuarial specialists, we assessed the methodology and confidence levels used by Profmed; and
- With the assistance of our internal actuarial specialists, conducted a recalculation of the risk adjustment using the same methodology applied by Profmed.

We have evaluated management’s experts by assessing their competence, capability, and objectivity and noted no aspects requiring further consideration.

The assumptions applied in determining the provision are appropriate, and we are satisfied that the movement of the provision in the Statement of Comprehensive Income and the related disclosure of the Insurance Contract Liability balance and assumptions are appropriate. The assumptions applied in determining the Risk Adjustment for Non-financial Risk are appropriate, and we are satisfied that the movement in the Statement of Comprehensive Income and the related disclosure of the Risk Adjustment for Nonfinancial Risk (RA) and assumptions are appropriate. We have reviewed the disclosure in the financial statements, to ensure compliance with the requirements of IFRS 17, Insurance Contracts.

Other Information

The Scheme’s trustees are responsible for the other information. The other information comprises the information included in the Annual Integrated Report which includes the Glossary of acronyms, Chairperson’s report, Report scope and boundaries, Organisational overview and external environment, Strategy, risk and business model, Corporate governance, Performance, Outlook, Statement of responsibility by the Board of Trustees, Report of the Profmed Audit and Risk Committee, Scheme information, Contact us and Notice of Annual General Meeting. The other information does not include the financial statements and our auditor’s report thereon.

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of the Scheme’s Trustees for the Financial Statements

The Scheme’s trustees are responsible for the preparation and fair presentation of the financial statements, in accordance with IFRS Accounting Standards as issued by the International Accounting Standards Board and the requirements of the Medical Schemes Act of South Africa, and for such internal

control as the Scheme's trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's trustees.
- Conclude on the appropriateness of the Scheme's trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists in relation to events or conditions that may cast significant doubt on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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

From the matters communicated with the Scheme's trustees, we determine those matters that were of most significance in the audit of the financial statements of the current period and are therefore the key audit matters. We describe these matters in our auditor's report, unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, we determine that a matter should not be communicated in our report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

Report on Other Legal and Regulatory Requirements

Non-compliance with the Medical Schemes Act of South Africa

As required by the Council for Medical Schemes, we report that there are no material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa that have come to our attention during the course of our audit.

Audit tenure

As required by the Council for Medical Schemes' Circular 38 of 2018, *Audit Tenure*, we report that the Deloitte & Touche firm has been the auditor of Profmed for 3 years (financial years ended 31 December 2023, 31 December 2024 and 31 December 2025).

The engagement associate director, Thelma Kajongwe, has been responsible for Profmed's audit for 1 year (financial year ended 31 December 2025).



Deloitte & Touche
Registered Auditor
Per: Thelma Kajongwe
Associate Director
04 May 2026

STATEMENT OF FINANCIAL POSITION

AS AT 31 DECEMBER 2025

	Notes	2025 R'000	2024 R'000
ASSETS			
Non current assets		1 581 368	1 224 927
Property, plant and equipment	2	22 048	23 133
Financial assets at fair value through profit and loss	4	1 559 320	1 201 794
Current Assets		284 321	203 094
Financial assets at fair value through profit and loss	4	244 745	163 403
Accounts receivable	5	987	1 287
Cash and cash equivalents	6	38 589	38 404
Total Assets		1 865 689	1 428 021
LIABILITIES			
Non-current liabilities			
Liability to members for future benefits	7	1 626 210	1 269 581
Current Liabilities		239 479	158 440
Insurance contract liability*	8	224 677	149 421
Accounts payable	9	14 802	9 019
Total Liabilities		1 865 689	1 428 021

*In line with Circular 42 of 2025, the Insurance Contract liability to future members has been renamed to the Liability to members for future benefits

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 DECEMBER 2025

	Notes	2025 R'000	2024 Restated R'000
Insurance revenue		2 687 758	2 528 336
Insurance Service Expense**			
Net claims incurred			
Claims incurred		(2 306 321)	(2 216 898)
Third-party claim recoveries		-	138
Accredited managed healthcare services	10	(71 004)	(68 392)
Insurance acquisition cash flows	13	(37 661)	(35 834)
Attributable expenses incurred	11	(135 283)	(129 989)
Adjustments to the liability for incurred claims	8	(56 398)	(2 751)
Insurance service result		81 091	74 610
Other income			
Investment income	14	356 680	179 372
Sundry income	15	913	1 258
Other Expenditure			
Administration fees and other operative expenses	12	(76 008)	(69 510)
Asset management fees	16	(6 048)	(5 136)
Profit or loss for the year before amounts attributable to members for future benefits		356 628	180 594
Transfer to liability to members for future benefits**		(356 628)	(180 594)
Surplus for the year		-	-
Relevant healthcare expenditure*		(2 433 723)	(2 288 036)

* CMS Circular 32 of 2025 requires "relevant healthcare expenditure" to be presented as a separate line item. Refer to note 1.16.2

**Insurance service expenses in accordance with IFRS 17 include amounts attributable to members for future benefits, the total value of insurance service expenses is

2 963 295 (2024: 2 634 320). CMS Circular 6 of 2025 requires medical schemes to present "amounts attributable to future members" separate from "insurance service expenses" and the "insurance service results. Refer to note 1.16.3

STATEMENT OF CHANGES IN MEMBERS' FUNDS AND RESERVES FOR THE YEAR ENDED 31 DECEMBER 2025

	Accumulated Funds R'000
Balance at 1 January 2024	-
Total comprehensive income for the year	-
Surplus for the year	-
Balance at 31 December 2024	-
Total comprehensive income for the year	-
Surplus for the year	-
Balance at 31 December 2025	-

* Based on the requirements of IFRS 17, the Scheme was identified as a mutual entity which is different to the accounting under IFRS 4. It is expected that the remaining assets of the Scheme will be used to pay current and future policyholders. As the scheme is in a surplus position, it recognised a liability in its statement of financial position to provide coverage to future members. Refer to Note 7.

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2025

	Notes	2025 R'000	2024 R'000
Cash flow from operating activities			
<i>Cash receipts from members and providers:</i>			
Cash receipts from members - contributions		2 688 358	2 528 598
Cash receipts from members and providers - others		905	1 308
<i>Cash paid to providers, employees and members:</i>			
Cash paid to providers and members		(2 356 589)	(2 319 310)
Cash paid to providers and employees—attributable and other expenses		(245 643)	(234 914)
Net cash from/ (used) in operations		87 032	(24 246)
Cash flow from investing activities			
Acquisition of property, plant and equipment	2	(243)	(290)
Proceeds on disposal of property, plant and equipment		49	27
Funds invested in financial assets at fair value through profit and loss	4	(100 000)	(80 000)
Funds withdrawn from financial assets at fair value through profit and loss	4	-	30 000
Interest: Call and current bank accounts	14	12 552	12 396
Net rental income	14	796	2 224
Net cash utilised in investing activities		(86 847)	(35 643)
Net increase/ (decrease) in cash and cash equivalents			
Cash and cash equivalents at beginning of year		38 404	98 293
Cash and cash equivalents at end of year	6	38 589	38 404

NOTES TO THE ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER 2025

1. SUMMARY OF ACCOUNTING POLICIES

The material accounting policies applied in the preparation of these financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated.

1.1 BASIS OF PREPARATION

The financial statements of the Scheme are prepared in accordance with International Financial Reporting Standards (IFRS) and the manner required by the Medical Schemes Act of South Africa. The financial statements are prepared under the historical cost convention, except for the following:

- Certain financial assets and liabilities measured at fair value and,
- Insurance assets and liabilities measured in terms of IFRS 17.

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires the Scheme's management to exercise judgement in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the financial statements, are disclosed in Note 8 and Note 22.

The new and amended standards and interpretations that are issued, but not yet effective, up to the date of issuance of the Scheme's financial statements are disclosed below. The Scheme intends to adopt these new and amended standards and interpretations, if applicable, when they become effective

Amendment to IFRS 9, "Financial Instruments" and IFRS 7, "Financial Instruments: Disclosures" Classification and Measurement of Financial Instruments

These amendments:

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

IFRS 18 Presentation and Disclosure in Financial Statements

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

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

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

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

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

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

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

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

1.2 PROPERTY, PLANT AND EQUIPMENT

Land and buildings comprise an office building which is partly owner-occupied and stated at historical cost less the accumulated depreciation of the building. Land is not depreciated. Other property, plant and equipment is stated at historical cost less accumulated depreciation and accumulated impairment losses. Historical cost includes expenditure that is directly attributable to the acquisition of the items. Subsequent costs are included in the carrying amount when it is probable that future economic benefits associated with the asset will flow to the Scheme and the cost of the item can be measured reliably. Repairs and maintenance are charged to the Statement of Comprehensive Income during the financial period in which they are incurred.

Depreciation on buildings, furniture and equipment is calculated using the straight-line method to allocate their cost over their estimated useful lives.

The estimated maximum useful lives of the assets are:

Buildings	30 years
Office furniture	10 years
Office equipment and software	3 years
Vehicles	5 years

The assets' residual values and useful lives are reviewed and adjusted if material. Gains and losses on disposals are

determined by comparing realisable proceeds with carrying amounts. These are included in the Statement of Comprehensive Income as Sundry income.

Where components of an item of furniture and equipment have different useful lives, they are accounted for as separate items. There were no changes in the useful lives from prior years.

1.3 FINANCIAL INSTRUMENTS

Financial assets and liabilities are recognised when the Scheme becomes party to the contractual provisions of the instrument (the trade date). The Scheme classifies its financial assets into categories, namely financial assets at fair value through profit and loss and at amortised cost. The classification depends on the purpose for which the financial assets were acquired. The Scheme determines the classification of its financial assets at initial recognition.

Initial recognition of financial instruments

All financial instruments are initially recognised at fair value, which represents the consideration receivable or given, plus direct transaction costs. Regular purchases and sales of financial instruments are recognised on trade date, which is the date on which the Scheme commits to purchase or sell the instruments. Subsequent to initial recognition, financial instruments are measured as set out in the paragraphs below.

Accounts receivable

Accounts receivable are non-derivative financial assets that have fixed or determinable payments that are not quoted in an active market. Subsequent to initial recognition, they are measured at amortised cost, using the effective interest-rate method. A provision for impairment is raised when there is objective evidence that the Scheme will not be able to collect all amounts due according to the original terms of receivables.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

Accounts receivable from the Road Accident Fund

The timing and monetary value of recoveries from the Road Accident Fund (RAF) are considered to be uncertain and therefore debtors are not raised for amounts receivable at year-end.

(I) Classification

The Scheme classifies its financial assets in the following measurement categories:

- those to be measured at fair value; and
- those to be measured at amortised cost.

The classification depends on the entity's business model for managing the financial assets and the contractual terms of the cash flows. For assets measured at fair value, gains and losses will either be recorded in profit or loss. For investments in equity instruments that are not held for trading, this will depend on whether the Scheme has made an irrevocable election at the time of initial recognition to account for the equity investment at fair value through profit or loss (FVPL).

(ii) Recognition and derecognition

Regular purchases and sales of financial assets are recognised on trade-date, the date on which the Scheme commits to purchase or sell the asset. 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 transferred substantially all the risks and rewards of ownership.

(iii) Measurement

At initial recognition, the Scheme measures a financial asset at its fair value plus, in the case of a financial asset not at FVPL, transaction costs that are directly attributable to the acquisition of the financial asset. Transaction costs of financial assets carried at FVPL are expensed in profit or loss.

Debt instruments

- Subsequent measurement of debt instruments depends on the Scheme's business model for managing the asset and the cash flow characteristics of the asset. There are two measurement categories into which the Scheme classifies its debt instruments:
- Amortised cost: Assets that are held for collection of contractual cash flows where those cash flows solely represent payments of principal and interest, are measured at amortised cost. Interest income from these financial assets is included in Interest income using the effective interest-rate method. Any gain or loss arising on derecognition is recognised directly in profit or loss and presented in other gains or losses. Impairment losses are presented as a separate line item in the Statement of Comprehensive Income.
- FVPL: Assets that do not meet the criteria for amortised cost are measured at FVPL. A gain or loss on a debt investment that is subsequently measured at FVPL is recognised in profit or loss and presented net within other gains/(losses) in the period in which it arises.

Equity instruments

The Scheme measures all equity investments at FVPL. Dividends and interest from such investments are recognised in profit or loss as investment income when the Scheme's right to receive payments is established. Changes in the fair value of financial assets at FVPL are recognised in Investment income in the Statement of Comprehensive Income.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

For financial assets carried at fair value, the allocation of fair value measurements into the fair value hierarchy is reflective of the significant inputs used in making the measurements. The fair value hierarchy is based on the following levels:

Level 1: Where inputs are determined directly by reference to published price quotations (unadjusted) in an active market for identical instruments;

Level 2: Where inputs other than published price quotations included in Level 1 that are observable for assets, either directly (i.e. as prices) or indirectly (i.e. derived from prices), are used;

Level 3: Where the fair values are determined using a valuation technique based on assumptions that are not supported by observable market data.

1.5 STRUCTURED ENTITIES

IFRS 12 describes a structured entity as 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;
- (d) financing in the form of multiple contractually-linked instruments to investors that create concentrations of credit or other risks (tranches).

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

accomplish their respective investment objectives.

1.4 IMPAIRMENT OF FINANCIAL ASSETS

The Scheme assesses at each Statement of Financial Position date whether there is objective evidence that a financial asset or a group of financial assets is impaired. A financial asset is impaired if, and 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 (loss event) and that loss event has an adverse impact on the estimated cash flows from the asset that can be reliably measured.

An asset is impaired if its carrying amount is greater than its recoverable amount. The recoverable amount of all assets is the greater of the selling price or value in use. In assessing value in use, the estimated future cash flows are discounted to their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset.

Impairment of receivables (other than those related to insurance contracts) and other financial assets carried at amortised cost

The Scheme assesses on a forward-looking basis the expected credit losses associated with its accounts receivable. IFRS 9 allows a provision matrix to be used to estimate ECL for these financial instruments. The provision matrix is based on historical observed default rates, adjusted for forward looking estimates. At every reporting date, the historical observed rates are updated.

Impairment of assets

Other assets are tested for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs of disposal and value in use. For the purposes of assessing impairment, assets are grouped at the lowest levels for which there are separately identifiable cash inflows which are largely independent of the cash inflows from other assets or groups of assets (cash-generating units). Non-financial assets that suffered an impairment are reviewed for possible reversal of the impairment at the end of each reporting period.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

Reversal of impairment

Impairment losses are reversed when the recoverable amount exceeds the carrying amount of an asset which has previously been impaired. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised. Subsequent recoveries of receivables previously impaired are recognised through the Statement of Comprehensive Income.

1.5 DERECOGNITION OF FINANCIAL INSTRUMENTS

Financial assets are derecognised when the rights to receive cash flows from the financial assets have expired or have been transferred or when, on transfer, the Scheme retains the contractual rights to receive the cash flows of the financial asset but assumes a corresponding liability to transfer these contractual rights to another party and consequently transfers substantially all the risks and benefits associated with the asset.

Where the Scheme retains substantially all the risks and rewards of ownership of the financial asset, the Scheme continues to recognise the financial asset.

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

Where the Scheme neither transfers nor retains substantially all the risks and rewards of ownership of the financial asset, the Scheme determines whether it has retained control of the financial asset. In this case:

(i) if the Scheme has not retained control, it derecognises the financial asset and recognises separately as assets or liabilities any rights and obligations created or retained in the transfer;

(ii) if the Scheme has retained control, it continues to recognise the financial asset to the extent of its continuing involvement in the financial asset

Financial liabilities are derecognised when the contractual obligations are discharged or cancelled or expire.

1.6 OFFSETTING OF FINANCIAL INSTRUMENTS

Where a legally enforceable right of offset exists for recognised financial assets and financial liabilities, and there is an intention to settle the liability and realise the asset simultaneously or to settle on a net basis, all related financial effects are offset.

1.7 CASH AND CASH EQUIVALENTS

Cash and cash equivalents include cash on hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less which are readily convertible to a known amount of cash and are subject to insignificant risk of change in value.

1.8 PROVISIONS

Provisions are recognised when the Scheme has a present legal or constructive obligation and, as a result of past events, it is more likely than not that an outflow of resources embodying economic benefits will be required to settle the obligation, and a reliable estimate of the amount of the obligation can be made.

Provisions are measured at the present value of the Scheme's best estimate of the cash flows to settle the present obligation for claims (excluding claims from members and providers) and other expenses incurred and notified to the Scheme as at the Statement of Financial Position date.

Where there are a number of similar obligations, the likelihood that an outflow will be required in settlement is determined by considering the class of obligations as a whole. A provision is recognised even if the likelihood of an outflow with respect to any one item included in the same class of obligations may be small.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

Provisions are measured at the present value of expenditure expected to be required to settle the obligation using a pre-tax rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to passage of time is recognised as an interest expense.

1.9 MEMBER INSURANCE CONTRACTS

Contracts under which the Scheme accepts significant insurance risk from members by agreeing to compensate the member or other beneficiary if a specified uncertain future event (the insured event) adversely affects the member or other beneficiary are classified as insurance contracts. The contracts issued compensate the Scheme's members for healthcare expenses incurred.

IFRS 17 and mutual entity considerations

Based on the requirements of IFRS 17, the Scheme was identified as a mutual entity which is different to the accounting under IFRS 4.

It is expected that the remaining assets of the Scheme will be used to pay current and future policyholders.

As the Scheme is in a surplus position, it recognised a liability in its statement of financial position to provide coverage to future members.

This liability is in essence incurred because the Scheme is obliged to:

- provide coverage to that member;
- pay incurred claims of that member; or
- provide coverage to future members (IFRS 17.B71 liability).

On measurement of the liability to future members, the fulfilment cash flows of this liability are measured incorporating information about the fair value of the other assets and liabilities of the Scheme.

There is an accounting mismatch between the measurement of this liability and the measurement of property and equipment which are measured at cost less accumulated depreciation and accumulated impairment. This resulted in a liability greater than recognised assets in the financial statements. The impact of the mismatch is immaterial and therefore no adjustment has been made for this. Although the Scheme is solvent for regulatory purposes it has negative equity. As a result of the recognition of the liability to future members, an additional onerous contract liability was not recognised.

Identification of insurance contracts

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

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

Level of aggregation

The Scheme as a whole was identified as a portfolio. All contracts issued by a scheme are subject to similar risks and managed together. As the Act specifically constrains the entity's practical ability to set a different price or level of benefits for members with different characteristics the scheme as whole was also identified as the group. The Scheme assesses if the group as whole is onerous or profitable.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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Onerous contract assessment

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

Recognition and derecognition

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

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

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

Initial and subsequent measurement

Premium allocation approach (PAA)

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

The Scheme uses the concept of contract boundary to determine what cash flows should be considered in the measurement of groups of insurance contracts. This assessment is reviewed every reporting period. Cash flows are within the boundary of an insurance contract if they arise from the rights and obligations that exist during the period in which the member is obligated to pay contributions, or the Scheme has a substantive obligation to provide the member with insurance coverage or other services.

A substantive obligation ends when both of the following

criteria are satisfied:

- the Scheme has the practical ability to reassess the risks of the portfolio of insurance contracts and set a price or level of benefits that fully reflects the risks of that portfolio; and
- the pricing of contributions related to coverage to the date when risks are reassessed does not reflect the risks related to periods beyond the reassessment date.

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

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

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

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

- a. the Liability for Remaining Coverage; and
- b. the Liability for Incurred Claims, comprising the fulfilment cashflows (future cashflows adjusted for the risk adjustment for non-financial risk)

Liability for remaining coverage

For insurance contracts issued, on initial recognition, the Scheme measures the liability for remaining coverage at the amount of expected contributions received. The Scheme does not adjust the carrying amount of the Liability for remaining coverage to reflect the time value of money and the effect of financial risk, as the time between providing each part of the services and the related premium due date is no more than a year.

The liability for remaining coverage at the year-end reporting date is the difference between the actual cash collected for contributions and the expected contribution receipts recognised as insurance revenue for the period. The liability for remaining coverage will not be discounted as there is no significant financing component per IFRS 17.56.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

Liability for incurred claims

The Scheme measures the liability for incurred claims as the fulfilment cash flows (profitability weighted estimate of the present value of the future cash flows and risk adjustment for non-financial risk) relating to incurred claims. The future cash flows are not adjusted for the time value of money and the effect of financial risk as these cash flows are expected to be paid in one year or less from the date the claims are incurred.

The estimate of the future cash flows in terms of the liability for incurred claims 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. Refer to note 22.

The Scheme shall apply judgement when determining an appropriate estimation technique for the risk adjustment for non-financial risk and consider whether the technique provides concise and informative disclosure so that users of financial statements can benchmark the performance against the performance of other medical schemes.

1.10 INSURANCE SERVICE EXPENSES

Insurance service expenses include:

- incurred claims and benefits excluding investment components;
- other incurred directly attributable insurance service expenses;
- changes that relate to past service (i.e. changes in the FCF relating to the LIC);
- 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.

Insurance acquisition cash flows

These expenses comprise commissions or fees paid to brokers and remuneration to internal new business consultants on new member insurance contracts as well as renewal commissions and any other expenses related thereto and that are costs directly attributable to individual contracts and the group of contracts. Insurance acquisition costs are expensed by the Scheme when it incurs the cost.

Accredited managed healthcare fees

Accredited managed healthcare fees comprise amounts paid or payable to a third party for managing the utilisation, costs and quality of healthcare services provided to the members of the Scheme. Accredited managed healthcare fees are expensed as incurred and are categorised into fees for accredited managed healthcare services based on the accreditation by the Council for Medical Schemes of the managed healthcare service provider.

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

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

The Scheme allocates the expected premium receipts to each period of insurance contract services on the basis of the passage of time.

1.11 INSURANCE REVENUE

1.12 INVESTMENT INCOME

Investment income comprises dividends and interest on cash and cash equivalents and other financial assets at fair value through profit and loss. Interest income is recognised using the effective interest-rate method, taking into account the principal amount outstanding and the effective rate over the period to maturity, when it is determined that such income will accrue to the Scheme.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

Dividend income on investments is recognised when the right to receive payment has been established. This is the ex-dividend date for equity securities. Where dividend income accrues to the Scheme through unitised instruments, dividend and interest income is recognised after the units are sold and the income realised. Capitalisation shares received in terms of a capitalisation issue from reserves, other than share premium or a reduction in share capital, are treated as dividend income.

1.13 RETIREMENT BENEFITS

Defined contribution plan

The Scheme's employees belong to a defined contribution retirement fund, governed by the Pensions Fund Act, where the Scheme pays employee contributions to the fund. Once the contributions have been paid, the Scheme has no legal or constructive obligations to pay further contributions if the pension fund does not hold sufficient assets to pay all employees their entitlement. The pension contributions are recognised as staff remuneration when they are due and payable.

1.14 LEASES

Leases are categorised as operating leases. Income arising from leases is disclosed as net rental income over a straight-line basis over the period of the lease term. The leased property is included in the Statement of Financial Position according to its nature.

1.15 ADMINISTRATION FEES AND OTHER OPERATIVE EXPENSES

Administration expenses include administration fees, non-accredited managed care fees, Scheme expenses, Board and committee expenses, marketing, communication, internal new business consultant remuneration and expenses, and other expenses. These costs are expensed as incurred.

1.16 RE-PRESENTATION OF COMPARATIVE INFORMATION

1.16.1 INSURANCE ACQUISITION CASHFLOWS DISCLOSURE IN THE INSURANCE CONTRACT LIABILITY RECONCILIATION

In previous periods, insurance acquisition cash flows which are expensed when incurred were disclosed within the liability for remaining coverage (LRC) rather than the liability for incurred claims (LIC) in Note 8. The disclosure in Note 8 has been amended by restating the 2024 financial statement line items, as detailed below.

Impact of the Correction

The following tables summarise the impact of the correction on the Scheme's financial statements, specifically note 8. Insurance contract liability:

Note 8: Insurance Contract Liability

	As previously presented (R'000)	Adjustment (R'000)	As re-presented (R'000)
LRC excluding loss component	35 834	(35 834)	0
LIC Present value of future cashflows	0	35 834	35 834
	35 834	0	35 834

Conclusion

Management has corrected the classification in the current year and prior period comparatives. The correction has no impact on total insurance contract liabilities or profit or loss for any period presented.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

1.16.2 RELEVANT HEALTHCARE EXPENDITURE

Nature of the re-presentation

As required by CMS Circular 32 of 2025, "relevant healthcare expenditure" is presented as a separate line item and comprises net claims incurred, accredited managed healthcare services (no transfer of risk), and net income/(expense) from risk transfer arrangements /reinsurance.

Impact of the re-presentation

The re-presentation represents a change in presentation as per the below in the Statement of Comprehensive Income:

	(R'000)
Relevant healthcare expenditure	(2 288 036)

Conclusion

The revised presentation enhances the relevance, understandability and comparability of the financial statements and aligns with regulatory expectations.

1.16.3 AMOUNTS ATTRIBUTABLE TO MEMBERS FOR FUTURE BENEFITS

Insurance service expenses, in accordance with IFRS 17, were previously included amounts attributable to members for future benefits on the Statement of Comprehensive Income.

During the current financial year, Circular 6 of 2025 issued by the CMS introduced revised presentation requirements, requiring medical schemes to present amounts attributable to members for future benefits separately from insurance service expenses and the insurance service result.

Impact of the re-presentation

The re-presentation represents a change in presentation as per the below in the Statement of Comprehensive Income:

	As previously presented (R'000)	Adjustment (R'000)	As re-presented (R'000)
Insurance service expense: Amounts attributable to future members	180 594	(180 594)	-
Transfer to liability to members for future benefits	-	180 594	180 594
	180 594	0	180 594

Conclusion

The revised presentation aligns with the CMS regulatory requirements.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

2. PROPERTY, PLANT AND EQUIPMENT

	Land and buildings R'000	Office equipment & software R'000	Office furniture R'000	Motor vehicle R'000	Total R'000
31 December 2025					
Opening carrying amount	22 525	201	240	167	23 133
Acquisitions/improvements during the year	17	226	-	-	243
Disposals: Cost	-	(227)	(17)	-	(244)
Disposals: Accumulated depreciation	-	179	17	-	197
Depreciation charge	(880)	(196)	(125)	(80)	(1 280)
Closing carrying amount	21 662	184	115	87	22 048
Cost or valuation	29 660	1 289	704	400	32 053
Accumulated depreciation	(7 998)	(1 105)	(589)	(313)	(10 004)
Carrying amount	21 662	184	115	87	22 048
31 December 2024					
Opening carrying amount	23 186	415	282	247	24 130
Acquisitions/improvements during the year	214	57	19	-	290
Disposals: Cost	-	(31)	-	-	(31)
Disposals: Accumulated depreciation	-	23	-	-	23
Depreciation charge	(875)	(263)	(61)	(80)	(1 279)
Closing carrying amount	22 525	201	240	167	23 133
Cost or valuation	29 643	1 289	721	400	32 053
Accumulated depreciation	(7 118)	(1 088)	(481)	(233)	(8 920)
Carrying amount	22 525	201	240	167	23 133

No items of property, plant and equipment have been pledged as security.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

3. ANALYSIS OF CARRYING AMOUNTS OF FINANCIAL ASSETS AND LIABILITIES PER CATEGORY

	2025 R'000	2024 R'000
Financial assets at FVPL		
Non-current	1 559 320	1 201 794
Current	244 745	163 403
Financial assets at amortised cost		
Cash and cash equivalents	38 589	38 404
Accounts receivables	987	1 287
Financial assets at amortised cost		
Financial liabilities measured at amortised cost	14 802	9 019

4. FINANCIAL ASSETS

4.1 MOVEMENT IN FINANCIAL ASSETS

	Notes	2025 R'000	2024 R'000
Beginning of the year		1 365 197	1 154 285
Capital contribution		100 000	80 000
Withdrawals		-	(30 000)
Total gain		285 020	108 206
Net realised gain on financial assets	14	45 130	32 553
Unrealised fair value gain	14	239 889	75 653
Asset management fees	16	(4 464)	(3 841)
Interest from financial assets	14	48 506	47 053
Dividends	14	9 808	9 493
Fair value at the end of the year		1 804 065	1 365 197
Less current portion		(244 745)	(163 403)
Non-current portion at year-end		1 559 320	1 201 794

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

4.2 FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT AND LOSS

	Notes	2025 R'000	2024 R'000
Non-current			
Equity securities		827 524	561 571
Bonds and cash instruments		731 796	640 223
Total non-current	3	1 559 320	1 201 794
Current			
Bonds and cash instruments		244 745	163 403
Total current	3	244 745	163 403

5. ACCOUNTS RECEIVABLE

	2025 R'000	2024 R'000
Financial receivables	987	1 287
Total accounts receivable	987	1 287

As at 31 December 2025, the carrying amounts of accounts receivable approximated their fair value. Interest is not charged on overdue balances.

6. CASH AND CASH EQUIVALENTS

	2025 R'000	2024 R'000
Cash at bank and on hand	9 317	10 557
Short-term bank deposits	29 272	27 846
Total cash and cash equivalents	38 589	38 404

Cash and cash equivalents comprise cash on hand and deposits held with reputable financial institutions and are subject to low credit risk, as counterparties have strong external credit ratings. The carrying amounts of cash and cash equivalents approximate fair value due to their short-term nature.

The weighted average effective interest rate was 5.38% (2024: 6.15%) on cash and call account balances.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

7. LIABILITY TO MEMBERS FOR FUTURE BENEFITS

	2025 R'000	2024 R'000
Opening balance	1 269 581	1 088 986
Movement	356 628	180 594
Amount settled in the current year	-	-
	1 626 209	1 269 581

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

8. INSURANCE CONTRACT LIABILITY

	LRC excluding loss component R'000	LIC Present value of future cashflows R'000	LIC Risk adjustment R'000	Total R'000
31 December 2025				
Opening assets	(4 630)	(1 784)	-	(6 414)
Opening liabilities	7 946	143 356	4 533	155 835
Net opening balance	3 316	141 572	4 533	149 421
Changes in comprehensive income				
Insurance revenue	(2 687 758)	-	-	(2 687 758)
Insurance service expenses				
Incurred claims and other insurance service expenses	-	2 510 130	-	2 510 130
Adjustment to LIC	-	54 350	2 048	56 398
Insurance acquisition cash flows	-	37 661	-	37 661
Total amounts recognised in comprehensive income	-	2 602 141	2 048	2 604 189
Cash flows				
Premiums received	2 688 358	-	-	2 688 358
Claims and other insurance service expenses paid	-	(2 491 872)	-	(2 491 872)
Insurance acquisition cash flows paid	-	(37 661)	-	(37 661)
Total cash flows	2 688 358	(2 529 533)	-	158 825
Transfer to other items in the statement of financial position				
Closing assets	(5 160)	(880)	-	(6 039)
Closing liabilities	9 076	215 060	6 581	230 716
Net closing balance	3 916	214 180	6 581	224 677

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

8. INSURANCE CONTRACT LIABILITY (Continued)

Reconciliation of cashflows to Statement of Cashflows

Included in cash paid to providers, employers and members is:

Cash paid to providers and members	2 356 589
Insurance acquisition cash flows	37 661
Directly attributable expenses	135 281
	<u>2 529 533</u>



NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

8. INSURANCE CONTRACT LIABILITY (continued)

2025
R'000

Closing balance consists of:

Insurance contract receivables

Contributions outstanding	(5 160)
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Amounts due from members and providers	(880)
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Insurance contract payables

Credit balances in insurance contract payables	9 076
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Amounts due to members and providers	52 460
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Liability for incurred claims	162 600
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Risk adjustment	6 581
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Net closing balance	224 677
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LRC
excluding
loss
component
R'000

LIC
Present
value of
future
cashflows
R'000

LIC
Risk
adjustment
R'000

Total
R'000

31 December 2024

Opening assets	(6 304)	(827)	-	(7 131)
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Opening liabilities	9 358	173 239	5 022	187 619
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Net opening balance	3 054	172 412	5 022	180 487
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Changes in comprehensive income

Insurance revenue	(2 528 336)	-	-	(2 528 336)
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NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

8. INSURANCE CONTRACT LIABILITY (continued)

	LRC excluding loss component R'000	LIC Present value of future cashflows R'000	LIC Risk adjustment R'000	Total R'000
Insurance service expenses				
Incurred claims and other insurance service expenses	-	2 415 082	-	2 415 082
Adjustment to LIC		3 240	(489)	2 751
Insurance acquisition cash flows*	-	35 834	-	35 834
Total amounts recognised in comprehensive income	-	2 454 156	(489)	2 453 667
Cash flows				
Premiums received	2 528 598	-	-	2 528 598
Claims and other insurance service expenses paid	-	(2 449 161)	-	(2 449 161)
Insurance acquisition cash flows paid*	-	(35 834)	-	(35 834)
Total cash flows	2 528 598	(2 484 995)	-	43 603
Transfer to other items in the statement of financial position	-	-	-	-
Closing assets	(4 630)	(1 784)	-	(6 414)
Closing liabilities	7 946	143 356	4 533	155 835
Net closing balance	3 316	141 572	4 533	149 421

*Refer to Note 1.16 for further details.

Reconciliation of cashflows to Statement of Cashflows

Included in cash paid to providers, employers and members is:

Cash paid to providers and members	2 319 172
Insurance acquisition cash flows	35 834
Directly attributable expenses	129 989
	2 484 995

The above reconciliation has been provided in the current year due to communication from the CMS.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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8. INSURANCE CONTRACT LIABILITY (continued)

Closing balance consists of:

	2024 R'000
Insurance contract receivables	
Contributions outstanding	(4 630)
Amounts due from members and providers	(1 784)
Insurance contract payables	
Credit balances in insurance contract payables	7 946
Amounts due to members and providers	35 106
Liability for incurred claims	108 250
Risk adjustment	4 533
Net closing balance	149 421

9. ACCOUNTS PAYABLE

	2025 R'000	2024 R'000
Financial liabilities		
Sundry accounts payable	14 802	9 019
	14 802	9 019

As at 31 December 2025, the carrying amounts of accounts payable approximated their fair value because of the short-term maturities of these liabilities.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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10. ACCREDITED MANAGED HEALTHCARE SERVICES

	2025 R'000	2024 R'000
Dental benefit management	1 964	1 909
Disease risk management	4 419	4 227
Hospital pre-authorisation and case management	49 774	47 675
Pharmacy benefit and clinical risk management	13 381	13 118
Provider profiling	1 121	1 118
Trauma benefit management	345	345
	71 004	68 392

11. ATTRIBUTABLE EXPENSES INCURRED

	2025 R'000	2024 R'000
Fees paid to the Administrator	128 769	123 343
Broker remuneration management	1 472	1 411
Claims management	28 032	26 852
Contribution management	13 278	12 719
Customer services	29 941	28 680
Financial management	8 854	8 482
Information management and data control	34 859	33 389
Member record management	11 585	11 095
Third party claim recovery services	748	715
Actuarial fees	1 131	1 270
Benefit management services	3 493	3 571
Member communication expenses	1 890	1 805
	135 283	129 989

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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12. ADMINISTRATION AND OTHER OPERATIONAL EXPENDITURE

	Notes	2025 R'000	2024 R'000
Association fees		922	846
Bank charges		1 826	1 697
Computer expenses		1 654	1 877
Council for Medical Schemes expenses		1 753	1 689
Depreciation		1 280	1 280
External audit fees*		1 638	1 805
Audit services		1 638	1 805
Audit services		-	-
Fees paid to the Administrator		4 316	4 136
Internal audit services		2 158	2 068
Governance and compliance		2 158	2 068
Insurance		2 003	1 837
Legal fees		2 347	1 951
Marketing and communication expenses		35 599	30 786
Office rental		259	279
Principal Officer remuneration		6 320	6 065
Printing and stationery		808	878
Staff costs		9 709	8 695
Telephone and postage		27	24
Travel, accommodation and conferences		96	75
Trustee and committee member remuneration	17	4 540	4 348
Other expenses		877	1 211
		76 008	69 510

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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*The split for the fees paid to Deloitte & Touche are presented below

	Notes	2025 R'000	2024 R'000
Audit of the annual financial statements		1 493	1 652
Regulatory related services		96	52
Other assurance and related services performed under the standards as issued by the IAASB		49	101
		1 638	1 805

13. INSURANCE ACQUISITION CASHFLOWS

	2025 R'000	2024 R'000
Broker fees	18 171	17 000
Internal new business consultants' remuneration and expenses	19 490	18 834
	37 661	35 834

No distributions other than broker fees were paid to independent brokers.

14. INVESTMENT INCOME

	2025 R'000	2024 R'000
Dividend income on assets held at fair value through profit and loss	9 808	9 493
Interest income	61 057	59 449
Assets held at fair value through profit and loss	48 506	47 053
Call and current bank accounts	12 552	12 396
Net realised gain on assets held at fair value through profit and loss	45 130	32 553
Net unrealised gain on assets held at fair value through profit and loss	239 889	75 653
Net rental income	796	2 224
	356 680	179 372

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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15. SUNDRY INCOME

	2025 R'000	2024 R'000
Prescribed amounts included in income	550	796
Profit/ (loss) on disposal of equipment	1	18
Profit/ (loss) on disposal of equipment	362	444
	913	1 258

16. ASSET MANAGEMENT FEES

	2025 R'000	2024 R'000
Management fees	4 464	3 841
Consulting fees	1 584	1 295
	6 048	5 136

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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17. TRUSTEE AND COMMITTEE MEMBER REMUNERATION

The following table records the remuneration paid to, and considerations paid for, trustees and other committee members during 2025:

31 December 2025	Fees for meeting attendance R	Travel and Accommodation R	VAT R	TOTAL R
Adv JJ Crouse	713 696	27 332	-	741 028
Mr HP du Toit	355 975	14 696	-	370 671
Mr GS Harvey**	426 708	22 596	-	449 304
Ms NE Jandrell	153 275	7 562	-	160 837
Prof CA Joseph	392 800	7 815	-	400 615
Ms ND Maida	345 400	7 514	-	352 914
Mr PL Marais*	94 106	-	-	94 106
Ms K Naidu *	70 988	-	-	70 988
Dr Y Omar Carrim *	85 225	-	-	85 225
Mr J Prinsloo *	85 225	-	-	85 225
Ms KPM Simelane	319 050	7 767	-	326 817
Mr E Steenkamp	62 738	-	-	62 738
Mr RN Theunissen *	153 350	-	21 825	175 175
Dr J Welgemoed	441 100	14 366	63 996	519 461
Dr HA Woerman	228 113	15 993	-	244 106
Mr AHG Wright	325 050	26 157	49 126	400 332
Total	4 252 799	151 797	134 947	4 539 542

* Independent Board committee members

** The chairperson's fee is for holding office

Trustee appointment, election and resignation dates are disclosed in the Corporate Governance report.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

17. TRUSTEE AND COMMITTEE MEMBER REMUNERATION (Continued)

The following table records the remuneration paid to, and considerations paid for, trustees and other committee members during 2024:

31 December 2025	Fees for meeting attendance R	Travel and Accommodation R	VAT R	TOTAL R
Adv JJ Crouse	375 154	24 400	-	399 554
Mr HP du Toit	377 360	20 115	-	397 475
Prof Gumede	126 525	-	-	126 525
Mr GS Harvey**	973 285	24 678	-	997 963
Ms NE Jandrell	423 420	15 091	-	438 511
Mr M Jeena	126 525	-	-	126 525
Prof CA Joseph	365 585	9 398	-	374 983
Ms ND Maidi	285 740	7 796	-	293 536
Mr PL Marais*	77 591	-	-	77 591
Ms K Naidu *	51 728	-	-	51 728
Dr Y Omar Carrim *	53 480	-	-	53 480
Mr J Prinsloo *	80 955	-	-	80 955
Ms KPM Simelane	231 468	18 118	-	249 586
Mr E Steenkamp	51 728	-	-	51 728
Mr RN Theunissen *	138 150	-	20 723	158 873
Dr J Welgemoed	384 160	26 805	57 953	468 918
Total	4 122 854	146 401	78 676	4 347 931

* Independent Board committee members

** The chairperson's fee is for holding office

Trustee appointment, election and resignation dates are disclosed in the Corporate Governance report.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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18. NET SURPLUS/(DEFICIT) PER BENEFIT OPTION

The Scheme offered five benefit options in 2025. The principal features of each option are explained in the Business Model on page 14.

The benefit options performed as follows:

2025	ProPinnacle R'000	ProSecure Plus R'000	ProSecure R'000	ProActive Plus R'000	ProSelect R'000	Total R'000
Insurance revenue	240 568	253 189	686 372	888 730	618 899	2 687 758
Insurance service expenses	(258 013)	(256 919)	(709 462)	(842 667)	(539 606)	(2 606 667)
Claims incurred	(245 093)	(235 933)	(654 677)	(721 426)	(449 192)	(2 306 321)
Adjustments to the LIC	(5 311)	(7 267)	(11 323)	(24 759)	(7 738)	(56 398)
Insurance acquisition cash flows	(1 174)	(2 117)	(6 705)	(14 897)	(12 768)	(37 661)
Third-party claim recoveries	-	-	-	-	-	-
Accredited managed healthcare services	(2 213)	(3 991)	(12 642)	(28 086)	(24 072)	(71 004)
Attributable expenses incurred	(5 311)	(7 267)	(11 323)	(24 759)	(7 738)	(56 398)
Insurance acquisition cash flows	(4 222)	(7 611)	(24 115)	(53 499)	(45 836)	(135 283)
Insurance service result	(17 445)	(3 730)	(23 090)	46 063	79 293	81 091
Other income						
Investment income	11 116	20 046	63 504	141 088	120 926	356 680
Sundry income	28	51	163	361	310	913
Other expenditure						
Administration fees and other operative expenses	(2 364)	(4 262)	(13 504)	(30 079)	(25 799)	(76 008)
Asset management fees	(188)	(340)	(1 077)	(2 392)	(2 051)	(6 048)
Net (deficit) /surplus	(8 853)	11 765	25 996	155 041	172 679	356 628
Average number of members during the year	1 062	1 915	6 067	13 479	11 553	34 077

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

18. NET SURPLUS/(DEFICIT) PER BENEFIT OPTION (Continued)

2024	ProPinnacle R'000	ProSecure Plus R'000	ProSecure R'000	ProActive Plus R'000	ProSelect R'000	Total R'000
Insurance revenue	234 585	237 952	661 143	801 272	593 384	2 528 336
Insurance service expenses	(270 659)	(237 137)	(718 196)	(701 458)	(526 276)	(2 453 726)
Claims incurred	(262 512)	(224 705)	(671 235)	(610 967)	(447 479)	(2 216 898)
Adjustments to the LIC	(416)	906	(3 722)	(555)	1 036	(2 751)
Insurance acquisition cash flows	(1 182)	(2 040)	(6 631)	(13 763)	(12 218)	(35 834)
Third-party claim recoveries	-	-	120	-	18	138
Accredited managed healthcare services	(2 256)	(3 894)	(12 656)	(26 267)	(24 072)	(71 004)
Attributable expenses incurred	(5 311)	(7 267)	(11 323)	(24 759)	(23 319)	(68 392)
Insurance acquisition cash flows	(4 293)	(7 404)	(24 072)	(49 906)	(44 314)	(129 989)
Insurance service result	(36 074)	821	(57 053)	99 814	67 108	74 610
Other income						
Investment income	5 918	10 212	33 194	68 891	61 156	179 372
Sundry income	42	72	233	483	429	1 258
Other expenditure						
Administration fees and other operative expenses	(2 289)	(3 954)	(12 846)	(26 716)	(23 704)	(69 510)
Asset management fees	(169)	(292)	(950)	(1 972)	(1 751)	(5 136)
Net (deficit) /surplus	(32 572)	6 853	(37 422)	(140 500)	103 238	180 594
Average number of members during the year	1 131	1 952	6 346	13 171	11 692	34 292

The allocation of the attributable expenses incurred across the options is based on the average number of principal members per option during the year.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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19. RELATED PARTY TRANSACTIONS

Administration agreement

Administration fees were paid to the Administrator, PPS Healthcare Administrators, a wholly owned subsidiary of PPS Insurance Company Limited. Administration fees were charged in line with market-related rates. The Administrator is deemed to form part of key management personnel of the Scheme as it participates in financial and operating policy decisions but does not control the Scheme. A division of the Administrator also provides accredited managed healthcare services.

Transactions with related parties

	Notes	2025 R'000	2024 R'000
Statement of Comprehensive Income			
PPS Healthcare Administrators			
Administration fees	11	133 086	127 479
Hospital pre-authorisation and case management	10	49 774	47 675
Disease risk management	10	4 419	4 227
Provider profiling	10	1 121	1 118

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

The administration agreement is in terms of the Rules of the Scheme and in accordance with instructions given by the Board. The agreement is automatically renewed each year unless notification of termination is received or following the cancellation of the Administrator's accreditation or the issue of a lawful directive to this effect by the Council for Medical Schemes in terms of the Medical Schemes Act 131 of 1998, as amended.

Key management personnel and their close family members

The Scheme is controlled by the Board; fifty percent of whom are elected by the members of the Scheme and fifty percent are appointed by the Board.

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the trustees and the Principal Officer. The disclosure deals with full-time personnel that are compensated on a salary basis (Principal Officer) and parttime personnel that are compensated on a fee basis (trustees and independent committee members). Close family members include close family members of the trustees and the Principal Officer.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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Transactions with key personnel (trustees and Principal Officer) and their close family members

	2025 R'000	2024 R'000
Statement of Comprehensive Income		
Remuneration	10 860	10 413
Principal Officer and Board of Trustees	10 349	9 990
Independent committee members	511	423
Contributions received	766	713
Claims incurred	523	534

The terms and conditions of the transactions with related parties, other than the administrator, were as follows:

Transaction	Nature of transactions and terms and conditions thereof
Contributions received:	These are the contributions paid by the related parties as members of the Scheme in their individual capacities. All contributions were on the same terms as applicable to other members.
Claims incurred:	These are amounts claimed by the related parties as members of the Scheme in their individual capacities. All claims were paid in terms of the Rules of the Scheme, as applicable to other members.
Contribution debtor:	These are outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts.
Claims reported not yet paid:	These are claims that have been reported but not yet paid due to the fact that the Scheme's year-end fell between the claim payment runs. All claims are settled within 30 days of being received, as applicable to third parties or other members.

20. COMMITMENTS

The Scheme had not made any commitments for future capital or lease payments as at year-end.

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21. FINANCIAL RISK MANAGEMENT

21.1 Financial risk factors

The Scheme's activities expose it to a variety of financial risks, including the effects of changes in the equity market price, credit risk and interest rates. In particular, the key financial risk is that the proceeds from its financial assets are not sufficient to fund the obligations arising from its insurance contracts. The most important components of this financial risk are liquidity risk, credit risk, interest rate risk and market risk. The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potentially adverse effects on the financial performance of the investments which the Scheme holds to meet its obligations to its members.

Risk management and investment decisions are carried out by the Investment Committee in terms of recommendations which are approved by the Board. The Committee identifies and evaluates financial risks associated with the Scheme's investment portfolio.

The Board provides written principles for overall risk management, as well as written policies covering specific areas, such as interest rate risk, credit risk, use of derivative financial instruments and investing excess liquidity. The Board approves all of these written policies.

21.2 Market risk

a) Interest rate risk

Interest rate risk is the Scheme's exposure to changes in interest rates. The main exposure to the Scheme would be a reduction in interest income on investments if interest rates were to decrease.

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

The table below summarises the Scheme's exposure to interest rate risk. Included in the table are the Scheme's money market securities, derivatives and swaps, fixed deposits, deposits on call and current bank accounts at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

	Up to 3 months R'000	4 - 12 months R'000	1 - 5 years R'000	Total R'000
2025				
Total exposure	73 508	141 986	799 636	1 015 131
2024				
Total exposure	131 801	70 006	640 223	842 030

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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These amounts are classified as follows:

	Notes	2025 R'000	2024 R'000
Financial assets			
- Non-current	4	559 320	1 201 794
- Current	4	244 745	163 403
- Cash and cash equivalents	6	38 589	38 404
		1 842 654	1 403 601

Interest rate risk sensitivity analysis

A change of 100 basis points in interest rates at the reporting date would have increased/(decreased) the amounts attributable to future members to the amounts shown below. The analysis assumes that all other variables remain constant.

	Amounts attributable to members (R'000)		Insurance contract liability to members (R'000)	
	100bp increase	100bp increase	100bp increase	100bp increase
2025	(40 032)	43 828	64 614	165 999
2024	(44 228)	48 947	131 628	(21 709)

b) Currency risk

All of the Scheme's investments and benefits are Rand-denominated and therefore do not have significant net currency risk. The scheme is exposed to currency risk related to drugs and appliances being imported. The weakening of the Rand will have an adverse effect on the claims experience of the Scheme.

c) Price risk

The Scheme is exposed to equity securities price risk because of investments held by the Scheme and classified in the Statement of Financial Position as Financial assets at fair value through profit and loss. The Scheme is not exposed to commodity risk. To manage the price risk arising from investment in equity securities, the Scheme diversifies its portfolio within the limits prescribed by the Medical Schemes Act and Regulations.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

The table below summarises the Scheme's exposure to equity securities price risk:

	Up to 1 month R'000	1 - 3 months R'000	4 - 12 months R'000	1 - 5 years R'000	Total R'000
2025					
Total exposure	-	-	-	827 524	827 524
2024					
Total exposure	-	-	-	561 570	561 570

21.3 Credit risk

Credit risk is the risk of loss arising from the inability of a third party to service its contractual obligations. The Scheme's principal financial assets are cash and cash equivalents, accounts receivable and investments. The Scheme's credit risk relates primarily to its trade and other receivables, investments and cash and equivalents.

The receivables are in respect of:

- contributions due from members;
- amounts recoverable from members and service providers; and
- accrued interest.

The Scheme manages credit risk by:

- actively pursuing all contributions not received after three days of becoming due, as required by Section 26(7) of the Medical Schemes Act 131 of 1998, as amended;
- suspending benefits on all member accounts when contributions have not been received for 30 days;
- terminating benefits on all member accounts when contributions have not been received for 60 days; and
- ageing and pursuing unpaid accounts monthly.

The amounts presented in the Statement of Financial Position are net of provision for impairment, estimated by the Scheme's management, based on prior experience and the current economic environment.

All of the Scheme's debt investments at amortised cost and FVPL are considered to have low credit risk, and the loss allowance recognised during the period was therefore limited to 12 months' expected losses. Management considers 'low credit risk' for listed bonds to be an investment grade credit rating with at least one major rating agency. Other instruments are considered to be low credit risk when they have a low risk of default, and the issuer has a strong capacity to meet its contractual cash flow obligations in the near term.

The credit risk on liquid funds is limited because the counter-parties are banks with high credit ratings assigned by international credit rating agencies. There is no significant concentration of credit risk with respect to receivables as the Scheme has many members who are nationally dispersed.

The Scheme only dealt with financial institutions demonstrating strong creditworthiness. At year-end the major financial institutions that the Scheme contracted with had the following credit ratings as assessed by Standard & Poor's:

ABSA Bank	BB
FirstRand Holdings	BB
Investec Ltd	BB
Nedbank	BB
Standard Bank	BB

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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Exposure to credit risk

For the disclosure of the maximum exposure to credit risk on Accounts receivable, financial assets and Cash and cash equivalents, refer to Note 3.

Accounts receivable that are less than sixty days past due are not considered impaired. The ageing analysis of these receivables is as follows:

	Notes	2025 R'000	2024 R'000
Fully performing		987	1 287
Past due: 4 - 30 days		-	-
Past due: 31 days and older		-	-
Total accounts receivable		987	1 287
Provision for doubtful debts		-	-
	5	987	1 287

The asset managers' credit investment process comprises three distinct yet interrelated aspects:

- **Bottom-up fundamental credit analysis**

Potential investment is deal-screened, which entails a high-level review of quantitative (business financials) and qualitative (market positioning, competition and quality of management) factors. A full review entails a detailed fundamental analysis of the investment and the submission of a credit report to the credit investment committee for consideration and approval. Investments approved become part of the potential investment universe and they are continually monitored.

- **Top-down macro-economic**

Systematically evaluates and scores each macroeconomic factor that may have an impact on the portfolio. Also influences the overall exposure of the funds, strongly influencing both buy and sell decisions.

- **Market factor analysis and portfolio construction (which incorporates risk management)**

Investment decisions are made within a defined risk framework. Given the downside risk inherent in credit, it is critically important to limit exposure to vulnerable sectors that are more defensive or positioned to strengthen.

21.4 Liquidity risk

The Scheme manages liquidity risk by monitoring cash flows. The Scheme is exposed to daily calls on its available cash resources, mainly from claims. Liquidity risk is the risk that cash may not be available to pay obligations when they are due, at a reasonable cost, under normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation. To meet the conflicting objective of enhancing returns while also providing high liquidity, the combined Scheme portfolios have explicit constraints that guarantee liquidity of at least 20% of the Scheme assets within a week.

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

Approximately 96% of the Scheme's insurance claims liabilities are settled within three months after the claim was incurred and the balance of the claim's liability is settled within six months.

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	2025 R'000	2024 R'000
Cash and cash equivalents	38 589	38 404
Accounts receivable	987	1 287
Current portion of financial assets	244 745	163 403
Total current assets	284 321	203 094

	0 -12 months R'000	+12 months R'000	Total R'000
31 December 2025			
Maturity of financial assets			
Financial assets at fair value through profit and loss	244 745	1 559 320	1 804 065
Accounts receivable	987	-	987
Cash and cash equivalents	38 589	-	38 589
Maturities of financial liabilities and insurance contract liabilities			
Accounts payable	14 802	-	14 802
Insurance contract liability to current members	224 677	-	224 677
Insurance contract liability to future members	-	1 626 210	1 626 210
31 December 2024 - Restated			
Maturity of financial assets*			
Financial assets at fair value through profit and loss	163 403	1 201 794	1 365 197
Accounts receivable	1 287	-	1 287
Cash and cash equivalents	38 404	-	38 404
Maturities of financial liabilities and insurance contract liabilities			
Accounts payable	9 019	-	9 019
Insurance contract liability to current members	149 421	-	149 421
Insurance contract liability to future members	-	1 269 581	1 269 581

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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*The above liquidity risk analysis has been amended to include financial assets. This addition to the disclosure is per communication from the CMS. The comparatives have been restated

21.5 Capital management

The Scheme's objectives when managing capital are to maintain the capital requirements of the MSA and to safeguard the Scheme's ability to continue as a going concern to provide benefits for its stakeholders.

The risk is that there could be insufficient reserves to provide for adverse variations on actual and future experience. The MSA requires a minimum ratio of accumulated funds (Insurance contract liability to members) expressed as a percentage of gross premiums (insurance revenue) to be 25%. The Scheme's ratio was 43.4% as at 31 December 2025 (2024: 41.5%).

21.6 Investment risk

Investment risk is the risk that the investment returns on accumulated assets will not be sufficient to cover future liabilities. Continuous monitoring takes place to ensure that appropriate assets are held where the Scheme's liabilities are dependent upon the performance of the investment portfolio and that a suitable match of assets exists for all liabilities.

The performance of this portfolio is measured against the JSE All Share Index. The table below indicates the sensitivity of the amounts attributable to future members of the Scheme to movement in the JSE All Share Index assuming that the movement of the market is realised:

	Amounts attributable to future members R'000					
	Increase in market			Decrease in market		
	30%	15%	5%	5%	15%	30%
2025	414 474	388 935	372 038	355 233	338 511	313 568
2024	212 830	199 961	191 477	183 106	174 783	162 345

The fair values of financial assets by hierarchy level are:

	Level 1 R'000	Level 2 R'000	Level 3 R'000	Re- classification
2025				
Financial assets at fair value through profit and loss	827 524	799 636	-	-
2024				
Financial assets at fair value through profit and loss	561 570	803 627	-	-

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For financial assets carried at fair value, the allocation of fair value measurements into the fair value hierarchy is reflective of the significant inputs used in making the measurements. The fair value hierarchy is based on the following levels:

- Level 1:** Where inputs are determined directly by reference to published price quotations (unadjusted) in an active market for identified instruments;
- Level 2:** Where inputs other than published price quotations included in Level 1 that are observable for assets, either directly (i.e. as prices) or indirectly (i.e. derived from prices), are used;
- Level 3:** Where the fair values are determined using a valuation technique based on assumptions that are not supported by observable market data.

21.7 Structured entities

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

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

Investee fund	Net asset value of investee fund R	Fair value of Scheme's share of net asset of investee fund R	% of Scheme's share of investee fund's net assets %
M&G Life Core Equity (Capped SWIX) Fund (PROCCX)	2 054 561 603	335 333 277	16.32%
M&G Life Global Fixed Income Fund (PRFGFI)	45 780 192	45 774 291	99.99%
Abax Equity Prescient Fund	6 996 515 045	302 982 809	4.33%
Ninety One Stable Money	2 363 296 625	254 611 136	10.77%
Ninety One Dynamic Bond	441 422 976	441 422 976	100.00%
Ninety One MAC	276 536 023	63 365 597	22.91%
Ninety One PROILB	51 440 640	51 440 640	100%
Old Mutual CAPI Tracker Fund	8 606 550 503	124 393 212	1.45%

The strategy of the investee funds provides exposure to the South African equity market. The Scheme is not exposed to any further risks of financial loss beyond the fair value of its share in the investee funds as outlined in the table above.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

22. CRITICAL ACCOUNTING JUDGEMENTS AND AREAS OF KEY SOURCES OF ESTIMATION UNCERTAINTY

The Scheme makes estimates and assumptions that affect the reported amounts of assets and liabilities within the next financial year. Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

Key assumptions concerning the future and other key sources of estimation uncertainty at the Statement of Financial Position date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities in the next financial year, are discussed below.

22.1 Significant judgements

22.1.1 Mutual entity considerations

A medical scheme is not legally defined as a mutual entity and the assessment as to whether the Scheme is a mutual entity was done based on the principles set out in IFRS.

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

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

Although the rules do not specify how the assets should be distributed on liquidation, 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 contributions, or payment to members on liquidation (based on votes taken by members).

It is therefore expected that the remaining assets of the Scheme will be used to pay current and future members. Based on the above, the Scheme meets the definition of a mutual entity in IFRS. The Scheme has therefore developed an accounting policy in terms of the IFRS 17 guidance for mutual entities and the educational material as issued by the IASB and the Scheme recognises any cumulative profit or losses as part of the insurance liability attributable to future members (which forms part of the insurance contract liabilities on the face of the statement of financial position).

Consequently, the statement of 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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

22.1.2 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 on a Scheme level.

22.1.3 Liability for incurred claims

The liability for incurred claims is a provision made for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme by that date. Additionally, under IFRS 17, the risk adjustment reflects the compensation that an entity requires for bearing the uncertainty, with respect to the amount and timing of the cashflows that arise from non-financial risks. This provision is determined as accurately as possible based on a number of factors, which include previous experience in claims patterns, claims settlement patterns, changes in the nature and number of members according to trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim.

The risk adjustment reflects the compensation that an entity requires for bearing the uncertainty, with respect to the amount and timing of the cashflows that arise from non-financial risks. This risk adjustment should reflect the risk that the Scheme is bearing for the uncertainty of timing, severity and number of reported cashflows. The risk adjustment compensates a medical scheme for bearing non-financial risks such as claims risk, the risk of uncertainty with respect to the severity, frequency and timing of claims. A bootstrapping model is used to determine the risk adjustment for non-financial risk. The methodology of the model is:

- The risk adjustment for non-financial risk on the LIC is calculated at an option level and combined to determine the risk adjustment at a scheme level.
- The confidence level has been set at 75% to reflect the risk tolerance of the IBNR provision.

The Scheme has chosen not to disaggregate changes in the risk adjustment and as such will disclose the changes in the insurance service result.

22.2 Significant estimates

22.2.1 Estimates of future cash flows to fulfil insurance contracts

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

Each scenario specifies the amount, timing and probability of cash flows. The probability weighted average of the future cash flows is calculated using a deterministic scenario representing the probability weighted mean of a range of scenarios.

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

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

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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22.2.2 Methods used to measure the insurance contracts

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

Judgement is involved in assessing the most appropriate technique to estimate insurance liabilities for the claims incurred. The generally accepted actuarial methodology used in assessing the estimated claims outcome of insurance liabilities is the chain ladder method.

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

Run-off triangles are used in situations where it takes time after the treatment date for the full extent of the claims to become known. It is assumed that payments will emerge in a similar way in each service month. The proportional increase in known cumulative payments from one development month to the next can then be used to calculate payments for future development months.

The following was considered when estimating the LIC:

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

23. INSURANCE RISK MANAGEMENT

The primary insurance activity carried out by the Scheme is assuming the risk of loss from members and their dependants as a result of claims that are directly subject to the risk. These risks relate to the insured healthcare events of the Scheme's members. As such the Scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contracts. The Scheme also has exposure to market risk through its insurance and investment activities.

The Board has developed and approved a documented policy for the acceptance and management of insurance risk to which the Scheme is exposed. Reference has also been made to the requirements of the MSA in compiling the insurance risk management policy. This policy is reviewed annually and the benefit options available to the members are structured to fall within the acceptable insurance risk levels specified. The annual business plan is structured around the insurance risk management policy.

The Scheme manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, protocols as well as the monitoring of emerging legislative, environmental and actuarial issues.

The Scheme uses several methods to assess and monitor insurance risk exposure, both for individual types of risks insured and overall risks. These methods include internal risk measurement models, regular comparison of budgeted versus actual claims, sensitivity analyses, scenario analyses and stress testing. The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts, using established actuarial principles. The principal risk is that the frequency and severity of claims is greater than expected. Insurance events are, by their nature, random and the actual number and size of events during any one year may vary from those estimated using established statistical techniques.

The table below summarises the concentration of insurance risk, with reference to the carrying amount of the insurance claims incurred, by age group and in relation to the type of risk covered and benefits provided.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

Concentration of insurance risk

Claims incurred for services rendered in the 2025 year were as follows:

Age grouping (in years)	In-hospital R'000	Chronic R'000	Day-to-day R'000	Other R'000	Total R'000
< 26	146 465	7 496	23 589	23 314	200 864
26 - 34	91 877	13 307	13 868	20 420	139 472
35 - 49	150 923	26 764	22 762	40 449	240 898
50 - 64	305 677	56 914	45 436	72 540	480 567
> 65	811 769	163 620	112 862	158 670	1 246 920
Total	1 506 710	268 100	218 518	315 393	2 308 722
Other claims adjustments					(2 401)
Claims incurred					2 306 321

Claims incurred for services rendered in the 2024 year were as follows:

Age grouping (in years)	In-hospital R'000	Chronic R'000	Day-to-day R'000	Other R'000	Total R'000
< 26	137 118	8 937	24 835	22 060	192 950
26 - 34	91 430	12 655	13 472	19 534	137 091
35 - 49	146 993	24 161	23 001	37 647	231 802
50 - 64	325 097	59 398	45 469	73 839	503 803
> 65	749 110	143 866	107 241	152 982	1 153 199
Total	1 449 747	249 017	214 019	306 062	2 218 845
Other claims adjustments					(2 067)
Claims incurred					2 216 898

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

CONTINUED

- **In-hospital** benefits cover all costs incurred by members while they are in hospital to receive pre-authorised treatment for medical conditions.
- **Chronic benefits** cover the cost of certain prescribed conditions or medicines consumed by members for chronic conditions/diseases, such as high blood pressure, cholesterol and asthma.
- **Day-to-day** benefits provide cover for out-of-hospital medical attention, such as visits to general practitioners and dentists, and prescribed acute medicines.

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

All the contracts are annual in nature and the Scheme has the right to change the terms and conditions of the contracts at renewal. Management information, including contribution income and claims ratios by option, target market and demographic split, is reviewed monthly. There is also an underwriting review programme that reviews a sample of contracts on a quarterly basis to ensure adherence to the Scheme's objectives.

Sensitivity analysis to insurance risk variables

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

The table below indicates how sensitive the Scheme's results are to changes in the claims experience:

	Change in variable	2025 R'000	2024 R'000
<i>Amounts attributable to future members Insurance contract liabilities</i>			
Insurance service expenses	5% higher	130 333	122 683
		2025 R'000	2024 R'000
Risk adjustment with a 75% confidence level – as reported		6 581	4 533
Risk adjustment with a 80% confidence level		10 003	6 419

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

Claims development

Claims development tables have not been presented as the uncertainty regarding the amounts and timing of claims payments is typically resolved within a year. In the majority of cases, claims are resolved within four months from the time they are reported to the Scheme.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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At year-end, a provision is made for those claims outstanding that have not yet been reported as well as a risk adjustment to reflect the risk that the Scheme is bearing for the uncertainty of timing, severity and number of reported cashflows. The risk adjustment compensates a medical scheme for bearing non-financial risks such as claims risk, the risk of uncertainty with respect to the severity, frequency and timing of claims.

24. CONTINGENT ASSET

The Scheme grants assistance to its members in defraying expenditure incurred in connection with the rendering of any relevant health service. Such expenditure may be in connection with a claim that is also made to the Road Accident Fund (RAF), administered in terms of the Road Accident Fund Act No. 56 of 1996. If the member is reimbursed by the RAF, the member is obliged contractually to cede that payment to the Scheme to the extent that they have already been compensated. The outstanding claims at year-end amounted to R54.3 million (2024: R52.1 million).

25. NON-COMPLIANCE MATTERS

- 25.1 In terms of Section 26(7) of the Medical Schemes Act 131 of 1998, contribution income shall be received within three days of becoming due. There were instances where the Scheme did not receive all contributions within three days of becoming due. The Scheme has implemented and continues to apply a rigorous debt collection process to recover outstanding contributions and to mitigate the risk of non-compliance on an ongoing basis.
- 25.2 In terms of Section 33(2) of the Medical Schemes Act 131 of 1998, each benefit option shall be selfsupporting in terms of membership and financial performance and be financially sound. At the end of the year, the ProPinnacle option, incurred an operational deficit (amounts attributable to future members less other income and asset management fees). This deficit was anticipated and arose primarily from buy-down risk, including anti-selection by members migrating to more affordable options, as well as higher than expected claims experience. Loss-making options are subject to higher annual contribution increases in order to restore financial sustainability over time.
- 25.3 In terms of Section 35(8) of the Medical Schemes Act 131 of 1998, a medical scheme shall not invest any of its assets in a medical scheme administrator. The Scheme, through one of its unit trust investments, had investments in a medical scheme administrator. The Scheme was granted exemption from this requirement by the CMS.
- 25.4 In terms of Section 59(2) of the Medical Schemes Act 131 of 1998, a valid claim submitted to the Scheme should be paid within 30 days after the day on which the claim was received. The Scheme's policy is to settle all claims supported by valid documentation within 30 days and there are processes in place to monitor this. In limited instances, due to technical issues, claims were paid after 30 days from receipt. The specific reasons for these delays have been identified and rectified.

26. SUBSEQUENT EVENTS

No adjusting or non-adjusting events have occurred between the accounting date and the date of this Report that would affect the 2025 results.

27. GOING CONCERN

The financial statements have been prepared on the basis of accounting policies applicable to a going concern. This basis presumes that funds will be available to finance future operations and that the realisation of assets and settlement of liabilities and commitments will occur in the ordinary course of business.



SCHEME INFORMATION

1. REGISTERED ADDRESS AND THIRD-PARTY SERVICE PROVIDER DETAILS

1.1 Registered office address and postal address

Profmed Place
15 Eton Road
Parktown, Johannesburg

Postnet Suite #351
Private Bag X30500
Houghton
2041

1.2 Administrator

PPS Healthcare Administrators
(Accreditation no. Admin 37)
PPS Centurion Square
1262 Heuwel Avenue
Centurion

Private Bag X103
Lyttelton
10140

1.3 Auditors

Deloitte and Touche
The Deloitte Building -
5 Magwa Crescent
Waterfall City
Johannesburg

Private Bag X6
Sunninghill
2157

1.4 Investment advisors

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(Financial Service Provider no. 2545)
1st Floor, Illovo Edge
1 Harries Road
Illovo

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Private Bag X1
Melrose Arch
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1.5 Actuaries

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Midrand

Private Bag X17
Halfway House
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1.6 Attorneys

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Profmed App: Download from your smartphone store
Walk-in centres: PPSHA, PPS Centurion Square, 1262 Heuwel Avenue, Centurion



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PROFMED

Notice of 55th Annual General Meeting

Notice to members

Notice is hereby given that the 55th Annual General Meeting of the members of Profmed will take place on Wednesday 03 June 2026 at 15:30. The meeting will be held on a virtual meeting platform, details of which will be communicated to members.

AGENDA

- 1 To receive and adopt the annual financial statements for the year ended 31 December 2025 (including the reports of the trustees, the Audit and Risk Committee and the auditor).
- 2 To approve the appointment of Auditors for the year ending 31 December 2026.
- 3 To accept the Profmed Remuneration Policy by means of a non-binding advisory vote.
- 4 To approve the remuneration of trustees for the 2026/2027 year.
- 5 To announce the election of three (3) trustees in accordance with rule 20.1.2. The Board (including the retiring trustees) currently comprises a medical specialist, a general practitioner, a dentist, an advocate, an accountant, an actuary, and a human resources specialist. In calling for nominations, trustees were urged to consider that the Board should be representative of the membership of Profmed, the race demographics of South Africa, and gender representation.
- 6 To transact such other business as may be transacted at the Annual General Meeting (subject to the Rules of Profmed and in particular rule 28.1.6, and the provisions of the Medical Schemes Act No. 131 of 1998, as amended).

The Remuneration Policy and the trustee remuneration document are available at www.profmed.co.za.

By order of the Board of Trustees.

Craig W Comrie
Principal Officer and Chief Executive